District Health Accounts for Surkhet, Nepal

Fiscal Years 2005/06 and 2006/07

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The first Nepal National Health Account (NNHA) has been documented in December 2006 and it has been used as a tool specifically designed to inform the health policy process, including policy design and implementation, policy dialogue, and the monitoring and evaluation of health care interventions. As country has committed to decentralized health services, the resources spent at each level have to be carefully studied. Financial cuts have occurred in primary health care units for the higher level tertiary care providers. A holistic political and economic decentralization is desirable but there remains a major role for central guidance, standards and evaluation in an accountable manner for better functioning of peripheral health system.

In this context, developing District Health Account (DHA) is essential to make the district health expenditure more effective, efficient and sustainable way. The NNHA framework of the Government of Nepal (GoN) was adopted in the development of the DHA. This was intended to facilitate comparison and establish a link with the NNHA. Therefore, MoHP has selected Surkhet district for developing DHA. The DHA data provided concrete estimates of how much was spent for health care in the district, where the resources for health care in Surkhet came from, where these resources went, what kinds of health care were paid for, and at least for expenditures at household level, who were benefited from the use of these resources.

This study has demonstrated how the DHA as a tool can be developed and generated at district level, and illustrated the usefulness of the exercise and used the experience as a stepping-stone towards creating an enabling environment for long-term DHA work under decentralized settings.

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Abbreviations

CBO	Community Based Organization
CBS	Central Bureau of Statistics
DDC	District Development Committee
DHA	District Health Accounts
DHO	District Health Office
EDP	External Development Partners
FCHV	Female Community Health Volunteers
FHCP	Free Health Care Policy
GoN	Government of Nepal
HDI	Human Development Index
HH	Households
INGO	International Non-Governmental Organizations
MWDR	Mid-Western Development Region
MoHP	Ministry of Health and Population
NGO	Non-Governmental Organizations
NHP	National Health Policy
NLSS	Nepal Living Standard Survey
NNHA	Nepal National Health Account
NPC	National Planning Commission
NRs	Nepali Rupees
OECD	Organization for Economic Cooperation and Development
OOP	Out of Pocket
PHCC	Primary Health Care Centers
RDO	Regional Directorate Office
RoW	Rest of the World
RoNE	Rest of the Nepal Economy
SHP	Sub-Health Posts
SLTHP	Second Long Term Health Plan
TBA	Traditional Birth Attendants
VDC	Village Development Committees
WHO	World Health Organization

Executive Summary

Ministry of Health & Population (MoHP) initiatives to record and manage information in terms of health care finance, providers, and services gave rise to such milestones as the public expenditure review of the health sector and the Nepal National Health Account (NNHA), both of which were used as tools in informing and shaping national health policy (NHP).

As the country moves forward to a decentralized health system, the need for a similar instrument to rationalize the district health care delivery system led to discussions about the feasibility and desirability of developing a district health account (DHA), which focuses on identifying health issues at district level, particularly in terms of health expenditure, health care functions and sources of funding.

After consultations with higher officials at MoHP, a district health accounting exercise was conducted in Surkhet district in Mid-Western Development Region (MDWR), looking at fiscal years 2005/06 and 2006/07.

The National Health Accounting framework of the Government of Nepal (GoN) was adopted in the development of the DHA. This was intended to facilitate comparison and establish a link with the NNHA. The NNHA framework provided the definitions and classifications of financing sources, health care providers and health care functions.

A rapid assessment for purposes of identifying key stakeholders, players and elements comprising the district health care system was done based on key informants interview and field visit. Information on the public sector (central and local level government) spending on health was collected mainly from the records and reports of the District Health Office (DHO), Regional Directorate Office (RDO), and the Regional and Zonal Ayurvedic Hospitals under the MoHP. A survey was also conducted to obtain data and information on household out of pocket (OOP) expenditure. Likewise, a survey of private medical / drug stores, private nursing home, and I/NGOs was undertaken to obtain data and information on health care spending by these acknowledged private financing agents for health care.

Some of the data gathered for DHA estimation were either not disaggregated or were not available for the years in which the estimates were made, hence informed assumptions and procedures were introduced to extrapolate the likely expenditure data that fit into the particular cells in the DHA matrix for the given fiscal year (FY) estimates.

The total health expenditure in the district for FY 2005/06 is estimated at NRs. 338.76 million, and grew by 5.7 percent to an estimated NRs. 358.03 million in FY 2006/07. Household OOP expenditure accounted for

the largest share of total health expenditure in the district. Recorded at NRs 267.48 million, and accounting for 78.96 percent of total health expenditure in the district in FY 2005/06, and growing further to NRs. 276.84 million, accounting for 77.32 percent of total health expenditure in FY 2006/07, the proportionate share of household OOP health expenditure in the district exceeded that reported in the NNHA, which estimated the household (HH) OOP expenditure at around 60 percent of total health expenditure in Nepal.

The largest proportion of total health expenditure in the district went to the financing of curative care, which at NRs 217.62 million accounted for more than half, or 64.24 percent of total health expenditure. Expenditure on medical goods got the second largest share at NRs 64.38 million, accounting for 19.01 percent of total health expenditure in the district during the accounting period. Transportation expenditure came third, which at NRs 27.56 million, accounted for 8.13 percent of total health expenditure, and even exceeded the total amount spent for preventive and public health expenditure, which at NRs 16.5 million accounted for less than 5 percent of health expenditure in the district. Administrative and capital costs used up NRs 9.61 million (2.84%) while laboratory and diagnostic costs used up NRs 3.09 million, accounting for 0.91 percent of total health expenditure in the district during FY 2005/06.

The DHA exercise in Surkhet district has demonstrated that constructing a DHA is both feasible and desirable, as it provided a tool for assessing the adequacy and efficiency of district allocation and spending policy and yielded useful data and credible information on the major sources and uses of health care funds in the district. The DHA data provided concrete estimates of how much was spent for health care in the district, where the resources for health care in Surkhet district came from, where these resources went, what kinds of health care were paid for, and at least for expenditures at household level, who were benefited from the use of these resources. When used in conjunction with other socio-economic and epidemiological data, the DHA can be used to inform financing policy as well as measure and assess the impact or implication of health financing policy on the distribution of the burden of payment among various stakeholders, the efficiency of use of public or community funds, and the effectiveness of incentives and sanctions to draw out resources from various financing agents, among others.

To optimize the use of the DHA as policy tool, it is necessary that the DHA estimates are periodically updated and its data collection systematized by institutionalizing health finance data recording and reporting by government and organized sectors, supplemented by the conduct of periodic surveys to update household health expenditure patterns and estimates. For this purpose, the study recommends that a high level NNHA / DHA review and development body be convened and empowered to move the health accounts work forward and put in place the institutional and technical infrastructures for continuing data collection, data processing, and NNHA / DHA estimation work. Sustained technical assistance and support from external development partners (EDP) may need to be provided over the next five to ten years to institutionalize the NNHA / DHA as an integral part of the national statistics and data system.

1 Introduction

Government of Nepal formulated in 1991 a NHP aimed at improving health conditions of the people of Nepal with emphasis on delivery of the full range of essential preventive, promotive, curative, and basic primary health services. One health post in each of the 205 electoral constituencies was to be converted into primary health care center (PHCC). The policy featured the parallel provision of Ayurvedic and other traditional health services, community participation, human resources for health development, resource mobilization, decentralization and regionalization, drug supply and health research (NHP: 1991). One of its major objectives was to strengthen decentralization and regionalization with focus on autonomy of peripheral units. The District Health Offices (DHO) were given prominent roles in planning and management of curative and promotive health services from district to village levels.

In-consistencies in priority and focus of the different periodic health plans relative to the budget prompted the GoN's MoHP to develop a 20-year Second Long-Term Health Plan (SLTHP) for the year 1997-2017. The SLTHP addresses disparities in health care, assuring gender sensitivity and equitable community access to quality health care. It provided a guiding framework to build successive periodic and annual health plans that seek to improve the health status of the population. It also developed appropriate strategies, programs, and action plans that reflect national health priorities that are affordable and consistent with available resources. Moreover, it established co-ordination among public, private and NGO sectors and development partners (SLTHP: 1997). The SLTHP, among others, aims at improving inter-and intra-sectoral co-ordination and provides the necessary conditions and support for effective decentralization with full community participation. Current national policy has emphasized the state's responsibility towards ensuring citizen's right to health. The ongoing periodic plan focuses on ensuring access to quality health services by all citizens irrespective of gender, religion, political ideas, socio-economic status etc. Its long-term vision is to establish conditions for delivery of quality health services, accessible to all citizens, but with particular focus on the low-income (NPC: 2007). Likewise, the interim constitution of Nepal 2007 has regarded health as a "fundamental right of the people". These plans underscore the increasing role of the state in providing health services to the population.

In recent years, MoHP has initiated various activities to record and manage information in terms of health care finance, providers and services. Public expenditure review of the health sector and NNHA are milestones in this

regards. Ministry of Health & Population produced the NNHA for two FYs (2001/02 and 2002/03) in the year 2006. The MoHP has used it as a tool to inform the health policy process, including policy design and implementation, policy dialogue, and the monitoring and evaluation of health care interventions. The NNHA is an instrument that helps government and private sector to manage national health expenditure more efficiently and effectively. It is also expected to help strengthen public trust and confidence in government policies, particularly with regards to building a national health system that delivers programs and services based on needs that people themselves have identified as active partners in the development process.

With the country's commitment to a decentralized health system, the need for a similar instrument to rationalize the district health care delivery system is crucial. After Nepal's remarkable political change from a constitutional monarchy to a federal republic in 2008, vertical as well as horizontal fiscal management became an over-riding concern. With decentralization and the newly installed political and institutional setup, the anticipated demand for local autonomy in identification of health care issues and programming of health services makes it imperative to develop health accounts that would facilitate assessment of health sector needs and performance at district level, which in turn could give more depth and meaning to the analysis of the NNHA. This could lead to re-designing public policy at the district level based on local prioritization of the choices and options. The public policy choices will then be more demand-driven in the context of local analysis rather than the currently supply-driven or program-driven policies from an aggregate prospective.

The DHA exercise was designed to focus on identifying health issues at district level, particularly in terms of health expenditure, health care functions and sources of funding. The study also intended to analyze the distributional implication of health services in the context of social inclusion. This would have required some form of equity analysis in terms of socio-economic and demographic characteristics of the HH.

Acknowledging the importance of DHA, preliminary work has been done to apply the NNHA framework in developing a DHA in Chitwan. Other related works to assess the new free health care policy (FHCP) and its anticipated costs and benefits has made imperative the development of the DHA as an instrument to help make district health care expenditure more effective, efficient, and equitable in a more sustainable way.

This study proposed to develop a DHA for Surkhet district of Bheri Zone, Mid-western Development Region (MDWR). As a sub-set of the NNHA, the study would also attempt to answer the following questions:

i. Where do the resources come from?

ii. Where do the resources go?

iii. What kinds of services and goods do they purchase?

iv. Whom do they benefit?

Objective

The overall objective of the study was to develop a DHA for Surkhet district of MWDR, Nepal for two FYs (2005/06 and 2006/07).

2 Methodology

Study Area

After several consultations with higher officials at MoHP, this study has purposively selected Surkhet district for developing a DHA. The choice of this district was based on its observed diversity in terms of socio-economic profile of HH as well as ecological and geographical conditions. Also, there were a number of health care providers - public, private and NGOs / INGOs operating in the district, which makes it an ideal site for assessing the various dimensions of health care delivery and provision.

The study area - Surkhet District - of MWDR is located about 500 km from the capital city of Kathmandu, and falls under administrative zone Bheri. Surkhet is the regional headquarters of MWDR. Its demographic features included a total population of about 288,527 with total HH numbering 45,047. The average HH size was about 5.34 and population density is 118 per square kilometer. A large segment of the population resided in the rural areas, with a marginal 10.98 percent of the district's total population residing in urban areas. Human Development Index (HDI) of the district was 0.486, which put the district in 22nd position among the 75 districts of Nepal. Agriculture was the main economic activity of a large segment of the population, while a nominal segment was engaged in trade, commerce and other industrial activities.

The health care system in the district was mixed in terms of service providers, scope of services and financing agents. There were different stakeholders that included public sector, private sector, Community Based Organizations (CBO), NGOs and INGOs who were providing health care services. The public sector was the primary provider of the health care services in the district. There was one regional hospital with a bed capacity of 50, representing the apex of the district's tiered health care delivery system. There were four PHCCs, each with three-bedded capacity, 38 sub-health posts (SHP), with 186 traditional birth attendants (TBA) providing primary health services in the district; and about 980 female community health volunteers (FCHV), 920 of which serve in the Village Development Committees (VDCs) and 60 in the municipalities. Besides, providing allopathic services, the public sector also provided Ayurvedic services through a zonal Ayurvedic hospital and two Ayurvedic centers in Vidhyapur and Rakam.

The private sector provided health services in the district through private clinics, private dental clinics, nursing homes, drug stores and community health cooperatives. In addition, bilateral and non-governmental aid agencies working in the health sector were also found in the district. There were four private institutions, of which two were private health care providers and the remaining two were NGOs

that provide related facilities. There was no private hospital in the district, but there were a good number of private clinics where drugs and medicines were sold. There was no data on the number of drug stores, but this might correspond with the number of private clinics. There were no separate private practitioners in the district as almost the same people who worked for the public sector also worked in the private sector on part-time basis. In Surkhet district, the records showed that there was one Medical Doctor, 36 Pharmacists, 23 Health Assistants, 53 Nurses, 146 Health Workers, and seven Ayurvedic Officers / Assistants.

Desk Review

A review of relevant literature was done for developing the framework of DHA to understand sources of health care financing, providers of health care survey and functions of health care services. The main literature reviewed, among others, included NNHA (2001-2003 and 2004-2006), an unpublished DHA for Chitwan (FY 2004/05), Framework for NNHA (2004) published by GoN, and Organization for Economic Cooperation and Development (OECD) manual for health accounts of World Health Organization (WHO).

Framework for DHA

The National Health Accounting framework of the GoN was adopted in the development of the DHA. This was intended to facilitate comparison and establish a link with the NNHA.

National Health Account comprises two basic components viz. National Health Expenditure, giving the estimates of health expenditure on health care functions, and Total Health Expenditure providing estimates of National Health Expenditure plus capital formations of all healthcare providers. The NNHA has attempted to address the following questions, although the last one is not explicit:

- Where do the resources come from?
- Where do the resources go?
- What kinds of services and goods do they purchase?
- Whom do they benefit?

The NNHA framework provides the definitions and classifications of financing sources, health care providers and health care functions. The sources of funding have been classified further among the headings of general government, private HH and rest of world (RoW). Within the general government headings (that exclude social security funds), the sub-headings include central government, general tax revenues, earmarked taxes (health tax on alcohol and tobacco), and local governments / municipalities. A social security / national health insurance fund was kept as a separate sub-heading under general government. The private sector expenditure included social insurance enterprises, other private insurance enterprises, private HH OOP expenditure, non-profit institutions serving HH, corporations (offering market goods other than health insurance). Likewise, the sub-headings under RoW / foreign funds included official donor agencies, international not-for-profit agencies and other foreign funds.

Under the health care provider classifications were hospitals, nursing and residential care facilities, providers of ambulatory health care (primary care providers), retail sales outlets and other providers of medical goods. The provision and administration of public health programs, general health administration and insurance, other industries (rest of the Nepalese economic) and RoW have been further classified under different sub-headings.

Likewise, the functional classifications included curative care, rehabilitative care services, long-term nursing care, ancillary health care services, medical goods dispensed to out patients, preventative and public health services, health program administration and health insurance, health related functions-capital formation of health care provider institutions, education and training of health personnel, research and development in health, drinking water and sanitation, administration and provision of social services to those living with disease and impairment, administration and provision of health related cash benefits, all other health-related expenditures.

The NNHA code and one-way classification are provided in Annex 1.

A rapid assessment for purposes of identifying key stakeholders, players and elements comprising the district health care system was done based on key informants interview and field visit. These basically covered health care providers, financing agents, financing sources – internal and external, health services and goods offered and consumed, institutional resources – capital and human resources, population served / covered by health services, payment systems / schemes, health insurance schemes, if any, employers providing health benefits to employees / other population groups etc. Data sources such as expenditure reports, among others, were also identified. An inventory of all key actors and important elements comprising the district health care system, including their classification was the principal output of this activity.

A dummy matrix for DHA was prepared after mapping of the district health care system. The main financing agents identified were: central government, local government, NGOs, and HH and RoW. Pertinent health care functions included: curative care, laboratory, transportation, medical goods, preventive and public health, and administration and capital.

The main health care providers included: hospitals, ambulatory care providers, retail outlets, public health providers, administration and capital, and rest of Nepal economy (RoNE).

Data

The required data for this study was collected from various sources. A district health care system mapping was done, from which a data plan was developed upon obtaining information on possible sources of data required to construct the DHA. A general map of the district health care system was generated after the first visit to the district.

The information on the public sector (central and local level government) spending on health was collected mainly from the records and reports of DHO, RDO, and the regional and zonal Ayurvedic hospitals under the MoHP. This was supplemented by key informant interviews to obtain information on data completeness, quality, and availability. Data and information derived from these sources constituted a large fraction of the estimated public spending on health. Likewise, information on health care spending was also collected from DDC and municipality for the accounting period while for VDCs, the information was obtained from only ten VDCs and was later extrapolated to estimate the expenditure of all VDCs in the district.

A survey was also conducted to obtain data and information on HH OOP expenditure. Likewise, a survey of private medical / drug stores, private nursing home, and NGO / INGO was undertaken to obtain data and information on health care spending by these private sources of health care funds.

Household level cross sectional data was collected from the HH through structured interviews administered at the HH level. A questionnaire consisting of information block

on demographic and socio-economic profile, health behavior and practices, etc. was developed. The demographic and socio-economic profile information included details on HH members along with their individual characteristics such as age, sex, education, employment status etc. Since the study also aimed at examining distributional aspects on health care system, the information on their consumption expenditure was also collected to facilitate the beneficiaries' analysis. Likewise, use of preventive and public health services like immunization, maternal and child health, reproductive health, disease control etc were also collected. The HH survey questionnaire is provided in Annex 2.

A pre-test of HH questionnaire was done at Matschyegaun VDCs and Kirtipur Municipality of Kathmandu district for five days during January 20-25, 2009. A total of 40 (10% of total sample size) HH were interviewed during the pre-test of HH questionnaire. The HH questionnaire was accordingly revised and finalized before the main survey begun. The HH survey was conducted in February 2009. For purposes of the HH survey, ten local enumerators were trained for two days and sent to collect data at different places of Surkhet district. While selecting the local enumerators, special attention was given to make the group inclusive in terms of gender and marginalized / disadvantaged group. The local enumerators were selected from those with academic background on health education and were pursuing study for bachelors and masters degree of health education at Surkhet education campus. The list of enumerators and field assistant is provided in Annex 3.

Sampling Strategy for HH Survey

Considering variation on HH of Surkhet district in terms of their socio-economic profile, a stratified random sampling method was adopted. In the first stage, the district was divided into four strata namely urban (municipality), semi urban (surrounding municipality), rural east (East) and rural west (West). In the

Table 1. Population and Sample

Surkhet	VDCs Selected	Wards *	HH Size	Sample Size
West	Bijaura	2	66	9
		9	113	16
	Babiyachaur	2	208	30
		5	132	19
Surrounding	Lekgaun	1	153	22
		7	114	16
	Lekhparajul (Ramghat)	5	201	29
		7	110	16
East	Maintara	9	206	30
		4	232	33
	Rakam	8	72	10
		5	22	3
Municipality	Birendranagar Municipality	3	396	57
		8	768	110
Total			**2793**	**400**

* Wards were selected randomly using random numbers table. Figure inside the Ward column indicates ward number as each VDC has 9 Wards only. The total number of HH in each selected ward was collected from CBS. Household has been selected at the sampling Interval of 7 with sample proportion of 0.14

second stage, two VDCs from three strata East, West and surrounding of municipality were randomly selected. There is only one municipality which was selected to represent an urban area. In the next stage, two wards from each of the VDCs and municipality were randomly selected using random numbers table.

Sample size for each of the stratum was determined based on proportional stratified random sampling method. The detail of selection of VDCs / municipality and wards including the population and sample size is given in Table 1.

The information obtained from the Second Nepal Living Standard Survey (NLSS) - II and other documents available at district level was used to formulate and design the questionnaire. The sample size of 400 for HH survey was determined using NLSS-II figure of Central Bureau of Statistics (CBS) for Surkhet district. The sample so determined is about one percent of the total HH in the district.

Survey of Private Medical Centers, Drug Center, Nursing home and Education and Training Institute and NGOs

A survey of private medical centers, drug centers, nursing home and education and training institute was also conducted using a checklist. The checklist for information collection from these centers is provided in Annex 4.

A total of 10 medical and drug centers, one nursing home and one education and training institute were surveyed during February 11-28, 2009. The list of medical drug centers, nursing home and training institute is provided in Annex 5.

A survey of NGOs was also conducted covering all NGOs found to be active in health care services delivery during the February 11-28, 2009 site visit. The checklist was likewise used as instrument to collect required information from NGOs. The list of NGOs providing health care services in the district was obtained from the annual report of the DHO, Surkhet. The list of NGOs surveyed is also provided in Annex 6.

Estimation Procedures and Assumptions

Some of the data gathered for DHA estimation were either not disaggregated or were not available for the years in which the estimates were made, hence it was necessary to inject some assumptions and procedures to extrapolate the likely expenditure data that fits into the particular cells in the DHA matrix for the given FY estimates. For example, HH data for two FYs (2005/06 and 2006/07) were derived from the HH survey conducted in the year 2009 to collect 2008 HH health expenditure data purposively for the DHA estimation. On the other hand, data from local government and NGOs were derived from institutional records for monitoring or accounting purposes, or from key informant interviews, and were generally not disaggregated according to the requirements of the DHA, although the expenditure data were from the FY being estimated.

The procedures and assumptions used in the DHA estimation are summarized as below:

1. **Extrapolation of HH Data:** District and VDC level demographic information was collected from the records of the CBS Nepal. Data was stratified for sampling purposes, and calculations were made on the total population of each stratum. An estimate of total health expenditure for each stratum was arrived at by estimating the average per capita expenditure per stratum as derived from the HH survey and multiplying it with the total population of each stratum. The total expenditure for the district was calculated by summing up the estimated expenditures of each stratum.

2. **Extrapolation of VDC Data:** Data collected from 12 VDCs was extrapolated and applied to all 51 VDCs to arrive at the health expenditure estimates of VDCs for the whole district.

3. **Extrapolation of Private Medical Expenditure:** Information gathered from key informants were used to estimate the total number of private medical clinics and drug stores, and the health expenditure data was extrapolated from the average expenditure of the sampled medical clinic / stores.

4. **Estimation of HH Health Expenditures for FYs 2005-06 and 2006-07:** Since HH data was collected in 2009, with a recall period of 2008, the central bank price index was used to estimate the HH health expenditures for the given FY. The price index for each health function category was used to adjust the estimated HH expenditure for the FY where DHA estimates were made. No adjustments were made with respect to HH income over the years as it was assumed that health expenditures were income inelastic.

5. **Estimation of Disaggregated Data on Health Care Functions and Providers:** Nepal National Health Account and HH level information were used to disaggregate data on health expenditures among various functions of health care. For example, data on HH proportionate expenditures were used to calculate the distribution of total HH health expenditures among the various functions of health care. Similarly, NNHA proportions were used in disaggregating the government health expenditure by functions.

3 Results and Discussions

3.1 Health Expenditure by Financing Agents

The main financing agents in the district were Central Government, Local Government - DDC, VDC and Municipality, HH and RoW.

Table 3.1 provides an estimate of total health expenditure by financing agents for two FYs (2005/06 and 2006/07). The total health expenditure in the district for FY 2005/06 was estimated at NRs. 338.76 million while that for FY 2006/07 was estimated at NRs. 358.03 million.

The total health expenditure in the district shows an increasing trend by 5.7 percent from FY 2005/06 to 2006/07. Similarly, increasing trend is observed by source of expenditure in absolute amounts, although HH OOP expenditure shows a decline in terms of relative share of total health expenditure in FY 2006/07 over that of FY 2005/06.

Central government spent NRs. 53.42 million and NRs. 59.67 million, which are 15.8 and 16.7 percent of total health expenditure for FY 2005/06 and 2006/07 respectively. Local government, on the other hand, spent NRs. 0.52 million and NRs. 0.72 million accounted for only a nominal share of total health expenditure in the district at 0.1 percent of total expenditure in FY 2005/06. Local government share of total health expenditure increased marginally to 0.2 percent in FY 2006/07.

The share of RoW was NRs 17.34 million in FY 2005/06 accounting for 5.1 percent of the

Table 3.1 Health Expenditure by Financing Agents (NRs. in Millions)

Financing Agents	FY 2005/06 (% share of Total Health Expenditure)	FY 2006/07 (% share of Total health Expenditure)
Central Government	53.42 (15.8)	59.67 (16.7)
Local Government	0.52 (0.1)	0.72 (0.2)
Households (HH)	267.48 (79.0)	276.84 (77.3)
Rest of the World (RoW)	17.34 (5.1)	20.80 (5.8)
Total	**338.76 (100)**	**358.03 (100)**

Source: HH Survey, NGOs / Private Medical / Nursing Home Survey, Public Expenditure Survey at District Level (2009)

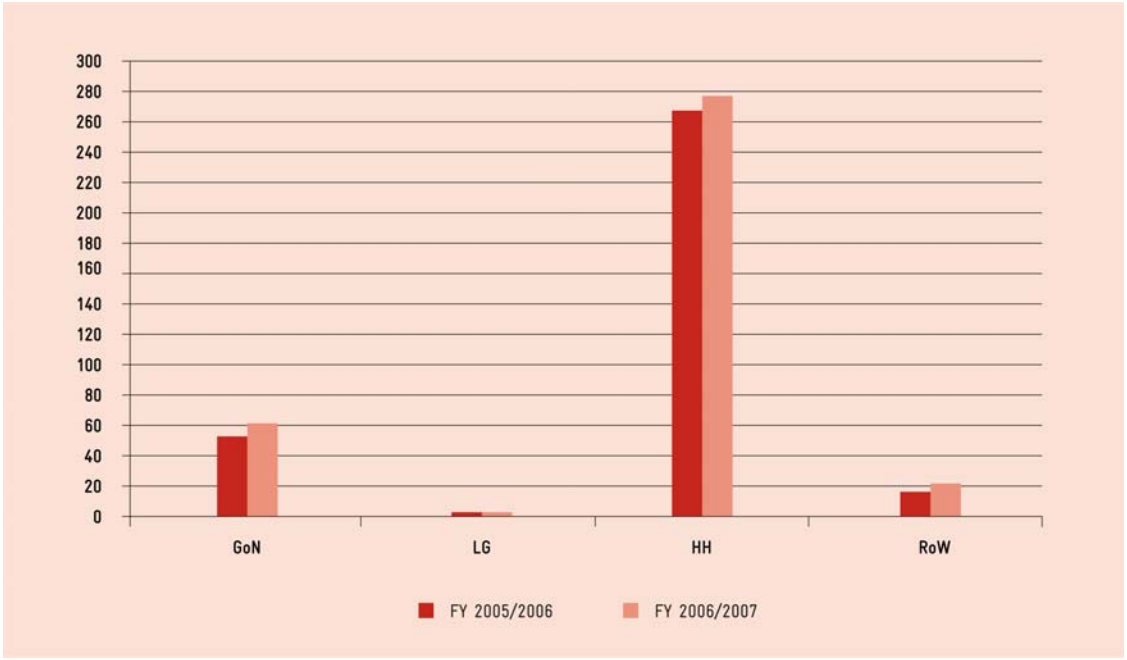
total health expenditure in the district, and gradually increased to NRs. 20.8 million in FY 2006/07 accounting for around 5.8 percent of total health expenditure in the district for the period. The share of the RoW in the district health expenditure is significantly lower than that recorded in the NNHA where RoW shared around 21 percent of total health expenditure (NNHA: 2004-2006).

Household OOP expenditure accounted for a substantially high proportion, representing the largest share of total health expenditure in the district (Figure 3.1). Recorded at NRs. 267.48 million, accounting for 79.0 percent of total health expenditure in the district in FY 2005/06, and at NRs. 276.84 million, accounting for 77.3 percent of total health expenditure in FY 2006/07, the proportionate share of HH OOP health expenditure in the district exceeded that reported in the NNHA (2004-2006), which estimated the HH OOP expenditure at around 50 percent of total health expenditure in Nepal.

The larger share of HH OOP expenditure relative to the NNHA may be partially explained by the higher cost of access to services in the district as indicated by the fairly large transport cost, recorded at eight percent of total HH health expenditure. Secondly, limitations on the completeness of data obtained from the review of expenditure records of PHCC, HP, and SHP, which often failed to reflect the direct flow of funds from NGOs, INGOs and even from local governments to those institutions, may have understated the total health expenditures from these financing agents. Thirdly, poor recording of information at local level may have likewise failed to reflect the full amount of government health expenditure in the district, thus underestimating their full share of total health expenditure. Clearly, an adjustment of the estimates of health expenditure from non-HH financing agents would have been ideal, but was not possible as there were no adequate studies done to estimate the degree and extent

Figure 3.1 Health Expenditure by Financing Agents in FYs 2005/06 and 2006/07

(NRs. in Millions)



Note: GoN: Government of Nepal, LG: Local Government, HH: Households, RoW: Rest of the World, FY: Fiscal Year

of under-reporting of health expenditure from these sources. Nevertheless, the level of under-estimation of spending from the other sources relative to that of HH would have to be in the order of magnitude of at least 70 percent to approximate the proportion reflected in the NNHA. It is also quite possible that the HH burden of spending for health care is much higher in the Surkhet district because of possible inequalities in the distribution of resources from other financing sources across the various districts in Nepal.

3.2 Health Expenditure by Functions and Financing Agents (F*A)

Table 3.2.1 presents the estimates of health care expenditure for particular health care functions by financing agents in the Surkhet district for FY 2005/06.

As shown in Table 3.2.1, the largest proportion of total health expenditure in the district went to the financing of curative care, which at NRs. 217.62 million accounted for more than half, or 64.2 percent of total health expenditure. Expenditure on medical goods got the second largest share at NRs 64.38 million, accounting for 19.0 percent of total health expenditure in the district during the accounting period. Transportation expenditure also took up a substantially high share of total health expenditure of the district at NRs. 27.56 million, accounting for 8.1 percent of total health expenditure, and even exceeded the total amount spent for preventive and public health expenditure at NRs 16.5 million (5.0%). Administrative and capital costs used up NRs. 9.61 million (2.8%) while laboratory and diagnostic costs used up NRs. 3.09 million, accounting for 0.9 percent of total health expenditure in the district during FY 2005/06.

Table 3.2.1 shows that the burden of payment for curative care, medical goods, transportation, and laboratory services was borne mostly by HH. Households covered practically cent percent of expenditure for transportation, and accounted for 70.9 percent of expenditure for laboratory services, 87.0 percent of expenditure for curative care, and 96.7 percent of expenditure for medical goods. The central government spent NRs. 40.06 million, or 18.4 percent of curative care expenditure and NRs. 1.27 million, or 1.97 percent of medical goods expenditure. Non-government organization and government, on the other hand shared

Table 3.2.1 Health Care Functions by Financial Agents for FY 2005/06 (NRs. in Millions)

Health Care Functions	GoN *	LG	NGO	HH	Total	Percent
Curative Care	40.06	0.13	2.81	174.61	217.62	64.2
Laboratory	0.90	0	0	2.19	3.09	0.9
Transportation	0	0	0	27.56	27.56	8.1
Medical Goods	1.27	0	0	63.11	64.38	19.0
Preventive & Public Health	8.04	0.39	8.07	0	16.50	5.0
Admin and Capital	8.96	0	0.64	0	9.61	2.8
Total	**59.23**	**0.52**	**11.53**	**267.48**	**338.76**	**100.00**
Percent	**17.5**	**0.1**	**3.4**	**79.0**	**100.00**	

Note: GoN: Government of Nepal, LG: Local Government, NGO: Non-Government Organizations, HH: Households
* Expenditure of official donors was lumped with central government expenditure
Source: HH Survey, NGOs / Private Medical / Nursing Home Survey, Public Expenditure survey at District Level

almost equally the burden of payment for preventive and public health services, with NGOs spending slightly less at NRs. 8.07 million relative to spending by central and local government combined at NRs. 8.43 million. Households spending on preventive and public health programs were relatively small and insignificant, and were mostly reflected under spending on transportation and medical goods.

It is interesting to note that while local governments and NGOs appeared to have prioritized preventive and public health care by apportioning at least 70 percent of their health care expenditure on this health care function, the central government spent less than 15 percent of its total health care expenditure on preventive and public health care, opting instead to apportion 67.6 percent of its total health care expenditure for curative care.

Table 3.2.2 presents the estimates of expenditure in the district for health care functions by financing agents for FY 2006/07. The total expenditure for curative care was recorded at NRs. 222.43 million out of the total health expenditure of NRs. 358.03 million, accounting for 62.1 percent of total health expenditure in the district during the accounting period. Expenditure for medical goods had a share of 19.0 percent, followed by expenditure on transportation of eight percent. Preventive and public health expenditure functions accounted for 7.8 percent, while administrative and capital expenditure accounted for 2.2 percent of total health expenditure. Laboratory expenditure was estimated at less than one percent of health expenditure for FY 2006/07.

Notable changes in expenditure pattern are observed in FY 2006/07 over that of FY 2005/06. For one thing, there was a significant increase by 68.8 percent in the absolute amount spent for preventive and public health functions from NRs. 16.50 million to NRs. 27.86 million. This resulted in the increased relative share of preventive and public health spending from five percent in FY 2005/06 to 7.8 percent in FY 2006/07. Slight reductions in the relative share of spending are reflected for curative care, which declined to 62.1 percent in FY 2006/07 from 64.2 percent in FY 2005/06, and for transportation cost, which slightly declined to eight percent in FY 2006/07 from 8.1 percent in FY 2005/06. Expenditure for these items, however, continued to increase in absolute amounts between the two FYs. The relative shares of health expenditure for laboratory and medical goods were fairly constant, while that of administrative and capital cost declined in both absolute amount and in relative share of total health expenditure.

Table 3.2.2 Health Care Functions by Financial Agents for FY 2006/07 (NRs. in Million)

Health Care Functions	GoN *	LG	NGO	HH	Total	Percent
Curative Care	39.21	0.13	2.37	180.73	222.43	62.1
Laboratory	0.90	0.00	0.00	2.27	3.17	0.9
Transportation	0.00	0.00	0.00	28.52	28.52	8.0
Medical Goods	2.74	0.00	0.00	65.32	68.06	19.0
Preventive & Public Health	15.96	0.60	11.30	0.00	27.86	7.8
Admin and Capital	7.36	0.00	0.64	0.00	8.00	2.2
Total	**66.16**	**0.72**	**14.31**	**276.84**	**358.03**	**100.00**
Percent	**18.5**	**0.2**	**4.0**	**77.3**	**100.00**	

Source: HH Survey, NGOs / Private Medical / Nursing Home Survey, Public Expenditure survey at District Level (2009) *Expenditure of official donors was lumped with central government expenditure

Note: GoN: Government of Nepal, LG: Local Government, NGO: Non-Government Organizations, HH: Households

Notwithstanding the noted changes in expenditure patterns between FY 2006/07 and FY 2005/06, HHs continued to bear the greater burden of payment for curative care, medical goods, laboratory, and transport cost. Households continued to account for cent percent of expenditure on transportation, and accounted for 71.6 percent of payment for laboratory services 87.6 percent of payment for curative care and 96 percent of payment for medical goods. The absolute increase in central government spending for medical goods from NRs. 1.27 million in FY 2005/06 to NRs. 2.74 million in FY 2006/07 probably accounted for the slight decline on HH burden of payment for this item from 98 percent in FY 2005/06 to 96 percent in FY 2006/07.

3.3 Health Expenditure by Providers and Financing Agents (P*A)

Table 3.3.1 presents the estimates of health care expenditure paid to health care providers by financing agents for FY 2005/06. The main providers, among others, included all hospitals, providers of ambulatory care, retail outlets, public health programs and general administration.

As shown in Table 3.3.1, hospitals had the largest share of health care payments, accounting for 33.97 percent of total health expenditure in the district during the accounting period FY 2005/06. Households paid a total of NRs. 93.04 million to hospital providers, accounting for 80.9 percent of total payments to hospitals while the central government spent NRs. 21.40 million, or 18.6 percent of total payments to hospitals during the same period. The substantially high proportion of HH expenditure for hospital providers may be attributed to its large payment for services rendered in private hospitals.

Ambulatory care providers had the second largest share of health care payments accounting for 31.6 percent of total health care expenditure in the district during the accounting period. Households paid a total of NRs. 83.77 million to providers of ambulatory care, while central government paid a total NRs. 20.84 million to the same category of providers in FY 2005/06. Retail outlets had the third largest share of health care payments at 18.6 percent, while public health care providers got a fairly low share at 4.9 percent. Administration had the lowest share at 2.8 percent of total health care payments in FY 2005/06.

Table 3.3.1 Health Care Providers by Financing Agents for FY 2005/06 (NRs. in Million)

Health Care Providers	GoN	LG	NGO	HH	Total	Percent
Hospitals	21.40	0.13	0.50	93.04	115.06	34.0
Ambulatory Care	20.84	0.00	2.31	83.77	106.91	31.6
Retail outlets	0.00	0.00	0.00	63.11	63.11	18.6
Public Health	8.04	0.39	8.07	0.00	16.50	4.9
General Administration	8.96	0.00	0.64	0.00	9.61	2.8
Rest of the Nepal Economy	0.00	0.00	0.00	27.56	27.56	8.1
Total	**59.23**	**0.52**	**11.53**	**267.48**	**338.76**	**100.00**
Percent	**17.5**	**0.1**	**3.4**	**79.0**	**100.00**	

Source: HH Survey, NGOs / Private Medical / Nursing Home Survey, Public Expenditure survey at District Level (2009)
Note: GoN: Government of Nepal, LG: Local Government, NGO: Non-government Organizations, HH: Households

Central government paid a total of NRs. 8.04 million to providers of public health services, while local government and NGOs paid NRs. 0.39 million and NRs. 8.07 million respectively for the same category of health care providers. Under general administration, central government recorded the largest sum of payment at NRs. 8.96 million while NGOs recorded it at NRs. 0.64 million during the accounting period.

It should be noted at this point that the availability of disaggregated data and information on administrative costs at local level is seriously limited by the failure to record separate accounts of expenditure for administration of health care delivery under some providers as classified in the NNHA Framework. The local government did not keep a separate account for administrative expenses in the delivery of health services since all administrative expenses of the local government were lumped together as a single account. Likewise, NGOs working on different domains did not generally keep separate accounts of administrative expenditure for health care from those of other services provided by them. Thus, no available data on administrative cost of health care delivery could be obtained from local governments and NGOs working on multiple sectors. Only central government and NGOs with dedicated health services were able to provide data on administrative cost of health care delivery.

The estimates of health expenditure paid to various providers by various financing sources for FY 2006/07 is shown in table 3.3.2

As in FY 2005/06, providers of hospital care got the largest share of total health expenditure in the district in FY 2006/07, with total payments amounting to NRs. 117.35 million, or 32.8 percent of total health expenditure in the district in FY 2006/07. Households continued to spend a significantly large sum of NRs 96.3 million for hospital services, while government including official donor agencies spent NRs 20.42 million for the same services. Providers of ambulatory care got the second largest share of health care payments, with NRs. 110.99 million, or 31.0 percent of total health care expenditure during the same period. The retail outlets got NRs. 65.32 million, or 18.25 percent of total health expenditure for the period, which was wholly paid for by HH. Again, the most significant increase in payments went to providers of public health, which at NRs. 27.86 million, accounted for 7.8 percent of total health expenditure compared to 4.9 percent in FY 2005/06. Smallest amount and share of payment went to general administration of health care, which had NRs. Eight million, or 2.2 percent of total health expenditure during the review period. The same data limitation on administrative expenses observed in FY 2005/06 applies.

Table 3.3.2 Health Care Providers by Financing Agents for FY 2006/07 (NRs. in Million)

Health Care Providers	GoN	LG	NGO	HH	Total	Percent
Hospitals	20.42	0.13	0.50	96.30	117.35	32.8
Ambulatory Care	22.42	0.00	1.87	86.70	110.99	31.0
Retail outlets	0.00	0.00	0.00	65.32	65.32	18.2
Public Health	15.96	0.60	11.30	0.00	27.86	7.8
General Administration	7.36	0.00	0.64	0.00	8.00	2.2
Rest of the Nepal Economy	0.00	0.00	0.00	28.52	28.52	8.0
Total	**66.16**	**0.72**	**14.31**	**276.84**	**358.03**	**100.00**
Percent	**18.5**	**0.2**	**4.0**	**77.3**	**100.00**	

Source: HH Survey, NGOs / Private Medical / Nursing Home Survey, Public Expenditure survey at District Level (2009)
Note: GoN: Government of Nepal, LG: Local Government, NGO: Non-government Organizations, HH: Households

3.4 Health Care Functions by Providers (F*P)

Table 3.4.1 presents the estimates of expenditure for health care functions by providers in the district for the accounting period FY 2005/06. The main headers of health care functions include curative care, laboratory, transportation, medical goods, preventive and public health, and administration and capital expenditure while main providers are classified as all hospitals, ambulatory care, retail outlets, public health, general administration and Rest of Nepalese Economy (RoNE).

As shown in table 3.4.1, hospitals and providers of ambulatory care are the main providers associated with curative care expenditure and laboratory services, while ambulatory care providers and retail outlets are the main providers associated with expenditure on medical goods. The sole provider associated with health-related expenditure on transportation services is the rest of Nepalese economy. Providers of public health care are the sole providers associated with expenditure on preventive and public health services. It is not clear whether this pattern is a reflection of limitations on the availability of disaggregated data on health care expenditure by providers or a reflection of district health system reality. Indeed, it is probably reasonable to expect that providers of hospital services might also have associated expenditures on medical goods, and perhaps even transportation services provided by ambulances, although disaggregated data on these expenditures may not be available, or the full cost of these services may have been passed on directly to HH as non-disaggregated user charges.

Table 3.4.1 shows that hospitals have provided curative care valued at NRs. 114.16 million while ambulatory care providers provided the same function valued at NRs. 103.45 million, giving a total of NRs. 217.62 million worth of curative care consumed in the district during the FY 2005/06. Ambulatory care providers also provided NRs. 2.19 million worth of laboratory services, while hospitals provided an estimated NRs. 0.90 million for the same function.

Table 3.4.1 Health Care Functions by Providers for FY 2005/06 (NRs. in Million)

Health Care Functions	Providers							
	Hospitals	Ambulatory Care	Retail Outlets	Public Health	Admin & Capital	RoNE	Total	Percent
Curative Care	114.16	103.45	0.00	0.00	0.00	0.00	217.62	64.2
Laboratory	0.90	2.19	0.00	0.00	0.00	0.00	3.09	1.0
Transportation	0.00	0.00	0.00	0.00	0.00	27.56	27.56	8.1
Medical Goods	0.00	1.27	63.11	0.00	0.00	0.00	64.38	19.0
Preventive and Public Health	0.00	0.00	0.00	16.50	0.00	0.00	16.50	4.9
Administrative and Capital	0.00	0.00	0.00	0.00	9.61	0.00	9.61	2.8
Total	115.06	106.91	63.11	16.50	9.61	27.56	338.76	100.00
Percent	34.0	31.6	18.6	4.9	2.8	8.1	100.00	

Source: HH Survey, NGOs / Private Medical / Nursing Home Survey, Public Expenditure survey at District Level (2009)
Note: RoNE: Rest of Nepal Economy

The RoNE is the sole provider of transportation services amounting to NRs. 27.56 million in the FY 2005/06. Ambulatory care providers provided medical goods valued at NRs. 1.27 million while retail outlets have provided NRs. 63.11 million worth of medical goods, yielding a total of NRs. 64.38 million for the same function in the district. The providers of preventive and public health care provided services valued at NRs. 16.50 million for public health programs. Administration and capital rendered work valued at NRs. 9.6 million.

Table 3.4.2 provides an estimate of health care functions by providers in the district for the accounting period FY 2006/07. It shows that all hospitals provided curative care valued at NRs. 116.45 million in FY 2006/07, while the ambulatory care providers provided curative care valued at NRs. 106.09 million in the same year, giving a total of NRs. 222.43 worth of curative care services in FY 2006/07. While there is no change in the ranking of health care functions in FY 2006/07 relative to that of FY 2005/06, it is notable that the value of preventive and public health care consumed in FY 2006/07 was significantly larger than that in FY 2005/06.

3.5 Equity on Health Expenditure

An analysis of the distribution of health expenditure considering various equity-related variables, which include primarily age, gender and consumption expenditure by the HH, was done for year 2008. The preliminary results are briefly described below.

3.5.1 Per Capita Household Health Expenditure by Age and Sex

Table 3.5.1 shows the distribution of health expenditure among various age groups in the district. The age groups have been stratified into five categories as shown in Table 3.5.1. This classification has been made in line with the NNHA (2004-2006).

Table 3.4.2 Health Care Functions by Providers for FY 2006/07 (NRs. in Million)

Health Care Functions	Providers							
	Hospitals	Ambulatory Care	Retail Outlets	Public Health	Admin & Capital	RoNE	Total	Percent
Curative Care	116.45	105.98	0.00	0.00	0.00	0.00	222.43	62.12
Laboratory	0.90	2.27	0.00	0.00	0.00	0.00	3.17	0.89
Transportation	0.00	0.00	0.00	0.00	0.00	28.52	28.52	7.97
Medical Goods	0.00	2.74	65.32	0.00	0.00	0.00	68.06	19.01
Preventive and Public Health	0.00	0.00	0.00	27.86	0.00	0.00	27.86	7.78
Administrative and Capital	0.00	0.00	0.00	0.00	8.00	0.00	8.00	2.23
Total	**117.35**	**110.99**	**65.32**	**27.86**	**8.00**	**28.52**	**358.03**	**100.00**
Percent	**32.78**	**31.00**	**18.25**	**7.78**	**2.23**	**7.97**	**100.00**	

Source: HH Survey, NGOs / Private Medical / Nursing Home Survey, Public Expenditure survey at District Level (2009)
Note: RoNE: Rest of Nepal Economy

Table 3.5.1 Per-capita Household Health Expenditure by Age and Sex

Age Group	Male (NRs.)	Female (NRs.)	Average (NRs.)
0 - 5 Year	789	474	649
6 - 15 Year	1,301	1,053	1,187
16 - 50 Year	2,195	2,823	2,518
Over 50 Year	4,112	3,498	3,827

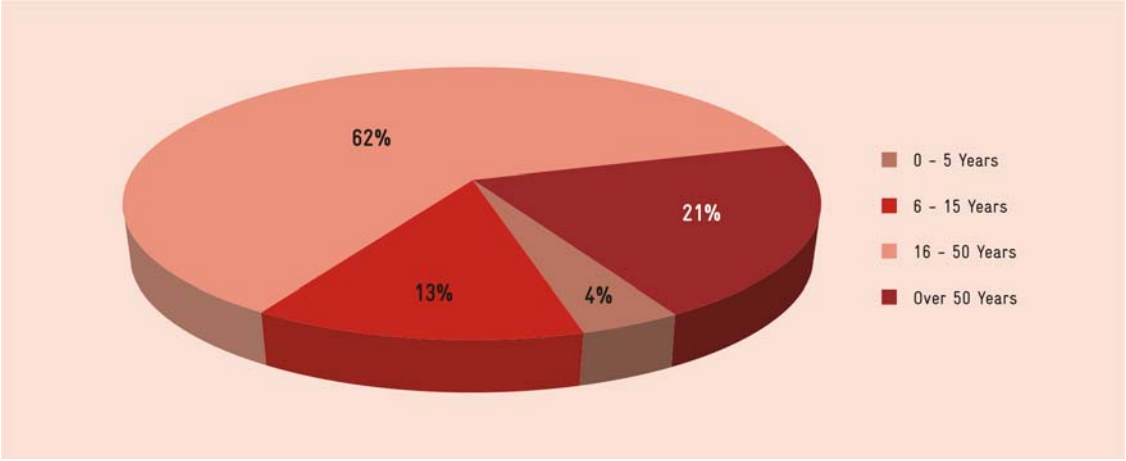
Source: Household OOP Expenditure Survey, 2009

Table 3.5.1 shows a higher per capita expenditure in a year for higher age groups. It indicates that the per-capita health expenditure in a year is highest among the over 50 years old population. The average per capita expenditure was as high as of NRs. 3,827 for this age group in the district during 2008. The table shows that per capita expenditure for males is higher than that for females within the same age group. In fact, the per capita expenditure for males is higher than that for females on all age group except for the 16-50 years old age group, where female per capita health expenditure exceeds that of males, probably on account of higher reproductive health care cost among females in this age group. The average per capita expenditure for both male and female combined for the age group of 16-50 years old was NRs. 2,518.

When disaggregated by gender, males had per capita expenditure of NRs. 2,195, while females had per capita expenditure of NRs. 2,823. The 6-15 years old age group had the third highest per capita health expenditure, with an average of NRs. 1,187, while the age group 0-5 years old had least per capita expenditure of NRs. 649.

Figure 3.5.1 shows the distribution of total HH OOP health expenditure, according to various age group users or beneficiaries of health care services. It shows that the distribution of HH OOP health care expenditure generally favors the reproductive age of 16-50 years old group, with the senior citizens of the over 50 years old age group taking a poor second place in the apportionment of HH OOP health care expenditure.

Figure 3.5.1 Percentage Distribution of Household Health Expenditure among various Age Groups



Source: Household OOP Expenditure Survey, 2009

As shown in Figure 3.5.1 the age group 16-50 years old took up a significant share at 62 percent of total HH health care expenditure. The age group of the over 50 years old took up the second largest share, accounting for 21 percent of total HH health care expenditure while the age group of 6-15 years old had the third largest share with 13 percent of the total HH expenditure on health. The 0-5 years old age group accounted for just four percent of total health expenditure by the HH.

Since it had not been possible to disaggregate health care expenditure data from other financing sources, by gender and other equity-related variables, the overall share by age and gender in the total health expenditure of the district could not be estimated. It is possible that the distribution of HH OOP expenditure by gender and age group is merely a reflection of the gap in health care expenditure by other financing sources, which are then compensated for by higher HH OOP expenditures. For instance, the fact that the 0-5 year olds have the least share of HH health care expenditure may be a reflection of the larger amounts that government and NGOs may be spending for this age group. Conversely, the larger share of HH expenditures spent on the reproductive age groups and the over 50 years old may be a reflection of the relative lack of government and other financing sources provision for these age groups.

The HH health expenditure data disaggregated by gender would tend to indicate gender bias for males, in all age groups except those in the reproductive ages. The larger per capita health expenditure for females in the reproductive age group is probably also more influenced by the relatively larger need for women's health care in the reproductive age groups, rather than a definitive gender bias in favor of females in this age group. The HH survey does not provide sufficient data and information to clarify and explain the larger per capita health expenditures for males in the non-reproductive age groups. It could be argued that males are at higher health risk than females in these groups, but no data evidence on this had been generated by the survey.

3.5.2 Per Capita Household Health Expenditure by Consumption Quintile

An attempt was also made to analyze per capita expenditure of the HH according to different consumption quintile. Household's average expenditure for a month was captured through HH survey. The HH, with different expenditure categories, were later categorized into five different consumption quintiles, from poorest to richest quintile.

Table 3.5.2 shows that the second poorest quintile had the least per capita health expenditure with HH spending NRs. 1,597 per capita per annum. The poorest quintile spent more than the second quintile, indicating that health expenditure for this class is a greater burden relative to total HH expenditure. This also implies that the HH members in the poorest quintile are more vulnerable to illness and injuries, resulting in high frequency of care or high levels of health expenditure during the year. The poorest quintile had a per capita expenditure of NRs. 1,773 during the year. It is also notable that the per capital health expenditure in the second poorest quintile is significantly lower than that of the third and

Table 3.5.2 Per-capita Household Health Expenditure by Consumption Quintile

Consumption Quintile	Per Capita (NRs.) Expenditure
Poorest Quintile	1,773
Second Quintile	1,597
Third Quintile	2,325
Fourth Quintile	2,659
Richest Quintile	3,820

Source: Household OOP Expenditure Survey, 2009

fourth quintile, whose per capital health care expenditure was estimated at NRs. 2,325 and NRs. 2,659 respectively during the year. The per capita health care expenditure of HH in the third and fourth quintiles is almost NRs. 1,000 higher than those of the two poorest quintiles. The richest quintile had the highest per capita health care expenditure of all, with NRs. 3,820 spent per year in the district.

3.5.3 Per Capita Household Health Expenditure by Ethnicity

Table 3.5.3 presents the distribution of HH health expenditure among various ethnic classes. The various ethnic classes were classified into three broad categories, namely: (a) Upper caste, (b) Janajatis, and (c) Dalits. Since, the HH survey recorded the remaining different castes as other category; a separate header for others is also presented in Table 3.5.3.

Table 3.5.3 shows that among the various ethnic groups, the Janajatis had the least per-capita expenditure of NRs. 1,327 per year. The

Table 3.5.3 Per-capita Household Health Expenditure by Ethnicity

Ethnicity	Per Capita (NRs.) Expenditure
Upper Castes	2,588
Janajati	1,327
Dalits	1,715
Others	2,720

Source: Household OOP Expenditure Survey, 2009

Dalits, on the other hand, are spending more for health care than the Janajatis, which probably indicates that the disease burden is heavier in this relatively poorer class. The so-called upper caste had a relatively higher per capita expenditure of NRs. 2,588 during the year, which probably indicates their relatively better access to health care services in both public and private sector. Rest lumped under the "Others" category had the highest per capita health care expenditure of NRs. 2,720 during the year.

4 Conclusions and Recommendations

This study has demonstrated that constructing a DHA is both feasible and desirable, given the need to develop a useful and practical tool to formulate policy on health financing at the district level, and to measure progress towards achieving the goals of the State in improving the rationality of the distribution of resources for health care among its various sources and uses. It has also demonstrated the usefulness of the NNHA framework as a platform for developing a DHA, which can be linked and compared with the NNHA, although not all the account heading in the NNHA framework can be constructed, given the more limited scope and scale of health and financing operation of the district.

The study has also shown the need to either collect or periodically update primary HH level data dedicated to the DHA purpose, or to expand the scope and scale of the NLSS to enable it to generate health expenditure data that is valid at the district level for use in constructing a DHA. This means that the size of sample HH covered at the district level will have to be increased to provide statistically valid measures of HH health expenditures in all districts or in a sample of representative districts.

Additionally, there is also need to institute measures to improve the system and methods of recording and reporting health expenditure data by government and other financing agents to make them congruent with the NNHA framework. To achieve this, it might be necessary to initiate and facilitate dialogue among the health and finance stakeholders of central and local governments, as well as NGOs and private sector, to agree on a common framework for classification of programs, financing sources and expenditures for purposes of district health accounting.

Notwithstanding the data and system limitations, the Surkhet DHA has yielded credible and useful information on the major sources and uses of health care funds in the district. The DHA data provided concrete estimates of how much was spent for health care in the district, where the resources for health care in Surkhet came from, where these resources went, what kinds of health care were paid for, and at least for expenditures at HH level, who were benefited from the use of these resources. Briefly, the district was estimated to have spent NRs. 338.76 million for health care in FY 2005/06, about a third (34%) of which went to hospitals, 31.6 percent went to providers of ambulatory care, 18.6 percent went to retail outlets, and 8.3 percent went to the RoNE who provided for transport to access services. The greater bulk, or 64.2 percent, of these resources were used to purchase curative care services, mostly from hospitals (52.4%) and providers of ambulatory care (47.5%). A

sizeable proportion, or 19.0 percent, was used to purchase medical goods from retail outlets. Very little was used to purchase preventive / public health care (4.9%), administrative services and capital (2.8%). In short, most purchases went to meeting emergency present needs (curative care), and very little went to investment in improved future health (preventive and public health) and health service capacity development (administration and capital). Needless to say, and even with no data to show, these services benefited mostly the sick and the sickly. Happily, the DHA data showed an improved picture in FY 2006/07, with the GoN investing a little more in preventive and public health, raising its total share of health care expenditure to 7.8 percent from a measly 4.9 percent in FY 2005/06.

The Surkhet DHA data also showed that HH OOP spending accounted for the largest proportion of resources poured into health care provision and delivery. Accounting for 79 percent of total health expenditure in FY 2005/06 and 77.3 percent in FY 2006/07, HH bore most of the burden of payment for health care. Central government also made significant resource contribution to the health care system in the district, but not enough to cover the enormous health care needs of the population.

There are important policy implications that can be extracted from the data generated by the DHA, but policy analysis and recommendation is not the focus of this study. Rather, this study simply points the way towards developing a very useful tool to guide the assessment of current policy and the formulation of future policy. Despite its current limitations, the data generated are useful and important for both central level policy decision makers and district level program managers. For sure, the quality and completeness of data can be improved, but this study has demonstrated that DHA estimation can be done, and the data that can be generated by such an effort can be a useful and rich source of policy and program ideas that are more responsive to the needs of the district.

More specifically, the DHA gives the big picture in terms of resource flows in the district and provides policy analysts with a snapshot of whether and how these resources were used to address the critical health needs of the population. In the case presented in this study, the critical need appears to have been curative care as indicated by the decision made by HH and the central government to allocate a substantial proportion of health care funds to pay for use and provision of those services.

Epidemiological analysis might be used to complement this study in order to point out whether investing in curative care for a given set of health care problems is a wise use of scarce public and community resources, but it's difficult to argue against the decision of those HH faced with a critical present need for curative care. Time and again, experience has shown that HH faced with critical and emergency medical needs will seek curative care and exhaust all means to finance its use, even if it's not the most efficient way of addressing that particular health problem from a community perspective. It is, therefore, up to government to look at the big picture and determine how best to use public resources to address a community problem.

The DHA is a tool that government can use to look at the big picture. When used in tandem with other epidemiological, social and economic data, the DHA can inform government on how best to address health care problems, using both program and financing policy. This study has demonstrated how the DHA as a tool can be developed and generated at district level. The methods used in this study need not be the model and template for developing future DHA for Surkhet or for other districts. Rather, this study merely illustrated the usefulness of the exercise and used the experi-

ence as a stepping-stone towards creating an enabling environment for long-term DHA work.

More specifically, the study recommends that a discussion group be immediately convened by the Planning Office of MoHP to review the methods and results of this study and put together a more institutionalized system of DHA updating anchored on an upgraded district health finance recording and reporting system, supplemented by an expanded and regularly updated NLSS. The comprehensiveness, accuracy, and usefulness of the Surkhet DHA matrix generated by this study can be debated and analyzed, but only for purposes of drawing up an improved system of DHA generation that uses both institutional data systems and periodic surveys, which should be supported as part of the national statistical system. Cost is always a consideration, and in this case, the discussion group may look into alternative means of collecting and disaggregating data that will not require extensive surveys, but will still yield the kind of information that are needed to set up the DHA.

The NNHA / DHA data generation system is an evolving process and by its nature, needs to collect time series data over the long-term. It is envisioned that the system will require at least five to ten years of data and system evolution to mature into an institutional statistical system. Local experts and expertise need to evolve and grow with the NNHA / DHA institutionalization. International experts may be called in occasionally, if needed, to provide intermittent assistance, but only as a third eye of sorts, to correct or call attention to some myopic tendencies when local problems are viewed too close, or to supplement the needed human-hours of high caliber national or district officials who may not find sufficient time to do needed review and analysis to stimulate creative policy development processes. In the long run, however, the NNHA / DHA system is a national system that is operated and maintained by, and for, the Nepalese people.

Annexes

Annex 1

Nepal National Health Accounts Code and One-way Classification Table

A.1. One-way Classification of Health Expenditure by Health Providers on FYs 2005/06 and 2006/07 (NRs. in Million)

NCP Code	Providers of Health Care in Nepal	FY 2005/06	FY 2006/07
NP1	All hospitals	0	0
NP1.1	Hospitals	199.63	205.17
NP1.1.1	Tertiary hospitals	0	0
NP1.1.2	Secondary hospitals	0	0
NP1.1.3	Primary hospitals	4.38	3.33
NP1.2	Psychiatric hospitals	0	0
NP1.3	Specialty hospitals	0	0
NP1.9	All other hospitals	0	0
NP2	Nursing and residential care facilities	0	0
NP2.1	Nursing care facilities	0	0
NP2.2	Residential mental health/substance abuse facilities	0	0
NP2.3	Community care facilities for the elderly	0	0
NP2.9	All other residential care facilities	0	0
NP3	Providers of ambulatory health care (Primary care providers)	75.82	79.7
NP3.1	General practices (GP clinics)	0	0
NP3.2	Dental clinics	0	0
NP3.3	Other registered allopathic health care providers	0	0
NP3.4	Registered non-allopathic health care providers	0	0
NP3.5	Unregistered health providers	0	0
NP3.6	Out-patient care providers	0	0
NP3.6.1	General out-patient care providers	0	0
NP3.6.2	Family planning centers	0	0
NP3.6.3	Out-patient mental health and substance abuse centers	0	0
NP3.6.4	Free-standing ambulatory surgery centers	0	0
NP3.6.5	Dialysis care centers	0	0
NP3.6.9	All other out-patient multi-specialty centers	0	0

NCP Code	Providers of Health Care in Nepal	FY 2005/06	FY 2006/07
NP3.7	Medical and diagnostics laboratories	0	0
NP3.8	Providers of ambulatory health care services	0	0
NP3.9	Other providers of ambulatory health care	0	0
NP3.9.1	Ambulance services	0	0
NP3.9.2	Blood and organ banks	0	0
NP3.9.3	Providers of all other ambulatory health care services	0	0
NP4	Retail sale outlets and other providers of medical goods	0	0
NP4.1	Pharmacies	0	0
NP4.1.1	Allopathic pharmacies/dispensaries	30.67	31.74
NP4.1.2	Non-allopathic pharmacies/dispensaries	2.15	2.23
NP4.2	Retail sales outlets and other suppliers of optical glasses and other vision products	0	0
NP4.9	Retail sales outlets and other suppliers of hearing aids, medical appliances (other than vision products), and all other pharmaceutical and medical goods	0	0
NP5	Provision and administration of public health programs	16.5	27.86
NP6	General health administration and insurance	9.61	8
NP6.1	Government administration of health	0	0
NP6.2	Social security funds	0	0
NP6.3	Other social insurance	0	0
NP6.4	Other (private) insurance	0	0
NP6.5	All other providers of health administration	0	0
NP7	Other industries (rest of the Nepalese economy)	0	0
NP7.1	Providers of occupational health care services	0	0
NP7.2	Private households (classified as providers of home care)	0	0
NP7.3	All other industries (classified as secondary providers of health care)	0	0
NP9	Rest of the world	0	0
	Total	**338.76**	**358.03**

A.2. One-way Classification of Health Expenditure by Health Care Functions on FYs 2005/06 and 2006/07 (NRs. in Million)

Code	NNHA Functions	FY 2005/06	FY 2006/07
NF1	Curative care services	0.13	0.13
NF1.1	In-patient curative care	0	0
NF1.1.1	Allopathic hospital in-patient care	79.29	80.97
NF1.1.2	Allopathic hospital out-patient care	17.54	17.25
NF1.1.3	Non-allopathic hospital in-patient care	0	0
NF1.1.4	Non-allopathic hospital out-patient care	1.16	1.29
NF1.1.5	Other in-patient curative care	0	0
NF1.2	Day cases curative care	0	0
NF1.3	Out-patient curative care	44.8	46.87
NF1.3.1	Basic medical and diagnostic services	57.7	59.72
NF1.3.2	Out-patient dental care	0	0
NF1.3.3	All other discipline-specific specialized medical care services	0	0
NF1.3.4	Non-allopathic medicine and other health care services	0	0
NF1.3.9	Curative home care services	0	0
NF2	Rehabilitative care services	0	0
NF2.1	In-patient rehabilitative care	0	0
NF2.2	Day-cases of rehabilitative care	0	0
NF2.3	Out-patient rehabilitative care	0	0
NF2.4	Rehabilitative home care	0	0
NF3	Long-term nursing care	0	0
NF3.1	In-patient long-term nursing care	0	0
NF3.2	Day-cases of long-term nursing care	0	0
NF3.3	Long-term nursing care (home care)	0	0
NF4	Ancillary health care services	0	0
NF4.1	Clinical laboratory services	2.19	2.27
NF4.2	Diagnostic imaging	0	0
NF4.3	Patient transport and emergency rescue	27.56	28.52
NF4.9	All other ancillary services	0	0
NF5	Medical goods dispensed to out-patients	1.27	2.74
NF5.1	Pharmaceuticals and other medical non-durables	0	0
NF5.1.1	Prescription medicines	0	0
NF5.1.2	Over-the-counter medicines	0	0
NF5.1.2.1	Allopathic medicines	61.82	63.95
NF5.1.2.2	Non-allopathic medicines	2.19	2.27

Code	NNHA Functions	FY 2005/06	FY 2006/07
NF5.1.3	Other medical non-durables	0	0
NF5.2	Therapeutic appliances and other medical durables	0	0
NF5.2.1	Glass and other vision products	0	0
NF5.2.2	Orthopedic appliances and other prosthetics	0	0
NF5.2.9	All other miscellaneous medical durables including hearing aids and medico technical devices, such as wheelchairs	0	0
NF6	Preventive health care and public health services	11.63	22.75
NF6.1	Family health (MCH and FP) and reproductive health services	0	0
NF6.1.1	Safe motherhood services including newborn care and family planning	0	0
NF6.1.2	Infant and child health	0	0
NF6.1.3	Family planning services	3.82	4.31
NF6.1.4	Young people's sexual and reproductive health	0	0
NF6.1.5	Other reproductive health	0	0
NF6.2	School health services	0	0
NF6.3	Prevention and management of communicable diseases	0	0
NF6.3.1	Immunization (except EPI)	0	0
NF6.3.2	Water and food borne disease control	1.62	0.22
NF6.3.3	Tuberculosis and leprosy control	0.13	0.27
NF6.3.4	STDs	0	0
NF6.3.5	Vector borne diseases	0.1	0.31
NF6.3.6	Other communicable diseases	0	0
NF6.4	Prevention and management of non-communicable diseases	0	0
NF6.5	Occupational health care	0	0
NF6.9	All other public health services	0	0
NF7	Health programme administration and health insurance	0	0
NF7.1	Government administration of health and health-related social security	5.09	6.3
NF7.2	Private health administration and health insurance	0	0
NFR	Health related functions	0	0
NFR.1	Capital formation of health care provider institutions	17.84	16.84
NFR.2	Education and training of health personnel	2.88	1.05
NFR.3	Research and development in health	0	0
NFR.4	Drinking water and sanitation	0	0
NFR.5	Administrative and provision of social services to those living with disease and impairment	0	0
NFR.6	Administrative and provision of health related cash benefits	0	0
NFR.9	All other health-related expenditures	0	0
	TOTAL	**338.76**	**358.03**

Annex 2

Household Survey Questionnaire

1. Survey Information						
1.1 Household ID:						
1.2 Address: VDC:			Ward:		Tole:	
1.3 Date of Interview (DD/MM/YY):						
1.4 Interviewer's Name:						
1.5 Is this a Replacement Household?	☐ Yes		☐ No			
2. Household Information						
2.1 Name of the Household Head:						
2.2 Name of the Respondent:						
2.3 Respondent's Relation with HH Head:						
2.4 Religion:						
2.5 Language:						
2.6 Caste:						
2.7 Household Size (Verify it with Section 4):						
Interviewer's Comment:						
Name of Supervisor:				Signature:		
Supervisor's Comment:						
Date:						

3. Wealth, Income and Accommodation Information

3.1	What is the structure of the house?	☐ Cement Bonded Bricks/Stones	1
		☐ Mud Bonded Bricks/Stones	2
		☐ Wood/Branches	3
		☐ Unbaked Bricks	4
		☐ Other Material	5
3.2	How many floors are there in your house?		
3.3	How many rooms are there in your house?		
3.4	How much land do you possess (Including the area covered by house)?	Area: Bigha/Ropani:	Kattha/Aana:
3.5	Do you have land in urban city? Area:	If yes, Name of the City: Bigha/Ropani:	Kattha/Aana:
3.6	If someone wants to purchase whole Land, what price you would be accepting?	NRs.:	
3.7	Is your own production sufficies your consumption throughout a year?	☐ Yes	☐ No
3.8	If no, how much do you spend on purchasing food from market?	NRs.:	
3.9	Write down your household expenditure of last months	NRs.:	
3.10	Do you save out your monthly income? Write down saving or deficit for last months:	NRs.:	
3.11	What is the source of deficit financing?		
3.12	What is the monthly cash earning of all family members?	NRs.:	

4. Household Member's Information*

4.1 Member's ID	4.2 Name of Member	4.3 Sex	4.4 Age	4.5 Marital Status	4.6 Occupation	4.7 Education
		1. Male 2. Female	Write in Years (If less than 1 Year, write 0)	1. Married 2. Unmarried 3. Widowed 4. Separated	1. Employed (Wage Earners) 2. Self Employed 3. Unemployed / Retired 4. Student 5. Housewife 6. Others	1. Illiterate 2. Literate without Formal Schooling 3. Primary School (1-5) 4. Lower Secondary (5-10) 5. 10th and 10+2 6. Above 10+2 7. Diploma/Technical 8. Others

Note: Household consists of family members sharing same kitchen. Donot include the members sharing home however not sharing same kitchen. Include the name of the members who has been staying at home for at least one year.

5. Illness and Injuries Information

Please write down the name of the family members who suffered from any illnesses/injuries during past 12 months.

Member's ID	Name of the Member

5. Illness and Injuries Information

5.1 **Member's ID**	5.2 **What was the type of illness or injuries encountered ?**	5.3 **What was the remedy sought to cure the illness or injuries?** (Ask for first time and repeat if necessary) 1. Treatment at own home 2. Treatment at other's home 3. Health Institutions (If 1., go to Section 7. If 2., go to Section 8)

6. Health Institutions Information

Member's ID	6.1 Where did you consult for treatment? Government Health Institution 1. SHP 2. HP 3. PHC 4. Hospital 5. Mobile Clinic 6. Ayurved Centre Private Health Institution 7. Pharmacy/Clinic 8. Private Hospital	6.2 What was the mode of transportation? 1. Walked 2. Carried 3. Ambulance 4. Other vehicle 5. Stretcher 6. Doko 7. Cart 8. Other (specify)	6.3 What was the total transportation cost? (Including accompanying person, from Home to Service Centre to Home.) Write down total.	6.4 Whom did you consult with? Government Health Worker 1. Doctor 2. Paramedic (HA, AHW etc.) 3. Kaviraj/Vaidya Private Health Worker 4. Doctor 5. Paramedic 6. Kaviraj/Vaidya 7. Other

6. Health Institutions Information

Member's ID	Write down Expenditure on following			Hospitalization				6.12 What was the accommodation cost of accompanying person during stay at hospital?
	6.5 User/Doctors Fee	6.6 Diagnostics Test, Lab Tests, X-rays, MRI, CT-Scan etc.	6.7 Medicine	6.8 Staying Costs	6.9 Surgery/ Test etc.	6.10 Meal	6.11 Any other Costs	

6. Health Institutions Information

Member's ID	6.13 Did you take any unprescribed medicine during the period of treatment sought? (If yes, write down the total amount spent on purchase of those medicine)	6.14 Did you receive any money for treatment of your illness or injuries? (If yes, write down code of provider) 1. Government (DDC/VDC/ Municipality/DAO/Ministry etc.) 2. NGO/INGO 3. Private Sector (Write down code separated by comma in case of multiple response)	6.15 What was the total amount received?	6.16 Did you make any follow up visit for same illness or injuries? 1. Yes 2. No (If yes, repeat from 6.1 again)	6.17 Did you fully recover from the illness or injuries? 1. Yes 2. No (If no, repeat from 6.1 again)	6.18 Did you again suffer from any other illness or injuries? 1. Yes 2. No (If yes, repeat from question 6.1)

7. Treatment at Home

7.1 Member's ID	7.2 What kind of treatment did you seek at home? 1. Self Treatment 2. Traditional Healer 3. Health Workers 4. Others	7.3 Self Treatment (Write down in NRs.)		7.4 Traditional Healer/ Health Worker (Write down in NRs.)			7.5 Did you seek remedies at home again? 1. Yes 2. No (If yes, repeat from 7.2)	7.6 Did you fully recover from the illness/ injuries from self treatment? 1. Yes 2. No (If yes, go to 7.7 If no, go to 5)	7.7 Did you again suffer from any other illness or injuries? 1. Yes 2. No (If yes, go to 5.3. If no, end the interview for the particular member)
		Medicine	Other Cost (If any)	Fee	Kinds	Medicine			

8. Treatment at Others Home (Traditional Healer/ Health Worker Home)

8.1 Member's ID	8.2 Transportation Cost (If any)	8.3 Expenses			8.4 Did you make any follow up visit for same illness/injuries? 1. Yes 2. No (If yes, repeat from 8.2 again)	8.5 Did you fully recover from the illnesses/injuries from self treatment? 1. Yes 2. No (If no, go to question 5.3)	8.6 Did you again suffer from any other illness or injuries? 1. Yes 2. No (If yes, go to question 5.3)
		Fee	Kinds	Medicine			

9. Other Health Services

Did any family members took any of following health services during past twelve months?

9.1 **Services** 1. Immunization 2. Maternity 3. Family Planning 4. Nutrition 5. Others	9.2 **Member's ID**	9.3 **Where did you take the services?** **Government Health Institution** 1. SHP 2. HP 3. PHC 4. Hospital 5. Mobile Clinic 6. Ayurved Centre **Private Health Institution** 7. Pharmacy/Clinic 8. Private Hospital 9. Health Worker's home 10. Other (specify)	9.4 **Enumerator please probe for expenses on followings:**				9.5 **Did you receive any incentives from others?** 1. Yes 2. No (If no, end questionnaire)	9.6 **What was the amount received?**
			Transportation	Medicine	Fee	Other Costs (if any)		

Annex 3

List of Enumerators and Field Assistant / Data Analyst

Field Assistant / Data Analyst

1. Mr. Sumanta Neupane

List of Enumerators

1. Ms. Durga Pokhrel
2. Mr. Jeeban Kumar Acharya
3. Mr. Khadka Bahadur Chand
4. Ms. Laxmi Rantabhat
5. Mr. Mahendra Prasad Acharya
6. Mr. Prakash Nepali
7. Mr. Rajendra Podel
8. Mr. Shanta Gautam
9. Mr. Surat Bahadur BC
10. Mr. Thakur Prakash Bhandari

Annex 4

Check Lists for Information Collection

1. List of Information Collected from Private Health Care Providers

I. Schedule of services and charges
   a. Public health & preventive services
   b. Outpatient consultation
   c. Inpatient care

II. Service hours
   a. Day service only
   b. 24-hour service

III. List of health / medical care-givers
   a. MD, General Practice
   b. MD, Specialist
   c. Nurses
   d. ANM/Midwife
   e. Lab Technicians
   f. Volunteer Workers
   g. Others

IV. Number of operating beds for hospital

V. Bed occupancy rates

VI. Classification of patients (age, gender, economic class) served and number served per classification per month, quarter, or year

VII. Sources of capital and operating funds
   a. Owner's equity
   b. Grants from Government or NGOs or EDPs
   c. Loans
   d. Revenues
   e. Donations
   f. Others

VIII. Revenues and expenditures in FYs 2005/06 and 2006/07
   a. Expenses to pay personnel salaries and wages
   b. Expenses in maintenance and operation, e.g., electricity, water supply, etc.
   c. Expenses to purchase medical supplies and medicines
   d. Other expenses

IX. Sources of revenues and amount per source in FYs 2005/06 and 2006/07

a. User fees paid by patients directly
b. Claims paid from health insurance
c. Claims paid by employers
d. Claims paid by other donors
e. Government subsidy
f. Others

2. List of Information Collected from NGOs / INGOs

I. Profile of NGO / INGO

a. Nature of business or public services
b. Clients / beneficiaries of business or services
c. Nature of health benefits offered
    i. Benefits for employees
    ii. Benefits for clients / beneficiaries

II. Health care performance in FYs 2005/06 and 2006/07

d. Number of clients / employees given health services
e. Type of services given
f. Cost of benefits paid for personal health care (curative care)
g. Cost of benefits paid for group or community care (public health)

III. Administrative cost incurred by NGO / INGO in provision of services / benefits

h. Salaries of support non-medical staff
i. Maintenance and operating expenses, e.g. electricity, water, telephone, etc.
j. Capital outlay cost (office equipment, building, etc.)

3. List of Information Collected from External Donor Partners (EDP)

I. Verify nature of participation in district health system (whether funding source/agent, direct service provider, etc.

a. ICHA classification of EDP
b. Description/explanatory note for classification

II. Profile of EDP

c. Description of health projects or activities in district
d. Type and number of health service beneficiaries in district
e. Activities and projects in other districts, if any

III. Health-related Performance in FYs 2005/06 and 2006/07

f. Number of beneficiaries served
    i. Direct beneficiaries for personal health care
    ii. Indirect beneficiaries for group health or public health programs
g. Cost of benefits rendered

IV. Administrative costs incurred in FYs 2005/06 and 2006/07

h. Salaries of non-medical support staff
i. Office maintenance and operating expenses
j. Capital outlay (office equipment, building, etc.)

Annex 5

List of Medical Drug Centers, Nursing Home and Training Institute

1. Srijana Medical Store
2. New Thapa Medical Center
3. Aasha Medical Center
4. Tripti Drug Store
5. Panch Koshi Drug Store
6. Supath Medical Store
7. New Surkhet Medical Hall
8. Chaudhary Optical House
9. Chaudhary Aurvedic Aaushdhalaya
10. Maya Medical Store
11. Deuti Nursing Home

Annex 6

List of NGOs

1. Simi OVC
2. Nepal Red Cross Society
3. Merie Stops
4. Digo Bikas
5. CECI
6. Nepal Family Health Association
7. GTZ

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