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Ministry of Health & Population

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Social Service Unit
Pilot Initiative (2013 - 2015)

	Indicator	2015	2013
1	Percentage of target group patients who said the free or partially free service provided by the SSU at the hospital was 'good'	68.2	NA
2	Percentage of target group patients who said the free or partially free service provided by the SSU at the hospital was 'satisfactory'	26.5	NA
3	Percentage of target group patients reporting no delays and/or problemsin accessing services/medicines	75.0	NA
4	Percentage of target group patients who knew about the free service before coming to the hospital	65.9	33*
5	Percentage of target group patients who came to know about free service through sources other than hospital staff/doctors	67.7	23.5*
6	Percentage of target group patients who felt good about cleanliness of the hospital	75.8	NA
7	Percentage of target group patients who felt good about the behavior of the service providers	94.7	NA

Evaluation Report

NHSSP

ACKNOWLEDGEMENT

The mandate of the Government of Nepal is to create a more just, prosperous and socially inclusive society for all citizens. Within this, the responsibility of the health sector is to ensure that good quality health services are available and accessible to everyone - and particularly to women, the poor and the disadvantaged. To this end, all institutions across the Ministry of Health (MoH) have been striving to ensure equity in health service provision for many years.

In this respect, MoH has allocated grants to central, regional, sub-regional and zonal hospitals for the provision of free or partially free health services to key target groups since 2009/10. These groups include the poor, helpless, disabled, elderly, survivors of gender based violence and female community health volunteers.

More recently, a framework was established to help make health services more socially inclusive. Specialised social service units (SSUs) were set up in 2013 and 2014 in eight referral and central hospitals to ensure prompt access to effective curative services for members of key target groups. To this end, NGOs were also contracted to raise public awareness on SSUs, support service delivery and help meet recording and reporting requirements.

Following SSU establishment and a minimum of one year's operations at each site, it is now time for a formal evaluation of the inputs, activities and results to better inform hospital management and MoH on the achievements, lessons learned, challenges and recommendations going forward. Such an exercise will also provide important insights for the implementation of the Ministry's third Nepal Health Sector Strategy (NHSS-3, 2015-20) and the preparation of annual work plans and budgets (AWPBs) in the years ahead. In particular, it will provide vital information to MoH for the proposed establishment of SSUs in all secondary and tertiary level hospitals across the country.

MoH's GESI Section has worked tirelessly since 2011 to help establish and operationalise all eight SSUs. Accordingly this evaluation can play an important role in helping to develop plans to further strengthen its support in the period ahead.

For carrying out this evaluation, I would like to express my deepest appreciation to all those who have contributed their time and efforts. My special gratitude goes to MoH's Joint Secretary Mr. Narayanraj Timilsena and his team, and to Mr. Parba Sapkota, Mr. Mukunda Sharma and Mr. Keshab Pandit. The consultants who conducted the SSU evaluation, Mr. Kumar Upadhyaya and Mr. Devi Prasai, also deserve our sincere thanks. In addition, I would like to acknowledge my appreciation for the crucial role played by NHSSP's GESI team - Mr. Sitaram Prasai, Ms. Deborah Thomas and Ms. Rekha Rana.

Shant Bahadur Shrestha
Secretary

ACKNOWLEDGEMENTS

The Interim Constitution of Nepal 2063 (2007) establishes that "Every citizen shall have the right to basic health care services free of charge from the State as provided by law." Towards meeting this goal MoH has, since 2009/10, provided grants to central, regional, sub-regional and zonal hospitals to provide free or partially free health care services to target group patients. The scheme targets poor patients, helpless patients, those with disabilities, senior citizens, gender based violence survivors, and female community health volunteers.

More recently, an operational framework has been established to implement and expand the scheme and Social Service Units (SSUs) have been piloted in eight referral and central hospitals. Their purpose was to increase access to curative services for targeted patient cohorts by ensuring the prompt, efficient and smooth flow of services. NGOs have been contracted to promote awareness of SSUs, support service delivery and assist facilities meet recording and reporting functions.

Following the establishment of pilot SSUs in 2013 and 2014 there is a need to conduct an evaluation to inform hospital management and MoH of the operating modalities, achievements, lessons learned, challenges and constraints faced. The evaluation will potentially inform NHSS-3 implementation and annual work plans and budgets (AWPB) in the years ahead. Further, it will provide the guidance needed to roll out of the initiative to all secondary and tertiary level hospitals.

The GESI Section of MoH has worked tirelessly since 2011 to support the social service unit initiative. In this regard, I would like to extend my sincere gratitude to Mr. Shant Bahadur Shrestha, Secretary, MoH for his guidance and leadership. I am also very grateful to my team in the MoH for working relentlessly on this important issue. I particularly thank Mr. Parba Sapkota, Mr. Mukunda Sharma and Mr. Keshab Pandit for their enduring support.

I am deeply appreciative of the efforts of the SSU chiefs and facilitators, regional health directors and DHO and DPHO heads for their efforts to address issues faced by women and poor and excluded people. I am also grateful to all the health workers who seek to reach and support these groups.

The Consultants who conducted the SSU evaluation, Mr. Kumar Upadhyaya and Mr. Devi Prasai also deserve sincere thanks.

I greatly acknowledge the support provided by the Nepal Health Sector Support Programme (NHSSP) for this evaluation of SSUs. My special thanks go to the GESI team of Mr. Sitaram Prasai, Ms. Deborah Thomas and Ms. Rekha Rana.

G. D. Thakur
Chief, Public Health Administration, Monitoring and Evaluation Division

EXECUTIVE SUMMARY

A. Background and context

Beginning in 2012/13, social service units (SSUs) have been established in eight referral hospitals (including three central hospitals) in Nepal as a pilot initiative. The aim is to increase access to curative services by promoting the prompt, efficient and smooth flow of these services to targeted patients. Target patients are defined as 'poor,' 'helpless,' 'patients with disabilities,' 'senior citizens,' 'gender-based violence survivors', and 'female community health volunteers.'

The *Social Service Unit (SSU) Establishment and Operation Guidelines* (2012, revised in 2014), guide the functioning of the SSUs, the provision of services to target groups and the monitoring and reporting of progress. NGOs are contracted to work with SSUs to promote awareness of SSUs, to facilitate and support service delivery to targeted patients, and to support SSU recording and reporting.

The Population Division of the Ministry of Health and Population (MoHP), with support from the Nepal Health Sector Support Programme (NHSSP), commissioned an independent evaluation of the initiative to inform hospital management and MoHP about the achievements, challenges, constraints and lessons, and to provide inputs to the Nepal Health Sector Strategy (2015-20). The evaluation was carried out between March and August 2015. The evaluation reviewed reports and documents; carried out in-depth stakeholder interviews, field visits and observations; collected and analysed data from the hospitals and carried out a cost-benefit analysis in three of the hospitals and a clients' survey in six of the hospitals.

B. Key findings

Hospital and SSU records collected for 2013/14 and 2014/15 at three hospitals (Seti Zonal, Bheri Zonal and Bharatpur) provide trend data to assess the capacity of SSUs to deliver services and compliance with the processes set out in the government's SSU guidelines. From this data we find that on aggregate there has been a significant improvement in the capacity of SSUs at these three hospitals and their compliance with SSU procedures:

- The SSUs' capacity to identify and serve their target groups has significantly increased. The overall capacity rating has gone up from 79% in 2013 to 93% in 2015.
- SSU compliance with the guidelines has increased significantly. The overall compliance rating went up from 63% in 2013 to 88% in 2015.

A client survey at six of the eight SSU hospitals provided insight into the extent to which SSUs are accurately targeting beneficiaries, client perceptions of the functioning of SSUs, and client access to information on free services. Compared to a similar exercise in 2013 in three hospitals we find greater awareness of subsidies among target group patients:

- The free or partially free services are highly targeted to the poor. Well over 80% of the target group clients accessing the free and partially free services were poor.
- Target group awareness about free services has increased significantly. The percentage of target group patients who knew about the free services before coming to the hospitals went up from 33% in 2013 to nearly 66% in 2015.

- The monopoly of information on free services by hospital staff and doctors has been 'broken'. The percentage of clients who knew about the free services through sources other than hospital staff and doctors went up from 24% in 2013 to 68% in 2015.
- Nearly 95% of clients said that the free and partially free services were either 'good' or 'satisfactory.' A similar percentage said the behaviour of care providers was either 'good' or 'satisfactory.' (The scale used was: 'good,' 'satisfactory' or 'bad.')

A cost-benefit analysis of the establishment and operation of SSUs was undertaken in three of the hospitals. These costs included capital costs such as building, furniture and equipment; human resources; and overheads such as consumables, repair and maintenance and utilities. The benefits included 'time saved of service providers/managers' due to SSU establishment and 'preventing the false poor from accessing services meant for the poor.' The results of the analysis show a high cost-benefit ratio:

- The average cost-benefit ratio for SSUs set up and operational is 1.41, which is high and shows that the replication of SSUs across hospitals for streamlining the management of free and partially free service is a worthwhile endeavour.

Feedback from hospital management and the findings of this evaluation endorse the added-value of SSUs:

- SSU establishment has significantly reduced the time care providers spend on identifying target groups and deciding on fee exemptions.
- SSUs are evolving into anchors of good governance. The Excel based management information system (MIS) served as an anchor of integrity in Bheri Zonal Hospital during a corruption investigation by the Commission for the Investigation of the Abuse of Authority (CIAA).
- A high level of service to the poor and other targeted patients has been achieved with the help of facilitators from local NGOs despite the fact that the NGOs do not get significant financial advantage from the partnerships.
- Dissemination of information about free and partially free service through different media (leaflets, brochures, seminars, local radios and NGO activities and meetings) among the wider public beyond hospital staff and their close circles has become possible through partnership with local NGOs.

C. Good practices and new initiatives

- Bharatpur SSU/hospital has started using staff nurse volunteers in addition to the partner NGO facilitators. This practice, has not only enhanced its capacity to serve the target groups, but is creating possibilities for economising on the cost of SSU facilitators in the long run.
- Bharatpur Hospital SSU has started deploying SSU facilitators for three shifts.
- Bharatpur Hospital has integrated its pharmacy with the SSU.
- SSUs have evolved into a single door for other targeted programmes (HIV/AIDS, nutrition rehabilitation, geriatric care) besides the free or partially free services for the six target groups at Koshi Zonal, Bharatpur and Western Regional hospitals.
- All the SSUs coordinated free round-the-clock service to the victims of the April and May 2015 earthquakes — an activity not envisaged in the SSU guidelines.

D. Challenges and constraints

Budget related:

- The budgets for free services are inadequate for the actual client load at the hospitals.
- Lack of reference to the use of the conditional and medicine grants in the SSU guidelines is hampering the proper use and accounting of the available funds.
- Delayed fund release to the SSU NGOs is resulting in delayed payments to SSU facilitators.

Targeting:

- The identification of the poor and targeting the scheme to the poor still poses some problems, with some free or partially free transactions still occurring outside the SSUs.

Service packages:

- The free service package to target group patients varies widely across hospitals.
- The clause in the SSU guidelines concerning limits for per-patient costs is not practical or adequate for chronic patients requiring regular services, patients requiring admission into the intensive care unit (ICU), and patients requiring long hospital stays.

Partnership with NGOs:

- The role of partner NGOs is sometimes marginalised.
- Western Regional Hospital is interested to create regular positions for SSU facilitators in the hospital and hire them directly without partnering with a local NGO. This option is not envisaged by the SSU guidelines. SSU facilitators in most hospitals expressed preference for such permanent jobs.

Institutional challenges:

- Frequent change of leadership (at the level of medical superintendent [MeSu] and SSU chief) has affected the capacity of SSUs.
- An appropriate institutional home for SSUs is needed in MoHP.
- The three central level hospitals have yet to fully operationalise their SSUs.

Health service challenges:

- Doctors tend to prescribe expensive medicines.
- The referral system faces fundamental problems and requires systemic reforms.
- The post-hospital care of gender-based violence (GBV) survivors, the homeless and abandoned children at one central hospital poses problems due to the lack of appropriate institutional arrangements for social protection agencies.

Functioning of SSUs:

- SSU staff have inadequate competence on using the ethnic classification of the Health Management Information System (HMIS), and on information management and basic knowledge of medicines.
- The non-integration of the hospital billing system with the SSU Excel programme results in duplication of data entry (about clients and costs).
- Despite progress in disseminating the free and partially free health service provisions among the general public through different media, the flow of information regarding free and partially free service provision is inadequate in some areas.

- The qualitative part of the regular SSU report is never filled in and reported by SSUs.

Political-economy context:

- Political issues affect the management of large referral hospitals, including conflict between trade unions. This impacts the provision of free or partially free care services.
- The use of free care funds to cover the cost of hospital staff health care at the hospitals continues.

E. Conclusions and recommendations

Significant progress has been made by some of the pilot SSUs during the short period of their establishment. Some SSUs and their hospitals have taken new initiatives aimed at improving their performance. The partnership arrangements with local NGOs, the dedication of the NGO facilitators, and the leadership of the SSU chiefs and medical superintendents have played a key role in the achievements.

However, the eight hospitals vary widely in terms of their progress in establishing and operationalising their SSUs. Given the challenges and constraints, MoHP and the hospitals need to take practical actions to ensure that the SSUs fulfil their missions in the coming years.

Based on the findings of this evaluation the recommendations are as follows:

1. Further enhance SSUs' capacity.
2. Strengthen partnerships with local NGOs.
3. Improve the flow of information on free or partially free services to the target groups, especially to remoter populations.
4. Support the process of adapting the SSU model to central hospitals.
5. Improve the budgeting system for free and partially free services so that the budget provided to SSUs is based on the local realities of the hospitals including:
    - local poverty incidence
    - client loads
    - per-patient expenditure
    - prescribed benefit packages.
6. Tie the use of conditional and medicine grants to the provision of free and partially free services and introduce budget sub-headings to streamline the use of these funds.
7. Standardise and enforce the benefits package (check-ups, investigation, medicines and other services) to the target groups based on the nature and size of hospitals.
8. Review the effectiveness of Bharatpur Hospital's practices of (i) deploying NGO facilitators for the night shift and (ii) the SSU handling the pharmacy.
9. Update the SSU guidelines.

F. Road map

The findings of the evaluation were presented to MoHP at workshops in June and August 2015, and a road map was prepared by the Population Division to carry forward MoHP's recommendations (see Section 9.3). MoHP agreed that the following should happen:

1. The SSU Management and Monitoring Committee (SSU-MMC) should be moved from the Population Division and kept under the Project Coordination Committee (PCC) for the time being.
2. The role of SSUs should include coordinating other hospital based social protection programmes.
3. The SSU-MMC should form a task force to define, standardise and enforce benefits packages (check-ups, investigation, medicines and other services) to the target groups under the free or partially free service.
4. The following groups, (besides the current six groups), should also be eligible for free and partially free services:
    - Groups qualified by decision of the government, such as victims of natural disasters, martyrs' families, beneficiaries of fully or partially phased-out social protection programmes, and others. The endangered and highly marginalised ethnic groups (as defined by the Janajati Mahasangh— a body that represents Nepal's ethnic groups) should also be considered if the government decides to include them in the scheme (without considering their socioeconomic status).
    - Clients brought by the police (victims of accidents, prisoners, and legal clients for free treatment and investigation) and with no other sources of funds.
5. Develop guidance to ensure earmarked budgeting for free and partially free services is based on the local realities of hospitals.
6. The SSU guidelines should be updated to accommodate the above changes and improve the monitoring and evaluation criteria and indicators.

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ACRONYMS

BS	Bikram Sambat (Nepali Official Era)
CIAA	Commission for the Investigation of the Abuse of Authority
DDC	district development committee
DFAT	Australian Department for Foreign Affairs and Trade
DFID	Department for International Development (UK)
DoHS	Department of Health Services
ECG	electrocardiogram
FCHV	female community health volunteer
FY	fiscal year
GBV	gender based violence
GESI	gender equality and social inclusion
HIV/AIDS	human immune-deficiency virus/auto-immune deficiency syndrome
HMIS	Health Management Information System
ICU	intensive care unit
ID	identification
ID	inpatient department
MeSu	medical superintendent
MIS	management information system
MoFALD	Ministry of Federal Affairs and Local Development
MoHP	Ministry of Health and Population
NA	not available
NGO	non-governmental organisation
NHSP	Nepal Health Sector Programme
NHSSP	Nepal Health Sector Support Programme
NICU	neonatal intensive care unit
NPR	Nepali Rupee (Currency)
OPD	outpatient department
PHA	public health administrator
PHCC	primary health care centre
PMW	Paropakar Maternity and Women's (Hospital)
PMW	Paropakar Maternity and Women's Hospital
SAHW	senior auxiliary health worker
SSU MMC	SSU Management and Monitoring Committee
SSU	social service unit
SWAp	sector-wide approach
ToR	terms of reference
VDC	village development committee
WRH	Western Regional Hospital, Pokhara

1 INTRODUCTION

1.1 Background

The Government of Nepal is committed to improving the health status of its citizens and has made impressive health gains despite conflict and other difficulties. The Nepal Health Sector Programme-1 (NHSP-1), the first health sector-wide approach (SWAp) in Nepal, ran from July 2004 to mid-July 2010. It was very successful and brought about many health improvements. Building on these successes, the Ministry of Health and Population (MoHP) and its external development partners designed a second phase of the programme (NHSP-2, 2010-2015). NHSP-2's goal is to improve the health status of the people of Nepal. Its purpose is to improve the utilisation of essential health care and other services, especially by women and poor and excluded people.

Technical assistance to NHSP-2 is being provided from pooled external development partner support (DFID, World Bank, DFAT) through the Nepal Health Sector Support Programme (NHSSP). NHSSP is a five-year programme (2010–2015), funded by the Department for International Development (DFID) through a consortium partnership and managed by Options Consultancy Services Ltd and including as partners Oxford Policy Management and Crown Agents. NHSSP is being delivered in two phases and is providing technical assistance and capacity building support to help MoHP deliver against the NHSP-2 Results Framework and prepare its Nepal Health Sector Strategy (2015-20).

The following are the key areas of NHSSP Phase II support:

- health policy and planning;
- health systems and governance;
- health financing;
- gender equality and social inclusion (GESI);
- essential health care services;
- procurement and infrastructure;
- monitoring and evaluation;
- aid effectiveness.

1.2 Social Service Units

The Constitution of Nepal 2072 (2015) says: "Every citizen shall have the right to basic health services free of cost and no one shall be deprived of emergency health services." Towards meeting this goal MoHP has, since 2009/10, provided grants to central, regional, sub-regional and zonal hospitals to provide fully or partially free of charge health care services to target group patients. The scheme targets poor patients, 'helpless patients,' patients with disabilities, senior citizens, gender-based violence survivors, and female community health volunteers (FCHVs).

In 2012 initial guidelines were developed for the functioning of social service units (SSUs) to administer free or partially free services at central, regional, sub-regional and zonal hospitals. Social service units have been established in eight referral and central level hospitals as a pilot initiative to increase access to curative services by promoting prompt, efficient and smooth flow of these services to targeted patients. NGOs are being contracted to work with SSUs to promote awareness of SSUs, facilitate and support service delivery to targeted patients and support SSUs to carry out their recording and reporting responsibilities.

The SSU Management and Monitoring Committee (SSU-MMC) of MoHP's Population[1] Division is responsible for the overall running of SSUs while individual SSUs function under a hospital SSU Management Committee.

The guidelines that specify how SSUs should be run (the SSU guidelines) were revised in 2071 (2014) based on an August 2013 progress review of the pilot initiative. The revised guidelines have provisions for monitoring indicators. Based on the performance of these pilot SSUs, MoHP plans to gradually roll out this initiative to all secondary and tertiary level hospitals with NHSSP's support.

1.3 About This Evaluation

Given this background, the Population Division of MoHP with support from NHSSP, commissioned an evaluation of the initiative to inform hospital managements and MoHP about the achievements, lessons learned, challenges, modalities and the constraints they faced. The evaluation was also expected to provide inputs to NHSS (2015-20) snd the annual work programme and budget of the coming years including direction to roll out the initiative to all secondary and tertiary level hospitals. The evaluation was carried out through MoHP/NHSSP hired experts between March and July 2015. Besides reviewing relevant reports and documents, the evaluation involved the following tasks:

- In-depth interviews with stakeholders at the central level and at the eight hospitals hosting pilot SSUs.
- Collection, triangulation and analysis of information from the eight hospitals (the Excel-based records, Health Management Information System (HMIS) records and other hospital records) including cost benefit analysis in three of the hospitals (Seti Zonal, Bheri Zonal and Bharatpur).
- Critical observation and interactions with the users of the Excel-based recording and reporting system related to the functioning and maintenance of the system.
- Survey of 395 target group clients from six of the hospitals with SSUs[2].

Additionally, collection and analysis of information from four selected hospitals that are expected to refer clients to the pilot-SSU hospitals was also carried out to get a sense of the functionality of the current referral system.

This is the report of the evaluation and its main focus is on (as per the evaluation's terms of reference at Annex 8):

- performance of the SSUs against agreed indicators
- performance of the partnership with local NGOs
- functionality of the Excel based SSU management information system (MIS)
- feasibility of SSUs coordinating with other social protection programmes.

Additionally, a section of the report sums up the state of the referral system between satellite hospitals and selected SSU pilot hospitals.

[1] Interviews with Population Division and NHSSP officials have revealed that the committee has not been functional, despite the provision in the guidelines, and the Population Division has taken up the role prescribed for the SSU-MMC in the social audit guidelines.

[2] The survey could not be carried out in Kanti Children's and Paropakar Maternity and Women's hospitals due to lack of adequate daily client flow during the evaluation period. The daily client flow was too small for the quantitative data collection.

Preliminary findings of the evaluation were shared in a workshop of stakeholders at the Hotel Annapurna Kathmandu on 26 and 27 June, 2015. The workshop inputs and feedback were incorporated into this report.

Subsequently, the key findings were shared with a team comprising Dr Sinendra Upreti, Director-General, Department of Health Services; Mr Mahendra Shrestha, Chief of Policy, Planning and International Division; Mr Parba Sapkota and Mr Mukunda Sharma of the Population Division, Mr Sitaram Prasai, NHSSP gender and social inclusion (GESI) adviser, and Ms Rekha Rana, NHSSP GESI Coordinator, on 4 July 2015. Consultation meetings were also held with the hospital managements of Kanti Children, Bir and Paropakar Maternity and Women's hospitals to contextualise the findings and recommendations. (The understanding reached during these consultation meetings are outlined in the Annex 1 hospital-wise facts sheet).

Finally, a second workshop of stakeholders, on 31 August 2015 at the Yak and Yeti Hotel, Kathmandu, discussed the findings and recommendations of the evaluation and suggested inputs for the preparation of a SSU Road Map. The Road Map was finalised by the GESI Section of the Population Division with consultant inputs based on suggestions from the final workshop.

2 PERFORMANCE OF THE PILOT SSUS BASED ON THE SSU GUIDELINES' PERFORMANCE ASSESSMENT CRITERIA

The SSU guidelines (2014) prescribe four types of indicators for carrying out periodic performance assessment: capacity, compliance, results and outcomes. The indicators have been formulated to show an ideal state (score '4'). The total score received by a hospital in one round of monitoring can be compared with the total in the next round. The status on each indicator can be scored from '1' (lowest) to '4' (highest) using integral numbers.

Tables 2a, b, c and d provide a quick reference to the indicators prescribed by the guidelines.

Table 2a: SSU capacity indicators

	Indicator
1	SSU is adequately and appropriately staffed (one officer level full-time unit chief, one office assistant, adequate number of facilitators with balance of gender and local ethnic diversity)
2	All SSU staff fully understand the guidelines, their roles and responsibilities and hospital systems
3	SSU has capacity to use recording and reporting formats and Microsoft Excel-based MIS
4	SSU works as a team with demonstrated leadership, good communication and high motivation to achieve the unit's mission
5	SSU is well equipped with necessary space, furniture, computers, and supplies
6	SSU is well supported by the SSU committee and hospital units/departments

Table 2b: SSU process (compliance) indicators

	Indicator
1	SSU working and reporting schedules are followed strictly
2	Patient-wise documentation is kept well, prescribed forms and records filled in appropriately
3	Prescribed authorities for fully free and partially free service are fully delegated to SSU
4	Expenditure per patient is regularly recorded and budget ceiling is strictly followed
5	Target groups unaccompanied by informed family members or acquaintances are well supported and facilitated
6	Effective coordination and communication is maintained with SSU sub-committee and other departments, including with the one-stop crisis management centre, where applicable, and for round-the-clock service provision to the target groups
7	The names of persons receiving partial or full free service are displayed in a public place to discourage the use of the service by well-off persons

Table 2c: SSU result indicators

	Indicators
1	The specified target groups consist of ….% of total patients benefiting from free or partially free services
2	The specified target groups consume ….% of total hospital budget for free or partially free service
3	The proportion of beneficiaries with valid ID cards or letters from appropriate institutions confirming their beneficiary identity is ....%
4	The proportion of beneficiaries referred from other health facilities is .....%
5	The proportion of beneficiaries from adjoining districtsis.....%
6	The proportion of beneficiaries from rural areas is.....%
7	The proportion of beneficiaries from disadvantaged groups according to MoHP's HMIS classification is similar to their proportion in the population of the districts currently served by the hospital

Table 2d: SSU outcome indicators

	Indicator
1	Percentage of target group patients satisfied with free or partially free service provided by the SSU at the hospital
2	Percentage of target group patients reporting no delays in accessing services/medicines linked to receipt of free or partially free care
3	Percentage of target group patients aware about their rights to free service provision
4	Percentage of target group patients who knew about the free service before coming to the hospital
5	Percentage of patients who came to know about free service through sources other than hospital staff
6	Amount of funds for free and partially free services from sources other than MoHP in last fiscal year
7	The hospital has fully owned the SSU

2.1 Overall Performance of the SSUs

Five of the pilot SSUs (at Seti Zonal, Bheri Zonal, Bharatpur, Koshi Zonal and Western Regional Hospitals) became operational in financial year 2012/13. All except the SSU at Koshi Zonal Hospital use the Excel-based recording and reporting system. Three central level hospitals (Kanti Children, Bir and Paropakar Maternity and Women's (PMW) hospitals) have established SSUs but they are yet to become fully operational as they are still struggling to adapt the current SSU model to their ground realities. The SSUs at Bir and Paropakar Maternity and Women's Hospitals have hired partner NGOs for facilitating the free or partially free service to the target groups. Kanti Children's Hospital is yet to hire a partner NGO.

Data available to the evaluation: Baseline information on capacity and compliance at Seti Zonal, Bheri Zonal and Bharatpur hospitals are available for 2013, and the evaluation collected equivalent data for 2015. For the Western Regional and Koshi Zonal hospitals data on capacity and compliance is only available for 2015. The Excel-based recording and reporting system in four of the hospitals

has generated information on result indicators. Information on outcome indicators was not available for any of the hospitals prior to the evaluation but was collected by the evaluation in six hospitals.

The evaluation undertook a clients' survey in six of the hospitals (except for Kanti Children's and PMW) and a cost benefit analysis in three hospitals (Seti-Zonal, Bheri-Zonal and Bharatpur). Information concerning target groups' knowledge about the free and partially free service gathered from client exit interviews[3] carried out in 2013 (in Koshi Zonal, Bharatpur and Bheri Zonal hospitals) provide very useful additional information. Table 2.1a shows the sources of information used.

Table 2.1a: Information sources used by the evaluation (sources are marked 'X')

Hospital	Capacity and compliance scores for 2013	Capacity and compliance scores for 2015	Result scores for 2013	Result scores for 2015	Outcome scores for 2015	Client exit interviews 2013	Client survey 2015	Cost benefit analysis
Seti Zonal	X	X	X	X	X		X	X
Bheri Zonal	X	X	X	X	X	X	X	X
Bharatpur	X	X	X	X	X	X	X	X
Western Regional		X			X		X	
Koshi Zonal		X			X	X	X	
Bir					X		X	
Paropakar Maternity								
Kanti Children								

The following is a summary of overall progress and achievements based on the information sources mentioned above. The details of the progress and achievements are presented in the next sections of the report.

Available SSU records show significant improvements between 2013 and 2015 at Seti Zonal, Bheri Zonal and Bharatpur hospitals:

- SSU capacity to identify and serve the target groups has increased significantly. Overall capacity rating has gone up from 79% (2013) to 93% (2015).
- SSU compliance with the guidelines has increased significantly. The overall compliance rating has gone up from 63% (2013) to 88% (2015).
- The percentages of Dalits and women among total clients accessing free and partially free service have remained approximately over 23% and around 50% respectively (in 2013 and 2015).

[3] The study was carried for NHSSP/MoHP by Kumar Upadhyaya.

The client survey (2015) shows the following:

- The free or partially free services are highly targeted to the poor. Well over 80% of the target group clients accessing free or partially free services were poor.
- Target group awareness about free services has increased significantly. The percentage of target group patients who knew about the free service before coming to the hospital went up from 33% (2013) to nearly 66% (2015).
- The monopoly of information on free service by hospital staff/doctors has been broken. The percentage of clients who know about the free services through sources other than hospital staff/doctors went up from nearly 24% (2013) to 68% (2015).
- Nearly 95% of clients said the free or partially free services were either 'good' or 'satisfactory.' (The scale used was: 'good,' 'satisfactory,' or 'bad.')
- Nearly 95% of clients said that the behaviour of care providers was either 'good' or 'satisfactory.' (The scale used was: 'good,' 'satisfactory,' or 'bad.')

The cost-benefit analysis shows the following:

- The average cost-benefit ratio for an SSU set up and in operation is 1.41, which is high and shows that replication of SSUs across hospitals for streamlining the management of free and partially free service is a worthwhile endeavour.

Interviews with stakeholders and observations by the evaluators showed the following:

- SSU establishment has significantly reduced the time care providers spend on identifying target groups and deciding on fee exemptions.
- SSUs are evolving into anchors of good governance. The Excel-based MIS is served as an anchor of integrity in Bheri Zonal Hospital during a corruption investigation by the Commission for the Investigation of the Abuse of Authority (CIAA).
- A high level of service to the poor and other targeted patients has been achieved with the help of facilitators from local NGOs, despite the fact that the NGOs do not gain significant financial advantage from the partnership.
- The dissemination of information about free and partially free services through different media (leaflets, brochures, seminars, local radios and NGO activities and meetings) among the wider public beyond the hospital staff and their close circles has become possible through partnerships with local NGOs.

2.2 SSU Performance at Capacity and Compliance Level

Baseline performance rating was carried[4] out in 2013 for three of the eight pilot hospitals: Seti Zonal, Bheri Zonal and Bharatpur. These hospitals were again rated during the evaluation process in 2015. Their performance ratings against agreed indicators relating to (i) capacity to identify and serve the target groups, and (ii) compliance with the rules laid down in the SSU guidelines were compared. Tables 2.2a and 2.2b show that the capacity and compliance of the SSUs have improved significantly over the last two years.

Average SSU capacity rating has gone up from 19 marks (79%) in 2013 to 22 marks (93%) in 2015.[5]

4The performance rating was carried out by an external consultant together with the SSU chief. Three central hospitals (Kanti Children, Bir and Paropakar Maternity and Women) have not been rated as they are still in the process of operationalising the SSUs.

[5]The indicators comprising capacity are shown in Table 2a in the beginning of section-2 of this report.

Average compliance rating for the three SSUs has gone up from 18 marks (63%) in 2013 to 25 marks (88%) in 2015.

Table 2.2a: Overall SSU rating against capacity and compliance indicators for three hospitals

Sets of indicators	Average score against indicators		Average score in percentage	
	2013	2015	2013	2015
Capacity to identify and serve the target groups (Maximum score: 24)	19	22	79	93
Compliance to rules laid down by the guidelines (Maximum score: 28)	18	25	63	88

As Table 2.2b shows, the capacity scores for Western Regional and Koshi Zonal hospitals in 2015 are 20 and 21 respectively and above the average score of 19 for the three hospitals in 2013. (These two hospitals were not rated during 2013.) The compliance scores for Western Regional and Koshi Zonal hospitals in 2015 are 21, and above the average score of 18 for the three hospitals in 2013.

Table 2.2b: SSU scores for Koshi Zonal and Western Regional Hospital (capacity and compliance)

Sets of indicators	Total score against indicators for Koshi		Total score against indicators for WRH	
	2013	2015	2013	2015
Capacity to identify and serve the target groups (Maximum score: 24)	Not Available	21	Not Available	20
Compliance to rules laid down by the guidelines (Maximum score: 28)	Not Available	21	Not Available	21

Source: Score sheets for the SSUs (see Annex 1 for the hospital-wise scores).

2.3 SSUs'Performance at Result andOutcome Levels

The SSU guidelines prescribe specific indicators to assess performance at result and outcome levels. The evaluation found improved SSU performance against result level indicators where comparable data is available. Data for outcome level indicators was available for 2015 and some proxy data was used for two indicators for 2013; the overall level of performance at outcome level is good. Interviews with hospital level stakeholders and information from the clients' survey and cost-benefit analysis confirm the improvement in SSU performance at result level and good performance at the outcome level. Tables 2.3a and 2.3b show the performance rating at these levels.

Table 2.3a: The performance of the pilot at results level

	Indicator	2015	2013
1	The percentage of poor[6] among the surveyed sample beneficiaries who received free or partially free service as "poor" clients	84%	NA
2	The percentage of beneficiaries with valid ID cards or letters from appropriate institutions confirming their beneficiary identity	71.6	47.8
3	The percentage of beneficiaries referred from other health facilities	10.4	3.0
4	The percentage of beneficiaries from adjoining districts	27.5	26.9
5	The percentage of beneficiaries from rural areas	60.6	63.9
6	The percentage of beneficiaries from disadvantaged groups according to MoHP's HMIS classification		
	Dalits	24.1	22.9
	Disadvantaged Janajati (ethnic groups)	29.9	26.6
	Disadvantaged caste groups in Tarai	12.6	12.3
	Muslims (religious minority)	4.1	4.8
	Relatively advantaged Janajatis	3.3	4.1
	Upper caste groups	26.7	29.3
7	The proportion of beneficiaries from target groups (as per SSU records)		
	Poor	61.3	73.3
	Helpless	5.0	1.8
	Disabled	10.8	2.9
	GBV survivors	0.6	0.6
	Senior citizens	20.8	19.0
	FCHVs	1.6	0.9
	Others	0.2	1.5
8	Proportion of women among SSU beneficiaries	49.9	50.6

Sources of information: SSU records for #2-7and clients' survey for #1.

Notes to Table 2.3a on number of SSUs covered:

- The percentage of indicator 1 has been compiled from six hospitals' data which was covered by the clients' survey.
- The percentages of indicators 2 to 5 have been compiled from the data of three hospitals.
- The percentage of indicator 6 has been compiled from data of five hospitals included in the clients' survey.
- The percentage of indicator 7 has been compiled from data of eight hospitals.
- The percentage of indicator 8 has been compiled from data of seven hospitals.

[6] Proxy indicators (source of income, clothing and shoes, means of transport used for hospital travel and schooling of children at private vs government schools) were used to identify real poor among the sample clients who accessed free or partially free service.

Table 2.3b: SSU performance at outcome level for six hospitals

	Indicator	2015	2013
1	Percentage of target group patients who said the free or partially free service provided by the SSU at the hospital was 'good'	68.2	NA
2	Percentage of target group patients who said the free or partially free service provided by the SSU at the hospital was 'satisfactory'	26.5	NA
3	Percentage of target group patients reporting no delays and/or problems in accessing services/medicines	75.0	NA
4	Percentage of target group patients who knew about the free service before coming to the hospital	65.9	33*
5	Percentage of target group patients who came to know about free service through sources other than hospital staff/doctors	67.7	23.5*
6	Percentage of target group patients who felt good about cleanliness of the hospital	75.8	NA
7	Percentage of target group patients who felt good about the behaviour of the service providers	94.7	NA

Sources of information: Clients' survey carried out as part of the evaluation in six of the hospitals.

* These data have been calculated from the sample of 85 patients interviewed in Bheri Zonal, Koshi Zonal and Bharatpur Hospitals in 2013 (SSU Study Report-2013, NHSSP/MoHP). Although the sample was small, the information gives some rough idea about the situation two years back.

3 COST-BENEFIT ANALYSIS

The study carried out a cost-benefit analysis in Seti Zonal, Bheri Zonal and Bharatpur hospitals. The benefits of SSU are many, but only the following two benefits have been included in the cost-benefit analysis[7]:

- Time saved of service providers/managers.
- Preventing the false poor from accessing services meant for the poor.

3.1 Time Saved of Care Providers

When the task of screening poor patients was shifted to SSU facilitators, care providers (including doctors and other medical staff) saved significant time. The time saved per day (eight working hours) of different staff involved in SSU-related tasks was converted into costs saved based on their salaries and benefit costs. The monetary equivalents of the time saved in Nepali rupees (NPR) by different types of services across the three hospitals are shown in Table 3a[8].

Table 3a: Benefits in NPR resulting from provider's time saved due to establishment of SSUs

Tasks	Seti Zonal hospital		Bheri zonal hospital		Bharatpur hospital		Total	Percent
Total time saved	Monthly saved	Yearly saved	Monthly saved	Yearly saved	Monthly saved	Yearly saved		
Inpatient (IP) consultation and discharge	16,235	211,049	26,960	350,476	15,727	512,535	1,074,059	29.6
Emergency services	2,654	34,497	7,961	103,493	4,744	61,675	199,665	5.5
Outpatient (OP) consultation	18,014	234,178	17,910	232,825	32,859	427,161	894,164	24.6
Diagnostic services	7,648	91,776	14,419	187,452	625	8,125	287,353	7.9
Administrative services	53,474	641,690	23,412	304,351	17,995	233,932	1,179,972	32.5
Grand total	**98,024**	**1,213,189**	**90,661**	**1,178,597**	**71,949**	**1,243,429**	**3,635,215**	**100.0**

The facilitator deals with the poor patients, fills in client identification forms, screens patients, guides patients to wards, and facilitates the collection of drugs from the store and keeps records of the patients. These tasks used to be undertaken by hospital providers and administrators (in the absence of an SSU). Thus, where SSUs are functional, care providers save a considerable amount of their professional time during client consultations.

3.2 Preventing 'False Poor' From Accessing Free Services Meant for the Poor

The prevented 'false poor' is the difference between the number receiving free or partially free service under the 'poor' category and the 'real poor' as assessed by evaluators using proxy indicators (as mentioned in footnote 6). A total of 100 clients' forms were assessed for each of the three hospitals to determine the proportion of 'false poor' among the beneficiaries accessing free or

[7] Time saved by consumers and their attendants, improvement in efficiency, and accountability and transparency are not included in the benefits due to lack of baseline information on them.
[8] Current exchange rate of NPR 159: 1 UK pound.

partially free service under the 'poor' category. Table 3b shows the results of the assessment in which we:

- took the proportion of false poor we identify from the 100 assessed forms at each hospital;
- used this to estimate the proportion of 'false poor' out of the total client load of each hospital; and
- used that data to estimate the cost savings from preventing the 'false poor' from accessing free or partially free services.

Table 3b: Prevented false poor

Hospital	Total clients	Proportion of 'false poor'	Detected false cases	Unit cost (in NPR)	Total cost (in NPR)
Seti Zonal	7618	12.0 %	917	754	691439
Bheri Zonal	2308	2.9%	67	789	52716
Bharatpur	2043	5.0%	103	1529	157097
Total	11,969	9.1%	1087		901252

3.3 Costs Incurred in Set Up and Operation of SSUs

The following costs were included in the cost-benefit analysis:

- capital costs (buildings, furniture and equipment)
- human resource costs
- overheads (consumables, repair and maintenance and utilities) (see Table 3c).

Table 3c: Costs (in NPR) of SSU set up and operation across the three hospitals

Cost of SSU	Seti Zonal	Bheri Zonal	Bharatpur
Building, furniture, and equipment	33,061	52,417	51,320
Human resources	912,000	912,000	942,000
Overheads	65,000	65,000	173,920
Total	1,010,061	1,029,417	1,167,240

3.4 Cost-Benefit Ratio

The benefit to cost ratio is much higher than 1 in all three studied hospitals, even without including the benefits to the client in terms of their time and effort saved. The analysis shows that the mean benefit to cost ratio for the three hospitals is 1.41. The ratio for Seti-Zonal Hospital is 1.89 and for the other two hospitals is 1.2 each. These results clearly support the case for the establishment and replication of SSUs in hospitals with sizable client loads. Table 3d shows the details of the ratio calculations for the three hospitals. The data is based on the data in Tables 3a, 3b and 3c.

Table 3d: Cost-benefit analysis (cost and benefit figures in NPR)

Hospital	Saved time	Prevented false poor	Total benefits	Cost of SSU	Cost benefit ratio
Seti Zonal	1,213,189	691,439	1,904,627	1,010,061	1.89
Bheri Zonal	1,178,597	52,716	1,231,313	1,029,417	1.20
Bharatpur	1,243,429	157,097	1,400,526	1,167,240	1.20
Total	3,635,215	901,252	4,536,467	3,206,718	1.41

4 CLIENT PERSPECTIVE: KEY FINDINGS FROM THE CLIENT SURVEY

Three hundred and ninety six (396) SSU clients receiving free or partially free services were surveyed in six of the SSU hospitals using a Nepali language questionnaire. The purpose of the survey was mainly to get information related to the proportion of poor among SSU clients, client satisfaction with the services provided and the behaviour of service providers, clients' knowledge about SSU services and feedback on problems and delays faced and suggestions for improvement. See Annex 7 for the questionnaires.

4.1 Percentage of Poor Among Clients Surveyed

The number of clients surveyed per hospital varied from over 40 to over 100 depending on the daily client load in the hospitals. The survey per hospital continued for three to four days and almost all of the clients who received free or partially free service through the SSU during the survey period were interviewed. These clients comprised different target groups eligible for free or partially free services. Four proxy indicators were used to assess the poverty status of the clients. Table 4a shows the proxy indicators and their interpretations.

Table 4a: Proxy questions or indicators and the percentage of poor among respondents

	Question or proxy indicator of poverty	Poor, if the answer is:	Percentage of poor among respondents
1	What means of transport was used to visit the hospital?	Public bus, cycle, rickshaw or on foot	77 (7% on foot)
2	Which school (private or government) do the family's children study at?	Do not go to school or go to government or community school	84
3	Whether someone from the family was working abroad (other than India)	No one working abroad	85
4	What type of shoes did the client wear?	Barefoot or slipper	82
Percentage poor based on the average of the four proxy indicators			82%
Percentage poor based on the average of the latter three proxy indicators			84%

The percentage of the poor among the free or partially free service recipients was 82% based on the averages of the four proxy indicators. The percentages based on three of the proxy indicators were much closer to the 'means of transport' indicator. The average percentage of the poor is better calculated based on the three latter indicators — giving a percentage of 84%. This assessment suggests that the accuracy of targeting poor and other target groups by SSUs is reasonably good.

4.2 Target Groups of Respondents

Of the 396 respondents, 365 fell into the target group category (see Table 4b). Comparison of the data from sample respondents with the data in Table 2.3a shows that the sample does not deviate much from that of the MIS data. The data also confirms that the poor and senior citizens make up most SSU beneficiaries.

Table 4b: Hospital-wise sample number by target group category

Hospital	Poor	Helpless	Disabled	Senior citizens	GBV survivors	FCHVs	Total
Bharatpur	50	0	0	15	0	0	65
Bir	27	4	9	29	0	2	71
Koshi Zonal	36	0	3	17	0	0	56
Seti Zonal	25	2	1	15	0	2	45
Bheri Zonal	18	1	0	18	1	1	39
Western Regional	71	1	3	12	0	2	89
Total	**227**	**8**	**16**	**106**	**1**	**7**	**365**
Percentage	**62%**	**2%**	**4%**	**29%**	**0%**	**2%**	

4.3 Behaviour of Service Providers

A very high proportion of clients rated the behaviour of the service providers either 'good' or 'satisfactory' from among the three options of 'good,' 'satisfactory,' and 'bad.' The relatively lower percentage given for the Western Regional Hospital was most likely because during the survey almost all clients were being refused free medicines due to short supply. (The SSU Chief had voiced her concern about this before the survey began.)

Table 4c: Satisfaction with the behaviour of service providers

Hospital	How was the behaviour of service provider?					
	Good	Satisfactory	Bad	Total	Total 'good or satisfactory'	Percentage 'good or satisfactory'
Bharatpur	65	12	3	80	77	96.3
Bir	59	11	1	71	70	98.6
Koshi Zonal	46	15	0	61	61	100.0
Seti Zonal	28	16	1	45	44	97.8
Bheri Zonal	19	20	0	39	39	100.0
Western Regional	53	31	16	100	84	84.0
Total	270	105	21	396	375	94.7

4.4 Information About Free or Partially Free Services

The survey assessed whether the clients had heard of the free or partially free services before coming to the hospital. During the 2013 assessment of selected hospitals, it was found that many clients were not informed of the services and a significant proportion of them heard of the free or partially free services only after coming to the hospital. Additionally, the information was mostly confined to the narrow circles of the hospital staff and doctors, and their relatives and acquaintances.

Against this background, the survey gives an insight into the changes that have taken place during the last two years. One important change concerns the source of information regarding free or

partially free service. Except for Bir hospital, the percentage of clients who came to know about the free or partially free service from sources other than the hospital staff has been impressive (see Table 4e). All the hospitals have carried out information dissemination campaigns in collaboration with their partner NGOs.

The analysis also shows some limitations of the information campaigns (see Table 4d). In Bharatpur, Bheri Zonal and Western Regional hospitals, the percentage of people who knew about the free service before coming to the hospital was lower than at the other three hospitals. These hospitals, therefore, need to focus their information campaigns on rural and possibly remote areas, as rural clients comprise 67% to 76% of all SSU clients in these hospitals. Tables 4d and 4e sum up the findings.

Table 4d: Clients who knew about free service before coming to the hospital, 2015

Hospital	Did you know about the free service before coming to the hospital?		
	Yes	Total respondents	Percentage 'yes'
Bharatpur	45	80	56.3
Bir	55	71	77.5
Koshi Zonal	50	61	82.0
Seti Zonal	33	45	73.3
Bheri Zonal	22	39	56.4
Western Zonal	56	100	56.0
Total	261	396	65.9

Table 4e: Sources of information about the free or partially free service, 2015

Hospital	Sources of information about the free or partially free service					
	Hospital staff, doctor and nurses	Family members	Other health workers & FCHVs	Radio, TV and newspaper	Total	% other than hospital staff
Bharatpur	8	22	7	4	45	82.2
Bir	42	8	0	0	57	26.3
Koshi Zonal	8	12	4	10	52	84.6
Seti Zonal	9	5	3	2	33	72.7
Bheri Zonal	5	2	6	3	23	78.3
Western Zonal	15	8	24	8	59	74.6
Total	87	57	44	27	269	67.7
Percentage	32	21	16	10	100	

4.5 User Charges Paid By Clients

Tables 4f and 4g provide information on user charges paid by target group clients served by the SSUs in different hospitals (Client survey, 2015). Table 4f shows that out of the sample of 396 respondents, nearly 60% of those classified as poor pay user charges compared with 14% of the FCHVs and 43% of the senior citizens.

Table 4f: Clients paying charges for medicines and investigations by target groups

	Types of clients						Total
	Poor	Helpless	Disabled persons	Senior citizens	GBV survivor	FCHVs	
Number of clients who paid user charges	134	2	9	46	0	1	192
Number of clientswho did not pay user charges	93	6	7	60	1	6	173
Percentage of clients who paid user charge	59.0	25.0	56.3	43.4	0.0	14.3	52.6

Source: Clients' survey 2015

Table 4g shows that medicine costs are the largest cost item followed by bed charges and lab services respectively.

Table 4g: Amount of user charges paid by target group clients (in NPR) for medicines and other charges

Patient type	How much paid for medicine?	How much paid for lab?	How much paid for ultra-sonograms**	How much paid for bed charge?	How much paid for other charges**	How much paid total?
Mean (NPR)	3,562	931	512	2,215.00	655	4,549
Standard deviation	5,709	1,785	716	3,505	1,395	7,545
Median*	250	750	—	—	—	1,000
No of responses	140	77	62	14	67	195

*Used median value of total expenditure because the standard deviation is higher than mean.

** Ultrasound sonograms are colloquially called video X-rays in Nepal.

*** The other charges were not specified in the questionnaire. Therefore there is no definite answer to what costs are included in 'other charges.' Costs of blood, dressing, ambulance and CT scan are not covered by the previous questions.

4.6 Open Suggestions From Clients

The survey asked the clients a question related to areas of improvement in the future. This was a multiple response question. There were 644 responses from the clients. Nearly one-fourth of the responses suggested an increment in the benefit amount for the patient and a similar number of responses suggested the provision of good medicines. About one-fifth suggested improvement in patient facilitation. The next suggestion was decreasing waiting time. About a tenth of responses concerned improvement in the behaviour of service providers. Table 4h shows the results of the analysis.

Table 4h: Suggestions from clients

Feedback/suggestions from clients	Response count	
	Number	Percentage
Decrease waiting times	98	15.2
Improve lab and x-ray service	49	7.6
Increase benefit amount for patients	154	23.9
Improve patient facilitation	128	19.9
Provide good medicines	148	23.0
Improve behaviour of service providers	67	10.4
Total	644	100.0

5 REFERRAL OF PATIENTS TO SSU-HOSTING HOSPITALS

The evaluation team visited a sample of four district hospitals to assess their protocols and practices of referring poor and target group patients to referral hospitals with SSUs. It was found that in the case of outpatient (OPD) services, referrals are done orally and are not recorded. In the case of emergency and inpatient (indoor) services, referrals are done through small write-ups on patients' registration slips in the form of "refer to higher centre." The names of referred hospitals were never mentioned on the forms examined. However, the doctors on duty typically tell patients about possible options orally, but it is left to patients to decide whether and where to go.

In the case of obviously poor patients, doctors tend to mention the name of the government hospital (the higher centre). Although in some cases, they just mention the place verbally (e.g., Nepalgunj) without specifying any hospital and let the client decide which hospital in that place to visit.

Referred patients are not followed up except in cases where the patient is personally known and/or the doctor in the referred hospital is also personally known.

Interviews with hospital staff revealed that patients' decisions on which hospital to select appears to depend on:

- the name (profile) of the hospital
- the distance to the hospital
- referral doctor's suggestion
- expected cost of treatment.

Only one medical superintendent in the visited hospitals was aware of a referral form prescribed by MoHP. However, no doctors were using the referral form as they find it very time consuming given the fact that they usually feel time-pressed even to write down prescriptions.

SSU records show that the percentage of SSU clients referred from satellite hospitals or health facilities was about 3% (in fiscal year 2070/71) and about 10% this fiscal year (2071/72). This increase was mainly due to the number of earthquake victims.

The clients' survey data also show that the percentage of referred clients was about 7%. Excluding Bharatpur Hospital data (which has a very high proportion of referred patients due to the relatively high number of earthquake victims) would bring the percentage to about 3%. Sample analysis of referral data in Bardiya District Hospital also shows the percentage to be around 3%.

The above findings reflect the fundamental problems with the referral system and the need for its systemic strengthening. The current eight hospitals with SSUs, their satellite hospitals and health facilities cover a large geographical region. The referral system is not limited to referrals from one district hospital to one or the other secondary or tertiary hospital. The evaluators are doubtful if short-term or piecemeal measures can work to improve referral practices for SSU clients without addressing the more systemic problems of the referral system which need to be embarked on within the context of broader referral systems reforms.

6 GOOD PRACTICES AND INITIATIVES

The evaluation found that the SSUs at the different hospitals have initiated measures and practices to improve SSU performance and to better serve the target groups. The following bullet points are some notable initiatives:

a) *Intern volunteers* — Bharatpur SSU/hospital has started using staff nurse volunteers in addition to the facilitators from the partner NGOs. This practice has not only enhanced its capacity to serve the target groups but also created possibilities for economising on the costs of SSU facilitators in the longer run.

The hospital invites nursing graduates for internships of six months at the hospital and takes 20 of them at a time for this. Five of these volunteers are placed at the SSU counter for a month and then deployed at other departments for the rest of their internships. After a month, another batch of five volunteers is placed at the SSU after serving in other departments. These volunteers thus naturally link the SSU with other departments.

Since it is mandatory for nursing students to have at least six months of internship at hospitals after graduation to qualify for regular positions, there is a continuous supply of such volunteers. Bharatpur (Chitwan) has several nursing schools to supply these volunteers.

b) *Three shifts* — Bharatpur Hospital SSU has started deploying facilitators for three shifts.

The hospital has started this practice based on the prevailing assumption that facilitators need deploying during the night shift to serve the target groups. The SSU guidelines envisage round-the-clock services to the target groups. So far only Seti-Zonal Hospital has expressed its intention to follow suit.

Obviously, the intention behind the initiative is good. The key question, however, is whether this practice is cost-effective (or even just effective). So far all eight pilot SSUs/hospitals have been providing services to the target groups round-the-clock seven days a week by coordinating with emergency and inpatient departments. It is too early to assess the added-value of this new initiative. The initiative needs to be assessed after a year or so to see its cost-effectiveness.

c) *Integration with pharmacies* — The hospital pharmacy has been integrated with the SSU at Bharatpur Hospital and partially at Seti-Zonal Hospital.

Providing all services to the target groups through one ‘door’ (SSUs) sounds ideal from the perspectives of target groups. The steps taken by Bharatpur Hospital to integrate the pharmacy with the SSU (and to some extent Seti Zonal Hospital) thus appear to be beneficial meaning that target groups do not need to separately access drugs from the hospital store or a medical shop. However, managing the inventory of medicines requires specialist medical knowledge and skills, personnel time, and adequate space and equipment and furniture. Bharatpur is somehow coping with the space and furniture limitations. Further observation and assessment is needed to decide whether or not this practice should be replicated in other hospitals. (Note that the Supreme Court recently directed all government hospitals to have their own pharmacies. It is yet to be seen how this directive will be taken forward by MoHP.)

d) *Integration with other programmes* — The SSUs have evolved into a single door for different targeted programmes (HIV/AIDS, nutrition rehabilitation, and geriatric care) besides the free or partially free service for the six target groups in Koshi Zonal, Bharatpur and Western Regional hospitals.

MoHP, through its different wings, implements a number of targeted health programmes across the country at hospital level. These programmes have different implementation guidelines and tend not to be coordinated at the central level. Often these targeted programmes are funded by donor agencies and once funding stops they remain a legacy at the hospitals. In some cases, the programmes are not adequately funded by the centre or by donors and require support from the hospitals for free investigations or medicines.

The hospitals are under pressure from patients to provide some sort of continuity to the targeted programmes noted above, despite the lack of adequate financial support from MoHP. As a result, the SSUs at the above-mentioned three hospitals are trying to serve the target groups of these programmes with whatever resources they have.

The role of the SSUs, however, is limited to exempting the cost of services or medicines for patients of the targeted programmes and does not cover other managerial functions (screening, monitoring, reporting and so on) related to the programmes. This poses the question as to whether the mandates of SSUs needs to be expanded to include coordinating these socially targeted programmes and that they should be supported with additional resources to implement them. It is too early at this stage to fully integrate these programmes in SSUs because the programmes follow different guidelines and modalities. Therefore the role of the SSUs vis-à-vis other social protection programmes should, for now, be limited to coordinating screening and the fee exemption process, and keeping records of these transactions.

e) *Other target groups* — All the SSUs coordinated free and round-the-clock service to the earthquake victims, an activity not envisaged by the SSU guidelines.

In the wake of the April and May 2015 earthquakes, all the SSUs coordinated free round-the-clock service to earthquake victims. Note that there is also the closely related practice of providing free or partially free services to vulnerable groups not specified by the guidelines (e.g., persons wounded during the People's Movement, families of martyrs, marginalised ethnic groups, HIV patients) in some hospitals (Bir, Bharatpur and Western Regional).

This raises the question as to whether or not victims of natural (or man-made) disasters and other vulnerable groups currently served by the hospitals should be officially listed as SSU target groups, besides the officially listed six groups. The two stakeholder workshops where the findings of the evaluation were shared suggested including these groups as SSU target groups.

7 CHALLENGES AND CONSTRAINTS

Despite the previously described achievements of the SSUs, the SSUs and their hospitals still face significant challenges and constraints. These are described below.

7.1 Budget Related

a) Budget provision for free service is proving inadequate for the client load at the hospitals.

There is no clear relationship between the budget and the number of targeted clients served. For example, Seti hospital SSU served four times more clients in 2071/72 (2014/15) than in 2070/71 (2013/14), but received only 45% more grant for medicines. The conditional grant for Bheri hospital remained stagnant while the hospital served about 20% more clients in 2014/15 compared to the previous year. With the increase in awareness about the free services and the subsequent increasing demand from target groups, the hospitals are finding it very difficult to cope with the increasing demand. This experience is not limited to these hospitals.

Koshi Zonal Hospital served over 18,000 target group patients in 2013/14, but due to budgetary constraints, it served only about 12,000 patients in 2014/15 (Table 7a). Other hospitals too are finding it difficult to cope with the increasing demand for free services due to their limited grants for this. Western Regional Hospital provided only investigation services free or partially free in the latter part of 2014/15, as they exhausted the fiscal year budget months before the end of the year. Seti Zonal Hospital reported using a significant portion of its income to make up for the lack of adequate budget from MoHP for free and partially free service.

Table 7a: Average subsidy per fully or partially free patient (SSU) in NPR

Hospital	Total patients served		Total patients served by SSU		Total conditional and grant medicine		Average subsidy per SSU clients for free or partially free care	
	2013/14	2014/15*	2013/14	2014/15*	2013/14	2014/15	2013/14	2014/15
Seti zonal	87,309	117,988	3,893	11,427	10,680,000	13,859,000	2,743	1,213
Bheri zonal	92,735	85,049	2,904	3,462	5,800,000	6,000,000	1,997	1,733
Koshi zonal	192,612	125,588	18,138	10,335	18,700,000	10,100,000	1,031	977
Bharatpur	160,868	190,975	3,628	3,065	7,450,000	5,500,000	2,053	1,795
Kanti Children	164,519	154,250	209	447	12,050,000	8,721,000	57,656	19,510
Bir Hospital	400,218	429,891	0	4,844	27,628,000	29,000,000	0	5,987
Maternity		55,353	208	444	1,000,000	13,200,000	4,808	29,730
Total	**1,098,261**	**1,159,094**	**28,980**	**34,023**	**83,308,000**	**86,380,000**	**2,875**	**2,539**

**Extrapolated based on 9 months data*

Table 7b shows the lower level of subsidies for all types of patients. The per patient average subsidy reduced in all the hospitals except Koshi Zonal Hospital due to the increasing number of clients in 2014/15 compared to the level of the total conditional and medicine grants (Table 7b). For example, in Seti Zonal Hospital, SSU clients increased by 194% in 2014/15 but the subsidy (grant) increased by only 29.8%. Koshi Zonal Hospital was forced to cut down the number of free service clients due to

the hospital's inability to pay for medicines purchased the previous year, as a result of which the supplier had stopped supplying medicine and so the number had steeply gone down.

Table 7b: Average subsidy per patient (NPR for free and charged clients both)

Hospital	Total patients served by hospital		Total patients served by SSU		Total conditional and grant medicine		Average subsidy per patient (all patients)	
	2013/14	2014/15*	2013/14	2014/15*	2013/14	2014/15	2013/14	2014/15
Seti zonal	87,309	117,989	3,893	11,427	10,680,000	13,859,000	122	117
Bheri zonal	92,735	85,049	2,904	3,462	5,800,000	6,000,000	63	71
Koshi zonal	192,612	125,588	18,138	10,335	18,700,000	10,100,000	97	80
Bharatpur	160,868	190,975	3,628	3,065	7,450,000	5,500,000	46	29
Kanti Children's	164,519	154,250	209	447	12,050,000	8,721,000	73	57
Bir Hospital	400,218	429,891	0	4,844	27,628,000	29,000,000	69	67
Maternity	NA	55,353	208	444	1,000,000	13,200,000	NA	238
Total	**1,098,261**	**1,159,094**	**28,980**	**34,023**	**83,308,000**	**86,380,000**	**76**	**75**

**Extrapolated based on 9 months data*

Note to Table 7b: As per MoHP's instructions, bed charges have been abolished in all zonal hospitals. However, Seti and Bheri hospitals only removed the bed charge for ordinary beds. Other hospitals have increased the proportion of free beds. In central level hospitals, over half of the beds allocated to free care, whoever uses them, need not pay anything. But SSU records did not catch those clients who used free beds. Therefore, the per patient subsidy was calculated by dividing the total conditional and medicine grants by total patients of the hospital (SSU + beyond SSU). Both analyses showed that the per patient subsidy decreased sharply from 2013/14 to 2014/15 due to the greater increase in patients in all hospitals compared to the level of conditional and medicine grants.

Table 7c shows how expenditure on free care increased in four of the six hospitals between 2013/14 and 2014/15 while it decreased in two of the six hospitals for which data is available.

Table 7c: Expenditure (NPR —conditional and medicines grants) on free care as % of total hospital expenditure

Hospital	2013/14	2014/15
SetiZonal Hospital	6.56	8.68
BheriZonal Hospital	2.41	3.74
KoshiZonal Hospital	4.09	3.81
Bharatpur Hospital	3.05	2.34
Kanti Children Hospital	1.34	2.59
Bir Hospital	na	0.38
ParopakarMaternity and Women's Hospital	0.07	0.11

Another issue related to hospital budgeting is worth discussing. At one time, MoHP declared all hospital beds to be free for all and the hospitals expected reimbursement from the MoHP for the

income foregone. Seti Zonal Hospital also reduced the prices of investigations by about half as per the directives received from the National Public Health Laboratory, thus reducing their annual income from laboratory services by nearly half. Koshi Zonal Hospital also spent millions of rupees for free or partially free services based on instructions from a MoHP team.

Koshi Zonal Hospital has payments due to venders (for pharmacy) of NPR 3 million. The venders have therefore stopped supplying the medicines and other materials due to the non-clearance of the dues. Therefore in 2014/15 the hospital was forced to cut down on providing free medicines to the target groups (except the helpless and GBV survivors). The proportion of targeted clients thus decreased from 28% of total clients in 2013/14 to 10% in 2014/15.

Similarly, Bheri Zonal hospital has NPR 7.5 million of outstanding payments to make for drugs and medical supplies, and thus in 2014/15 cut down the items of free medicines from 63 to 32. In the case of Western Regional Hospital, the number of free drugs was reduced from over 200 previously to 30 in 2014/15 due to the shortage of funds.

The hospitals were not compensated by MoHP for the amounts spent or their reduced incomes. Re-imbursements from MoHP have tended to be the exception rather than the rule. The above incidences hit against the basic rationale of establishing hospitals on separate acts or development board acts as semi-autonomous entities that can generate local resources. MoHP (or the central level authority) should find ways of reimbursing such costs arising from their directives. The best option would be not to initiate actions that interfere with the income sources and long-term sustainability of hospitals.

At the central level, there are no clear and transparent criteria for hospital budgeting. The current budgeting practice does not consider the context, client load or other relevant factors while providing budgets to different hospitals.

b) Lack of reference to the use of conditional and medicines grant in the SSU guidelines hampers the proper use and accounting of available funds.

Another budget-related issue prevails at the hospitals — some medical superintendents (MeSus) and most accountants consider SSUs as venues for spending limited funds with little oversight. There is a historical background to this confusion. The Government of Nepal started grant provision to referral hospitals in 2003 with a directive specifying the target groups, but without any mechanisms in place for identification, facilitation, fee exemption to the target groups and monitoring from the central or local level. What happened to the fund was entirely left to hospital managements.

When MoHP initiated the pilot SSUs in 2013, the hospitals generally considered this as an attempt to curb their freedom to spend the grant funds. Some hospitals resisted the formation of SSUs in the beginning. The SSU guidelines (original and revised versions) are silent on the question of budget headings and breakdown for the free or partially free services; this has encouraged some MeSus and accountants to perceive SSUs as a means of spending limited hospital budget with few financial controls over their actions; see for example box 7a.

For example, during the evaluation some hospital staff asked how much of the ‘conditional grant’ (money meant for target groups) could be spent on furniture and other expenses. At Western Regional Hospital no medicines were being provided free to target group patients although NPR 300,000 remained unused in the medicines budget. There was also a mismatch between the

expenditure for the target groups as recorded by the SSUs and that recorded in the accounts at all the hospitals. SSU records show the actual expenses but accounts consider purchase of medicines or lab reagents as expenses to be billed against budget allocations intended for free or partially free care administered by the SSUs.

Box 7a: Gaps in use of the budget intended for SSUs

SSU staff at Western Regional Hospital were not provided with any training, even on using Excel (as recommended). The SSU was unaware of the use of the budget sent to the hospital for capacity building and promotional activities. No promotional activities have ever been carried out. After raising this issue with the hospital management, action has been taken to use the money.

At Koshi Zonal Hospital the NGO has not been provided with any budget for training and promotional activities.

The conditional and medicines grants refer to budget lines provided by MoHP to cover the costs of providing free or partially free care to target groups. The addition of a clear clause in the SSU guidelines linking the 'conditional' and 'medicines' grants from MoHP to free and partially free services, and also specifying the budget breakdown with appropriate sub-heading, can clarify the confusion and reduce resistance by MeSus and accountants on using the funds for the poor.

c) Delayed fund release to NGOs resulting in delayed payment to SSU facilitators.

Most of the NGOs complained of delays in payment from the hospital resulting in the delayed payment of facilitators' salaries. The delays were sometimes due to delays in central level budgetary processes, which the hospital had no control over. At other times, the funds transfer from the hospital account to the NGO account was delayed. The Western Regional Hospital is paying the salary directly to the facilitators without transferring the funds to the partner NGO account, based on a memo of understanding between the hospital and the NGO, and therefore they do not face this issue. The NGOs at Bheri Zonal and Bharatpur hospitals reported paying the facilitators from the NGO reserve funds at times due to late payment from the hospitals.

7.2 Targeting

a) The identification of the poor and targeting the scheme to the poor still poses some problems, with some free or partially free transactions still occurring outside SSUs.

The results of the client survey show that about 85% of the beneficiaries served by the SSUs are poor. Only about 60% of the clients in the survey received SSU services under the target group headings of 'poor' and 'helpless'. This clearly suggests that a significant proportion of the other target group clients are also poor. Most of the senior citizens accessing the services were also poor. Table 7d below shows the composition of the sample by target groups as classified by the SSUs. The assessment of 'false poor' SSU clients in three hospitals also suggests that the accuracy of targeting is reasonably good with only about 9% 'false poor' beneficiaries identified on aggregate.

Table 7d: Composition of client survey sample by target groups

Target groups	Frequency	Percent
Poor	227	57.3
Helpless	8	2.0
People with disability	16	4.0
Senior citizens	106	26.8
Survivors of GBV	1	.3
FCHVs	7	1.8
No response	31	7.8
Total	396	100.0

Despite reasonable targeting accuracy, there is clearly room for further improvement in targeting funds more closely to prescribed beneficiaries. Also, there continues to be free or partially free service and medicine related transactions outside the remit of SSUs (see Box 7b). Seti Zonal Hospital has been distributing free medicines to all without SSU involvement since the time when MoHP introduced 40 free medicines for district hospitals, because there was no district hospital left when the hitherto Kailali District Hospital was up-graded to Seti Zonal Hospital. In the backdrop of budgetary constraints for SSU-facilitated services to the six target groups, the merit and justification of this 'free for all' distribution is highly questionable. Similarly, some MeSus and doctors were found recommending free or partially free service outside the SSU (at Nepalgunj and Bharatpur). This practice, though not wide spread, needs to be discouraged, as all free or partially free transactions are more efficiently and transparently channelled through the SSUs. At Bir Hospital the high percentage of Brahmin/Chhetris (the so-called high castes who tend to be better off) that make up the SSU beneficiaries (50%) in 2014/15 combined with the fact that only 26% of SSU beneficiaries learned about the SSU from non-health staff also raises concern about targeting errors.

Box 7b: Bypassing the SSU

"The MeSu sometimes bypasses the SSU and recommends free services. The MeSu once came and asked us to confirm the total SSU expense as 67 lakhs (NPR 6,700,000), if someone asked, and handed over the expenses sheet. (This was done in the backdrop of a CIAA investigation of corruption inside the hospital.) Unless the SSU partner NGO is invited to periodic reviews in the hospital, the NGO has no way of knowing the reality. (As per the SSU's records, the total expenses were around NPR 4,700,000 lakh. However, some of the free services like daily food expenses of patients on free beds are not at present recorded by the SSU.)

SSU partner NGO respondent, Bheri Zonal Hospital

Pressure from the non-poor for free services is still significant and non-poor patients often produce recommendation letters from their VDCs and municipalities. It is common practice for local bodies to recommend free services to poor as well as non-poor people. There are also reports of genuinely poor people being denied letters of recommendation because they are not complying to VDC initiatives to make the VDC open defecation free, and do not have a household toilet. As a result, SSUs cannot fully rely on the recommendations of local bodies and need to rely on their own screening criteria and framework to take final decisions on cost exemptions.

SSU staff's inadequate competence on identifying the poor is also contributing to targeting errors, as evidenced while checking the 'poor' identification forms filled in by SSUs. Interviews with SSU staff revealed that their understanding of the poor identification form was inadequate in some cases.

Some hospitals also provide free or partially free services to groups not specified by the guidelines including persons wounded during the People's Movements, the families of martyrs, marginalised ethnic groups, and HIV patients. And all the hospitals had provided free or partially free services to earthquake victims, although the SSU guidelines do not envisage free services for these groups.

7.3 Service Package

a) The free service packages to the target group patients tends to vary widely across hospitals

There is a wide variation in the free service package provided at different hospitals vis-a-vis medicines, investigations, operations, ICU and other charges (Table 7e). Although medicines are mostly provided free to all target groups, other services are charged at varying rates.

Table 7e: Existing benefit packages for targeted free and partially free care at referral and central hospitals

	Hospital	Benefits				
		Consultation	Investigation	Medicines	Procedures	ICU
1	Seti	OP/IP/emergency	All lab tests, X rays, ultrasound, ECGs	All medicines prescribed by providers	All types surgical procedures	limited
2	Bheri	OP/IP/emergency	All lab tests, X rays, ultrasound, ECGs	38 essential drugs only	All types of surgical procedures	limited
3	Bharatpur	OP/IP/emergency	All lab tests, X rays, ultrasound, ECGs	61 essential drugs only, 11 surgical goods	Only 50% off in procedures	No
4	Koshi	OP/IP/emergency	All lab tests, X rays, ultrasound, ECG	*No provision	All types of surgical procedures	Limited
5	Bir Hospital	OP/IP/emergency	Only routine tests	No provision (Nepal German Dispensary provides)	Virtually no	No
6	Western regional**	OP/IP/emergency	Routine and a few selected tests	21 essential drugs***	All types of procedures	
7	Maternity		Limited lab test, X rays, ultrasound, ECGs	Essential drugs limited	All types surgical procedures (but access is limited)	Limited: only 2 cases in a month
8	Kanti** Children	IP	Limited lab tests, X rays, Ultrasound, ECGs	9 essential drugs	All types surgical procedures (but access is limited)	Limited: only 2 cases in a month

* Medicine provided to helpless and GBV victims only.

** Benefit provided to persons who could not pay the bill at discharge.

*** Number of drugs reduced from 100+ to 21 due to budget limitation.

There is a common tendency for hospitals to offer more essential drugs at the beginning of the fiscal year, reducing gradually as the volume of available funds shrinks. Thus, there is no guarantee of minimum essential drugs, investigations and procedures. Target groups also have limited access to ultrasound tests, intensive care unit (ICU) care and surgical interventions. There is a growing demand for such tests and procedures but provision is limited, and a few hospitals have allocated a 'limited quota' for the target groups. Even the poor are sometimes forced to buy medicines due to lack of medicines in stock or budget constraints (Box 7c). Analysis of the client survey data shows that even the poor end up paying a significant amount of fees for different services.

Box 7c: Funding shortages

"I am forced to stop providing essential drugs due to shortage of funds" — Medical Superintendent, Koshi ZH

"My hospital wants to include more services, but was forced to reduce existing drugs list because of the funding limitation" —Medical Superintendent, Western RH

"Due to the increasing number of patients the hospital is forced to reduce the list of essential drugs" — Medical Superintendent, Bheri ZH

It is too ambitious to expect hospitals to provide everything free for target group patients. However, the need to standardise the benefit package based on the nature and size of the hospital in question is necessary to avoid random practices across hospitals and promote accountability and fairness.

b) The clause in the SSU guidelines concerning limits to per-patient costs is not practical in the cases of chronic patients requiring regular services, patients requiring admission into ICUs due to serious health issues, or patients requiring long hospital stays.

The load of chronic patients or repeat patients in the hospitals is high (see Table 7f). There is a steady increase in the proportion of senior citizens (irrespective of their economic status) accessing free or partially free services. Many of these patients (and other target groups) have chronic illnesses requiring regular and repeated health services (blood transfusions and treatment and testing for HIV, diabetes and hypertension). Others require admission into the ICU or long hospital stays. Medical protocols do not allow the cutting off of such services in the middle of the treatment even if the cost of treatment is ten times higher than the per-patient limit specified by the guidelines.

Table 7f: Proportion of senior citizens and repeat clients

SSUs	Percentage repeat clients among SSU clients		Percentage senior citizens among all SSU clients		Proportion of senior citizens among only repeat SSU clients	
	2071/72	2070/71	2071/72	2070/71	2071/72	2070/71
SetiZonal Hospital	72.7	61.4	22.7	31.5	34.9	11.7
BheriZonal Hospital	14.6	15.2	13.7	19.1	35.5	19.3
Bharatpur Hospital	NA	NA	22.9	36.5	NA	NA
Western Regional Hospital	NA	NA	14.6	28.7	NA	NA

Another practical difficulty is that the costs per-patient cannot be estimated in advance in most cases and can only be calculated at the end of treatment. For a number of chronic illnesses, the final costs cannot be calculated since the treatment needs to continue for the patient's lifetime. A separate provision is needed in the guidelines to manage such cases.

7.4 Partnership with NGOs

a) The role of partner NGOs is sometimes marginalised.

The procurement of NGO services is typically done for only a year at a time leaving the NGO uncertain about longer-term commitment. NGO contracts do not cover an overhead or management costs and some NGOs take a percentage from facilitators' salaries to cover these costs. The role of NGOs has mostly been confined to supplying the SSU facilitators. NGOs also reported hospital management dominance in the selection and hiring of facilitators. The case (outlined in box 7d below) from Bheri Zonal hospital is an example of conflict centring on selection and hiring of facilitators for the SSU.

Box 7d: The hiring of SSU facilitators

The case of the hiring of two new SSU facilitators in Bheri Zonal hospital a few months ago demonstrates a number of issues involved in the NGO partnership. Of the two persons hired, one left for another more lucrative job within a month. The other has been deployed at the emergency billing counter by order of the MeSu. The SSU chief has therefore not allowed the facilitator to sign the SSU attendance record as she says that the facilitator is working at the emergency billing counter and not the SSU.

The MeSu, when asked about the facilitator, responded that she was working at the billing counter, but was mainly assigned SSU-related tasks, facilitating target group clients. The claim of the MeSu was not accepted by the SSU chief. Interviews with the concerned facilitator revealed that she was mainly working on emergency billing but was also facilitating SSU clients. After some observations and cross checking with other facilitators, it became clear that she was not working as a SSU facilitator, although she had been hired as one.

An interview with the NGO management team revealed that the selection and hiring process was highly influenced by the MeSu, and in fact the two last hires were virtually selected by the MeSu and the NGO was just a witness to the whole process. The NGO management also stated that there were complaints from some quarters that no Madhesi (southern plains origin) staff had been selected. "Now that staff recruitment is due, there are again pressures on us from the MeSu, but we have refused to budge this time," reported the NGO management.

When the SSU chief was asked the possible way out from this mess, she showed her interest to hire a male facilitator (all the facilitators are female) of Madhesi ethnic background for evening duty. The evaluators presented this option to the MeSu and he showed willingness to accept the proposal. It is yet to be seen how things will pan out in the future.

This case illustrates the conflict of interests while hiring the SSU facilitators. The case also shows the marginalisation of the 'partner' NGO in the selection and hiring of facilitators. In this particular case, even the SSU chief was bypassed by the MeSu.

The NGOs have expressed an interest in involving themselves in the broader remit of issues relevant to free or partially free service. For this, the hospital management or the SSU needs to invite them as 'partners' to discuss and decide matters concerning the delivery of free and partially free services. The NGO partner in Bheri Zonal hospital has even suggested their readiness for raising funds for free services from the private sector if the hospital management supports such an initiative.

b) The Western Regional Hospital is interested to create regular positions for SSU facilitators in the hospital and hire them directly without partnering with an NGO. The facilitators in most hospitals expressed the preference for such an arrangement.

The SSU guidelines do not envisage this option. One rationale for partnership with a local NGO was that the facilitators provided by NGOs would better serve the patients than a civil servant and also that the cost of the service would be cheaper, as NGO facilitators can be paid lower amounts than the amount paid to the lowest government servant: the helper (peon). The hospital management, when confronted with the question of whether such client-focused services would be possible from a public servant, replied that the matter depends on how the terms and conditions of the job are formulated and implemented. Given the Western Regional Hospital's determination, letting them go ahead with their intention would provide an opportunity to experiment with a different modality of SSU and to learn lessons.

7.5 Institutional Challenges

a) Frequent change of leadership (at the level of MeSu or SSU Chief) has affected the capacity of SSUs.

There have been five medical superintendents and four SSU chiefs in Bharatpur Hospital and four SSU chiefs in Western Regional Hospital between 2013 and 2015. One consequence of this rapid turnover has been that SSU staff-created errors in the Excel based data sheet during this period of frequent leadership changes at Bharatpur Hospital. The SSU budget of the Western Regional Hospital was not used at all in 2014/15 until the last week of the last month of the fiscal year. The issue however needs to be understood within the broader context of MoHP's human resource management system, and as such the Population Division does not have much leverage for addressing this issue.

b) Institutional home for SSUs in MoHP

The institutional home of SSUs in MoHP was discussed during the Road Map preparation workshop. Participants indicated that the Curative Division, and not the Population Division, was the right home for SSUs. However, the Curative Division was not in a position to accept the new responsibility given its limited human resource capability. Finally, the workshop suggested to move the SSUs under the MoHP's Project Coordination Committee (PCC) for the time being and take an appropriate permanent decision in due time.

One MeSu commented:

> *"There is no place in MoHP to approach to discuss and resolve hospital-related issues. A separate central level division or department for this would facilitate the process. Based on experience, the Curative Division is not a good option."*

c) The three central level hospitals have yet to fully operationalise the SSUs.

Bir Hospital has appointed a SSU Chief and selected a partner NGO. The SSU only deals with the cases of outdoor patients. The SSU has recently started recording some of the free and partially free service related transactions (limited mainly to outdoor patients) into its Excel MIS programme.

The SSU is authorised to exempt fees up to NPR 2,000 per case and cases requiring higher amounts are referred to the director. The authority to exempt fees during the evening, night and morning hours has been delegated to the head of the Emergency Department. The previous arrangement of authority delegation to heads of departments was withdrawn due to budgetary pressures.

The Paropakar Maternity and Women's Hospital established a SSU in 2013 and has selected a partner NGO. However, the total annual number of clients receiving free or partially free services was reported to be only 444 in 2014/15 and 208 in 2013/14. Similarly, Kanti Children's Hospital has appointed a SSU chief and decided to select a NGO partner. The total annual SSU client load for this hospital in 2014/15 was estimated to be 447.

These three central hospitals need to further adapt the SSU model to their realities and will require more time and possibly some support during the process of adjustment and adaptation. However, it has been agreed in all three hospitals that properly recording and accounting the transactions related to free or partially free services by their SSUs should be the main priority in the immediate future.

7.6 Health Service Challenges

a) Doctors tend to prescribe expensive medicines

It was reported that many doctors tend to prescribe relatively expensive medicines. Prescribing expensive medicines puts unnecessary pressure on the already limited SSU budgets and this in turn can reduce the number of target group clients. There are several factors that may motivate doctors to prescribe expensive medicines — this may be due to poor cost-consciousness, to not being aware of the poor and vulnerable status of patients, as well as possible financial gain for doctors if medicines have to be purchased from outside pharmacies.

The introduction of a colour coded registration ticket for target group patients could be used to alert doctors to avoid prescribing expensive medicines to such patients. This would however require a slight change in the service procedure with patients first needing to go to the SSU before obtaining the registration ticket. In the longer term, improved prescribing practices and stronger oversight of those practices is required.

b) Post hospital care of GBV survivors, homeless people and abandoned children

The Paropakar Maternity and Women's hospital has been implementing another pilot programme for GBV survivors besides the free care service through SSU. They have reported that comprehensive care for survivors of GBV including rehabilitation, legal support and mental health support is still a problem. Lack of 24 hour services, especially for gender based violence survivors was another problem mentioned by them. As they have reported, the rehabilitation and reintegration of street patients, abandoned children and patients with mental problem is difficult.

7.7 Functioning of SSUs

a) SSU staff competence on the ethnic classification of the Health Management Information System (HMIS), information management and basic knowledge about medicines is still inadequate.

The Western Regional Hospital SSU wrongly recorded Gurungs and Magars as 'relatively advantaged Janajatis (ethnic groups). Bharatpur Hospital SSU for fiscal year 2014/15 used the wrong caste/ethnic classification (neither the old version nor MoHP's new version), and the staff poorly understood the classification and its purpose. MoHP changing the HMIS classification and not informing the hospitals in a timely way was another problem.

The recording and reporting function is still fragile in some SSUs due to the inadequate skills of the staff and dependency on a single staff member for handling data. There is a persistent risk of data mismanagement and data loss:

- At Seti Zonal Hospital SSU, one staff is just coping with the Excel based recording and reporting system after a better-trained staff left the post.
- Bharatpur Hospital SSU staff created serious data mismanagement while attempting to convert the existing Excel database into an Access database.
- Western Regional Hospital SSU deleted the whole database file for fiscal year 2014/15 without any backup copy.

SSU staff often have to rewrite the free medicines recommended by doctors and send slips to stores. Some SSUs are also handling the inventory of medicines (at Seti Zonal and Bharatpur Hospitals) although this function requires staff to have a basic medical knowledge and skills. Although some have acquired these skills, care should be taken to ensure that there is enough SSU staff with the basic knowledge required for the tasks expected of them. In fact, two tiers of educational requirements would be ideal for running the SSU as envisaged in the guidelines: (i) for client facilitators and filling in the initial client registration form, and (ii) for those who record and report the information on the computer software. If the management of supplies is included in the scope of work then these skills also need to be factored in.

Overall, inadequate competence to administer the free care funds can compromise data security and reliability. Simply allocating a budget from MoHP for strengthening these skills might not be sufficient as the case at Bheri Zonal Hospital shows where the allocated budget from MoHP for training was not used. Monitoring from the centre is necessary.

b) The non-integration of the hospital billing system with the SSU Excel programme results in duplication of data entry (about clients and costs).

For example, Seti-Zonal hospital's SSU first prints the bills from the billing system and then again enters the cost information into the Excel based SSU MIS programme, thus duplicating efforts and resources. Other hospitals also use hospital software to collect data for the MIS but have not made any attempt to integrate the two programmes. This is a good opportunity that needs to be exploited for better data management and efficiency. Shifting the SSU MIS from the Excel based system to an Access based one alongside basic skills training will ensure better security and will provide an opportunity to assess how data from the current hospital MIS could be accessed by the SSUs.

c) Despite apparent progress in disseminating the free and partially free health service provisions among the wider public through different media, the flow of information regarding free and partially free service provision is inadequate in some areas.

This problem is very obvious in the case of Bheri Zonal, Bharatpur and Western Regional hospitals; where only about 56% of surveyed clients were aware of the provisions before coming to the hospitals. There is a need to develop target group focused information campaigns in these areas. (The percentage of pre-informed clients for other hospitals was well over 70%.)

d) The qualitative part of the regular SSU report is never filled in and reported.

While the regular quantitative report that is automatically generated by the SSU Excel database is considered useful by SSU staff, none considered the qualitative part of the SSU report useful. The qualitative report covers (i) issues or problems faced, (ii) actions taken at the local level, and (iii) support demanded from the higher authorities during the reporting period. SSU staff and hospital management prefer to share such issues verbally, unless strictly instructed to do otherwise by higher authorities. Given this reality, it would be better to remove this part of the report from the guidelines.

No one from the SSU Management and Monitoring Committee (SSU-MMC) at the Population Division followed up on why hospitals were not sending the qualitative part of their SSU report. This reflects gaps in monitoring by the centre. The qualitative report is an example of a new reporting method introduced which lacks the interest and incentives for users and managers to implement this.

7.8 Politico-economic Context

a) The political context of hospital management

Due to internal (staff trade union related) problems, Kanti Children's Hospital has not been able to operationalise the SSU so far, despite appointing the SSU chief. The case in Box 7e from Bheri Zonal Hospital also illustrates how organizational politics can affect the service adversely.

Box 7e: Internal politics affect delivery of free or partially free care **

On two occasions the billing counter at Bheri Zonal Hospital refused to bill for SSU target clients in 2014: from 7 Bhadra to 11 Bhadra (August) and 25 Kartik to 30 Kartik (November). They did this to assert their demand for incentives to do their regular work, as the SSU chief was perceived to be receiving such an incentive. It appears that this was part of the organizational politics going on inside the hospital. On reporting this event to the chief district officer (CDO), the MeSu was forced to solve this problem. (Like many government staff, hospital staff form groups based on political affiliations and sometimes based on common interests. Conflicts among the different groups sometimes surfaces on the issue of MeSu selection and so on.) MoHP appointed a new MeSu to the hospital during the evaluation period.

Bheri Zonal Hospital

b) The use of free care funds to cover the costs of hospital staff care at the hospital

The hospitals have not had a separate budgetary provision for staff health care services. They do not have separate records on the use of free care funds by staff. It is difficult to assess the exact amount of funds used by staff. Interviews at the hospitals confirmed that staff still access the funds. This issue has been repeatedly discussed since the start of the SSU pilot, and the initial idea of using a certain percentage of hospital income for staff health care has not been implemented. The issue was discussed during the evaluation's preliminary findings dissemination workshop, but no concrete agreement was reached.

> *"Hospital staff and their relatives have been accessing free or partially free services and the hospital management has not identified ways of preventing this." — Bir Hospital*

During a meeting with the evaluators, the management of Bir Hospital agreed to limit the number of beneficiaries from relatives of staff/doctors by strictly following the guidelines of the Civil Service Act: providing subsidised services to only the spouse, children (up to 18 years of age), father and mother, and not to other relatives. The management pointed out the practical difficulty of preventing staff from accessing free care from the conditional or medicines grants.

8 APPROPRIATENESS OF M&E INDICATORS AND PROPOSED REVISIONS

The criteria and indicators prescribed by the monitoring and evaluation (M&E) framework of the SSU guidelines were the main basis of this evaluation. As mentioned earlier in the beginning of Chapter 2, the framework consists of criteria and indicators at four levels/aspects of evaluation — capacity, compliance (process), results and outcome.

The indicators in the guidelines were formulated with the assumption that change/progress over time can be measured, scored and compared, and contextual information for comparison of change or progress will be available. During the evaluation, it was observed that the assumption holds true for most of the indicators but not others.

Table 8a lists indicators that need revising and related issues.

Table 8a: Issues related to some of the prescribed indicators

Level/aspect of evaluation	Not so useful indicators	Issues related to the indicator
Capacity	The SSU is fully owned and supported by the SSU sub-committee and hospital units/departments	The SSU sub-committee has never functioned as a 'committee' as such. The medical superintendent (MeSu) has been functioning as the de facto committee in all cases. Support to SSU by other units/departments often rests on the MeSu's leadership and attitude towards the SSU.
Compliance (Process)	Coordination and communication is maintained with SSU sub-committee and other departments/units, including with the one-stop crisis management centre, where applicable, and for round-the-clock service provision to the target groups?	The number of departments and units is large and the scoring tends to be too subjective.
	Expenditure per patient is regularly recorded and budget ceiling strictly followed	Expenditure per patient can and should be recorded. However, it is very difficult to estimate beforehand the budget a patient might require.
Result	The specified target groups consist ....% of patients benefiting from free services and consume ….% of total hospital budget for free services.	The rationale behind this indicator was to ensure that the resources are not spent outside the six listed target groups. With the current practice and agenda to revise the target groups (including victims of man-made and natural disasters), this indicator will not give meaningful information at present. The indicator can be used once the target groups have been updated.
	The proportion of beneficiaries from adjoining districtsis.....%	It was assumed that over time, the proportion would increase with SSU efforts. However, it is clear that the catchment area of a referral hospital is driven by multiple factors, and demand from target groups in adjoining districts is beyond the influence of a SSU or the referral hospital.

Level/aspect of evaluation	Not so useful indicators	Issues related to the indicator
	The proportion of beneficiaries from disadvantaged groups according to MoHP's HMIS classification is similar to their proportion in the population of the districts currently served by the hospital.	It was assumed that over time, the proportion would increase to an optimum level with SSU efforts. However, no authentic information about the base proportion of these different social groups in the catchment area of a hospital is available for comparison. A hospital's catchment area does not follow the official borders of DDCs, VDC, and wards. A more practical option would be to formulate the indicator as, "The proportion of SSU beneficiaries from disadvantaged groups as per the HMIS classification is comparable or greater than their proportion of the hospital's patients."
Outcome	Amount of funds for free and partially free services from sources other than MoHP in last fiscal year.	None of the hospitals have raised any significant amount of funding from other sources. An indicator about what proportion of the hospital income (excluding grants from MoHP) is used for free or partially free services could be considered, but there are clear indications that not much of hospitals' income will remain after paying for staff salaries and incentives.
	The hospital has fully owned the SSU.	A 'hospital's' owning of an SSU is too complex to measure. Hospitals neither own nor disown anything like the SSU. The key point is the working relationships between the MeSu, accounts section, wards, laboratory and SSU.

To conclude, a revisit of the guidelines indicators is necessary based on the insights that have been gained over the last two years of SSU implementation in the pilot hospitals. It is proposed that the major changes required in the indicators are as discussed above. However, some minor adjustments in other indicators are also needed based on experience. Suggested modifications to the monitoring and evaluation criteria and indicators are outlined in Table 8b, 8c, 8d and 8e.

Table 8b: SSUcapacity (maximum score for each indicator = 4; minimum score = 1)

	Indicator	Score
1	SSU is adequately and appropriately staffed having sufficient number with appropriate gender, ethnic (as per local diversity) and skills mix (health, computer and social work)	
2	All SSU staff are fully familiar with the guidelines, their roles and responsibilities	
3	All SSU staff fully understand the clients screening, recording and reporting formats	
4	At least two SSU staff are competent in the use of recording and reporting software used by the hospital	
5	The SSU works as a team with demonstrated leadership, good communication and high motivation to achieve the unit's mission	
6	The SSU is well equipped with necessary space, furniture, computers, and necessary supplies	
7	All SSU staff are familiar with the billing system and patient movement between hospital departments and units	

Table 8c: SSU compliance (process)(Maximum score for each indicator = 4; minimum score = 1)

	Indicator	Score
1	SSU working and reporting schedules are followed strictly	
2	Patient-wise documentation is kept well, prescribed forms and records filled in appropriately in hard copies as well as in computer software	
3	Prescribed authorities for fully free and partially free service are fully delegated to SSU	
4	Prescribed procedures for approving patient's expenditure beyond the authority of the SSU chief are followed strictly	
5	Target group members unaccompanied by informed family members or acquaintances are well supported and facilitated	
6	The SSU committee at the hospital level meets and reviews SSU progress at least once per every trimester reporting period of the government	
7	The names of persons receiving partial or full free service are displayed publicly to discourage the use of the service by well-off persons	

Table 8d: SSU performance against result indicators

	Indicator			Status
1	The percentage of beneficiaries with valid ID cards or letters from appropriate institutions confirming their beneficiary identity			
2	The percentage of beneficiaries referred from other health facilities			
3	The percentage of beneficiaries from rural areas			
4	The average subsidy provided to each SSU beneficiary per financial year			
5	Percentage of beneficiaries from disadvantaged groups according to HMIS classification			
	Among total SSU clients	**Status**	**Among total hospital clients**	**Status**
	Dalits		Dalits	
	Janajatis[9]		Janajati	
	Madhesi		Madhesi	
	Muslims		Muslims	
	Brahmins/Chhetris		Brahmins/Chhetris	
	Others		Others	
6	The percentage of beneficiaries from target groups			
	Among total SSU clients	**Status**	**Among total hospital clients**	**Status**
	Poor		Poor	
	Helpless		Helpless	
	Disabled		Disabled	
	GBV survivors		GBV survivors	
	Senior citizens		Senior citizens	
	FCHVs		FCHVs	
	Others		Others	
7	Proportion of women among SSU beneficiaries		Proportion of women among hospital patients	

[9] Includes Newars

Table 8e: SSU performance against outcome indicators

	Indicator	Status
1	The percentage of poor patients among the total beneficiaries of free or partially free service	
2	Percentage of target group patients satisfied with free or partially free service provided by the SSU at the hospital	
3	Percentage of target group patients reporting no delays and/or problems in accessing services/medicines	
4	Percentage of target group patients aware of the free service provision before coming to the hospital	
5	Percentage of target group patients who came to know about free service through sources other than hospital staff/doctors	
6	Percentage of target group patients who felt good about the behaviour of the service providers	
7	Percentage of the total hospital annual income spent on free or partially free services	

9 CONCLUSIONS AND RECOMMENDATIONS

9.1 Conclusions

Significant progress (described in Section 2.1) has been made by some of the pilot SSUs during the short period of their establishment in terms of:

- enhancing their capacity to properly identify and serve the target groups in compliance with the guidelines;
- better targeting of the poor and target groups, and client satisfaction with the service and behaviour of the care providers;
- contribution towards good governance of the health services by increasing transparency and accountability;
- enhancing the awareness of the target groups about the free or partially free service; and
- freeing up a significant amount of care providers' time from the task of identifying target groups and deciding on fee exemptions.

A cost-benefit analysis in three of the hospitals shows the worth of replicating the SSU model in other comparable hospitals across the country.

Some of the SSUs and their hospitals have taken new initiatives to further improve their performance:

- The systematic use of volunteer staff nurses in SSUs, in addition to the facilitators from partner NGOs, and the deployment of SSU facilitators across three shifts at Bharatpur hospital/SSU.
- The integration of the hospital pharmacy with the SSU at Bharatpur Hospital and partly by Seti-Zonal Hospital.
- Coordination of free or partially free services with other hospital-based social protection programmes (HIV/AIDS, nutrition rehabilitation, geriatric care) by Bharatpur, Koshi-Zonal and Western Regional hospitals.
- The coordination of round-the-clock free services to earthquake affected people at all the hospitals.

The partnership arrangements with local NGOs and the dedication of the facilitators provided by them, and good leadership of the SSU chiefs and medical superintendents have played a key role in the achievements.

However, the eight hospitals vary widely in terms of their progress in establishing and operationalising the SSUs. In particular, the three central hospitals in Kathmandu (Bir, Kanti Children and Paropakar Maternity and Women hospitals) are still in the process of working out appropriate ways of adapting the SSU approach to their ground realities and historical legacies. These three hospitals require more support from the Population Division/MoHP to adapt and operationalise the SSU approach in the coming days.

The SSUs also face significant challenges (see Section 7) that need to be addressed by the hospitals and MoHPto further improve SSU performance. The recommendations for priority actions are presented below.

9.2 Recommendations

Given the challenges and constraints, MoHP and the hospitals need to take actions to ensure the SSUs fulfil their mission effectively and efficiently in the coming years. Based on the findings of this evaluation the main recommendations are as follows:

a) Further enhance SSU capacity

The following three areas of capacity enhancement have been identified:

- ✓ Upgrade SSU facilitators' skills and knowledge concerning use of HMIS caste/ethnic code, poor identification form and computer.
- ✓ Upgrade the Excel based recording and reporting system into an Access based system for better data security and ease of integration with other hospital software systems.
- ✓ Initiate the systematic use of volunteers to supplement the NGO-hired facilitators in all SSUs following the example of Bharatpur Hospital SSU.

Given the contribution that the computer (Excel) based recording and reporting system has made in making SSU transactions transparent and accountable, the installation of an upgraded Access based recording and reporting software (yet to be developed) should be an integral part of the SSU in all hospitals irrespective of their nature, size or geographical location. In the longer term, the integration of the Access-based programme into hospitals' services management software and gradually linking it to the internet must be ensured to further enhance SSU capacity.

Development of the Access based software should consider among other things, (i) the parameters of the existing Excel based programme, (ii) the revised HMIS caste/ethnic codes, (iii) parameters from the updated guidelines including the revised M&E indicators, and (iv) the conditional and medicines grants and the rules for their use.

We recommend the introduction of two tiers of educational requirement for facilitators based on their role: one type of requirement for facilitators managing front desks (receiving, screening, registering and facilitating clients) and different requirements for those who record information on the computer software, analyse information and prepare reports.

b) Strengthen partnerships with local NGOs

The existing partnerships have enabled SSUs to perform well and can be replicated in other hospitals that establish SSUs. However, a few measures are needed to strengthen these partnerships further. It is important to ensure that there are regular meetings between hospital management (including SSUs, MeSus and accounts sections) and the partner NGOs to share experiences, sort out issues affecting the partnership and discuss future steps. Such meetings can also address the issues of delayed payment to NGOs and improve NGO's involvement in SSU affairs. The partner NGO in Bheri Zonal Hospital has shown readiness to raise funds from the private sector for free or partially free services. There is a possibility that the current partnership might lead to a tripartite partnership (hospital-NGO-private sector) and this model could be one for MoHP to promote.

c) Improve the flow of information on free or partially free service to target groups

The client survey undertaken during the evaluation found that about 66% of the target groups coming to the six hospitals knew about the free or partially free services before coming to the hospital. Bheri-Zonal and Bharatpur Hospitals have undertaken information dissemination

campaigns, but these have not reached remote catchment areas. A future focus should be to target such campaigns to selected remote locations.

At Bir Hospital information on free or partially free services is mostly confined to hospital staff, doctors and nurses. Only about 24% of the clients there had learned about the free or partially free service from sources other than hospital staff. While this would suggest the need for more dissemination of information to target groups the hospital is already struggling with the pressure for free treatment and has reduced its services significantly due to budgetary constraints. Given the severe budgetary constraints at several hospitals, information dissemination and demand generation should be proportionate to the budget available for free and partially free service.

d) Support the process of adapting the SSU model to central hospitals

The central hospitals will require a longer time to adapt the SSU model to their realities and will require support from MoHP during the process. However, as agreed with hospital managements during the evaluation process, the priority should be given to ensuring transparent one-door recording, accounting and reporting of all free and partially free related transactions following the conditional and medicine grants provided to the hospitals.

e) Improve budgeting system for free and partially free services

Two aspects need to be considered in the budgeting system. One aspect concerns MoHP providing budgets based on local realities. The second aspect relates to the use of the conditional and medicines grants.

All but two central hospitals reported an inadequate budget for the free and partially free services, four of the hospitals have drastically reduced the scope of free or partially free services, and two were somehow coping with the help of hospital income to make up the gaps. At the evaluation dissemination workshop, stakeholders recommended an earmarked budgeting system (with clear sub-headings) for free and partially free services based on hospitals' realities related to:

- ✓ local poverty incidence
- ✓ client load of the hospital
- ✓ per-patient expenditure
- ✓ prescribed benefit packages.

See Annex 4 for an initial formula for standardising budget allocations for free and partially free care across hospitals.

It is recommended that the SSU guidelines link the conditional and medicines grants from MoHP to funding free and partially free services and also specify the budget breakdown with appropriate sub-headings. This will reduce the misuse of the funds intended to subsidise the treatment costs of target group patients. See Annex 5 for the recommendations on rules to be introduced into the SSU guidelines.

f) Standardise and enforce the benefits package (check-ups, investigation, medicines and other services) to the target groups based on the nature and size of hospitals

In the light of high variations in the benefits package delivered by different hospitals, and further curtailment in the packages due to budgetary constraints, there is a need to standardise and enforce the package. We recommend that the Population Division convene a task force to determine

standard benefit packages for target group patients based on the type and size of hospital. See Annex 3 for our initial proposals on standardising the packages.

g) Review the effectiveness of Bharatpur Hospital's practices of (i) deploying NGO facilitators for the night shift and (ii) SSU handling the hospital pharmacy

These practices have been initiated recently and require some time to settle. Although the evaluators noticed some immediate advantages to clients, the longer-term resource and management implications need to be seriously studied before taking decisions regarding these practices.

h) Update the SSU guidelines

The delivery of free and partially free services is carried out in compliance with the guidelines. Many of the challenges and constraints discussed, as well as the recommendations made in this report, automatically concern one or more clauses in the guidelines. In a few cases, additional clauses need to be added. The following are the main aspects that need to be covered in the revised guidelines:

- ✓ rules defining the use of conditional grant fund and medicine grant fund;
- ✓ service provision for legitimate groups (e.g., victims of man-made or natural disasters) other than the currently defined six target groups;
- ✓ expanded role for SSU to coordinate other social protection programmes at the hospital level;
- ✓ newly defined benefit packages across different types of hospitals;
- ✓ updated poor identification form;
- ✓ updated monitoring and evaluation criteria and indicators; and
- ✓ removal of the qualitative part of the report from the guidelines.

The legitimate target groups for free and partially free services could include (in addition to the current six groups) the following groups:

- ✓ Victims of man-made and natural disasters (due to armed conflict, earthquakes, floods, landslides, epidemics) and martyrs' families as decided by the government.
- ✓ Beneficiaries of fully or partially phased out hospital based social protection programmes (child malnutrition, HIV/AIDS and others) based on the government's decision.
- ✓ Endangered and highly marginalised ethnic groups as defined by the Janajati Mahasangh and agreed by the state without assessing their economic status.
- ✓ Clients brought by the police (victims of accidents, prisoners, legal clients) for free treatment and investigation due to lack of other sources of funding.

9.3 Road Map for SSUs

A workshop of key stakeholders was held at the Hotel Yak and Yeti on 31 August 2015 to discuss and decide on key issues related to the future of the SSUs (see participants in Annex 2). Key findings (achievements and challenges) and recommendations of the SSU evaluation mission were presented. The workshop was chaired by Mr Kedar Bahadur Bogati, chief of the Population Division.

The workshop requested the Population Division to develop a road map based on the recommendations of the consultant and decisions taken at the workshop, and submit it to the SSU-Management and Monitoring Committee for consideration. The road map prepared by the

Population Division is presented below and includes key decisions taken at the workshop and a plan of action (Table 9.1):

- The SSU Management and Monitoring Committee should be moved from the Population Division and kept under the MoHP's Project Coordination Committee (PCC) for the time being. A decision regarding its appropriate long-term home should be decided in due time. The chief of the Curative Division in MoHP expressed their readiness to house the committee if MoHP provided them with necessary capacity support, as their capacity is very limited.
- The role of SSUs should cover the coordination of other hospital based social protection programmes. The coordinating role should consist of screening clients, facilitating fee exemptions, guiding them through hospital systems as required and recording transactions. Appropriate ways of fully integrating all the social protection programmes under one wing of the hospital and central levels should be identified and worked out in the longer term.
- The benefits package (check-ups, investigation, medicines and other services) to target groups under the free and partially free services will be defined, standardised and enforced based on the type and size of the hospital. The SSU-MMC needs to form a task force of a health service delivery expert, health economist and management expert to facilitate this task.
- The following groups, besides the currently served six groups, should be covered by the free or partially free services:
    - Groups qualified for free or partially free services by decisions of the government (such as victims of natural disasters, martyrs' families, beneficiaries of fully or partially phased out social protection programmes, and others). The Janajati Mahasangh defined endangered and highly marginalised ethnic groups could be considered for inclusion if the government's decides to include them in the scheme without considering their economic and other status.
    - Clients brought by the police (victims of accidents, prisoners, and legal clients for free treatment and investigation) with no other sources of funds.
- An appropriate guide should be developed and enforced to ensure an earmarked budgeting system with clear sub-headings for the free or partially free services, considering the following criteria as recommended by the workshop held at the Annapurna Hotel:
    - local poverty incidence
    - client load of the hospital
    - per-patient expenditure
    - prescribed benefit package.
- The SSU guidelines will be updated as required, particularly covering the following aspects:
    - Rules defining the use of conditional grant funds and medicine grant funds (as suggested in Annex 5 below).
    - Service provision for other legitimate groups other than the currently defined six target groups (as outlined in recommendation 9 (h) above.
    - Expanded role for SSUs to coordinate other social protection programmes at the hospital level (as outlined in section 6 (d) of this report).
    - Newly defined benefit packages across different types of hospitals (as suggested in Annex 3).

- Updated poor identification form (as suggested in Annex 6 below).
- Updated monitoring and evaluation criteria and indicators (as outlined in Section 8 of this report).
- Removal of the provision and the format for the qualitative part of the report from the guidelines.

The Population Division's GESI Section prepared the following plan of action (Table 9a) to take forward the recommendations of the evaluation mission and the two stakeholder workshops. The GESI Section will mobilise other units at the central and hospital level to ensure timely implementation of the plan. Where necessary, the GESI Section will prepare micro-plans for the SSU hosting hospitals aimed at implementing the action plan.

Table 9a: SSU plan of action

	Action areas and actions to be taken by SSU-MMC to implement the recommendation	Implementation timeline
1	SSU capacity enhancement • Further train SSU facilitators'on the use of HMIS caste/ethnic code, poor identification form and computers. • Upgrade the Excel based recording and reporting system into an Access based system for better data security and ease of integration with other hospital software systems. • Initiate the systematic use of volunteers to supplement NGO hired facilitators in all SSUs following the example of Bharatpur Hospital SSU	September-December, 2015
2	Uniformity in benefits package to target groups • Develop and implement the standards (refer to Table 7e)	September-December, 2015
3	Strengthening partnerships with local NGOs • Initiate regular meetings between hospital management (including SSUs, MeSus and accounts sections and the partner NGO to share experiences, sort out issues affecting partnerships and to discuss future steps • Undertake exploratory meetings with partner NGOs on the possibility of broadening the partnership with other private agencies for increased support to SSUs' missions	September-December, 2015
4	Improve information on free and partially free services • Promote targeted information dissemination campaigns on free or partially free service to the target groups in Bir, Western Regional, Bheri and Bharatpur hospitals	January-March 2016
5	SSU model adaptation in central hospitals • Provide technical and managerial support to central level hospitals while they adapt the SSU model, ensuring that all free or partially free services provided through conditional and medicines grant from MoHP are properly accounted for.	January-March 2016
6	Review and analysis of new initiatives • Undertake review missions involving cost-benefit analysis and hospital systems experts and take appropriate decision regarding (i) the effectiveness of the recent practice of Bharatpur Hospital SSU to deploy NGO facilitators for the night	January-March 2016

	Action areas and actions to be taken by SSU-MMC to implement the recommendation	Implementation timeline
	shift, and (ii) the practice of the SSU handling the pharmacy at Bharatpur Hospital	
7	Replication of SSU model • Replicate the piloted SSU model in more hospitals based on MoHP's funding and monitoring capacity. (Proper recording and reporting system to account for all free or partially free services should be an integral part of the replication.) The criteria for replication should be: • patient loads • achieving a balance of SSUs across the country's provinces (in line with the new Constitution of Nepal) • intensity of the impact of the recent earthquake.	January-March 2016
8	Improved budgeting system for free and partially free services • Initiate and implement an improved budgeting system (refer to Annex 4 for developing the system.)	March-May 2016
9	Updating the SSU guidelines • Update the SSU guidelines as recommended under Section 9.2 of this report.	March-May 2016

Annex 1: Hospital-wise Facts Sheet

Annexes 1.1 to 1.8 describe for each hospital, the status of their SSUs in terms of their:

- capacity to identify and serve the target groups
- compliance to rules and procedures prescribed by the SSU guidelines,
- selected results level indicators
- selected outcome level indicators.

This is followed up by information on each SSUs/hospitals' NGO partnership arrangements, new initiatives, and key challenges and constraints (specific to the hospital/SSU).

The performance scoring was not done for the three central level hospitals (Annexes 1.6 to 1.8), as they are still in the process of figuring out an appropriate model for running their SSUs. In the cases of Koshi Zonal Hospital and Western Regional Hospital, the performance ratings are available only for 2015 and not for 2013.

In the case of result and outcome level indicators, the baseline scores (2013) are not available and the plan to compare the current situation with the baseline situation was not possible, although result indicators for 2013 are available for some hospitals. The tables related to these indicators show the situation as of 2015 (during the evaluation).

Annex 1.1: Seti Zonal Hospital

a. Performance against prescribed criteria and indicators

Table A1.1a: SSU Capacity (maximum score for each indicator = 4)

	Indicator	Score 2013	Current status (April 2015)	Score 2015
1	SSU is adequately and appropriately staffed (one officer level full-time unit chief, one office assistant, adequate number of facilitators with balance of gender and local ethnic diversity)	4	A male officer with public health background is SSU chief and there are five female and two male facilitators (with medical and different ethnic backgrounds, including Tharu) and an office assistant. Of seven facilitators, one male facilitator with computer recording responsibility has been replaced by a woman facilitator and one male facilitator now handles computer recording.	4
2	All SSU staff fully understand the guidelines, their roles and responsibilities and hospital systems	4	SSU staff demonstrated good understanding of guidelines, responsibilities and hospital systems.	4
3	SSU has capacity to use recording and reporting formats and Microsoft Excel based MIS	3	One facilitator can use Microsoft Excel based MIS for recording and reporting and local computer institute has supported him now and then. All staff have obtained basic course in Excel. The other staff assist him in recording now and then. The level of confidence is still not sufficient.	3
4	SSU works as a team with demonstrated leadership, good communication and high motivation to achieve the unit's mission	4	A new SSU chief is providing good leadership. Communication among facilitators and the chief is good and all show good job motivation.	4
5	SSU is well equipped with necessary space, furniture, computers, and supplies	3	The SSU is fully equipped and has a good working space (three times than in 2013).	4
6	SSU is well supported by the SSU committee and hospital units/departments	4	The SSU is well supported by the SSU committee and hospital units/departments	4
	Total score	**22**		**23**
	Percentage (out of 24 full score)	**92%**		**96%**

Table A1.1b: SSU Compliance (process)(Maximum score for each indicator = 4)

	Indicator	Score 2013	Current status	Score 2015
1	SSU working and reporting schedules are followed strictly	3	SSU works two shifts (8 am to 2 pm, and 2 pm to 8 pm). Reporting schedules are strictly followed.	4
2	Patient-wise documentation is kept well, prescribed forms and records filled in appropriately	3	Patient-wise documentation is kept well, prescribed forms and records are filled in appropriately, although a few lapses were noticed.	4
3	Prescribed authorities for fully free and partially free service are fully delegated to SSU	4	Prescribed authorities for fully free and partially free service are fully delegated to the SSU	4
4	Expenditure per patient is regularly recorded and budget ceiling is strictly followed	2	Expenditure per patient is regularly recorded and budget ceiling is strictly followed	4
5	Target groups unaccompanied by informed family members or acquaintances are well supported and facilitated	4	Target groups unaccompanied by informed family members or acquaintances are well supported and facilitated	4
6	Effective coordination and communication is maintained with SSU sub-committee and other departments, including with the one-stop crisis centre, where applicable, and for round-the-clock service provision to the target groups	4	Coordination and communication is maintained with SSU committee and other departments, for round-the-clock service provision to the target groups.	4
7	The names of persons receiving partial or full free service are displayed in a public place to discourage the use of the service by well-off persons	1	The names of persons receiving partial or full free service are not displayed in a public place.	1
	Total score	**21**		**25**
	Percentage (out of 28 full score)	**75%**		**89%**

Table A1.1c: SSU performance against result indicators

	Indicator	2015	2013
1	The percentage of poor patients among sample beneficiary exit interview patients who received free or partially free service as "poor" clients	91.1%	NA
2	The percentage of beneficiaries with valid ID cards or letters from appropriate institutions confirming their beneficiary identity	69.2%	33.2%
3	The percentage of beneficiaries referred from other health facilities	0.0%	0.2%
4	The percentage of beneficiaries from adjoining districts	26.4%	25.3%
5	The percentage of beneficiaries from rural areas	54.2%	52.1%
6	The percentage of beneficiaries from disadvantaged groups according to MoHP's HMIS classification		
	Dalit	30.6%	25.4%
	Disadvantaged Janajati	28.1%	23.2%
	Disadvantaged caste groups in Tarai	0.3%	0.7%
	Muslims (religious minority)	0.1%	0.3%
	Relatively advantaged Janajati	1.7%	2.8%
	Upper caste groups	39.2%	47.5%
7	The proportion of beneficiaries from target groups		
	Poor	57.7%	69.7%
	Helpless	3.9%	1.6%
	Disabled	4.4%	3.4%
	GBV survivors	0.6%	0.3%
	Senior citizens	31.5%	22.7%
	FCHVs	2.1%	2.4%
	Others	0.0%	0.0%
8	Proportion of women among SSU beneficiaries	52.3%	48.5%

Sources of data: Client survey for indicator 1 and SSU record for indicators 2–8

Table A1.1d: SSU performance against outcome indicators

	Indicator	2013	2015
1	Percentage of target group patients satisfied with free or partially free service provided by the SSU at the hospital	NA	97.8%
2	Percentage of target group patients reporting no delays and/or problems in accessing services/medicines	NA	80.0%
3	Percentage of target group patients aware of the free service provision before coming to the hospital	NA	73.3%
4	Percentage of target group patients who came to know about free service through sources other than hospital staff/doctors.	NA	72.7%
5	Percentage of target group patients who felt good about cleanliness of the hospital	NA	82.2%
6	Percentage of target group patients who felt good about the behaviour of the service providers	NA	97.8%

Source of information: Client survey

b. NGO partnership

The hospital selected National Health Vision Care (NHVC) Dhangadhi as the partner NGO and has been working with this NGO for the last two years. The NGO raised the following key points concerning its partnership with the hospital:

- The NGO needs to be invited to periodic reviews in the hospital and for training events related to SSU performance.
- The NGO needs to be supported with a small fund to cover some of its management costs. The NGO deducts 10% of staff salaries for this purpose, which is undesirable. Though the SSU facilitators are officially NGO staff, they are mostly (except for one of the seven), chosen by the hospital. The NGO does not get any benefits from this collaboration. Putting "Joint collaboration between Seti-Hospital and the NGO" under the SSU signposts in the hospital would give some advantage to the NGO.
- The free services are reaching the target groups better than in previous days. In the early days, there was no recording system to tell where the services were going; but now the systems give a clear idea. The SSU recording system has made transactions transparent.
- The identification of the poor still poses a challenge and unless ID cards for the poor are distributed by the Government, the issue will remain to an extent despite efforts of SSU.
- Publishing the names of patients who receive free services would be a good idea to discourage the rich from accessing the services.
- The use of interns in the SSU was thought to not be a practical or useful idea as the NGO thought that interns or volunteers could not be found.

c. New initiatives by the SSU/hospital

The hospital MeSu was not sure if the health insurance scheme will really work. He said seminars had been held now and again on the health insurance scheme during the last few years, but the scheme has not picked up so far. In case it picks up, the SSU could support the poorest persons' insurance premiums after confirming the eligibility of applicant by screening them. There were no other social protection programmes based at the hospital.

d. Key challenges and constraints

1. Staff skills (particularly of the staff responsible for Excel data handling) are not yet sufficient and require further training. Training on data sorting techniques is particularly necessary. Integration between the hospital billing system and the SSU Excel programme is necessary to avoid data entry duplication.
2. The qualitative part of the reporting has always been done verbally and never recorded on the report format, although monthly SSU team and SSU sub-committee meetings report and discuss issues. This part of the SSU report was not considered so important.
3. Some medicines (initially in the list of 40 free medicines) are still freely distributed by the hospital to all patients. This practice continues since the days when the hospital was just a district hospital. The total amount of funds that goes for this free distribution was not available due to the lack of a proper accounting system. These are transactions outside of the SSU, and require phasing out in the years to come.
4. Hospital staff also receive free health services due to the lack of a separate budget heading for this. However, such cases are registered under the others category of clients. There are other

categories of patients (such as HIV) who require free services. The six-category client definition of SSU requires further review and expanding.

5. There is a tendency for doctors to recommend expensive medicines and this consumes large parts of the budget meant for the target groups. If NPR 100 worth of antibiotics can do the job, why use an expensive one? However, the doctors while recommending the medicines are usually not aware whether the patient falls under a target group category. The introduction of colour coded registration tickets for target group patients would help doctors not to recommend expensive medicines at least for target group patients. This would however require a slight change in the service procedure as patients would need to first go to the SSU before obtaining their registration tickets.
6. The hospital does not charge for beds irrespective of the category of patients. This has reduced hospital income significantly. As directed by MoHP, in 2014/15 the hospital reduced the prices of most lab tests and this has reduced the income of the hospital tremendously in the last one year.
7. Promotional activities related to free health services through the SSU in the past years have tremendously increased the flow of target group patients in the hospital. The budget for free services has not, however, increased proportionately, thus consuming a huge portion of the hospital's budget. The number of clients receiving free service has more than doubled over the last two years while the budget has remained at the same level. The annual budget of NPR 3 million is not sufficient when the monthly expenditure is about NPR 500,000 to 600,000.
8. There is no place in MoHP to approach to discuss and resolve hospital-related issues. A separate central level division or department for this would facilitate the process. The Curative Division would not however be a good option based on experience.

Annex 1.2: Bheri Zonal Hospital

a. Performance against prescribed criteria and indicators

Table A1.2a: SSU Capacity (maximum score for each indicator = 4)

	Indicator	Score 2013	Current status (April 2015)	Score 2015
1	SSU is adequately and appropriately staffed (one officer level full-time unit chief, one office assistant, adequate number of facilitators with balance of gender and local ethnic diversity)	4	A female officer level SSU chief and five female facilitators (one with medical background, one from Tharu community, two with knowledge of Awadhi language) and an office assistant. Of six facilitators selected, one has left recently and the other serves the emergency billing section.	3
2	All SSU staff fully understand the guidelines, their roles and responsibilities and hospital systems	3	SSU staff demonstrated good understanding of guidelines, responsibilities and hospital systems.	4
3	SSU has capacity to use recording and reporting formats and Microsoft Excel based MIS	3	Two facilitators can use the Microsoft Excel based MIS for recording and reporting and the chief of the Records Section supports them in their task. Their level of confidence is still not sufficient and no training has been provided to the staff.	3
4	SSU works as a team with demonstrated leadership, good communication and high motivation to achieve the unit's mission	4	SSU chief provides good leadership. Communication among facilitators and chief is good and all show good job motivation.	4
5	SSU is well equipped with necessary space, furniture, computers, and supplies	3	Except for a phone landline, the SSU is fully equipped and has a good working space.	4
6	SSU is well supported by the SSU committee and hospital units/departments	3	SSU is well supported by the SSU committee and hospital units/departments.	4
	Total score	**20**		**22**
	Percentage (out of 24 full score)	**88%**		**92%**

Table A1.2b: SSU compliance (process)(maximum score for each indicator = 4)

	Indicator	Score 2013	Current status	Score 2015
1	SSU working and reporting schedules are followed strictly	2	SSU works two shifts (8 am to 2 pm, and 10 am to 4 pm). Reporting schedules are strictly followed.	4
2	Patient-wise documentation is kept well, prescribed forms and records filled in appropriately	2	Patient-wise documentation is kept well, prescribed forms and records are filled in appropriately.	4
3	Prescribed authorities for fully free and partially free service are fully delegated to SSU	4	Prescribed authorities for fully free and partially free service are fully delegated to SSU	4
4	Expenditure per patient is regularly recorded and budget ceiling is strictly followed	2	Expenditure per patient is regularly recorded and budget ceiling is strictly followed	4
5	Target groups unaccompanied by informed family members or acquaintances are well supported and facilitated	3	Target groups unaccompanied by informed family members or acquaintances are well supported and facilitated	4
6	Effective coordination and communication is maintained with SSU sub-committee and other departments, including with the one-stop crisis centre, where applicable, and for round-the-clock service provision to the target groups	3	Coordination and communication is mostly maintained with SSU committee and other departments for round-the-clock service provision to the target groups. Some gaps in service during evening and night were reported by the SSU chief.	3
7	The names of persons receiving partial or full free service are displayed in a public place to discourage the use of the service by well-off persons	2	The names of persons receiving partial and full free services are displayed in a public place to discourage the use of the service by well-off persons. (Even the name of a doctor was posted once! Nevertheless, some well-off persons are still accessing services.)	4
	Total score	**18**		**27**
	Percentage (out of 28 full score)	**64%**		**96%**

Table A1.2c: SSU performance against result indicators

	Indicator	2015	2013
1	The percentage of poor patients among sample beneficiary exit interview patients who received free or partially free service as "poor" clients	92.3%	NA
2	The percentage of beneficiaries with valid ID cards or letters from appropriate institutions confirming their beneficiary identity	90.6%	60.2%
3	The percentage of beneficiaries referred from other health facilities	0.7%	0.4%
4	The percentage of beneficiaries from adjoining districts	29.3%	28.5%
5	The percentage of beneficiaries from rural areas	67.0%	69.5%
6	The percentage of beneficiaries from disadvantaged groups according to MoHP's HMIS classification		
	Dalit	22.5%	18.0%
	Disadvantaged Janajati	16.6%	14.4%
	Disadvantaged caste groups in Tarai	13.5%	15.6%
	Muslims (religious minority)	12.5%	14.6%
	Relatively advantaged Janajati	9.4%	1.7%
	Upper caste groups	25.7%	35.7%
7	The proportion of beneficiaries from target groups		
	Poor	68.1%	71.0%
	Helpless	2.0%	2.9%
	Disabled	5.8%	8.6%
	GBV survivors	0.3%	0.6%
	Senior citizens	19.1%	13.7%
	FCHVs	3.0%	2.9%
	Others	1.6%	0.4%
8	Proportion of women among beneficiaries	47.9%	49.0%

Sources of data: Clients survey for indicator 1 and SSU record for indicators 2–8

Table A1.2d: SSU performance against outcome indicators

	Indicator	2013	2015
1	Percentage of target group patients satisfied with free or partially free service provided by the SSU at the hospital	NA	100.0%
2	Percentage of target group patients reporting no delays and/or problems in accessing services/medicines	NA	89.7%
3	Percentage of target group patients aware of the free service provision before coming to the hospital	NA	56.4%
4	Percentage of target group patients who came to know about free service through sources other than hospital staff/doctors (out of those who were aware of the free service before coming to the hospital)	NA	78.3%
5	Percentage target group patients who felt good about cleanliness of the hospital	NA	NA
6	Percentage of target group patients who felt good about the behaviour of the service providers	NA	100.0%

Source: Clients survey

b. NGO partnership

The hospital selected UNESCO CLUB Banke as its partner NGO and has been working with it for the last two years. The NGO raised the following points concerning its partnership with the hospital:

- Identification of the real poor is still a big challenge despite the current guidelines. VDC recommendations are not always reliable. Poor ID is the only way out in the long term.
- The MeSu sometimes bypasses the SSU and recommends free services. The MeSu once came and asked us to "confirm the total SSU expense as 67 lakh (NPR 6,700,000), if someone asked" and handed over the expenses sheet. (This was done in the backdrop of a CIAA investigation of corruption inside the hospital.) Unless the NGO is invited to periodic reviews in the hospital, the NGO would have no way of knowing the reality. (As per the SSU's records, the total expenditure was around 47 lakh. However, some free services like daily food expenses of patients in free beds are not recorded by the SSU.)
- "If something goes wrong inside the hospital, we are also blamed now and then, although we have nothing to do with the problem."
- There are delays in budget release for SSU staff salaries and sometimes, the hospital delays payment to NGOs.
- The last two hires were highly influenced by the MeSu and one left the job for another regular job in the Safer Motherhood Programme and this has created problems in SSU operation. There were complaints from some quarters that no Madhesi staff were selected. Now that staff recruitment is due, there are again pressures but the NGO says it has refused to budge.
- The upgrading of software also requires upgrading staff educational requirements. The current guidelines need to be revised appropriately, as they prescribe no minimum educational requirements. There could maybe two tiers of educational requirements — one for client facilitators and the other for using software for recording and reporting.
- There is a huge scope for collaboration for volunteer service with the private and non-profit sectors in the district. If the hospital takes the initiative, the NGO can do a lot in building these partnerships and using them for free services to the poor. The combination of core SSU staff and volunteers (interns) is a real possibility.

c. New initiatives by the SSU/hospital

There are currently no other social protection programmes at the hospital. No new initiatives by the hospital were noticed. However, the hospital has been displaying the names of patients who get free and partially free services, on account of being poor, daily on a white board to discourage the use of the service by non-poor people. The staff reported that this has discouraged the well-off from accessing the free and partially free service.

d. Key challenges and constraints

1. Two NGO staff were recently added. The SSU chief was not consulted by the MeSuon about their hiring. Both were placed at the Emergency Billing Counter and not at the SSU. And one of them just left for another job. The other one works at the emergency counter from 2 to 7:30 pm. The SSU chief has refused to 'own' these new staff as she feels they were hired to serve the MeSu's interests. The MeSu considers these staff are doing SSU work at the billing counter. A concerned staff member also reported that her job was divided between facilitating SSU clients and billing.

2. One staff from the NGO had just left. The vacant position is in process of recruitment. The SSU chief would prefer a male staff from the local Madhesi community and place for evening duty from 2 pm to 7:30 pm and cover services to the target group during evening and night.
3. The SSU staff had not been provided with any training, even on Excel use, as recommended.
4. The second qualitative part of reporting was always done verbally and never recorded on the report format. The staff and other concerned were comfortable with verbal reporting. For the last two years no one had ever questioned them about this.
5. The MeSu was found recommending medicines from the store and Sajha (a health cooperative enterprise which provides drugs at counters in many hospitals in Nepal) without the recommendation of the SSU. While the evaluation consultants were still in the store, two staff came and got medicines directly from the MeSu and the store provided them. There are transactions outside of the SSU.
6. Some hospital services are never costed and charged, such as dressing materials and medicines used during and after operation or accidents. The SSU uses two forms to recommend for free and partially free medicines and investigations. The hospital needs to introduce another form for capturing charges that are currently not costed and charged.
7. Some poor patients come to the hospital without VDC recommendation because they have no toilets in their houses and the VDC does not recommend "poor" unless they have a toilet. This happens as some VDCs are encouraging families to build toilets.
8. A well-off patient (89 years old) admitted that he had been provided with NPR 6,290 worth of free service by the MeSu against the rules. Sometimes, the SSU fund is used to provide drugs that were to be provided from the Safer Motherhood Programme. The Hospital Development Committee chairperson also reported undue pressure for such services from the well off. The chances of misuse of medicines meant for the poor are high and a 'central bidding and local procurement' policy and practice is needed. From the perspective of good governance, outsourcing the supply of medicines is a better option than using hospital stores. Hospital stores should only buy and keep medicines for inpatients.
9. There is a need to delegate more authority to SSU chiefs which would free up the time of MeSus for other important duties.
10. There is the need to prioritise and standardise the medicine recommendation process, e.g., if NPR 100 worth of antibiotics can do the job, why use an expensive one?
11. There are irregularities in the grading of disabilities, and people who come for disability certification are often refused service by the doctors on duty.
12. MoHP does not compensate the hospital for expenses incurred for free beds, although beds were made free through a declaration of the health minister a few years back.
13. An SSU agency at the central level is necessary for better streamlining the welfare programmes within one window. Similarly, there is a need to harmonise the guidelines and rules of different welfare programmes.
14. The billing counter twice refused to bill target clients (7 to 11 Bhadra and 25 to 30 Kartik). The staff did this to push for incentives for their regular work (the SSU chief receives such an incentive). It appears that this was part of the organizational politics inside the hospital. On reporting this event to the CDO, the MeSu was forced to solve this problem. (Note that hospital staff form groups based on political affiliations and sometimes on common interests. Conflicts between different groups sometimes surface on the issue of MeSu selection and so on.)
15. Though the MeSu claimed that the SSU staff placed at the evening emergency billing counter was doing SSU related tasks, no evidence of this was seen.

Annex 1.3: Western Regional Hospital

a. Performance against prescribed criteria and indicators

Table A1.3a: SSU capacity (maximum score for each indicator = 4)

	Indicator	Current status (April 2015)	Score 2015
1	SSU is adequately and appropriately staffed (one officer level full-time unit chief, one office assistant, adequate number of facilitators with balance of gender and local ethnic diversity)	A pharmacy officer (a female) who recently joined the hospital is SSU chief. She and an assistant work partly for SSU and the pharmacy. Of the six facilitators, five are women. One facilitator, however, has been placed at the ticket counter from the beginning and so is not available for SSU activities. Two facilitators continued from the International Nepal Fellowship (INF) have a health background.	4
2	All SSU staff fully understand the guidelines, their roles and responsibilities and hospital systems	SSU staff mostly understand the guidelines, their roles and responsibilities and hospital systems	3
3	SSU has capacity to use recording and reporting formats and Microsoft Excel based MIS	The SSU has capacity to use recording and reporting formats and Microsoft Excel based MIS. One facilitator does daily recording while another oversees her work.	4
4	SSU works as a team with demonstrated leadership, good communication and high motivation to achieve the unit's mission	The SSU generally work as a team with demonstrated leadership, good communication and high motivation to achieve the unit's mission.	3
5	SSU is well equipped with necessary space, furniture, computers, and supplies	The SSU is fully equipped but has a limited space (one reasonably sized room.) However, it is located slightly away from the main entrance.	3
6	SSU is well supported by the SSU committee and hospital units/departments	The SSU is generally supported by the SSU committee and hospital units/departments	3
	Total score		**20**
	Percentage (out of 24 full score)		**83%**

Table A1.3b: SSU compliance (process)

	Indicator	Current status	Score 2015
1	SSU working and reporting schedules are followed strictly	The SSU works two shifts: 8 am to 1 pm; 1 pm to 8 am. The two INF supported facilitators work 10 am to 5 pm and manage the SSU and its facilitators. Reporting schedules are generally followed.	3
2	Patient-wise documentation is kept well, prescribed forms and records filled in appropriately	Patient-wise documentation is well kept, and prescribed forms and records filled in appropriately. Unlike in other hospitals, the target group identification form is filled in once for a new patient and is not filled in when the patient revisits the hospital. (In other hospitals, they ensure non-repetition during data entry into Excel.)	4
3	Prescribed authorities for fully free and partially free service are fully delegated to SSU	Authority is delegated to the SSU for all free or partially free service except for operations, and for medicines that are not available in the hospital's pharmacy, for which the MeSu has the authority. The SSU chief's authority is delegated to one senior facilitator and in her absence any facilitator is empowered to determine on the free or partially free service and the SSU chief formalises the transaction later.	4
4	Expenditure per patient is regularly recorded and budget ceilingis strictly followed	They have never entered the costs into the computer database since the SSU started. The evaluation is the first time when someone noticed and questioned this. (Getting cost information was also a challenge in other hospitals during the early days, but the problems were solved gradually. Information providers tend to resist in the beginning.)	1
5	Target groups unaccompanied by informed family members or acquaintances are well supported and facilitated	Target groups unaccompanied by informed family members or acquaintances are well supported and facilitated	4
6	Effective coordination and communication is maintained with SSU sub-committee and other departments, including with the one-stop crisis centre, where applicable, and for round-the-clock service provision to the target groups	Coordination and communication is maintained with departments. There is coordination with child nutrition, the Bipanna Nagarik Kosh (Impoverished Citizen's Fund), HIV/AIDS, Methodoneprogrammes when required.	4
7	The names of persons receiving partial or full free service are displayed in a public place to discourage the use of the service by well-off persons	There is no public display of the names of people receiving free and partially free services.	1
	Total score		**21**
	Percentage (out of 28 full score)		**75%**

Table A1.3c: SSU performance against result indicators

	Indicator	2015	2013
1	The percentage of poor patients among sample beneficiary exit interview patients who received free or partially free service as "poor" clients	86.4%	NA
2	The percentage of beneficiaries with valid ID cards or letters from appropriate institutions confirming their beneficiary identity	NA	24.6%
3	The percentage of beneficiaries referred from other health facilities	NA	0.0%
4	The percentage of beneficiaries from adjoining districts	NA	47.3%
5	The percentage of beneficiaries from rural areas	NA	71.3%
6	The percentage of beneficiaries from disadvantaged groups according to MoHP's HMIS classification		
	Dalit	27.8%	35.3%
	Disadvantaged Janajati	46.0%	41.4%
	Disadvantaged caste groups in Tarai	20.7%	15.8%
	Muslims (religious minority)	0.5%	1.2%
	Relatively advantaged Janajati	0.8%	1.4%
	Upper caste groups	4.3%	4.9%
7	The proportion of beneficiaries from target groups		
	Poor	62.7%	79.9%
	Helpless	1.3%	1.0%
	Disabled	6.1%	3.8%
	GBV survivors	0.3%	0.1%
	Senior citizens	28.7%	14.6%
	FCHVs	0.9%	0.5%
	Others (other categories of patients were recorded as poor)	0.0%	0.0%
8	Proportion of women among the beneficiaries		46.1%

Sources of data: Clients survey for indicator 1 and SSU record for indicators 2-8

* Some information was not available as the SSU accidently deleted the data file for FY 2071/72 (2014/15) and there was no backup. Other information was captured from their presentation in Kathmandu.

Table A1.3d: SSU performance against outcome indicators

	Indicator	2013	2015
1	Percentage of target group patients satisfied with free or partially free service provided by the SSU at the hospital*	NA	84.0%
2	Percentage of target group patients reporting no delays and/or problems in accessing services/medicines	NA	74.0%
3	Percentage of target group patients aware of the free service provision before coming to the hospital	NA	56.0%
4	Percentage of target group patients who came to know about free service through sources other than hospital staff/doctors (of those who were aware before coming)	NA	74.6%
5	Percentage of target group patients who felt good about cleanliness of the hospital	NA	73.0%
6	Percentage target group patients who felt good about behaviour of service providers	NA	84.0%

*Source: Clients survey. * Percentage is lower than that of other hospitals. As the stock of most medicines for free distribution was out during the survey and the target group clients were mostly refused free medicines and this might have affected their opinion negatively.*

b. NGO partnership

The hospital selected the International Nepal Fellowship (INF) as the SSU partner NGO. The INGO has been a partner for years and used to run its Social Care Unit to provide free services to the poor. When MoHP's Population Division decided to establish the SSU in this hospital two years back, the hospital selected this INGO for partnership to run the SSU and has been working with it since then. INF has two representatives on the Hospital Development Committee.

INF provides appointment letters to the facilitators for one year which specify the source of their salaries. However, the salaries are paid directly by the accounts section of the hospital. Unlike in other hospitals, the NPR 1,500,000 grant is not given to INF and is directly handled by the hospital. As a result, there is no delay in salary payments to SSU facilitators whilst in other hospitals delays are due to the longer channel (hospital–NGO–SSU facilitators).

INF is in the process of phasing out its activities at the hospital. It has deputed two staff to the SSU and tops up their salaries regularly. However, the other government hired (although 'officially' through INF) staff does not receive top-ups from INF. During the recent hospital board meeting, INF agreed to support the two SSU staff for one more year. Ideally, INF would like the hospital to fully integrate these two staffs into the government system with adequate compensation. The hospital management is also in favour of creating permanent government positions for all SSU staff.

The INF supported staff feel uncertainty about their future careers as they see INF phasing out. Their preference is to continue working in their current capacity in the hospital. It is doubtful if the government system in the hospital can compensate these staffas well as INF is doing.

The hospital management has asked the INF to be transparent regarding the top up amount paid to these two staffs and INF has agreed to provide the information in the future.

The hospital management intends to hire SSU staff directly (as they are doing now, albeit with the official support of INF) by creating new staff positions within the hospital. The current SSU-guidelines have not envisaged this modality of running the SSU.

c. New initiatives by the SSU/hospital

The SSU has been doing some coordination work related to HIV/AIDS, the Child Nutrition Programme, Methadone (with the National Centre for AIDS and STD Control, NCASC) and the Impoverished Citizen's Fund (BNK). Usually they provide free or partially free investigative services and sometimes medicines to their target groups. The SSU also provides free services (investigative) to poor Aama Suraksha (Safer Motherhood Programme) patients who are not covered by the programme. In the case of geriatric ward patients, investigation and sometimes medicines services are provided through the SSU.

The hospital has a geriatric ward for eight patients. The ward provides a 50% subsidy on medicines and investigation. Senior citizens who need admission are taken to the geriatric ward; but the SSU is not involved in the identification and record keeping of these patients. The SSU is involved when it comes to providing free medicines and investigations to these patients.

The Aids Health Care Foundation (AHF— an INGO) recently started its activities in the hospital and provides counselling and antiretroviral treatment (ART) services. The programme has only NPR 10,000 per month for medicines and this amount is too small to cover the medicine costs of patients and so the SSU ends up providing free or partially free medicines and investigative services to these people.

d. Key challenges and constraints

1. SSU staff have not been provided with any training, even on Excel use (as recommended). The SSU was unaware of the use of the budget sent for capacity building and promotional activities. No SSU promotional activities have ever been carried out. After the evaluation team raised this issue with the hospital management, action has been taken to use the money.
2. There was a problem while starting the Excel data sheet and support was received from a visiting SSU facilitator from Bharatpur Hospital. Since then there have been no problems and the two facilitators have good Excel skills. However, the data sheet for fiscal year 2014/15 was deleted by a facilitator and he said he intends to recreate it during the next two weeks. This shows lack of data security awareness and arrangement.
3. Other groups that the hospital has been serving such as martyrs' families, clients sent by the police, people with HIV/AIDS and prisoners are recorded as 'poor' by SSU while earthquake victim patients are recorded separately. No entries have been made under the 'others' category. Gurungs and Magars have been classified as relatively advantaged ethnic groups during record keeping, but they are only regular janajatis.
4. The second, qualitative part of reporting has always been done verbally and never recorded on the format. The staff and other concerned were comfortable with this verbal reporting.
5. The SSU chief does not recommend medicines that are to be provided from outlets other than the hospital pharmacy. This is also the case with surgery. The MeSu recommends subsidies on these medicines and surgery.
6. The hospital used to distribute 295 types of free medicines but now it is forced to distribute only a limited number due tolack of budget. There is currently a shortage of medicines and most patients are not provided any medicines and the hospital only provides investigation services in most cases. For some cases, the SSU (INF supported facilitators) manage medicines through other sources. Accordingly, the flow of patients has reduced to half of its normal level. SSU clients have gone down to 30 from 60 a day.
7. There have been five SSU chiefs during the last two years. However, due to the role of the de facto SSU chief (INF supported), there have been no major disruptions in services. Moreover, the authority delegation and mutual trust has compensated for the frequent SSU chief turnover. The staff on duty at the billing counter usually agree to provide free services to patients recommended by any SSU staff. However, one staff member only accepts the signature of the two INF supported staff and not of other facilitators. At one time, a person had taken blood for testing and there was the risk of the blood clotting, but the duty person refused to provide free service as neither of the two INF supported staff were on duty.
8. The SSU budget of NPR 1.5 million in 2014/15 was almost all spent on staff costs and no activities were done through this budget. The additional NPR 300,000 for medicines was also not used. The MeSu and chief of accounts were not fully aware of the latter budget. After an evaluator raised this issue with them, they organised meetings and took a quick decision to make best use of the budget. It was ironic that many poor patients had been refused

medicines, as medicines were not available with the pharmacy, while the money meant for medicines for the poor remained unutilised.

9. As a rule hospital staff get 90% free treatment and their families/dependents get 50% free. Now and then some staff ask for fully free services and refusing them is sometimes difficult.

Annex 1.4: Bharatpur Hospital

a. Performance against prescribed criteria and indicators

Table A1.4a: SSU Capacity (maximum score for each indicator = 4)

	Indicator	Score 2013	Current status (April 2015)	Score 2015
1	SSU is adequately and appropriately staffed (one officer level full-time unit chief, one office assistant, adequate number of facilitators with balance of gender and local ethnic diversity)	4	One officer level full-time unit chief, six facilitators (one male of Janajati background and five female, three with medical background). Four interns also assist SSU's work.	4
2	All SSU staff fully understand the guidelines, their roles and responsibilities and hospital systems	2	SSU staff demonstrated good understanding of guidelines, responsibilities and hospital systems.	4
3	SSU has capacity to use recording and reporting formats and Microsoft Excel based MIS	3	Four facilitators got computer training (on Access programme) and starting this fiscal year, the Excel based recording system was changed into Access based system by a trained facilitator. Despite training, the recording and reporting system is still heavily dependent on one of the facilitators.[10]	3
4	SSU works as a team with demonstrated leadership, good communication and high motivation to achieve the unit's mission	1	SSU chief provides good leadership. Communication among facilitators and chief is good and all show good job motivation.	4
5	SSU is well equipped with necessary space, furniture, computers, and supplies	3	Except for the lack of a phone landline, the SSU is fully equipped and has a good working space.	3
6	SSU is well supported by the SSU committee and hospital units/departments	2	SSU is well supported by the SSU committee and hospital units/departments	4
	Total score	15		22
	Percentage (out of 24 full score)	63%		92%

[10] The data entry for the Nepali month of Jestha (May/June 2015) had not started during the time of the evaluation (by third week of Jestha). The previous practice of daily data entry has been replaced by entry after completion of month and report generation requires a minimum of six working days and is not instantaneous. Replacement of previous Excel based system by self-designed Access Programme has changed some features too.

Table A1.4b: SSU compliance (process) (maximum score for each indicator = 4)

	Indicator	Score 2013	Current status	Score 2015
1	SSU working and reporting schedules are followed strictly	2	SSU works three shifts (7 am to 1 pm; 1 pm to 7 pm; 7 pm to 7 am). Reporting schedules are strictly followed.	3
2	Patient-wise documentation is kept well, prescribed forms and records filled in appropriately	2	Patient-wise documentation is generally well kept, prescribed forms and records mostly filled in appropriately. Section 3 of ID form is not filled in for Bote, Majhi, Musahar and Chepang ethnic groups. Wards still use old version of ID form and send it to SSU. Incomplete forms were observed.	3
3	Prescribed authorities for fully free and partially free service are fully delegated to SSU	2	Prescribed authorities for fully and partially free service are fully delegated to the SSU. When the relatively well-off attempt to get free or partially free services, the SSU Chief sometimes engages the MeSu for final decision.	4
4	Expenditure per patient is regularly recorded and budget ceiling is strictly followed	3	Expenditure per patient is regularly recorded and budget ceiling strictly followed	4
5	Target groups unaccompanied by informed family members or acquaintances are well supported and facilitated	3	Target groups unaccompanied by informed family members or acquaintances are well supported and facilitated	4
6	Effective coordination and communication is maintained with SSU sub-committee and other departments, including with the one-stop crisis centre, where applicable, and for round-the-clock service provision to the target groups	1	Coordination and communication is mostly maintained with SSU committee and other departments for round-the-clock service provision to target groups. Facilitators work three shifts. Facilitators working in morning shifts take rounds of wards. Coordination with Emergency Department concerning identification of target patients was sub-optimal.	3
7	The names of persons receiving partial or full free service are displayed in a public place to discourage the use of the service by well-off persons	1	Names of persons receiving partial or full free service are not displayed in a public place to discourage use of services by well-off persons. Monthly display on noticeboard is being considered by SSU chief.	1
	Total score	14		22
	Percentage (out of 28 full score)	50%		79%

Table A1.4c: SSU performance against result indicators

	Indicator	2015	2013
1	The percentage of poor patients among sample beneficiary exit interview patients who received free or partially free service as "poor" clients	86.3%	NA
2	The percentage of beneficiaries with valid ID cards or letters from appropriate institutions confirming their beneficiary identity	59.4%	53.5%
3	The percentage of beneficiaries referred from other health facilities	59.7%	8.2%
4	The percentage of beneficiaries from adjoining districts	29.4%	27.4%
5	The percentage of beneficiaries from rural areas	76.4%	72.1%
6	The percentage of beneficiaries from disadvantaged groups according to MoHP's HMIS classification		
	Dalit	14.9%	14.5%
	Disadvantaged Janajati	42.3%	35.4%
	Disadvantaged caste groups in Tarai	0.0%	5.4%
	Muslims (religious minority)	1.1%	0.9%
	Relatively advantaged Janajati	0.0%	7.2%
	Upper caste groups	41.7%	36.6%
7	The proportion of beneficiaries from target groups		
	Poor	55.1%	60.1%
	Helpless	5.1%	3.3%
	Disabled	1.7%	2.2%
	GBV survivors	0.2%	0.3%
	Senior citizens	36.5%	22.9%
	FCHVs	1.3%	0.8%
	Others	0.0%	10.3%
8	Proportion of women among the beneficiaries	48.7%	49.6%

Sources of data: Clients survey for indicator 1 and SSU record for indicators 2-8

Table A1.4.1d: SSU performance against outcome indicators

	Indicator	2013	2015
1	Percentage of target group patients satisfied with free or partially free service provided by the SSU at the hospital.	NA	96.3%
2	Percentage of target group patients reporting no delays and/or problems in accessing services/medicines	NA	72.5%
3	Percentage of target group patients aware of the free service provision before coming to the hospital	NA	56.3%
4	Percentage of target group patients who came to know about free service through sources other than hospital staff/doctors.	NA	82.2%
5	Percentage of target group patients who felt good about cleanliness of the hospital	NA	83.8%
6	Percentage of target group patients who felt good about the behaviour of the service providers	NA	96.3%

Source: Clients survey

b. NGO partnership

The hospital selected Sahavagi Nepal as the partner NGO and has been working with this NGO for the last two years. The NGO raised the following key points concerning its partnership with the hospital:

- The SSU is becoming more and more systematic in its work and so the targeted groups are accessing services more. The SSU provided 24-hour service during the earthquake catastrophe and the staff worked around the clock. There have been five MeSus and four SSU chiefs in two years, and this created difficulties communicating with them. The MeSus and chiefs have not had much idea about the SSU and its mandate and their short duration has not allowed for proper communication. They have not been clear on the importance and role of the SSU.
- There are delays in budget release for SSU staff salary payment and sometimes the hospital delays payment to NGOs. The first payment was received six months late and the second payment three months late.
- NGO support to the SSU should be for a longer term to result in impact. Things have just started taking shape and being systematic.
- The SSU faced problems during the first SSU and one of the following chiefs. They were interested in providing free services to their own people and were not concerned with the SSUs objectives as such. An SSU staff members told the evaluators:

  "When we faced problems, they did not help us as if we were outsiders.Doctors still bring in some people for free treatment and they already sign the form. However we provide the service but do not countersign the forms. Influential persons from outside (Executive Officer of the Municipality) also come with persons for free service."

  A check of SSU records for the month of Jestha showed that there were a total of 35 such "recommended" cases out of the total 1442 patients (new and old).
- It takes a long time to separate out new patients and old patients. The SSU had still to enter data for the month of Jestha. Report preparation was said to take six working days including data input for medicines.

c. New initiatives by the SSU/hospital

Bharatpur Hospital/SSU has taken a number of initiatives in the last two years:

- Introduced a dress code in the initial days, which was later replicated by other SSUs.
- Coordination of free or partially free service to clients of the Child Nutrition Programme, HIV programme, and geriatric programme.
- Systematic use of volunteers for the SSU.
- Integration of pharmacy into the SSU.
- Three shift deployment of facilitators.

d. Key challenges and constraints

1. One facilitator has improved computer skills in using Access programme. The SSU Excel based recording and reporting system was converted into an Access Programme starting this fiscal year (2014/15). The conversion has changed programme features: reports are not automatically generated and take six full working days. The HMIS code used is wrong: no Madhesi group is

included in the records. Staff also showed confusion regarding the classification. As a result, the data from the last year cannot be compared with this fiscal year. No consultations regarding the change from an Excel based system to the Access programme were carried out with the Population Division. This happened against the backdrop of the frequent change of MeSu and SSU chief (five and four respectively over two years). The daily data entry system has been replaced by monthly data entry. Trimesterly reporting has been replaced with monthly reporting. The facilitator was somehow swayed by features of Access Programme and with the go-ahead signal from the then SSU chief, undertook this change.

2. The second, qualitative part of the reporting has always been done verbally and never recorded on the report format. The staff and other concerned are comfortable with verbal reporting.
3. The SSU chief engages the MeSu when relatively well-off patients try to get free service. Some wards still use the old form to recommend free medicines to patients. Some doctors were found to recommend free medicines to poor patients. When such recommendations come to the SSU, SSU staff do not sign them. The evaluator checked all the records of free and partially free services for the month of Jestha. There are free and partially free transactions outside of the SSU too.
4. All social programmes should be integrated into the SSU at the hospital level from the management perspective. The idea to have a separate central level government agency to look after hospitals and SSU sounds good. When the MeSuwas in the MoHP central office last time, he felt totally lost, as there was no one to whom he could communicate SSU issues. He was clueless as to who the concerned person was to discuss issues he was facing.
5. The SSU chief has questioned whether the budget meant for medicine purchase or for the poor can be used for buying bed sheets or other furniture. (There are no clear-cut rules for the use of conditional grants.)
6. The accounts section hesitates to share budget and expense related information with the SSU.
7. Non-poor recommended by the local bodies for free service should be provided only 25% free services. A system of grading the free service (25%, 50%, 75% and 100%) would be useful.
8. The NGO should hire people from the medical field. The SSU should also include counselling services, for which a nurse might be required.

Annex 1.5: Koshi Zonal Hospital

a. Performance against prescribed criteria and indicators

Table A1.5a: SSU Capacity (maximum score for each indicator = 4)

	Indicator	Current status (April 2015)	Score 2015
1	SSU is adequately and appropriately staffed (one officer level full-time unit chief, one office assistant, adequate number of facilitators with balance of gender and local ethnic diversity)	A male statistical officer with experience of exemption provision (Bir Hospital) is the chief. There are 2 female and 3 male facilitators (with social science backgrounds). The SSU chief is a Madhesi who speaks local Maithili language. All other facilitators belong to 'upper' castes (Brahmins and Chhetris). Two facilitators handle computer recording. But computer is used only for typing purposes. The data are recorded and summarised manually as they do not yet use the Excel based system.	4
2	All SSU staff fully understand the guidelines, their roles and responsibilities and hospital systems	SSU staff stated fair understanding of guidelines, responsibilities and hospital systems. But it came to be known that three facilitators have limited knowledge about the guidelines — their work is limited to filling requiredforms. The HMIS coding and assessment part is not completed.	3
3	SSU has capacity to use recording and reporting formats and Microsoft Excel based MIS	The Excel based MIS is not being used in this hospital and the computer is only used for typing. Records are kept on registers and summarised using calculators. Although staff have not been oriented on the Excel based MIS the two facilitators can use Microsoft Excel and the system could be operated easily.	3
4	SSU works as a team with demonstrated leadership, good communication and high motivation to achieve the unit's mission	SSU chief (2years) provides moderate leadership. Communication between facilitators and the chief is better and all show good job motivation. There is good coordination among SSU staff.	4
5	SSU is well equipped with necessary space, furniture, computers, and supplies	The SSU is fully equipped but has a very limited space (two small rooms) However, it is located near the main entrance (a good thing). Space is limited	3
6	SSU is well supported by the SSU committee and hospital units/departments	The SSU is well supported by the SSU committee and hospital units/departments	4
	Total score		**21**
	Percentage (out of 24 full score)		**88%**

Table A1.5b: SSU compliance (process)(maximum score for each indicator = 4)

	Indicator	Current status	Score 2015
1	SSU working and reporting schedules are followed strictly	The SSU opens at 9am and works till 4 pm. There are no assigned persons before and after these hours. The SSU chief claims that he stays in the hospital premises therefore service is available round the clock. However clients may not know his residence and if they do could be reluctant to approach him there.The SSU sends progress reports on time. It has been delayed only once.	3
2	Patient-wise documentation is kept well, prescribed forms and records filled in appropriately	Patient-wise documentation is kept well, prescribed forms and records are filled in appropriately, although a few shortfalls were noticed (e.g. charge and drugs costs not recorded in register). Patient wise costs are not recorded.In the case of poor clients, identification letters have been attached on only a few applications.	3
3	Prescribed authorities for fully free and partially free service are fully delegated to SSU	The prescribed authorities for fully free and partially free service are fully delegated to the SSU.	4
4	Expenditure per patient is regularly recorded and budget ceilingis strictly followed	Expenditure per patient isseldom recorded. The budget ceilingwas not strictly followed in 2013/14, and the SSU took cost data from the hospital's billing software and used this to report to the hospital development committee on the budget spent on free and partially free care. This year (2014/15) the budget ceiling is being strictly followed and expenditure is on track.	3
5	Target groups unaccompanied by informed family members or acquaintances are well supported and facilitated	Target groups unaccompanied by informed family members or acquaintances are well supported and facilitated.	3
6	Effective coordination and communication is maintained with SSU sub-committee and other departments, including with the one-stop crisis centre, where applicable, and for round-the-clock service provision to the target groups	Coordination and communication is maintained with the SSU committee and other departments. The SSU chief stated that service is available round-the-clock; however, finding the chief's quarters can be problematic.	4
7	The names of persons receiving partial or full free service are displayed in a public place to discourage the use of the service by well-off persons	There is no noticeboard in a public place to display the names of the persons who receive free care. The mobile phone numbersof the SSU chief andfacilitators are not disclosed to the general public.	1
	Total score		**21**
	Percentage (out of 28 full score)		**75%**

Table A1.5c: SSU performance against result indicators

	Indicator	2015	2013
1	The percentage of poor patients among sample beneficiary exit interview patients who received free or partially free service as "poor" clients	72.1%	NA
2	The percentage of beneficiaries with valid ID cards or letters from appropriate institutions confirming their beneficiary identity	NA	NA
3	The percentage of beneficiaries referred from other health facilities	NA	NA
4	The percentage of beneficiaries from adjoining districts	NA	NA
5	The percentage of beneficiaries from rural areas	NA	NA
6	The percentage of beneficiaries from disadvantaged groups according to MoHP's HMIS classification		
	Dalit	24.0%	20.7%
	Disadvantaged Janajati	15.8%	17.8%
	Disadvantaged caste groups in Tarai	26.3%	24.8%
	Muslims (religious minority)	6.5%	7.1%
	Relatively advantaged Janajati	4.7%	7.6%
	Upper caste groups	22.7%	21.9%
7	The proportion of beneficiaries from target groups		
	Poor	71.3%	76.7%
	Helpless	3.6%	1.3%
	Disabled	2.9%	2.0%
	GBV survivors	0.3%	0.8%
	Senior citizens	21.2%	18.6%
	FCHVs	0.7%	0.3%
	Others	0.0%	0.1%
8	Proportion of women among beneficiaries	50.4%	50.7%

Sources of data: Clients survey for indicator#1 and SSU record for indicators#2-8

Due to non-use of Excel based recording and reporting programme by Koshi Zonal Hospital, some of the information (#2-5) is not available.

Table A1.5d: SSU performance against outcome indicators

	Indicator	2013	2015
1	Percentage of target group patients satisfied with free or partially free service provided by the SSU at the hospital.	NA	100.0%
2	Percentage of target group patients reporting no delays and/or problems in accessing services/medicines	NA	77.0%
3	Percentage of target group patients aware of the free service provision before coming to the hospital	NA	82.0%
4	Percentage of target group patients who came to know about free service through sources other than hospital staff/doctors	NA	84.6%
5	Percentage target group patients who felt good about cleanliness of hospital	NA	61.7%
6	% of target group patients who felt good about behaviour of service providers	NA	100.0%

Source: Clients survey

b. NGO partnership

The NGO Sanjivani has been working with Koshi Zonal Hospital for a decade (from before the introduction of the SSU) supporting poor patients. Particularly, it has been facilitating free medicines and health services, and also arranging blood and blood bags. In 2014, Sanjivani was selected as the partner to run the SSU.

Regularity and continuity of the service is not possible with volunteers who do get any incentives. Their motivation will be less and orientation costs high. However, fully paid civil servants cannot be expected to carry the poor and destitute patients from the street. They may not be kind-hearted. Thus, the concept of semi volunteerism (partly paid volunteers) fits in this context. The SSU facilitators are paid nearly half as much but demonstrated better performance than regular hospital staff.Thesemi volunteers should have insurance, holidays and more allowances for better performance.

At present, only the salary part of the budget is paid to the NGO. The budget for promotional activities and capacity building remains with the hospital. This has led to dual accountability. If all activities are outsourced to the NGO, more poor patients will be benefited by the SSU. The role of the hospital could be confined to monitoring and supervision. NGOs are flexible and can generate the additional resources for the treatment of poor people (arranging blood, referral transport, and offering transport costs home).Government staff, with rigid law and regulations, have difficulties working for poor people.

The role of NGOs could be expanded to raising funds, in addition to their current role of providing human resources to run the SSU. A local trust fund should be established with donations from the benevolent, businesspersons, and social organizations.

c. New initiatives by the SSU/hospital

Besides the six target groups, the SSU is also coordinating treatment for victims of the earthquakes, nutritional rehabilitation, kidney dialysis and Kala-azar treatment (on recommendation from the district health office). It also coordinates with Sanjivani and other NGOs to arrange funds for the transport of the poorest patients.

d. Key challenges and constraints

1. The proportion of targeted clients served by the SSU out of all hospital clients decreased considerably from 28% in 2013/14 to 10% in 2014/15 due to the shortage of funds and the reduced benefit package. In 2013/14, a total of 14 joint secretaries of the Government of Nepal (from the Office of the Prime Minister and MoHP) instructed the hospital to offer more services to the poor people free of charge and claim for additional reimbursements. The hospital served more poor patients (28% of the total inpatients) as per the instruction and requested reimbursement of NPR 3 million; but MoHP was unable to reimburse due to lack of funds.
2. Payment is due to suppliers for pharmaceutical products (drugs) worth NRP 8.5 million, with NRP 3.2 million outstanding. The allocated funds for free care do not cover the demands for drugs, and investigation expenses. In 2014/15 free services included only free investigation and free medicines to the destitute and GBV victims.
3. There is no identity card for people poor and VDC secretaries recommend free treatment to whoever requests them. Last year many non-poor civil servants, hospital staff, police, pensioners and journalists took advantage of free care. The local development officer should

instruct VDC secretaries only to recommend the real poor. The health posts and sub-health posts too do not send clients with proper referral slips that indicate if the client is poor. Finally, the real poor often do not come to the hospital for free care as they have no knowledge about its availability. Efforts to air the message are insufficient.

4. The role of the chair of the hospital development board is limited to that of facilitator and he or she has no authority to take disciplinary actions. Senior citizens who are better off should be discouraged from taking free care. And the capacity of SSU employees should be enhanced in screening, reporting and recording.

Annex 1.6: Bir Hospital

Over 80% of Bir Hospital's beds are free irrespective of the income status of patients. Some routine investigations in the hospital are free for all and concessions of 25 to 50% are provided in other non-routine investigations. 100% exemption is very rare.

Authority to exempt fees up to NPR 2,000 has been given to the SSU unit's administrative officer. The head of the Emergency Department has the authority to exempt fees for target group clients (after 5pm until 9am) except for the cost of CT scans. The authority for free and partially free services costing more than NPR 2,000 is decided on by the hospital director. In the previous authority delegation arrangement, the director only looked after only cases of poor patients. One administrative officer looked after the cases of staff and families and another looked after the rest of the target groups. This change came due to financial pressures.

a. Performance against prescribed criteria and indicators

Total target group patients served during the last year are as follows:

Table A1.6a: Different target groups served (May 2014 to May 2015)

Target group	Total number	% of total patients
Poor	1,350	36%
Helpless	196	5%
Senior citizens	1,598	42%
Disabled	593	16%
GBV survivors	3	0.1%
FCHVs	48	1%
Total patients served	3,783	100%
Total male	2,314	61%
Total female	1,469	39%
Total cost (in NPR)	**2,053,746**	

Source: SSU record, Bir Hospital

The different groups served according to the HMIS classification for three months (March-May) and also the department-wise break-down are as follows:

Table A1.6b: Different HMIS groups served (March to May 2015)

Target group	Total number	Percentage of the total
Dalit	50	8%
Janajati	195	33%
Madhesi	32	5%
Muslim	16	3%
Brahmin/Chhetri	297	50%
Others	0	0%
Total patients	**590**	

Source: SSU record, Bir Hospital

Routine performance evaluations of the SSU against the prescribed indicators are not so useful as the hospital is still in the process of adapting and adopting the SSU model. Only a few of the free or partially free services are recorded by the SSU, and most such transactions are yet to be properly recorded. Sanjivani (the partner NGO) besides supplying seven facilitators to the SSU, is also continuing its social work from its allocated office room at the hospital. Bringing all free or partially free transactions under one window is still a difficult task.

However, the following table has been prepared from the information of the clients' survey. The survey clearly shows that although more than 77% of the people coming to the hospital for free services knew about such services before coming, 74% among them came to know from hospital staff (doctors and nurses). This shows a virtual monopoly on knowledge of the free or partially free service by the hospital staff and doctors and nurses.

Table A1.6c: SSU performance against outcome indicators

	Indicator	2013	2015
1	Percentage of target group patients satisfied with free or partially free service provided by the SSU at the hospital.	NA	98.6%
2	Percentage of target group patients reporting no delays and/or problems in accessing services/medicines	NA	66.2%
3	Percentage of target group patients aware of the free service provision before coming to the hospital	NA	77.5%
4	Percentage of target group patients who came to know about free service through sources other than hospital staff/doctors	NA	26.3%
5	Percentage of target group patients who felt good about cleanliness of the hospital	NA	78.9%
6	Percentage of target group patients who felt good about the behaviour of the service providers	NA	98.6%

Source: Clients survey

b. NGO partnership

The SSU was officially established in May 2014 with the selection of Sanjivani Nepal as the facilitating NGO for free and partially free health services. Sanjivani was selected to run the SSU. It has been providing the services of seven facilitators, including five women. They all work single shifts from 9am to 5pm. One facilitator is mainly deployed to look after and provide care to helpless patients and sometimes guide patients to wards. Another is deployed at the Emergency Department. Sanjivani's services and records cover patients who come to the OPD and Emergency Departments during the daytime plus some inpatients.

Sanjivani has been working with the hospital for decades (before the SSU) supporting poor patients. Particularly, it has been facilitating access to free medicines and health services, and arranging blood and blood bags. However, the scope of work of Sanjivani is limited as compared to other partner NGOs at the regional or zonal hospitals, as most target group patients get free or partially free service through hospital departments directly without SSU involvement.

c. Key challenges and constraints

The hospital reported the following major challenges and constraints:

1. Most patients coming to the hospital demand free services. Except for some patients referred by political leaders/technocrats or hospital doctors and staff, patients generally tend to be poor. As a result, there is tremendous pressure for free or partially free services. It is practically impossible to provide all these patients with free or partially free services due to budgetary constraints. With the hospital's daily patient flow being around 1500, the hospital's approach focuses on limiting access of these patients to free and partially free service.
2. Target group identification, particularly identification of the poor, the helpless and GBV survivors, poses some difficulties. Clients often come without proper documents and try to pressure for free services. Although only category A and category B people living with disabilities are entitled to free or partially free service, in practice even category C and D people with disabilities demand free services.
3. The hospital charges 50% to 75% of the costs of non-routine investigations and so target group patients do not get fully free services and thus sometimes leave the hospital angry without using the services.
4. Sometimes free medicines are not available and clients are forced to leave unsatisfied.
5. Hospital staff and their relatives often access free or partially free services and the hospital management has not identified ways of preventing this.
6. The SSU is located on the top floor of the hospital and is not easily accessible to the target groups. Given the pressure to limit the free or partially free service due to budgetary constraints, the hospital management is not in favour of moving the unit to a more visible location.
7. The hospital is still using an old target group identification form prepared by the hospital years ago.

d. Way forwards

A meeting held on 19 August 2015 at the hospital with the attendance of the director, administrative officers, accounts officer, SSU chief, Sanjivani's chief, the head of the Emergency Department and the evaluation consultants reached the following understanding:

1. The SSU will coordinate and compile all records of free or partially free services provided through different avenues (free bed and investigations of inpatients, exemptions made by the Emergency Department during off-office hours, oxygen and other free services, free food expenses, and free services provided by the Kristina Foundation at the hospital). For this the SSU will collect information from the Kristina Foundation every month and from the Emergency Department every day. The SSU will collect exempted amount from zero bills from the records of the accounts department.
2. Limit the number of beneficiaries from relatives of staffs/doctors by strictly following the guidelines of the Civil Service Act: i.e. providing subsidised services to only spouses, children (up to 18 years of age), fathers and mothers, and not to other relatives.
3. Further tighten the screening process to focus on really poor patients.
4. Inpatients will also be asked to fill in free service application forms to enable the SSU to keep track of the free services provided through the inpatient department.
5. Appropriate software for free or partially free service related management information system needs to be developed prepared to ease the tasks of the SSU. The current Excel based system needs to be replaced by new software.

Annex 1.7: Paropakar Maternity and Women's Hospital

a. Performance against prescribed criteria and indicators

The PMW hospital specialises in child delivery related care and most of its services are provided for free. However, treatments before child delivery, treatment of children after delivery (including medicine provision), and treatment for diabetes, high blood pressure, and dialysis (sometimes) are not free. The use of ventilators is not free. The SSU was established in August 2013.

Note that routine performance evaluation against the prescribed indicators at this stage will not be useful, as the hospital is still in the process of adapting the SSU model to its functioning.

The progress data for the second half of fiscal year (FY) 2013/14 and for 2014/15 (to May 2015) regarding the clients served are as follows:

Table A1.7a: Target groups served during FY 2013/14 (second half)

Target group	Total number
Poor	74
Helpless	31
Disabled	11
Senior citizen	3
GBV survivors	8
FCHVs	0
Total patients served	**127**
Total cost	**NPR 353,530**

Source: SSU record, PMW Hospital

Table A1.7b: Target groups served during FY 2014/15 (to Jesth 2072 — May/June 2015)

Target group	Total number
Poor	192
Helpless	74
Disabled	98
Senior citizen	50
GBV survivors	18
FCHVs	9
Total patients served	**441*** **
Total cost	**NPR 611,594**

Source: SSU record, PMW Hospital

*** The numbers are for up to the Nepali month of Jestha. By the end of 2014/15 (mid-July 2015), the number had reached 503.

The patient load is about 1.5 per day per four facilitators. On some occasions, there are as many as five patients a day and the facilitators reported being extremely hard pressed to carry out their work. (Note: the patient load at Seti Zonal Hospital is about 50 per day for seven facilitators, equivalent to 30 for four facilitators.)

The hospital is in the process of creating and using hospital service management software. The hospital management has been advised to properly integrate activities of the SSU into the software to avoid duplication. However, it remains to be seen if they will follow this advice.

b. NGO partnership

The NGO CAP Nepal was hired to facilitate the provision of free services in Shrawan 2071 (July 2014). The NGO provides four women facilitators. Three of them have a medical background and one a management background. Two facilitators are deployed for the morning shift (8am to 2pm) and two for the afternoon shift (1pm to 7pm). During duty hours, one facilitator works mostly at the Gynaecology Ward and GBV unit to identify target group clients, take case histories, inform doctors, and conduct preliminary examinations and counselling when necessary. The others mostly stay at the SSU office.

CAP Nepal has networked with other NGOs that work against GBV, including Sathi, WOREC, SathSath. This network has been useful for referring clients above age 18 for longer term rehabilitation and counselling. CAP Nepal keeps GBV survivors up to age 18. A significant time of these SSU facilitators is spent on the identification and facilitation of GBV cases. Although they need to carry out counselling now and then, they are not trained on counselling.

c. Key challenges and constraints

The hospital faces the following challenges and constraints related to managing the free or partially free services:

1. Comprehensive care for GBV survivors including rehabilitation, legal support and mental health support is still a problem. There is a lack of 24-hour services especially for gender based violence survivors despite the presence of a one-stop crisis management centre (OCMC) due to a shortfall of staff.
2. The rehabilitation and reintegration of homeless people, abandoned children and patients with mental problem is difficult.
3. Lack of poor identity cards results in unnecessary pressure from relatively well-off persons for free services.
4. The heavy flow of earthquake victims from late April 2015 made difficulties in categorizing target patients.
5. Managing the extra food and lodging expenses of care takers and accompanying children of SSU patients, and sometimes expenses for medicines (not available at the hospital) has been difficult with the lack of available petty cash. Now and then, facilitators and other hospital staff end up paying such expenses from their own pockets. (Even when there is budget in the hospital, the fund release process can sometimes take weeks even when the money is urgently required.)
6. The impractical maximum per patient costs for free patients in the current guidelines.
7. Inadequate compensation for SSU facilitators.
8. Lack of photocopy facility during evening hours forces facilitators to pay photocopy charges from their own pockets.

Annex 1.8: Kanti Children's Hospital

a. Performance against prescribed criteria and indicators

The hospital was established in 1963 and is the only referral hospital for paediatric care in the country. It has 327 beds and total of 536 (258 government positions) staff. Due to internal (staff trade union related) problems, the hospital has been unable to operationalise its SSU, despite appointing an SSU chief. The hospital, however, has been providing free services to clients and more than 80% of its beds are free of charge. A performance evaluation against prescribed criteria and indicators is not useful as the hospital has not yet operationalised its SSU.

b. NGO partnership

The hospital recently established an SSU but has not selected a facilitating NGO. At a meeting of NHSSP's GESI advisor and evaluation consultants with the Hospital Management in July 2015 an understanding was reached that the hospital would soon select an NGO for the SSU facilitating role.

c. Key challenges and constraints

Based on its experiences of providing free services, the hospital presented the following key challenges of implementing free services:

1. Lack of robust and practical criteria for identifying the poor and the land ownership criteria provided on the identification form is not practical to use[11]
2. Clients from remote places come without proper recommendations from their local authorities.
3. Hospital staff, and patients and their families are mostly unaware of the provision and rules for free services and they often misunderstand that all services in government hospitals are free.
4. MoHP often does not reimburse funds spent on free services and the capacity of the hospital to fulfil increased public demands is limited.

[11]The hospital is still using a very old form that is not recommended for use by the SSU guidelines.

Annex2: Participants of SSU Roadmap Workshop, August 2015

	Name	Designation	Organisation
1	Dr Padam Bahadur Chand		MoHP
2	Dr Gunaraj Lohani		MoHP
3	Dr Ramesh Kumar Kharel	Division Chief	PHCRD, DoHS
4	Mr Parba Prasad Sapkota	Under Secretary	MoHP,Population Division
5	Mr Mukund Sharma	Section Officer	MoHP,Population Division
6	Mr Sagar Dahal	Sr PHA	MoHP
7	Mr Prakash Ghimire	SAHW	DoHS
8	Mr Ramesh Prasad Adhikary	Sr PHA	Management Division, DoHS
9	Mr Ram Krishna Adhikari	Under Secretary	MoHP
10	Mr GS Pokharel	Sr PHA	DoHS
11	Mr Hem Raj Pandey	Public health officer	DoHS
12	Mr Sitaram Prasai	GESI Adviser	NHSSP
13	Ms Rekha Rana	GESI Coordinator	NHSSP
14	Mr Devi Prasai	Consultant	
15	Mr Kumar Upadhyaya	Consultant	

Annex 3: Proposed Standard Benefit Packages for Target Groups

Currently, the hospital's benefit packages largely depend on the availability of the services, client load, and size of funding. As discussed above, each hospital has its own separate benefit package developed to offer care to the target groups. Many hospitals previously had a longer list of essential drugs, tests and procedures, but have been forced to reduce the number due to budgetary constraints. Some hospitals (Koshi and Bheri) are surviving with difficulty (nearly bankrupt) and have therefore cut down the size of the benefit packages.

Developing a standard benefit package for all hospitals is difficult due to the varied availability of services in hospitals. Some have specialised care while others do not, some are about to go bankrupt because of payment dues. At present, some have bigger benefit packages and other have smaller ones. Thus, a single standard will probably not fit all referral hospitals.

The following two steps are proposed for working out the benefit packages:

- *Step 1: Develop specific benefit package for each hospital:* The existing benefit package is currently hardly affordable by many hospitals because of many clients and limited funds. But referral hospitals have to offer more drugs than district hospitals. Referral hospitals should offer a minimum of 80 drugs to targeted patients free of charge (district hospitals now provide 72 free essential drugs free of charge). The list of free essential drugs should be developed by each respective hospital based on the range of services provided, cost effectiveness, value for money, choice of drugs, patient load, and availability of funds. The listed drugs should be made available to targeted groups 24/7, year round and lists should be reviewed annually.

- *Step 2, Develop minimum common benefit package:* Once all referral hospitals have developed their lists of free essential drugs, the SSUs should review the common listed free drugs for referral hospitals and make a standard list of essential drugs and an additional list of free drugs for referral hospitals.

The generic package is given in Table A3. It should be adapted in the local context and services should be provided to targeted patients registered in inpatient, outpatient and Emergency Departments free of charge or at partial charge as mentioned in the guidelines.

Table A3: Proposed generic benefit package for targeted free care at referral hospitals

Benefits	Descriptions
Consultations:	• Consultations by generalist and specialist doctors
Essential drugs:	• At least 60 essential drugs and medical/surgical goods as defined by hospital development committee
Investigations: • Pathological tests: • Radiological tests:	 • Routine and special lab tests available in hospitals • Ultrasound, general and special X rays, CT Scan wherever available
Procedures:	• Minor, intermediate and major surgical procedures • Medical supplies as demanded by procedures • Blood and blood transfusion services • Follow up including dressings and medication.
Special care:	• NICU and ICU care (as approved by medical superintendents)

Benefits	Descriptions
Bed care:	• Inpatient care up to 10 days in general beds • Nursing care and support
Food and logistics:	• Food, care and support as per hospital regulations
Referral:	• Referral care including ambulance service up to NPR 5,000
Others:	• Physiotherapeutic services
Total amountof benefit per episode (maximum) as per guidelines	Inpatient= NPR 10,000 Emergency/outpatient = NPR 2,500

Annex 4: Potential Formula for Improved Budgeting of Free and Partially Free Services

Developing formulae for resource allocation is a challenge for the health system particularly in Nepal where hospitals tend to inflate the number of outpatient, inpatient and emergency visits to leverage more funds. Aper capita-based funding formula was adopted in 2008 for the replenishment of revenue under the free care programme at district hospitals and below level facilities, but it has not worked well due to inflated claims. Secondly there is a risk associated with quality of care: In the absence of effective oversight, a hospital may compromise quality to serve more patients in order to get more funding. Therefore, monitoring and oversight should be strengthened to ensure that quality is not compromised and numbers of patients are not inflated. These are prerequisites in adapting formulas for allocating resources.

There is a common principle that a formula for allocating resources should be simple in the beginning and gradually become complex to adjust to upcoming issues. Several factors have been taken into account in developing a draft formula for SSUs:

- The size of conditional grants is determined by the average unit cost of OP, IP and emergency visits (obtained from the Excel based programme), and the number of clients of respective departments.
- Demands for free care are growing fast, and client flow is likely to increase in the future.
- A hospital may save funds by increasing efficiency (by reducing wastage and correcting the under utilization of human and physical resources and by applying economies of scale).
- It is assumed that the growth rate of exempted patients will be higher where the incidence of poverty is higher.

The following formula has been developed for the initial years for the three types of care taking into account the above variables. It is suggested that they are revised gradually according to need.

- *Formula A1:* Size of earmarked grant for targeted free OP care = {(average unit cost of OP in the last year)x (1+inflation rate)} x{(number of targeted free patients in OP in the last year)x (1+ expected growth rate)} x efficiency factor
- *Formula A2:* Size of earmarked grant for targeted free IP care = {(average unit cost of IP in the last year)x (1+inflation rate)} x{(number of targeted free patients in OP in the last year)x(1+ expected growth rate)} x efficiency factor
- *Formula A3:* Size of earmarked grant for targeted free emergency care = {(average unit cost of emergency in the last year)x (1+inflation rate)} x{(number of targeted free patients in emergency in the last year)x(1+ expected growth rate)} x efficiency factor

The total size of earmarked grant to hospital ‘A’ for targeted care= A1+ A2+A3

The applied formulas in A1, A2 and A3 are given below in Tables A4a, b, c and d:

Table A4a: Applied formula for inpatient costs (NPR)

Average unit cost of IP discharges in last year	expected inflation rate 12% (1+0.12)	Inflation adjusted unit cost	Number of targeted free IP discharges in last year	Expected growth rate 15% (1+0.15)	Growth adjusted patients	Efficiency factor (5% saved due to economies of scale) (1-05)	Size of earmarked grant for IP
1200	1.12	1344	2000	1.15	2300	0.95	2,936,640

Table A4b: Applied formula for outpatient costs (NPR)

Average unit cost of OP in last year	Expected inflation rate 12% (1+0.12%	Inflation adjusted unit cost	Number of targeted free OP patients in last year	Expected growth rate 15% (1+0.15)	Growth adjusted patients	Efficiency factor (5% saved due to economics of scale) (1-05)	Size of earmarked grant for OP
250	1.12	280	5000	1.2	6000	0.95	1,596,000

Table A4c: Applied formula for emergency costs (NPR)

Average unit cost of emergency in last year	Expected inflation rate 12% (1+0.12%)	Inflation adjusted unit cost	Number of targeted emergency patients in last year	Expected growth rate 15% (1+0.15)	Growth adjusted patients	Efficiency factor (5% saved due to economics of scale) (1-05)	Size of earmarked grant for emergency
200	1.12	224	1000	1.15	1150	0.95	244,720

Using the above calculations the total earmarked grant for targeted free care at "Hospital A" would be NPR 4,777,360.

Annex 5: Rules Defining Use of Conditional and Medicines Grants

1. Conditional grants or earmarked funds should be used for the treatment of the defined targeted groups only. It should not be used for other purposes.
2. Hospitals should charge the services under the earmarked grant or conditional grant at the user fee rate fixed by the hospital development committee. The hospital can charge user fees for offered essential drugs, pathological, radiological/imaging, medical and surgical procedures, ICU, NICU services; hospital beds and other available allied services.
3. The charged amount for the offered care to targeted groups should be treated as an income of the hospital and be deposited in the bank account of the hospital development committee.
4. Conditional grants or earmarked funds can be used for purchasing listed essential drugs, medical supplies, and other goods demanded by medical and surgical interventions only.
5. The hospital should spend its conditional grants or earmarked funds by obtaining the recommendation of its SSU's chiefand procurement committee.
6. Quantification and specification of listed essential drugs and medical supplies should be done in consultation with the SSU chief and respective heads of department.
7. The fragmented procurement of drugs and medical supplies should be discouraged.
8. Hospitals should establish a pharmacy as per MoHP instructions and all essential drugs and medical supplies should only be dispensed through this pharmacy.
9. Procurement of drugs and medical supplies should be done in accordance with the existing procurement acts and regulation of the Government of Nepal.
10. The drug dispensing records of pharmacies and drug dispensing expenditure of SSUs should be cross-checked every month and any errors corrected.
11. Hospitals should not raise the user fees to charge under the conditional grant or earmarked grant.
12. Hospitals should allocate the fund for three trimesters once expenditure that is more likely to exceed the allocation and cost containment measures are taken into account. This helps make services available to targeted groups round the year.
13. Existing over prescribing patterns at the beginning of the year and low prescribing patterns at the end of the fiscal year should be discouraged.
14. Hospitals will use rational prescribing pattern recommended by the Department of Drug Administration/MoHP and avoid prescribing high cost and less effective drugs.
15. Hospitals will avoid unnecessary tests and procedures so as to contain costs.
16. Hospitals will report to MoHPon a trimesterly basis on the allocation and expenditure of the conditional grant or earmarked fund including funds allocated for the medicines.

Annex 6: Recommended New Poor Identification Form

(Proposed changes are in *italics*.)

Government of Nepal, Ministry of Health and Population
.....Hospital

1. Patient's personal details

a. Full name: b. Age: c. Sex: d. Parent's name (if under 18):

e. Patient's address (i)District: ..... (ii) VDC/municipality.....(iii) Ward no.:

f. Contact phone, if available: g. HMIS ethnic group:…….

2. Other details about the patient

a. Referred from other health facilities? .....Yes/No b. Has used free service this fiscal year?...Yes/No

c. Under which category does the patient want free service? (i) Ultra-poor/poor, (ii) helpless, (iii) person with disability, (iv) senior citizen, (v) victim of gender-based violence, (vi) FCHV, (vii) other state-defined group.

Has a valid ID or letter to justify his/her belonging to above category? .....Yes/No

3. Patient's economic condition

If the patient wants free service for being poor or helpless, then complete the following assessment:

- ***a) Patient and/or her/his family members*** *(i) work as unskilled labour, (ii) work as skilled labour (iii) are employed by public or private agency (iv), work in Gulf countries or Malaysia or other countries outside the region, (v) have own agriculture, (vi) have own trade or business (Note: circle all applicable categories. Most families in Nepal have more than one source of income).*
- ***b) Patient's family (i) do not send children to school, (ii) send children to government school, (iii) send children to private school***
- ***c)*** *The patient came to hospital (i) barefoot, (ii) wearing slippers, (iii) on cotton shoes, (iv) wearing leather shoes*

Note: Ticking a(i), b(i) and c(i) means 'ultra poor;' a(ii), b(ii) and c (ii) means 'poor' and others are 'non-poor'). Apply your judgments in contradictory or doubtful cases. Consult with SSU Chief or even the MeSu in doubtful cases. After checking appropriate options under a-c above, state the overall poverty status of the patient by checking appropriate option below.

c. The patient is: ultra-poor ☐ poor ☐ non-poor ☐

I am unable to afford my treatment from my/my family's income I request free/partially free health services from the hospital. The above detail is true and if proved otherwise I agree to face the court as per the law.

Patient's or his/her caretaker's signature

Date:

Prepared by:	Approved by:
Name	Name
Position	Position
Signature	Signature

Annex 7: Client Survey Questionnaire

Consent of the clients Yes/No

Exit interview tool (put circle in the appropriate number)

Name of the clients..... IP/OP/EM card no.....

1. Client Profile

1.1 Age ☐ 1.2 Sex ☐ 1.3. Ethnicity..... ☐ (use HMIS code)

2. Assess status: 2.1 Poor ☐ 2.2 Destitute ☐ 2.3 Disabled ☐ 2.4 Senior citizen ☐ 2.5 Victim of GBV ☐ 2.6 FCHV ☐

Par 1: Proxy for economic status

3. What means of transport did you use while coming to this hospital?

3.1. Own Car ☐ 3. 2, Taxi ☐ 3.3 Motorcycle ☐ 3.4 Ambulance ☐

3.5 Public Bus ☐ 3. 6. Bicycle ☐ 3.7 On foot ☐ 3.8 Other..... ☐

4. Where do your children or children of your family study?

4.1 Private school ☐ 4.2 Public school ☐ 4.3 other ..... ☐

5. Do you have any family member who is service-holder or who is in gulf-country for earning?

5.1 Yes ☐ 5.2 No ☐

6. Observe the shoes of the clients.

6.1 Used leather shoes ☐ **6.2 Cotton shoes** ☐ **6.3 Slipper** ☐ **6.4 Bare foots** ☐

Par 2: Questions

7. How is the cleanliness of the hospital? "

7.1 Good ☐ 7.2 Fair ☐ 7.3 Bad ☐

8. Were there unnecessary delays and hassles by the hospital units/departments in providing you the free services/medicines?

8.1 Yes ☐ 8.2 No ☐

9. Do you know about free care serviceoffered in the hospital before coming to hospital?

9.1 Yes ☐ 9.2 No ☐

10. If yes, how did you know first?

10.1 Family Member ☐ 10.2 FCHVs ☐ 10.3 Health workers ☐ 10.4 Radio ☐ 10.5 TV ☐

10.6 Newspaper ☐ 10.7 others.... ☐

11 Do you think the quality of medicines and services provided by the hospital are substandard for the poor

and disadvantaged and superior to the rich and people with connections?

11.1 Yes ☐ 11.2 No ☐

12. How is the behaviour of the care provider?

12.1 Good ☐ 12.2 Fair ☐ 12.3 Bad ☐

13. Are you satisfied withthe free service provided by the SSU at the hospital?

13.1 Fully satisfied ☐ 13.2 Partially satisfied ☐ 13.3 Not satisfied ☐

14. What suggestions do you have for improvement of service in the hospital?

1.

2.

3.

Thank you for paying attention!

Annex 8: Terms of Reference for the Evaluation

EVALUATION OF THE PERFORMANCE OF PILOT SOCIAL SERVICE UNITS IN SELECTED HOSPITALS MARCH-JUNE 2015

BACKGROUND

The Government of Nepal is committed to improving the health status of its citizens and has made impressive gains despite conflict and other difficulties. The Nepal Health Sector Programme-1 (NHSP-1), the first health sector-wide approach (SWAp) in Nepal, ran from July 2004 to mid-July 2010. It was very successful and brought about many health improvements. Building on these successes, the Ministry of Health and Population (MoHP) and its external development partners designed a second phase of the programme (NHSP-2, 2010-2015), which began in mid-July 2010. NHSP-2's goal is to improve the health status of the people of Nepal. Its purpose is to improve the use of essential health care and other health services, especially by women and poor and excluded people.

Technical assistance to NHSP-2 is being provided from pooled external development partner support (DFID, World Bank, Australian Aid, KfW and GAVI) through the Nepal Health Sector Support Programme (NHSSP). NHSSP is a five-year programme (2010–2015) funded by the Department for International Development (DFID) and managed and implemented by Options Consultancy Services Ltd and partners Oxford Policy Management and Crown Agents. NHSSP is providing technical assistance and capacity building support to help MoHP deliver against the NHSP-2 Results Framework. The following are the key areas of NHSSP support:

- health policy and planning;
- health financing;
- public financial management;
- monitoring and evaluation;
- procurement and infrastructure;
- essential health care services;
- gender equality & social inclusion (GESI)
- the preparation of NHSP-3.

SOCIAL SERVICE UNITS

The Interim Constitution of Nepal 2063 (2007) says: "Every citizen shall have the right to basic health care services free of charge from the State as provided by law." Towards meeting this goal MoHP has, since 2009/10, provided grants to central, regional, sub-regional and zonal hospitals to provide fully or partially free of charge health care services to target group patients. The scheme targets poor patients, 'helpless patients', patients with disabilities, senior citizens, gender based violence survivors, and female community health volunteers.

Within the past years a framework has begun to be established for the systematic functioning of this scheme. Social service units (SSUs) are being established in eight referral and central hospitals as a pilot initiative to increase access to curative services to promoteprompt, efficient and smooth flow of the services to targeted clients. NGOs (facilitating NGOs) are being contracted to work with SSUs to promote awareness of SSUs, facilitate and support service delivery to targeted patients and support SSUs to carry out their recording and reporting responsibilities.

The SSU Management and Monitoring Committee of MoHP's Population Division is responsible for the overall operation of SSUs while individual SSUs function under hospital SSU management committees. The guidelines that specify how SSUs should run (the SSU guidelines) were revised in 2071 (2014).

MoHP conducted progress review of piloted hospital SSUs in August 2013. Based on the findings of the review and recommendations, MoHP revised the guidelines with provisions of monitoring indicators. Based on the performance of these pilot SSUs, MoHP plans to roll out this initiative to all secondary and tertiary level hospitalsfrom 2015/16 (BS 2072/73). NHSSP is supporting this pilot initiative.

RATIONALE FOR THE ASSIGNMENT

Following the establishment of eight pilot SSUs in 2013 and 2014, there is a need to conduct an evaluation to inform hospital management and MoHP about the achievements, lessons learned, challenges, modality and the constraints they face. The evaluation will provide inputs to NHSP-3, and the annual work plan and budget (AWPB) and business plan of forthcoming years. Furthermore, it will provide the direction to roll out of the initiative to all secondary and tertiary level hospitals.

This ToR is for a consultancy assignment to carry out these tasks.

PURPOSE AND OBJECTIVES OF THE ASSIGNMENT

The purpose of the assignment is to undertake an evaluation of the pilot SSUs and to support MoHP to develop a road map for SSUs, particularly in NHSP-3.

Specific objectives of the evaluation are to assess the following:

1. Performance of the SSUs at present against the agreed indicators related to SSU capacity, compliance, results and outcomes as set out in the revised SSU operational guidelines. The evaluation will assess SSU effectiveness in targeting free hospital services to defined target groups, and the appropriateness of SSUs for different types of hospitals. The team will interview hospital staff and observe working practices. SSU users and hospital patients will also be interviewed. Challenges and constraints to the functioning of the eight SSUs will be identified at each site, and recommendations will be made as to how these can be overcome.
2. Review the performance of the public private partnership arrangement (including the role of NGOs as an SSU partner) modality for operationalising SSUs and the factors that have enabled or undermined good performance, and identify the appropriate model of SSU. This will include a cost-benefit analysis,i.e. assessing additional cost and benefits of adding SSU within the existing hospitals.
3. Functionality of the newly installed Excel-based recording and reporting systems in four of the SSUs and identification of further inputs required to make this functional. Assessment of whether or not the MIS is linked up with existing hospital records and also that it should be scaled up to all SSUs and any adaptations required.
4. The level of coordination and collaboration between SSUs and other hospital-based social protection programmes, and identify any duplication of effort and systems that could be harmonised for greater efficiency and impact. Based on the situation, assess the feasibility and benefit of SSUs expanding their remit to coordinate and manage other social protection

programmes (including citizens 'relief, compensation and financial assistance, hospital based nutrition programme for children, GBV (including OCMC), geriatric wards, etc.)

5. The feasibility and challenges of integrating the above programmes and propose appropriate modality and suitable institutional arrangement to operationalize the targeted programmes.

TASKS

The assignment includes a set of related tasks:

Briefing and review of key documents

The consultants will be briefed by the Chief of the Population Division and NHSSP's GESI adviser on the scope of the work and expected deliverables.They will undertake a review of key documents including the SSU guidelines (2012); the free health care services study report (2012); the pilot SSU review report (2013); the annual review report (2014); the Excel based monitoring and reporting system; the GBV clinical protocol (draft); the citizens relief, compensation and financial assistance manual. These documents will be provided by NHSSP.

Design the methodology of the evaluation

Design the overarching framework, timeline and the methods to use for data collection. This will include consultations with national stakeholders and visits to all pilot SSUs. There is a greater variability of bed size, nature of the hospital services, performance, and management of SSU. Therefore, the evaluation will cover all eight pilot SSUs out of referral and central level hospitals. Key questions and lines of enquiry for each stakeholder at national level and in the focal hospitals and SSUs will be developed.

The methodology will include interviews with key hospital stakeholders including the medical superintendent, and chairperson of the hospital development committee, and a selection of hospital staff to assess how well the SSU is working with hospital departments and staff (including medical stores), the level of ownership of the SSU by the hospital and the perceptions of the functioning of the SSU from a wide range of stakeholders.

Interviews will also be taken with the central level key officials: Chief of Curative Division, Chief of PPICD, and Chief of HR&MFD, Director General of DoHS, and Director of Management Division, FHD, PHCRD and also four hospitals from adjoining locations of Koshi-zonal, Bharatpur, Bheri-zonal and Seti-zonal hospitals will be checked for whether they are informed about the SSU services.

The team will need to interview SSU staff and observe working practices, they will document the use of the MIS, analyse MIS data, and assess the extent to which the SSU guidelines are followed. Assessment will be made on the basis of the promotional activities, among others implemented by the SSU and the support provided by the SSU for referral (out of the hospital) will also be observed.

A selection of SSU users and hospital patients will also be interviewed to hear how users and patients perceive SSU and learn their experiences in using the service; this will be undertaken by a locally hired person who will be guided by the consultants.

Interaction with the facilitating NGO will be necessary to understand how the public-private partnership (PPP) modality is working from their perspective, challenges faced, and the sustainability and replicability of the modality. Costings data will also be collected.

Information collection on the implementation of other hospital based social protection programmes will also be required.

Quantitative Part

The evaluation will collect and analyse the limited quantitative data including inputs to the SSU, costs, exemptions, compliance, effects (results) and outcomes. They will document the use of the MIS and analyse MIS data as demanded by the objectives.

Chief of Population Division and NHSSP's GESI Advisor will review the methodology and tools, and their comments incorporated as appropriate.

Consult with national stakeholders

The consultants will consult with key national stakeholders including Population Division, Policy, Planning and International Cooperation Division (PPICD), Curative Division, Human Resources and Financial Management Division, Management Division, and Director General of Department of Health Services.

Field visits

The consultant team will visit all eight pilot SSUs. The first two SSUs will be visited by both the consultants to have shared understanding and to fine-tune the evaluation tools and procedures and thereafter they will divide the SSU visits between themselves.

At the end of the visit to each SSU the consultant team will debrief the Medical Superintendent, the Chair of the Hospital Development Board, the facilitating NGO and the SSU staff to validate the findings of the visit.

Analysis of data

The consultants will undertake data analysis. This will include comparison with baseline data collected on the functioning of SSUs at three hospitals in 2013.

Preparation of the evaluation report

Debriefing will be organised at the central level to stakeholders after field visits to share the major findings and summary of recommendations and get feedback for the road map of SSU.

The consultants will draft the evaluation report in English and share this with Population Division, Curative Division, PPICD andNHSSP team for their comments and inputs. A final draft will then be submitted to NHSSP for quality assurance and onward submission to the Population Division.

Dissemination of the evaluation report and preparation of a SSU roadmap

The consultants will facilitate a workshop with government stakeholders to disseminate the key findings of the evaluation and support the MoHP to develop a road map for SSUs. Participants will include all national stakeholders consulted by the consultant team and the medical superintendents from selected SSUs.

The road map will consider:

- Pace for scaling up
- Adaptation of SSU model to different types of hospitals

- Institutional arrangements and modalities for scaling up
- The remit of SSUs, if deemed appropriate, shall expand their role to incorporate other hospital social protection programs

DELIVERABLES

The consultants will produce three deliverables:

- Methodology, tools and workplan for the evaluation.
- An evaluation report that includes SSU performance, gaps and constraints, good practices, and recommendations for the future.
- A draft road map for SSUs based on discussion and agreements made at a consultative workshop with the government.

TIMEFRAMES

A team of two consultants will be contracted for 67 days in total. This includes 36 days for the lead consultant and 31 days for the next consultant. A local researcher will be hired at each SSU site to collect data from a sample of SSU users and hospital patients and a data entry person will be hired in Kathmandu. The assignment will be carried out between March and June 2015. The days to complete the various tasks plus travel time are detailed below:

Process	Number of days		
	Lead consultant: 36 days	Next consultant: 31 days	Local researcher & data entry person
Briefing, consultations & document review	3	3	
Development of tools	3	3	
Field visits and assessment of SSUs including interviews with hospital management and staff, SSU staff, and NGOs	12	10	
Interviews with SSU users and hospital patients			16
Data entry person			6
Data analysis and report writing	8	7	
Debriefing workshop and finalise the report	2	2	
Dissemination of evaluation and facilitation of a road map for SSUs	2	2	
Travel	6	4	
Total days	36	31	22

REPORTING

The lead consultant will report regularly to NHSSP's GESI advisor and from time to time to the chief of the Population Division on progress of the assignment and any problems encountered. The other consultant will work in close coordination with the lead consultant.

The terms of reference have been reviewed and approved by the Chief of the Population Division, who will be kept informed of progress during the assignment and will receive a copy of the draft and final reports.

QUALIFICATIONS, COMPETENCIES AND SKILLS REQUIRED

The consultants hired to carry-out this assignment will have the following qualifications, competencies and skills:

Lead consultant:	Consultant	Research assistant
• Good understanding of GESI issues in Nepal's health sector, hospital management and services provided by Nepal's hospitals. • Good understanding of SSUs. • Previous experience of undertaking assessments of health institutions and understanding of related political economy issues. • Excellent report writing skills in English. • A social sciences, public health or business administration master's degree. • At least 10 years' experience working on development projects including significant experience with government systems.	• Good understanding of GESI issues in Nepal's health sector, Nepal's public health system, hospital management and services provided by Nepal's hospitals. • Nepal's health financing system • Social protection programs related to health services • Excellent report writing skills in English. • Health economics • At least 10 years' working experience on development projects including significant experience with government systems.	• Extensive experience of undertaking qualitative research, specifically case studies. • Preference will be given to women who have done similar types of work in the past to ease interaction with female patients.