**Interview details**

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| Participant ID | PMKAT02 |
| Institution | Nepal Health Sector Support Programme III |
| Years of experience | 10 years in Nepal |
| Start time | 13:45 |
| End time | 14:45 |
| Name of interviewer | Bibhu Thapaliya |
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| Name of transcriber | Lucie Sabin |

# PARTICIPANT:

I worked for the NHSSP from 2010 to 2021. I had different roles but mainly in support of the government health system for improving access to service by the poor and marginalized, as well as improving the quality of care. The focus was mainly on reproductive health and a very small portion on child health and newborn health. And also focusing on basic health services development.

# INTERVIEWER:

In relation to reproductive health, what were your specific inputs?

# PARTICIPANT:

Yeah, I work together with a team of six people. We were altogether seven at one time, six at some time supporting the government. Reproductive health is more focused on the family welfare division. We would look for the identification of needs using evidence or maybe we did a study ourselves. Sometimes, we supported the government to do the study or assessment. Based on the recommendations, we help the government to introduce interventions or expand interventions to increase access as well as the quality of maternal and newborn health services and family planning. That was the focus.

So we would be involved in designing the pilot and implementing pilot test evaluation. If it is successful, scale up. And scale-up will include budgeting in the government system, capacity building of the government, organising various levels and continuing monitoring of the implementation.

And based on this experience, policy dialogue, and if necessary, policy introduction, more guidance of implementation in national programs.

# INTERVIEWER:

So let me divert the topic to the barriers and the gaps that were prominent in your opinion in the health system of Nepal that made access to ANC very difficult for pregnant women.

# PARTICIPANT:

I wouldn't say access to ANC is difficult for pregnant women. I don’t know about the new DHS data yet but if you look at the DHS data, the majority of women, I think almost 80% or even more have at least one antenatal care visit and antenatal care is available in almost all health facilities in Nepal. And Nepal has outreach clinics. Because of that, I don't see access per se as problematic from the perspective of service availability but from the perspective of the women. There may be an issue for some women to don't come to the system although service is available. I think there are still some women’s empowerment issues: what they want to do and whether they are able to do it. In some communities, women are not allowed to walk alone. They need a company person to go to a place that is maybe half an hour of walk. That still is a barrier for them. I think Nepal did so much improvement in antenatal care. So the barrier is quite less regarding just access.

# INTERVIEWER:

Does it mean the demand side problems are higher than the supply side issues?

# PARTICIPANT:

Supply, in terms of availability is quite good. Other factors can play into why women are not using or not.

They are very few studies on demand side of antenatal care utilisation in Nepal are very few because antenatal care utilization is quite good. We conducted a study in 2012 and the main reason why women don't come is that they are not allowed to come alone. I think that was the main reason. The majority of women know that they need to come to ANC check-ups. Awareness does not seem to be a problem. But regarding access, whether they can come by themselves or they are allowed to come by themselves seems to be a problem. Wherever communities have that culture, antenatal care access is poorer if you look at the DHS data.

# INTERVIEWER:

And what about antenatal screening for sexually transmitted diseases?

# PARTICIPANT:

As long as I know, Nepal doesn't have the guidance or practice of screening sexually transmitted diseases in women. It is in the antenatal care protocol that they need to be screened for STIs but the service is not available everywhere. We have antenatal care all over Nepal but screening for STIs is available only wherever there are laboratory facilities. That will be less than 200 government health facilities, hospitals and a few Primary Health Care centres. As I mentioned, the availability of antenatal care is very good but when you go deep into the service and look at the quality and the components. Then what we call availability becomes poor. So number one, the screening is not available everywhere. Number two, it is the capacity of the government to have these screening services. Do the government want to have these screening services available all over Nepal unless we have a very simple test cost-effective for the considered issue? For example, recently, we had COVID tests, very simple and cheap tests that we can do everywhere.

I think it is not about the women’s issue, it is more about the government's willingness and capacity issues. This is my impression.

# INTERVIEWER:

Why do you think the government does not prioritize STI screening for pregnant women?

# PARTICIPANT:

My understanding of the government has system is that resource is not available for everything we want to do. The government has to provide prioritised programs based on cost-effectiveness. For example, a lot of women are anaemic compared to STIs but the government is not able to introduce anaemia screening to all pregnant women. The policymaker or programmer has to choose which one is more important in terms of the prevalence of the problem and the feasibility of the introduction of a solution to solve the problem. For example, is a very simple test available? Do I need to establish a lab to do the screening or can I just use a rapid test such as for HIV? I don’t know if these tests are available for syphilis and hepatitis B and how much they cost. I don’t have any idea. The government, when they introduce something, really has to think about the costs. They have to prioritize various problems within the system.

# INTERVIEWER:

Given the literature review and a few interviews with workers and policymakers we conducted we found that it's made mandatory for every health institution to have screening for HIV, syphilis and hepatitis B. But practically, it is not implemented everywhere. When we talk to government officials, especially in the Department of Health, there is a certain degree of refusal to agree that it's not implemented. Why do you think it could be so?

# PARTICIPANT:

Protocol is a guideline that we need to give this test. For example, if I worked in a health facility and I want the woman to have this test but I don’t have it, I can refer this woman to a higher level facility. That would be a protocol. You know, the protocol doesn't mean that I have to do all the things that are in the protocol. Because of the hierarchy of the healthcare system in Nepal, you cannot implement all the protocols. That is my understanding of what a protocol is. The government mandate is what must be there. If you look at basic health services and free services, they need to be available everywhere and it is a constitutional mandate. And from my understanding, these tests are not included in the mandate. Protocol and mandate are a bit different. So if it is a mandate, the government has a mandate, they have to implement it. If it is a protocol, they train the health workers to do it but it doesn't have to be everywhere. It could be everywhere if they had the money but the money is scarce and they have to prioritize. They have to prioritize. For example, they might make the tests mandated at the primary healthcare level and they would tell the women to go to this place. So protocol and mandate are a bit different for me.

# INTERVIEWER:

Who decides what to prioritize?

# PARTICIPANT:

The government officials have to look at the evidence and then at the division level, they decide to prioritize. Normally all the division advocate for having particular things in the system. For example, a simple protein test of the urine for all pregnant women is really easy to implement. That was advocated to be part of the ANC package but it is still not yet there. The decision to do and prioritise by the program manager doesn't mean that it will be implemented because resources are scarce. The second example is we wanted to have a number of lab tests available for basic health services when we were developing basic service protocol. We had a lot of tests but there were deleted by higher-level. This basic service protocols and budgets and all these things go to the cabinet level. They see that the cost is too high, it is just not possible. The prioritization by the managers doesn't mean it will happen. But from my experience, in this level of advocacy, changes to introduce something take time as long as financial matters are involved. Unless one big organisation like the WHO says: “Okay, let’s put all these tests available in the whole country” and puts in money, then it will happen.

# INTERVIEWER:

What are your thoughts on the federal context of Nepal? Do you think it complicates the implementation of any policy?

# PARTICIPANT:

I think there is again the mandate and protocol issue. If an implementation is a mandate, then I think there is a kind of opportunity. When some mandates happened from a higher level, like a constitutional mandate, the government request the implementation. But in reality, whether it can happen or not, especially in remote areas or difficult areas is hard to ensure. But when it is a mandate and local governments are responsible and budgets are provided, then I see that they will be able to implement it and that it is their responsibility. So I see it as an opportunity. But if it is a protocol guideline which is not mandated, then it is the discretion of the local government or the health coordinator. First, they need to be convinced that it is important. Then, they need to convince their elected members to give them a budget to implement. So it is a little bit complicated. They can ignore it and not implement it because they can choose to do something much more appealing. Maybe building a facility might be much more appealing than just adding a small service which no one really knows.

The quality of care will be challenged when quality is a soft issue. You only see when the quality is poor. You don’t see it when the quality is good. I think opportunities and challenges exist.

# INTERVIEWER:

What is the role of the provincial level in this context?

# PARTICIPANT:

I guess this is the heart of the governance issue. I have not followed the details in 2022 so I don’t know if it changed but until 2021, as long as I know, clarity was not there about the roles of local and provincial governments. Until now, the role of an institution in Nepal is linked to its ability to provide a budget.

If I am a central level or a provincial level and I give a budget to the local level, my voice is heard. If I am not able to give, my voice is not heard. It was like this until 2021 but the legal provision may have changed. Once the legal provision is changed, it may be different. So far, Nepal has 753 small local governments and eight provincial and central governments. They are all government. When everyone is a government, none of the government can say to another something, unless you provide something.

# INTERVIEWER:

Do you think the health service providers’ level of knowledge, awareness or to a certain degree their attitude towards certain problems could be a problem to implement services efficiently?

# PARTICIPANT:

I think so. In any service, the important thing is health workers’ availability. As you look at the quality of care framework, providers have to be available, the tools and the technology that they need to implement need to be available, and health workers have to be trained but that doesn't mean that the quality will be there. What you mentioned about attitudes is so important. At the same time, motivation. These two are very much important for providing the quality of care of any particular service. I think that is a fundamental issue in the quality of care in Nepal.

# INTERVIEWER:

About the motivation, could the lack of incentive or the lack of periodic training to update them about certain policies and protocols be beneficial? Do you see any gap there?

# PARTICIPANT:

Incentive as such is yes and no. Nepalese health workers have very low salaries. A little bit of extra money does give incentive, but that doesn't really solve the problem.

A regular update and making a system where the health workers are provided updates would be, I think, important. But on the other hand, how can the government do this regular updating system for all issues? It is difficult to think about it. For motivation, I think an important thing is job satisfaction. If people are satisfied with their job and people are appreciated for what they are doing, that kind of motivation comes. Motivation is a complex matter, so just financial or training… Nepal has done so much for training actually.

Maybe positive supervision and support from higher-level that motivate them to do their job may be more important than just ad hoc training. We come for training and we go back. We don't even know if we implement the newly acquired or something we learned.

# INTERVIEWER:

For example, we interviewed some nurses in the antenatal services and they didn't receive training for eight years. So it may be a problem for motivation.

# PARTICIPANT:

If we say that training motivates people, yes, that would be. But I'm not sure training is motivation. Training is for me, capacity building. Training is for me to do the job I am supposed to do. Actually, I haven't got training in Nepal when I was working for 10 years, no training for me one time. But the work I did was appreciated. And there are so many ways of learning. We learn every day. If the government introduced something, I have to be trained. But if I am doing what I am doing every day, why do I need to be trained? But if my supervisor comes and tells me “Oh, you are doing a good job. This is very nice. Maybe you can improve this area.”, that was much more important for me. But I don’t think we can compare everybody. I don’t know but the motivation of health workers just by training, for me, is a problem.

# INTERVIEWER:

But for example, in the case of sexually transmitted diseases, we see some discriminatory behaviour and maybe training might be essential to avoid this.

# PARTICIPANT:

Yes, but that is not motivation. That is capacity. For me, if I do something I don't know and you think that will be solved by training, then that is capacity but it will not be solved by training. Maybe there is something else; motivation or attitude issues. I know these discriminatory behaviours are there. Whether it is capacity issues or attitude issues, I think somebody has to do in-depth studies or maybe some exist already. And how to improve that, is not my expertise area.

# INTERVIEWER:

You said earlier that the mandate has to come from the authoritative body for it to be implemented uniformly. You also said that there is no mandate for STI screening but only protocols. Did I get that right?

# PARTICIPANT:

I haven't seen any mandate with STIs like basic health services. Basic health services are a mandate of the constitution. In that regulation, these tests are not included. We tried to put it but it was not accepted. It was just not possible to implement it.

# INTERVIEWER:

Because of the budget?

# PARTICIPANT:

Yes, because of budget. The government has to look at, per capita, how much they can afford to provide basic health services. In the end, they reduce it down to what is feasible.

# INTERVIEWER:

Could you tell us more about the process when you tried to incorporate this agenda and you proposed to the government that there should be more STI screening? How long ago was it?

# PARTICIPANT:

Actually, I was never involved in STI screening advocacy. I was involved in the development of the basic health services protocol. During that time, we put a number of tests. For example, haemoglobin and protein tests. Syphilis tests were included but not the whole STI as such. In the end, these services were not included. Not one. So it's not only STI. It's not that the government thinks that STIs are not important or syphilis is not important. They just don't do everything.

# INTERVIEWER:

There's a lot of effort into preventive and curative aspects of HIV. It's free of cost.

# PARTICIPANT:

And HIV tests, information campaign and PMTCT comes from program budgets like Global Fund budget, UNICEF budget but it doesn't go into the basic services categories. In Nepal, until now, there is basic services that goes through the constitutional mandate and there are programs. For example, TB medication and tests go through the TB program. Some of the TB drugs are included in basic health services but not all of them. Unincluded ones go through the TB program. It is the same for HIV. So if we have very strong program in the country, such as TB, NTC, HIV ones, things go parallel.

# INTERVIEWER:

Government bodies work in close coordination with big funding organizations and non-governmental organisations. What are the challenges there, in terms of communication, teamwork and coordination?

# PARTICIPANT:

Actually, Nepal is a country where coordination and teamwork among the various stakeholders is so good. Most of the time an organization or a group of organization will lead the introduction, scale-up or advocacy of a certain area or issues and a number of organization is behind it. So I think coordination is very good in Nepal. I don't see problem in that.

# INTERVIEWER:

Could there be language barriers? When you were working for NHSSP, I'm just assuming you were speaking English or even if you learned Nepali, there could be other people working closely with the government whose native language would not be Nepali.

# PARTICIPANT:

I'm not sure. Yes, if I am a mission chief or a big shot like UN, such kind of people when they go to big government meetings like Ministry of Health higher-level meetings, every meeting is in Nepali. So they always have their workers, like assistants, who are translating for them. They have the earphone and simultaneous translation is done for them to be able to participate in such meeting. If you work with division-level people, all of them can speak English. Nepalese are so polite that if there is a meeting at the division level and if there is one non Nepalese speaker, they switched to English. I speak Nepali so I cannot speak for everybody but this is my observations. I don't see a meeting happening in Nepali and somebody who cannot speak or understand Nepali just sitting there. That would be very unusual. However, it could happen in the provincial level because the provincial level understanding of English may be a bit different. But at the central level, I have never. I would say language may not be a big barrier.

# INTERVIEWER:

Going back to the mandate, you said that WHO, as a powerful global organization, could tell the government to mandate certain kind of tests for pregnant women. What are the barriers for WHO, being a powerful organization, to get these things implemented through the local governments or the major government in any national context.

# PARTICIPANT:

Actually, I didn't say that the WHO is powerful and they can make the government to do whatever they want. The WHO was involved in the basic health service protocol development but none of the outside bilateral or multilateral organizations can make the government to do in Nepal what the government cannot do. And I don't believe that is right. The government has the authority or the capacity to decide what is good for Nepal.

These organizations are actually advisers to the government to say “this is something we need to look at, this is something we should implement” but the decision has to be taken by the government. On the other hand, what I see, is like if the Global Fund comes with money and introduce something, then the government is very happy to give a space for any organisations as long as it is good for Nepal. I think that the roles of the external development partners in Nepal is much more advisors unless they can give funding.

For related to your question, about WHO, the WHO never give funding. WHO is much more an advisor partner. Actually when I think about it, they gave money for non-communicable diseases (NCD). So for some area they do but not every area. I think if WHO has a will and they think this one is very important, they find money and they fund together with advice.

For example, for NCD, they give quite a good amount of money and after five or some years the government implement it themselves. So I guess WHO, in regards to STI will be “do we think this is most important for Nepal to introduce?” if they think so, they will bring the money.

# INTERVIEWER:

And what about the monitoring of the diseases? For example, we can have the prevalence of HIV and HIV testing is really well reported by health facilities but is is not the case for syphilis and hepatitis B. How is it implemented at the national level?

# PARTICIPANT:

I think I have mentioned already but HIV testing comes from the Global Fund program so the test is available in a lot of places. Regarding syphilis and hepatitis B, if the test is not available how can we know that the situation is there or not. There is nothing to be monitored.

# INTERVIEWER:

We conduct interviews in Kapilvastu in health posts. They test for syphilis and hepatitis B but when we have a look at the data, they don't report any testing.

# PARTICIPANT:

I think you have to look at the IHMIS form. If it is included or not. I don’t remember. There are things that are included but not reported because things are not perfect in Nepal. There are things not included so it's also not reported because it is parallelly monitored by the organization who are supporting that program. So that reporting may goes to that organization that supporting that program and may not be integrated into the system. I have no idea about the details of that level.

# INTERVIEWER:

Let's talk a bit about the ANC process and gaps there. We all know that STI is a taboo subject in Nepal. And since it's related to a very private sphere of any human being, and since it's sexually transmitted, people are not really willing to talk about it. They have every right to do so but even in hospitals, the counselling procedures are found to be very weak; no separate room for counselling in many places and counsellors are also not updated and trained adequately. So what are your thoughts on that? Do you see it as a big gap and what could be the reasons?

# PARTICIPANT:

I agree with you, it's a big gap. If you go and observe antenatal care, most of the antenatal care rooms are really busy places. There will be women inside the room and the process of antenatal care is less than 5 minutes. In non-busy sites, I think they could have spent more time but in busy sites, they don't have time. The availability of health workers to do ANC may be an issue if you go to hospitals where they have a number of women lining and waiting for antenatal care.

Then, privacy and confidentiality is not yet an issue in Nepal. I think it's a cultural issue. In Nepal, we are involved in the issues of everybody's. My issue being known by everybody seems to be quite normal. So the woman even themselves do not think that five people lining up inside the room is a problem. But as we talk about STI, my understanding is that if they have such issue, the counselling will happen in a separate room. Then the problem comes “why I am taken to a separate room?” and everybody thinks “what's wrong with me?” For me, having the space to allow the privacy to be maintained when staff counsel is not possible in majority of places, not done or not given priority. So yes, there is a big issue of the counselling regarding availability of health workers and rooms to do all such things and then the attitude of the health workers as well as the program about how important this is for counselling. I guess if this program become a national screening and that every woman has to have it, then it would not be an issue. But if the screening has to happen to particular groups and the process of ANC has to change, it might be an issue. If I see a woman that is at high-risk, I need to start screening then the privacy process has to change. I see that it doesn't happen in many places.

# INTERVIEWER:

Before finishing this interview, if you think we've missed anything to ask or you want to say something, that is very important, but we didn't cover during our conversation, please feel free to share.

# PARTICIPANT:

I just think maybe this study may advocate on necessary services for pregnant women. Maybe you can go in depth with people who are expert in motivation issues. For example, why I don’t do a number of things when I provide ANC even if it is in the protocol.