



The
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**Health System Actors' Participation
in
Primary Health Care in Nepal**

Jiban Kumar Karki

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requirements for the degree of
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Dedication

To my father Jnan Bahadur Karki and my mother Ram Kumari Karki who sacrificed their dreams to fulfil mine.

Declaration

I declare that this thesis submitted for the degree of Doctor of Philosophy is the result of my own research, except where otherwise acknowledged. I confirm that no portion of this thesis has been submitted for another degree or qualification to this, or any other university or institution.

Jiban Kumar Karki

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List of Abbreviations and Acronyms

AHW	Auxiliary Health Worker
ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
BPHC	Basic Primary Health Care
CBHI	Community Based Health Insurance
CBO	Community Based Organization
CBS	Central Bureau of Statistics
CDO	Chief District Officer
CHL	Community Health Leader
CHW	Community Health Worker
CLAS	Local Committees for Health Administration (Spanish - Comunidades Locales de Administración en Salud)
CMA	Community Medical Assistant
CP	Community Participation
CPHC	Comprehensive Primary Health Care
CPN- UML	Community Party of Nepal - United Marxist Leninist
CSDH	Commission on Social Determinants of Health
DAO	District Administration Office
DDC	District Development Committee
DHO	District Health Office
DHS	Department of Health Services
DoHS	Depart of Health Service
EPI	Expanded Programme on Immunization Clinic
FCHV	Female Community Health Volunteers
FGD	Focus Group Discussion
FP	Family Planning
GDP	Gross Domestic Product
GOBI	Growth monitoring, Oral rehydration for diarrhoea, Breast feeding and Immunization
GoN	Government of Nepal
HA	Health Assistant
HFMC	Health Facility Management Committee
HFOMC	Health Facility Operation and Management Committee
HIV/AIDS	Human Immunodeficiency Virus / Acquired Immune Deficiency Syndrome
HMIS	Health Management System Information
IMF	International Monetary Fund
INGO	International Non-Governmental Organization
Lao PDR	Lao People's Democratic Republic
LDO	Local Development Officer
MBBS	Bachelor of Medicine, Bachelor of Surgery (in Latin: Medicinae Baccalaureus, Baccalaureus Chirurgiae)

MCH	Maternal and Child Health
MCHW	Maternal and Child Health Worker
MDG	Millennium Development Goals
MDM	Medecins du Monde - France
MOHP	Ministry of Health and Population
MUAC	Mid Upper Arm Circumference
NC	Nepali Congress
NGO	Non-Governmental Organization
NHRC	Nepal Health Research Council
NR	Nepalese Rupee (Nepali currency)
ORC	Out Reach Clinics
ORS	Oral Rehydration Solution
PHASE	Practical Help Achieving Self Empowerment
PHC	Primary Health Care
PhD	Doctor of Philosophy
PNC	Post Natal Care
PRA	Participatory Rural Appraisal
RPP	Rastriya Prajatantra Party (National Democracy Party)
SBA	Skilled Birth Attendants
SDG	Sustainable Development Goal
SPHC	Selective Primary Health Care
SSI	Semi Structured Interview
TA	Technical Assistant
TB	Tuberculosis
TBA	Traditional Birth Attendant
TH	Traditional healers
UHC	Universal Health Coverage
UK	United Kingdom
UML-P	United Marxist and Leninist Party
UN	United Nations
UNICEF	United Nations Children's Fund
US	United States
VDC	Village Development Committee
VDCTA	Village Development Committee Technical Assitant
VHW	Village Health Worker
WB	World Bank
WHO	World Health Organization
WTO	World Trade Organization

Abstracts accepted for conference presentation based on this PhD work

- 1 Ninth European Congress on Tropical Medicine and International Health (ECTMIH), Basel, Switzerland, September 2015, (Abstracts accepted) for Poster Presentation, Title: Health System Actors' Participation in Primary Health Care in Nepal. (<http://onlinelibrary.wiley.com/doi/10.1111/tmi.12574/epdf>) Page 373-374) (could not attend)
- 2 Fourteenth Britain Nepal Academic Council (BNAC), Study Day Liverpool John Moores University, Liverpool, UK, 4-15th April 2016, Health System Actors' Participation in Primary Health Care in Nepal (abstract) – Oral presentation, (<http://bnac.ac.uk/wp-content/uploads/2016/03/2016-NSD-Abstracts.pdf> page 11) (attended)
- 3 Fourth Global Symposium on Health Systems Research November 14-18, 2016, Vancouver, Canada, (Abstracts accepted) for Poster Presentation, Title: Health System Actors' Participation in Primary Health Care in Nepal (could not attend)

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Abstract

Background:

Nepal was an early adopter of World Health Organization's (WHO) Primary Health Care (PHC) approach with Community Participation (CP) for delivery of basic health care service. These approaches have formed the mainstay of efforts related to provision of health care services in Nepal. However, it has struggled with its implementation because of developmental challenges, poverty, civil war and geography. Hence, it becomes important to seek to understand the dynamics around CP and PHC and how these relate to broader development challenges in the country. The main aim of this research is to understand how various Health System Actors participate in PHC in Nepal and what its implications are in PHC

Methods:

In order to understand CP in PHC a qualitative case study method was undertaken. Forty-one semi-structured interviews, four focus group discussions (FGD) and observation were conducted with 26 groups of grass root level and district level health systems actors in two Village Development Committees (VDC) of Sindhupalchok district of Nepal in 2014. This study examined how these actors understand PHC and CP, how they participate in it and what motivates or hinders them to participate in PHC. The results are based on data collected from interviews, FGDs, observation and the field notes.

Results:

There was very low understanding about PHC and CP among actors in these VDCs. Often, CP for these actors was a 'tokenistic participation' which was limited to material contribution, voluntary labour and financial donation in PHC infrastructure development and maintenance. Participation in Health Facility Management Committees and Female Community Health Volunteer were the only mechanisms of CP in PHC, which rarely represented community views. Existing traditional health system was not taken into account. Decisions were imposed top down without considering local context, practices and without involvement of local actors. The main motivations for CP amongst participants were material benefit, social recognition and religious merits whereas geography, opportunity cost, lack of awareness and socio-cultural discrimination, were barriers to participation.

Discussions / Conclusions:

PHC with CP needs to be contextualized to accommodate, learn and benefit from the existing traditional health system. Similarly, a stronger policy measure is needed to minimize if not to eradicate the discrimination against gender, caste, ethnicity and poverty to increase CP in PHC. In the current socio political situation, geography and current status of infrastructural development in Nepal, neither the government nor the nongovernmental / private sector alone are able to address the increased health care need. Therefore, a wider broad partnership based PHC with CP is recommended as a way forward to ensure basic health care service in Nepal. This has been even more important where reconstruction of the health system is underway after the devastating 2015 earthquake, for the community to feel ownership of local health system.

CHAPTER ONE

Introduction

1.1 What is this research about?

Nepal follows the Primary Health Care (PHC) with Community Participation (CP) approach to deliver basic health care service to its population. It is one of the early adopters of this approach promoted by World Health Organization (WHO (1978)) that emphasizes participation of all the relevant actors in all aspects of PHC. It still strongly follows the PHC approach of delivering health care with community participation, that is even more important in the current changed social and political context of Nepal which demands people's participation at all levels. However, there are huge disparities in access to health care, people's participation and success of PHC especially in the rural parts of Nepal. To enable us to plan the health system better there is a need to understand more on PHC, CP, Health System Actors and what motivates or hinders people to participate. The main aim of this research is to understand how various Health System Actors participate in PHC in Nepal and what its implications are in PHC.

This research is a systematic investigation of participation of Health System Actors in PHC at the community level in Nepal. It is done by analysing these actors' perspectives on PHC, CP and their participation in the process. Furthermore, their relationship with each other is investigated and analysed to identify factors motivating and hindering their participation in PHC.

Recently, health systems have generated a significant global and national interest. Health systems are recognized as an important component of society as a platform to address health problems of low-income populations (Gilson, 2012). In this regard, there has been increased interest in health systems and policy research in low and middle-income countries (Adam et al., 2012). This renewed interest in health systems along with PHC and calls for universal health coverage (UHC) has resulted in health policy and systems research recently becoming an important global priority (Ghaffar et al., 2013). Recently UN has put UHC as one of the Sustainable Development Goals (Jha et al., 2016). Since PHC is an important part of health systems, the ways of thinking about health systems affect the space for PHC and vice versa. Therefore, it is important to understand PHC to understand the health systems.

WHO (1978) defined Primary Health Care as:

"...an essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination".

Furthermore, PHC is an integral part of the country's health system and works as the first point of contact of the people to the health system and represents as the first element of continuing health care process (WHO, 1978, Dookie and Singh, 2012). The basic pillars of PHC are social equity, multi sectoral approach, appropriate technology, promotive and preventive health care approach and community (De Maeseneer et al., 2007). Here, CP is people's participation in the planning, organization, operation, and control of PHC where community determines their collective needs and priorities and assumes responsibilities for such decisions (WHO, 1978). Furthermore, CP is treated as a vehicle influencing decisions that affect people's lives and acts as an avenue of distribution of power more evenly between and within communities, health workers, decision makers, state and international stakeholders (Marston et al., 2013).

Health System Actors are the people and organizations working at local, national, regional and global level to ensure the availability and delivery of health service for the common people including themselves (WHO, 2007a). There are many words to describe different people and organization who are active in health care in Nepal, details of these actors are presented in chapter four. I am going to use the word 'actor' to describe these. Other words used are users, partners, collaborators, participants, stakeholders or beneficiaries but 'actor' is preferable because it is more neutral since it comes with fewer connotations. Similarly, participation has been explored in many different ways in many different contexts which are reviewed in detail in chapter three. My starting point is to understand how these actors participate in PHC and interact with each other. I am considering PHC with a holistic approach which includes all aspects of health systems in the community i.e. both modern as well as traditional aspects of health systems at the community level. A detailed review of the literature related to health systems, Health System Actors, PHC and community participation is presented in chapter three.

The Alma Ata Declaration envisioned it as a health system itself, not just a health service at a primary level (CSDH, 2008, Bhatia and Rifkin, 2010). Therefore, we need to understand what is

going on in PHC if we want to understand overall health systems challenges. Similarly, our health systems models need to be informed by the empirical understanding of the PHC. It has been argued that if this is not addressed carefully, an imperfect health system will display the effects of the 'inverse care law' (Tudor Hart, 1971). This theory suggests that it is the well-off who get the health benefits first and the poorer get it later (Jacobs et al., 2012) or might not get it at all. Irrespective of the level of its operation, whether it is at the international, national or local level, Health System Actors are the main components of the health system at all levels. Not only the Health System Actors in policy making positions but other actors, for example, frontline health workers at the bottom of the system, patients and citizens are equally important and their actions and interactions also represent health systems (Gilson, 2012). Even though this research does not consider people just accessing the health service as participation in PHC, it is still important to understand about these actors and how various Health System Actors participate in PHC. By knowing their participation or non-participation in PHC, it will be easier to organise PHC so that everyone in the community have equitable access to the health services.

Community participation was accepted as an important component of rural health care services even before it was formally described as part of PHC by the Alma Ata Declaration (Djukanovic et al., 1975). In respect of community participation, the Alma Ata declaration (WHO, 1978) suggested that PHC:

"...requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of PHC, making the fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate".

The suggestion that PHC with community participation is one of the means to achieve Health for All by the year 2000 was mainly influenced by the success of China's 'barefoot doctor approach' and other similar successful community-based health care approaches in India, Kenya, Cuba, Tanzania and Venezuela (Magnussen et al., 2004, Rohde et al., 2008, Bhatia and Rifkin, 2010). In such approaches local ordinary people were trained to provide basic health care services using local resources. Many countries around the world followed WHO's Alma Ata call for PHC as a means to achieve 'Health for All by 2000' and adopted community

participation as a tool for that (Zakus and Lysack, 1998). A detailed account of health systems, PHC and community participation is presented in chapter two.

Though it had been highlighted as an important aspect of health services in the World Health Organization's constitution (WHO, 1948) only after the Alma Ata declaration in 1978 did community participation become a major component of PHC. This has an understanding that people should be involved in identifying problems and developing cost effective solutions to their health problems themselves (De Kadt, 1982, Justice, 1987). Sometimes, the terms community and community participation are overused and over-exploited terms and especially community participation has been treated uncritically in the development sector, rarely questioning its necessity (Clever, 1999). Furthermore, there have been arguments that people's health has been taken away from the community and that the control still lies within the medical profession and that medical technology dominates. This has been suggested as a barrier to effective community participation (Brownlea, 1987). There are also those who argue that there is no such thing as a single community but different groups of actors who jostle with each other to have their say or to benefit (Clever, 2001). However, it has been suggested that health care interventions with community participation have produced better health outcomes than those without such participation (Preston et al., 2010). Therefore, if community participation is regarded as an essential component of health care intervention it is important to fully understand it.

This research explores health systems actors' perspective on PHC, their participation in it, their relationship with other actors in this process and the reasons why they participate in it or not. This research is conducted in two Village Development Committees (VDC) of Sindhupalchok district in Nepal. These communities are chosen as research setting because they appear to be representative of many other VDC in Nepal. Furthermore, these VDCs were relatively easy to access for data collection and better suited from a logistical point of view for me. I have further explained how these VDCs were selected in section 3.4.

1.2 Why is this research important?

Immediately after the Alma Ata Declaration in 1978, it was criticized as being unfeasible, over ambitious, costly, human resource intensive and as a cheap version of health care by some of the promoters of the Selective PHC (Walsh and Warren, 1980, Unger and Killingsworth, 1986). A considerable resistance from politicians and experts was put up against communities

planning and running their own health systems (Werner, 2002). Despite such resistances, PHC and community participation has been central to major health policies whether it is Selective PHC approach, WHO's PHC revitalization, achieving Millennium Development Goals (MDGs) by 2015, or universal health coverage (WHO, 2008b, Jacobs et al., 2012) especially when it is about providing health care service. The new global health priorities, the Sustainable Development Goals (SDGs) have also proposed participation of wider stakeholder groups for improved governance of health systems (WHO, 2015a). Therefore, the PHC approach has still been promoted as one of the key approaches of providing health care services especially for people living in developing countries (WHO, 2008b, Bhatia and Rifkin, 2010, Marahatta, 2012, Jacobs et al., 2012, Rijal, 2013). It is believed that the PHC approach managed to bring people to the centre of health care and establish community participation as one of the key elements of health care systems in almost all of the major health policies and programmes. Therefore, it is important to know more about community participation in PHC.

Since it has been argued that PHC is wider than even the health system because it includes other sectors as social determinants of health and needs greater action, this makes community participation, even more relevant (Walley et al., 2008). Furthermore, since community participation is taken as a key component of PHC (Bender and Pitkin, 1987) it is important to understand how this works at the community level. For this, it is necessary to explore the reality of community participation and look at the relationship of the actors involved in this process at the community level by studying how various Health System Actors view PHC, their participation in it, how different Health System Actors interact with each other, and what determines such participation and interaction.

In addition to this, there are multiple realities and multiple truths (Given, 2008) perceived by different actors about their participation in PHC. For example, government health workers' perspective of PHC is different from that of shamans, traditional healers and other actors. The same applies regarding their perspective about various actors and their role in PHC. Therefore, multiple actors have their own perspectives about the realities of illness, treatment, their role, their motivation for participation as well as barriers to their participation in these processes and relationship with other actors. Multiple realities will affect the findings of this research. For example, the same health practitioner working as government health worker exercises more power over other actors than while practising privately. At the earlier case he draws power from the government system whereas working as the private health provider he does

not have such power. Similarly the cause of different illnesses perceived by the traditional healers and the modern health workers are different. For example, the modern health practitioners base their treatment on scientific facts whereas the traditional health practitioners often base their practices on assumption of presence of super natural beings and mostly knowledge transfer through learning from elderly on herbal medicines (Ongugo et al. 2012). Understanding these realities will help to address these issues by employing appropriate approaches, in various PHC interventions. This research aims to fill this gap.

1.3 What is known about participation in PHC?

At the community level, very little is known about what 'participation' really means. Key questions include; who participates, what are the determining factors, who determines who to participate, how do gender, caste, ethnicity and geographical factors (distance) affect such participation. It is important to understand the context in which participation is occurring, what are the inclusion and exclusion criteria and how people interact in this process but such questions have not been explored adequately. Most of the studies on community participation in PHC consider it as an output rather than as a process (Rifkin, 2014), for example, numbers of people participated in certain intervention but do not explore the underlying dynamics and contexts. Furthermore, most of the studies of community participation present an outsider' view, mostly of an evaluative nature rather than focussing upon what the actors' perspectives are about the programme, process, participation and interaction. Therefore, there is a need to explore these from the health systems actors' perspective, how they understand these things in their real life situation rather than just quantifying it (Oakley, 1989, Oakley, 1991). Even though some argue that people pay lip service to community participation and this covers hidden agenda and resource brokerage (Nichter, 1986, Green, 1991), there have not been enough studies to analyse these issues clearly which are separate points and deserve separate attention.

The WHO (WHO, 1948) defined health as *"a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity"* which the Alma Ata Declaration (WHO, 1978) adopted. The Alma Ata Declaration defined PHC as an evidence-based, socially acceptable, affordable, locally available essential health care service involving both modern and traditional health workers as appropriate as a first contact into the healthcare system for the people in the community with their full participation (WHO, 1978). It was also suggested that community participation is a critical component for the success of the PHC (Reynolds,

1987). Therefore, community participation has become one of the central ideas in almost all contemporary national and international health policies (WHO, 1986, Parry and Wright, 2003, WHO, 2008b). However, CP is still treated only as community mobilization rather than as community empowerment (Bhatia and Rifkin, 2010), where the former just means community having to accept professionals' assessment and activities. The latter means transforming attitudes and behaviours so that the community can make decisions about their lives themselves. Furthermore, 'community' has been interpreted as a site of intervention and as a place or as a belonging, however, it can still be marginalized through exclusion and inequality (Hughes and Mooney, 1998).

Even though community participation has been an important component of PHC, there has been a mixed response to its appropriateness especially because of its political nature which challenges established vested interests. Some of the Health System Actors, especially the Western modern medical professionals do not want to hand over the power of the community as advocated by the promoters of PHC with CP (Madan, 1987, Hall and Taylor, 2000). Therefore, sometimes even the countries where PHC is successful, for example, Costa Rica had to drop the community participation component after some time (Zaidi, 1994). The argument is that the concept of community participation is mostly externally sponsored and imposed by organizations, for example, WHO, UNICEF and World Bank as a condition for funding for health as well as other programmes rather than community initiated approach. It is argued that often such interventions are implemented without sufficient consideration of different social, cultural and local contexts (De Kadt, 1982). For example, community participation in the Bamako Initiative programme, an initiative to support local government and community to strengthen PHC in Nigeria was claimed to have been ineffective (Uzochukwu et al., 2004). Some of the reasons for this highlighted were local hierarchies, geographical constraints and male dominance.

Furthermore, even though community participation is supposed to reduce power gaps between the community and the health system (Jacobs et al., 2012), in areas where there was participation in the above programme it was not at the management and decision-making levels. There have been quite a few studies about community participation in PHC but most of them especially in Nepal are from around 1980s and 1990s (Stone, 1986; Bently, 1995; Bichmann and Chaulagai, 1999; Rifkin et al.1988) and are carried out from an outsider's perspective. Since major political changes, Maoist insurgency, end of monarchy and increase in

remittance has taken place in last few years, peoples understanding about health care has changed, therefore, there is a need to explore current situation of PHC and CP in Nepal.

1.4 Aim, Objectives and Research Questions of the study

The main purpose of this research is to understand how various Health System Actors participate in PHC in Nepal and what its implications are in PHC. This research aims to explore the differential perspectives and practices on the participation of the main actors in the PHC setting. For this purpose, I seek to explore and understand these actors' perspective about PHC, their participation in it, their relationship with each other while participating in it, and why participation differs among these actors. Furthermore, I have looked at the factors facilitating and hindering these actors' participation in PHC.

The specific objectives of this study are to find out:

- Who are the actors in PHC in Nepal
- What they understand by PHC, CP and Actors.
- What is the role of these actors.
- What is the relationship between these actors.
- What motivates and hinders these actors to participate in PHC.

The main research question and sub-questions for this research are:

How do government actors, nongovernment actors, community members, and other Health System Actors participate in PHC?

Sub-questions to explore answers for above main question:

#1 Who are the actors in the proposed research setting in Nepal?

#2 What are the roles of these actors in Primary Health Care?

#3 What do these actors understand by PHC, CP and health systems actors?

#4 What is the relationship between different actors?

#5 What are the motivations and barriers to participate in PHC for health systems actors?

I have presented in chapter three the process followed to seek answers for these questions.

1.5 Overview of the thesis

CP in PHC has a significant place in health system especially for a developing country like Nepal where a fully functional health care system is still under developed. Even though there has been some research about community participation in PHC, there is little evidence regarding how different Health System Actors especially those at the lower end of the system mainly the villager participate in it. Inspired by my own experience of working in the health sector and based on various studies around the subject I have explored the Health System Actors present in Hagam and Fulpingkot Village Development Committees (VDCs) of Sindhupalchok in Nepal, their role in PHC, their relationship with each other and factors motivating and hindering their participation. Furthermore, I have looked at the implication of these in PHC, CP and Health System Actors in general and in Nepal in particular. I have presented the overview of this research as follows:

In chapter one, I briefly presented this research, its relevance, my research questions and overview of this thesis.

In chapter two I critically examine the literature about health systems, PHC and CP in PHC which guided me to focus my study. I provide an overview of health systems in general and health systems in Nepal in particular. Furthermore, in this chapter I present the background of development of PHC and CP. Then I explain, contrast, compare and synthesize relevant literature in health system, PHC, health systems actors and their participation in PHC. Recognizing that there are differences in health systems between developed countries and developing countries, I focus my review mainly on the studies related to the developing countries and focus upon Nepal. In the final section I review various frameworks available for assessing CP in PHC, and their use in my study in Nepal. Finally, I explain about the knowledge gap in the literature and relevance of this research.

In chapter three, I present the methodological approach I followed for this research and explain the research paradigm and the rationale for using the qualitative case study approach for this study. To do so, I discuss semi-structured interview, Focus Group Discussion (FGD), observation and field notes methods. I have also explained about the study population, sampling procedure, researcher's positionality, pilot study, inclusion and exclusion criteria, research validity and ethical consideration of this study. A theoretical sampling technique was followed to select various Health System Actors present in Hagam and Fulpingkot VDCs of

Sindhupalchok district for this research. Twenty-five males and sixteen females were interviewed and four FGDs were conducted. These interviews were transcribed, translated and analysed using thematic analysis approach using the qualitative data analysis software NVivo 10. The findings with preliminary discussions for this research are presented in chapter four to seven.

Chapter four presents my findings and discussion about the health systems actors present in Hagam and Fulpinkot VDC of Sindhupalchok district, including those who influence these actors' participation in PHC. Furthermore, this chapter presents the role of various Health System Actors in PHC. These actors have been presented as government Health System Actors and nongovernmental Health System Actors. These are further categorized as having direct involvement in the health system and those involved only indirectly depending upon various roles these actors play in PHC.

Chapter five presents my findings and discussion about the relationship among different actors present in my study area and those who influence their participation in PHC. Relationships among different actors plays a significant role on their participation in PHC. This follows from the group of the actors presented in chapter four and analyses their relationship among them. Furthermore, I present the similarities and differences and the key issues emerged relating to caste and ethnicity, gender, politics, trust and about actors with multiple roles.

Chapter six presents my findings and discussion about the motivation for participation in Primary Health Care for Health System Actors. I have presented about use of various health services by various actors. I have presented the motivation for participation as motivation because of benefit and social pressure. The benefits are education, financial gain and political interest. whereas the social pressures are moral obligation, social recognition and professional obligation. I have presented the issues which emerged for participation as dynamics of actor groups, demand and supply side factors for motivation, power differentials, benefits and belief system to present how these affect various actors' participation in PHC.

Chapter seven presents my findings and discussion on the barriers to participation in PHC for Health System Actors. I have presented these barriers as personal barriers, physical barriers, social barriers and political barriers. Actors' age, education, gender and ignorance are presented as personal barriers whereas lack of services, financial situation and access are

presented as physical barriers. Furthermore, ethnicity, caste and social status have been discussed as social challenges and conflict of interest and mistrust are presented as political barriers for participation in PHC.

Chapter eight presents the discussion on my research findings in relation to literature. I have discussed implications of above findings for our understanding of PHC, CP and Health Systems Actors. I have discussed about multiplicity and complexity of health systems actors, roles of other actors and schism between Western and traditional health systems. These represent our understanding about these actors and its implication for our health system. Similarly, I have discussed about replicability of successful approaches, for example, Female Community Health Volunteers (FCHV) in intersectoral participation in PHC and pros and cons of involving existing traditional Health System Actors in PHC. Finally, I discuss the implications of increasing privatisation of health services in Nepal.

Chapter nine presents the conclusion for this PhD research based on my research questions, related literature, methodology used, findings, discussions and recommendations. This research concludes that CP in PHC is still relevant in delivering health care for people living in countries like Nepal. However, it realizes that there is very limited understanding of PHC, CP and health systems actors. Furthermore, the idea of one fits all approach of PHC and understanding CP as token participation has hampered participation in PHC to a great extent, and subsequently the success of PHC as a whole. Therefore, there is a need to contextualize the concept of PHC and CP to fit the local context. Similarly, where practicable financial, social, political and cultural factors should be taken into account to ensure the participation of people otherwise discriminated. Finally, there is a need to take into account the contribution of the existing traditional health system, private practitioners and other social determinants of health for better PHC.

CHAPTER TWO

Literature Review

Health System, Primary Health Care and Community Participation

2.1 Introduction

This chapter presents what is currently known about concepts, definitions, reviews and frameworks of health systems actors' participation in PHC within current literature.

I conducted a literature data base search with different search terms related to community participation and primary health care as discussed in section 2.2, details of which is attached herewith in appendix V. I have explored how the PHC fits within health systems and how health systems actors participate in PHC and interact with each other. Community participation in PHC in the context of developing countries and Nepal is the main focus of this literature review. However, literature on health systems, and issues related to PHC and health systems development also has been included because these constitute the health system as a whole and are important to understand the health systems better.

To fully understand community participation in PHC, we need to better understand how PHC fits in with the general health system. Therefore this literature review is conducted to answer the following questions:

- What is the health system?
- What is the history of development of health system in Nepal?
- Who are the Health System Actors?
- What is known about the interaction among Health System Actors?
- What is PHC and the history of development of PHC in Nepal?
- What is known about community participation in PHC in Nepal?
- CP in PHC globally.

Addressing these questions will provide context for the primary research part of this PhD.

2.2 Literature search strategy

To identify existing literature, definitions of terms, gaps and uncertainties a scoping search related to health systems, PHC and community participation in PHC was carried out. I carried

out a narrative review (Grant and Booth, 2009, Bryman, 2012) and a thematic analysis (Braun and Clarke, 2006). A narrative review is the review of published material that provides examination of subject matter with comprehensive details (Grant and Booth, 2009). Narrative reviews are comprehensive and cover a wide range of issues within a given topic area where as a systematic review has narrow focus, prescribed methods which does not allow comprehensive coverage (Collins and Fauser, 2005). I followed narrative review approach because it gave me freedom to review the wide area of literature for more holistic interpretation (Dijkers, 2015) on health system, PHC and CP to find the gaps. This approach was deemed appropriate as a systematic review approach would have limited the review to narrow areas of very specific questions (Dijkers, 2015).

2.2.1 Database search:

The literature search was run using various search terms in university data base Ovid MEDLINE(R) In-Process & Other Non-Indexed Citations, Ovid MEDLINE(R) Daily, Ovid MEDLINE(R) and Ovid OLDMEDLINE(R) 1946 to 2013.

The search terms used were Primary Health Care, PHC, health systems, health policies, health systems actors, health systems actors' interaction, participation, community participation, partnership and collaboration. In the process of my literature review I ran searches in combination of different search terms details of those are attached as appendix V to VII of this thesis.

2.2.2 Grey literature search:

Since the topic of research is of a great importance to government, national and international organizations who have published a lot of literature related to health systems, PHC and community participation it is important to include the grey literature to get broader view on available evidence (Mahood et al., 2014). Therefore, appropriate grey literature on health systems, PHC and CP in PHC was searched in Google, Google Scholar, WHO website and Nepal government websites to include those in this research. These were mainly the annual health reports from the department of health services in Nepal, UN publications, WHO reports, and National health policies of Nepal. These were used to understand health system, PHC and CP in Nepal and globally.

2.2.3 Search results:

The database search identified 158 articles related to Nepal. These articles were either about Nepal or they had referred to studies about Nepal. However, only 16 were about health system, PHC or CP in Nepal, details of these articles has been attached herewith in appendix VII. Based on this literature other related literatures was searched within included articles' reference lists and those cited by others which were relevant to my research, for example, based on the articles by Lucy Gilson, Julio Frenk in Health Systems and Policies and by Susan Rifkin, Judith Justice, David Sanders, David Mc Coy, Uma Kothari in case of PHC and Community Participation. I contacted various authors to discuss with them the current trend of community participation in PHC in developing countries.

Furthermore, my research required literature in health systems, PHC and CP; therefore, I employed an iterative search strategy, rather than employing one search strategy. For example, I followed the literature cited by the key authors on their publications to further explore on health system, community participation and PHC. This allowed me to explore on these topic broadly.

In the following sections I have presented the findings of my literature review. These include the findings on health systems, Primary Health Care and Community Participation in PHC. I have presented the overall findings first and then have moved to specific findings about Nepal.

Findings from the literature review

2.3 Health Systems

In this section, I will present the current global status of health system debate and consider questions, for example, "what is a health system?", why it is important to study them and what are the challenges. Furthermore, I will discuss the health systems development in Nepal and the health systems actors.

Since health system is an important part of a society it generates a lot of national and global interest. It has been suggested that health system provides a platform to launch dedicated efforts to address health issues and improve the health condition of low income populations (Gilson, 2012). This is recognized as an important element of every society not only to provide and influence health but as a vital part of society, reflecting its value in the society (Gilson et al., 2007, Gilson, 2012). Gilson et al. (2011) point out that :

"Health policies and systems are complex social and political phenomena, constructed by human action rather than naturally occurring".

WHO (2000) defines health systems as:

'all the activities whose primary purpose is to promote, restore or maintain health'.

In addition to this health system includes the social determinants of health, for example, safe housing, access to education, public safety, social support and infrastructures including roads. Furthermore, health systems include a full range of players and services i.e. all the donors, implementers and beneficiaries at central, regional, district and community level. However, there are not any universally accepted definitions of a health system since they have been defined differently for different purposes by different scholars (Hsiao, 2003).

WHO's definition of health implies that everything related to health is part of the health system. WHO (2007a) stresses that health system are *"Everybody's business: Strengthening health systems to improve health outcomes..."*. However, it still leaves out the "software" part of the system i.e. ideas, interests, values, norms and power which are critical to guiding the relationship amongst various Health System Actors (Sheikh et al., 2011). At the same time WHO's definition of health systems does not cover the integration of private and public, primary and secondary components and lacks insight into the role of public regulations (Barnett and Barnett, 2009). Frenk (1994) presents health systems as a complex dynamic set of relationships among major actors i.e. health service providers, population, the state, those generating resources and other sectors that contribute to the health services. Therefore, health systems are affected by various contextual factors, for example, personal, organizational and social factors which affect staff, their motivation as well as the beneficiaries' response to health services (Gilson et al., 2011, Lavis et al., 2012).

Health systems not only benefit people by preventing and treating illnesses but they improve people's lives by generating security within society and including them into the developmental process with political support (Gilson et al., 2007). Furthermore, health systems are a complex web of relationships which are highly influenced by trust; they can be defined in two ways, either based on what they do or by their components (Gilson, 2003, Gilson, 2012). At the macro level, the health system focuses on the overall dimensions of health whereas at the micro level it goes to the level of exploring behaviour of individual actors and even the

households (Hsiao, 2003). Murray and Frenk (1999, 2000) point out that health systems should contribute to improve people's health which sometimes might mean free health service for the poor and fee for those who can pay whether that is in the form of indirect taxes or direct expenses.

2.3.1 Types of health system

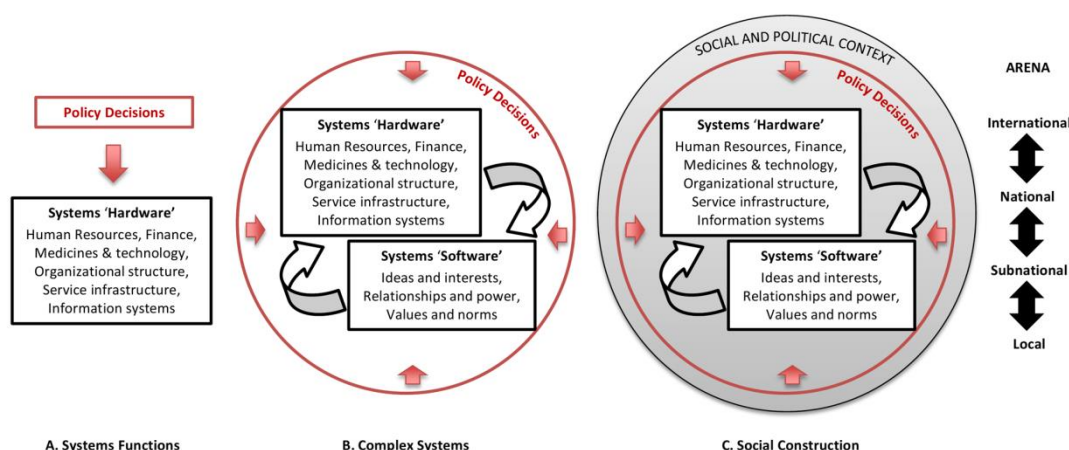
Though different people have defined health systems differently, broadly health system can be treated either just as a health care system or as a complex system of system components, system functions, people and their interrelationships. There are various models of health systems based on how they are funded and how they are run. Stevens and van der Zee (2008) discuss a functional model of health system. This model of the health system considers four models; they are Beveridge model, the Bismarck model, the international health insurance model and entrepreneurial or market model, sometimes also called out of pocket health expenses model. In the Beveridge model of health systems health service is financed, managed and provided by the state from its income sources. In the Bismarck model, instead of the state, the health service is provided by the private sector financed through insurance partly covered by employees and partly by employers. England, Sweden and Denmark follow Beveridge model whereas Germany and the Netherlands follow Bismarck model of health systems (Bevan et al., 2010, Lagomarsino et al., 2012). The International health insurance model is a combination of these two where the health service is provided by the private sector but funded through government run insurance providers. In the entrepreneurial model health services are mostly provided privately by the market and financed through government regulated insurance and people's personal expenses. Canada follows international health insurance model and United States of America mostly follows market model (Hohman and Chua, 2006). Most of the developing countries follow a combination of one or more models because neither the state can afford Beveridge model, nor the whole population can follow the market model.

Until the 1980s, influenced by political ideology, health systems used to be categorized in three ways. They were public assistance, health insurance and National Health Service health care systems corresponding to their affiliation towards pre capitalist, capitalist and socialist political ideology (Terris, 1978). In the public assistance system, health care is provided by the government but only to those who cannot afford it normally. In the health insurance model the cost of care is born by insurance which can be run by private companies, state, employers or jointly but it is free at the point of service. In the national health model the state provides

the health care service to its entire citizens free of charge at the point of service. Based on this typology, the Nepalese health care system still seems to be following the public assistance model of pre capitalistic political ideology for the majority of the population and for some of the urban rich population a private charge for health care service is available which has been further discussed in section 2.3.2.

Sheikh et al. (2011) categorised health systems into three types and have explained pictorially (figure 2.1) how health systems look depending on whether the context is taken into account or not. First, as the WHO health system building blocks, which is an example of a health system which functions as systems hardware. The second type is a complex system where both hardware and software influenced by the policy decisions present. Finally, the third type is a social construction of the health system which is similar to the complex system but guided by the social and political context.

Figure 2.1: Types of Health Systems



Source: Sheikh et al. (2011)

WHO (2007a) proposed a health systems framework with service delivery, health workforce, information, medical products, vaccine and technologies, financing and leadership / governance as six building blocks of a health system. It aimed to achieve improved health, responsiveness, social and financial risk protection and improved efficiency through access, coverage, quality and safety. It is basically a functional model of health systems. It is the most commonly used health system framework. However, even though the WHO framework gives a common and simple framework for research, it is not suitable to analyse dynamic, complex

and inter-linked systems. Furthermore, the equal weight given to all the building blocks is not appropriate because it ignores the demand side, power differentials, and the interaction among components (Mounier-Jack et al., 2014).

Furthermore, a recent WHO report (WHO, 2007a) recognizes the importance of PHC for its underpinning values of universal access, equity, participation and intersectoral action. At the same time it comments that the PHC approach is expensive and suggested to involve the private sector in delivering health care. This skims over a whole complex policy debate about comprehensive vs selective PHC fought out in 80s and 90s. Even though it mentions public participation, involvement of NGOs and the private sector it does not explicitly talk about community participation the way the Alma Ata Declaration advocated, promoting community participation and PHC as inseparable entities. Furthermore, WHO health systems building block framework is silent on the important parts of health systems, which are people, participation and power and also doesn't consider the content, process and actors as suggested by Walt and Gilson (1994) in their health policy analysis framework triangle. Gilson and Raphaely (2008) suggested that politics, power and processes are important for understanding policies so inquiry into these must be integrated into the study of health policies and systems.

2.3.2 Health system development in Nepal

The modern medical practice was first introduced in Nepal around 1740. Its wider use only began in 1890 with establishment of Prithvi Bir Hospital in Kathmandu, followed by similar establishment of smaller facilities in other parts of the country (Dixit, 1995). So, Nepal has a very short history of development plans compared to many other countries and so is the history of health service (Acharya and Cleland, 2000). The first systematic development plan was announced in Nepal just before World War II, which was cancelled and a second plan announced in 1949 by then Rana rulers (Aaron, 1972). Formally, the Western model of health systems started with periodic development plans in 1951 and the opening of the international airport in Kathmandu. Before that, only a few missionary and government hospitals were in operation mainly within Kathmandu valley and the surrounding areas (WHO, 2007b), but the rural population had relatively less access to modern health care. The first five-year development plan not only introduced the first general health plan of Nepal but also initiated several vertical disease based intervention programmes covering areas all over Nepal (Rai et al., 2001). For example, Malaria eradication was started in 1955, leprosy and tuberculosis

treatment in 1958, family planning in 1966, smallpox eradication and Mother and Child Health (MCH) programme in 1968. The first formal mention of health as a policy in Nepal was its entry into the Civil Code in 1963/64 followed by other acts (Dixit, 1995, WHO, 2007b).

Nepal has included health in all its periodic development plans from the first plan in 1956 to the current 13th plan in 2013. A new health policy was formulated in 1991 with the aim of upgrading the health status of the rural population by making basic health services available at the VDC level, which is claimed to be the turning point of the health system in Nepal (MOHP, 1991, Sapkota, 2013, Rijal, 2013). This same policy positioned PHC as the means to provide minimum essential basic health care services to the population of Nepal. At the same time this policy emphasized the involvement of private for profit and private not for profit agencies to provide health care services. However, as a consequence this and subsequent health policies in Nepal encouraged mushrooming of private clinics, hospitals, medical colleges and vocational training institutes which brought a flood of problems as well as opportunities, threatened the right to health and limited government control over people's health (Mishra and Acharya, 2013). Higher cost for services and drugs, unnecessary tests, low quality of care and exclusive services only to higher socio economic sectors of the population have been common characteristics of private health service provision in low and middle income countries (Basu et al., 2012). Similarly, due to the privatization of health services around the world out of pocket expenses for health services especially for the poor have been problematic (Travis et al., 2004). All these problems are prevalent in Nepal.

From 1991 to 2011 Nepal introduced fifteen health-related policies, four health strategies, three health plans and four government periodic plans in Nepal (MOHP, 1991, WHO, 2007b, Shrestha and Pathak, 2012). These policy changes were introduced at different times to address various contemporary issues not covered by the Nepal Health Policy 1991. Emphasis on PHC, MCH at a local level, mobilization of the private and not for profit sectors as complementary ways of health care were some of the areas these new policies focused. A major shift in health service use and pressure was experienced when the interim constitution 2007 of Nepal declared free basic health care as every citizen's right. Subsequent first three year Interim plan 2007/2009 put the declaration into action specifying preventive, promotive and curative health services as primary health care service (WHO, 2007b, Shrestha and Pathak, 2012).

Theoretically, the formal health system structure all over Nepal is the same in all 3,376 VDCs (MoFALD, 2015). Sub-health posts are the basic levels of government health care unit present in each VDC of Nepal to provide primary health care service to about 5000 population where there is no other higher level health care unit. The highest level of government Health System Structure is the Ministry of Health and the lowest level of structure is the Health Post / Sub-health post in the VDC level, between which there are regional health offices and district health offices, area health posts called Primary Health Centres and Health Posts. Though centrally planned for the service and activities of the health posts and sub-health posts, the district health offices are fairly decentralized to operate and manage health services within their jurisdiction for all hospitals, PHC centres, health-posts and sub-health posts. This is uniform all over the country (DoHS-Nepal, 2013). All the sub-health posts have been upgraded to health posts recently (DoHS, 2016).

During the Maoist insurgency between 1996 and 2006 some of the existing sub-health posts and higher health care infrastructures were destroyed and over a dozen health workers were killed (Devkota and van Teijlingen, 2010). Health service providers were absent from their posts. Supply chains were disturbed and often movement was restricted disturbing monitoring and supervision. This in combination led to a deterioration of the already fragile health services especially in the rural areas of Nepal (Klement and Silverman, 2003, Devkota and van Teijlingen, 2010).

Though equipped with sufficient plans, policies and commitment Nepal has not been able to implement all these policies and plans in rural and hard to reach areas mainly due to management deficiency, poor accountability, under-utilization of community participation and ignorance of the importance of other sectors in health service development. As a result, there is a huge disparity in health indicators in urban vs rural populations, hills vs low land (Terai) and among different caste groups. For example, 57% from higher caste, 40% from untouchable and 34% from ethnic groups in the hills received Antenatal Care (ANC) from skilled birth attendants whereas for the whole group it is 48% for hills and 37% for Terai and similar trends are seen in other indicators, for example, family planning, nutrition and HIV/AIDS (Bennett et al., 2008). Even though Terai is flat land with better transport facility and better access to these services, these indicators are worse because of higher discrimination against gender, caste and ethnicity, here ethnic group denotes a culturally distinct group whereas caste denotes hierarchically ranked lineage originally representing people's occupation but currently

used as basis for discrimination (Gellner, 2007, Subedi, 2010). In addition to this there is difference in access and indicators because of difficult geography, poverty and road access.

The National Health Policy 1991 of Nepal strongly emphasizes the PHC and free essential basic health care service is part of it (MOHP, 1991, Sapkota, 2013, Rijal, 2013). A strong and effective health system is suggested as a prerequisite in reducing the burden of disease and achieving the health MDGs, therefore, the importance of the study of health system has risen recently (Shakarishvili et al., 2010). Similarly, strengthening PHC based health systems has been promoted by the WHO to its member countries (WHO, 2009). Every health system involves participation of various actors and their interaction so the health system is better understood through the study of interaction between principal actors and their interrelationship (Frenk, 1994). Since PHC exists as part of health systems, the study of PHC and health systems actors within PHC needs to be informed by an empirical understanding of PHC. Furthermore, it is argued that despite the continuous effort to achieve universal health coverage and MDGs many developing countries have not managed to do so. It is mainly because of weak health systems and conflicting demands from disease specific vertical health care interventions (Travis et al., 2004, Bosch-Capblanch et al., 2012). Therefore, understanding different components of health systems, for example, PHC and Health System Actors' participation is important.

2.4 Health System Actors

Broadly, Health System Actors can be categorized in two groups, national actors and international actors (Ono, 2001). At the international level they are organizations, for example, World Bank (WB), World Trade Organization (WTO), International Non-Governmental Organizations (INGO), Bilateral organizations, Academic institutions, international associations, and individuals. These organizations influence international as well as country health system by providing loans, by trade policies, policy research and grants respectively. Similarly at national level they are state ministries, political parties, bureaucracy, private agencies, local representative bodies (DDC, VDC), Community (CBOs, FCHVs, THs), individuals, NGOs and other support organizations (Ono, 2001). Here local actors are included as national actors. These actors' understandings, experiences and interpretations construct and bring life to health policies and health systems (Gilson et al., 2011). Furthermore, as envisioned and prioritized by the Alma Ata declaration on PHC, participation of these actors in planning, organizing, operating and control of PHC is one of the key components of most health systems.

It is claimed that participation contributes to the full use of all available resources from local, national and international levels. This approach has been equally shared by UN in MDGs, post MDG Health for All debates as well and recently in SDGs. The success of health systems is believed to depend upon how well different Health System Actors collaborate with each other around the shared vision (Swanson et al., 2012).

These actors are policy makers, financiers, implementers, service recipients and advocates of services. For the purpose of this study, those who are involved in delivering, receiving and advocating for primary health care will be treated as Health System Actors. Most of the Health System Actors participate in some form of power exercise whether it is authoritative power to control decision making or power to implement the programme even at the grass-root level (Lehmann and Gilson, 2012).

2.5 Interaction among health systems actors

Interaction is a process of engaging one or more actors by common motivation (Parsons, 1951). Every health system involves interaction between various health systems actors based on their relation, exchange of knowledge and ideas and their interrelationship (Frenk, 1994). A health system involves interaction of all the actors present in the community, for example between governmental Health System Actors, governmental non-Health System Actors, nongovernmental for profit actors, nongovernmental not-for-profit actors, civil society organizations, traditional practitioners, political party leaders, media and people from all walks of life (WHO, 1986). Understanding the worldview of these actors about different aspects of health systems and their relationship is important for an effective health system.

It has been suggested that people's knowledge and relationship among them leads to improved health system understanding, policy making and implementation which subsequently helps better health system functioning (Molyneux et al., 2009). Health equity is dependent on reaching beyond the government partnering with wider actors, for example, civil societies, voluntary sectors and private sectors. Therefore, their participation in policy and implementation processes is important for attaining better results in providing health services (WHO, 2008a, Molyneux et al., 2009).

Looking from a management perspective, Lehman and Gilson's (2012) study of relationship of community-level health professionals in remote areas of South Africa found that power is

exercised at every level of policy implementation, which equally applies to the aspect of PHC delivery. At the higher level there was power of hierarchy and power in budget allocation whereas at the lower level it was withholding labour and non-participation in the programme. A study of the Tanzanian PHC by Schmidt and Rifkin (1996) suggested that though there is a growing emphasis on community participation, there has always been concern about how to assess it. Therefore, it is important to study participation at all levels.

In the policy sphere, stakeholders' participation, collaboration, involvement and interaction are suggested as essential elements for delivering PHC where power is one of the main components of the process (WHO, 1978, WHO, 1986). In practice, however, only those who support them are brought into it for token participation and those who have their own views or conflicting ideas are discouraged to participate. It is done so to defuse those alternative ideas, views and perspectives (Mohan, 2006). Even the very act of being drawn into participation can be an exercise of power over the participants, for example the local knowledge shared during the process of participatory research, for example, Participatory Rural Appraisal (PRA) is often used to legitimize a predetermined agenda rather than empowering the participants (Kothari, 2001).

In formal structures health systems actors' participation takes place in different domains of the participation as listed by Rifkin et al.(1988). These domains of participation are needs assessment, leadership, organization, resource mobilization and management. To get involved in these domains of participation these health systems actors interact with each other by different means. Meetings, indirect information, visits, public campaigns and door- to-door visits are some of the means of interaction. At the same time influencing factors, for example, differences in power, local politics, economic status, social norms, values, government policies, prevailing conflicts and context which affect and shape people's participation are taken into account. The majority of people in Nepal interacts with each other through informal processes, for example, family gatherings, neighbourhood meetings, festivals and celebrations where people share various aspects of their life experience including health, directly and indirectly. These interactions are as equally important as those happening in the formal processes. Both formal and informal participation in PHC are explored in this inquiry.

2.6 Primary Health Care

PHC is defined by the WHO as:

"... essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination"(WHO, 1978).

Development of PHC in the periphery of the Alma Ata Declaration is discussed in following sections:

2.6.1 PHC before Alma Ata

Credit for the introduction of modern medical systems in some developing countries can be given to the colonial rulers. However, initially these services were introduced for colonials and missionaries who also suppressed existing traditional health services (Gish, 1979). Between 1920 and the Second World War the modern health service in developing countries was dominated by curative treatment delivered either by these missionaries and colonial systems or by occasional vertical interventions, for example, yellow fever control in Brazil and malaria control in India (Smith and Bryant, 1988).

Kruk and Freedman (2008) identified that before the 1978 international Conference for PHC there have been two main trends of health service development in developing countries. Initially it was vertical intervention for specific diseases control, for example, programmes against malaria in Africa and Asia (Unger and Killingsworth, 1986), yaws control in Africa (Garner and Sanders, 1997) and smallpox eradication programmes in West and Central Africa (Foege et al., 1975). The second major trend was the development of urban centred hospital based curative health services (Gish, 1979, van Olmen et al., 2012). During this period it was noticed that multiple vertical programmes were not sustainable in the long run and led to serious problems. This realisation led to the introduction of integrated PHC systems during the 1970s and 1980s leading to WHO's Alma Ata Declaration in 1978 with its commitment to equity, community participation, universal coverage and health for all by 2000 (Segall and Vienonen, 1987, Kruk and Freedman, 2008).

2.6.2 PHC after Alma Ata

Universal access, community participation, intersectoral involvement, use of appropriate technology and cost effective use of available resources are the underlying principles of PHC (Tarimo and Webster, 1994, Segall, 2003). When PHC was being advocated by WHO and its member countries there were three health care service structures in practice around the world i.e. hospital based medical care, vertical disease specific health programme and community based PHC (Unger and Killingsworth, 1986). It needs to be understood that although PHC is the first point of contact for an individual into the health system it is not only medical care. Neither this community-based care is only for developing countries, but it is a wider comprehensive health care approach (Wass, 2000); because it involves preventive, promotive and curative aspect of health care as basic health care service (Magnussen et al., 2004). Furthermore, in PHC, people are supposed to participate in deciding their health care themselves and contribute resources as appropriate. PHC can be comprehensive PHC or selective PHC. Comprehensive PHC is a developmental process by which people improve their health and lifestyle that involves other social determinants of health. Whereas, selective PHC addresses population health by intervening in disease specific cases to improve individual health at lower cost (Rifkin and Walt, 1986).

PHC is believed to be influenced by China's bare foot doctor approach where PHC services used to be provided by the locals for the locals (Gish, 1979, Justice, 1987). Furthermore, it was influenced by a range of other PHC interventions successfully run in other countries by state and non-state organizations (Lawn et al., 2008). The concept of involving local people to provide health service locally had started around the 1930s and was formalized around 1947 in China after Mao's long march where it was advocated to integrate the Chinese traditional medicine system and modern Western medical system together (Sidel and Sidel, 1975, Chan and Lee, 2002).

Around the same time similar systems of modern and traditional medicine were practised at Jamkhed in India with support from the community and Christian Medical Commission (Arole and Arole, 1975), in Cuba by the new government led by Fidel Castro (Fernandez, 1975) and in Indonesia as community health programme through the integrated community development programme (Nugroho, 1975). On one hand, similar programmes were run in Niger where modern health services were delivered through village health workers (Fournier and Djermakoye, 1975) and in Tanzania as the rural PHC programme (Chagula and Tarimo, 1975).

Most of these health programmes were successful locally (Newell, 1975). On the other hand the health systems practised especially in post-colonial developing countries were struggling because the health system left behind by the colonial rulers was not enough for the population as it was developed mainly for people living in urban areas (Zaidi, 1994). In the existing system, there was neither sufficient infrastructure nor enough trained human resources to cover the rural areas of developing countries.

These successful and comprehensive community based health care programmes together with the need to extend health care services to rural people in developing countries led to the thinking and planning of the Alma Ata Declaration (WHO, 1978). PHC was endorsed by WHO member countries as a means to reduce inequality in health through universal access to health services (Rasanathan et al., 2011). The objectives of this declaration were social justice, equity, participation, multisectoral collaboration, use of appropriate technology and sustainability of the PHC service for the people who were not served by then urban based health care services (WHO, 1978, Bhatia and Rifkin, 2010).

Therefore, PHC according to the WHO definition means providing health education, food and nutrition, water and sanitation, immunization, child and maternal health and prevention and control of endemic diseases by treating common diseases and injuries and providing essential drugs to people locally with their full participation (Unger and Killingsworth, 1986). Some critics say that WHO declaration for PHC is a reaction to the failed assumption that the urban medical care will trickle down to rural areas (Muhondwa, 1986) and to the failure of disease specific vertical programme, for example, malaria eradication programmes. Therefore, PHC is sometimes taken as reaction to the failures of other approaches rather than a plan for a success (Newell, 1988).

2.6.3 Challenges of development of PHC after Alma Ata

Immediately after the Alma Ata Declaration while WHO and its member countries were still promoting PHC to achieve Health For All by 2000 some of the major players of the PHC Declaration 1978 started to explore its alternatives (van der Geest et al., 1990). PHC was divided into three types, Comprehensive PHC (CPHC), Basic PHC (BPHC) and Selective PHC (SPHC). CPHC included water and sanitation as a component of PHC whereas BPHC did not and SPHC dealt with only about five to eight diseases mostly of paediatric nature (Unger and Killingsworth, 1986). The credit for introducing selective PHC goes to Walsh and Warren (1980)

who argued that PHC approach is unattainable, costly and human resource intensive. They proposed Selective PHC approach to address population health by prioritizing and treating diseases with high morbidity, lower intervention cost and diseases for which there are proven treatments available. Their argument for the superiority of Selective PHC over the original WHO PHC was based on cost effective analysis of indicator changes in mortality or death averted. Their approach was based on two step health planning i.e. ranking of diseases in priority ordering considering morbidity, prevalence, risk of mortality and feasibility of control and another step was to decide the intervention based on cost effectiveness (Berman, 1982).

Walsh and Warren's (1980) idea of a Selective PHC was discussed in a conference organized by the Rockefeller Foundation in Bellagio, Italy in 1979 from which UNICEF, one of the co-authors of the Alma Ata Declaration shifted its focus from comprehensive PHC to selective programmes. As a result UNICEF introduced GOBI (Growth monitoring, Oral rehydration for diarrhoea, Breast feeding and Immunization) programme for children in 1982 (Wisner, 1988, Bryant and Richmond, 2008). The advocates of selective PHC preferred short term disease specific intervention over the original PHC vision of strengthening all aspects of health systems simultaneously. Therefore, PHC was tagged as a cheap version of health services designed only for poor people in developing countries (Tarimo and Webster, 1994, Irwin, 2010). By the late 1980s even within WHO the two Director Generals who followed tenure after Dr Mahler who was the Director General of WHO at the time of Alma Ata Declaration rejected the broad view of PHC promoted by WHO, and promoted more disease focused vertical health services (Magnussen et al., 2004). At the same time the World Bank was promoting its structural adjustment policies for developing countries which introduced the user fee concept for health care services as cost recovery approach, changing the role of the state from service provider to regulator and encouraging involvement of the private sector in health care service delivery, with consequences for development of PHC.

Furthermore, recently there has been a growing interest and practice of contracting out PHC services to public and private providers especially from donor communities and Governments in some developing countries (Mills et al., 2002, Liu et al., 2004). It is argued that contracting out increases coverage of the health care service to the underserved population if it is practised as in the PHC in the UK (Palmer, 2000). Though contracting has been promoted for better outcomes, cost effectiveness, use of private sectors' flexibility and decentralized decision making, it has equally been criticised for creating inequity in health services, not being

sustainable in the long run, low coverage, insufficient monitoring from the government and higher costs than the government service (Loevinsohn and Harding, 2005). Therefore, though contracting out the health services is advocated as a solution to provide service more effectively it has been pointed out that it still requires strong governance, sufficient resources, government's skill for monitoring the quality and a strong system in place (Mills, 1998, Mills et al., 2002).

Currently because of huge inequities in population health, inadequate progress towards achieving MDGs, inadequate human resources to deliver the health services in developing countries and most importantly weak and weakening health systems, there has been a renewed interest in PHC (Lewin et al., 2008). As a consequence, revitalization of PHC was suggested as an approach to address above issues of universal access to health and to achieve MDGs (Walley et al., 2008). The ethos of revitalizing PHC is assigning everybody a role in partnership with the communities, including the state and other funders as well as implementing bodies. PHC is highlighted as more important and wider than before and claim for greater action and attention (Walley et al., 2008), this continues in recent SDGs as well through UHC (SDG 3.8).

2.6.4 PHC in Nepal

As Nepal was opened to the outside world only after 1950 and systematic development plans started only from 1956, the modern era of planned health system development started only from 1960s. Two types of health services started at the same time between 1950 and 1980 in Nepal. Both the disease specific vertical health programme and clinic based curative health services were run side by side. For example, programmes, for example, leprosy control in 1963, tuberculosis control 1965, small pox eradication programme 1967 and family planning and maternal child health project in 1968 were running alongside the development of hospitals and other infrastructures in Nepal (Dixit, 1995).

Nepal was one of the early adopters of PHC after Alma Ata Declaration of PHC (Dixit, 1995). Nepal used a realistic approach as envisioned by WHO's PHC approach in use of scarce resources, for example, use of auxiliary health manpower instead of fully qualified health professionals, use of appropriate technologies and community participation in providing PHC services. Nepal employed village health workers (VHW) as first point of contact for PHC who were made responsible for motivating the community to participate in PHC agendas, collect

census, detect and treat certain diseases, for example, malaria, TB, leprosy and check nutritional status of children. The Government of Nepal later introduced another cadre of community level health workers as CHL (Community Health Leader) one in each ward and they were volunteers and their role was similar to the VHW. They were supervised by the main health worker of the health post and are assumed to be capable of delivering basic curative health care (Stone, 1986).

Despite the continuous commitment of the Government of Nepal to adhere to the PHC since Alma Ata 1978 and endorsement of the PHC approach again through PHC revitalization in 2008, most of the studies conducted in Nepal show a grim picture of the status of the community participation aspect of PHC in Nepal. For example, a study by Stone (1986) about community participation in PHC Nepal reported no effective coordination between the health worker and the community, where she interviewed the village women and reported it qualitatively. Bently (1995) also highlights that there were challenges in allocating resources for health in remote areas of Nepal, which was based on the review of the literature and health care organization in Nepal. Similarly, Hoff (1992) suggests that traditional medicine is still preferred over modern medicine in some remote parts of Nepal and Poudyal et al. (2003) suggest that the role of traditional practitioner is still equally important in providing health care service in rural areas of Nepal. Furthermore Rai et al. (2001) suggest that even though Nepal has fully embraced PHC approach it has not been able to fully match its expansion with required expansion of local health workforce and supplies and neither of them are efficiently and equitably distributed.

2.7 Community participation in PHC

Community Participation is people's active involvement in the planning, organization, operation, and control of PHC where community determines their collective needs and priorities and assumes responsibilities for such decisions.

The Alma Ata declaration in 1978 emphasized CP by stating:

"PHC requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate" (WHO, 1978).

As envisioned and prioritized by this Declaration and reinforced by different WHO policies (WHO, 1981, WHO, 1986, WHO, 2008a) community participation has been one of the primary elements of any PHC plan whether it is health for all by 2000 or attain MDGs by 2015. This has been continued in WHO's MDG to SDGs strategy (WHO, 2015a) as well for improved governance in health systems. The emphasis on community participation is explained as a result of the necessity to shift from urban medical based centralized curative health systems solely managed by medical professionals to rural based decentralized preventive systems. The aim was to widen the area of health services beyond the health sector i.e. to wider development intervention rather than only as a medical service (Rifkin, 1990). Since PHC is a part of health systems and community participation as an essential component of PHC, it is important to gain an in-depth knowledge of various aspects of community participation to fully understand health systems and PHC.

Participation is a political and dynamic process which takes multiple forms and serves different interests (White, 1996). Participatory development is inclusion of local people's knowledge in programme planning as an integral part of the development process (Midgley et al., 1986, Mosse et al., 2001). Therefore, participation in a real sense is listening to people's voices, getting them involved in the decision making process and ensuring that they own the decisions irrespective of power, status and income of the people involved. Furthermore, community participation has been understood as a powerful appealing tool and to some extent an emotional one because it is argued that it lowers intervention costs, builds a sense of belonging and integrates the community thus allowing the community to help in their own development. Such an approach can ensure that policies reflect local need.

Community participation involves sensitization of communities and individuals to receive benefits and contribute in development activities and involving them in the decision making process from conception to sustaining and control (Oakley, 1989). Sometimes it is taken just as a tokenism where input is received but is discarded over time (Brownlea, 1987). Bracht and Tsouros (1990) studied the process of participation and gave an account of what is participation, who participates, why participate and how participation is facilitated. They defined participation as the process of engagement with projects or activities formally or informally, actively or passively for the benefit of the actor, others in the community or society as a whole. They suggested the process of participation as engagement of ordinary people in

decision making, policy making, planning and implementation, can be realised through involvement in committees, groups and clubs. They mainly suggested processes and means of participation, for example, participation as self-managed groups; self-help groups, volunteers, social movement groups, advocacy groups, social networking groups, development activists, media and planners.

A study by Awortwi (2013) on community development in African and Latin American communities suggest that the economic status of the community actors has a positive correlation with participation meaning the poorer the people the lower the participation and vice versa. Which shows participation is fundamentally related to resources, power and their control (Sawyer, 1995, Jacobs et al., 2012). Therefore, it might be a burden for a poor person if it takes their time and resources and does not reimburse it the way they would get paid from other activities, i.e. no payment for loss of their opportunity cost. Whereas, for the government it might mean additional free resources and for elites an extra instrument to exercise power.

Community participation has so far been taken to indicate active or passive involvement of people responding to the direction given by policy makers or programme implementer or health professionals (Rosato et al., 2008). A study of the Zambian health system by Mogensen and Ngulube (2001) suggested that the assumption that community participation always reduces the gap between the government and the community is questionable. They found that Zambian health system reforms overemphasized community participation and restructured the administrative set up of health systems accordingly. This reduced the morale and motivation of frontline health workers, which ultimately challenged the success of the reform. Therefore, it is still questionable what the ideal level of participation is and what is the process for achieving that.

Participation can be bottom up where empowerment of stakeholders in the lower strata of the system is emphasized by building control, capacity and resources towards the intended changes. Whereas in a top-down approach community participation is more for the participation of stakeholders in certain interventions but decisions for participation and interaction are made by outsiders, for example, government employees, business leaders or selected community leaders (Laverack and Labonte, 2000)

Though written in the context of American society the following analogy of community and community participation by Kaufman (1959) still holds true in many respects in community participation in PHC:

Perhaps the notion of community arena or field can be made more comprehensible by the use of analogy. community field as a stage with the particular ethos of the local society determining the players and the plays. If the orientation is democratic and primary social contacts are dominant, many engage in script writing and acting and there are relatively few spectators.The same persons are likely to appear again and again, while the others either sit passively as spectators, or are carrying on their limited interest shows on other stages, unmindful of the community drama.

In case the orientation is autocratic, as in a prison or to a lesser extent a totalitarian society, both the script and names of the cast are handed down from above; such orders may even state when the audience is to applaud.

Source: Kaufman, (1959 Page 10)

Both community and participation mean different things in different contexts, so it is not possible to consider community participation outside social, political and cultural context (Rifkin, 2009). The most common form of community participation found in PHC is passive participation as health service utilizer as well as resource contributor rather than active participation in the management and planning of health services (Tarimo and Webster, 1994).

Though the need for greater community participation in health has been emphasized since the Alma Ata Declaration, there have not been enough studies on the process of participation (McCoy et al., 2012). The majority of studies about participation in health has either been about the service provider or health facility management committee as a form of participation (Sepehri and Pettigrew, 1996). McCoy et al. (2012) found four articles out of three hundreds and forty one that mentioned community participation process to some extent. However, these still did not explore the dynamics of how the formal participation took place. For example, Iwami and Petchey (2002) study in Peru was about the functions of community participation in Local Committees for a Health Administration (in Spanish - Comunidades Locales de Administración en Salud - CLAS) programme and Loewenson and Rusike's (2004) study in Zimbabwe was about the impact of participation of health committees on health system performance. The study in Peru was a comparative case study of two models of

community participation whereas the study in Zimbabwe was study of mechanism of community participation before and after a PHC intervention. Both of these study used qualitative study approach with key informant interviews and FDGs.

There is some scepticism regarding the claim that community participation is a prerequisite for the success of PHC. For example, Ugalde (1985) claims that delivery of PHC is possible without community participation. He argues that the failure of PHC is not because of non-participation but because of incompetence, corruption and mismanagement by the government. He further points out that the concept of PHC and community participation is a political response to external pressure to expand health services in rural area and an attempt to legitimize the service available in urban area. He argues that the community participation promotes consumer society and destroys traditional norms. Furthermore, he claims that the community participation is used as a tool to generate free resources to save the state resources and sometimes community participation is used by the state to control other actors.

Werner (2002) is also sceptical about all people's action oriented terms like; participation, empowerment, mobilization and ownership and questions whose participation, whose empowerment and whose mobilization. Furthermore, he questions in the case of community ownership, who owns it and who decides on who owns, whether it is community or someone in the name of community who takes control and makes decisions. Often community participation is initiated and promoted by governmental and nongovernmental organizations whereas it is argued that participation is most effective when it is initiated by the community itself (Madan, 1987). Walt (1988) gives an example of community participation as participation of community health workers (CHW) which was considered as the backbone of the PHC approach but later was treated as a vertical programme rather than a part of PHC. Still, it is notable that the concept of community participation in PHC changed the views of community from being treated just as a passive service user to becoming an active contributor in decision making, resource contribution and advocacy thus shaping it as a part of health care services as a whole (Cornwall, 2000).

Chilaka (2005) uses Rifkin et al.'s (1988) framework of measuring community participation in the Roll Back Malaria Programme in five African countries Uganda, Ghana, Tanzania, Nigeria and Bukina Faso. He claims that it was not only the participation but the financial resources available, availability of man power and general infrastructure of the respective countries that

shaped the success or failure of the programme. Similarly Askew and Khan (1990) give examples of processes of community participation from family planning programmes in Bangladesh, China, Philippines, Thailand and South Korea. They noticed that managers and implementers wanted communities to participate as recipients of services but not as power sharing in decision making and resource mobilization. They found that most of the programmes are planned top down to implement programmes or policies designed and decided at central level.

Preston et al. (2010) carried out a systematic review of studies that looked into the outcome of community participation, finding that there are neither many such studies nor there are any that look specifically at analysing the process of community participation. However, they found that 38% of the 37 studies they reviewed showed positive health outcomes and 65% reported better access to health services because of community participation. Furthermore, the randomized control trial with safer motherhood intervention in Makawanpur district in Nepal reported that the intervention with community participation reduced maternal and infant mortality significantly (Manandhar et al., 2004). Similarly, the equity fund project in Cambodia which facilitated the local community to take the lead in designing, implementing, administering, leading and managing their health care programme themselves increased community participation as well as people's access to PHC (Jacobs and Price, 2006). Both of these cases were successful because community participation was common in both of these cases, people fully participated in their health system themselves.

These arguments for and against community participation suggest that no single community is like another. They are not homogenous but a complex mix of different people of different status, different interest, having different power and income from different strata of society (Midgley et al., 1986, Zakus and Lysack, 1998). Therefore, expectation of full community participation might be over ambitious, impossible and impractical as might be the various claims of participation as a prerequisite of social change and redistribution of power.

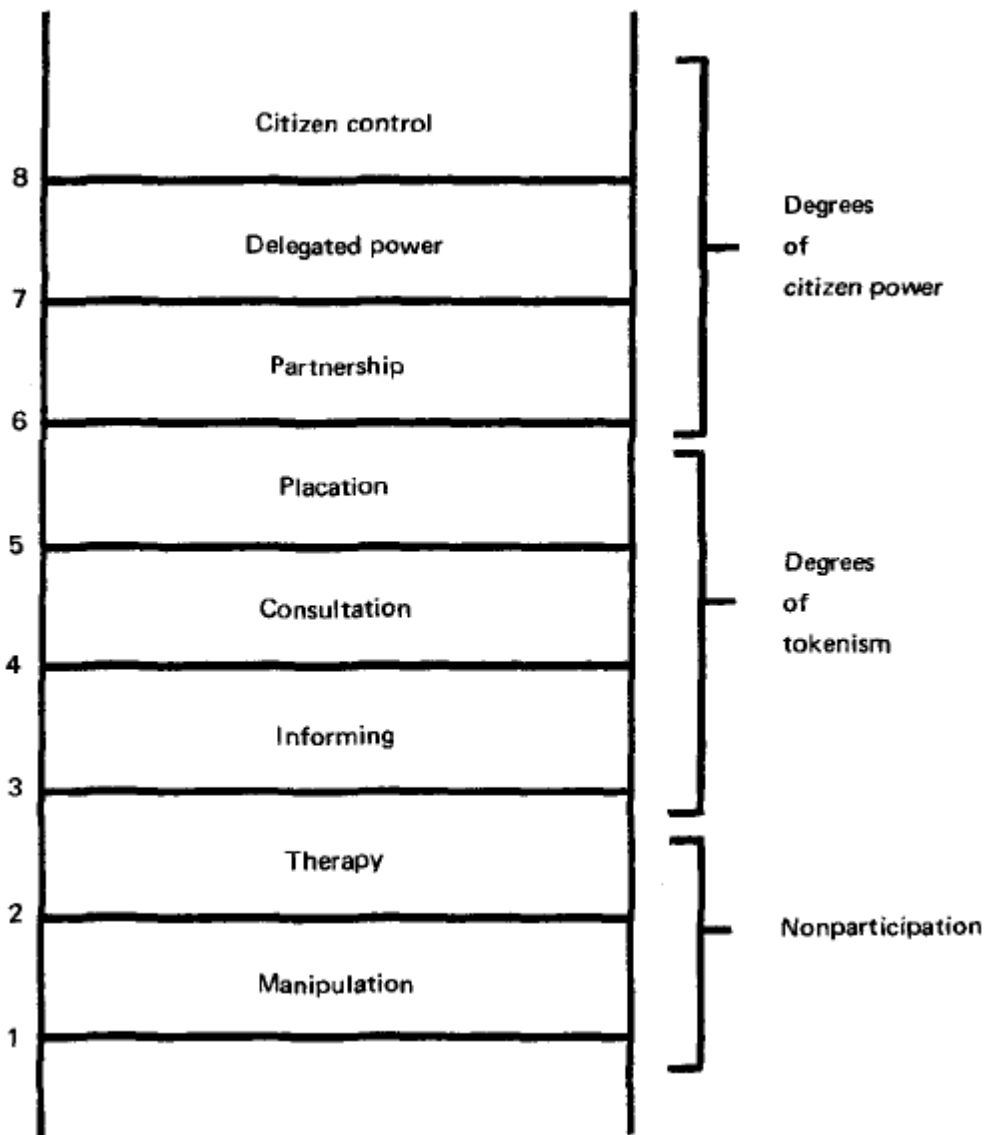
2.7.1 Assessing community participation

There are various ways of examining actors' interaction, participation, involvement and collaboration in various disciplines. For example Arnstein's framework (1969) was used in housing, Rifkin et al.'s (1988) framework to assess participation in PHC and use of stakeholders analysis framework for business project managements (Jepsen and Eskerod, 2009). Though not

explicitly for assessing community participation in PHC but different scholars have suggested different ways of looking into the level of participation in different disciplines, some of which are illustrated in following sections:

A framework for measuring citizen participation was first proposed and published by Arnstein (1969) as a '*A Ladder of Citizen Participation*', for assessing people's participation in transport and housing where she argues that participation is all about power (figure 3). She explains that the redistribution of power enables ordinary citizens to participate in economic and political processes. Though it was developed in the context of citizens' participation in transport and housing in the United States, Arnstein's ladder of citizen participation is still used for setting theoretical frameworks for stakeholders' involvement in many disciplines including health (Tritter and McCallum, 2006). The main contribution of Arnstein's framework of citizen participation is the recognition of different levels of citizen participation starting from manipulation which is non participation as level 1 followed by therapy, informing, consultation, placation, partnership and citizen control as highest level of participation as level 8.

Figure 2.2: Arnstein's ladder of citizen participation



Source: Arnstein (1969)

Various other scholars developed their own ladder of participation for different discipline based on Arnstein's ladder of participation. For example, Roger Hart (1992) proposed a ladder of participation by describing it as a process of sharing decisions among actors which affect their life and he argues that participation is the fundamental human right of every citizen. Burns et al. (1994) proposed a similar ladder with 12 rungs divided into three main groups, citizen non-participation, citizen participation and citizen control where civic hype, a sort of marketing message for participation, is the lowest rung of the ladder and independent control is the optimum level of participation. Choguill (1996) proposed a participation ladder with

empowerment as the highest rung followed by partnership, conciliation, dissimulation, diplomacy, informing, conspiracy and self-management as the lowest rung of the ladder. Pretty (1995) suggested a different model of participation with seven levels of participation starting from manipulative participation as non-participation to self-mobilization as an optimum level of participation. Wilcox (1994) proposed a framework of measuring participation which has 5 levels from providing information being the lowest to consultation, deciding together, acting together and finally supporting individual community initiatives as the optimum level of participation.

Hyder et al. (2010) used a stakeholder analysis approach to study participation of different stakeholders to explore about their roles, influences and interactions in various policies and interventions they studied in Afghanistan, Bangladesh, India, China, Uganda and Nigeria. For this study they categorized the stakeholders on a scale of one to five based on their current level of power/influence. Agrawal (2001) suggested six types of community participation in community forestry in India i.e. nominal, passive, consultative, activity-specific, active and interactive participation. Where the lowest level of participation is just membership in a group and the highest level of participation is when the participation is in decision making and community's voices are reflected in the decisions.

Cohen and Uphoff (1980) proposed a framework for assessing community participation in the context of rural development. This framework assesses and analyses participation based on dimensions of participation and context of participation. Here the dimensions of participation are what kind of participation, who participates and how they participate. The context of participation is further divided into project characteristics and task environment where the former is related to the effects of project, programme or activity whereas task environment is related to social, cultural, political, economic, and geographical factors that affect the participation. This is a quite comprehensive framework for assessing and analysing community participation.

Rifkin et al. (1988) developed a framework for assessing community participation, which is widely used in various health interventions including community participation in PHC. The framework analyses participation based on participants' involvement in needs assessment, leadership, organizations, resource mobilization and management as factors influencing the process of community participation. These domains of participation were derived based on

studies of community participation in over 100 MCH/FP programmes case studies from different countries (Rifkin, 1990). The degree of participation is worked out in the scale of one to five where one is for narrow, 2 for restricted, 3 for mean, 4 for open and 5 for the wide degree of participation. These domains of participation are context dependent and can be increased or decreased as needed Laverack G (2001).

These frameworks shows that Arnstein's (1969) framework was used as a base for developing other frameworks to suit their own discipline by other actors. These are developed as generic frameworks to suit most of the discipline where people's participation is an important aspect of the process (Tritter and McCallum, 2006). For example, Roger Hart (1992) developed the framework to assess the participation as process. Burns et al (1994), Choguill (1996), Jules Pretty (1995), Wilcox (1994) altered the number of categories of participation and used different words for level of participation to suit their discipline or intervention. Similarly, Hyder et al (2010) used stakeholder analysis approach to assess community participation whereas Agrawal (2001) explained participation in 6 different stages as nominal participation to interactive participation. Furthermore, the framework developed by Cohen and Uphoff (1980) is used for assessing community participation in community development activities and the framework developed by Rifkin et al (1988) is used to assess community participation in PHC.

Among these, the framework developed by Rifkin et al (1988) is widely used in assessing community participation in health sector. For example Draper et al. (2010), Sepehri and Pettigrew (1996), Tatar (1996) and Kelly and van Vlaenderen (1996) used this model to assess community participation in various PHC interventions in different countries. This framework is used because it presents community participation graphically as different legs of a spider gram. These legs represents the people's participation in PHC in organization, need assessment, leadership, resource mobilization and management. The level of participation are plotted at the scale of 1-5 on these legs for above domains of participation, and these points are connected to form a spider gram, wider the spider gram higher the participation.

However these different frameworks for assessing community participation suggest that there is no uniformity in available frameworks and their use, rather they are governed by discipline, context and power involved in the process. Still, it is suggested that assessment of community participation should include assessment of the extent and scope of community participation,

the process of participation, capacity of and support for participants and the impact of participation (Jolley et al., 2008).

Among these frameworks, Rifkin et al.'s (1988) framework of assessing community participation is widely used in analysing community participation in PHC. For example, Draper et al. (2010) used Rifkin et al.'s (1988) framework by applying process indicators to relatively rank the participation. Furthermore, Sepehri and Pettigrew (1996) used the same framework to compare community participation in two middle hill villages of Nepal by using in-depth interview and non-participant observation. This study is a comparative case study of the community participation in two health posts in two VDCs, one with community financing scheme and another with government financing. In both VDCs over 90% of the participants did not know about the health committee, they contributed resources but were not involved in decision-making. The existing traditional healing practices were not taken into account. Therefore community participation was basically imposed by the state and it was not working.

A qualitative study by Tatar (1996) using Rifkin's et al.'s (1988) framework in the PHC system in Turkey concluded that community participation was minimal. Here, the professionals and medical doctors took community participation as a tool to implement their decisions over the community. There was insufficient knowledge about PHC and community participation in both professionals and community. Furthermore, health was perceived only as a medical service and there was over centralization of power where neither community participation nor other components of PHC approach were present. Both health professionals as well as community people shared a same view about it (Tatar, 1996, Tatar and Tatar, 1997).

A study in South Africa by Kelly and van Vlaenderen (1996) has given a good account of the process of community participation in health projects: they refer to participation as a process of communication and a common action between communities and the health service providers. They recognize that the majority of studies is about developmental processes rather than processes of participation and admit that there is not much research on the latter. They looked into participation using grounded theory and explored how participants experienced participation. They presented the process of participation as modes of participation which are: Participation as a resource provider, non-community members, representatives of beneficiaries and a coordinator. Their findings suggest that politics of race and ideological

differences play a crucial role in actors' engagement with the project and their process of participation.

This confirms Rifkin's (1986) conclusion from her study based on case studies of over 100 health programmes involving community participation that there is not a universally acceptable form of participation since it is a context sensitive dynamic process that needs multi sector involvement. Rifkin (1986) further suggests that politics play a major role especially when participation shifts the power structure which is often a sensitive issue in the community. She outlines the ways how people participate as follows:

- As a recipient of the service for benefit, it will be a passive participation.
- Take part in activities by providing resources to the project in the form of free labour, land, other resources contribution. Still they are not the ones who decide how to participate.
- Take part in implementing the programme and have some managerial responsibilities, they decide how the activities are run but not which activities.
- Participation in monitoring and evaluation, here people participate in monitoring the progress of the activities but still not the extent of participation.
- Participation as a planner, here the people participate in the planning process. These are mainly community leaders, teachers who can decide which project or programme to implement and can negotiate with the government to provide the required human and other resources.

Not many studies about community participation in health explore an individual actor's involvement. However, a systematic review of the studies of community participation in health from developing countries by McCoy et al. (2012) suggests that the participation of actors can be seen from various perspectives such as, their role in governance, management, resource generation, as an outreach service provider, as an advocate, as an advisor and as a social leveller. Still this review did not explore how different actors participated with one or more roles as listed above in any intervention as tracer and how their social, political, hierarchical and power played any role or not.

2.7.2 Community participation in PHC in Nepal

After the declaration of Alma Ata (WHO, 1978) most of the developing countries followed the PHC approach prioritizing community participation. Nepal was one of those at the forefront to

take this approach forward (Dixit, 1995). There have been some studies in Nepal in community participation mainly in rural development (Bista, 1999), forestry (Lama and Buchy, 2002, Nepal, 2006), agriculture and some in health (Stone, 1986, Sepehri and Pettigrew, 1996). However, I found that there are a limited number of studies in PHC on how participation really works, how various actors interact especially at the community level. Despite the government promoting for community participation in PHC, the limited studies in Nepal in this discipline do not give a clear concept of various aspects of community participation. For example, Oswald (1983) studied traditional healers' participation in delivering some components of PHC in Nepal. He acknowledges that there has always been debate about traditional healers' role in improving the PHC service in Nepal but at the same time claims that involving traditional healers in TB and Leprosy treatment showed that their participation brought a considerable increase in people using the PHC service.

Sepehri and Pettigrew (1996) studied community participation in PHC in two hill villages of Western Nepal. They suggested that the level of community participation was low there. They claim that over 90% of the population even did not know of the existence of Health Facility Management Committees. Most of the members of the committee did not know what their role was and some admitted that they do not go to the meetings since they were in the committee just for the social prestige. Village health workers were inactive and only 19% of the respondents noticed their presence. Health volunteers were partially functioning but since they were female they had limited influence in their community due to social, cultural and gender biases. They further reported that participation was low because of heterogeneous socio cultural hierarchy in the community, for example, caste, kinship, ethnicity, gender-bias and wealth differences. However, possible limitations of this study are that the stratified sampling might have missed important participants and there was no enquiry about whether the participants understood about PHC, community participation and actors or not. Furthermore, since the study was about community drug scheme, the participation was heavily influenced because of cost of the medicine the villagers had to pay; this might have compromised their view about their participation in PHC.

In a study of health systems in Kaski district of Nepal Bichmann and Chaulagai (1999) highlight that at every level there was a health committee i.e. at district, VDC and ward level who were responsible for ensuring people's participation in PHC through community leaders. They used Rifkin et al.'s (1988) framework to assess the level of participation of different actors in needs

assessment, leadership, organization, resource mobilization and management as various domains of participation. They found that the committees' activities were limited and in most cases they were not functioning. Neither committee members/leaders nor the people were clear about community participation. The common understanding by health professionals about community participation was that communities should be contributing resources rather than involved in decision-making processes. They concluded that there was low community participation due to social structure, people's suspicion about participation, suppression of community initiatives by elites and superiority shown by the health professionals over community people.

Though these studies shed some light on community participation in PHC in Nepal they do not give an in depth insight into how the participation process works. They do not answer whether it was initiated by policy makers, elite health workers, village elites and imposed to the community (top down) or initiated by the community. Neither do these studies tell us whether they are built on existing social cultural practices (bottom up) nor how various ethnic groups, women and traditional healers perceived it. Furthermore, since then the situation in Nepal has changed socially, politically and from access point of view significantly there is a further need to explore more about community participation in PHC.

2.7.3 Motivations and barriers to participation

Motivation is defined as the reason for doing something voluntarily (Zimmerman and Rappaport, 1988). Locke and Latham (2004 Page 388) defined motivation as "*...motivation refers to internal factors that impel action and to external factors that can act as inducements to action*". It represents motives for people's desires, needs and actions to do something. Furthermore, Vroom (1964 Page 7) defined motivation as "*A process governing choices made by persons among alternative forms of voluntary activity*". People are motivated to do certain things for some specific reasons.

Financial incentive, social recognition and religious merits are some of the motivations for participation in PHC. Whereas inadequate knowledge, perceived gender role and power relationships are some of the barriers to participation (Atkinson et al., 2011). Similarly, other barriers to participation are lack of support from policy makers, poverty and social norms (Owusu, 2011). Lack of mechanism to feedback local concerns to higher level mechanism is another barrier to participation for local actors (Levers et al., 2007).

Participation of various Health System Actors in PHC depends on actors' economic status, social-cultural norms, social value systems and cultural beliefs. Similarly, actors' class, caste, language spoken by them and their ethnicity affects their participation. Furthermore, their means of communication, expectations, conflict of interest, leadership, formalities and social divisions significantly affect their participation in any activities including PHC. These factors along with other context specific factors, for example, social institutions, education, awareness, motivation, social boundaries and distance affect people's participation in PHC and their relationship with other actors in the system. This research will explore how these and other factors present in the study area affect Health System Actors' participation in PHC and their interactions.

2.8 Gaps and Implications

From this review, it is established that community participation is present in most of the policies, programmes and projects related to PHC and it is suggested as one of the key components of PHC. Furthermore, PHC is still taken as one of the means to provide basic health care services to people residing especially in developing countries. Especially since the Alma Ata Declaration (WHO, 1978) PHC and community participation have been key components of health systems and PHC is even treated as a health system in its own right (CSDH, 2008, Bhatia and Rifkin, 2010). Nepal has followed a PHC approach with community participation since Alma Ata 1978 and it is still committed to it. However, very little is known regarding the extent to which such processes are occurring. There have been some studies about community participation in PHC in Nepal but most of these were completed in the 1980s and 90s and mainly show outsiders' perspectives about community participation and are of evaluative nature. Since the social, cultural and political situation in Nepal has considerably changed in last few years and the Government of Nepal has renewed its commitment to PHC through signing in to the revitalization of PHC (Rijal, 2013), it is important to understand current Health System Actors and their participation in PHC to understand PHC in Nepal.

Therefore, this research plans to fill this gap by systematically investigating participation in PHC in a real world setting by exploring how various Health System Actors perceive PHC, their participation in it, and their relationships with each other. This study will also explore about what motivates and hinders their participation in PHC in Nepal.

2.8.1 What is already known about this topic?

This review establishes that PHC is a part of health systems with community participation as one of the key component. Furthermore, it establishes that Health System Actors are the main part of health system so it is essential and important to understand these actors' participation in PHC and their relationship with each other to understand the PHC and the health system. At the same time this review reveals that the PHC is interpreted differently in different contexts. For example PHC system, PHC approach, PHC services and PHC setting. Therefore, for this research PHC is considered a holistic approach including both modern and traditional approaches of health care within geographical and social space of Hagam and Fulpingkot VDCs of Sindhupalchok district in Nepal. Similarly, the geographical and social spaces of these two VDCs are the setting for this study. The PHC in Hagam and Fulpingkot VDCs are selected as case studies for this research.

2.8.2 What will this study add?

Most of the studies in this area have been from an outsiders' perspective and more of an evaluative nature from researcher's perspective. Since I have been involved in this area from a long time and being a Nepali I hope this research presents more insiders' perspective. This research systematically investigates the perceptions of PHC and community participation by exploring health systems actors' perspective and participation in PHC, their role in it, their relationship with each other in the participation process and facilitators and barriers to participate. This study presents what the actors understand about and how they perceive PHC and CP, how they participate in the process, what is their relationship with each other, what are their roles in the process and what facilitates or hinders their participation in PHC. This study will present these from actors' own perspective. This study used the qualitative case study approach, used semi-structured interview, focus groups discussion and observation as data collection tools and employed thematic approach to analyse the data.

The main research question and sub questions formulated in section 1.4 are restated again as:

Main question:

How do government actors, nongovernment actors, community members, and other Health System Actors participate in PHC?

Sub-questions to explore answers for above main question:

#1 Who are the actors in the proposed research setting in Nepal?

#2 What are the roles of these actors in Primary Health Care?

#3 What do these actors understand by PHC, CP and health systems actors?

#4 What is the relationship between different actors?

#5 What are the motivations and barriers to participate in PHC for health systems actors?

In chapter three I will present my methodological approaches of this study.

CHAPTER THREE

Methodological Approach

This chapter outlines the design, methods and analysis procedure employed in this research. It provides my rationale for choosing qualitative research methodology and a case study approach. It then describes the inclusion criteria for sampling, data collection, data management and analysis procedures. Furthermore it describes the, ethical consideration and limitations of methods chosen.

3.1 Philosophical basis for this research

Terre Blanche and Durrheim (2007) suggest that the positivist paradigm is suitable for quantitative research in finding answers for what, how much or finding causal relationships that are often formulated for hypothesis testing and answered by numbers. Interpretivist paradigm assumes that the world and knowledge are generated through people's social and contextual understanding (ontology) and the way we understand what we understand (epistemology) by using qualitative methods, for example, narrative, interviews, observations, ethnography, case study/studies or phenomenology. The interpretivist paradigm often answers why and how questions rather than what, when and how much questions. Furthermore, interpretivist paradigm assumes the existence of multiple realities to be studied from inside the system letting the data explain the meanings through inductive approach (Given, 2008). In health systems research where it is important to understand effectiveness of service, intervention, policy and phenomena it is important to understand what works in different contexts and how it works. A constructionist paradigm assumes that knowledge is not given but is created and negotiated (Legard et al., 2003). This approach assumes that individuals seek meanings of the world they live and work. These meanings are formed through interaction with each other focusing on the constantly changing context where actors live so the participants construct it for their particular situation (Creswell, 2009).

3.2 Epistemology

This research recognizes that there are multiple realities and multiple truths about health system in the community (Gilson et al., 2011). The implication is that the government health workers' perspective of PHC is different from that of shamans, traditional healers, families and other actors and the same applies regarding their perspective about participation and

interaction. Similarly, different actors have their own perspective about illness, treatment, childbirth, their participation in these processes which have been presented in detail in chapter 4 onward. Both modern and traditional approach of PHC are taken as means of studying different aspects of community participation so that views of all the actors present in the community could be represented in this study.

I followed the constructionist – interpretivist approach of interpreting participant's own meanings and used a qualitative inductive approach to data analysis (Bryman, 2004, Thomas, 2006, TerreBlanche and Durrheim, 2007). Here the interpretivist approach stresses understanding of the social world by interpreting it as the participants would do and the constructionist approach suggests that social properties are outcomes of the relationship between different individuals (Bryman, 2004). Furthermore, the constructionist approach emphasizes socially constructed nature of reality and assumes that there are multiple realities and they are continuously changing (Given, 2008). This research is guided by the constructionist view that the knowledge is not discovered but constructed by the perspectives of the actors involved. Following this approach I observed what is happening in terms of CP in PHC naturally in the field (Guba and Lincoln, 1994, Patton, 2002). I did not go to the field with any rigid theory and hypothesis as such but only with an idea what subject to look at. However, I gathered general idea of possible actors present in the field from my literature review and my own experience as an implementer of a PHC programme in Nepal which helped me to decide on sampling and data collection. This further helped me to elucidate the phenomena, concepts and ideas emerging from my research.

Since this study aims to explore in-depth understanding of how various Health System Actors participate in PHC at the local level, a case study approach was applied for this research, which I have described in detail in section 3.4.2.2. It explored how different socio-cultural norms, power, gender, religion, caste, economic status, social status, affiliations, legislation, value systems, internal conflicts and power played a role in their perspectives of PHC, their participation in it and their relationship with each other. I started out planning to explore MCH but later found that this would miss important aspects of PHC so I expanded the focus to PHC as a whole.

3.3 Research paradigms:

Kuhn(1970) defined research paradigm as

"accepted model or pattern" and further elaborated "...the paradigm functions by permitting the replication of examples any one of which could in principle serve to replace it. In a science, on the other hand, a paradigm is rarely an object for replication. Instead, like an accepted judicial decision in the common law, it is an object for further articulation and specification under new or more stringent conditions"(Kuhn, 1970:23).

Paradigms are systems of understanding based on the questions they consider and methods they follow (TerreBlanche and Durrheim, 2007). Furthermore, paradigms are the interrelated practice and thinking that define the nature of enquiry along with ontology, epistemology and methodology. Here ontology informs the nature of the reality and what can be known about it, epistemology guides what is the nature of the knowledge and where the knowledge is to be sought and methodology specifies the way the researchers to explore whatever it is believed can be known about it (Tuli, 2011). In other words, paradigm is a worldview, a general perspective and a way of breaking down the complexity of the real world (Patton, 2002). Paradigm defines how the world works, how the knowledge is extracted and how to use this knowledge. Paradigm, ontology, and epistemology and broadly the methodologies are sometimes used interchangeably with worldview. TerreBlanche and Durrheim(2007) elaborated the concept in a matrix form with dimensions vs paradigms, which is presented in table 3.1:

Table 3.1: Research paradigms

Paradigm	Ontology	Epistemology	Methodology
Positivist	Stable external reality Law like	Objective Detached observer	Experimental Qualitative Hypothesis testing
Interpretive	Internal reality of subjective experience	Empathetic Observer subjectivity	Interactional Interpretation Qualitative
Constructionist	Socially constructed reality Discourse Power	Suspicious Political Observer constructing versions	Deconstruction Textual analysis Discourse analysis

Source: TerreBlanche and Durrheim (2007)

Since this research is about understanding the perspective of different health systems actors in PHC, their participation in this programme and their interaction in this process an interpretive – constructionist paradigm is followed. Ontologically these paradigms suggest that reality is socially constructed and is within the participants' lived experiences, which is exactly what this research aimed to understand within these actors' natural setting from their own experiences, as understood by them (Elliott and Timulak, 2005). This was approached by using qualitative methodology which enabled the participants to construct meanings and knowledge of their realities themselves (Tuli, 2011).

3.3.1 Paradigm guiding this research:

In line with an interpretivist – constructivist paradigm I am using a case study design that includes a range of qualitative methods to allow participants to give their accounts of events and allows me to observe and interpret the influences on CP in PHC. This paradigm does not aim to uncover "truths" but explores how understanding on PHC, CP and Health System Actors are socially constructed. This approach often follows inductive reasoning by looking into patterns and associations generated from the real world and strongly focuses on interpretation and description (Snape and Spencer, 2003).

3.3.1.1 Qualitative research

Qualitative research is a process of generating knowledge about people, society, behaviour, human problems or phenomena through building a complex, holistic picture by analysing experiences, words, and views of informants through research in their own natural setting without disturbing the site any more than necessary (Creswell, 1994, Bassett, 2004, Creswell et al., 2007, Creswell, 2009). Qualitative research deals with talk or words rather than numbers by seeking answers for "what" and "how" questions rather than asking questions, for example, "how large" and "how many" as in quantitative research. It aims to interpret social phenomena, for example, interactions, relationships and behaviours based on the meanings people place on them and often by deconstructing the researcher's perspective as well as the researcher's own ideas, emphasizing and looking into the multiple realities from people's perspectives (Pope and Mays, 2006, Given, 2008, Dongre et al., 2010). Qualitative research uses various methods and materials, for example, case studies, interviews, personal experiences, biographies, artefacts, historical texts, observational records and videos which

describe personal experiences to study and interpret the phenomena under study (Denzin and Lincoln, 2011).

Furthermore, qualitative research is not a linear process, it is rather a recursive process that starts right from the beginning of research and needs many iterative steps in each stage of research i.e. research questions, research design, data collection, data analysis and interpretation of the result (Stake, 1995, Thomas, 2011). The iterative process involves comparing the responses of various participants with the research questions until saturation is obtained. Similarly, in data analysis and interpretation of findings going back and forth to the findings and data is necessary to ensure that conclusions are valid.

Patton (2002) suggested three broad characteristics of qualitative research based on design, data collection and field work and analysis strategies. Those are:

“rigorous methods for doing fieldwork that yield high-quality data that are systematically analysed with attention to issues of credibility.

the *credibility of the researcher*, which is dependent on training, experience, track record, status, and presentation of self; and

philosophical belief in the value of qualitative inquiry, that is, a fundamental appreciation of naturalistic inquiry, qualitative methods, inductive analysis, purposeful sampling, and holistic thinking” Patton (2002, Page 584).

This research followed naturalistic inquiry. *“Naturalistic inquiry happens in the setting where the phenomena naturally occur”* (Given, 2008). It assumes that there are multiple realities based on people's relationship with each other and their context and the researcher does not manipulate the findings (Patton, 2002). It explored the Health System Actors' perspective in PHC and their participation in it. As for the data collection and fieldwork strategy a rich detailed data was collected by conducting semi-structured interviews and focus group discussions with purposively selected Health System Actors, observation and field diary. It followed inductive analysis and creative synthesis which is a combination of smaller simple elements of knowledge to form a more complex whole by immersing into details to generate patterns, themes and interrelationships to understand whole phenomena of actors' participation. A qualitative case study approach was employed for this study that I have described in the following section.

3.3.1.2 Case study approach:

Case study is a research approach for the analysis of people, groups, events, phenomena, projects, institutions or systems to see them from multiple perspectives with the help of one or more methods of inquiry (Stake, 2005, Thomas, 2011). Robert Yin (2009) defines case study as a process of an in-depth empirical study that investigates contemporary phenomena in their natural setting where boundaries between context and phenomena are not clear. Case study methods are best suited when the research is about the phenomenon and have the following three characteristics (Hancock and Algozzine, 2006). Firstly the research seeks answers for what, how and why questions that needs rich descriptions and insightful explanations. Secondly, this method is appropriate when the study is in real world natural setting, i.e. the context is equally important and thirdly when the research is more of exploratory nature than confirmatory. Furthermore, this approach of inquiry is used for developing in-depth analysis of single or multiple cases by studying multiple documents, interviewing people, observation and studying physical artefacts. In-depth study of the studied cases or case is presented by descriptions of the themes emerging from the study (Creswell et al., 2007). Both qualitative as well as quantitative data collection methods can be used in case study approach which can be described as explanatory, descriptive, exploratory, holistic or embedded and the cases can be single cases or multiple cases (Yin, 2009). The details of case study approach have been presented in Figure 3.2 below.

Table 3.2: Case study approach

Subject	Purpose	Approach	Process
Special or outlier case Key case Local knowledge case			
	Intrinsic Instrumental Evaluative Explanatory Exploratory		
		Testing a theory Building a theory Drawing a picture, illustrative Descriptive Interpretative Experimental	
			Single or multiple Nested Parallel Sequential Retrospective Snapshot Diachronic

Source: Thomas (2011)

Since one group of actors affect another group's participation and relationship the nested case study approach is used for this study. A nested case study approach is different from the multiple case study approach in the sense that several case studies are part of a greater whole which in itself is a case study (Thomas, 2011). For this research, the study of Health System Actors' participation in PHC is a single case but imbedded within are cases of various Health System Actors' participation and their relationship. As each group is composed of different individuals and some of the individuals are affiliated with different organizations these can be considered as cases within cases.

I used a case study approach to explore and contrast CP in PHC in two VDCs of Sindhupalchok district. Each of which was dealt with as one case for analysis. I have explored, compared and contrasted CP in PHC in Hagam and Fulpingkot VDCs.

3.4 Background, context, study location and study population

Nepal is a mountainous country bordered by China in north and India in other three sides (figure 1). The area of the country is 141,181 sq km and has a population of 2,64,94,504 (Nepal CBS, 2012). Nepal is divided into 5 development regions, 14 Zones and 75 districts. There are 3276 VDCs and 191 municipalities (MoFALD, 2015) in 75 districts of Nepal. Each VDC is divided into 9 wards, which is true for all the VDCs in Nepal. Currently the average life expectancy is 71 years for female and 68 for male (WHO, 2015b). The literacy rate is 75%. There are 125 caste/ethnic groups and 123 languages and dialects spoken in Nepal (CBS-Nepal, 2013, CBS-Nepal, 2014). There are three major ecological regions. They are mountains (3000 metre to 8848 metres), Hills (1000 to 3000 metres) and Terai (lower than 1000m) (CBS-Nepal, 2013). Currently 95 public hospitals, 25 Primary Health Centres (PHCs), 676 Health Posts (HPs), 3129 Sub-health Posts (SHPs), 12790 Out Reach Clinics (ORCs), 16579 Expanded Programme on Immunization Clinics (EPIs), 445 Nongovernmental Organization (NGO) run health clinics and 315 private health institutions are providing health care services to this population in Nepal (MoHP-Nepal, 2012).

Sindhupalchok district lies in the North Eastern Part of Nepal bordering Kathmandu, Kavrepalanchok, Rasuwa, Nuwakot, Dolakha districts of Nepal and Tibet (figure 2). Hagam and Fulpingkot VDCs can be reached by 4 to 5 hours bus ride from Kathmandu the capital city of

Nepal plus 4 hours and 2 hours walking respectively from the nearest road head. More detailed account of these two VDCs is presented in sections 3.4.1 and 3.4.2.

I selected this area because it broadly represents the characteristics of other VDCs in Nepal especially in terms of combination of Health System Actors, ethnic groups, changing accessibility for road access, political changes and communication access. Furthermore, I have been involved in the area through a NGO PHASE Nepal for which I work, therefore I knew most of the participants that made access easy and helped to get rigorous data for this research. To minimize the limitation I clarified my participants the importance of this research and its independency from my work, which has been further discussed in sections 3.5 and 3.13.3.

Figure 3.1: Map of Nepal (Study district Sindhupalchok highlighted)

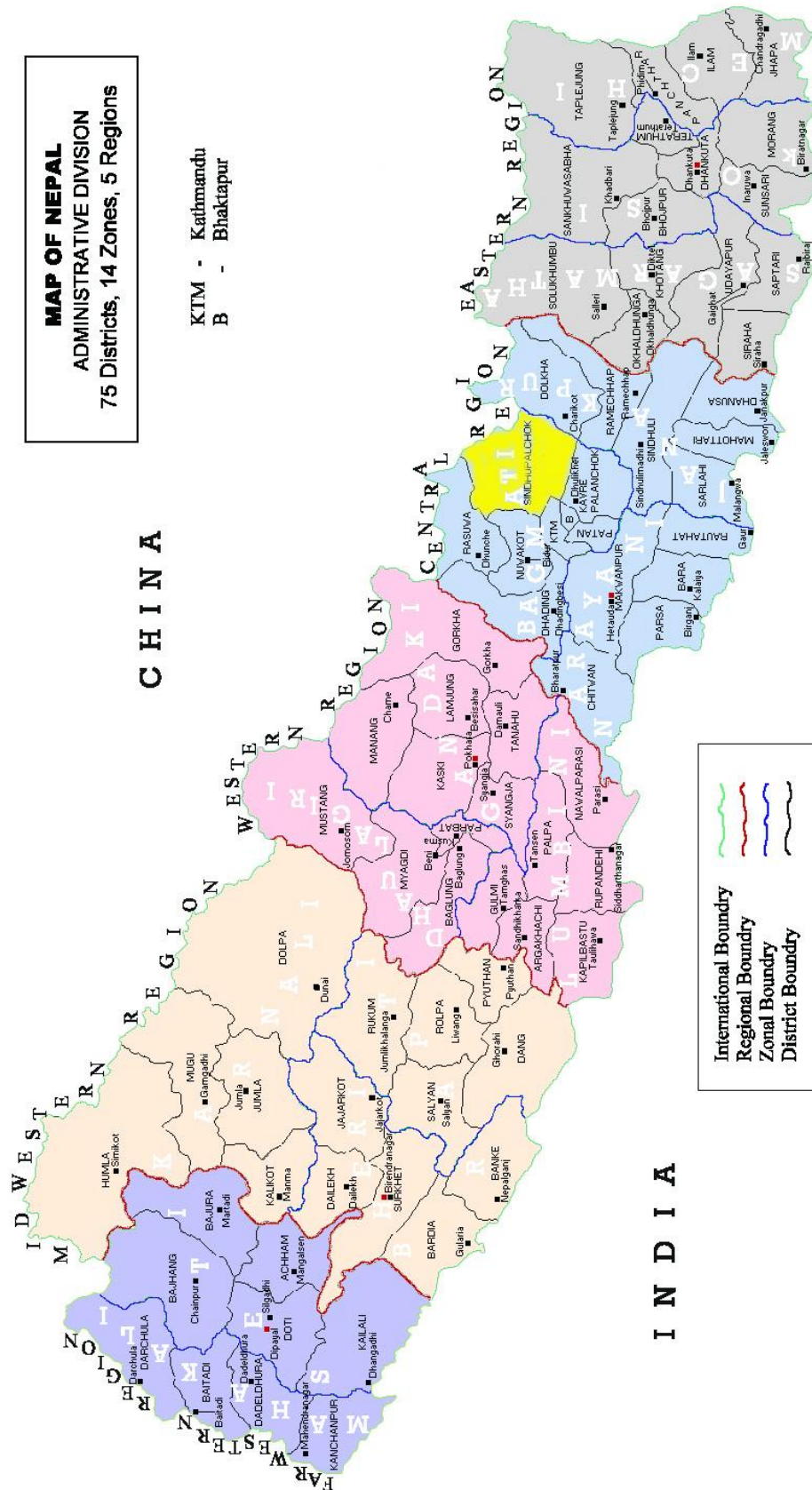
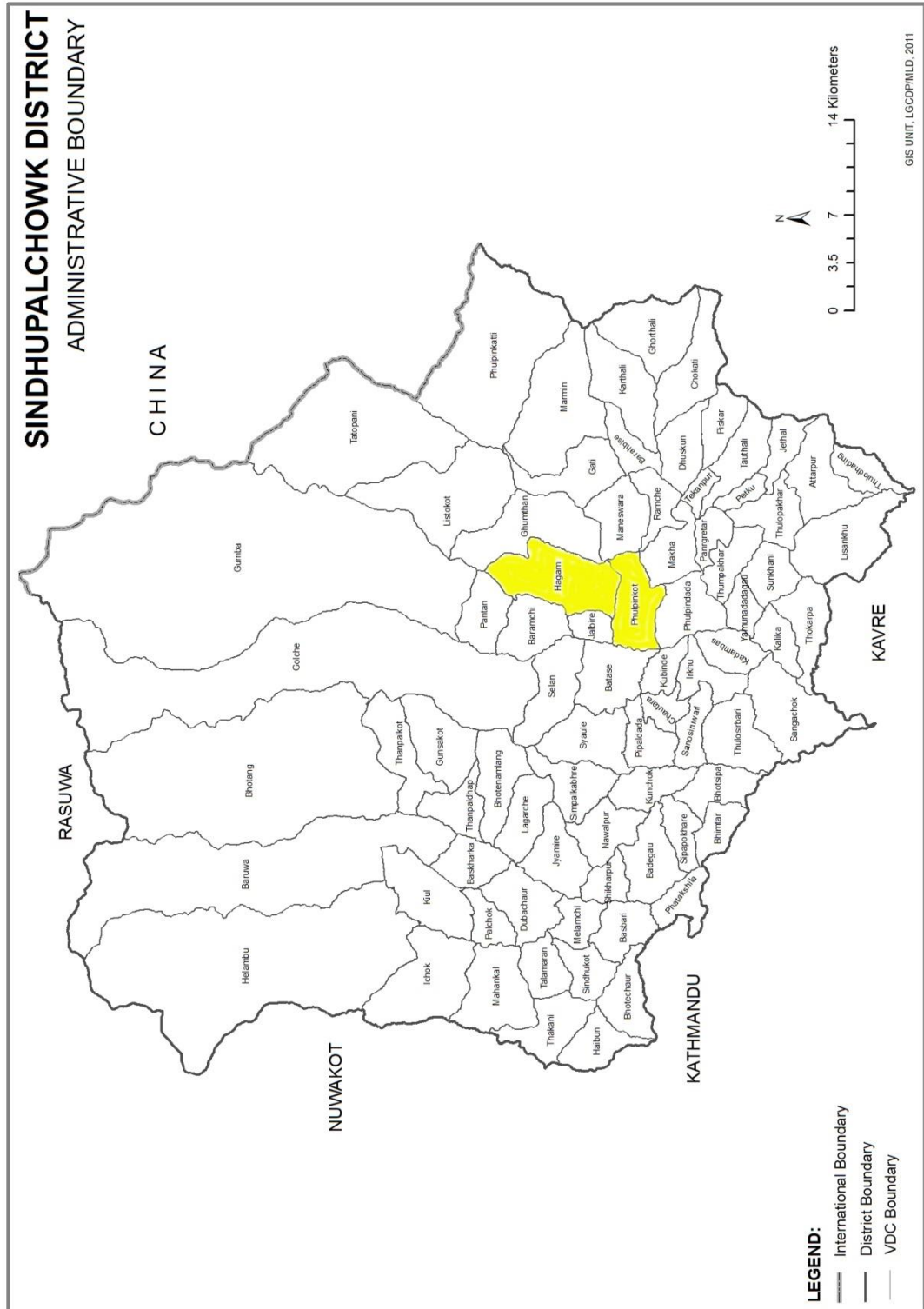


Figure 3.2: Map of Sindhupalchowk district (Study VDCs Hagam and Fulpingkot highlighted)



3.4.1 Hagam VDC

Hagam VDC is one of the 79 VDCs of Sindhupalchok district and it is about 90 km away from Kathmandu. This VDC is part of hilly region with sub-tropical climate with altitude ranging from about 1400 metres to 2400 metres. This VDC has 818 households with 3847 people (Nepal CBS, 2012) living there. Understandings of personal health, hygiene and sanitation are relatively low in this VDC. Drinking water supply system is still primitive and inadequate and so is the sanitation situation. It is because of the scarcity of drinking water sources and interconnected households. This makes it difficult to maintain the cleanliness and personal hygiene. In addition to this, villagers keep domestic animals within their compound and often keep small animals, for example, goats, pigs and chickens inside their houses. This makes them and consequently the villagers more vulnerable to vector borne diseases.

There are eight small villages of 50 to 70 households each and a big village with about 350 households in this VDC. It takes up to eight to ten hours to walk from one end of the VDC to another end and there are no road connecting between them. There is one VDC office, one sub-health post, one secondary school and seven primary schools in this VDC. Drinking water facility is poor in all of the villages, for example in some villages one small spring is serving over 100 households where people line up to fill up their water buckets. This accelerates the sanitation problem even if people want to maintain proper cleanliness and hygiene. Since the villages are very scattered it makes it difficult for people to use the health services and to send their children to the secondary school. There is one regular health clinic established by PHASE Nepal and runs occasional Out Reach Clinics (ORCs) in different villages with bigger populations. However, there is a sustainability issue about this clinic because the NGOs often phase out their projects after some time because of their funding limitations.

The population composition in Hagam is Tamang (71.8%), Chhetri (0.6%), Newar (19.2%), Kami (8.1%) and others (0.3%) whereas in Fulpingkot it is Brahmin (11.7%), Chhetri (28.2%), Tamang (39.1%), Magar (1.2%), Newar (7.1%), Kami (3.8%), Gurung (1.1%), Gharti (1.4%), Damai (1.4%), Thakuri (0.7%), Majhi (2.1%), Sarki (2.1%) and others (0.3%) (Nepal, 2012). Most of the Tamangs follow Buddhism whereas some Tamangs, Newars, Kamis and others follow Hinduism as their religion. There are some newly converted Christians in the village, who are mostly Dalits and some Tamangs. The attraction for conversion into Christianity is a belief that Christianity does not follow a caste system. However, this did not seem to work in both Hagam and Fulpingkot VDCs because majority of the villagers still follow Hindu ideology which

supports caste system even if they follow Buddhism and Christianity, hence caste based discrimination is still prevalent in both VDCs.

Tamangs and Newars have their own languages whereas others speak Nepali (the national language) which is understood by most of the villagers including Tamangs and Newars, except some elderly women. Most of the people are still engaged in subsistence farming but recently the younger males and females from most of the households go abroad including Middle East, Malaysia and India for wage labour. Some of the villagers who cannot afford to go abroad to work go to Tibet, Kathmandu and other cities of Nepal for work. Recently a fair weather road has been constructed which connects Hagam with other parts of the district and Kathmandu but it is very rudimentary and dangerous. There is a micro hydropower project under construction in Hagam which has created some employment opportunity in this village. Road access and increased income has increased people's access to health care services to some extent.

Similar to most of the remote villages of Nepal this village also had its share of problems and suffering from decade long Maoist insurgency in Nepal that lasted from 1996 to 2006 (Singh, 2004). This insurgency destroyed then VDC building and significantly stagnated various development processes in this VDC. Despite various problems the Maoist insurgency provoked, it increased people's political and social awareness level (Manchanda, 2004, Muni, 2010). Because of which the discrimination against caste, economic status and gender has been decreased to some extent. For example: caste-based discrimination is less in public places and it is socially recognized as inhumane.

There are three private medicine shops in this VDC; two are in the biggest village where PHASE Nepal runs its clinic and another nearby the government sub-health post. These two villages are at half an hour's walking distance from each other. These shops sell medicines which are not available in the government sub-health post and the PHASE Nepal clinic. In each ward, there is one FCHV, one or two mothers' groups, few traditional healers and some herbal medicine practitioners. At the time of study, there were 17 traditional healers in ward 6, 7 and 8 of Hagam VDC and two to three in each of other wards. Most of the traditional healers are Tamangs; few are Vishwokarmas (Dalits) and none from Newars whereas two of the health workers are Newars and one from Tamang and none from the Vishwokarmas.

3.4.2 Fulpingkot VDC

Fulpingkot VDC lies in the south of Hagam VDC and is relatively more accessible from the road compared to Hagam. There are 3815 people living in 904 households in this VDC (Nepal, 2012). The population is composed of Brahmins, Chhetris, Ethnic groups (Tamangs, Newars) and Dalits (Bishwokarmas). The population composition of this VDC is more heterogeneous compared to that of Hagam. There are 11 small villages each of 40 to 50 households and other households are quite spread from each other. Tamangs live at the higher part of the VDC and others at the lower part. Schools, water supply and other physical facilities are centred around central and lower part of the VDC where Chhetris, Brahmins and Newars live compared to the upper part of the VDC where majority of residents are Tamangs.

People in the lower part of the VDC especially Brahmin, Chhetries and Newars are relatively more educated than the Tamangs at the upper part. Similarly, the health and hygiene situation in Tamangs and Dalit settlements are worse compared to other settlements. Similar to Hagam VDC the animals are kept within the household compound and small animals and chickens are kept inside the houses, which makes it difficult to maintain good sanitation and hygiene. This is more common in Tamang and Dalit (untouchable) households compared to Brahmin / Chhetri households.

There are three secondary schools, five primary schools, one sub-health post and one VDC office in this VDC. The secondary schools are in the main settlements and both the sub-health post and VDC office are relatively centrally located but still at a distance of about 4-5 hours walk away for mainly two villages Chilaune and Okhrini. People from Chilaune access the health and other services from neighbouring VDCs Mankha, Pangretar and Fulpingdanda but people from Okhrini do not have such access, which limits their access to various services including the essential health care services. Access to facilities, for example, health, education, market and transport decreases as the altitude increases in Fulpingkot VDC.

There is an Out Reach Health Clinic run by PHASE Nepal in upper part of the VDC which provides health services to surrounding villages which mainly houses Tamangs. There are no private clinics in this VDC but majority of the population especially those in the lower part of the VDC visit private health service providers in nearby market places in Jalbire, Khadichaur, Balefi and Kathmandu. There are more traditional healers in Tamang communities compared to Brahmin / Chhetri communities. Use of the modern Western medical services is more

common among Brahmin/Chhetris community and so is the knowledge about it. Similar to other VDCs in Nepal one or two members from each household from this VDC are either working abroad or in some cities within Nepal, Tibet or India. Still the majority of the population who are still living there are engaged in subsistence agriculture but some of them are engaged in it commercially as well.

This VDC also had its share of suffering from decade long Maoist insurgency. Because of which the VDC building was destroyed, the health service was stopped and over a dozen people were displaced from this VDC either because of them joining the insurgency or by running away from it.

This area is rapidly changing socially, economically and culturally and so are people's understanding and expectations for various government services. Because of the political conflict, change of power structures, lack of locally elected body of representatives and volatile political situation, uncertainty are common phenomena in both of these VDCs. Especially during the period of Maoist insurgency the power dynamics changed, which has brought some positive change in expression of the voices of oppressed groups. Having said that, there are still groups of people from different age groups, castes and ethnic groups who still have less voice than others. This is a common phenomenon all over Nepal so from this point of view this area is a representative area. To ensure their voices in this research I have included these excluded groups of people, for example, women, Dalits and the elderly in the study as much as possible.

It is a striking feature of the Nepalese health system that at the lowest level of the health system i.e. at the VDC level; all 3,376 VDCs (MoFALD, 2015) of Nepal have the same formal health system structure. However, even though similar formal and informal Health System Actors might be present in each VDC all across the country the context is different. Therefore, a complete generalization of the findings from studies from these two VDCs is not possible, rather understanding the mechanism of work in this particular context allows to understand whether these hold true in different contexts or not. This way it can be generalized to some extent to similar cases, situations and contexts with sufficient essential similarities as a naturalistic generalization (Stake, 1978) but still cannot be fully replicated.

Though the formal health system structure and actors are similar in each VDC all over Nepal, I am aware that because of diverse social, economic, cultural, caste, religion, political context and geographical and social accessibility the actors' participation in PHC and their relationship among various actors found from this study will vary from other VDCs in Nepal. Even though the findings from this research present a general view about health systems actors' participation in PHC for most of the VDCs in Nepal, it does not represent the exact situation of all VDCs of Nepal other than the above two VDCs. Therefore, transferability and adaptability of the findings from this research needs a careful comparison and extrapolation as suggested by Patton (2002).

3.4.3 Recent earthquakes in Nepal and its implication on this research.

There was a devastating earthquake on 25th April 2015 followed by similar one on 12th May 2015 in Nepal. It was after my data collection but I managed to return to the field for few weeks after the earthquake. The earthquake destroyed 605245 houses and damaged 288,255 houses beyond repair in 14 districts of Nepal and killed 8891 people (confirmed deaths). A total of 3057 deaths were from Sindhupalchok. Over 90% of the houses in both Hagam and Fulpinkot VDCs were destroyed including 21 schools and two sub-health post buildings beyond repair. This has significantly affected people's life. There is an issue of access to health care since the earthquake has completely destroyed the existing health infrastructure, destroyed the equipment and supplies in both Hagam and Fulpinkot. The health workers are providing health services from temporary structures. The staff are living in tents with villagers. Some part of PHASE Nepal clinic buildings were still useable in both VDCs, therefore, the staff from PHASE Nepal were able to respond to the victims of the earthquake immediately and continue to provide the service regularly with the medicine and supplies salvaged from the rubble underneath.

During my visit after the earthquake, people in Hagam shared their experience of the earthquake that most of the social barriers fell for some time because of the earthquake. Rich and poor, higher caste and lower caste and educated and less educated suffered equally. Everybody worked together in rescuing, helping, shared whatever was left, cooked together and ate together. Many people were injured from the earthquake but there was shortage of medicine because most of the medicine was damaged, the health workers were traumatized and they had lost their own homes as well. All the villagers got together to address the immediate problems including those related to health care. They built a good relationship with

each other, helped each other and were motivated to help for each other's survival. Even though the social class, caste and hierarchy is returning, there are still feel of togetherness among the villagers. It seems the community spirit will continue for some time until full normality returns, if it ever returns. From this research findings point of view, more people are helping each other and sharing, therefore, their relationship is improving. Since almost all of the villagers lost everything, they are trying to address their needs individually rather than collectively, but for communal activities, for example, clearing the debris from the school compounds, repairing the footpaths, repairing the water supply community participation has been increased.

Even though I collected data for my PhD from these two VDCs before the recent earthquake and these information are based on my personal experience and encounters, this is an important event worth mentioning here. As explained above this earthquake has destroyed the entire health infrastructure and has shaken everybody's confidence in these VDCs. Therefore, as every major event in Nepal, for example, the recent political changes have affected the health system, there is high chance that this earthquake will also leave a footprint how people develop their health system further. Needless to say, because of the destruction everybody in the community needs to participate to restart their life and their health system locally.

3.4.4 Study population

The study population is the total number of a clearly defined class of relevant people, objects, places or events selected for the research purpose. Representatives from entire population of Hagam and Fulpingkot VDCs of Sindhupalchok district plus other health systems actors active in this VDC at the time of research was the study population for this research. Therefore, theoretically, the entire population plus other health systems actors active in these two VDCs are the study population for this study.

This research recognizes that the health systems in both of these VDCs are influenced by external offstage actors, for example, Health Post responsible for health services in these two VDCs, District Health Office, district and regional level political party leaders, development organizations working in the district and private hospitals in the district. Including these actors in this research was beyond the scope of this research because of time and resource limitation but their perceived role and influence was identified and documented where possible.

Though this research recognizes the differences, for the purpose of this research the terminologies stakeholders, participants, collaborators or actors are used synonymously. Similarly, the terminologies collaboration, participation, cooperation, involvement, coordination or interaction means participation for this study. Direct as well as indirect involvement of the actors are explored to achieve an in-depth understanding of health systems actors' participation in PHC.

3.4.5 Included population

This research included health systems actors present in Hagam and Fulpingkot VDCs of Sindhupalchok district as well as offstage actors. Offstage actors who were not physically present in the VDC but had a significant role in PHC in these two VDCs were also taken into consideration. These health systems actors were found during the data collection process. During the piloting of the data collection tools some of the actors were interviewed. Remaining actors were found through these participants and from 'gatekeepers' in both Hagam and Fulpingkot VDCs through snowballing. To ensure the participation of all major groups of actors I included at least one or two actors from each actors group I found. These included women, elderly, people from different caste and ethnicity, modern medical health workers, traditional healing practitioners and offstage actors where possible. I excluded the actors who were not present in the VDC at the time of study, highly politicized actors and highly religious actors.

To explore the participation of these actors in PHC, their relationship among these actors were analysed. Similarly the motivations and barriers to participation in PHC for these actors were analysed. Participation of different actors in PHC was assessed based on how frequently they were involved in different aspects of PHC other than accessing the available services. For example, whether they participated in VDC budget allocation for health or not, how different decisions were made, who managed the staff and the medicines. These aspects were compared between different actors and between two VDCs.

3.5 Researcher's positionality

The researcher's positionality is connected with power and resistance that influences the focus of research, its objective and the questions asked which affects not only access to the data and its quality but in the knowledge constructed as well (Walt et al., 2008). I have been involved in implementation of PHC programmes in partnership with government line agencies in Hagam

and Fulpinkot VDCs since 2006 and 2007 respectively. This has enabled me an easy access to some of the actors in the field to build trust and rapport which helped to get access to other actors and get in-depth information. At the same time I was aware that such past involvement in the project might have compromised the responses from the participants. To minimize the effect I used SSIs, FGDs and observation methods and clearly explained about my current positionality as a researcher. I explored the participants' perspective in this study but at the same time I brought out my perspective about the phenomena studied. Though most of the people in Hagam and Fulpinkot spoke Tamang language in their home, they understood and spoke Nepali language fluently. I used Nepali language to interview, for FGD and for communication. To communicate with those who did not understand Nepali I hired a local native Tamang-language-speaking female translator. She interviewed some of the female participant and accompanied me during my interview with some of the female participants who preferred to have another female present during my interviews. To ensure that her interview captured a true picture of participants' understanding about the interview questions we listened to audio immediately and she explained the responses.

3.6 Methods and methodology

The field study was conducted between February 2014 to July 2014 in Hagam and Fulpinkot VDCs of Sindhupalchok district. An ethical approval to conduct this research was obtained from Nepal Health Research Council (NHRC) in Nepal before data collection process was started (Appendix III).

3.6.1 Sample size and sampling procedure

The process of selecting a portion of the study population for the purpose of the research is known as sampling and the portion of the population selected for the study is called sample which ideally is representative of as many aspects of the population under study as possible (Presly, 1996). When the objective of the study is to get in-depth information about the phenomena or context random sampling is not an appropriate approach of sampling (Flyvbjerg, 2011). A theoretical sampling procedure was followed with outlining the best possible samples to start and other samples were selected by snowballing (Mays and Pope, 2000). I wanted to include representatives of all the actors who have role in PHC. Some of the obvious ones were the formal health workers, VDC personnel, traditional healers and village leaders, whom I wanted to include because they would give me rich information, these were my first choices.

Between 10 and 40 participants are regarded as acceptable sample sizes for a qualitative study (Mason, 2010).

Since this research needed rich information from different health systems actors, a purposive sampling (also known as a purposeful sampling) technique was used for this research. Purposeful sampling is a method of explicitly selecting information rich samples for in depth study of the topic under study (Patton, 2002, Green and Thorogood, 2013). Purposive sampling is a part of theoretical sampling (Coyne, 1997). The sample size is likely to be larger due to inclusion of sufficiently diverse characteristics and / or due to nesting of different groups of samples in one study (Ritchie et al., 2003). To do this, I followed stratified purposeful sampling with snowballing (Flick, 2008) because I wanted to select a representative sample from each actor groups with rich information. In this study I wanted the sample to represent a range of socio economic, power, ethnicity, caste and class differences, therefore I interviewed 41 participants before I found that no new information was being obtained i.e. I had achieved data saturation. Similarly, seven, seven, eight and ten participants were included in four FGDs respectively. Participants with possibility of having rich information about PHC and CP and representing certain actors groups were approached with the help of village leaders, FCHVs, health workers and teachers as appropriate for both interviews as well as the FGDs.

3.6.2 Socio demographic details of Interview participants

Seven semi-structured interviews were piloted in Ryale VDC of Kavrepalanchok district before 41 main semi structured interviews and four focus group discussions were conducted in Hagam and Fulpinkot VDCs of Sindhupalchok district. Twenty-five male and 16 females were interviewed as different actors in main study. Among these actors, seventeen were from ethnic group Tamang, twelve Chhetries, five Vishwokarmas (so called untouchable caste also called Dalit), four Brahmins and three Newars. There are some other offstage actors, for example, Department of Health Services, District Health Office (DHO), District Development Committee (DDC) and District Administration Office (DAO) who have role in PHC but are beyond the scope of this research to analyse their participation in PHC. However I interviewed one Public Health Officer from district health office.

Table 3.3: List of Semi Structured Interview Participants:

Interview Number (#)	Participant Code	Gender	Age	Caste	VDC	Participant's main affiliation
1	VN550086	M	40	T	Hagam	Village leader, chair of many committees
2	VN550087	M	25	T	Hagam	Private medicine shop owner / health worker
3	VN550088	M	46	N	Hagam	Government Health worker, private medicine shop owner
4	VN550091	M	40	T	Hagam	VDC technical assistant, local leader
5	VN550092	M	47	T	Hagam	Political party leader
6	VN550093	M	40	T	Hagam	Political party leader
7	VN550095	M	35	T	Hagam	Businessman, chair of local health clinic management committee
8	VN550098	F	41	N	Hagam	Leader of women group, ordinary citizen
9	VN550103	M	27	V	Fulpingkot	Dalit, works in cooperative office, educated
10	VN550105	M	56	C	Fulpingkot	Teacher
11	VN550108	M	31	C	Fulpingkot	Teacher, local youth leader
12	VN550109	M	40	C	Fulpingkot	Sub-health post chair person
13	VN550110	M	47	C	Fulpingkot	Head teacher, secondary school
14	VN550112	M	35	N	Fulpingkot	VDC technical assistant
15	VN550120	F	29	B	Fulpingkot	Ordinary citizen
16	VN550127	F	27	V	Fulpingkot	Untouchable ordinary citizen
17	VN550130	F	28	C	Fulpingkot	Ordinary citizen, educated
18	VN550131	F	30	V	Fulpingkot	Teacher
19	VN550133	F	50	T	Hagam	FCHV
20	VN550135	F	45	T	Hagam	FCHV

21	VN550136	F	40	V	Hagam	FCHV
22	VN550140	F	41	V	Hagam	FCHV
23	VN550141	M	48	T	Hagam	Traditional healer
24	VN550142	M	25	T	Hagam	Teacher, ethnic leader
25	VN550145	M	41	T	Hagam	Government Health post helper
26	VN550147	N	38	B	Hagam	Teacher of secondary school
27	VN550151	F	32	T	Hagam	FCHV, well educated
28	VN550155	M	25	T	Fulpingkot	Traditional healer
29	VN550156	M	64	T	Fulpingkot	Traditional healer
30	VN550162	F	28	T	Fulpingkot	Ordinary citizen
31	VN550163	F	32	T	Fulpingkot	Teacher (interview assistant)
32	VN550166	F	51	C	Fulpingkot	FCHV
33	VN550167	M	62	C	Fulpingkot	Village leader, farmer
34	VN550168	M	65	B	Fulpingkot	Spiritual healer
35	VN550174	F	35	C	Fulpingkot	Women activist
36	VN550175	M	63	C	Fulpingkot	Ex-teacher, NC leader, cooperative advocate
37	VN550188	M	43	T	Hagam	Village leader, traditional healer
38	VN550190	M	48	C	Jalbire	Former VDC chair, political leader for the area that includes both Hagam and Fulpingkot
39	VN550191	F	42	C	Fulpingkot	MCHW
40	VN550193	F	36	C	Fulpingkot	Women activist
41	VN550194	M	33	B	DHO	District Health Office, Health officer

Table 3.4: List of Focus Group Discussion participants:

FGD #	FGD code	VDC	Description
1	VN550138	Hagam	FGD with selected male members of the community in Hagam
2	VN550144	Hagam	FGD with self-selected FCHVs in Hagam
3	VN550182	Fulpingkot	FGD with self-selected FCHVs in Fulpingkot
4	VN550192	Fulpingkot	FGD with selected male members of the community in Fulpingkot

3.6.3 Semi structured interviews

Interviews can be categorized as structured, unstructured and semi-structured interviews. Structured interviews are those where a standardised set of structured questions are asked and responses are ticked where as an unstructured interview resembles a conversation where the interviewer and interviewee might set an agenda for the discussion and the researcher listens and facilitates (Thomas, 2011). Whereas in unstructured interview there is a topic and some idea of what to ask but it is more flexible (Bryman, 2004, Gibson and Brown, 2009). However, this still has a list of topics or issues as interview guide but the sequence of conversation might differ from interview to interview (Given, 2008). In semi-structured interviews the interview schedule reminds the researcher of the issues to be discussed as well as potential questions, follow up questions and probes to encourage the interviewee for in-depth explanation and elaboration on the issue. Semi-structured interviews are conducted by asking open-ended questions to the interviewee initially, and based on the response; the researcher seeks elaboration by usual prompts, nods, encouragements and asking more questions to explore the topic more deeply (Britten, 2006). Therefore, an in-depth interview is a technique used to obtain interviewees' perspective on the research topic where they express their personal feelings, opinions and experiences of how they interpret the world (Milena et al., 2008). I used semi-structured interview technique because it allowed me to have a fairly clear guide to follow my research questions, was flexible to allow the participants to explain their understanding on the enquiry openly and allowed me to probe for further discussion about the topic.

Topic Guide

Initially I developed my interview and FGD schedule from my research questions which I had developed based on the gaps in my literature review. I piloted this schedule in the field and adjusted as appropriate. The interview and FGD schedules I used in the field have been attached in this thesis as appendix I and II.

Interview process

I followed the interview schedule sequentially, however sometimes I had to ask the questions out of order to maintain the flow of the conversation. Gradually as my interviews progressed it became clearer to me to probe at right time to get more information related to my research questions. On a few occasions the interviews became too long because the participants kept explaining their life experiences even if I probed them back to my research topic. Two participants, one traditional healer and cooperative worker finished interviews early. A villager called the traditional healer to treat his son and the cooperative worker had to leave for his family reason. There were some instances when the interviews were interrupted because of the phone call in participant's mobile phone, these were resumed after they finished their telephone conversation. In such situations, the context of the conversation were recapped before the interviews were resumed. I conducted all of my interviews in quiet places, often inside the participants' houses where possible with their consent for interview and recording.

3.6.4 Focus Group Discussion (FGD)

Focus Group Discussion is a group interview where several participants discuss on a tightly defined topic interacting with each other to construct a meaning on the topic (Bryman, 2004). FGD offers an opportunity to participants to express their perception, impression and thoughts about the topic of discussion in a group (Milena et al., 2008). FGD aims to generate valuable information on the topic expressed freely by the participants. Therefore, FGD is a data collection method explicitly using group interaction as part of the method by encouraging the participants to talk with each other, share experiences, exchange anecdotes and comment each other's views (Robinson, 1999, Barbour and Schostak, 2005). To avoid digression it is conducted in a fairly formal environment, i.e. the researcher facilitating the process asking a set of questions related to the intended inquiry (Fontana and Frey, 1994). It is an interview style designed for a small group to discuss a particular topic moderated by the researcher (Berg, 2001). This is a useful tool for exploring people's experiences and knowledge to examine their views and the reasons behind them (Kitzinger, 1995, Pope and Mays, 2006). It

allows the participants to explore group norms, values and the way they operate by opening the conversation even about delicate issues and to express their criticism in synergy to draw out themes which otherwise might be left underdeveloped in an interview (Kitzinger, 2006, Denzin and Lincoln, 2011). FGD provides an opportunity to observe the interactions of the participants at the same time getting the information on the issues under discussion (Morgan and Spanish, 1984). Number of participants in a FGD can be between 4 to 12, however the main consideration should be to have enough participants to have an useful discussion but not too many that leaves some of the shy ones not contributing in the discussion (van Teijlingen et al., 2013).

I shared my FGD schedule with the group at the start of the discussion. Discussion was started with general conversation, for example, how they are doing, how is the life in the village and seasonal work in the field. Then we started the discussion by asking questions where do they go if they have any health need, who decides where to go and who pays. This is followed by the discussion about the available health services, their participation and decision making processes. They discussed and debated on the benefit and difficulties of participation in PHC activities. We also discussed what motivates and discourages them from participation in PHC. Sometimes one of the participants probed themselves if the discussion diverted away from the health topic.

Sample

In this research, participation of a fair representation of actors from different ethnic groups, castes, social, economic and cultural groups and gender was ensured by purposively selecting participants for both semi-structured interviews and the FGDs. I ensured the inclusion of actors from different walk of life in my FGDs to ensure the involvement of those often unheard of. I conducted four FGDs, two from each VDC, one each with selected FCHVs and one each with selected group of men.

FGD process

I faced some challenges during my FGDs. In my focus group discussions with men there were some participants who were out spoken and tried to dominate the discussion, therefore, I had to remind them the ground rule of letting other participants to contribute. Another challenge was that they digressed from the main topic of discussion many times and I had to interrupt their discussion to bring them back to the subject of research. Contrary to this I had to

repeatedly probe participants to participate in the discussion during my FGD with FCHVs, however they participated comfortably after some time. FGD offered me a chance to observe the participants engaging into the discussion and their interaction.

3.6.5 Observations

To increase the validity of qualitative research it is important to collect the data using different methods so that the findings from different source and methods can be triangulated (Flick, 2004). It is to validate what the interviewees and focus group participants tell in the interview and discussion are accurate. Observation allows us to observe in real time what is happening, which helps to validate the data we have collected by other means, which tends to be contingent on memory. Narratives collected by other means can also change over time as participants make sense of their experiences, and they might also focus on “headline” issues. Furthermore, sometimes, based on interview and focus group settings, context, environment, seasons, presence of other participants, perception of interviewer and interviewee the interview data only may not present the whole picture; this is where observation has its place (Pope and Mays, 2006). Based on how the observations are made this can be categorized in as four types. They are as a complete observer, observer as participant, participant as observer and a complete participants (Gold, 1958, Junker 1960 in (Atkinson and Hammersley, 1994). Furthermore the observations can be categorized as structured observation, unstructured observation, systematic observation, participant observation, non-participant observation, simple observation and contrived observation (Bryman, 2004). In my case it was simple observation as a complete observer.

Observation process

I stayed in the field for one month each in each VDC continuously during my data collection period to observe some of the activities the health systems actors participated. During this period, I attended informal meetings, religious ceremonies, visited health clinics and observed some traditional healing practices. My observation was more for observing people’s participation in various aspects of their life rather than just their participation in PHC, which helped me to understand dynamics of their participation in various aspects of their life.

Main aim of my observation was to see how people participate in different aspects of their life including their participation in PHC. I was mainly interested to see the process of their participation, whether they participate voluntarily or there was any other factors involved. I

observed as a complete observer without participating in their endeavour actively as much as it was possible (Atkinson and Hammersley, 1994). Furthermore, I looked at various actors' relationship with each other while participating. I used my research questions as my guide to observe people's participation. However, in some cases my presence automatically made some effect even though I explicitly made it clear that I was just an observer. I tried to make some notes in some of the observations but people were not comfortable when they noticed it, therefore often I recorded my observation story later. I managed to observe many incidents of people's participation but only 12 of them I made a considerable note. I did not follow a separate observation schedule but indirectly followed the same schedule I used for my interview and FGD.

While observation offers rich and fuller description of the issues studied to create a trustworthy data at the same time it is very dependent on the researcher's ability, requires a substantial amount of time and resources and infrequently occurring issues are difficult to capture (McKechnie, 2008). One of the challenges I found while observing social activities and events was that the participants took very long time to discuss even a single issue. Most of the time only one or two people led the whole incident. Women, elderly and people from marginalized caste groups rarely participated in social and decision making events.

I observed people attending modern health services, traditional health service, people waiting for their turn in grain grinding mills, people participating in ritual ceremonies and women participating in anti-alcohol campaign. I mainly observed how they participate in these activities and events. For example, I observed that people were more comfortable to access the traditional healers than the modern medicine practitioners. I could tell that by observing their friendly faces while chatting to the service provider. Similarly I observed that people still strongly follow traditional healers and priests. Similarly, I could clearly see the gendered behaviour in the shops, water taps, village ceremonies but less in government offices, government health posts and among NGO staff. Therefore, my observation was more to get the background feel of people's participation in different aspects of their life including their participation in PHC. However, most of the incidents I observed were not related to PHC directly, therefore, I could not fully relate their participation to PHC, but only as background information.

3.6.6 Research diary

It is common in qualitative research that a systematic recording of the situations and conditions of where and how the data were collected is maintained right through the whole process of data collection in the form of a research diary to include some reflection on feeling and thoughts about content and participants. It gives a first person account of the social situation from the researcher's perspective and can be used to complement and compare the data collected through other methods (Burgess, 1981).

I maintained a research diary of data collection during the data collection period. Often I dictated notes from my informal conversations as audio records and transcribed as diary. These captured informal interviews, discussions and observations. This complemented data collected from semi-structured interviews, focus group discussions and observations.

3.7 Ethical considerations

The four most important considerations of any research ethics are to confirm voluntary participation, informed consent, no harm to the participants and anonymity and confidentiality (De Vaus, 2001, Orb et al., 2001). I obtained ethical approval from Nepal Health Research Council (NHRC) to conduct my research in Nepal. I informed my interview and FGD participants about my intended research. For initial few interviews I selected my participants as advised by gate keepers. Once I got the idea of possible actor groups, I used snowballing approach to select my participants. I met them, explained about my research and expressed by interests to interview them. I clearly explained to all the participants about the purpose of research, their right of not to participate as well as their right to quit from the interview process at any time.

Most of the time people accepted and gave time, usually the next day or sometime later the same day. I found that often the actors I approached with my request to interview checked with other actors whom I had already interviewed or the gatekeepers to check about the topics I talked and any risks or benefit associated with it. Some of the participants declined to be interviewed. One woman declined because someone had promised her to pay but did not pay at the end in the past for the similar interview and one traditional healer did not want to be interviewed because he thought the educated people do not respect their practices. Another participant said this to me later during my interview with him. During such visits I explicitly made it clear that they can decline to participate. I made it clear that they can do so right away, can send message with someone, can call my interview assistant and can tell when

I turn up for the interview if they do not want to participate. Therefore, I think my prospective interviewees had enough time, information and choice to participate as well as not to participate in my research. Same procedure was followed for FGDs. I ensured that all the participants in FGDs had chance to voice their views clearly. For that sometime I had to request the dominant participants to stop and give chance to others to put their views. I probed and gave sufficient time to the participants to think and speak their views both during interviews and FGDs.

Once my participants were purposively selected and agreed to participate in my research I obtained written consent from all of my participants who were able to write and I obtained verbal consent and thumb print from those who could not write after reading them the contents of consent document. They were given an opportunity to ask questions about my research as well as anything about the research questions before, at any time during the interviews, and at the end of the interview I explicitly asked them whether they want to share anything more and / or ask me any questions. Furthermore, I asked female participants whether they want to be interviewed by a female interview assistant instead of male researcher or want to be interviewed in presence of her. I asked all the interviewees beforehand whether they wanted to participate in their own house or somewhere else, in presence of someone they know or in their own. I assured them that the information they give will be kept confidential and most importantly “do no harm” principle will be followed while using the information they provide. I have not disclosed the names of my participants anywhere in this Thesis and have no intention to do so in any future publications either.

3.8 Data collection

I started my data collection by visiting the villages. Since I worked as an employee of PHASE Nepal for many years in my study VDCs it was easy for me to access the community. Once I built rapport about my research in the village, I started to talk with people in the community informally. I started from their view about current and past health situation of people in these VDCs. During these conversations I probed participants to explain about currently available health service providers and those who they think influence the health services. I asked them to explain about how they deal with health and non-health issues related to PHC in their villages. During these conversations they explained why and why not they participate in various activities related to PHC.

3.9 Pilot study

The pilot study in qualitative research serves dual purpose, firstly to refine the methods, tools and techniques and secondly to use the data in the main research since in qualitative study each interview is a progression of the previous one and should enhance this (van Teijlingen and Hundley, 2005). Once I got ethical approval from Nepal Health Research Council in Kathmandu I went to Ryale VDC of Kavrepalanchok district with my pilot interview schedule. I conducted seven semi-structured interviews for piloting my interview schedules. I contacted the government health worker of sub-health post in Ryale and discussed about my research. He suggested some obvious health system actors I could interview. From various people he suggested I interviewed one health worker, one traditional healer, one FCHV, one member of HFMC, one teacher and two ordinary villagers. I transcribed and translated these interviews with a help of my interview assistant and transcriber. I read and re read these pilot interview transcriptions to generate some initial themes of my study and changed my interview schedule.

During my pilot study I realized that the interview schedule I had prepared originally had too many questions and some were not directly related to my research questions. Pilot study helped me to reduce the number of questions to focus on my research questions more. It helped me to diversify my participants for my main interviews who were mentioned by my pilot study participants. Furthermore, from my pilot study, I found it was not possible to quantify the level of participation of different actors in PHC within my time and study framework. Therefore, instead of probing my interview participants to explain their level of participation in PHC I probed them to explain more about how they participated in it.

I conducted my FGDs with FCHV in respective sub-health posts in Hagam and Fulpingkot. Whereas, I conducted my FGD with males in Hagam in one of the villager's house and in Fulpingkot in the house of chair of HFMC.

My main data are from semi-structured interviews and FGDs. The data from my field notes and observation are to confirm further validity of data I obtained from my interviews and FGDs. These data represent what various health systems actors feel and shared about PHC in these two VDCs.

3.10 Inclusion and exclusion of participants

For this research, all the members of the community including anyone from outside who has any direct or indirect connection with PHC in Hagam and Fulpingkot VDCs at the time of data collection is within the universe of the Health System Actors. Therefore, theoretically anyone present within these two VDCs during the study period is a prospective participant for semi-structured interviews and focus group discussions. I also included offstage actors who were not present in these two VDCs but still influenced PHC for this study. For practical purposes due to the nature of the theoretical sampling, participants for both semi-structured interviews and focus group discussions were selected purposefully initially and later by snowballing to ensure rich data. In theoretical sampling the researcher collects and tentatively analyses information immediately after the data collection to ensure that a rich data is collected (Coyne, 1997). I included participants from different caste groups, gender, ethnicity, economic class, social class and offstage actors to get diverse perspectives.

3.11 Data management and analysis

Qualitative research generates a huge amount of textual data in the form of field notes, interview transcriptions, transcribed notes of focus group discussions and sometimes verbatim notes from interviews and observations (Pope et al., 2000). These notes and transcriptions do not explain the research itself but the researchers needs to analyse and interpret those data to draw meanings. Data collection and analysis goes side by side in qualitative research. It is almost impossible for a qualitative researcher not to do so since the researcher is in the field during the data collection period. Often after each interview or FGD the researcher compares notes, generates further relevant questions and develops themes for analysis (Lehmann and Gilson, 2012).

I recorded both semi-structured interviews and focus group discussions using digital audio recorders. The recordings were transferred to a laptop computer every day. I listened to the interview recordings regularly to accommodate changes needed in the interview schedule to accommodate information regarding new emerging themes. I hired transcribers and translators to transcribe and translate my interviews, focus group discussions and my other informal meeting recordings. Therefore, I was able to translate and transcribe most of my interviews during my data collection period in Nepal. Initially my transcriber transcribed from Nepali audio to Nepali script. These transcriptions were translated to English by my translator. However I transcribed and translated initial few interviews myself to get a better view of the

emerging themes. I translated some transcriptions back to Nepali from English to ensure that no meaning was lost during the translation. Some of my interviews were taken in Tamang, therefore these interviews had to be translated and transcribed into Nepali before it was translated to English.

3.11.1 Data management

At the end of my field work I generated following data:

- a) Audio records of the semi-structured interviews and focus group discussions.
- b) Transcripts of the interviews and discussions from audio recordings.
- c) My notes from my diary and observation.

Immediately after the interview each participant was assigned a unique code to anonymize the data. After transferring the audio records of the interviews into the computer they were given a code and thereafter these audios were transcribed under those codes. Any names mentioned in the interviews were replaced by more common positions. However the name of the organizations whose activities are open to public anyway are kept to give the better context, the names of the NGOs working in these two VDCs and the name of the government offices. But name of individuals has been anonymized even if they had requested me to mention their names. Audio records and transcripts are backed up into the password protected personal laptop as well as in the University File store. These data are anonymized and I will use these data only for my PhD thesis and related publications.

I conducted most of the interviews and all four of the FGDs myself. I prepared separate notes when there was anything not captured during the interview recordings. Because of the gender and language issues some of my interviews were conducted by my interview assistant. At the end of every interview I discussed with my interview assistant about the interview she had conducted to ensure that she followed the interview schedule and captured the responses accurately. Professional transcribers and translators transcribed and translated my interview and FGDs for me. I read each transcript to ensure that the transcripts accurately represented the audio recordings. Since I conducted most of the interviews it was easier for me to ensure that the transcripts accurately represented the interviews. I transcribed and translated first few interviews myself to immerse enough into the process.

3.11.2 Data analysis

I used thematic approach to analyse my data (Braun and Clarke, 2006). In this approach the transcripts are coded freely into descriptive themes. These codes are assigned to sub themes and grouped to major themes in the process of finding themes for analysis and interpretation. This approach is inductive and themes are developed using constant comparison methods (Barnett-Page and Thomas, 2009). This approach involves familiarization with data, coding, searching for themes, reviewing themes, defining and naming themes and writing up. I have briefly discussed different processes involved this approach in the following sections:

3.11.2.1 Familiarization with the data

I conducted most of the interviews and all the FGDs myself; therefore, I had a very good idea of my data. To fully immerse into the data I listened to the audio records and read and reread the transcripts immediately after my interviews were recorded and the transcripts were ready, listing key ideas emerged (Ritchie and Spencer, 2002, Fathalla and Fathalla, 2004). I read my transcripts simultaneously when I was still doing some of my interviews so that I could see the patterns developing while my other interviews progressed. I was excited as well as overwhelmed by the amount of data generated and the themes emerging around my research questions. Initially it looked everything important. However, after reading more I could see the important and less important themes. Since I collected my data myself there were fewer surprises. During this stage I made notes of possible codes.

3.11.2.2 Generating initial codes

Based on the notes I made during data collection and data familiarization process above, I started to code the data highlighting topics that were interesting and relevant to my research questions. Here code refers to the segment of the transcript which can be a word, few words or segment of a paragraph. I coded the data with my research question in mind. I used the data management software NVivo 10 to manage my data.

3.11.2.3 Searching for themes

Once I coded most of my transcripts I started to see the relevant themes. I generated a list of sub themes based on these codes and started to group these according to these sub themes simultaneously. In this process I printed out the table of different codes to combine overarching sub themes to fewer sub themes. At the same time I worked on the overarching themes and sub themes. I used NVivo to manage all my transcripts to group the pieces of data

I coded together to sub themes. An iterative process was applied to generate themes from sub themes. The sub themes were generated openly and later grouped according to the research questions.

3.11.2.4 Reviewing of themes, naming themes and report writing

Once all interview and FGD transcripts were coded these were put in a tabular form i.e. the interview quotes against sub themes visually. Themes were formed by combining sub themes. Subjective judgement was needed in this process of assigning sub themes to main themes. Some of the codes were used in more than one sub themes and themes because of their relevancy. Once these themes, sub themes and coded texts were plotted in a tabular form the interpretation and analysis was started. The main themes from this study related to my research questions are presented and analysed in chapters 4 to 7. I used the thematic approach over framework approach because it gave more flexibility in coding and developing the themes but at the same time I used my research questions to guide for generating themes.

3.12 Research validity and research reliability

Evaluation of research is prerequisite for accuracy of findings, soundness of methods and the integrity of the conclusion reached which is centred around checking reliability and validity (Long and Johnson, 2000). It is acknowledged in qualitative inquiry that there are multiple realities of common understanding by different actors, therefore, for reliability and validity researchers try to build the trustworthiness of their findings through transparency and rigour of the study design, data collection and interpretation (Gilson et al., 2011). Triangulation is one of the approach to validate the research by observing the issues by combining at least two sets of data, methods, theories and / or researcher (Flick, 2004). Validation is the process of checking whether the data collected from two or more sources, methods or by different researchers agree (Fathalla and Fathalla, 2004).

Rigour of case study and qualitative inquiry can be obtained by prolonged engagement with the subject of inquiry, using conceptual frameworks/theories developed in previous works, purposively selecting the cases and samples. Furthermore, this can be done by selecting multiple cases and triangulating, negative case analysis, peer debriefing, respondent validation and transparent presentation of the data collection and data analysis methods (Stake, 1995, Sharts-Hopko, 2002, Gilson et al., 2011). To increase the rigor of this research I purposively selected my participants, observed various social and cultural events in the community, stayed

in the community for a prolonged time and discussed with many villagers about PHC and their participation informally.

To ensure credibility and transferability of this research I used semi-structured interview, FGD, observation and field notes as my data collection methods and collected thick descriptive data to enable comparison of findings from other similar context in future (Guba, 1981). The authenticity of the findings is enhanced because of the saturation of the data during the data collection process. I considered data saturation where no new information were emerging from new interviews. The validity of the findings were achieved through triangulation of the findings obtained from focus group discussions, observations and informal meeting notes.

In this chapter, I have presented an overview of various possible methodological approaches suitable to explore my research questions. I have also detailed the appropriate research paradigm, research methods, the study population, data collection, data analysis and the methodological limitations. In next four chapters, I will present my research findings with my preliminary analysis and discussions.

In chapter four I will present my findings and preliminary discussion on Health System Actors in Hagam and Fulpinkot VDCs and their role in PHC.

CHAPTER FOUR

Health Systems Actors and their Role in PHC

4.1 Introduction

This chapter identifies, discusses and analyses the different actors involved in health system in Hagam and Fulpingkot VDCs of Sindhupalchok districts. It discusses the role of various actors in PHC in these two VDCs. These are discussed as actors present in this VDC and their roles in PHC. Furthermore, this chapter presents on what actors understand about PHC, CP, their roles and contribution in PHC.

4.2 Process of identifying actors:

Actors directly involved with the formal health care system were identified by discussions with those actors, during the rapport building, observations and formal interviews. The informal health systems workers, for example, traditional healers, priests, Lamas and herbal medicine practitioners were identified through informal meetings with the villagers and observation, as well as interviews with both formal and informal health systems actors. Other actors who are not directly involved in health services, but still participate in PHC were identified through the interviews with different actors and themselves. For example, the sub-health post caretaker in Hagam VDC mentions other actors present in the VDC as:

There is sub-health post where I work; there is PHASE (NGO). There is a SUAAHARA (nutrition programme run by Save the Children) programme from 'Tukisanstha' (a local NGO called Tuki Sangh). There are four jhankris in ward number 5; actually there are many jhankris in every ward. Our sub-health post has four sanctioned posts (AHW/CMA, MCHW/ANM, VHW and a caretaker) but there are only two staff currently, a VHW and me (caretaker). It has been many years that there is no CMA and MCHW. I bring medicines from the district and Primary Health Care Centre. I open health post at 10 am and clean it. If there are no other staff then I also provide some medicines to patients (Government worker, male).

The principal of a local secondary school in Hagam VDC mentions different actors involved in PHC as,

.....in Hagam VDC, the organization which is continuously providing health service is PHASE Nepal. From the governmental side, there is sub-health post.Informally there are political leaders, teachers, social workers and others who are aware about

need of health service. There are also health service providers who work in health from business point of view. Local people feel that they are getting services from private medicals also along with that from dhami/jhankris (faith healers / shaman) and Lamas. They provide services using traditional practices, for example, jadibuti (herbs). There is superstition as well (Teacher, male).

Different actors were identified from the similar interviews and FGD with other actors. The process of identifying various actors is summarized in table 4.1:

Table 4.1: Process of identification of actors

SN	Actors	Process of identification of actors
1	Community Medical Assistant (CMA) also called Auxiliary Health Worker (AHW)	I visited sub-health posts in both Hagam and Fulpingkot VDCs and found from the staff working there that CMAs are the head of the government sub-health posts. However, these posts were vacant at the time of my research in both VDCs.
2	Auxiliary Nurse Midwife (ANM)	Since I work for a NGO called PHASE Nepal which works in Hagam and Fulpingkot VDCs, I knew that they are present in both VDCs providing safe motherhood services in both VDCs. In absence of other health workers, they provide general health care service as well.
3	Village Health Worker (VHW)	Currently the VHW is the head of the sub-health post in Hagam VDC. Since he is one of the gatekeepers for accessing some of the other actors,, for example, the caretaker and FCHVs, I met him for my interview with him, and many times during my data collection period.
4	Mother and Child Health Worker (MCHW)	Because of the absence of the CMA, the MCHW is the head of the sub-health post in Fulpingkot VDC. I contacted her before the start of my data collection, during the interview and many times during the data collection process.
5	Female Community Health Volunteer (FCHV)	During the rapport building process in both VDCs I visited the sub-health posts and talked with the VHW and MCHW. During these meetings they informed me of the whereabouts of the FCHVs. FCHVs interviewed helped me to meet other FCHVs for interviews and FGDs.

6	Health Facility Management Committee (HFMC)	During the meeting with health workers and FCHVs, the members of the HFMC were identified and some of them were interviewed.
7	Caretaker (peon)	I met the caretaker of Hagam at the sub-health post and interviewed him. I visited the caretaker of Fulpingkot at her home, because she was on leave, following the death of her husband, who had died in a vehicle accident.
8	Village Development Committee (VDC) secretary	While talking with different health workers and HFMCs, the role of VDC Secretary was also discussed. The VDC Secretary is automatically the Secretary of HFMC. However, VDC secretaries were not present in either Hagam or Fulpingkot VDCs at the time of data collection; their posts were taken by the VDC technical assistant.
9	VDC technical assistant	I visited VDC offices in both VDCs to tell them about my research and to request interviews. They were interviewed during the process of data collection.
10	Security personnel (police)	I went to meet the security personnel during my data collection. They declined to be formally interviewed but were happy to talk about their role in the community. There are not any police posts in Hagam and Fulpingkot, but the one in the neighbouring VDC Jalbire serves for Hagam and Fulpingkot as well.
11	School teachers	During the rapport building and during interviews with different people, schoolteachers were mentioned as active actors of PHC. They were involved in interviews and FGDs as appropriate.
12	Private health service providers	During rapport building and interviews with government health workers, private health service providers were mentioned. A private medicine shop owner in Hagam was interviewed. There are none in Fulpingkot but they can get private health services from nearby Jalbire VDC.
13	Nongovernmental organization (NGO) health service	I am involved in PHASE Nepal, therefore I knew about different NGO health service providers in both VDCs.

	providers	
14	Traditional healers	During the rapport building meetings, interviews and observations, different actors mentioned traditional healers as one of the main health service providers in both VDCs. They were therefore involved in the research. I personally met many of them, and interviewed some of them.
15	Herbal medicine practitioners	These actors were mentioned by various actors during informal meetings, observations and interviews. I met and interviewed some of them.
16	Lamas (Buddhist priests)	
17	Hindu priests	
18	Political party leaders	During the data collection period, different actors mentioned the role of political party leaders and village heads in PHC in both VDCs. It was mentioned that the current political party leaders have a more active role than the ex-political party leaders and the village heads. Some of them worked as gatekeepers to access other actors for my research.
19	Ex-political party leaders	
20	Village heads	
21	Cooperatives	During interviews with different actors, people mentioned groups or committees in which other people are involved. They mentioned how cooperatives, mothers' groups, income generation groups and youth clubs were involved in Primary Health Care.
22	Mothers groups	
23	Income generation groups	
24	Youth clubs	
25	Villagers	Villagers are the main actors of the health system in both Hagam and Fulpingkot VDCs. Villagers might be different actors at different times, depending on which actor's hat they wear. When they do not have any identification as other actors they are identified as villagers. However, most of the villagers have multiple roles. Since the health system and most of the actors revolve around villagers, they are the most important actors in any health system.
26	Offstage actors	These are the actors mentioned important by different actors interviewed during the research process. They include district authorities, for example, the District Health Office, District Development Committee and Chief District Officers' Office.

		Even though these actors are not physically present at a local level, they have a power over the local health system, and a significant role in shaping the health system at the VDC level.
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4.3 Detailed description of actors and their roles

I have broadly divided the actors into two groups: government actors and nongovernment actors. Actors who are directly or indirectly salaried by the government or appointed by the government are categorized as government actors, and those who act on their own accord are the nongovernment actors. Different actors play their role in shaping health systems in these VDCs. These actors and their roles are analysed and discussed in subsequent sections.

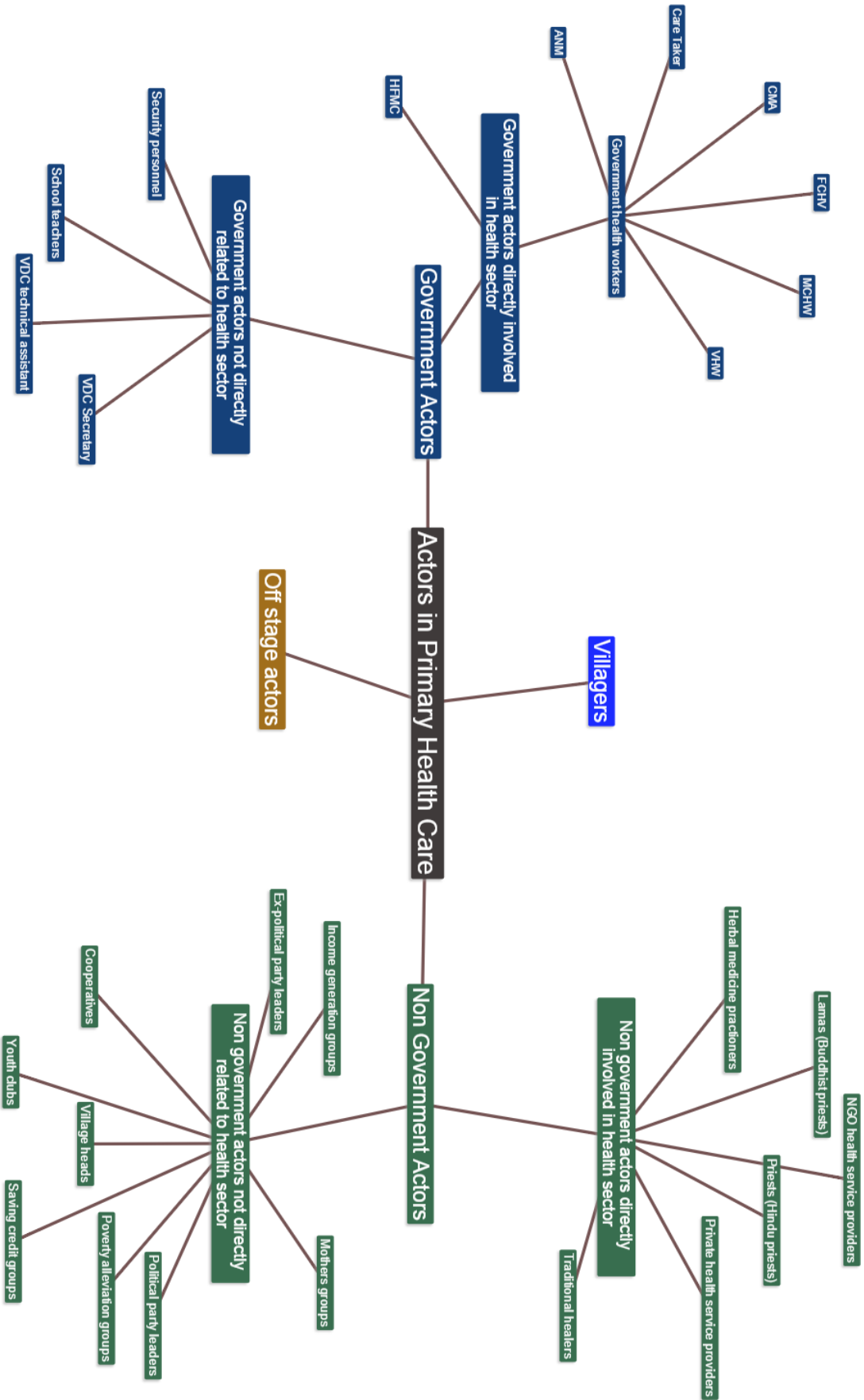
Actors who are related to the formal government health system are categorized as government actors. Those who are involved in the health system privately, traditional healers and those from nongovernment organizations are termed as nongovernment actors. There was some difficulty in categorising people who act as different actors at different times, i.e. those with multiple roles. For example, the government health worker in Hagam (interview #3) runs a private medicine shop. Most of the villagers, government actors, for example, the sub-health post caretaker, teachers, VDC technical assistants and VDC secretaries support PHC as required by their roles, as well as on a voluntary basis.

Twenty-six categories of actors were found in Hagam and Fulpingkot VDCs (Table 4.1). Some of the actors were absent from the field at the time of research; for example no CMAs or VDC secretaries were present in either VDC. Similarly the offstage actors exercise their power over local actors from a distance; these are district level actors,, for example, the DHO, LDO and CDO, and the police. They are taken into account because they also have a significant role in PHC in these VDCs. Some of the obvious actors,, for example, government health workers, political party leaders and schoolteachers were identified during the literature review process, and were verified during the interviews. The rest were identified during semi structure interviews, by asking participants to nominate other actors working in health systems in their villages. Similarly, some of the actors were picked up from names mentioned by the respondents, during piloting of the interview schedule and main interviews.

Among these actors, some were mentioned by most of the interview participants, but some came up only a few times during the interview process. For example, VHW, MCHW, ANMs,

FCHVs were mentioned by almost all of the actors interviewed, whereas traditional healers, priests, Lamas and other indirect actors, for example, DHO, CDO, LDO, political party leaders and mothers' groups were only mentioned indirectly, and sometimes after many probes. During conversation they were prompted to discuss their participation in PHC. These actors are divided into two broad groups of government actors and nongovernment actors, and are further divided as those directly involved in health and those involved indirectly, in both the categories. Health systems actors present in Hagam and Fulpingkot VDCs are shown in figure 4.1 and discussed in subsequent sections.

Figure 4.1: Primary Health Care Actors



4.3.1 Government Actors and their roles

I observed during my research that government employees and nominees, mainly those who receive a salary or some kind of monetary benefit, are the main influencing actors in the PHC. The sub-health posts in Hagam and Fulpingkot are supposed to have one CMA, one VHW, one ANM or MCHW and one caretaker in each sub-health post and one FCHV in each of nine wards providing required health services. The first five posts are full salaried posts, appointed and paid by the central government. Occasionally these staff are temporarily employed and paid by the District Health Office or the VDC. The FCHVs are nominated by the local health workers and villagers and approved by the District Health Office, but they are volunteers. FCHVs get occasional update trainings from the District Health Office through their resource persons, or the VDC level health workers. Other employees who get a regular salary from the state in these two VDCs are the teachers, VDC secretary, VDC technical assistant and security personnel i.e. police. Though not present currently, the chairperson and vice chairperson of the VDC, once they are elected, get some allowance per month from the VDC fund. These actors seem to support each other when other actors make a formal request for help. The degree of their participation in PHC to some extent seems dependent on their personal relation with each other. The government actors seem very powerful and make most of the decisions; and other actors' participation seems more of a formality. For example, when asked about who makes the decision about various health programmes run by government, one of the participants responded:

Those decisions are made by higher authorities (refers to Government Officials in the district). We are not involved in making decisions about where and what kind of health programmes are to be conducted (Villager, male).

It is mostly the government actors who make decisions regarding PHC at a village as well as a national level.

Regarding the health matters, we won't know. The(mentioned the name of the health worker in Hagam) will know regarding this. We don't have control over deciding where to conduct a programme. If any health programme is introduced in Hagam VDC, then it is conducted in Bisingghar (name of the village in Hagam where the government sub-health post is situated) by the VHW. They decide about where and how to conduct the programme. For example, a health programme comes for ward number 8, the people there cannot say whether it should be conducted there or not. If it is conducted

there then it will be easy too. The government health workers decide it themselves (Villager, male).

This shows that any decision about health is made at central and district levels, and the people in the VDC implement that. Therefore, participation of local actors is not significant in making decisions about their health needs.

4.3.1.1 Government actors directly involved in health sector

4.3.1.1.1 Community Medical Assistant (CMA) also called Auxiliary Health Worker (AHW)

According to a recent report from the Department of Health Services in Nepal, there are 2,127 sub-health posts and 1679 health posts in Nepal (DoHS-Nepal, 2013). Each VDC has either a health post or a sub-health post to provide basic primary health care services to people living there. Since over 73% of the population live in these VDCs (CBS-Nepal, 2014) the majority of the population is served by these health posts and sub-health posts. In the government health system in Nepal, there are no doctors employed below the Primary Health Centre level.

Therefore, health posts are served by Health Assistants (HA), and sub-health posts by CMAs. However, while theoretically this is true often both of these health facilities are served by CMAs. CMAs are medical professionals with 18 to 24 months of basic medical training, who are appointed in the health posts and sub-health posts to treat basic diseases, prescribe medicines and promote preventive health care measures. In rural Nepal, CMAs are the backbone of the health system (Neupane and Gulis, 2010). This is because only they are allowed to practise medicine at sub-health post level, whereas ANMs and MCHWs are not. Unfortunately, in both VDCs, these CMA posts were vacant at the time of study (interview #25, #33, #39) and their posts were occupied by the lower level staff who are not legally qualified to provide curative health care and prescribe medicines. These posts are sanctioned centrally by the Government of Nepal. I found that in Hagam, no one has been appointed to the post for over 10 years, so the money had lapsed at central level. At Fulpingkot, the person assigned had been working somewhere less remote for the past 5 years. Other actors did not seem happy about it and complained. For example, some of the participants shared their view:

A person who is of lower level position than what the government should appoint is placed for that position. He is providing the services what he is not supposed to provide (Teacher, male).

Here the participant means that the VHW is doing the work, which he is not qualified to do. This has created some personal clashes with other actors, who know that he is not qualified to do the job he is doing, and also creates dissatisfaction with the government for not filling the sanctioned post.

It is the skill as well as the competency of the existing staff member the villagers complain about, especially about the medicine he is prescribing, which he is not supposed to do:

However, what the VHW does is if a person has fever, he can take just 500 mg of capsules but he gives them capsules of 1000 mg. Those who can tolerate the high doses will not get affected but those who cannot may even die due to high dose (Villager, male)

Here villagers including other actors complain about the VHW for his malpractice and complain about the government because the government has not been able to fill the sanctioned posts.

Currently there is a sanctioned post in health post which is not filled. There is a quota for AHW (meaning there is vacant post of CMA/AHW). However, there is no person to fill this post (Villager, male).

Such dissatisfaction is expressed by the villagers and by other actors. This has created negative feeling about the government health workers and government health services. As a result, it has hindered people's participation in PHC.

4.3.1.1.2 Auxiliary Nurse Midwife (ANM)

These female health workers have 18 to 24 months' health training, mainly in basic midwifery skills before they are appointed in the health centres for the job. Unfortunately, in both of the VDCs there were not any ANMs appointed from the government, though there were two ANMs working in each VDC from PHASE Nepal.

Regarding the vacant post of MCHW/ANM in Hagam, the villagers blame the existing VHW for not letting anyone stay in the village when they are appointed, saying he is unsupportive and discourages whoever is appointed to the post. The community say that he has a vested interest to do so, because if above posts are filled the new person will be the head of the sub-health post. The current VHW does not want this to happen, because he will lose additional income and his prestige as well.

4.3.1.1.3 Village Health Worker (VHW)

VHWs are the grass-root level health promotion staff employed by the Government. They are trained for 90 days in basic primary health care and immunisation (Acharya and Cleland, 2000). There are about 4000 VHWs working all over Nepal. Recently the Government has started to promote these VHWs to CMA level. Though their assigned role is to conduct household visits, immunise children, keep records of pregnant women and provide basic treatment, in case of one of the study VDC the VHW is the head of the health facility. This has compromised the quality of the care and regularity of the health service in this VDC. First because he is not qualified to provide a curative health service, and secondly because he can be busy with reporting and manning the post, which is supposed to be done by the CMA. Many interview participants in Hagam have expressed this view. It has caused a power struggle between this VHW and the community. From my observation during my interview with the VHW and other participants, the VHW seemed to concentrate more on maintaining his power position, than on doing his duty. The community blame him for not reporting the situation to the District Health Office and request the post is filled.

However, the VHW in Hagam presented a different story about the transfer of the MCHW (she was trained as ANM) differently:

Before the establishment of an NGO (he meant PHASE Nepal) in our village, a MCHW (mentions her name) from Dolalghat, Kavrepalanchok district had come here. She ought to know her own duties by herself, does not she? However, she could not conduct proper pregnancy care services to the women. She even wasn't able to make ANC cards. She used to only support me in immunization services. I told her that she should provide antenatal care services, delivery services as much as she knows. I also advised her that she could ask the things that she didn't know to the staff nurses or other staff, but she got transferred herself (Health worker, male).

I observed that the VHW has a monopoly in managing the government resources available for the VDC through the sub-health post. Similarly, he has a better social status: because he is the only modern health service provider from the Government in this VDC, he entertains the power the post carries. He seems worried that he would have to share his authority, as well as his prestige, if someone equal or higher than him in rank is sent by the District Health Office to work in Hagam VDC. That is why he seems less enthusiastic to fill the vacant posts. This

seemed only to apply to Hagam VDC; the MCHW in Fulpingkot seemed happy to have a colleague from the District Health Office to work alongside her. The power struggle in Hagam seemed to be for the resources and social prestige.

4.3.1.1.4 Role of the VHW

The government CMA is absent in both Hagam and Fulpingkot VDCs. There should be one ANM or a MCHW in each VDC. There are no ANMs from the Government in either VDC; there is no MCHW in Hagam. The government VHW in Hagam explains his role as:

First, it's the district public health office from where resources for health are received. However, they are not providing adequate support for the sub-health post. Particularly, there are 4 sanctioned posts in a sub-health post; 1 AHW (CMA), 1VHW, 1 MCHW/ANM and 1 office assistant (caretaker). However, these posts are not filled yet. The office assistant does support the sub-health post indirectly but all other health related jobs needs to be done as per the directions from district health office by me alone which is not possible (Health worker, male).

The government VHW is currently the head of the formal government health facility in Hagam VDC. His participation was found in all aspects of PHC, though other actors in the community do not take his leadership for granted. There is no formal system of preparing these VHWs for leadership, and management of the overall health programme in the VDC. However, they are supposed to implement preventive health programmes, run health education campaigns and immunise the children. When there was a CMA formerly, he used to manage the programme. The current VHW took over from him without any formal training or formal handover. As a result, the VHW was only seen to give leadership to the overall health matters of the VDC at a minimal level. He was involved more in programme management and needs assessment. He was responsible for mobilising regular resources provided by the government. The villagers relied on him to talk with the government line agencies, VDC and any other organizations willing to support health issues. Consequently, he is responsible for negotiating with the DHO, VDC, NGOs and others on any health matters. The community takes it for granted that their health needs assessment is done by the VHW in Hagam, and by the MCHW in Fulpingkot. The participation of the VHW and MCHW in PHC would appear to be more at activity level, than at system level. They participate, and encourage others to participate, in PHC activities, but are weak in encouraging others to participate at the higher organizational levels.

The government health service is almost absent in both Hagam and Fulpingkot VDC, because of the lack of the main staff (i.e. CMAs) in the respective sub-health posts. This has led to various problems in need assessment, programme implementation, management and resource mobilisation. Since these services are provided by staff who are not qualified to provide such services, especially the curative treatment, it is causing problems in people's participation in PHC. Furthermore, there are issues of lack of trust in government health services among other actors, especially the villagers.

4.3.1.1.5 Maternal and Child Health Worker (MCHW)

Currently there are 3985 Mother and Child Health Workers (MCHW) in Nepal (DoHS, 2014). This new branch of health worker was introduced in 1993 to reduce maternal and neonatal mortality by providing community services. There is no MCHW in Hagam. There is one in Fulpingkot VDC, who is from the neighbouring Jalbire VDC. Since there is no CMA in post in Fulpingkot, she has to manage the post, which she is not happy about. Unlike the VHW in Hagam, she is keen that the CMA post in Fulpingkot be filled, and confirmed that she has approached the District Health Office about it many times. However, she is not happy that she should have to do the CMA's job, because she is not qualified or skilled to do so.

4.3.1.1.6 Role of the MCHW

The MCHW in Fulpingkot VDC is mainly responsible for the 'safer motherhood' aspect of PHC. Her formal role is to make sure that all the mothers in Fulpingkot VDC get safer motherhood related information and to provide such services. Similarly, her role is to ensure child immunization in this VDC. At the time of this research, there was no one to head the sub-health post. She was working as acting main person of the sub-health post there, which she complained has significantly affected her formal role, and she has not been able to fulfil her new role as well. She is involved in the management aspect of the safer motherhood programme, and sometimes in the needs assessment. Because of her new role as the main person of the sub-health post, she is involved in overall programme management as well, but not much in other aspects of participation.

The government health workers are not available here. The health workers come here by source of political leaders. It has been 4 or 5 years since we had a regular CMA here. We are requesting for it to the district public health office. But, our voices are not heard. Therefore, the government health worker's presence here is zero. The government

health service is based on a MCHW providing immunization to children. The sub-health post is run by a peon. There is no CMA (Villager, male).

This shows how the lack of a particular health staff member affects the overall health system at the community level.

4.3.1.1.7 Female Community Health Volunteers (FCHVs)

Female Community Health Volunteers (FCHVs) are the lowest level of government health staff present in Nepal. However, they are not paid, nor do they have any status as staff. The government introduced the concept of the FCHV in 1988 to increase community participation and outreach health services especially in child immunization and safer motherhood programmes. Initially it was piloted in 28 districts, and by the end of 1993 national coverage was achieved, with about 50,000 FCHVs in place all over Nepal. There were nine FCHVs in one study VDC and ten in the other one. These FCHVs were found to be the only formal health systems actors regularly present in the community at the time of study.

Since they are volunteers, their perception about their role did not seem clear. I observed that everybody, especially the formal health systems actors, turns toward them if they want to do anything formally in the VDC. Though these FCHVs like to volunteer, sometimes that has put them in a difficult position. For example, in Hagam VDC one of the FCHVs spends more than seven to ten days a month attending different meetings, taking children for immunisations, carrying the vaccines to the immunisation centre and volunteering for other organizations' work, which she finds difficult. Her husband complains about it and wants her to quit from the FCHV post, but she still wants to continue to work as a FCHV.

I don't get any salary. I work for providing services to people of this ward. I was selected by the sub-health post staff. I have learnt things which the health workers teach me. If there are workshops I participate, I get about 200 rupees (US\$ 2). I went for a 15 days training for 75 rupees (US\$ 0.75) at the start. However, I do not get any regular monthly salary (Volunteer, female).

Even so, the FCHV wants to continue to work as a FCHV, because she thinks such work is prestigious and she can serve the villagers by learning new things. However, she admits that it is not easy for all of them, since some of the FCHV's husbands do not like what they are doing:

I wish to learn different things which the health workers teach in training and workshops and use that to serve people. Some FCHVs have problems because their husband or in-law are angry when they get involved in different programmes (Volunteer, female).

In Hagam VDC, there were three FCHVs from lower caste groups. Because of their caste, their role was limited, for example, they were not called for the delivery related jobs, since they are not allowed to go inside higher caste people's houses; even when they are called, they have to provide a service from outside the house. When asked one of the FCHVs replied:

“Q: Does caste makes any difference in it?

No. there is not. Some old people do so. However, people of our age are not so.

Q: Do people call you to their home for treatment?

Yes. They call me. However, in some families they do not allow me to enter into their houses. I provide my services from outside their house (Volunteer, female). ”

Despite these obstacles and difficulties, women are interested in working as FCHVs, because the Government recognizes them as an important component of the healthcare system. Furthermore, the Government offers free treatment for them at the district hospital, whereas ordinary citizens get a limited free basic health service only. Similarly, in a society where women have a very low social status, the FCHVs are respected by both men and women, which is another incentive. Other attractions of being an FCHV, though not explicitly expressed by them, are the opportunities for them to learn something new, to come out of house, and to be a useful member of the community. For example, one FCHV, when asked whether she regrets working as a FCHV says:

Sometimes I don't get free time and cannot attend some meetings and I cannot participate in some trainings. I get disappointed for that because I feel that if I could participate in it, I could learn new things (Volunteer, female).

Often, it is their desire to improve their knowledge about health that attracts village women to work as a FCHV:

Before being a FCHV I didn't know much about health. I had only little education.I am working as FCHV because I learnt a lot of things about health after I started to work as a FCHV. I was a fool before; I didn't know anything. I knew that we should focus on cleanliness but there are certain good ways of doing it, I didn't know about that before.

But after being a FCHV I started to learn about it, therefore, I am working as FCHV (Volunteer, female).

Another attraction is social recognition. Once they work as a FCHV, they are known in the community, and respected by the villagers.

Before only people of my ward used to know me but after being a FCHV, people of the whole VDC know me now. It is a self-motivated volunteering. Nowadays people do not work if they do not get money. However, even though I do not get money, I can serve the community and teach people the things I have learnt. Therefore, till now I am working as FCHV (Volunteer, female).

This shows that the FCHVs are one of the most active actors in the community, who participate in almost all of the PHC activities. Their main motivation to participate in PHC is the recognition from the government, social recognition, some material support from the government for free treatment, and an opportunity to come out of their cell of domestic activity, and to contribute something to the community in which they live.

4.3.1.1.8 Role of FCHVs

At the community level, FCHVs are the most active members of the health system. Almost all of the preventive health interventions go through them, especially those from the government. They also provide vitamin A supplements to the children, feed polio drops, and treat childhood pneumonia with cotrimoxazole. They motivate people to use available health services for safer motherhood, family planning and child immunisation, and they distribute oral contraceptives. They are the role models in the community so they have a good leadership role. From the health system point of view they are the health resources and the state is using them effectively. They are the backbone of the preventive aspect of women and children's health at community level. Since they are local members of the community, they are trusted and followed by their fellow community members. They have a significant role in programme management, but do not have much role as such in organizational development, resource mobilization or needs assessment. Since they are local, and the most active member of the health system in the community, often they are the first point of contact for health issues. Although the traditional health practitioners seemed suspicious of them at first, the work of the FCHVs still crosses over with that of the traditional healers, and vice versa. FCHVs act as

the bridge between the formal health system and the community. One of the reasons the villagers trust FCHVs more than other actors is because they are volunteers.

The government VHW explains how they rely on FCHVs for data collection and providing the health service in the VDC:

During the meeting on 25th day of every month, we discuss with the FCHVs about how many pregnant women are there in respective wards. We request them to visit respective households and gather required information as well as provide iron tablets to the pregnant women. The pregnant women receive iron tablets from them (Health worker, male).

FCHVs are proud to provide the services to their community.

I do check the pregnant and postnatal women. I have to provide them iron tablets and vitamin A capsules and feed polio drops to children. I also provide them Jeevanjal (ORS) and zinc tablets if they are suffering from diarrhoea (Volunteer, female).

The villagers appreciate the services provided by the FCHVs.

FCHV counselled us to feed babies only mother's milk for 6 months and to immunize children. They used to visit each house for giving advice. They inform us about the immunization days (Volunteer, female).

These findings suggest that the FCHVs are mostly involved in programme implementation and resource contribution as human resources themselves. Their participation in health needs assessment, in leading the programme and in management is not significant.

4.3.1.1.9 Health Facility Management Committee (HFMC)

The Health Facility Management Committee (HFMC), also called Health Facility Operation and Management Committee (HFOMCs) is a local committee, formed in each VDC, to manage the health systems within that VDC. The VDC Chairperson is supposed to be the chair of this committee. Since currently there are not any locally elected VDC representatives because there has not been a local election for last 14 years, this post is supposed to be taken by the VDC secretary who is working as acting head of the VDC as well. However, since these VDC secretaries stay in the district headquarter and look after more than one VDC, sometimes this

post is selected by the all party committee. Currently the chairpersons of HFMC in both Hagam and Fulpingkot are selected from the villagers. The head of the health institution is the de facto secretary of the committee. The other five members of the committee are selected from the community by the DHO, in cooperation with the villagers. The committee is set up to manage the health system within the VDC. However, even though the government expects this committee to manage the VDC health system, they are not given sufficient authority to do so. For example, all the staff are appointed by the government at a central level, and transferred to different places by the DHO. Therefore, the management committee does not have any authority over the staff so they cannot supervise and check on them.

The chairperson of the sub-health post management committee in Fulpingkot VDC shares his frustration as:

We are meant to check if the medicines which are provided free of cost by Nepal Government are good or not. We should also see the supply status and check those medicines which are received. We also suggest about staff of the sub-health post. However, our suggestions are not listened to. These are to be decided by the VDC personnel but they are not elected so the authority lies to district public health office. They are supposed to make the decisions but they do not listen to us. At this time, there is no representative or no constitution in our country. Therefore, everybody makes his or her own decisions. Staff are not present at the post and neither they listen to us (Villager, male).

Similarly, since the VDC secretary, the head of the sub-health post and one of the members can make any decision on behalf of the management committee, often the government staff can make whatever decision they want to make. Currently the role of the management committee is to mobilise people in health infrastructure development in the VDC, to raise awareness of health services, to lead delegations to government offices to request to fill the vacant posts, and to organise local volunteers. Though they do not seem to have authority in some of the aspects, they seem to be an active actor at the VDC level.

Currently there are three main people in the VDC, together they can decide anything in the VDC including in health. VDC chairperson (currently this post is held by the VDC Secretary) and head of the health facility, agriculture and veterinary sector are the members. Therefore, anything can be decided by these three. Currently the chairperson is from outside this district; he does not care about this place. What I have heard is that

the chairperson gave NRs 6000 (US\$ 60) to each government employee in the last meeting to pass his agendas without any conflict. Everything is unmanageable here (Villager, male).

4.3.1.1.10 Role of HFMC

Principally the HFMC is responsible for managing the formal health system within the VDC; but in practice, they have been just a rubber stamp to facilitate the existing government health workers in getting through the system. Their participation in leading the health system in the community seems limited to attending the formal meetings organised by the health workers. They are not involved in organisational development of the health system. Their main role is in mobilising resources; or more to the point, in mobilising the community for free resources for the health programme, in the form of financial support, free labour and resources in kind. Other actors complain, criticise and do not follow their advice mainly because the villagers think it is HFMC's responsibility to ensure presence of right health workers in their sub-health posts. This makes the committee as well as the villagers less motivated to participate in PHC.

The government health workers are aware of the limitation of the HFMC and often blame their higher authorities for the problem:

The management committee can do something only if resources are provided to them. The management committees of the ORC clinic and sub-health post are separately formed. The management committee can't always provide support unless they are provided with resources (Health worker, male).

In the case of Hagam the villagers expressed their concern about the misuse of the resources, and about the management committee not being involved in leading, managing and implementing. One of the participants expressed his frustration about the misuse of the resources.

The mobilization and management are done by(mentions the name of VHW) himself though there is a management committee. He does all the decisions regarding what to do with all those resources. Therefore, no one wants to invest money in it. I also had put about NRs 75,000 (US\$ 750) in it and they spent it very carelessly. Therefore, the representatives think that there is no use investing in health (Villager, male).

Some of the villagers argued that the responsibility of the HFMC is to identify the health needs of the people. At the same time they acknowledged that it is the people themselves who have to identify their health needs, but they do not do so:

Regarding need identification, there is a sub-health post management committee. The needs are to be identified by all citizens but in our VDC, there are difficulties in it (Villager, male).

Some of the members of the HFMC realise that it is their responsibility to manage the health system, manage resources, and ensure the implementation of the planned activities.

I am a member of the committee. We do things like hiring peon, collecting donation, approve the expenses details of the money that they bring. If we have to organize any new programme then we help them to organize it (Villager, male).

The participation of HFMC in PHC represents the level of people's participation in PHC. On one hand if the HFMC is active, can make decisions, and has access to higher authorities to discuss the local health issues at area and district levels, it can be seen as functioning at a higher level of participation. On the other hand, if HFMC is passive and cannot make any decisions, as in both Hagam and Fulpingkot, it can be said that community participation is less. If the HFMC cannot fulfil their assigned roles and responsibilities, they are less likely to be respected by the villagers, and hence their participation in PHC is lower, as in both Hagam and Fulpingkot VDCs.

4.3.1.1.11 Caretaker (also called peon)

These are the lowest level of paid staff of the government health system in Nepal. They are responsible for looking after the property, cleaning, and doing other logistical maintenance, for example, collecting firewood for sterilization, carrying medicine from the District Health Office or the Primary Health Care Centre and helping with child immunizations programmes.

However, in both Hagam and Fulpingkot these caretakers are checking patients and prescribing medicines. When asked about their skill and competency they claim that they learnt it from the health workers who worked there in the past (interview #25, quote in section 4.1)

Other actors, including the villagers, complained about this practice but still accepted the treatment, because the caretakers are the only people available to dispense the medicine, which is provided free of cost by the Government. I observed that villagers' reason for visiting

the sub-health post is more for the free medicine than for health advice from the caretaker and the VHW, because most of them know that they are not the authorised health workers anyway. Often villagers get advice from private medicine shop owners and other health workers for their health problem, but are referred to the sub-health posts to get free medicine. Sometimes villagers know from their earlier experiences which medicine they may have taken for similar problems, and go to the VHW or caretaker with empty sachets of medicine they used before to treat their problems, to show which medicine they need and request them. When there are NGO health workers available in the clinic they are the first point of contact; otherwise the VHW, MCHW and the caretaker are the first point of contact for modern health services in both Hagam and Fulpingkot VDCs. The villagers do not have any choice but to get services from people present in the sub-health posts. Therefore, they complain about the health service in their village:

Sub-health post provides treatment when we are sick. Currently there is no AHW there so it is being run by peon (sub-health post caretaker, helper). Citizens aren't getting much service from it (FGD, male).

I observed that the caretakers actually seem to exercise a considerable power over the community and to some extent over the health workers who visit the posts occasionally. They exercise power because they are the only ones available in the post to provide medicine. Similarly, they exercise some degree of power over the other health workers because they are the ones who stay at the post while other health workers go for their private work.

.....in the sub-health post we have seen that there aren't adequate staff. There must be AHW in sub-health post, isn't it? We see that VHW is performing the work of AHW (Villager, male)

The VDC technical assistant is responsible for reporting this to the relevant authority, i.e. the DHO and DDC, but he himself seems helpless.

4.3.1.1.12 Role of Caretaker

Caretakers' formal role is to maintain the cleanliness of the property and perform basic menial jobs, including transportation of medicine, equipment and vaccines to and from the DHO and the VDC. However in practice, in both VDCs they practise basic medicine from the respective sub-health posts. Their participation is mainly in helping senior health workers to run health programmes. The community trust them more because they are local, come to the health

facility regularly and most importantly they are less intimidating to the villagers, compared to other health workers. They are more trusted by the community because they are available when the community needs them. These caretakers are filling the gap of absentee health workers in both sub-health posts (interview #25, quote in section 4.1).

This is a typical representation of the Nepalese health system, mostly in remote areas of the country. It shows that health services are provided even by non-health workers. This has multiple implications on the overall health system. For example, the villagers are not getting even basic health services, if what they are getting is from a non-health worker. Villagers have nowhere to go when they need health services and this is leading to mistrust in the government health system.

4.3.1.2 Government actors not directly involved in health sector

4.3.1.2.1 VDC secretary

VDC secretaries are employed centrally by the Government of Nepal, and managed by the District Development Committee. They are the lowest level of formal representatives of the government bureaucracy at the VDC level. Their main role is to collect vital data, collect local taxes, coordinate developmental activities and manage the government budget in the VDC. In principle, every developmental activity, no matter who funds or implements it, must go through the VDC secretary, otherwise it is not recorded in the national system. Therefore, the VDC secretary plays an active role in the VDC and has considerable influence in various decision-making processes. For example, though the salary, medicine and other resources for the health facility and employees comes directly from central government, the VDC secretary has power over government health workers. This is because the VDC has a considerable amount of funding available for additional health programmes, which the VDC secretary may decide upon.

The VDC has been supporting for the health sector until now. Some budget is allocated for health by the VDC (Villager, male).

Similarly, the first point of contact for nongovernmental organisations and private practitioners who want to work in the VDC is the VDC secretary. These organisations or people need to get approval to work in the area on the recommendation of the VDC secretary, and the same applies for their annual renewals and reregistration. Due to her/his power for budget

allocation, as well as authority as described above, the VDC secretary exercises more power than other actors in the local health system.

4.3.1.2.2 VDC technical assistant

Often recruited locally, this is the government employee employed to help the VDC secretary. Normally, he or she performs the routine work of the VDC, while other important activities, for example, budget distribution and project approvals are done by the VDC secretary. Though their role is to support the VDC secretaries, the assistant can also exercise power over the community, and have influence over budget allocation and other decisions. They exercise this power because often the VDC secretaries are from other districts, are absent from the VDC, and get transferred quite frequently. Being local, the VDC technical assistant knows people, has better understanding of the priorities, context and better understands the power dynamics of the community. Furthermore, often the technical assistants are from influential families, know the local politics better, and have peer support in the community, which puts them in a better position to influence the decisions.

4.3.1.2.3 Role of VDC secretary and VDC technical assistant

The VDC secretary and technical assistant have a more leadership role in PHC. Currently the VDC secretary is a de-facto active member of the HFMC if not the chairperson, has control over the VDC fund and is responsible for coordinating with different stakeholders on behalf of the VDC. This puts her/him in a higher power position compared to other actors in the VDC. Even though the VDC secretary is supposed to make decisions based on suggestions from different stakeholders in the community,, for example, HFMC, FCHVs, NGOs, community leaders and other stakeholders, that rarely happens. They make their decisions without consulting other actors. Therefore, other actors blame VDC secretaries for not following the consensus, but deciding for themselves what they think is right. In both VDCs the VDC secretaries rarely come to the VDC, but make decisions while staying in the district headquarter. The VDC technical assistant has a similar role to that of the VDC Secretary.

Furthermore, both the VDC Secretary and the VDC Technical Assistant are involved in VDC resource mobilisation, and sourcing the resources from the district level stakeholders,, for example, the District Health Office, District Development Committee, NGOs, INGOs and private business organisations, hydropower companies and road contractors. They are less involved in

programme implementation, but participate in needs assessment and programme management in their respective VDCs.

The assistant secretary (VDC Technical Assistant) is always present in our VDC. Therefore, we suggested instead of the secretary he may work as the chairperson of the HFMC. He could work continuously in the activities of the monitoring the committee. Therefore, the assistant secretary was elected as the chairperson of committee. The assistant secretary as well as all the other members of the committee were also local residents. So with a hope that they would advocate for the free health care services to the community people, we decided to form the committee with them (Villager, male).

It is the VDC secretary who decides about the funding for health as well as other sectors. The villagers complain that there is very little participation of other actors in it.

It is done by VDC Secretary. We hear that it has been received. Representatives of political parties allocate money. We just hear about it. We don't know about it. We hear about that in general meetings and councils. We don't get that money. When we ask them about its whereabouts, they say that they invested it somewhere else (Villager, female).

The VDC council is responsible for allocating funding. There is no VDC council at the moment, therefore, the government has made an interim committee, of the government employees in the VDC, and representatives from the political parties, to make the decisions. One of the participants shares his concern about the current decision making process:

The budget allocation system here is after decision is made by village council, payment is transferred to an account, after proposal for a programme and forming a committee. Currently village council consists of one health worker, one VDC secretary and one veterinary worker. There are representatives from political parties who are also placed as evidence. However, there are legal difficulties for that because political parties don't have legal authorities. Therefore, they are just for formality. Once the secretary and other two sign the document, the legal process is complete (Villager, male).

Because of lack of locally elected representatives, the VDC Secretary and VDC Technical Assistant entertain stronger power in the decision making regarding the allocation of VDC

funds, and subsequently other important decisions. Since money is one of the main factors in mobilising people and other resources, this significantly affects people's participation in PHC.

4.3.1.2.4 Security personnel (police)

Though security personnel exercise more power over normal citizens than other actors, their involvement in Primary Health Care is very limited. During the data collection for my research, initially they were not prepared to give any information about their involvement in Primary Health Care, but later they agreed to discuss it informally. During informal conversation, the chief of local police explained that informally they have a role in PHC, but formally they do not have any. They said that their role is to maintain law and order. It was found that they are aware of other actors' presence and activities. Similarly, other actors also acknowledged the role of security personnel in cases of emergencies.

4.3.1.2.5 School teachers

These are another cohort of government employees present in each VDC of Nepal. Both of the study VDCs have many schools, so there are over 50 teachers in each VDC. Some of the teachers are from the same VDC, and others are from outside. These are the most educated members of the society; therefore they make a considerable contribution to PHC. Almost all of the other actors are in one way or another influenced by these teachers. The villagers and other actors listen to them, because they are known as most knowledgeable people in the community. Teachers are active actors in PHC, in both modern and also traditional health care. The community acknowledge teachers' role in PHC, for example the participants from a FGD in Fulpingkot shared:

The teachers also train them regarding eye care as well as referring according to health of students. So if any health related programs are to be conducted, schools are also involved in it. Teachers are also given trainings on health care... so now schools are more involved in health care (FGD, male).

However, currently almost all teachers are affiliated to some political party one way or another, therefore they follow a strong political ideology. I observed that such affiliation to political parties sometimes detaches them from other actors, including the villagers who may be affiliated to a different political ideology; this is a new phenomenon to be seen in these villages. Otherwise, teachers are among the most influential actors in both Hagam and Fulpingkot VDCs.

4.3.1.2.6 Role of Schoolteachers

Teachers are the most educated group of people in the community, especially in the rural part of Nepal. These teachers are the first point of contact for advice for most of the people in the community, regarding health as well as other personal issues. People recognise that the teachers have an important role in health care in the community:

Teachers have much role to perform in health because they are intellectual people. They help in increasing the level of awareness so because in schools they can increase awareness regarding health. They do have role in cleanliness and minor health related problems solving as well (Government worker, male).

Teachers are involved in health education, awareness campaigns and health advocacies. Their main participation is in leadership and resource mobilisation. If people have any issues, they ask teachers for advice. The teachers themselves agree that they support the health systems actively. Teachers are involved because the villagers trust them and want their support.

Teachers have a great role in health sector.So the role of teacher is significant in matters like stopping early marriage, giving health education regarding childbirth, receiving treatment, superstition, breaking old and bad traditions. are all possible through a teacher. People do follow things which teachers tell them (Teacher, male).

Since teachers are present more regularly in the community than government health workers, they build a better relationship with the community than the health workers who work in PHC. Often teachers work as a bridge between the villagers and the other actors.

The woman activist who is leading the anti-alcoholism and anti-wife-beating campaign stresses the role of the teacher as a supporter of their campaign.

Even if people of our village or male members or alcohol shop owners are not helping us much, teachers and intellectual people are helping us in the campaign. We are hopeful that they will be helping us until last stage. Mostly there are representatives from political parties and the teachers. They also have told us that they will help us (Villager, female).

Teachers not only give advice in the community, but also teach their students about health issues.

We teach our students about good life and family education which includes issues about pregnancy also. These things are included in curriculum as well. We make them aware about pregnancy, deliveries and childcare (Teacher, male).

From this, it can be seen that the role of the teachers in PHC is mainly in awareness creation and resource mobilization. They are not involved in needs assessment as such, except that their involvement in raising awareness helps other actors to make informed decisions. They are not involved in programme implementation and management.

4.3.2 Nongovernment actors and their roles

As with the government actors I have divided the nongovernment actors into those directly involved in PHC, and those not directly involved in PHC and discussed in the following section.

4.3.2.1 Nongovernment actors directly involved in the health sector

These are the health systems actors present in the community, who are neither directly related to the government nor receive anything from the government. As with governmental Health System Actors, for the ease of analysis and discussion these are also grouped into two groups i.e. those directly involved in providing health services, and those not providing health services. In terms of providing health services and shaping the PHC at a local level, this group of actors has a higher influence than the formal governmental Health System Actors. Especially in Hagam and Fulpingkot VDCs, villagers rely more on these actors than the formal governmental Health System Actors. Although I observed an increased effort from the government to bring nongovernmental Health System Actors, especially those who are practising traditional healing practices, into their system, there still seemed a huge gap among the actors themselves and the villagers.

4.3.2.1.1 Private health service providers

Private medical shops are privately owned medicine shops which sell medicine for profit. These can range from pharmacy department of mega hospitals to a few boxes of essential medicine in a local tea shops. Especially in the remote areas of Nepal the latter is the case, often these are also opened by people who are affiliated to health sectors one or another way, for example, trained health worker, employees of government health system even if non-medical employees, family members of health workers or someone who had some medical training in the past. Since they sell medicine for profit, they often charge high cost for medicine.

Most of such medical shop owners also offer some medical advices depending upon their knowledge and skill. For example, in the cities they offer even Doctors' consultation service, whereas, in the remote areas these can be just selling some basic medicine even by non-health shop owner. Especially in the remote areas these are open most of the days as well as whenever the villagers want to buy medicine any time of the day or night, because often these are run by local people.

In Hagam VDC, there are three private medical shops, where the villagers go for treatment of simple diseases and minor injuries. One of the medicine shops is run by an existing government health worker, whereas the other two are run by the local CMAs. I observed that the motive of these medicine shop owners is not only to make a profit by selling medicines, but also to maintain a position of power in the community for other purposes. For example, one of the medicine shop owners is the chair of the local youth club, and also represents a political party locally.

The government health worker who owns a private medical shop is accused of selling the government's free medicine from his shop, whereas the other medical shop owners are accused of over prescribing and over charging. Therefore, though from the outset these seemed normal medicine shops, the discussions and interviews with different actors in the community reveal that the medicine shop owners are running their shops to maintain their grip on the community for other purposes, as well as earning their livelihoods. For example, all three of the medicine shop owners are heavily involved in local politics, so they use their skill and resources to lobby and attract the ordinary people to their groups. Therefore, some of the actors do not think very highly of private medicine shop owners in Hagam.

To talk about private sector, the VHW works in the health post but he has a private medicine shop as well. The other is(mentions the name of a private medicine shop owner) who has a private medical. I have heard that he took training for that. We don't have any health services from his hands because his private shop is for making profit but we need better services.They are skilled but their behaviour is such that they think it better if the local educated people didn't visit them because they can't handle educated people. They say that they will provide good services to people whom they like. They charge more for medicines to the people they do not like (Villager, male).

Fulpingkot VDC did not have any private medical shops in their own VDC but their neighbouring VDC Jalbire has two private medicine shops, and the government Primary Health Care Centre (a higher facility than the sub-health post in these VDCs). People from both of these VDCs go to private hospitals in Khadichaur, Balefi, Chautara, Dhulikhel and Kathmandu. People admit that the health service available locally is only for simple health problems. For serious health problems, they go to private hospitals, even though they complain that it is very expensive to access these private health services.

4.3.2.1.2 Role of Private health service providers

In the case of Hagam and Fulpingkot VDCs, the private health service providers are mainly the medicine shop owners. Often these shops are opened by the health workers, but that is not always the case. Their participation in health is by providing health services to the people. Though they are criticized by other actors for making money from selling medicine, in general the villagers are grateful for the service they receive from these private medicine shop owners.

There are private medicals here. They own a private or personal shop and related with their income source as well. They don't provide much major services but the services should be bought. In this VDC, there are some people who are CMA, they are providing these kind of services (Villager, male).

There are other private health service providers further away, mostly in the less remote areas, district headquarters and Kathmandu. Currently these private health service providers are big players in health system in Nepal. Their influences can be seen in the communities as well. The role of the community level medical shops is not limited to selling their medicine and serving the community, but often includes referring the patients to higher centres. Often these medicine shops are blamed by the villagers for taking commissions from bigger hospitals for their referral. Bigger private health service providers complement the government health services to some extent, but they are creating two types of services: health services for the rich and for the poor, which is another area for further research. From the community point of view, private health service providers, on one hand, have provided health services which the state is not providing, but on the other, they have weakened the government health system by competing with it. For example, even at the VDC level the government health worker owns his own private medicine shop, where he spends more time than he does at the government post.

These problems persist all over Nepal. Their participation in PHC is mainly in the form of resource mobilization.

4.3.2.1.3 NGO health service providers

There are quite a few NGOs working in the health sector in both the VDCs. Most of the NGOs are working in preventive, rather than curative, health care with some exceptions. I observed that the NGOs do not always agree with government plans, policies and priorities. They seem to sympathize more with the community's needs and advocate the right to health care. This has created problem between the government health workers and NGO health workers. The government health workers regard the NGO as short term (interview #11), unreliable and not trustworthy. At the same time the NGO health workers see the government health workers as not supportive and not serious about their jobs, and treat them as those who neither provide a proper health service themselves, nor let others to do so. When they are in face-to-face meetings they treat each other nicely, but when I interviewed them separately they did not praise each other's work; instead, in some cases, they were completely against the actions and behaviour of 'the other side'. The VHW in Hagam shares his concern about the NGO's health service in Hagam VDC:

With NGOs who come here to work, we make discussions with them regarding how we can go together in making the national health programme successful. However, they work as per their organization's plan (Health worker, male).

4.3.2.1.4 Role of NGO health service providers

NGOs complement the government health services by providing health care together with the government health service providers. Often NGOs are involved in preventative rather than curative health services. Their approach is more towards the modern medical system than the traditional systems of prevention and cure. Their involvement in health is to fill the gap between the villagers' health need, and the available health services. They do this by advocacy, campaigns and support in direct health services. Another role they have is to encourage the traditional health practitioners to continue the good practices, adopt new practices and abandon the bad practices, for the benefit of the whole community. NGOs in both Hagam and Fulpingkot are involved in both preventive as well as curative health services. They encourage all the actors to participate in PHC. Their role in PHC involves all aspects of participation in needs assessment, programme implementation, programme management and resource mobilisation. They encourage all the actors to participate in these rather than participating

themselves. Different NGOs have different objectives for working in certain areas. From the state's point of view, NGOs are working in health sectors to provide health services to all the citizens, which is the state policy.

Talking about the VDC, the resources for health is with the VDC. Rather than telling that resources are there with sub-health post, there is a practice here that people visit NGO Clinic for treatment. However, NGOs provide services only for a limited period; they cannot provide services for long. But the people here think that all resources are from NGO.....people are receiving services and medicines from there. But these resources should have been provided by the government or sub-health post (Villager, male).

Since NGOs are temporary, their space in the local power structure is not significant. They have power over other actors and the community through the resources they bring. Since the NGOs' activities are of temporary nature, often they are not taken seriously by the state, except in the form of extra resources. Though NGOs' participation in PHC is significant at community level, their recognition at the national level is very limited. It is not only because of the small size of their contribution, but often because of their advocacy of various issues of citizens' health rights, that the government actors are infuriated.

Despite these problems, NGOs still manage to work in these VDCs, because they bring in additional resources. They advocate to reach to the backward community and excluded groups of people to provide services. Furthermore, they also fill the gap of absenteeism of the government staff and address the issue of lack of health services to some extent. This allows NGOs to work in these VDCs, because villagers are happy that they have some degree of health service, and the government health workers are happy because it takes some of their pressure off.

4.3.2.1.5 Traditional healers

It might have been my professional bias but I was surprised to find that the traditional healers are still the major player in PHC in both Hagam and Fulpingkot VDCs. Almost all of my interview participants except one admitted that they still visit traditional healers more frequently than they visit modern health services. They claimed that everybody in the community does so. Educated people in the community,, for example, school teachers and even the local health workers, first go to traditional healers before they decide whether to go

for modern medical treatment or not. This has given a tremendous power and space to the traditional healers in these villages compared to other health systems actors who provide health services. These healers treat people by mantras and chants. Over 20 men in each VDC practise traditional healing; I did not come across any female traditional healer in these VDCs. These traditional healers have a very good relationship with villagers, but they do not participate in any modern health service related activities, unless they do not have any other choice.

The traditional healers I interviewed did not trust the modern health service as such, except for treatment of some serious illnesses, for which they had been hospitalized themselves. Even in such cases they claimed that it was their children and other community members who decided to take them to the hospital, rather than themselves. They claimed they would have been ok without intervention. When asked about their participation in PHC, the traditional healers said that the villagers visit them whenever they need their service. Sometimes they are called to people's homes for treatment. They are well respected in the community. Therefore, though they did not exercise much power over other actors in decision making, they seemed to have a very strong influence in regard to people's health, and health systems locally.

Furthermore, I found that these traditional healers do not have any systematic route for training as a traditional healer. Their training varied from three days' to three years' of meditation, praying and chanting with their teachers. Interestingly their seniority is not based on the number of years of their training, but on their age, the elder traditional healer being more trustworthy in the community. The traditional healers, as well as the other actors, informed me that the numbers of traditional healers are decreasing since fewer people come to them these days. In addition to this, they said that the numbers of traditional healers are decreasing because fewer people are interested in being a traditional healer these days; even the children of traditional healers are not interested. Likewise, more people are interested in modern Western medicine, which also reduces the numbers of people visiting these healers.

My grandfathers were also Jhankri (traditional healer). I also had similar symptoms, so with a guru (teacher) I stayed in graveyard (where traditional healers meditate) for 15 days to become a traditional healer. However, my son says he does not want to be a traditional healer (Traditional healer, male).

Not only are the numbers of traditional healers decreasing, but the way they practise is also changing. They said they used to sacrifice chicken and goat for treatment in the past, but these days they rarely do that. Instead, they ask for eggs, rice, home brewed alcohol and other food items in return for their traditional healing services. They are changing their practices because the government health workers and the NGO health workers who promote modern Western medicine conduct various health awareness campaigns where they encourage villagers not to rely on traditional healers but to access the modern health services. The younger generation, especially those who are educated with a Western model of education, do not believe in traditional healing practices. However, those villagers who still believe in traditional healing, and those who cannot access modern health care because of distance, belief, or financial reasons, still access services from traditional healers. The traditional healers are changing their practices because modern medical practitioners and educated people are questioning them about the scientific bases of traditional healing practices.

The elderly in both VDCs relate health mostly to natural and spiritual things, for example, God, ghosts and other natural powers. Therefore, some of these people relate illness to one or more of these things, and believe that traditional healers can get rid of these external forces which are causing health problems:

We visit traditional healers when we suffer from problems like 'bhoot-pret' (ghost) or others (Villager, male).

Some people in the village still believe in ghosts and they think that if someone is 'attacked' by a ghost they get treatment from the traditional healers.

If someone is suffering from 'lageko' (imposed by someone or something) then they perform 'chinta' (meaning if someone is suffering from ghosts then the traditional healers perform their treatment rituals)(FGD, female)

The traditional healers treat people by chanting, and sometimes by feeling the patient's head, stomach and often the part of the body where the patient complains of the pain:

They only perform 'chintagarne' (treat people by chanting) if they are called. People call lama/jhankris as well (Volunteer, female).

People claim that they have first-hand experience of successful treatments from traditional healers:

If people suffer from headache, they say it is because of 'bhoot lageko (attacked by a ghost)'. We have seen that dhami/jhankris can also treat about 25 % cases (FGD, male).

Even though most of the participants admit that they have visited the traditional healers for treatment, some expressed very strong disagreement about its appropriateness for treating certain health problems. They seem to be selective in using different services based on their understanding about the problem, for example:

If a pregnant woman has malpositioned baby in her womb then dhamis (traditional healers) perform 'manchhaune' (treatment) telling that it is due to other causes. They give jadibuti (herbs) but those conditions are meant to be treated in a hospital which these traditional healers / herbal medicine practitioners won't know (FGD, male).

4.3.2.1.6 Role of Traditional healers

Traditional healers are the first point of contact for most of the people in the community especially for treating ordinary illnesses and childbirth and safer motherhood related problems. Therefore, their role in PHC is significant from community participation point of view. Most of the respondents including most of the health workers and the teachers agreed that they have been to the traditional healers for advice for their own or their children's illnesses. Before the start of the modern medical system, these traditional healers were the only health service providers in the community. Their healing methods are spiritual practices, praying, shamanisms and religious worships which are mostly faith based. I observed that many people are still in confusion whether to follow the traditional system or the modern medical system. Most of them said that they follow both and they are convinced that not all the diseases get better from either.

They go for check up with modern health workers and bring medicine but still go to dhami and jhankri for treatment (Villager, male).

Often the poor, elderly and women rely more on these traditional healers than the younger, educated and rich. Traditional healers have been practising for a long time and it is a part of their livelihood. There are at least 2-3 traditional healers in each ward thus numbering more than 20-25 in each VDC (interview #25). Currently the government health system does not recognize the services provided by these traditional healers, so their contribution does not come into the health management system information (HMIS) records. Instead, the

Government encourages them to motivate the people to use the modern medical system and sometimes trains them to do so.

It is not only their proximity that attracts the people to these traditional healers but also they are often from the same caste, culture, economic status which people feel more comfortable attending compared to the modern medical practitioners. Another reason for villagers using the traditional healers' services is that they do not charge a fixed fee as the modern health service providers. Villagers get the services on their doorstep at an affordable cost from a person they know which motivates people to use the traditional health services. In addition to that the traditional healers talk about god, ancestors, nature as a whole and relate health and problem to the bigger world than just the disease, which convinces people to follow their practices. Traditional healing practices do not have a standard procedure, instead the healers tailor their process based on people's social and financial status, that makes them more acceptable to the villagers. However, their participation and contribution in PHC is less recognized. From the participation point of view their contribution is by providing alternative way of health service which is also a resource.

4.3.2.1.7 Herbal medicine practitioners

These people practise herbal medicines. They get their training from their parents or teachers in the community. Some of them go to forest to collect herbs and some plant those herbs in their own field, often they do both. Often those who practise herbal medicine practise traditional healings as well. They said their practice is going down because herbs are becoming scarce so they cannot find sufficient herbs in the forest these days. They claim that though there is modern medicine people still come to them for basic treatments as well as for those cases when people do not get well from modern treatments. These herbal medicine practitioners claim that their treatment system is equally as effective as the modern medicine system. They believe that the modern medicine uses the same herbs and minerals that they use.

Now a day we get a medicinal cream. If we apply that in the parts where it hurts and put it in the sun. The pain goes away instantly. But the plant from which that cream is made is in our village. Now we have to pay lots of money for that cream while the plant is available here (Priest, male).

Similar to the traditional healers the villagers visit these herbal medicine practitioners alongside modern medical treatments and vice versa.

4.3.2.1.8 Role of Herbal medicine practitioners

Herbal medicine practitioners are also equally active in both of these VDCs. Compared to the traditional healers herbal medicine practitioners are fewer in the community. Their involvement in the PHC is as the occasional service provider. They learn their skill from their parents and village elderly and often their clients are elderly, women and children. The Government does not recognize their treatment as authentic so they are neglected in the formal health system though they still practise in the community. Their participation in PHC is in the form of contribution in alternative resources for health.

4.3.2.1.9 Lamas (Buddhist priests)

Though these priests mainly perform religious activities, occasionally they do some health related activities as well. People go to these Lamas if they are not well. More than treating people they perform worships (puja) chanting the Buddhist verses from their sacred book. I observed that this is more for psychological counselling than direct treatment. Almost all of the Buddhist people visit these Lamas regularly for prayer for betterment of their families and for their good health. These Lamas are well respected in the community. They perform health related activities but their participation in PHC and their relationship with other practitioners seemed very limited. Their main role is during the naming ceremonies of the new babies and performing the death rituals. Religiously every family must perform some function to mark birth and death. These Lamas seem to be functioning in their own. Their relationship with other actors is limited to their services and mostly seems it is one-way communication based on their study and their knowledge to the people who visit them. The villagers trust these Lamas very much and they seem to have more power over the community compared to some of the other actors. However, they did not seem to exercise their power in other than their religious practices. Even though Lamas are not involved directly in modern health services other actors who are involved in modern health services request these Lamas to convince the villagers for the use of modern health services, because the villagers rarely deny what these Lamas suggest they do.

4.3.2.1.10 Hindu Priests

Similar to Buddhist priests there are also Hindu priests in the study area. The main role of these priests is also to do religious rituals related to birth and death. These priests have more active role in community participation than the Lamas. These priests do not have direct role of treating the patients but they perform some religious ceremonies for their clients' good health. They perform the naming ceremonies, marriage ceremonies, after death rituals, annual memorial ceremonies and often the astrology based fortune telling. Because of the roles they play, these priests exercise strong power in the community. Villagers take advice from these priests before starting a new thing, for example people ask these priests about children's future if they are too sick or do not get better from any diseases for a long time, ask for advice before laying out a foundation stone for their houses and before starting a new business. Hindu families arrange certain religious ceremonies every year to scare the evil matters away from their homes for better health and for the good of the family, which are promoted and performed by these priests. These priests are consulted for matching stars to find out whether bride and groom are suitable for each other. Therefore, these priests have a strong influence in people's life. One of the priest in Fulpingkot practises traditional healing as well.

4.3.2.1.11 Role of Buddhist Lamas and Priests

Buddhist Lamas and Hindu priests are highly regarded in the community for their fortune telling and for their services on the birth and death rituals. When children get ill parents take them to these priests for blessings. Both of these priests offer services, for example, religious ceremonies, studying the stars for the babies and sometimes practise herbal medicine and shamanism. Because of their high status in the society, people take advice from them for household matters including treatment of illnesses.

Lamas also practise 'fukne'. They practise 'fukne' even when someone is suffering from toothache (Villager, male).

These practices are decreasing but in the study area, it is still common. In the communities where the majority of the people follow Buddhism people highly regard their Lamas' advice. These Lamas and priests also have a divided view about modern medical system and traditional systems. Since they are the educated people in the society, they often work as a catalyst to support the modern medicine system. Even when they prefer the modern medical systems, it is for their clients that they perform the religious rituals and ceremonies. Government and NGOs use these priests to motivate people to participate in various health

issues. From participation point of view, they are also an alternative resource for health system.

4.3.2.2 Non-government actors not directly related to health sector

These are the individuals, groups or organization who are not directly involved in health system but have significant influence over it. These actors exercise power over people directly working in health system by controlling through funding, policies and local politics. In the following section I will discuss about these nongovernment actors who are not health professionals but influence the health sector.

4.3.2.2.1 Political party leaders

Because of the recent political revolution and volatile political situation over the last few decades, Nepal is still in political transition. Maoist insurgency from 1996 to 2006 significantly changed the political equation of the whole country from centre to grass-root level. Especially after the dawn of democracy in 1990 and over a decade long Maoist insurgency that led to declaration of country as people's republic overthrowing the 240 years long monarchy, changed the power structure in all levels. A new relatively more inclusive power structure emerged in place of old regime in last decade. This gave a significant power to the local political party leaders. Therefore, currently these are the most powerful actors influencing every decision from central to grass-root level in all sectors and health is not an exception.

Local political party leaders have better access to information, finance and have power delegated to them from their higher levels. In Hagam and Fulpinkot VDC currently there are four major political parties who have a strong hold in the communities, they are Nepali Congress (NC), United Marxist Leninist (UML), Rastriya Prajatantra Party i.e. National Democracy Party (RPP) and United Maoist Party. Political party leaders often follow modern medicine and treatment systems rather than traditional system, however they have a good relation with those who practise traditional healing as well as for political reasons.

Party leaders mobilize the community for their own political benefits as well as for the benefit of the community. Their interest mainly lies especially in resource mobilization and decision making which are often guided by their political ideologies. They have a good relationship with most of the actors and the community follows what they ask them to follow especially of the same political ideologies. However, because of different political ideology, there are problems

of participation in various activities including primary health care. These two contradictory behaviours of political party leaders shows that their participation is value laden for their political ideology rather than their participation in health system for the benefit of the villagers as such.

I am currently working as a representative of a political party. Recently, I put forward the matter about health fund in the VDC council. They said that they used the money for maintenance of sub-health post and other activities. Actually, for the maintenance of sub-health post, the VDC allocates separate budget every year. It also allocates budget for immunization clinics every year. When I put these matters there, they say that now the system has changed. It is very awkward for us to put these matters repeatedly (Villager, male).

This shows that there was a conflict among the council participants about misuse of the budget allocated by VDC.

4.3.2.2.2 Ex-political party leaders

From the outset the current political party leaders and the leaders from the ex-regime and those who were in power in the past look the same but in reality they are different. These groups of political party leaders still hold power over those people whom they ruled when they were in power. There are cases where they had done personal favour, development activities or had not put extortion on ordinary people during their tenure, because of which they are still respected and followed by ordinary villagers. Since these were the leaders when most of the current health system was planned, established and run, they still feel ownership of the establishment and especially the elderly group of population follow these people. However, this group of leaders have a split view about the health system. They seem more comfortable with the traditional treatments, traditional healers, priests and suggest people to follow those practices. At the same time since they were the privileged group during their regime and being in well off group even now, they have taken the benefit of modern treatments. These two things put them in a difficult position to promote between what they believe and what they use. From their role in community participation point of view in PHC, they are one of the active actor groups and often act as gatekeeper to access the community. They have a strong influence in the community and people follow what they tell them to do.

4.3.2.2.3 Village heads

These are mostly the elderly people who earned their status by being a useful member of their community. During my observation I noticed that there are various ways of becoming a village head. In some communities, the village heads are selected by the villagers as a representative and in some they emerge out of the community because of their good work, but often the former is the case. Interestingly the village leaders have always been a male, so here as well it is seen a very strong gender bias. This is an informal system of governance. In some cases, they are even made by rotation i.e. rotating someone from certain community in every year or two. These people sometimes have a multiple role, they are traditional healer, village head, and a political party leader. They exercise a considerable power over the villagers and play important role in various decision making processes. The villagers follow what these people suggest. In case of participation in primary health care, those who are young prefer the modern health practices and the elderly group prefer the traditional healing practices. These people understand health differently than other actors. For example, especially the elder village heads think the process of childbirth is ok without medical support unless something is wrong. They believe that the majority of the population is not covered by the current formal health system. Elderly people, people from lower caste and people whose language is not Nepali are left out from the health services, they think. These are the views these elderly village heads express. Their common feeling seems, who cares about us.

4.3.2.2.4 Cooperatives

Cooperative is not a new concept in Nepal but they boomed since the dawn of democracy after 1990. There are various cooperatives in Nepal some of which are of the size of big banks running big businesses and hospitals and some small in the community level. Regardless of the size, the principle of the cooperative seems the same i.e. raise the fund from the members and reinvest where the members think better for their own benefit. These cooperative have a strong role especially in the modern health system. Some cooperatives are solely established for lending the money for health care. There are cooperatives established to lend money only to the women at the time of baby delivery so that they can take them to the health facilities if needed and can have a good diet after delivery. Because the money is collected from the members, the loan processing is not difficult and the interest rate is reasonable. Their participation in PHC is very active, but more in the modern aspect of health service. Since they are organized, they have a strong representation in the meetings, advocacy programmes and

community mobilization. People involved in cooperatives participate in PHC for the benefit of their members.

Health matters are also related with the cooperative. We conducted health songs in two or three programmes. We provided some amount of money for those who won in it. We conduct programs and songs related to health (Villager, female).

These cooperatives especially those run by women are more focused in women's health. I noticed that it is not only the money but the power they draw from their collectiveness is observed to be more effective. For example, the anti-alcohol and anti-wife-beating campaign run by the local women in Fulpingkot VDC during the data collection period was an indication of how they can be empowered from women's collective action, and one of their collective action is working together in their cooperative.

It has been about six years since we started 'milijuli (friendship) maternal and child cooperative' which work for the welfare of mother and children. We collect savings and deposit. We deposit 100 rupees (US\$ 1) every month. We deposit it in the cooperative, take loan when required and return it back within 6 months. In the group, we also discuss about how to care for mother and children to prevent their mortality. Since we established our cooperative there has not been deaths of mothers and children during childbirth or because of childbirth. In emergencies we take pregnant women to hospital in a stretcher or by bus as soon as possible (Villager, female).

4.3.2.2.5 Mothers' groups

These are the formal groups of women formed by the Government often under the leadership of FCHVs to communicate and disseminate formal health information and to collect health information from the community. They are encouraged to participate in PHC by the FCHVs but it is voluntary. These are the groups of people in villages who are actively involved in all aspects of PHC especially on women's health issues. In some places, these groups are registered with the government entity and in others, these are run informally. They are loose groups of women formed to support various community activities including health. They use the services and mobilize the community when needed. They have an active role in community mobilization. There is at least one mothers' group in each ward of both VDCs. Some of the mothers' group are very active; they participate in immunization campaigns, health education and nutrition programme voluntarily and some participate only when invited.

4.3.2.2.6 Income generation groups

These groups are similar to cooperatives but at a more informal level. Cooperatives are independent entities with their own constitution and staff whereas these groups are formed by the community under some government or nongovernment programme. Often some of these groups get eventually transformed into cooperatives but not always. The aim of these groups is to increase the income of their members by conducting simple vocational activities. During observation I noticed that sometimes these groups are also called saving credit groups, poverty alleviation groups, income generation groups, depending upon what sort of programme initiated them. The importance of these groups in PHC is that they provide loans to their members in health emergencies, deliveries and for other needs. These groups' involvement in PHC is more as users than active influencers. I observed that women's participation in these groups has brought them away from their household chores. This has helped them to understand their health needs, alternatives available and to make informed decisions for their health requirements, which eventually increases community participation in PHC.

4.3.2.2.7 Youth clubs

Even though the main motive of these groups is related more to sport, climate change and involvement in local politics, their involvement in PHC is also significant. I observed that they often support the modern medical practices and discourage the traditional systems. These groups are often mobilized by the political party leaders for their various political campaigns. Some of the youth clubs are involved in mobilizing the community in various activities in health awareness campaigns. When there is money in infrastructure development, for example, construction of health posts, repair, or maintenance these groups tend to come forward.

Therefore, in both Hagam and Fulpingkot VDCs, the nongovernmental actors are more active than the government actors especially in advocacy and awareness raising in health. Some of the actors are directly involved in health services. The nongovernmental actors participate in all aspects of participation to some extent. They bring in additional money, material resources and additional human resources for health which puts them in the centre of the local health system.

4.3.2.2.8 Role of nongovernment actors not directly related to health sector

Even though these groups of actors are not directly related to the health sector they still have a very strong influence in PHC. These are nongovernmental actors who do not have any formal role in PHC but because of the power they hold for various reasons they have a significant role in the health system. Currently political parties are very strong, their influence can be seen in almost all the sectors including PHC. Leaders from ruling political parties, oppositions as well as the leaders from the previous regime exercise power over other actors. Often the government health workers follow the ruling party's political ideology and get support from the local leaders. The political party leaders often lead the programmes and processes. Their main involvement is in resource management, community mobilization and leading the community.

The district level actors consult with district level political party leaders for advice on new programmes, infrastructure and needs assessments. These leaders participate in various issues including those related to PHC mainly to maintain their power over the community for their political benefit. They are very actively involved in VDC budget allocation processes and try to influence where the money is allocated. Their main role is to allocate the budget for the community where they have the majority of their followers. This tendency often leads to unequitable distribution of resources within the VDC. However, at present it is almost impossible to work in any area in Nepal without political consensus. Therefore, political leaders are the main players in health system including PHC.

Some actors operate as groups. Some groups raise money to run their activities whereas some work for some specific social issues,, for example, minimization of caste-based discrimination, stopping alcoholism or help in accessing health care and improving sanitation. Group members support each other when they need help and groups loan money to their members in case of emergencies including when they need money for their treatments. Their participation in PHC is for advocacy and resource mobilization. Some of the groups, for example, youth clubs are active in infrastructure developments. Youth groups get money for infrastructure, advocacy campaigns and community mobilization and mobilize the youth.

4.3.3 Offstage actors

In addition to above discussed actors present in Hagam and Fulpingkot VDCs there are other actors who have a significant influence over the local actors. These actors are often the district

government authorities, departments, ministries, bi-lateral organizations and sometimes even big INGOs. I will discuss about offstage actors in the following section:

As already mentioned in previous section, in the current health system structure in Nepal, the sub-health post is the lowest level on the organizational structure. Principally the sub-health post reports to the health post or Primary Health Care Centre, which reports to the DHO, which reports to the regional health service directorate and finally to the ministry of health through different departments. Even though one of the officers interviewed from the district health office claims that the planning and policy making starts from the grass-root level, that is rarely the case, because it is often the political party leaders and higher level government officials who make the decisions at all levels:

We plan at sub-health post or VDC level at Area level, of area at district level or District Development Committee. Then we forward plans to National Planning Commission or Ministry of Health (MoH). That is public participation. FCHVs represent the local community and head of the health facility as represents government staff at the local level. That is the first level of public participation. We demand for necessary/ specific programme. That's it (Government worker, male).

Furthermore, health system is not only related to Ministry of Health but also interlinked with other ministries and government departments too. Sometime in certain social issues, the district administration office and the District Development Committee have equal roles as that of the district health offices. For example, one of the mothers' groups who is working against men drinking alcohol and beating their wives, share their stories:

From CDO office Chautara (district headquarter of Sindhupalchok district) also said that we are doing a good work so they promised to help us. If we face any problem in our work then they are ready to help us (Villager, female).

It is not only the power they exercise over local health system but their behaviour also affects local health system. Health professionals' absenteeism is common problem of government health system in Nepal (Poudyal, 2012). The absenteeism of district level staff automatically affects village level staff because of the lack of monitoring and supervision. The villagers have very little say in addressing these issues. Similar to the education system in Nepal, the villagers think that the health service provided by the private health service providers is better than that provided by the government providers. The absenteeism of the health workers has fuelled

this belief more. If available, the villagers, who can afford it, prefer the private health service providers and private medicines compared to the government health service providers and medicine provided through the government health facilities. This poses a difficult scenario for both the health service providers and the villagers.

Even though it is claimed that plans and policies are developed based on the suggestions and feedbacks from the village level (interview #41), I observed that in practice it rarely happens. Often the policies and plans are made in the department and ministerial level and implemented downward. There is a mechanism to feed back the suggestions but it is hardly ever followed. For example, contrary to what the Health Officer (interview #41) claimed as above an interview participant in Hagam shared his view about the decision making process as:

There is no such person for making the decision. To talk about health, in health works/programs (mentions the name of government VHW) is responsible. He is responsible to decide about health related programs in this VDC because he knows who is better person for doing a specific job. Whether in health or in VDC, in every matter it is same. There is nothing we can do (Villager, male).

This view from the community leader confirms the former statement of the government health worker that there is no input from the community in the decision making process but it is decided by the government health workers for the community. I have observed that one of the District Health Officer during a discussion about community participation clearly said that he is the community. This is reflected during the decision making processes in the villages as well.

4.3.3.1 Role of Offstage actors

There are government health workers in District Health Office, Primary Health Centre and Health Post level who are responsible for various formal health services and activities in the VDC. These people exercise more authority and power over the local health workers and other actors. Their involvement in some aspects of participation is higher than local actors' participation in PHC. For example, their participation is mainly in decision making about the health need, human resource recruitment, budgeting and other resource mobilization. They get their power and authority from the State in the form of the organizational power they represent and the position they hold. They exercise these powers in the form of their regular job responsibility. Often they get this power from the state in the form of policies, rules and

guidance. They exercise their power through their formal and informal channels for example through their junior staff and public information.

A political party leader I interviewed in Jalbire VDC explained that he does not have a direct role with health but still has a significant influence in various decision making processes, for example, budget allocation, staff management, resource mobilization and health campaigns.

Actually local leaders have a significant role toward health sector. I have explained it to you before about bringing staff, managing physical infrastructures, and assisting in different health programmes of the state for creating a good working environment. There are many things that local leaders do. actually all local representatives, political parties, intellectuals, persons who are in leadership all work for health because it is very important sector (Villager, male).

A former teacher and leader of a cooperative movement tells me that they have an equal role as of the health workers to encourage people to use the appropriate health services because people come and ask for their advice.

We can create awareness among the people by telling them to go to the hospital, to go in time, not to just go to private medicine shop (called medical in Nepal) and not to trust dhama / jhankri (traditional healers). I tell them that even if they consult dhama / jhankri at the beginning, they should immediately go to the hospital after that (Villager, male).

Similarly, even though the primary aim of private medicine shop owners is to sell medicine and provide modern health services privately, he supports the overall health programme in the VDC.

Our role is to support the programmes that are proposed by the State. If we are informed about the programme which are being conducted in the VDC then we can choose whether they are required for us or not. Other roles are simply supporting the programs in any possible way we can (Villager, male).

This shows that the offstage actors have an important role in PHC. It would have been unwise to exclude these actors from this study because it would subsequently exclude their participation and views. Therefore, people's participation here means their involvement in providing, receiving and supporting modern, traditional as well as spiritual approaches applied

for betterment of population health from health perspective. Therefore, here participation in PHC can be direct involvement in providing, receiving, ensuring or supporting the health system no matter whether it is modern health system or traditional and spiritual approaches. These can be participation in providing health services, free labour contribution, contribution in policymaking, awareness creation about personal health and hygiene, performing traditional and spiritual healing practices. But this does not include those aspects of the community participation which are not directly related to health, for example it will not involve things, for example, participation in road construction, agriculture improvement, water and sanitation improvements, and school construction as participation in PHC though these also help in people's health to some extent in long run.

4.4 Key issues emerged from above findings on actors and their roles:

Above findings and analysis illustrate that different actors understand PHC, CP and the actors differently. There is a lack of recognition of each other's contribution in PHC and often have a malicious view about other actors. Similarly, there are differences in understanding each other's role. The following sections further discuss about actors' understanding about PHC, CP and actors and their roles:

4.4.1 What do actors understand about PHC?

Most of the actors do not understand what is PHC and what does it involve. The Alma Ata Declaration of PHC proposed PHC as a holistic approach including other sectors, for example, provision of safe drinking water, nutrition, food, agriculture, animal husbandry and inclusion of existing structure (WHO, 1978). However, no such inter sector coordination was seen in the study area. People understand PHC as existing modern health services no matter whether it is basic health service from the local clinics or the higher-level health services from hospitals. Furthermore, grass-root level actors refer PHC more as available health services from the government. They often even do not consider privately available health services as part of PHC. Therefore, there is a fundamental lack of understanding about the PHC among the grass-root level actors. People rarely refer to other sectors in relation to PHC.

Traditional health systems run parallel to the modern health system. Most of the actors in both VDCs access modern as well as traditional healing practices as complementary approach to each other. Despite the government policy of inclusion of traditional healing practices in health system, it is still not practised as part of PHC locally (MOHP, 1991, Tamang and Broom,

2010). Instead, modern health workers often treat traditional healers as backward and their treatment processes as outdated. Even though government actors are promoting modern health services the understanding about PHC among grass-root level actors is still low. It is mainly because of low level of awareness about PHC, lack of ownership of the system and difficulty in accessing the services. Furthermore, the traditional practitioners and their followers think that the modern health system is imposed over the traditional health system without considering its implication on the practitioners and the users. This has created conflict among the traditional healers and the modern Health System Actors. Therefore, it is not only the lack of understanding about what PHC involves but also the top-down approach of imposing the modern health system over traditional health system that has created problem in understanding PHC.

4.4.2 What do actors understand about CP?

The Alma Ata Declaration defined CP in PHC as people's full participation in decision making about their health system themselves from designing to implementation (WHO, 1978). However, at local level different actors understand community participation differently. Most of the actors understand their access to the available Western modern health services as their participation in PHC, no matter whether it is basic health services from the local clinics or higher level services from distant hospitals.

Another aspect of people's understanding as their participation in PHC is their contribution to infrastructure development and maintenance. Most of the actors especially the local actors contribute in cash, kind and free labour for construction and maintenance of the local health infrastructures. Similarly, many of the actors participate in health education and awareness campaigns. Most of the actors understand such involvement in these activities as their participation in PHC. Nepal has introduced different models to ensure CP in PHC. For example, village health leaders, VHW, MCHW, FCHVs and HFMC are some of the government introduced mechanisms for CP in PHC. Even these are more to support certain health interventions rather than overall CP in PHC except the HFMC. HFMC is one of the community participation mechanisms present at the local level but even this also represents only token participation. HFMC does not have any role in decision making in PHC and it hardly represents the community. However, FCHV is one of the most successful community participation mechanisms in Nepalese health system.

Similarly, there is no mechanism to participate in PHC other than through HFMC and FCHV at local level. There are other practical difficulties as well. For example, there is no mechanism of participation of multiple actors present in these VDCs to participate in PHC at the decision-making level. Therefore, the lack of CP can be because of lack of interest among higher-level actors to encourage grass-root level actors to participate in PHC. This is mainly because these higher-level actors, for example, international actors, central level government actors and district level actors might be reluctant to share the power, resources and the credit with the community as envisioned by the Alma Ata Declaration.

Furthermore, even if the higher-level actors agree for grass-root level actors to participate in PHC, the current mechanism of participation does not allow these multiple actors to effectively participate, i.e. in making decisions about their health systems themselves. It is because the current mechanism of participation in PHC through HFMC does not represent the community as such. The HFMC often represent village elites, men and people from higher caste that exclude Dalits, the marginalized and women. Therefore, there are multiple problems in understanding about CP in PHC. The current definition of CP in PHC is not clear about how multiple actors can participate effectively.

Furthermore, current health policies are not clear about the process of ensuring participation of grass-root level actors beyond the HFMC level, for example, if the HFMC is not representative there is no answer for how to make it more representative. Another fundamental challenge is that even if the system intends to ensure participation of grass-root level actors, is it possible? If it is not possible, is it worth carrying forward it as an important aspect of PHC? These are some of the questions worth further exploring.

4.4.3 What do actors understand about themselves?

Even though this research categorized 26 different actors who have roles or influence in PHC and recognize others' presence, they hardly recognize other actors' contribution in PHC. Such malaises seemed more to do with the power sharing, credit sharing and fear of losing access to common resources. Such behaviour is more from the government actors than from other actors, because the government actors assumed themselves to be the major player in PHC, which is one of the reasons of conflict between the government and nongovernment actors. The traditional and nongovernmental health system is bigger than the formal health system in access and influence, has a higher number of actors and more coverage, therefore when the

government actors try to take credit of the whole system, it creates conflict. The informal health system functions independently and to some extent it is beyond the control of the formal health system. Instead of recognizing, facilitating and coordinating other actors the government actors at local level try to control the informal sectors; that creates conflict between these two groups.

There is another issue on actors' recognition. The government recognizes CP only to HFMC and FCHVs. As explained above often the HFMC does not represent all the other actors present in the community and selection criteria of FCHVs are also often questionable. The government has some reserved seats for people from lower caste, poor and marginalized groups to represent in HFMCs and FCHVs, but because of the prevalent social, cultural and economic hierarchy they are hardly selected and their voices hardly make it to the decision making level. The offstage actors are more powerful and have more say in decision making than local level actors. Because of higher influence of these offstage actors in making decisions, there is a problem in ownership of the system by the local actors. Another phenomenon is that most of the key positions are held by a same elite group of actors, for example, the active members of HFMC, school management committee, water users' committee and cooperatives are common. Therefore, the participation in the form of committee members rarely represents the women, Dalits and people from marginalized groups. Therefore, CP in the form of members of certain committees and groups does not ensure the participation of all the actors.

4.4.4 What do actors understand about their roles?

Most of the actors had their role as defined by their profession. Often the formal health workers had their role defined by the professional training they had and the position they held in the system. The non-health actors had supportive role in PHC compared to those who had some health related professional skills. Informal Health System Actors, for example, traditional healers referred to their role as assigned by super natural power, knowledge they got from their parents as well as their skill to perform the healing process. Most of the health systems actors who are directly involved in delivering health services are aware of their role in the health system. However, some of the actors are fulfilling certain role as part of their daily chores. For example, the traditional healers, priests and Lamas take it for granted that they are selected by the society or god to perform certain duty. They perform those duties as part of their occupation. They often refer to god for selecting them to perform such duties. It is not

only these actors themselves but other actors mainly the villagers also believe that these actors were selected to fulfil certain duties.

4.4.5 What do actors understand about their contribution in PHC?

The government actors did not recognize contributions of other actors in PHC. Even though they ask for the material, labour and monetary contribution from other actors for PHC they did not have a system of recognition. Similarly, non-state actors complained that the government actors are not fulfilling their duties properly. Often there is conflict among the government and other nongovernmental actors. It is mainly related to power play and fear of sharing the resources among different actors. Even though salaried health workers agree that they work for their livelihoods, they also claim that they want to serve the community. Whereas, other actors say that salaried health workers are fulfilling their assigned duties for their livelihoods as well as for other financial and material benefit. Similarly, private modern medicine practitioners claim that they are providing service to the community, whereas, the villagers and other actors said that they are working for money.

Voluntary contribution in PHC and work of regular volunteers, for example, FCHVs and members of HFMC is highly respected by villagers and other actors. However, the members of HFMC are treated more critically. Villagers think that it is responsibility of the HFMC to ensure the regularity of the health services and staff in respective sub-health posts. But, HFMC do not have such role and authority, therefore, there is conflict between HFMC and other actors.

4.5 Summary

This section reveals that most of the actors do not understand what PHC is. It is not only in the actors' level but also in policy level, it is not clear what constitutes PHC. Current health system does not take the existing traditional health system into account even though this is included in the policies. There is dissatisfaction among the traditional health system practitioners and followers that Western modern health system is imposed upon them without provision of sufficient resources. Most of the actors are not clear what PHC actually involves, whether it involves the existing traditional health system or not. This has created conflict among these actors and has affected their participation in PHC. Furthermore, current mechanism of CP in PHC does not ensure participation of all the actors. Currently the mechanism of CP is through the HFMC which often exclude participation of marginalized, women and Dalits, and even if they participate their voices are not reflected in the decisions. The problem of CP also seems

more to do with the systemic problem rather than a local problem. The system is not clear how participation of all the actors is possible in making decision about their health system. Most of the informal actors fulfil their roles as part of their daily life whereas the formal health workers fulfil their roles as guided by their professional trainings or the positions they held. There is conflict in recognition of the contribution of multiple actors in PHC. Even though the government health policies mentions the contribution of informal and private health system, at the local level it is hardly so. Therefore, government and private health sector is always in conflict because of common working area and sharing of common resources.

4.6 Conclusion

All twenty-six types of actors present in Hagam and Fulpingkot VDCs had their own way of participating in PHC. Not all the actors participated directly in health but had a significant contribution in people's health in the VDC. Actors whose assigned as well as adapted role is to provide health services whether it is a Western medical system or the traditional and spiritual healing practices have a higher degree of participation in PHC than those who support PHC from the periphery. Government health workers, NGO health workers and traditional healers were the main actors to participate in PHC. The governmental and nongovernmental actors were promoting Western medical approach for general health care. Their participation in health needs assessment, health programme implementation, management and resource mobilization is more than other actors. The traditional and spiritual healing practice is engrained in the society in such a way that majority of the villagers have used such services at some point of their life and some of them are still using, without any promotion from the practitioners.

Most of the actors were aware of each other's presence in the community but often they did not want to acknowledge other actors' contributions in health systems. The government health system at local level hardly acknowledges the contribution of informal sector i.e. private, nongovernmental and traditional Health System Actors' contribution in primary health care. Informal health systems actors i.e. organizations as well as individuals are blamed of being motivated by financial benefit rather than service ideals by the governmental actors. Similarly, the nongovernmental actors believe government actors as less trustworthy, irregular and a bully. Whereas, other actors are suspicious of NGO health workers and think that they have some hidden agenda in addition to what is seen locally. When they are interviewed separately, they do not seem supporting each other, instead often they seem expressing malicious views

about other actors. Those actors who are providing direct health services have better relationships with each other and with the villagers than with those working in advocacy and supportive roles. Similarly, curative health services providers are recognized by the villagers more than those working in preventive health services.

Though villagers were found to be the main actors of health system, their role in the health system was mainly to act as catalyst towards promoting the health services, use of the available services and in resource mobilization. Villagers have limited say on health needs assessment, programme implementation and programme management. The government actors who have direct access to the resources, for example, VDC Secretary, VDC Technical Assistant, District Health Office and political party leaders have higher say in decision making in PHC than those who provide the health services and those who receive. This shows that however good policies are made at national level there is a gap in implementation.

In chapter five I will present the relationships of various actors in the process of their participation in PHC.

CHAPTER FIVE

Relationship between the Health System Actors in PHC

5.1 Introduction

This chapter presents the findings and discussion about relationship and interaction between various actors in the process of their participation in PHC in Hagam and Fulpingkot VDCs of Sindhupalchok district. Relationships between various actors are analysed and discussed in four different groups. It is between various actors who are directly involved in health and between those who are not directly related to health. Same approach is applied to analyse the relationship between nongovernmental actors and for mix of government and nongovernmental actors.

In this context, relationship is a means of sharing ideas, work and resources among different actors in health systems. Relationships can be productive as well as counterproductive for CP in PHC depending upon whether different actors involved in a particular action agree or disagree with each other. Furthermore, the relationship is seen as how different actors approach each other, how they help each other and how they respond to each other's work. In this chapter, the relationships between actors are interpreted based on their responses about their relationship with other actors (interview#1, #3), from their statements about other actors and from observation during data collection. During my research, I observed that most of the people were self-centred and mostly interested in their personal benefit. Furthermore, most of the actors with higher authority and power looked down at other actors. Similarly, actors, for example, villagers and other local actors seemed reluctant to approach other actors who had higher power and authority, especially to those who come from outside. Some of the villagers were hesitant even to access the available PHC services.

Now the relationship between dhami and jhakri is like, they do not believe in health workers and the health workers think dhami and jhakri are superstitious. So I do not think their relationship is good (villager, male).

My data showed that most of the actors were eager to explain about other actors' relationship rather than explaining about their own relationship with other actors. When directly asked about their relationship with any other actors they claimed that they have positive relationship (interview#1) whereas when talked about relationship between other actors they explained about their positive relationship as well as their conflict among them. For example, when I

talked with NGO health workers about their relationship with government health workers, they said they have a good relationship and the government health workers also said the same thing (interview#3, #39). However when I talked with villagers they said that the government health workers and the NGO health workers do not have a good relationship. My personal observation is that most of the actors have a tendency to complain about other actors' activities.

.....the relationship between them is like dhami and jhakri do not believe in health workers and the health workers think dhami and jhakri are superstitious. So I do not think their relationship is good (villager, male).

Therefore, the relationships among different actors are drawn from combination of their direct responses about their relationship with other actors, responses from other actors about their relationship with different actors and researcher's observation. The term relationship and interrelationships are used interchangeably in this research.

Based on the responses from the participants about their relationship with each other their relationship is grouped into following four categories:

Table 5.1: Relationship among actors

SN	Relationship	Description of relationship around PHC
1	No relation	There is no visible relationship between two actors. This can be because they do not have anything common to share because of the distance, difference in profession or because of the differences in each other's approaches. Such relationships hinder these people's participation.
2	Minimum relation or Neutral	When there is some relation between the actors but there is lack of acknowledgement of such relation. In such relationships the actors know the presence of other actors but often do not value their presence.
3	Working relation	When different actors can work and collaborate together if needed. This is when they work together at the implementation level, but do not share details of their activities, plan with each other beforehand. Such relationships can still motivate people to participate in PHC.
4	Working together	When actors are working together towards a common goal.

		<p>There is higher level of coordination and cooperation. In these relationships the actors plan together, share the pros and cons of the approaches and address those together to fulfil common objectives. Such relationships motivates different actors to participate in PHC.</p>
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Sometimes these relationships vary within the same groups of actors as well, especially if the actors have multiple roles. For example, the relationship between the government health worker and the VDC technical assistant is a working relationship when the government health worker is working in a sub-health post. When same person works as a private medicine shop owner she/he has no relation or are even against this health worker because of the change of role, even though both of them are government employees. This was evident from my interview with the VDC technical assistant who was very supportive of the VHW in Hagam (interview #4) for the health service provided by him but he complained about the government health worker having a private medicine shop, selling medicine at higher prices and charging for checking patients. It is because the VDC technical assistant is responsible for ensuring the fair businesses in the community. The relationships are presented as no relationship when there is no interaction between the actors related to PHC. There might still be relationship between these actors on other aspects of life but not related to PHC. For example, the relationship of schoolteachers and the political party leaders are active because of teachers' heavy involvement in political matters but they do not have any relationship regarding PHC. Similarly, the village priest will have a good relationship with most of the families for religious matters but do not always have relationship regarding their participation in PHC. Furthermore, the relationship among different actors seemed to vary over time, from project to project and with change in political atmosphere as well as with change of the national government. For example, the relationship between the government employees and NGOs was minimum in Hagam whereas it was mostly working relationship in Fulpingkot. Similarly the government employees change their relationships with the political party leaders depending upon which party represents the government at central and district level.

When there is no visible relationship among different actors because of their nature of job, distance or lack of interest in others' work it is no relationship. Sometimes no relationship can be because of their conflicting interests. When actors are aware of other actors' presence but rarely work together their relationships are categorized as neutral or minimum. When actors

support each other in their respective jobs, they have a working relationship. Some actors work together in PHC as team, their relationship is categorized as working together. Since there are 26 actors, there is a possibility of over 300 incidents of different combination of relationships among these actors. I have presented the relationships among these actors in matrix form in the figures 5.1 and 5.2 for Hagam and Fulpingkot VDCs respectively, which gives a picture of different relationship among various actors. In the relationship charts in figure 5.1 and 5.2 the letter “o” represents no relationship and/or conflicting relationship, “x” represents minimum relationship, “y” represents working relationship and “z” represents the working together relationship. I have presented the relationships of ANM with other actors in Hagam and relationships of private health service providers with other actors in Fulpingkot as example in following two paragraphs.

The relationship matrix in figure 5.1 shows that the ANM in Hagam has no relationship with the security personnel, which means the security personnel do not have any direct relationship with the ANM but she has some relationship with private health service providers and cooperatives even though they do not support each other much, because the former two sell their services whereas the ANMs provide their services free of cost. Furthermore, she has a working relationship with VHW, HFMC, caretaker, VDC technical assistant, school teachers, traditional healers, herbal medicine practitioners, political party leaders, ex-political party leaders, village heads, income generation groups and youth clubs. Whereas, she has a working together relationships with NGO workers and the villagers.

Similar relationship can be drawn from relationship matrix in chart 5.2 among different actors in Fulpingkot VDC. For example, the relationship between the private health service providers and the caretaker, traditional healers, herbal medicine practitioners, Lamas, Priests mothers groups and income generation groups is no relationship. Whereas, their relationship with ANM, FCHV, HFMC, VDC secretary, VDC technical assistant, security personnel, school teachers, NGO health service providers, political party leaders, village heads, ex-political party leaders cooperatives and youth clubs is minimum. Furthermore, the relationship between the private health service providers and the villagers is working relation but they do not have any working together relationship with any other actor groups. Similar relationships among different actors are shown in figure 5.1 and 5.2.

In addition, the relationships among key actors have been further discussed in detail in the subsequent sections of this chapter. Those actors who have most interaction with other actors are treated as key actors.

Figure 5.1: Actors' relationship in Hagam

Actors		Relationship among health systems actors in Hagam VDC of Sindhupalchok district																					
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22
ANM		1																					
VHW		2	Y																				
FCHV		3	Z	Z																			
HFMC		4	Y	Y	Y																		
Care Taker (peon)		5	Y	Z	Y	Y																	
VDC secretary		6	Y	Y	X	X	Y	Y															
VDC technical assistant		7	Y	Y	X	X	Y	Y	Z														
Security personnel		8	0	X	X	0	X	0	X	X													
School teachers		9	Y	X	X	X	X	X	Y	Y	X												
Private health service providers		10	X	Y	X	X	X	0	X	X	X	X											
NGO health service providers		11	Z	Y	Z	Y	Y	Y	Y	Y	X	X	X										
Traditional healers		12	Y	X	X	X	X	X	X	X	0	0	X	X									
Herbal medicine practitioners		13	Y	X	X	X	X	X	X	0	0	X	X	X									
Lamas (Buddhist priests)		14	Y	X	X	X	X	X	0	0	X	X	X	X									
Political party leaders		15	Y	Y	X	X	Y	Z	Y	Y	X	X	0	0	0								
Ex-political party leaders		16	Y	Y	X	X	Y	Y	Y	Y	X	X	0	0	0	X							
Village heads		17	Y	Y	X	X	Y	X	X	X	X	X	X	X	X	X							
Cooperatives		18	X	Y	X	X	Y	Y	Y	Y	0	0	X	X	0	0	Y						
Mothers groups		19	Z	Y	Z	Y	Y	Y	Y	Y	0	0	X	X	0	0	X	Y					
Income generation groups		20	Y	Y	Y	Y	Y	Y	Y	Y	0	0	X	X	X	X	X	X	Y				
Youth clubs		21	Y	X	0	0	0	0	0	0	X	X	0	0	0	0	0	0	0	0	0		
Villagers		22	Z	Y	Z	Y	Y	Y	Y	Y	X	X	Z	Z	Z	Z	Z	Z	Z	Z	Z	X	
Relationship matrix																							
No relationship		0																					
Minimum relation		X																					
Working relation		Y																					
Working together		Z																					

Figure 5.2: Actors' relationship in Fulpingkot

Actors		Relationship among health systems actors in Fulpingkot VDC of Sindhupalchok district																									
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23			
ANM		1																									
MCHW		2	Y																								
FCHV		3	Z	Z																							
HFMC		4	Y	Y	Y																						
Care Taker (peon)		5	Y	Z	Y	Y																					
VDC secretary		6	Y	Y	Y	X	Y	Y																			
VDC technical assistant		7	Y	Y	Y	X	Y	Y	Z																		
Security personnel		8	0	X	X	0	X	0	X	X																	
School teachers		9	Y	X	X	X	X	X	Y	Y	X																
Private health service providers		10	X	X	X	X	X	0	X	X	X	X															
NGO health service providers		11	Z	Z	Z	Y	Y	Y	Y	X	X	X	X														
Traditional healers		12	Y	X	X	X	X	X	X	X	0	0	0	X													
Herbal medicine practitioners		13	Y	X	X	X	X	X	X	X	0	0	0	X	X												
Lamas (Buddhist priests)		14	Y	X	X	X	X	X	0	0	0	0	X	X	X												
Priests (Hindu priests)		15	Y	X	X	X	X	X	0	0	0	0	X	X	X	0											
Political party leaders		16	Y	Y	X	X	X	Y	Z	Z	Y	Y	X	X	0	0	X										
Ex-political party leaders		17	Y	Y	Y	X	X	Y	Y	Y	X	X	X	X	0	0	X	X									
Village heads		18	Y	Y	Y	X	Y	Y	Y	Y	X	X	X	X	0	0	X	X	X								
Cooperatives		19	X	Y	Y	X	Y	Y	Y	Y	0	0	0	0	0	0	X	X	Y								
Mothers groups		20	Z	Y	Z	Y	Y	Y	Y	Y	0	0	0	0	0	0	X	X	Y	Y							
Income generation groups		21	Y	Y	Y	Y	Y	Y	Y	Y	0	0	0	0	0	0	X	X	X	X	Y						
Youth clubs		22	Y	X	X	0	0	0	Y	Y	0	0	0	0	0	0	X	X	X	X	0	0					
Villagers		23	Z	Z	Z	Y	Y	X	Y	Y	X	X	X	X	Z	Z	Z	Z	Y	Y	Y	Y	X				
Relationship matrix																											
No relationship		0	Minimum relation											X	Working relation						Y	Working together					Z

In the sections below I am going to describe the relationship among and between governmental actors and nongovernmental actors:

5.2 Relationship among government actors.

The sub-health post is the government health institution in the VDC, which in principle should have four staff. Both in Hagam and Fulpingkot VDCs there were only two staff in their respective posts at the time of study, one health worker and a caretaker (also called peon).

The DHO is responsible for the overall health system of the VDC, (i.e. the formal health programme and the resources) so the district level and VDC level government health workers have a formal relationship with each other. Here, the relationship is based on the level of authority and power between the district and local level actors. Similar differences were observed between the health workers and the peon in the VDC level. In the community level both the VHW in Hagam and the MCHW in Fulpingkot VDC complain about their line managers (i.e. the DHO) for not filling the vacant posts, for not sending the medicines and other resources in time and blame him for being unsupportive and ineffective. For example, the VHW in Hagam complained about DHO as:

The District Health Office is supposed to visit every health post and sub-health posts. In addition, they should provide required support to us and teach us the skills we do not know. For example, things, for example, logistics management, administrative management and new development in PHC. It is one of the main responsibilities of the DHO to do a regular supervision. However, in reality, it rarely happens. There are supervisors for each health programmes, for example, immunization supervisor, administrative supervisor, TB/Leprosy supervisor and statistical assistant in the DHO. They have not visited us recently. Even if they do they visit us only once in about every 2-3 years. Even when they visit us, they observe some of the office records and return quickly within one hour. I am not satisfied with this (Health worker, male).

The VHW here means that he wants different supervisors i.e. different section heads from DHO to visit his sub-health post regularly and mentor him and the staff. He reports that the staff from the DHO do not know the problem these posts face because they do not visit the post regularly. I observed that the sub-health post in Hagam do not have even basic facilities, for example, furniture, drinking water, appropriate toilets and even the building is in a very dilapidated state. The VHW in Hagam thinks that if the DHO visits the post more frequently

they could see those problems and would help to solve them. Similarly, the sub-health post in Fulpinkot even do not even have a toilet, the patients and the staff have to use the toilet of a neighbouring house. The VHW in Hagam means that these problems remain unnoticed by the DHO because they do not visit these posts. Since the resources is controlled by the DHO, VDC level health staff in both Hagam and Fulpinkot do not have any influence in how and where the resources are allocated.

I noticed that the relationship among most of the actors are somehow related to the amount of resources they bring in PHC i.e. higher the resources better the relationships, i.e. more towards working or working together relationships. For example, government health workers maintain a working relationship with the VDC secretary though they are not present in the VDC because the VDC often allocates money for health. The health workers know that they should have working relation with the VDC secretaries and the VDC technical assistants for funding. Similarly, government health workers maintain working relationship with the teachers. Since there are more teachers in each VDC than the health workers they need teachers' support in various health programmes, especially in health education campaigns. In return, health workers provide regular school health education and other health services and teachers support the health workers in their advocacy related activities (interview#13). Therefore, the process of their participation in PHC is by their mutual support to each other to do their respective jobs for mutual benefit and for benefit of the community.

This shows that the relationship among government health system actors is guided either by their assigned role and hierarchy or by their mutual benefit. In some cases, the actors were not supportive of each other, for example, the VHW in Hagam complained about his subordinate MCHW:

From the government health institutions, there are not many services for delivery. Recently a MCHW from Kavrepalnchok district was here. Even though she was a MCHW, she was not able to conduct pregnancy check-ups properly. I think there is much difference in persons who are MCHW and those who are ANM (Health worker, male).

When I checked with the VHW about the skill of this MCHW, he said the MCHW was not selected on merit but by some favouritism, therefore he suspected that she was not competent enough to handle the safer motherhood cases and was not even confident enough

to learn those skills from other health workers (interview #3). This shows that sometimes it is more the personal conflicts rather than professional issues that shape the relationship among various actors. However, the said MCHW was not available at the time of research to discuss whether it was a skill issue or personal conflict. Often, health workers seemed confined to their limited role rather than engaging other actors in PHC as a whole. Rather than supporting each other, the health workers seemed to complain about their own colleagues, for example the government health worker in Hagam complained about his co-worker as above.

However, when I discussed with the villagers they had different views about this issue. They said that the current VHW does not let anyone stay in the post because he will lose his role as the head of the sub-health post if a new person comes (interview #5). It is because the position as the head of the sub-health post brings prestige as well as extra financial benefits. Since he is a resident of Hagam VDC it becomes difficult for outsiders to challenge him. Therefore, instead of confronting him they transfer themselves somewhere else, so the vacant posts never fill. Because of this the main posts of sub-health post has been vacant for many years, which consequently has limited the availability of a health care facility in this VDC.

I observed that there is a conflict of interest between the local and outside actors even when they are from the same group. Often the local actors have a monopoly in providing the health services, selling their services and products, enjoying respect from the community and direct and indirect financial and material benefit (interview #6). This gives them power over ordinary villagers. When an outside member of staff joins, some of the benefits are automatically divided and the monopoly is broken. This creates conflict among these actors. Even if local actors are present in their respective posts, because of their involvement in regular household chores, for example, childcare, festivals, agriculture and animal keeping they are not always regular in their jobs. The health workers who are from outside they do not have those responsibilities, therefore they are more regular. This also creates conflict between these two groups.

Similarly, when one staff has to cover others' work because of absenteeism of the earlier colleague there is conflict (interview #3, #39). This happens mainly between the senior staff and junior staff. Often senior staff take leave from their regular work to go to district offices, to trainings and to various coordination meetings. During observation I noticed that some of these reasons are genuine whereas some are invented ones. This is more common among

government actors. This creates dissatisfaction among the staff who have to work in the posts on behalf the absentee senior staff. Often these staff also work on behalf of their seniors without appropriate qualifications and skills. It creates not only the conflict but it affects their efficiency, quality of services and morale of junior staff as well. For example, the MCHW in Fulpinkot complains:

My work is to help in maternal and child health, including immunization. However, I am not supposed to handle the immunization services in my own, it is the work of VHW (Village Health Worker) but due to lack of staff, I am doing that work too. I am handling ORC clinics and immunization clinic. I am not happy about that (Health worker, female).

Therefore, there is working relationship among the government actors but absenteeism, lack of resources, hierarchy and lack of trust affects their relationship.

5.3 Relationship among the nongovernment actors.

The relationship among various nongovernment actors is not as formal as among the government actors. I noticed that the nongovernmental actors work together and have a good relationship among them even though they seem suspicious of each other and compete for the same resources. They work together and support each other's activities. They seem to have a working together relationship with other actors, better than the government actors. Locally the nongovernmental actors work in harmony. However, because of their temporary nature and limited resources, other actors including the government health workers do not take nongovernmental actors seriously. A common complaint against them is that the short stay of NGOs does not serve their regular health service needs. The government health workers said that the NGOs bring additional health services outside regular government services which cannot be continued after NGOs phase out their services, it is problematic and creates mistrust of the government services (interview #33). This creates conflict between the government and NGO health workers and affects their relationship. The relationship among the NGO health service providers within same NGO seemed better compared to the relationship between the government health workers.

Both in Hagam and in Fulpinkot the relationship of the NGOs and the private medical practitioners is not positive (interview #1, #5, #33). Since one of the NGO working in these two VDCs, PHASE Nepal, provides medicine free of cost whereas the private medicine suppliers sell

medicine, that causes conflict between them. This has created negative feeling among the private medicine shop owners towards the NGOs and NGO health service providers. Due to absenteeism of government staff the villagers do not have positive relationship with the existing government staff. PHASE Nepal has filled that gap which has gained sympathy from the villagers, however that has created some conflict between government actors and NGO actors. In village level, district and national level the government is suspicious about NGOs. This is seen in both Hagam and Fulpingkot VDCs as well.

Regarding the organization (here the organization means the NGO), I have understood that the private providers sell medicines, they get money but organization provides it free of cost. So the relation is not good between them (Villager, male).

The nongovernmental organizations control the resources themselves even though they complement the government health services. Therefore, to access these resources most of the other Health System Actors maintain a working together relationship with NGO actors.

5.4 Relationship between government actors and nongovernmental actors.

Most of the nongovernment actors are complementing the government health services. I observed that both PHASE and Médecins du Monde (MDM - a French NGO) who work in Hagam and Fulpingkot are working from the government health post, work together with the government staff and add resources. For example, MDM provides safer motherhood services in Fulpingkot VDC and their staff work together with the MCHW. Since the nongovernmental actors need to follow the government health policies and work with the government health workers, the government actors try to exercise power over them. For example, even though the health workers employed by PHASE Nepal and MDM are higher qualified and better skilled than current government employees in both Hagam and Fulpingkot VDCs, they are still supervised by the government staff.

On one hand the government health workers often complain about the nongovernmental actors due to the temporary nature of their work and blame them for creating over expectation among the villagers (interview #3). The nongovernmental actors on the other hand blame the government health workers for their absenteeism, slow action and inadequate services. Therefore, from a distance the governmental and nongovernment actors seem working together but in practice they are not.

My experience of working in PHC in Hagam and Fulpingkot through PHASE Nepal shows that often the central, regional and district level stakeholders have a good view about the NGO services; because they bring additional resources.

Organization (means nongovernmental organization) is doing well. It does well for everyone and doesn't discriminate any one. They don't take money. So private medicals feel some difficulty because of them, it is because organization provides medicines free of cost. Organization provides fresh materials and good things. They bring good medicines (villager, male).

However, at a local level often entry of NGOs breaks the monopoly of the government as well as private health service providers whether it is in providing the health services or selling medicines. That brings conflict among them. In addition to that, NGOs conduct awareness campaigns where the villagers and other actors are made aware about health workers' roles, responsibilities and citizens' right. After a while, villagers and other actors slowly start to complain about absenteeism of government health workers, higher prices of medicines in private medicine shops (quote in 4.3.2.1) and people's right for health which affects NGOs' and these latter actors' relationship. The government health workers blame the NGO workers for these issues, hence they are not liked by the government health workers so their relationship is minimum relationship.

Furthermore, government actors behave like a ruler and treat other actors as the ruled which in the current democratic political situation is not entertained by other actors. Still, most of the nongovernmental actors work along with the government actors smoothly, therefore, their relationship is good. It is because the NGO health workers often get a mandate to work together with the government health workers and they need formal recommendation from government health workers and subsequently from the DHO to continue their work in respective VDCs. Therefore, even if the relationship is not good they have to work together.

NGOs have some autonomy in decision making in community level because of their independent access to the resources whereas the government health workers at the VDC level rarely have such freedom since most of the resources are allocated either centrally or at the district. This leads to some flexibility for NGO health workers to respond to the immediate health needs, which helps them to build working relationship with other actors including government health workers.

Therefore, the relationship between government and nongovernmental actors in the personal level is a working relation, for example when asked about her relationship with the nongovernmental health worker the MCHW interviewed in Fulpingkot said:

They had helped us in the field of pregnancy and delivery cases. They had one health worker and worked along with us. We used to visit together for delivery cases and antenatal check-ups (Health worker, female).

Here she is talking about MDM which had worked in Fulpingkot VDC in a safer motherhood programme in the past. She shares about her good relationship with them.

From the government health workers' perspective, the nongovernmental health workers are there to help them. This is seen in both local as well as district and national level. For example, since I am directly involved in implementation of PHASE Nepal's health programme in Hagam and Fulpingkot VDCs I have observed that the VHW do not report PHASE Nepal's contribution in PHC in Hagam to higher authorities. Instead, he reports the progress as their own achievement. When asked, he says there is no reason to include it separately because it is the government's job that PHASE is doing. In contrast, the MCHW in Fulpingkot mentions PHASE Nepal as a contributor in PHC in her reports to higher authorities. Therefore, there is no consistency in the process. However, in village level they acknowledge nongovernmental organization's contribution:

They are treating all patients. They are using the same register for pregnant women as we do. We both are working together in that. We do antenatal check-up, patient check-up and conduct delivery together. They are also telling people to visit health post (Health worker, female).

I noticed that the relationship among those who practise modern health services and those who practise traditional healing practices is not good. It is because the traditional healers have faith on their practices and to some extent it is their means of livelihoods. Modern medicine practitioners do not trust them because they think traditional healing practices do not have a scientific base and discourage people to use it. Therefore, they do not have a good relation with each other. This is reported by an interview participant as:

The relation between two (between government health worker and nongovernment health worker) is good. However, with dhامي/jhankris (traditional faith healers), I do

not think so, in between health and private sector, they might work in coordination with each other but not with Dhami/jhankris (Villager, male).

The conflict of interest among governmental and nongovernmental actors is noticed by the villagers and other actors as well. Some of the actors, who are pro nongovernmental organization supporters, complain about the government actors. This is more to do with the expectation of health services from the government stakeholders than to do with anything anti-government because people genuinely feel that it is government's responsibility to provide the health service.

Nongovernmental health organizations try to make friends with governmental bodies. However, the government health workers do not agree because if they are to work in coordination, they also have to work hard along with the nongovernmental health workers and should be sincere in their services. Governmental staff are not committed. Since the nongovernmental organization does good work, it creates difficulty for them. The nongovernmental organization aims to provide services effectively to develop the country and villages. However, it is not the same among the government organizations (Villager, male).

There is some competing interest between the government health workers and NGO health workers for their social respect in the community. Yet, there is no competing interest between them especially in providing the health services. Since government health workers have not been able to provide the health services regularly, it creates conflict with other actors. This is mainly due to limitation of resources and absenteeism of government health workers. The NGO health workers often have sufficient resources, and are more flexible and are regular in the community, this helps to build working relationship with other actors.

The governmental health workers think that the NGO worker should work under them, if resisted they are not happy and make their life difficult, for example when asked about government and NGO health workers relationship the government VHW in Hagam said:

Earlier (at the start of the project) there was not much support provided in immunization services by the NGOs. During an immunization clinic, I had much workload immunizing children. In addition to this, the same day children had to be checked for their nutrition status. Therefore, I could not manage everything alone. So I requested the NGO staff to help me with it. But, their attitude was different. They used

to think that their duty is just to organize clinics and nothing more (Health worker, male)

The government VHW in Hagam and MCHW in Fulpinkot are responsible for running the immunization services with support from FCHVs in their respective VDCs. NGOs have their own priorities and activities. They are not always available to run immunization services for VHWs and MCHWs, hence the above complaint by the VHW in Hagam. He wants the NGO workers to do his work. Since NGO health workers had to work with the government health workers, as a compromise they often have to follow what the government health workers want.

The relationship between the government health workers and the private health service providers is not harmonious. Even though the VHW in Hagam VDC runs his own private medicine shop, he does not think that the private health service providers are providing good services.

I do not think the people from private medicals provide good advice to people regarding immunization and other government health services. They are focused only on selling their medicine. They also do not advise people for regular check-ups, such as, to the pregnant women about correct medicines or advise people that without diagnosis they shouldn't take medicines (Health worker, male).

I noticed that it is more to do with competition for financial gain than to do with the quality and availability of health services provided by other private health service providers as this VHW claims.

Furthermore, the VHW in Hagam stated that the political party leaders do not support health sectors, even when they do they misuse the fund for their own benefit. He said that the political party leaders are more interested in financial gain for themselves and for their cadres rather than helping to ensure availability and improvement of PHC in their respective VDCs. For example, when asked about who makes the decision for the use of the resources, he says:

The political parties have their own party members. There are currently four or five parties in this VDC (Maoists, CPN-UML, RAPRAPA, United Maoists and Nepali Congress). These political parties support their own members and make plans for their members to work in good position. If the total budget is NRs.50,000 (US\$ 500) then only NRs.15000 (US\$ 150) is spent on real work and NRs.5000 (US\$ 50) is spent on technical

support. Thus, they take the remaining NRs.30, 000 (US\$ 300) for their own benefit. They have lowered the prestige of health sector (Health worker, male).

From these examples, it is seen that the relationship between government and nongovernmental actors are centred around personal benefit, power and perceived role and legitimacy of these actors. Nongovernmental actors as well as villagers understand the government health services as people's right whereas government actors especially the health workers behave as if they are superior to other actors including villagers. This seems affecting their relationship and subsequently the quality, availability and use of PHC in both of these VDCs.

5.5 Relationship between different actors and the villagers.

This section presents the analysis and discussion about the relationship among various health systems actors and the villagers in Hagam and Fulpingkot. It is important to present these relationships separately because villagers are the most important actors of a health system. Therefore, the relationship between villagers and various other actors is important. Here the villagers are those people who do not have any formal or elected roles in their village. Here the relationship is analysed as villagers' relationship with other Health System Actors.

The relationship between various actors and the villagers varies based on the benefit these actors bring to the community. In general, the villagers seemed neutral about the presence of various health systems actors in the community where as their inclination is towards those from whom they get the better and regular health services. I noticed that often the community is the space where various Health System Actors exercise their power and positions in order to influence the public to support their ideas, programme or practices. The villagers' participation in the PHC is more for the use of health services, whether it is modern medical services from the government health posts, NGO health workers and the private health service providers or from the traditional healers, religious priests and herbal medicinal practitioners. Villagers are more attached to those actors who are directly involved in providing health services than with those who just advocate for health or have only awareness raising programmes. For most of the actors the acceptance and support of the villagers is important for their success and to get power space within the community. For example, the NGOs cannot function in these VDCs if they do not have a strong support from the villagers. Similarly, the political party leaders need to have villagers' support to maintain their political ideology in these VDCs.

I observed that the villagers understood health service only as a curative health service. Therefore, those actors who are involved in preventive health education and advocacy are not considered as Health System Actors as such by the villagers. Often the political party leaders, village heads, teachers and VDC secretary are treated as outsiders by those who are engaged in providing health services and by the villagers, even though the villagers have a separate relationship with these actors. The villagers as well as direct health service providers blame other actors for using the health sector as a means to exercise their power over the villagers. Often the interpersonal relationship among various health systems actors is good who provide similar services and work for the same cause. However, their organizational relationship and participation in each other's programmes depends upon how much they complement each other's programme financially, share resources and benefit from each other. Therefore, the participation of various actors in PHC in the community level is complex. Furthermore, participation of different actors seemed as a means to occupy the space in the community to exercise their power and even to prove their existence.

5.5.1 Relationship between villagers and government actors who are directly involved in PHC

When discussing the government health workers, the villagers in Hagam mostly referred to the current VHW and the caretaker whereas in Fulpingkot it is MCHW and caretaker. In case of Fulpingkot people often referred to the absent CMA as well and often complained about him for not being regular when the post was filled in the past. There are FCHVs in both VDCs who are directly involved in PHC. In the following section I will discuss about relationship between villagers and these actors who are directly involved in PHC.

5.5.1.1 Relationship between villagers and the VHW in Hagam

Villagers have a mixed relation with the VHW in Hagam. There is no VHW in Fulpingkot. Even though villagers in Hagam complain about this VHW, they have no alternative but to go for treatment from him either from the sub-health post or from his private medicine shop. People complain about him charging higher cost for the medicine, for selling date expired medicines, and misuse of the fund he receives from various sources but still appreciate the health services they get from him. Whereas, the VHW does not complain about the villagers as such except blaming people for not helping him in various activities. For example, he complains that the villagers do not follow his advice, for example, maintaining personal health and hygiene, for

not taking their children for immunization and for not getting the safer motherhood health services.

Looking at the relationship of VHW with other actors I observed that the VHW does not have a working relationship with many actors. There seemed problems in accepting his authority, people blaming him for not doing his job properly and for misuse of the money he receives for PHC from the VDC and other sources. There seemed a tendency to blame him for everything that goes wrong in health in the community (interview #6). Some of the criticisms were genuine because of him not approaching the DHO to send appropriate health staff, for making his wife the chair of the mothers' group to handle their money (interview #8), for charging extra for the price of medicine he sells (interview #6) and for getting commission from the FCHV's dress fund by buying inferior quality garment (interview #19). However, his justification for his actions is different from the villagers, for example, he said:

There is a women's development group in this VDC. Earlier, it was at ward level, only in ward number 7. The VDC had allocated NRs.30, 000 (US\$ 300) for women development and welfare programme. My group formation activity is also for the women. Therefore, I thought why not use that money for group formation. My wife was the chairperson of the women development group. So I discussed with my wife that I needed 10 registers, some pens and plastic bag from that money. I told her to join me and form women groups. We are both responsible people and we could work together. She agreed with me. After I got the registers, I thought of the things to be included in the register. The first one was the group formation of people from every ward. The title of the activity was 'women and mothers group'. Thus, nine groups were formed just in nine days (Health worker, male).

He is blamed because he is the only one in the sub-health post from the government to work in health system in this VDC. The dissatisfaction of the villagers and other actors with the VHW are because of their perception of his behaviour within the community as well as a way of expressing their frustration towards the government services. Since there are no other government health service providers in Hagam other than this VHW, villagers have a working relationship with him even though they complain about his various weaknesses.

5.5.1.2 Relationship between villagers and FCHV

FCHVs have a working together relationship with the villagers. However, they have both positive and negative views about the villagers' behaviour. Their main complaint about the villagers is that the villagers do not follow the advice they provide about different health issues. For example, they say that the villager do not listen to their suggestions for pregnancy check, child immunizations, safe deliveries and other health and hygiene related issues. Most of the villagers appreciate FCHVs' work and often envy it. FCHVs bring health services to villages, help villagers in time of emergencies and remind villagers for immunization of their children. Furthermore, sometimes they take children for immunization and often accompany them to the health facilities for health check-ups. Therefore, especially the women in the community respect the FCHVs and listen to them.

FCHV counselled us to breastfeed for six months and immunize children. They visit each house and provide health advice. They inform us about the immunization days.

Therefore, I find it good to have health post and FCHVs here (Volunteer, female).

The villagers call FCHVs to their houses if they need any services from them. Since these FCHVs are volunteers, they do not charge anything from the villagers. One of the reason for villagers accepting the FCHV's service is that they are from their own community, they know the culture, are available when they need their help and do not cost them anything since they are volunteers. One of the FCHVs from Hagam shares her experience about her relationship with the villagers as follows:

They ask me whether they need to go for check-up or not during pregnancy, delivery and number of times they should visit for check-up. They also call me within 24 hours of labour if they can't deliver their baby at home. I visit them when they inform me.

Sometimes we won't know about it. In village areas, we have problem of workload as well. We should care the new-born baby properly and keep them warm. We shouldn't give it a bath before 24 hours of birth, I teach them so. I also visit them to provide vitamin A to the mothers (Volunteer, female).

This shows that both villagers and the FCHVs have a working together relationship among them.

5.5.1.3 Villagers' relationship with HFMC and Caretaker (peon)

The relationship between the villagers and the HFMC is of mixed nature. Some of the villagers appreciate the HFMC members for their voluntary work whereas some complain about their inefficiency, their lack of lobbying for the posting of an appropriate health worker and blame them for the lack of improvement in the overall health services in the VDC (Interview #25). It is because the villagers expect the HFMC to maintain regular staff presence and availability of sufficient supplies in the sub-health post. The HFMC has limitation because of lack of support from the DHO and absenteeism of staff they cannot meet these expectations, this creates problem in their relationship. HFMC members think that the villagers do not show sufficient interest in available health services, they are not interested in voluntary work for the infrastructure development and they do not participate in any activities other than use of the available health services. The HFMC in Fulpingkot VDC is more active than the one in Hagam therefore people in Fulpingkot have better relationship with their HFMC members (interview #39). The health workers in Fulpingkot encourage HFMC members to be more active than the health workers in Hagam. It is mainly because the VHW in Hagam want to have control over the health system whereas the health workers in Fulpingkot want to concentrate more on their job.

Villagers have a working together relationship with caretakers in both VDCs. It is because these caretakers are the only staff regularly present in these sub-health posts who offer some level of health services in absence of professional health workers. Similarly, the villagers support the caretaker for various activities and campaigns for which he has to spread the information on behalf of the sub-health post. This brings them together to support each other.

The caretaker's formal role is not to provide health services but both in Hagam and Fulpingkot VDCs there are no other health workers present regularly to provide such services. Therefore, the caretakers provide these services. This role better positions the caretaker to be in good relationship with all other actors since he / she is the regular contact available in the sub-health post. Therefore, most of the health systems actors present in these VDCs have at least working relationship with caretakers.

These findings show that the relationship between the villagers and the government health workers is mainly dependent on their regularity in the post and service they provide. The more regular they are in their posts, better the relationship. In case of Hagam and Fulpingkot

relationship between the villagers and the government health workers was not positive, especially because the government health workers were not regular in both Hagam and Fulpingkot VDCs which the villagers mostly complained about. Another complaint the villagers made about the existing health workers was not bringing the required CMAs in both Hagam and Fulpingkot.

The government health workers are not much available here. They stay in Jalbire (nearby market place) at night. They come here at 10 am and return at 2 pm. It was same before. We do not get good medicines from them and we cannot get emergency services from them. For example, if we suffer from diarrhoea at night, or there is a child delivery case, or cut injury or wounds then we have to visit Jalbire. However, after PHASE Nepal started to work her in the sub-health post it has been easier for us, therefore the villagers like PHASE workers more because they stay in the village. With the government services, if we visit them within 10 am to 2 pm we get services otherwise we don't and even that is not regular (Villager, female).

This shows that the absenteeism of staff is a main reason for unsatisfactory relationship between villagers and health workers. The government health workers get a bigger share of the complaints because the villagers' perception is that it is them who should be providing the health service.

5.5.2 Relationship between villagers and government actors who are not directly involved in PHC

Many government actors, though they are not professionally involved in health, still have a strong influence in PHC and consequently in people's health. For example, the VDC Secretary is not a health professional but he has a higher say in allocation of funding for health in the VDC. This section will discuss about the relationship between villagers and these government actors.

5.5.2.1 Relationship between villagers and VDC Secretary

Though VDC secretaries rarely visit villages, the villagers in Hagam and Fulpingkot have to rely on them for various governmental processes and procedures. Some of the activities, for example, vital registrations, land tax collection and day-to-day activities are delegated to VDC Technical Assistant by the VDC secretary. However, VDC secretary must be present for the activities, for example, project selections, budget allocations and VDC assemblies. Officially, the VDC secretaries are supposed to live in the VDC and work from there but because of

current volatile political situation they mostly live in the district headquarter or a place of their choice. Because of this, villagers do not have a working together relationship with VDC secretary and vice versa even though they have to rely on them for VDC fund allocations. Officially, the VDC secretary is one of the members of the HFMC, if not the chairperson, which puts him in power to decide about formal health system in the VDC. Principally, the VDC secretary is the one who allocates VDC fund for different programmes on recommendation from various political party representatives and other participants in the VDC assembly.

The authority that comes with the position of the VDC secretary puts him in a position to exercise power over other actors. Other actors have to keep a good working relationship with these secretaries for their own benefit. Therefore, even though there is interaction between the villagers and the VDC secretary their relationship is not always a working relationship.

5.5.2.2 Relationship between villagers and VDC technical assistant

The VDC Technical Assistant (VDCTA) is a local person employed by the VDC to work in absence of the VDC secretary. Since VDCTA is regularly present in the village, has authority to perform daily activities, is local and knows the context, the villagers have a working relationship with him. They mutually help each other. However, the villagers complain about VDCTA for not allocating sufficient fund for health and the VDCTA blames the villagers for misuse of the allocated funds and for not using the available health services.

5.5.2.3 Relationship between villagers and schoolteachers

Schoolteachers whether they are from their own village or from outside, are the role models for the villagers. Villagers seek advice from the teachers for their health problems especially things like basic information, for example, what is the problem, where to look for health services and how much it costs. Similarly, the teachers think that it is their responsibility to advise the villagers on the things they have knowledge of. Teachers are good advocate of PHC and mostly they follow Western medicines. The villagers and the teachers have working relationships. A teacher in Fulpingkot VDC shares about their relationship with the villagers as:

Villagers view teachers as leaders of society and if any problems occur in the village they are the ones to help. In schools, if there are complicated type of cases then we ourselves take the students to the health workers. We should find out whether there are health workers in the health post or not because the mobile clinic run by PHASE Nepal are open only few days a week. We also request FCHVs to conduct campaigns. At

other times, we have discussions with FCHVs regarding diseases and vaccination. Talking about relation with health organizations, we ring primary health care centres to find out whether the doctors are available or not. We help people to arrange ambulances. Some people come to us for help and we help them as needed (Villager, male).

Even though both schoolteachers and the government health workers get a salary from the central government, the school teachers in both Hagam and Fulpingkot are more regularly present in their schools than the health workers in their posts. It is mainly because the school management committee is more active and have higher power compared to the HFMC. The school management committee can recommend to fire the teachers if they are absent from their posts whereas the HFMC does not have such authority. Furthermore, absenteeism of the schoolteachers is immediately noticed because of the students whereas the absent health worker might not get noticed if there are other health workers in the sub-health post providing the service. In addition to this, people take their children's education more seriously than their health needs. Because of these reasons, the teachers are more regular than the health workers which put them in better position to have a working together relationship with the villagers as well as other actors.

5.5.3 Relationship between villagers and nongovernment actors who are directly involved in PHC

In the following sections I will analyse and present about the relationship between villagers and different nongovernmental actors. These nongovernmental actors are directly involved in PHC in Hagam and Fulpingkot VDCs.

5.5.3.1 Relationship between villagers and ANMs working for NGO

The ANMs' relationship with the villagers is very good. i.e. working together relationship. Since ANMs advocate and provide service for modern safer motherhood practices, women are grateful for the services they are getting which was not possible from the existing health staff especially in Hagam VDC. ANMs get support for their various advocacy and health education programmes from the villagers. However, the villagers who do not want to follow the Western medicines and services do not always have a good relationship with ANMs. The villagers are grateful for the services the ANMs provide to them and so are the ANMs for the support from the villagers. Therefore, the relationship between the ANMs and ordinary villagers is a function

of mutual benefit to each other. ANMs are the advocates of safer motherhood aspect of PHC in the community, therefore they are liked by especially by the women from the reproductive age group. A women activist in Fulpingkot says:

Till now we are having good relation with ANMs and they are also doing good to us (Villager, female).

5.5.3.2 Relationship between villagers and Traditional healers

Most of the villagers and the traditional healers have a working relationship with each other. On one hand the villagers often visit traditional healers before accessing modern health services because of their economic, cultural and social circumstances. On the other hand, the traditional healers' livelihoods rely on people using their services. Their relationship is stronger because these traditional healers are the part of the same society, culture, locally available, speak common languages and sometimes from their own family which makes them dearer compared to other health service providers. Furthermore, even when they need to be paid, they can be paid with what the villagers have in their house, have flexible prices and sometimes even do not need to pay. However, sometimes their relationship is not good because some of the villagers do not agree with traditional healing practices anymore. Similarly, some of the traditional healers complain that they are losing their livelihoods because people no longer trust their healing practices anymore. Some of the villagers even complain about the traditional healers for charging expensive fees.

With villagers, we have a very good relation. I told you before that mostly children and women visit me. They visit to us for problems, for example, 'batash lageko' or 'kharko' (health problems related to bowel movement and gastritis) (Male, traditional healer).

Some of the villagers do not believe in any form of traditional healing practices and they think that the modern Western health service providers and the traditional healers do not have good relation either.

On one hand dhami /jhankri (traditional healers) think that they are superior from other normal people. They say "I did the fhukfhak (traditional healing) so that person is fine, if you follow certain god then you will be fine, you did not follow certain god so you are sick". On the other hand, health workers examine which nerves is not working, which part of the body is not working, see where is the problem and which medicine will work. Now the relationship between them is like dhami, jhankri do not believe in health workers, and the health workers think dhami/ jhankri are superstitious.

Therefore, I do not think their relationship is good. Dhami/jhankri say that if only by taking medicine people would survive then the father of that doctor should have survived 100 years. Why did he die? Doctors say if you are that good then how many people in your family have survived long? Therefore, these people taunt and blame each other (Villager, male).

The relationship between the villagers and the herbal medicine practitioners is similar to that between the villagers and the traditional healers. Often even those who do not believe in traditional healers trust herbal medicine practitioners and claim it is more scientific compared to traditional healing practices. Everybody in the village, especially the elderly, knows about some useful herbs and uses their knowledge and skill to treat certain health problems. The herbal medicine practitioners claim that they still receive many requests from the villagers for herbal medicines but it has become difficult to collect herbs from the forest and other places because of over exploitation, commercialization and their inability to travel to collect those herbs due to old age. Since these herbal medicine practitioners are part of the society, served the villagers for a long time i.e. when there were no other alternatives available, they are well respected by the villagers. Therefore, their relationship is working relationship.

5.5.3.3 Relationship between villagers and Lamas

Since majority of the villagers in Hagam VDC is from Tamang ethnicity Buddhism is their way of life. They require Lamas for most of their rituals from birth to death. Lamas are involved in some of the health-related issues especially in spiritual healing practices. Villagers have a working relationship with Lamas and vice versa, because Lamas rely on villagers for their livelihoods and villagers rely on these Lamas for their religious rituals. Often elderly people are more inclined towards religious belief than the younger generation, they are in a good relationship with the Lamas.

We also need Lamas for health purpose. We don't know if we will go to heaven or hell after 'fukne' (chanting by Lama) done by Lama, but they are required. It is also our tradition (Villager, male).

Lamas, priests and village leaders have minimum or no relationship among themselves regarding PHC even though they have relationship with each other in other aspects of life. Similarly, they do not have any relationship with mothers' groups, income generation groups,

cooperatives, youth clubs and political party leaders whether they are current or the leaders from the past.

5.5.3.4 Relationship between villagers and Private health service providers

The villagers and the private health service providers have a mixed relationship. In one hand villagers are grateful for the health services provided by private health service providers but at the same time some of them complain about charging extravagant price for medicine, for over prescription and for selling date expired medicines.

....he had given expired drug to one of my friends. But he was a CMA so he knew about it. after he bought the medicine home, then only he knew that it was date expired (Villager, male)

Private medicine sellers acknowledge that they are there to make money but at the same time, they want to serve the people as well. They have a working relationship.

5.5.3.5 Relationship between villagers and NGO health service providers

The villagers and the NGO health service providers have a working together relationship. It seems mainly because one of the NGOs, PHASE Nepal currently working in Hagam and Fulpingkot VDCs has an intensive programme to support government health facilities. On top of that, NGO health workers seem to have strong community activities mainly for women and children. They encourage villagers to use the PHC services. These together have bonded their relationship and their help for each other.

NGOs also provide health facilities here, like other organization PHASE Nepal is also good, what I have heard is that the medicine provided by PHASE Nepal is very effective. I do not know about Hagam but the people of Fulpingkot who have taken the services and medicine provided by them, I have heard people praising them (Villager, male).

Having said that, since NGOs mostly promote Western medicine, those villagers who prefer to use the traditional healing practices do not always agree with what NGOs do. The villagers often complain about the pressure NGO workers put for the use of certain services especially the safer motherhood services, short nature of their programme and are sometimes suspicious about their over politeness. On one hand the villagers are suspicious of NGOs because some of the NGOs in the past have been involved in converting people into Christianity. On the other

hand, the NGO workers think the villagers are not following their advice, follow malpractices and are not taking the required health services in time.

5.5.4 Relationship between villagers and nongovernment actors who are not directly involved in PHC

In this section I present my findings and analysis about the relationship of villagers and the nongovernment actors who are not directly related to the health sector but still have significant influence in PHC. For example, village heads, cooperatives, mothers' groups, youth clubs and political party leaders are not professionally related to health sectors but they have significant influence in PHC, some of which have been discussed in following sections:

Village heads are often the first point of advice for the villagers for accessing any health services whether it is a Western formal health system or the traditional informal health system. For outside actors these village heads work as gatekeepers to access the villagers. These village heads draw their respect from the villager for their services to the community. Their relationship plays an important role for both the parties since one relies on their advice for their access to the health services and other for their respect to maintain their status quo and leadership in the community.

Villagers form cooperatives to solve their financial needs therefore often they have positive relationship with each other. There are often some conflicts of interest among those involved and not involved in cooperatives. Similar to cooperatives, income generation groups are also formed by the villagers themselves to mobilize the monetary resources they want to use at the time of their need. Since it involves handling of money, there are some conflicts of interest among those who are actively involved in operating the groups and the passive members but in general they have a working together relationship among themselves including with other villagers.

Since the mothers' group members are from the villagers themselves and do not have any restrictions to join, they have working together relationship with each other. These women groups spread information about health education campaigns, available health services and other health issues on behalf of the FCHVs and other formal health system workers. This keeps them in an important position to have a good relationship with villagers and vice versa.

Even though youth clubs are part of the community, these clubs do not have a good reputation among the villagers. Youth clubs are involved and are mobilized by different governmental, nongovernmental organization and political parties for leaderships, campaigns and health education. However, villagers blame youth club members for misuse of the fund, not fulfilling the responsibilities and not following different rules and regulations. Therefore, the relationship between the villagers and the youth clubs is shaped by some particular nature of youth clubs' activities rather than by the youth club as a whole.

Relationship between political party leaders and the villagers is of mixed nature. Villagers follow different political party leaders based on their political ideology. They are divided depending upon ideas that their respective political party leaders follow. This often leads to conflict among the villagers for different agendas different political party leaders put forward. Therefore, there is always a strong and dynamic relationship between the villagers and the political party leaders but that does not mean it is always positive. Villagers blame political party leaders for not allocating sufficient funds for PHC in both VDCs. Therefore, their relationship is not always stable.

Similar to political party leaders, villagers also have a dynamic relationship with ex-political party leaders. Often ex-political party leaders are not in power which puts them in defensive position from the active political party leaders and therefore on the side of the villagers who are always demanding some actions from the active political parties. For that reason often the relationship between the villagers and the ex-political party leaders is a working relationship. Since these ex-political party leaders are experienced people in the community the villagers seek advice from them in various issues including their participation in PHC.

5.6 Similarities and differences in relationships between different actors in Hagam and Fulpinkot

These relationships presented here apply for both Hagam and Fulpinkot VDCs. The differences if any are reported separately. For example, the main person in the sub-health-post in Hagam is a VHW whereas that in Fulpinkot is a MCHW. Similarly, there are Hindu priests in Fulpinkot who also have a role in PHC whereas there are not any Hindu priests in Hagam. There are more traditional healers and Lamas in Hagam than in Fulpinkot. Professionally MCHW's role is to provide maternity health care, for example, ANC, PNC, family planning services, advice for safe deliveries and run child immunization clinics. However, in Fulpinkot

because of absenteeism of CMA and VHW, the MCHW is running this sub-health-post from government side on her own with the help of a female caretaker. The MCHW and the caretaker are not formally authorized to prescribe medicine and to provide any curative treatments, but they still do so because there are not any other health workers in the post.

The relationship of MCHW with other actors is similar to that of the VHW but her role is more towards providing safer motherhood services to the villagers. However, she is more popular among the villagers compared to the VHW in Hagam. It is because she does not own any private medicine shops, is not involved in any controversial businesses, for example, the VHW in Hagam is, and she is less active outside her field compared to the VHW in Hagam.

People in Fulpinkot have better access to market, health facility, employment opportunities and access to better education compared to the people from Hagam. These have implications in people's interactions with other actors in the community. People in Fulpinkot have a better relationship with people from other caste than the people in Hagam. Similarly, they have better understanding of the social issues compared to people in Hagam. For example, the manager of a cooperative in Fulpinkot is a Dalit where the majority of the cooperative members is from higher caste and there are three teachers from the Dalit caste in Fulpinkot, whereas there are none in Hagam. This is reflected in other actors' relationship as well.

I noticed differences in relationship between actors in these two villages due to gender, caste, ethnicity and age as well. As discussed above the Dalits in Fulpinkot are better educated, work in various public posts compared to those in Hagam. The Dalits in Fulpinkot seemed more integrated with people from other castes and participated in PHC to a greater extent, which might have been because of their higher exposure to education as well as higher level of outside contacts among other villagers. The Newars, Chhetries and Brahmins had better relationship with each other and with other actors compared to Tamangs and Dalits because of their education, social status and economic condition. Women and the elderly seemed to have less interaction with other actors compared to men and young people. This was found in all caste and ethnicity groups but more in Dalits and Tamangs.

5.7 Key issues emerged from above findings about the relationships:

This analysis shows that the relationship among actors is a complex phenomenon which is guided by the social, cultural and political environment. Relationship between different actors

is shaped by their gender, caste and ethnicity, their political ideology and their mutual trust. Following sections highlight some of the main issues emerging from above analysis:

5.7.1 Caste and ethnicity

Caste is still one of the main factors in shaping people's relationships in the study area. There is high level of caste discrimination in both Hagam and Fulpingkot. Even though there is no caste system in Buddhism, because of the influence of the Hindu caste system the Tamangs of both Hagam and Fulpingkot equally follow a caste system. Caste has been so deeply rooted in the society that even the discriminated accept it without any complaints. Even the educated Dalit do not complain against the discriminating behaviour of higher caste people. Even though one of the FCHV from Dalit caste interviewed in Hagam claimed decreased discrimination against caste she admitted that they do not allow her to go inside higher caste people's home even to provide her service (quote in section 4.3.1.1, FCHV).

It shows that the higher caste people take services from Dalit women but they do not allow her to enter their house because she is supposed as impure. There is caste discrimination even among different Dalit castes. For example, blacksmiths do not eat food cooked by tailors.

Similarly, there is discrimination among different ethnic groups and higher caste people, however that is not felt to the extent as that between the Dalits and the higher caste. There is a strong tendency among the higher caste people to dominate people from other ethnic groups based on their caste. This has affected the relation between different actors. For example, the traditional healers from higher caste including those from different ethnic groups do not go to Dalit's houses easily because they do not eat in Dalit's houses. Dalit FCHVs are not allowed to enter into higher caste people's houses. These hamper their relationship and participation in PHC. Furthermore, because of social and cultural barriers, people from lower caste are often poor which makes them rely on higher caste people for their livelihoods. This traps them to follow the advice from higher caste people for various aspects of their life including their participation in PHC.

Therefore, caste and ethnicity of people plays a significant role on their relationships and their participation in PHC. Caste-based discrimination in Hagam is higher than in Fulpingkot. The lower discrimination in Fulpingkot is because the Dalits in Fulpingkot are relatively richer, educated and organized compared to those in Hagam.

5.7.2 Gender

Gender has a multiple effect in most of the social relationships. Even within the same categories of actors women have lower status and lower power compared to their male colleagues. Gender based discrimination is not only socially and culturally existing but also indirectly supported by the state. For example, the ANMs and CMAs have similar level of qualification but CMAs are always the head of the sub-health posts. Most of the actors in decision-making levels are male, for example the VDC secretaries and VDC technical assistants in both VDCs are men. Almost all of the VDC level political party leaders are men in both VDCs except where the state has made it mandatory to have women. All school management committee chairs and majority of the members are men and so are the chairs of HFMCs in both VDCs. FCHVs are the only female actors who have a significant role in PHC. Women are hardly present in decision-making positions and processes in PHC which subsequently affects their relationship with other actors. For example, one of the interview participant shares that women are not included in decision making in fund allocation and tells that even the budget allocated for women by the state are spent in other activities.

We are never invited in these matters. I do not know anything about it. I do not even know if they receive money or not. In the meeting, they didn't even give us the money which was allocated for women's programme last year. The government has underestimated us (Villager, female).

Gender discrimination is relatively lower in ethnic groups compared to higher caste Brahmins and Chhetries. For example, Tamang and Newar women in both Hagam and Fulpinkot have more freedom at household level than their higher caste colleagues. However, because of influence from higher caste people it is still there in the public sphere. Culture and social norms are used as an excuse to justify such discriminations. Gender-based discrimination is higher in Fulpinkot than in Hagam because of its higher percentage of higher caste people.

5.7.3 Politicization

People's affiliation to different political parties significantly affects their relationship with each other. Because of political instability in Nepal, change in power dynamics at the national level affects that at the local level as well. Often the head of the district offices are changed with the change of central government. Even though there are no locally elected representatives and councils all over Nepal since last 14 years, most of the political parties have their unit in each

VDC. Most of the PHC actors are affiliated with or influenced by political ideology one or other way. Similarly, most of the government health workers and other professionals are member of their professional organizations which are often politically connected. Therefore, most of the actors are politically aware and influenced by some political ideology. This political affiliation is reflected in their relationship with other actors. Often people affiliated with ruling political parties have a higher say in decision making. Because the government staff have to follow their superiors in district and central level who are influenced by ruling party's political ideology. These are appointed mostly based on of their political ideology. Therefore, the relationship among different actors is affected by their political affiliation. Often only those actors who follow similar political ideology work together and have a working relationship.

At the time of the study, one of the problems seen in Hagam is that the majority of the villagers follow Maoist party's communist ideology and support those parties. Whereas, the VHW and other private medicine shop owner follow Nepali Congress which follows the right wing political ideology. Therefore, often the villagers do not follow these health workers' suggestions about PHC. This affects these actors' participation in PHC because often they do not support the activities and ideas put forward by these health workers. A similar problem is seen in Fulpingkot as well because the VDC technical assistant, the VDC social mobilizer and the Chair of the HFMC follow the Maoist party's communist ideology whereas about 60% of the villagers follow Nepali Congress and United Marxist Leninist's (UML) political ideology. This brings a constant conflict among different actors. The tendency of various actors is to support only those actors who follow the same ideology or where there is direct benefit rather than benefit to the whole community. For example, the VDC secretary has not been able to do an annual VDC assembly in the VDC for last few years, instead they are doing it in district headquarter Chautara, because it is impossible to do it because of political conflict of above political party units in Fulpingkot VDC.

5.7.4 Lack of trust among actors

In both Hagam and Fulpingkot VDC most of the actors work together for PHC. However, they do not trust each other much when it comes to handling any project money. Often those who are responsible for dealing with money are blamed by other actors for misuse of those funds. This highly affects their relationships with each other and their participation in PHC. For example, the VHW in Hagam is blamed by FCHVs for getting commission from the purchases he made for their dresses.

“They don’t tell us other things. Before they had said that they received NRs 10,000 (US\$ 100) from VDC to purchase dress for nine of us and later they gave us saree of NRs 100 (US\$ 1) each, blouse of about NRs 50/75 (US\$ 0.5/0.75) each and a shawl of NRs 100 (US\$ 1) each and the rest was taken by the VHW (Volunteer, female).”

Another aspect of mistrust among different actors in PHC especially among those who are directly involved in providing health services is the mistrust on other actors’ skill, approach and appropriateness. The modern health service providers do not trust the traditional healers. The private health services providers complain about each other’s’ quality of services and the prices they charge. The general villagers are selective about their trust of other actors. The usual tendency of the villagers seems that they are always suspicious of other actors. Their feeling about the nongovernmental organizations is that latter always have hidden agendas. Similarly, their suspicion about the private health service providers is over charging for the medicines. Furthermore, actors trust actors from their own village more than the ones who have come to work from outside, that is the one of the reasons that villagers and other actors trust FCHVs and traditional healers more than those practising modern medicine.

For example, one of the VDC social mobilizer is blamed for misusing the money allocated for an irrigation project in one of the villages in Fulpingkot.

I will give you an example, in our ‘Dhandakhola’ (name of a river), there was a small irrigation project planned. I went there as a representative of Nepali Congress along with the other guy during the budget allocation meeting. In that meeting we allocated the budget as basket fund, like for irrigation and school, a certain amount of money was allocated. In ‘Kamigaun’ (name of the village where most of the residents are blacksmiths) also there was some irrigation plan. According to my calculation, NRs 50000 (US\$ 500) was allocated for these two projects, NRs 25000 (US\$ 250) for each irrigation project. I did not go there on the day of allocation of money. There was this fraud guy called Hera, who gave all NRs 50000 (US\$ 500) to one of the club, we did not get anything (Villager, male).

These mistrusts are mostly because of people’s involvement in misuse of money. When discussed with the VHW about such things, he claims that the criticisms are baseless. He agrees that there were some additional cost to cover his travel costs but all other fund was

used appropriately. In most of the cases people did not trust each other where money was involved.

Furthermore, it is common knowledge that that in country level the government does not have a choice but to welcome the external funding from nongovernmental organizations to invest and work in health sector because about 50% of the health sector budget is made up of international aid (Karkee and Comfort 2016). It is mandatory for NGOs to get approval from the Social Welfare Council (a government regulating body for NGOs in Nepal) to work in a particular district and VDCs. Once these approvals are taken the district authorities welcome the NGOs to work in their district and the VDCs. In most of the VDCs NGOs who bring resources and complement the government health service, are welcomed by the staff, political party leaders and other actors including the villagers. However, in some cases these NGO workers are not liked especially by the government health workers, especially in the area where government health workers are irregular in their posts, own private medicine shops or are engaged in other businesses. It is because once the NGO workers are regular the government health workers are also supposed to become so. Furthermore, once the NGO service providers start to provide health services together with the government health workers or in their absence, the government health workers lose their monopoly. Often they lose their additional incomes they get working privately and sometimes even the prestige. In addition to this because of the NGO's advocacy programme the villagers start to demand health services from the government health workers. If they are absent from their posts they complain about it. This develops mistrust between the government health service provider and those from NGO.

Therefore, when these relationships are analysed from trust point of view it revolves around actors' involvement in financial matter and the context. Furthermore, it is the flow of the money that shapes the relationship among different actors. It is the DHO, VDC and NGOs who put resources i.e. money, materials and manpower in PHC in both Hagam and Fulpingkot VDCs. I noticed that often the power revolves around the money. People and organizations who have put resources in PHC in these villages have working relationship with the villagers and other actors and those who try to exercise power without monetary support do not have working relationship with other actors including the villagers.

Even though it is beyond the scope of this research I noticed that relying on PHASE Nepal as well as other NGO health services in both Hagam and Fulpinkot VDCs seem to have created dependency. This has shifted the responsibility from the government to NGOs, which is not sustainable. Though not explicitly expressed, some of the HFMC members, government health workers and some political party leaders said that until PHASE Nepal provides the health services, government would not send required health workers to Hagam and Fulpinkot VDCs, there might be some truth in that.

5.7.5 Relationship of actors with multiple roles

Some of the actors including the villagers have a multiple role in PHC. These multiple roles affect their relationship with other actors. The members of the HFMC are responsible for managing the PHC in their VDCs but at the same time they are the users of available health services. The political party leaders, members of HFMC and village leaders are often the same people. Similarly most of the FCHVs are the chairperson of the mothers' groups, women groups and saving –credit groups. In Hagam VDC the VHW owns a private medicine shop. I observed that actors with multiple roles had better relationship with actors compared to those having only a single role. However, sometimes these multiple roles create problems on their relationships. For example, because of the VHW in Hagam owning a private medicine shop it is creating problem in his relationship with other actors, because other actors suspect that he is absent from the sub-health post more to open his private shop and he is suspected of mishandling the free medicine he gets for the sub-health post.

5.8 Conclusion

The study of relationship between various actors involved in PHC is one of the ways of looking into community participation in PHC. This study of relationship and interaction of various actors in the process of their participation in various aspects of PHC shows that the relationship of these actors reflects their degree of participation in PHC. This PhD research finds that the relationship among different actors depends upon their assigned or adapted role and their honesty in fulfilling their role / responsibility. Furthermore, it depends on their trust among different actors especially the villagers, caste / gender of actors, various roles these actors play, political affiliation of the actors and the resources these actors bring in PHC. Relationship between formal government health workers and the other actors including the villagers is not good mostly because of latter's absence from their respective posts. Similarly, the mistrust of the government health workers mainly by the villagers seemed one of the

challenges of relationship between these two groups of actors. Relationship of government health workers with other actors seemed to be compromised mainly because of the absenteeism of the main staff even though some of the government health staff present in the area are found to be working in their capacity for their assigned as well as assumed roles.

Relationship among the nongovernmental actors and other actors including the villagers seemed mostly depend upon the resources they bring, mutual help they offer to each other and services they provide. For example, the NGO health workers were liked by almost all of the actors because they have filled the gap of absenteeism of the government staff, provided health services and have brought additional resources and opportunities for the community. Similarly, the informal health service providers, for example, the traditional healers, herbal medicine practitioners and spiritual healers have a good relationship with majority of the villagers because they are local, available in abundance, offer their service within their social and financial limitations and most importantly they provide their services in people's home and free of cost if people cannot pay.

Therefore, in conclusion the strength of relationship between actors is influenced by:

- Having direct relevance and personal benefit to the individual.
- Whether it fits with their expectations and beliefs.
- The quality of the relationship (i.e. it is top-down formal paternalistic government services, or more a client/customer model where the individual has more control and choice e.g. with the traditional healers.).
- Basis of past experience/history.
- Views of others in their community.

In this chapter, I presented the Health System Actors' relationship with each other and on how their relationships with each other affect their participation in PHC. I also presented the key issues emerged which form these relationships. These key issues are gender, caste, ethnicity, social status, political status and their roles. In the following chapter i.e. chapter six I will present my findings and initial discussion on various actors' motivation to participate in Primary Health Care.

CHAPTER SIX

Motivation for participation in Primary Health Care

6.1 Introduction

Even though it is mostly used in business and organizational motivations, motivation for participation in PHC for some of the actors can be explained using Maslow's Hierarchy of Needs Theory (Maslow and Langfeld, 1943, AH, 1943). Since motivation for participation also follows the individual universal needs (Benson and Dundis, 2003) it can be equally used to analyse the motivations for participation in health sector as well. According to Maslow's Theory of Hierarchy of Needs there are five levels of basic needs which are presented in the form of pyramid. These needs are Physiological Needs, Safety Needs, Needs of Love, Affection and Belongingness, Needs for Esteem and Needs for Self-Actualization. According to Maslow, people move to higher level needs only after their lower level needs are fulfilled.

If all the needs are unsatisfied, and the organism is then dominated by the physiological needs, all other needs may become simply non-existent or be pushed into the background (Maslow and Langfeld, 1943).

Despite wide use of Maslow's Theory of hierarchy of needs in various disciplines for its simplicity it is also heavily criticized for it being too simplistic in human behaviour, for lack of consideration of role of culture / language in shaping human needs, for Maslow's claim of linear nature of hierarchy of needs (Neher, 1991) and also for lack of strong empirical evidence (Thielke et al., 2012). Frame (1996) challenges that the meaning of motivation at the basic level of needs and self-actualization is different, therefore, cannot be applied universally to all needs as explained by Maslow. Smith and Feigenbaum (2012) even blame Maslow that he misused concept of synergy to promote a person centered psychological position and Geller (1982) argues that Maslow's Theory is inadequate to explain the origin of human needs. Despite these challenges Maslow's hierarchy of needs theory is still used in many fields including health, for example, in designing different health services, analysing health workers' motivation (Lambrou et al., 2010, Sirgy, 1986) and to analyse the motivation for use of technologies for different age groups of population (Thielke et al., 2012). Though this theory lack strong empirical evidence of its usability in people's motivation for participation I consider it appropriate to analyse health system actors' motivation in participation in PHC, for its simplicity to use.

Therefore, even though it does not exactly apply in hierarchical order as explained in Maslow's hierarchical theory of needs, different actors' motivation to participate in PHC still fits with the components of Maslow's hierarchy of needs. For example, people participate in PHC for their livelihoods (physiological needs), for using the health services (safety), to be the part of the society (belonging), to get respect from other actors (esteem) and finally for feeling of morality (self-actualization). Where first two represents basic needs and later three are social needs, all of which can be used to describe how different actors participate in PHC in these two VDCs as well.

In addition to that, motivation for participation is guided by social, cultural, personal, religious, financial, and political factors. It highly depends on local, regional, national and international context. For example, the participation in social, cultural and religious activities has long been ingrained in the Nepalese culture but community participation in PHC was a new concept and a policy put forward by the government after The Declaration of Alma-Ata for Primary Health Care in 1978 (WHO, 1978). Community participation in PHC as envisioned by Alma Ata Declaration is the full, self-motivated engagement of people in planning, organizing, operation and control of PHC by utilizing local, national and other available resources for the benefit of people living in their community. People in Hagam and Fulpingkot have not understood participation that way. Rather, I found that people do not understand participation or engagement as a separate concept but it is inbuilt in their daily routine. However, it is only for certain things. For example, people participate in any social, cultural and religious events without even thinking about it whereas it is a very difficult to convince them to participate in other things,, for example, in many aspects of PHC because PHC is still a new concept for them. In addition to this, participation is mostly understood either as use of services or contribution of resources and free labour for various activities, including in PHC. Therefore, different actors participate in PHC for different reasons.

Participation in some cultural and agricultural activities are in practice for many years. For example, most of the farmers have a system of working together, mainly in busy planting and harvesting seasons. It is called a Sareli system (sometimes also called Lahare Parma) in which a group of farmers is formed from each household to complete planting or harvesting for every family one by one until it is completed for everyone. There is no such practice for any modern activities, including PHC. It is mainly because everyone understands the necessity for food production but not for clean water, immunization or other PHC activities.

When explicitly asked about participation people understand it mostly as the use of available health as well as other services. However, in practice they are seen to participate in various roles at different times. A typical example is that a teacher who teaches modern health education in the school takes his children to traditional healers regularly, helps in children immunization programme and mobilizes students in various health awareness campaigns. When asked about his belief in modern and traditional treatment systems, he replied that it should not be the choice of either one or another but this is a choice people make and often they choose what they need (interview#11). Even more interesting is that two teachers – one of whom I interviewed – practise traditional healing themselves. They believe that there is something super natural, higher than what we can see and claimed that their treatment works. The head teacher of the school (interview#13) said that his traditional healer teacher has treated students on several occasions in his school.

Traditional healers, Lamas and priests believe in spirits and claim that either gods or ghosts cause most of the diseases. Some people believe this and others don't. Most of the modern educated people and followers of the modern Western medical system treat traditional approaches of health care and traditional healers as primitive and backward. Since the government, NGOs and private practitioners advocate for modern health services and often discourage the traditional healing practices, traditional healing practitioners feel pressure to prioritize or move towards modern medicine. Since fewer of people are using traditional healing practices, traditional healers are losing their job and hence their means of livelihoods. Therefore, the traditional healing practices have become less economically viable to them.

6.2 Use of different health services by various actors

Use of health services by different actors significantly differs based on their gender, age, caste and social status. For ease of comparison, the use of health services can be ranked as low, medium and high, meaning rare use (hardly once a year), occasional use (2-3 times a year) and frequent use (more than 4 times a year) of the services respectively. This is common in both Hagam and Fulpingkot VDC.

When they have health problems the higher caste people access the Western modern health services more frequently compared to lower caste people. The lower caste people use the traditional healing practices more compared to the higher caste people. Elderly, poor young

women and lower caste people use traditional methods of health services more compared to young, rich, men and people from higher caste (interview#14). Lack of money, difficulty in walking, proximity of service, familiarity with the service providers and belief system encourages elderly to use traditional healing practices. Similarly, because of shyness, indecision, proximity and familiarity with the service providers, young women and lower caste people access traditional health services. Furthermore, because of higher opportunity cost to access modern health services, poorer people access traditional healing practices more compared to modern health services.

The following table presents how various groups of actors use different health services. These differences are because of people’s health beliefs, their attitude to change, their financial situation and their status in the society. Rather than presenting the use of health services by individual actors present in these two VDCs I have grouped these actors differently which still represents the actors in these VDCs. It is because the actor groups and their use of health services in both VDCs are similar, however where there is difference it has been presented separately.

The use of health services by different actors in both villages is very similar. Tamangs from both VDCs use the traditional health services more compared to modern health services. Other groups of people have very similar participation in PHC in both VDCs except Dalits. Dalits from Hagam use traditional health services more compared to Dalits from Fulpingkot. It is mainly because the Dalits in Fulpingkot are more educated and have better access to resources than the Dalits from Hagam. Based on SSIs and observation I populated Table 6.1 which shows the use of different health services by different groups of actors:

Table 6.1: Use of different health services by various actors

Actors vs use of services	Use of traditional healer	Use of modern Western health services	Use of Government health services	Use of private health services	Use of NGO health services
Higher caste people	Low	High	Medium	High	High
Lower caste people	High	Low	Medium	Low	Medium

Elderly people	High	Low	Low	Low	Low
Men	Low	High	High	High	High
Women	High	Low	Low	Low	High
Formally educated	Low	High	medium	Low	High
Uneducated	High	Low	Low	Low	Low

Colour coding

Colour			
Code	High	Medium	Low

The data show that use of traditional healing practices is high among lower caste, the elderly, women and uneducated people (Interview#14). It is because these groups of people are socially excluded and often discriminated. They are socially excluded because of lack of social capital or rather narrow network of social capital and lower access to resources. Another reason for use of these services by these people is that they are available closer to where they live, often provided by people whom they know and do not cost much for the treatment. These groups of people use modern health services less, whether it is provided by government or private health service providers. However, because of the promotion of safer motherhood health services by PHASE Nepal in both Hagam and Fulpingkot currently higher numbers of women use these services. Having said that, use of NGO health services is high among the higher caste people, men and educated people compared to lower caste, elderly and uneducated even if it is promoted more for the benefit of this latter group of people. This is because these groups are more aware of available health services than Dalits, elderly and uneducated people.

I noticed that people's financial situation is one of the main influencing factor for choosing between the Western modern methods of health services and the traditional methods of health services irrespective of the actors' caste, gender and age. The wealthier the people, the more they access modern Western health services, no matter whether these services are

provided by the government, by NGOs or by private organisations. Similarly, people with formal education used Western modern health services more compared to illiterate people whereas the illiterate people mostly used the traditional methods of health services. Looking from Maslow's hierarchy of need theory, the actors in both Hagam and Fulpingkot participate in PHC to fulfil their physiological needs.

6.3 Multiple motivating factors

It is common for many actors to have multiple motivating factors to participate in PHC. For example, the VHW in Hagam VDC is a government health worker, private medicine shop owner and at the same time he is a user of available health services. His motivation for participation in PHC is for his livelihood as well as additional financial gain. Similarly most of the FCHVs in both VDCs are chairperson of mothers' group in their respective wards, are members of the income generation groups and users of the available health services at the same time. This is common for most of the actors participating in PHC in both Hagam and Fulpingkot VDCs. Therefore, different people participate in PHC as different actors with different motivation at different times. For example, if applied Maslow's hierarchy of need theory the FCHV's motivation to participate in PHC falls under safety when they participate in it for receiving health services. Whereas, their other involvement in PHC falls under the esteem because they participate in PHC to get respect from the community as well as for their self-satisfaction. Furthermore, professional health workers participate in PHC for their livelihoods, political party leaders to maintain their political influence and other government actors to fulfil their duties. Therefore, there are multiple factors that motivate people to participate in PHC.

For this PhD research, various actors were explicitly asked about what motivates and what discourages them to participate in PHC. Motivations for different actors to participate were drawn out from their answers to above questions as well as the information drawn from the conversation with them.

As presented in Table 6.2, often the villagers participate in the PHC to use or receive available health services. Sometimes they participate to gather knowledge about the available services, no matter what type of health services are available. The government health workers, for example, VHW, ANM, MCHW and the Caretakers participate in PHC for their livelihoods. It is their job responsibility to provide the health services by participating in various activities in PHC. The FCHVs work voluntarily for social recognition. Other government actors, for example,

VDC secretary, VDC technical assistant and schoolteachers who do not directly provide the health services participate in PHC by involving themselves in various decision making processes as a part of their job. For example, the VDC secretary and the VDC technical assistants are involved in VDC budget allocation for health, coordination with various health service providers and the government stakeholders. This is part of their daily job responsibility. School teachers provide health education to students, help in various health campaigns and advise villagers for use of available health services. Teachers do so because of their job responsibility as well as for their interest in volunteering and for their political interest. Most of these fall in physiological needs in Maslow's hierarchy of needs theory.

The nongovernment health workers, for example, NGO health workers, traditional healers, priests, Lamas and herbal medicine practitioners participate in PHC for financial gain, social recognition professional satisfaction and to fulfil their interest to serve the community. Political party leaders and village heads are involved in PHC to spread their political ideology in the community and to show their influence and to exercise their power over other actors. Other actors, for example, various cooperatives, mothers' groups and income generation and saving credit groups participate in PHC for their groups' benefit. Their motivation to participate in PHC is to serve the community. Those who suffered in the past participate to make sure that their children do not suffer. The motivation for the local youths and youth clubs is financial gain, political interest and social recognition.

For the ease of analysis and discussion of the findings, motivation for participation in PHC for various actors has been presented as actors and their motivation for performing their roles in the following table:

Table 6.2: Motivation for participation in PHC

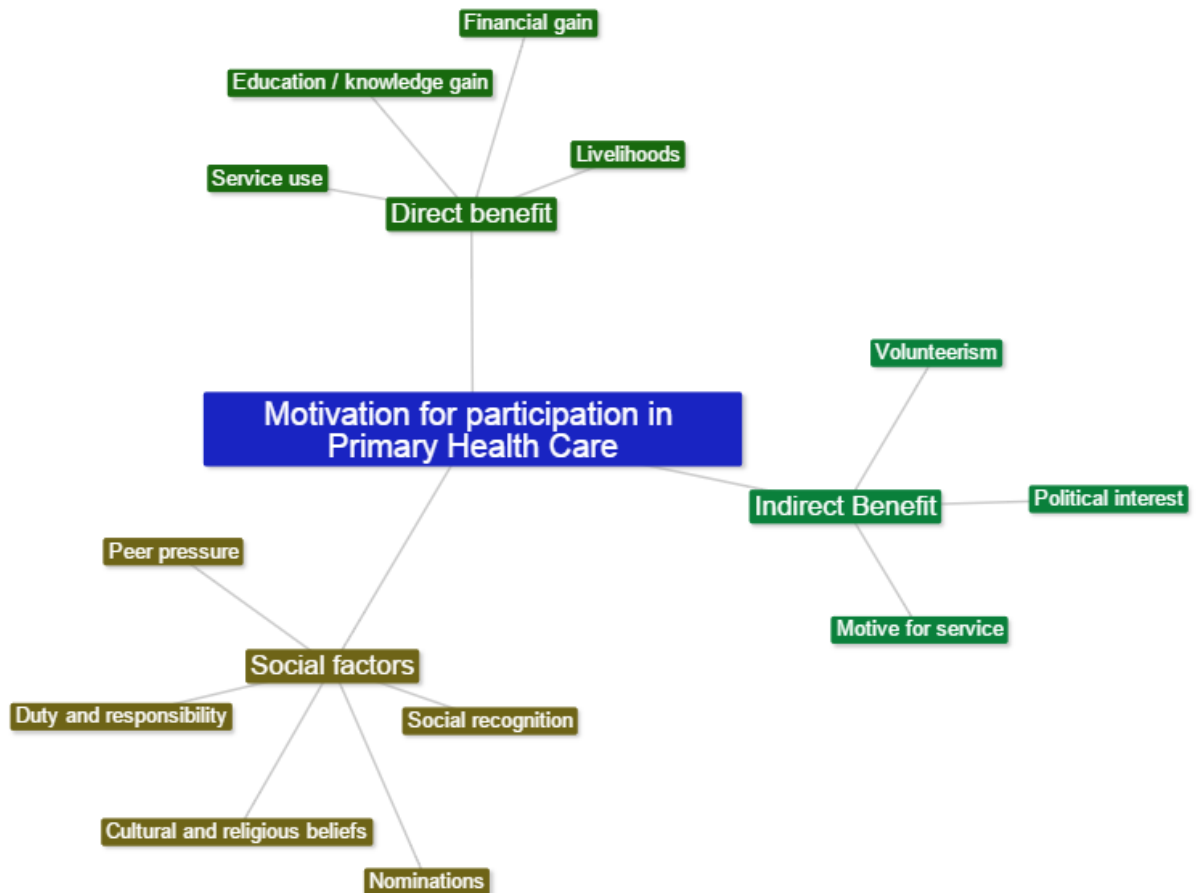
Actors Vs Motivation for Participation	Direct Benefit				Indirect Benefit			Social Pressure				
	Education/knowledge gain	Financial gain	Livelihoods	Service use	Voluntarism	Political interest	Motive for Service	Duty and responsibility	Peer pressure	Social recognition	Nominations	Cultural and religious beliefs
Villagers	x			x				x				x
VHW		x	x	x				x				
ANM		x	x	x				x				
MCHW		x	x	x				x				
FCHV				x	x		x		x	x	x	
Caretaker		x	x	x				x				
VDC Secretary		x	x	x		x		x				
VDC technical assistant		x	x	x		x		x				
Security personnel								x				
School teachers				x	x	x		x				
Private health service providers		x		x						x		x
NGO health service providers			x	x			x	x				
Traditional healers		x	x	x						x		x
Herbal medicine practitioners		x	x	x						x		x

Lamas (Buddhist priests)		x	x	x						x		x
Priests (Hindu)		x	x	x						x		x
Political party leaders and village heads				x		x	x					
Cooperatives				x			x					x
Mothers' groups				x			x					x
Income generation, saving credit and poverty alleviation groups				x			x					
Youth clubs		x		x		x				x		

Most of these motivations are guided by these actors' physiological and safety needs. However, almost all of the actors believed that doing something good in life for others, prayer and religious ceremony which improves their self-esteem. Villagers in both Hagam and Fulpingkot believe that if they do something good to other people in this life they will benefit in the future lives, it will benefit their children and it will be Dharma. Here the Dharma does not exactly mean following a religion as such, but it is higher than that for the benefit of larger universe.

Motivation for participation in PHC for various actors in Hagam and Fulpingkot has been discussed in details in the following sections:

Figure 6.1: Motivation for participation in Primary Health Care



6.4 Direct benefit

6.4.1 Education / knowledge gain

Education is highly regarded by most of the actors in both Hagam and Fulpingkot VDCs. Here education is more about gaining practical knowledge or skills in something useful rather than a theoretical knowledge. For example, villagers participate in health education activities, awareness campaigns with the hope that they will get some useful skill that can be used for some practical purpose, for example, women learning preparation of weaning food for babies, preparation of ORS by using salt and sugar water. Therefore, for many actors their interest to get these knowledge and skill motivates them to participate in PHC. This can be placed as their physiological need.

Often people who had experienced health problems themselves or by their families are interested to participate and encourage others to participate in PHC. When asked why do they

get involved in health system they said that it was good to listen to and contribute in the programme even if it was not directly beneficial to them because they can help others in need.

Time to time we are given information about important health issues. Sometimes the health workers call people and teach about health and diseases; for example, how different diseases occur and how it can be prevented. We visit sub-health post and participate in such activities with a hope that they will give some useful information. They provide us suggestions and advise us properly about different health issues. If we do not understand, we ask them and they answer us without any hesitation (Villager, female).

I observed that especially older people reported that it might benefit their younger generation if they know something about health. They explained that because of lack of health services and due to their own ignorance, there were cases where people died who could have been saved. One typical story shared by a mother who gave birth to six children but only two survived is that she thought most of her children would have survived if they had known about the resuscitation of new born babies the health workers practise these days. During my conversation with her she cried for a while thinking about her children which they buried which she thought were buried alive (interview#35). She hoped that it would not happen to other villagers if she could inform them in time about these issues. These groups of people seemed motivated to encourage others to participate in primary health care and other activities because they do not want others to suffer the way they did.

When the organizations teach us different things, I get chances to hear and understand about diseases and prevention. I am very happy for that. I cannot speak well but I do understand most of the things they talk and use my knowledge to serve other people (Volunteer, female).

One of the motivations for the village women to work as a FCHV is that they have access to various opportunities of training, meetings and mentoring where they can learn things about health, diseases and their possible remedies.

Before being a FCHV, I didn't know anything. I had only little education. After I started working as a FCHV, now I know many things (Volunteer, female).

It is not only the FCHVs but also other actors in these villages who participate in PHC as an opportunity to get new information about health services.

I participate in these programs because we can get better opportunity and information for health services (Villager, male).

Therefore, one of the motivations for different actors to participate in PHC is that they will gain some useful knowledge through their participation.

6.4.2 Financial gain

When people participate in something for money, their motivation for such participation is for financial gain. There can be direct and also some indirect financial gains from participation. For example, government provides NRs 1500 (US\$ 15) to new mothers if they deliver their babies in government delivery centres and even more if she had attended all four antenatal care check-ups. One such facility is available in nearby Jalbire VDC which is adjacent to Hagam and Fulpingkot VDCs. Similarly, people come to government and PHASE Nepal clinic because they get free treatment, which they have to pay if they receive this from private health service providers and traditional healers. Similarly, I noticed in both Hagam and Fulpingkot that people participate in different meetings more if they get allowances than in those where they do not get anything.

However, financial incentive is not always enough to motivate some people to participate. For example, most of the women from Hagam and some from Fulpingkot do not access the safe delivery service in government delivery centre in Jalbire because of the distance. It is almost 2-3 hours to walk to Jalbire for many villagers in Hagam, which pregnant women at delivery stage find difficult to do. Therefore, some women do not access that facility due to its remoteness, lack of time and information, and often because of financial constraints. One example as shared by a FCHV in Hagam:

If pregnant women are not able to deliver their baby at home, I suggest them to go to hospital. I have explained them that they will get NRs 1500 (US\$ 15) if they visit Jalbire Primary Health Centre for delivery. Some people say that they do not want to go for just NRs 1500 (US\$ 15), because it is insufficient for the expenses and too far away (Volunteer, female).

Private medical shop owners claim that they are involved in health activities because of two motivations. The first motivation they have is to earn their livelihood, and they claimed that if more people are convinced about the importance of modern health services they get more

customers which will increase their business, which is their physiological need. Other motivation is their self-satisfaction by serving the community this can be termed as need of belonging and self-esteem. The villagers expressed positively about the medicine shop owners. They thought that though medical shops are there to earn money they are useful in case of emergencies, especially when other providers are not there and insufficient.

Another private medical is also here at lower village. It is owned by (mentions the name of the private medicine shop owner). He does not fool the customers. It may be because he has good knowledge. He gives medicines as per the prescription because he is also involved in local politics. However, he doesn't stay in the medical regularly. Instead, his wife stays in their medical who is not qualified to dispense medicine (Villager, male).

This means that the villagers are grateful for this medicine shop owner for his service because he treats people appropriately. However, at the same time it implies that not all the private medicine shop owners do so. Villagers perceive that he is doing so because he is involved in local politics. Furthermore, villagers are not happy about his wife prescribing medicines because she is not a health worker. Here the motivation for participation in PHC for the private medicine shop owner is not only financial gain but to maintain his space in local politics i.e. self-esteem. I interviewed the same private medicine shop owner. He says that their service is appreciated by the villagers even if they have to pay.

The patients become thankful to us if they get required medicines. This encourages us to provide the health services. I also receive some financial benefits. I can also apply the things I studied in actual practice so that I do not forget what I learnt (Villager, male).

Yet, some of the villagers have a different view about the private medicine shop owners, for example the chair of the local NGO health clinic says:

The private sector is business oriented and the people working there think about their own benefit only. They try to sell their own services as far as possible by saying that their services are better. They tell that their medicines are more effective (Villager, male).

It shows that even the motivation to participate in PHC for the same actors is perceived by different actors differently.

One participant from Fulpinkot VDC explains in detail that most of the actors are motivated by prospective financial gains. Though it is not directly related to PHC, it implies that it applies in PHC as well (interview #36, quote in section 5.11.4)

This does not only show people's interest to unethical financial gain but also shows the discrimination against Dalits. Because of the sensitivity of the issue the respondent did not want to elaborate. However, people from Dalit community do not complain about such incidents, because they are used to it. One interview participant complains about corruption in the society:

Right now, the only thing people want is to distribute money among themselves and not to work. There is no one who can be trusted. At least one member of each party is corrupted. We cannot do anything about it. They give it the name of development work and make reports for it but put the money in their own pocket (Villager, male).

Such problems are present in both Hagam and Fulpinkot. Some of the actors participate in different programmes and formally get paid for their participation. For example, the FCHVs usually get allowances for their participation in training and meetings. Most of the NGOs provide meeting allowances to their participation. There is debate for and against such allowances, some argue that participants should be compensated for their opportunity cost whereas others think it will diminish the social value of volunteering. Some people participate in social activities for unethical financial gain. A Dalit teacher shares her experience about her participation in decision making for allocating funding for the health programme. She feels that the money was misused.

The resources and money collected was also messed up. We didn't know who had the money or who are spending it or where they spent. It was collected saying that from the interest we can buy different things we need. Neither the principal nor the interest was given back (Teacher, female).

From these findings, it can be concluded that there are three main ways that actors get financial benefit that motivates them to participate in PHC. The first is financial gain by receiving available services and taking allowances for participating in various activities. These benefits are often provided by government and nongovernment organizations to promote their activities and services. Another type of financial benefit is mostly by the people providing

health services. These are the group of actors who do not rely on their health services for earning their livelihoods but they do it for occasional financial gain. Finally there are some actors who participate in PHC because sometimes it provides them an opportunity for financial misappropriation.

6.4.3 Livelihoods

Those actors who make their livelihood by providing their services are interested to participate in health activities for their livelihoods and to make money from it. These are mainly the salaried staff, private health practitioners and traditional healers who earn their livelihoods by working in health sector or providing health services. Villagers did not complain about health service providers' salaries unless these employees were absent from their posts. Some complaints were heard from the villagers about the private medicine shop owners charging extra for the medicine even though these private medicine shop owners did not seem to be making a lot of money from selling medicines. Some of the traditional healers, Lamas, priests and herbal medicine practitioners receive certain amount of grains (about 3 Kgs of rice, maize, millet, wheat from each household) annually from the villagers for their services. On top of that, they receive some money as well as some food items each time they provided their services to the villagers. Since number of people following traditional healing practice is decreasing, traditional healers cannot make their livelihoods therefore they are engaged in other livelihoods activities as well.

The villagers' view about these health service providers is mixed. Some take this as a favour to them and the payment they make is as a gesture of thanks. For example, most of the health service users appreciated the services they receive from available health service providers, whether it is from modern health service providers or traditional healers. However, some complained that the traditional healers used to be easily accessible in the past but they are not easily available these days and also complained that they have increased their rate (interview #31). Traditional healers are also not accessible to some of the people in the community due to latter's poor financial situation, ethnicity or caste of the person seeking health services. Often Dalits are not allowed to enter the healers' houses and the traditional healers do not visit their houses either. There are some traditional healers from the Dalit caste, their service is often limited within their caste because they are still treated as untouchables by the people from higher caste. Despite these difficulties the Dalits still access traditional health system more than modern health system. Interestingly, some became traditional healers because they

were refused for treatment by other traditional healers. One traditional healer explains about his service and his charges:

When we do puja (worship) with chicken then we get some meat. If there is goat then we get flesh from goat's neck. They also give us rice. They offer us some money whatever they can. Sometimes we get NRs 200-300 (US\$ 2-3). We don't ask for a fixed amount. Those who can afford give us as we ask and those who cannot also give NRs 10-20 (US\$ 0.10-0.20). For our relatives and to those who are poor we do not charge anything. It is enough if we get a coin as a 'bheti' (offering) (Traditional healer, male).

It is not only the uneducated and poor people who follow the traditional healing practices but educated people also follow and recognize these services. They happily pay for the services, because they think it helps these traditional healers to earn their livelihoods:

It is like their profession since they can earn their livelihoods from it. People offer them money or goods for their works (Teacher, male).

He further shares his own experience of treatment of his mother by a traditional healer and about his bargain to lower the treatment cost.

My monthly salary was about NRs 1200 (US\$ 12) and the traditional healer demanded NRs 4000 (US\$ 40) for one night. He agreed to less as I told him that I could not afford. Then he decided to work in NRs 1800 (US\$ 18) (Teacher, male).

Therefore, earning their livelihood is one of the main motivations for most of the actors who are professionally involved in providing the health services.

6.4.4 Service use

Mere use of the health service is not a participation in PHC in its own but it is one of the strong motivations for people to participate in PHC. Use of health service and their positive experience in it encourages people to participate in other aspects of PHC, because they perceive it as a personal benefit to meet a personal need. Similarly, previous good experience of the service encourages them to use it again in the future. Furthermore, the service use itself can potentially benefit health outcomes through a) increased knowledge of how to self-care and when to access services and b) care provided by services. However, it is not only for their personal benefit they participate in PHC but they participate in different aspects of PHC for others' benefit as well.

As patients, they obviously participate in health for getting well or for their good health. In addition of using health services health is the most precious wealth for all of us. Therefore, they are willing to learn about it. Even if not in other things, in the matters related to health, there is higher participation. If there are any programs, meetings or workshops related to health, since it is important matter for all, they think that they can learn something about health, so they participate in it (Villager, male).

Sometimes people use health services even without knowing the benefit because they see others getting the services. For example, a new mother shared her experience about immunizing her children as:

I don't know but everyone is receiving immunization these days. My first daughter also received immunization so now also I immunized my daughter (Villager, female).

Therefore, service use itself will potentially benefit health outcomes through increased knowledge of how to self-care and when to access services as well as about the care provided by services. People participate in PHC to personally use the health services or to help others facilitate such services. Therefore, from Maslow's hierarchy of needs it falls into category safety and belonging because they are taking care of their and their family's health.

6.4.4.1 Facilitation to access available services:

People participate in PHC not only to access the health services but they participate in it to motivate others to participate. For example, motivation for participation in PHC for a female activist in Fulpinkot is to learn more about the available health services to ensure that others do not suffer the way she suffered. She shares a sad story about loss of her three children because of lack of awareness, lack of family support and lack of health services in the past:

It has been 18-19 years since I got married. I lost my first three children because there was no health post in the village and my mother and father-in-law did not support me to go somewhere else. At that time, no one understood about health. If I had visited for check-up during pregnancy probably I could have known about position of my baby. My first baby was of a complete 10 months pregnancy but the baby was in malposition. If there had been health workers to help me, my delivery could have been successful. My mother-in-law was with me to support, but I lost my baby, I did not know about the baby since I was unconscious. If the health post was here and if we were educated or

some educated person was in my family, I would not have lost my babies (Villager, female).

This story suggests that her motivation to participate in PHC seems to find meaning for the deaths of her children and prevent others from such incidents. This mostly falls on self-actualization, since it is more about accepting the facts and motivation to help others.

Furthermore, whenever I talked with participants about their participation in PHC, they referred to their past and current experiences of use of health services. This shows that participation in PHC is still a new concept in these two VDCs. When I probed for their knowledge and experience about higher level participation,, for example, their participation in decision making, leading and managing health services, most of the actors referred to the government authorities. These referrals meant district and higher level government authorities. This shows that only a few, especially the higher level actors were participating in these sorts of decision making.

6.5 Indirect benefit

6.5.1 Volunteerism

Many actors participated in PHC for indirect benefits. For example, some of the private medicine owners claimed that they are running their business even if there is loss because they want to serve the community. They said that they recover their loss from other works. I observed that most of the time they were selling other household goods as side business or more to the point they sell medicine along with the other commodities. They said that their main aim is to serve the community but they cannot do so because they need to earn their living as well. They complained that often people do not bring sufficient money for treatment and once they have debt from their shop they do not come back but rather go to other shops. It is not that they do not want to pay but often they do not have money. Because of this, the private medicine shop owners have difficulty in sustaining their business. People do not come back until they are seriously ill. When asked why they continue the business they tell that they have some professional obligation towards the community. They are trained as health workers with the aim to earn their living but at the same time to serve the community they are from; that is why they stick to the profession.

The reason that I am involved on this is that it is my area of interest. In the past I had taken training about community nutrition. Thereafter, I became more interested in these works (Villager, male).

A private medicine shop owner shares his feelings about his satisfaction when he provides health service to the people. This motivates him to continue his participation in health sector.

The medicines are very important. The patients express their gratitude when we provide them required medicines. This encourages us to provide the health services (Villager, male).

This shows that some of the actors participate in PHC because they feel happy to serve the community. This is more of the esteem in Maslow's hierarchy of needs.

6.5.2 Political interest

People affiliated with different political parties seem to participate in PHC to use it as a means to attract villagers towards their political ideology. They do so for the political benefits especially for elections. They influence decision making for allocating funds from VDC and other funding sources for their political benefit. They seem to compete with each other in attracting villagers, for which they encourage villager to get involved in health related activities. I also noticed that villagers take it for granted that the people affiliated to political parties should help them whether it is sourcing the fund for treatment, helping to find the means of transport for patients or even carrying patients to the health facilities if needed. Political party leaders did not seem to mind that either. When asked why they do, most of them said that the affiliation to political parties for them is a means to serve the community, though the villagers had different view about that. Villagers express very strong disbelief that political parties care much about people's benefit even though they expect them to support when needed. They blame the political parties for corruption and misuse of VDC and other funds. One participant explains it (quote #4 and #5 in section 6.4.2).

Local political party leaders mobilize the resources for health, advocate to use the available services and to participate in different health campaigns. Furthermore, they lobby their followers for getting the services from the government. They said that they do these as service to the community and at the same time they advocate for the political ideology they follow.

Educated people did not think very highly of local political leaders, they said that these political leaders pretend to serve the community but in reality they are after their own benefit.

I like to have a social life and I have objective of moving forward with collaboration with citizens (political interest). I feel that I have responsibility in health and other things as well, therefore, we should move together. I am the chairperson of school management committee as well as the HFMC. I was involved in construction of Illaka (area) police office. Since I am a local political representative people trust me, therefore, I was selected as the chairperson of the construction committee. Moreover, when we move in collaboration with citizens for their interest, I get a feeling of satisfaction. My objective is to contribute something in the social sector, for example, education, health and those related to people's benefit. I am happy to get involved in these works (Villager, male).

Some people participate in PHC activities even if they are not convinced themselves. For example, one Hindu priest who practises traditional healing for others goes to modern health facilities to treat himself and his family members. When asked the reasons for that, he said that traditional healing practices are for psychological soothing rather than to cure the diseases physically. He said that most of the people feel better after his chanting and praying. He admits that people need to get modern medical treatment if they have serious illness. People seemed to use the traditional healers because they are available when needed, healers speak the common language, are often from the same caste group and do not ask for a lot of money and also accept the payment in kind. Political parties use these healers because they have strong hold in the community.

Another is being a party representative, when I am called to participate in different meetings, everyone support me to work telling that I have knowledge about it. So I get involved on these activities (Villager, male).

For some political party leaders, participation is a chore to maintain political ideology in the community:

When people call me to represent my political party, I have to go there. I have to do the representation because I am involved in it. Therefore, I participate in it (Villager, male).

Hence, motivation for participation of political leaders in PHC is to maintain their political space in the community, even though most of them said that they want to serve their

community. In Maslow's hierarchy of needs pyramid it falls in the Esteem because they participate in PHC for their self-esteem and for gaining respect from other actors.

6.5.3 Motive for Service

Often people who are involved in primary health care voluntarily said that they did so to serve the community. Some of them said that they had free time therefore instead of staying at home they chose to serve the community. I observed that people who got involved because they wanted to serve the community were more motivated than those who were facilitated to participate by others, for example, by their relatives, health workers or community. The community as a whole seemed very interlinked that motivated them to serve the community for free. This interlinking is mainly because of their common culture, common neighbours, similar economic status and common geographical barriers. These factors significantly influence how they are engaged in various aspects of life. For example, people did not seem to take their health issues seriously. People who had sufficient to eat from their agriculture production or other income participated in health issues more than who did not have sufficient to eat. I noticed that that people did not even receive health services unless they were physically unable to work in their field. It is mainly because they had other pressing needs than worrying about their health. Therefore, I found that only wealthier people participated voluntarily in PHC

It is a common phenomenon among most of the villagers in both Hagam and Fulpingkot that they did not have any health plan, insurance or regular check-ups. This is also common to most of the Nepalese people. It is commonly found that people do not seek health services even when they were not well till they are unable to perform their daily physical labour. For women, this also affects the safer motherhood services, for example, ANC, PNC and attended deliveries. This is because pregnant women often do not even go for check-ups unless they are physically unable to work in the field. Women who did not have any check-ups during their pregnancies often discourage younger women to access such services as they do not see the point in attending. Some of the actors who were involved in PHC said they are helping to improve these issues.

I hope that there will be improvements in the health of women as a result of my work in health sector. I further hope that I can change their health related practices like improvement in cleanliness and health service utilization practices. Even after I leave

the service, everyone would remember me and the things I taught them if I manage to do so (Health worker, male).

In addition to being a government health worker in Hagam, he is interested in changing people's health practices because he wants to be remembered by the villagers for his contribution. From Maslow's hierarchy of need point of view it is for his self-esteem. This shows there can be multiple reasons for participation, for example, this health worker in Hagam participates in PHC for his livelihoods as well as for his self-esteem.

Similarly, the chair of the sub-health post management committee in Fulpingkot participates in PHC for humanity, which is also for self-esteem.

From the beginning, I was interested in social works. I thought that humanity is to involve in an important sector like health and to help others no matter what I would help. Therefore, I got involved in it (Villager, male).

People believe that religious devotion benefits them. Both Hinduism and Buddhism believe in after life i.e. rebirth. It is a commonly held belief that if you do good in this life you will have a better life next time around. Helping people in need is considered as religious devotion to god in both Hinduism and Buddhism. For example, in Hinduism, the belief is that one has to born 8.4 million times as different lives before rebirth as human, but you can get skipped some of it if you do good to others in this life. Therefore, often people relate their participation in any voluntary work including their participation in PHC as a religious devotion. They believe that if they serve people they do not need to do any religious devotion. Most of the actors who participate in PHC voluntarily think that it is like a religious devotion, or it is for religious merit.

I do not have to earn 'dharma' (religious merit) if I provide some services to people by my hard work, so I think that I will do something. Therefore, allowances are not the main motive. No female community health volunteers are receiving allowances, anyway. So I got involved in it to provide some services and to do something for others (Volunteer, female).

In both Hagam and Fulpingkot, I found that people are interested to help other people to access health services irrespective of their profession. For example, one of the teachers in Fulpingkot shared a story that she wants to participate in PHC because she wants to make people aware of the consequences.

I tell them to visit for check-up because health is a part of education. We learn it by reading. We also learn from experience, which we did not know earlier. For example, we tell people that if they do not receive immunization, they can suffer from different diseases and if they do not visit for antenatal check-ups their own and their child's life maybe in danger. This way we try to make them understand to save their own and their child's life (Teacher, female).

A local woman who is leading a campaign against alcoholism in Fulpingkot is doing so because she wants to reduce suffering of her fellow women. She shares her story that it is not easy to participate in certain things especially when it is mostly against men. However, she participates because she feels good about it.

Many women are suffering and if I could help them even a little bit it can be a relief for them. They are always facing difficulties in their family. Since their husbands are alcoholics, they never seem to have a good and peaceful life. If we could help them then they can have a good life. We want their husbands not to beat them and stop selling their harvest to others for alcohol. Therefore, I got involved in it thinking that we can improve this situation together. It has been 18-20 years since I am here in this village and no one complained about me. However, after being involved in this campaign, they backbite about me. But, I feel I haven't done a bad thing; it is a good work so I thought these backbiting are nothing. If women here can get a good life by our contribution then it is no problem for me to do it (Villager, female).

This represents a common phenomenon of a rural society in Nepal. Currently, most of the youths go to the cities to study or abroad to work, whereas most of the middle-age population are left in these villages. Often, men do not participate in household works except in heavy agriculture work, for example, ploughing, sawing, masonry and carpentry. These men are engaged in playing cards and drinking alcohol most of the time when they are not busy in their agricultural activities. This creates social and family problems, which is a serious issue in some part of Nepal including these two VDCs. Women's groups try to discourage these practices. The lady above leads one of the campaigns against alcoholism in Fulpingkot VDC. The story she tells represents the story of a typical Nepali society how women are treated, both those who suffer and those who try to resist it. She seemed worried about what the society will say about her involvement in anti-alcoholism campaigns. However, she seems convinced that her participation in it will benefit those suffering from alcoholism.

There are various motivations for actors to participate in PHC, one of them is personal interest to help other human being. Similarly, people participate in PHC to be remembered by other people, for religious merit (Dharma) and to be useful. I found that most of the actors who are involved in PHC other than for their livelihoods do so because they want to make their afterlife better by serving other people, as explained in previous section. It is mainly for self-esteem and to get respect from others, which fall in Esteem on Maslow's Hierarchy of Need.

6.6 Social factors

6.6.1 Duty and responsibility

People's involvement in various health-related activities other than receiving the service for themselves seemed to be guided mostly by their profession. Often, people participated in various health-related activities because they feel it is their assigned duty or responsibility – in other words, they do so out of a sense of duty. The deep rooted sense of responsibility (Ruano et al., 2012) to fulfil duties assigned to them seemed the main motivation factor here. This applied more to those actors who had a formal role in the health system assigned to them by the external actors (mainly government, NGOs). For example FCHVs (Female Community Health Volunteers), VHWs (Village Health Workers), CMAs (Community Medical Assistants) and other staff are involved in health systems as part of fulfilling their day-to-day responsibilities. When asked what motivates to participate in PHC, one of the participant replies:

Another thing is at office, I am a government employee. Government has assigned duties for me. I have to perform my duty well. It is my responsibility (Government worker, male).

Some actors participate in health-related activities even if they are not sure of the activity. For example, there are incidents when government health workers, NGO workers, political party leaders and their friends ask villagers to participate in certain health campaigns, for financial contribution as well as material contribution. Because of their personal and social relation these people cannot decline their request. Sometimes these people participate in these activities without fully understanding about it. For example, some of the FCHVs complained that they have to distribute some medicine which they do not know because other health workers asked them to do. Since they are volunteers, government health staff, NGO workers, and political party leaders use them because it is free to use them which often create conflict between these FCHVs and those actors who want them to work for free.

I am providing my services very efficiently and effectively. In ward number 7, I carry medicines to every house. It is my duty. I was given this responsibility, "they handed me the responsibility", I thought I could do this and I am doing it (Volunteer, female).

The above statement from a FCHV gives two messages: first, she did not volunteer to be selected but the HFMC including the health worker selected her to work as FCHV. Therefore, it was not her choice to be FCHV but others wanted her to work as FCHV. She did not have control over her selection. However, she says it is her duty to serve the community.

I noticed that FCHVs were involved in almost all of the health activities in their wards one way or another, no matter who is implementing it. To some extent, they seemed over exploited and some of them voiced their disapproval of this as well. Some of the FCHVs were not comfortable with it. It is because they are asked to do more activities than they are supposed to do mainly because they do not cost since they are volunteers. FCHV's roles are mainly to support government health service. Their main responsibilities are distribution of Vitamin A Capsules, distribution of deworming tablets to children under 5 years of age, provide health education, community based treatment of pneumonia, diarrhoea and refer serious children to health facilities (GoV-Nepal, 2010, Rasmussen, 2014). They report their activities to VHW or MCHW and participate in monthly HFMC meeting. However, when there are any health campaigns or health activities organized by government, nongovernment, VDC and political parties, these organizations use FCHVs (New-ERA, 2007). It is mainly because they are local, have access to the community and most importantly they are volunteers.

The VDC technical assistant realises the extra work the FCHVs have to do and allocates funding for health programme including some for the FCHVs hoping that it will benefit the common villagers. At the same time, he says it is his duty to participate in PHC as a government employee.

The main reason I am involved in it is that it is my duty. There are people who lack education or whose economy is low, they cannot spend money for health. If VDC could provide some funding it would be easier for them and they would be facilitated. If VDC could provide training or education to FCHVs, then those people who face difficulty won't have to suffer (Government worker, male).

Similarly, a teacher in Fulpingkot thinks it is their duty to inform the villagers about various information they need.

Teachers are change makers. They tend to make changes. They have knowledge about many things and they are informed. Teachers participate in different activities to spread information including health. It depends on the people whether they take the information or not. However, it is the duty of teachers to spread the message (Teacher, male).

I observed that teachers are highly respected and listened to in both Hagam and Fulpingkot. Villagers consult teachers for various personal and family issues. Teachers as well as the health promoters know that the villagers listen to teachers more than other actors. Teachers feel privileged to be able to help the people in need including on their health issues. Teachers feel it is their duty to help the villagers. Teachers rank themselves higher in social hierarchy than other actors, therefore, they seek respect in return for their social duty for helping other actors.

Even though most of the health workers who are employed by the government or nongovernment organizations participate in PHC as their assigned duty, they said that they wanted to work in this sector because they wanted to serve people. They said that it makes them happy to be able to help other people.

I had always an interest to work in health sector. If I keep doing this work then it is a kind of service to people; like 'dharma' (religion). People come to ask me about their problems. I feel happy to share the things that I know and share my experiences (Health worker, female).

Therefore, those actors who are working in health sector formally said that they participate in PHC because it is their duty and responsibility. Some of the actors motivated other actors to participate in PHC because they took it as their responsibility to help others. Often FCHVs motivated their friends and other villagers to participate in health campaigns, to get involved in mothers' groups and to provide free resources for health. They show their own example and talk about social recognition and religious merits to motivate.

Often people who are formally assigned a role within the health system are involved because of their assigned as well as felt professional obligations. This seemed to apply to most of the

health system workers whether it is health workers directly involved in health system or the members of the community, health facility management committee, occasional health programme management committees, for example, children immunization committee and clinic construction committee. Once people are involved in the committees they encourage others to participate in health related activities. I noticed that once the villagers are involved in a formal role, they take their job more seriously – sometimes more seriously than the salaried health workers. It was seen that when people are involved voluntarily they have higher tendency of making the programme successful whereas the formal health workers did not seem to care beyond the numbers they must have as their achievement. For the volunteer actors it is mainly because of the respect they get from the community for use of their time to help others. Similarly, it is because most of the Hindus and Buddhists believe that if one serves others in this life it will benefit them in their next life.

The traditional healers, Lamas and Priests also said that it is their moral obligation to serve the people in the community. They claimed that the god had chosen them to have the knowledge to serve other people in the community. Therefore, they assume it is their responsibility to serve other people. They seemed to think that they are superior to other villagers in the community. All health service providers seemed to be proud to be so and they reflected this in their behaviour to the people they serve. For example, most of them seem to consider whether one could pay or not before offering treatment. Often traditional healers did not treat educated people. When asked why they do not treat, they said that they are not comfortable because educated people especially teachers question about authenticity and appropriateness of their treatment procedures. In Maslow's Hierarchy of Needs it is Esteem.

6.6.2 Peer pressure

People do not always participate in PHC on their own choice sometimes they are forced into it by social pressure. Often these pressures are from peer groups, villagers and government. For example, the chairperson of PHASE Nepal clinic in Hagam shares his experience of how he was selected to work as the chairperson of the clinic management committee:

There was another person who managed it but later he went abroad. When he was here, he put forward that someone should replace him after he goes abroad. There were many people in the meeting. He said that anyone who could give time for it from within us could replace him. No one wanted to do it and they all requested me to do because my house was nearby. Since no one was willing to do, I agreed because it was

for our own benefit. So I got involved in it. Other friends were not willing. I involved in it because it was for welfare of our own village and if we did not do, who would do it (Villager, male).

In this case this person was selected as the chairperson of the local clinic committee because the clinic was near his house. Here he was put under pressure by the villagers because he lived near by the clinic.

People who are involved in primary health care, especially those who are not getting regular salary, claimed that they are providing this service to the community because they want to serve the community. However, some of them participate in PHC because of the social pressure, family pressure or pressure from their peer groups. For example almost all of the FCHVs said the biggest motivation for them to be FCHVs is that it feels good to serve the community and a social respect and recognition (Glenton et al., 2010, Gopalan et al., 2012), but at the same time some of them said that they accepted to be FCHVs because they were forced into it. In some cases the FCHVs were appointed by the health workers and HFMC without their consent.

Political party leaders also claimed that even if they are not in active posts they are continuously involved in all the activities in the village including those related to health because they want to serve the community. Often, it is something they could not avoid because villagers expect them to help in most of the activities including PHC. Some of the health workers, Lamas, Jhankris and Priests said that they participate in different activities, for example, trainings and campaigns not only for their own benefit but because they can serve the community. But in practice most of the actors also mentioned that once they are involved in PHC voluntarily they continue to participate in it, because the villagers want them to continue and often put pressure to do so by other actors. If they do not participate they are not taken seriously by the villagers.

One FCHV shared her story about her job and the possible implications if she does not do what they ask her to do. She implied that she was not satisfied with the job because she has to work the way the management committee and the health staff tell her to do. She is scared that if she does not work the way they ask her to do they might spread malicious views about her. Therefore, she is working as FCHV even though it is not entirely her choice:

The organizations tell me to do so. If I do not do it, they may tell me that I am not interested to serve the community (Volunteer, female).

Similarly, another Dalit FCHV in Hagam is working despite her lack of time for performing her household activities because the villagers trust her and insisted that she does the job. On the one hand she admits that she feels privileged to work as FCHV but at the same time she complains about her lack of time.

After they insisted I agreed to do this work (to work as FCHV) thinking that I could do if everyone thought so. I do not have any other problem but just problem of lack of time (Volunteer, female).

Similar to the FCHV above some of the traditional healers also complain that they are providing healing services despite their interest to not to do so. When I asked for reasons, one of the traditional healer in Hagam said that it is neither sufficient for their living nor they can leave it easily. Because they have been doing it for a long time, and there are some people who rely on their services, therefore, they cannot just quit. On one hand they are losing their livelihoods as less people are accessing traditional healing, yet on the other hand healers have to continue to provide services for those who still seek traditional healing services from them

If I do not do these then people will say I am unsupportive. Therefore, I must do it. I cannot leave it, neither it is easy for me to continue because this alone does not earn my livelihoods (Traditional healer, male).

One of the traditional healers in Fulpinkot said that he became traditional healer because he was forced to do so by his family. He said that after his traditional healer grandfather died his grandfather's spirit entered into his body. He said the spirit entered his body and made him shake his body the way other shamans do. He said he experienced this himself; therefore, he had to become a traditional healer.

....after any of our jhankri parents die, it catches one of their younger generations. So we have to compulsorily be a jhankri. Otherwise we might even die. Therefore, I did not become a jhankri (traditional healer) by my own interest, it was forced upon me by my family (Traditional healer, male).

In some cases, people participated in PHC due to social pressure but they continued to work in that post because they enjoyed it and they learnt new things. Therefore, it is combination of social pressure and their own interest that motivates some of the actors to participate in PHC.

During a meeting mothers group insisted me to be a FCHV ...till now I am working as FCHV because I learnt a lot of things about health. I did not know much about health before. I knew that we should focus on cleanliness but there are certain good ways of doing it. I did not know about it. However, later after being a FCHV, I learnt a lot about it. Therefore, till now I am working as FCHV (Volunteer, female).

These cases suggest that various actors participate in PHC even without their own interest but because of various social pressures. These pressures might be from their colleagues, family or the community themselves. This falls in esteem in Maslow's Theory because these actors respect others' suggestions to serve the community and for their self-esteem.

6.6.3 Social recognition

Often it is social recognition, especially if it is participation in PHC voluntarily that motivates people to participate in it. Because of the high respect people get from villagers as well as other actors for participating in something voluntarily, it is still a strong motivation for people to participate in PHC. This is expressed by a FCHV in Hagam.

Before only people of my ward used to know me but after being a FCHV, people of the whole VDC know me. It is a self-motivated volunteer. Nowadays people don't work if they aren't provided money. But even though I don't get income from this, I can serve the community and teach people the things I have learnt. Therefore I am working as FCHV (Volunteer, female).

Sometimes it is people's personal experience as well as suffering that motivate people to participate in PHC. For example, one of the traditional healers in Hagam shared his story with me that his younger sister died because no modern health services were available nearby and the traditional healers were not prepared to visit his house because they had other work to do. He said that if they had come to his house to treat his sister, she would have been still alive. Therefore, his motivation for becoming a traditional healer was to serve the community with the hope that others will not have a similar fate like him because of a traditional healer denying treatment.

I just wanted to know why this lama and jhakri (traditional healer) were being so superior and not treating my sister. I had in my mind that if I become a jhakri I would go even if it is late at night. When you have knowledge to cure somebody then you act a big person. You can say that I have some work so bring the patient here or I will come to your home later but they did not do that. So, I felt like what sort of people are these and I learned all this and villager are benefitting from this (Traditional healer, male).

This shows that social obligation play significant part in people's participation in PHC. Once people are engaged in serving their fellow villagers, they continue to do so because there are social recognitions, their feeling of good for serving others and often they believe it will bring benefits in the next life if they do well in this one. This is also self-esteem.

6.6.4 Nominations

Often people are elected or selected because of their family tradition of doing certain jobs. Though it is not related to health, in Nepal people often have caste-based jobs. For example, blacksmith's son is supposed to continue the job of blacksmith. This applies to tailors, cobblers, cleaners, priests and many others. A priest in Fulpinkot became a priest because his father was a priest. To carry out the religious rituals including those during birth and death for some of the villagers they served, someone from his family needed to be a priest. Similarly, a schoolteacher in Hagam became Lama because his father is a Lama and there is no one to take over from him. This mostly applies to the traditional healers, Lamas and herbal medicine practitioners rather than to modern health practitioners and other non-health actors.

These are family traditions which contribute towards livelihoods of the family. Therefore, these actors have multiple motivating factors. For example, other actors assume that these actors will carry on what their elderly were practising; their family expect them to continue and often nominate them to carry on the family tradition. For example there is tradition in highland Buddhist families to send the second son or daughter to practise as a monk or nun respectively. In extreme cases they can refuse to continue the tradition but often they are pressured to continue. Even though these appear to be family pressures, they are long-standing social constructs.

My father was a jhankri (traditional healer). My sister had suffered from 'kaamne' (shaking), therefore someone from my family needed to be jhakri. Later my guru

(teacher) transferred it to me and put me to 'gufa' (meditating cave) for meditation and learning (Traditional healer, male).

Often traditional healers, priests and Lamas follow their practices as their family tradition to continue their livelihoods.

I became jhakri (traditional healer) because my grandfather and father were Jhakri too (Traditional healer, male).

However, in some cases people participate because there was no one to do the job at the time they had to start. To some extent it is a social pressure that results in them participating.

People of this ward asked me that I should get involved in it since there were no other women who could do that. Therefore, they made me FCHV (Volunteer, female).

Another FCHV in Hagam shares her experience about how she was selected as a FCHV. The government health worker selected her even when she was not sure whether she would be able to contribute or not. From her experience, it shows that people do not have choice but to accept if someone asks them to volunteer in such things. However, once they are involved they feel that they are being useful and serving their community. This motivates them to continue their participation.

I told people that I would not do this but they insisted me to get involved in it.(mentions the name of the person) also said so. I told him that I didn't have good education. But he said that education was not necessary for it. When I disagreed,he said that he would make me involved in it anyway. He told me that no one would agree to do these works if I also didn't agree. It has been 7 years. I feel that I am doing something good (Volunteer, female).

Often villagers nominate someone as FCHV because of their education, awareness and motivation. Sometimes they do so without any consent from these candidates. However, once started these FCHVs continue to work because they are interested to help people.

During a meeting of women's group, a FCHV told that she was leaving her work. This was discussed among themselves and about her replacement candidate. We discussed and they asked me to be a FCHV to replace her saying that I could understand and I was educated as well. I thought for a while and accepted thinking that it was better to serve the community than just staying at home doing nothing (Volunteer, female).

Family profession also plays a strong role in people's participation in PHC, because those who are already involved in it know about the sector better. Therefore, they often encourage their children and other family members to get involved especially if it is related to their livelihoods. In some cases, even the voluntary works, for example, FCHVs are passed from one family member to another i.e. from mother to daughter and mothers-in-law to daughters-in-law. In these cases, their motivation is because of the social and other benefits attached to it and sometimes because they want to continue what their families are involved in as family tradition. From Maslow's Hierarchy of Need Theory it falls on Esteem.

6.6.5 Cultural and religious beliefs

Sometimes people get involved in health activities as a religious process. For example, I observed a religious ceremony in Hagam VDC where the whole community (one or two people from each household from the whole community of about 120 households) gathered to worship the rain god (called god Indra). They told me the story behind the ceremony is that a long time ago there was an extended period of drought, because of which the crops died and even the streams dried up. Because of this there was famine and the spread of disease. People in the community sought advice from the village elderly who suggested that it is because the god of rain is angry with them and suggested to worship the god by sacrificing a female goat and to spray the blood in the water and crop. The villagers did so, the rain god the 'Indra' saw that and could not tolerate the suffering of the people and made rain. Therefore, people started the tradition of sacrificing the goat and flooding the river with blood and sprayed the blood mixed water on their crops. Therefore, as a tradition every year in a certain day all the people from the community gather in a nearby stream, sacrifice the goat, mix the blood with the water in the stream where people compete to collect the blood mixed water to spread that on their crops. They believe that the god sees it and it rains within a week from the day they do this. Interestingly most of the people in the community claim that to happens every year. Even though this ceremony is not directly related to health it shows community cohesion. The main person (priest) who performs the main ceremony is the head of traditional healer from the village who also gets help from his disciples.

As explained in section 6.5.3 people in Nepal often believe in after life and they think if they do good work in this life they will be better on their next life. Once they are convinced about the cause they provide their time and resources:

The main theme of Hinduism is Sewa nai Dharma ho (means 'Service is religion'). I am inspired by this theme and the things like, care arises from heart. Therefore, thinking that I could help others, I got involved in it. Though currently, the nation has no such programmes to encourage us, it is the religion that I am inspired from. I am trying to work actively and I have provided the VDC and sub-health post with some land. If necessary, I can provide other things as well (Villager, male).

Not only the people with limited education but also teachers who are often the most educated groups of people in these villages have faith in religion. They take it as Dharma to serve other people therefore they participate in health sector because they believe that serving others is the best religion.

It is like 'dharma' (religious devotion) in Hindu tradition to teach people about health even if it is not our profession. It is great 'dharma' of Hindu tradition to teach what we know. It is 'dharma' to serve others and help others. It is said that 'sewa nai ho param dharma (service is the best religion) (Teacher, male).

In some cases, belief systems are so deeply rooted that even when there is no one present in some houses, neighbours or relatives are supposed to send someone to represent for any absentees in the rain god ceremony explained above. This shows how social and cultural ties shape people's participation and how people relate those to their own benefits. For example, with regard to the rain god worship ceremony, for general people it is a request for water from their god. For traditional healers it is their livelihood since they were given the money and grain. Furthermore it helped them to maintain their authority over the people. In addition to this the villagers help these traditional healers in their agriculture field free of cost for their services. For example, some of the senior traditional healers get 3-4 days of free labour from each household for the service they provide whereas the junior traditional healers got only 1-2 days every year. There is both trust in traditional healing practices as well as worry among the villagers about the bad feeling if they do not follow these traditions. Some of the villagers said to me that they will be cursed if they do not follow what these traditional healers tell them to do, however they did not say who will curse them. Therefore, it seems both trust and fear that makes villagers follow some of these practices. Interestingly it seemed that the traditional healers do not compete with each other, rather they seem to have the geographical boundaries but still they do not seem to mind people from one territory receiving the service from others areas.

Furthermore, there is a deep rooted cultural belief in both Hagam and Fulpingkot that doing something good for others will eventually benefit them as well. It is common not only among those involved in health professionally but also with those who participate in it indirectly. This belief motivates many actors to participate in PHC.

If we can help others when we are alive then it will be good. Even after we die everyone will remember that a person was good and sincere (Villager, male).

Therefore, motivation for participation in PHC among various actors seemed broadly guided by two factors. Firstly, those actors who had some personal interest or personal gain, and secondly those who were participating in PHC voluntarily to serve people. For example, the government employees, NGO employees, private health service providers and traditional practitioners participate in PHC for their livelihoods (physiological need in Maslow's Theory of Hierarchy of Needs). On one hand the political party leaders, village heads and members of different groups participate in PHC to impose their ideology on the villagers (safety and Esteem in Maslow's Theory). On the other hand those who participate in PHC voluntarily, for example, FCHVs, HFMC and Mothers' groups participate to help their fellow villagers as well as to feel good (Esteem in Maslow's Theory). However, most of the actors who participate in PHC also express that it is like Dharma (such as offering something to god) to serve other people, that will benefit everybody. Furthermore, people participate in PHC because of social pressure, family pressure, peer pressure and often because their family are participating in certain activities as their family tradition. In addition to this, there are cultural and religious beliefs that motivate people to participate in various activities including PHC.

6.7 Key issues emerged from above findings about motivation for participation:

This section briefly interprets the findings presented regarding actor's motivations for participation in PHC in relation to existing literature and the research question #5 (1.4). I will present reasons why different actors are reportedly motivated to participate in PHC, along with factors influencing participation in general and in Hagam and Fulpingkot VDCs in particular.

Motivation is a desire of different people to be involved in various activities for different reasons (Brownlea, 1987). Even though Zimmerman and Rappaport (1988) defined motivation for participation as involvement in any organized activities without pay, my study found that

people participate more if there is some material benefit attached. Often people decide to participate after judging the inputs and outcomes from their participation. The findings and initial discussion in this chapter established that those actors who have a formal role in the health system are involved mainly for their livelihoods and direct benefits compared to those who are indirectly involved and involved for social reasons. In one or other way most of the actors claimed during interviews that they are not involved in PHC only for their personal benefit but to serve the community as well. However, they did not say the same about other actors, or vice versa. I noticed that often actors blamed other actors' involvement in PHC to some benefit whether it is intrinsic or extrinsic. However, FCHVs were an exception most of the other actors liked and respected their work, and appreciated the fact that they worked voluntarily. As Gopalan et al. (2012) suggest, social recognition and a sense of social responsibility are two main motivation factors for those actors who participate in PHC free of any financial and material benefits. Therefore, the idea of potential benefit was one of the main motivations for these actors to participate in PHC in Hagam and Fulpingkot VDCs.

However, motivation for participation varies among actors. Often professional health workers participate in PHC for direct benefits and they motivate other actors to participate, explaining about indirect benefits, for example, doing good, spiritual satisfaction and religious merit.

Similar to FCHVs and other actors in Nepal, an assessment of community health workers in India's Accredited Social Health Activist (ASHA) health programme (Gopalan et al., 2012) found that earnings, feel of social responsibility and altruism, social recognition and feeling of self-efficacy were the main motivations for them to participate in this programme. Even though this study was conducted to explore the motivation for the Community Health Workers, it is equally applicable to other actors involved in PHC. From my findings above it can be said that people's participation in PHC is for either extrinsic benefit, salary, fees and profits or because of intrinsic motivation (Vallerand and Ratelle, 2002) to get rewards, spiritual satisfaction, religious merit and social recognition. I noticed that people participate in PHC for social recognition, volunteering and spiritual reasons for others' benefits only if their own health needs have been addressed first.

From above analysis and discussion, I have identified and presented following five major factors that shape the motivation of various actors to participate in PHC in Hagam and Fulpingkot VDCs of Sindhupalchok district:

6.7.1 Dynamics of actors groups

Influences of actors in the community varies based on other actors' effectiveness in the area. Here area means both geographical as well as professional areas. Influences of certain actors were found to be strong where there were not many other groups of actors present. However, the actors who were less proactive seemed to act more from behind the scenes. These applied to most of the actors. The traditional healers' participation in PHC is low where the modern health service providers are providing the health services regularly. Similarly, where there is majority of one political party participating in PHC, people associated to other political parties are reluctant to participate. However, the political affiliation may not be always based on political ideology but this can be because of some personal grievance with the leader or the supporter they know. Therefore, political ideology affects people's participation and sometime also the services they use.

Education level of the people affects their choice and participation in PHC. The traditional healing practices as well as even the religious rituals were lower in the area where more modern educated people were present. Traditional healers as well as religious priests and Lamas were more comfortable to work with average, uneducated villagers than the educated people. For example traditional healing practices are more common in Hagam than Fulpinkot and more in upper villages of Fulpinkot than lower ones. This is because the majority of people in Hagam are Tamangs who are less educated than people in Fulpinkot. Similarly, people in upper villages of Fulpinkot are less educated than those living in lower villages. People in lower villages of Fulpinkot are higher caste peoples, for example, Brahmins and Chhetries and those living in upper villages are Tamangs. Brahmins and Chhetries are more educated than Tamangs, Dalits and other castes, therefore their participation in PHC is higher.

Therefore, for many actors, maintaining power dynamics within the community was one of the main motivations for participation in PHC. Since most of the villagers participated in PHC one way or another, many actors took it as an entry point to influence other actors. Having said that not all of the actors participated in PHC for power space. Some of the actors participate in PHC genuinely to serve the community, some as their duty and responsibility and some as their tradition as discussed in section on nomination i.e. 6.6.4. Often actors related to different political parties work as bridge between offstage actors and the villagers. Local political party leaders approach their district leaders when they have to access offstage actors at the district

and higher level on behalf of other actors including the villagers. This is because political leaders have easy access to those actors whereas the villagers do not have such privilege.

Often modern health service providers use traditional healing practitioners as facilitators to convince the villagers. This is because the villagers trust more what the traditional healers say compared to what modern health service providers say.

6.7.2 Demand side and supply side motivation for participation

Often human necessity as well as personal interest to contribute in health systems motivated most of the actors to participate in PHC. People who needed health services participated in various aspects of PHC with the hope that they will be able to use it when they need it. This applies in participation in both modern health services as well as traditional healing practices. Common villagers participated in other aspects of PHC, for example, managing, leading and resource contribution for two reasons. Their first interest is to ensure that the health services are available in their area. Both modern health service providers and traditional healers encourage villagers to participate in it. For example, the participation of villagers in various modern health campaigns and construction of shrines, temples by traditional healers fall under such cases. Another strong motivation for most of the actors is their belief about afterlife. Almost all of the villager in both Hagam and Fulpingkot VDCs believe that if they do something good in this life they will benefit in the next life. This very thing motivates most of the actors to participate in PHC because they believe working in health is serving to other people.

Modern health service providers as well as the traditional healing practitioners participate in PHC to earn their livelihoods. Their needs of earning livelihood serves as a push factor for them to participate in PHC. Often people participated more in those aspects of PHC more which are more holistic in nature. For example, people participated more in nutrition-related health interventions than purely medical interventions. Similar result was found from a study of a PHC programme in Nigeria (Abdulraheem et al., 2012). It suggested that community participation in PHC is higher if it follows a more holistic approach that involves other aspects of community life, for example, agriculture and education.

6.7.3 Power differentials among actors

There are various power dynamics in PHC between different members of same group of actors as well as between different groups and members in both Hagam and Fulpingkot VDCs. Actors'

power play a significant role whether a certain actor participates in PHC or not. Actors gain their power from various sources. The government health workers get their power from their positions as government employee, the NGO health employees get their power from their position as health worker, the traditional healers get their power from their social identity and the political party leaders get their power from higher political authorities. For the government employees the power comes with their position because often they represent the government locally in their sector. In case of NGO, it is the money, material and the manpower they bring to the area that gives them power. As for the political party leaders, currently in Nepal there must be political consensus to do any activities whether it is health or non-health related. This puts political party leaders in a better position to negotiate, promote and even to allocate funding with the district and higher authorities. They entertain higher decision making authority compared to other local level actors.

Societal power plays an important role in people's participation, and it often stratifies the society (Kelly and van Vlaenderen, 1996). People at the higher strata of the society in Hagam and Fulpingkot wanted to maintain the status quo to maintain their power space. People from higher caste and with better financial situation were motivated to participate in PHC for this reason. Because of the power difference, often formal health service providers impose their ideas on villagers. Actors who have decision making power are motivated to participate in PHC more compared to those who do not have such power which demotivates people from such participation (Brownlea, 1987). Therefore, health workers, political party leaders, priests, Lamas are motivated more to participate in PHC than ordinary villagers. The interface among different government positions in the health system also affects their motivation for participation in PHC.

People's participation in PHC varied depending upon their knowledge about PHC and their social, cultural practices related to participation. This agrees with what (Campbell and Jovchelovitch, 2000) pointed out – specifically, that the level of knowledge and practice related to participation varies between different communities. Similar to a study of PHC in Guatemala (Ruano et al., 2012) the institutional stakeholders have more power compared to other local level actors in Nepal. This is more because of highly centralized human resource management of Nepalese health system. All the permanent health professional jobs are advertised, selected and appointed regionally and centrally. Even the District Health Office does not have hiring and firing authority for their staff who work in the district and in the VDCs. This place the

government health workers in higher power position compared to other actors. This also affects people's participation in PHC.

6.7.4 Financial benefit vs social recognition

A search for benefit from modern health practices whether it is in the form of health services or the knowledge for future benefit seems an interest for most of the actors in Nepal. Most of the actors who are involved in PHC also claim that they are there for self-esteem. However, their view about others' participation in PHC is different from their own claim. Often these actors said that other actors participate for material benefit. This shows that even though different actors work together in PHC, their motivation for participation is different. Most of the actors seemed to have had one or more bad experience, either in terms of their own health or the health of their family members. One of the reasons they want to participate in PHC seems to be to avoid such bad incidents in the future due to lack of knowledge.

Even though altruism motivates participants to participate initially, it is the direct benefits that attract them for long term participation (J. Hunter, K. Corcoran, S. Leeder, K. Phelps 2012). For example, a study in Tanzania on people's participation in a health intervention (Mutalemwa et al., 2009) found that participation is higher if there is a direct benefit from the interventions. This PhD research finds a similar situation in Nepal as well.

Most of the FCHVs and some other actors participate in PHC voluntarily initially but with time their priorities shifts and they are less motivated to participate unless there is some material benefit. One of the reasons for people participating in NGO programme is the provision of financial incentive for people's participation. Furthermore, a study in Colombia (Engelkes, 1990) found that decreasing financial benefit reduced people's participation in their Primary Health Programme. Therefore, lack of financial benefit demotivates people from participation (Molyneux et al., 2012). Some material and financial benefits motivate health workers for participation (Alfaro-Trujillo et al., 2012). A similar trend is evident in Nepal – where there is a financial incentive, more people are interested to participate, and vice versa. Feeling of being a special member of society (Ruano et al., 2012) by helping in PHC is another motivation for participation in PHC for some of the actors. However, lack of financial gain reduces the participation which confirms the findings from (Alfaro-Trujillo et al., 2012).

6.7.5 Belief systems (Traditional vs modern health services)

There are commonalities and differences on what motivates traditional and modern health service practitioners to participate in PHC. Those actors who practise traditional healing systems are the established practitioners in the society. Most of them often have those as their family profession or practices. They get involved in daily life of the villagers. They still have a significant space in the health system in Hagam and Fulpingkot. Villagers still practise both the system as required. Barbara Parker (1988) reported similar practices in Mustang, Nepal. Because of introduction of modern medicine and health practices these traditional practitioners are losing their livelihoods and their space in the community. Therefore, people's belief system affects their participation in PHC. For example, as reported by (Singh et al., 2015) one of the motivations for FCHVs to participate in PHC in Nepal is also a religious merits they believe it will bring to them and their families. Actors who participate in PHC without any material and financial benefit do so for religious merit, health knowledge, betterment of their own as well as family health, change in routine work, social recognition. However, somewhere in the back of their mind is a hope for future material or financial benefit.

6.8 Conclusion

People are motivated to participate in different aspects of PHC for different reasons. For example, it might be for their livelihoods, to serve the community, they are nominated, they are forced and because of their caste. Some participate for political benefit and others to maintain their status in the society. Whatever the reasons they participate for, most of them claim that they participate to serve the community. FCHVs and villagers participate in PHC to ensure the availability of the health services and to learn basic health knowledge to use it for themselves and others. Furthermore, FCHVs and other volunteers participate for their social recognition and religious merits. The political party leaders and the village leaders participate in PHC to maintain their political space. The modern health workers as well as the traditional healers work in PHC to earn their livelihoods. Some of the actors participate in health voluntarily whereas others are facilitated to join or sometimes even forced by the community, by their family and by their peers to join. Participation is higher where there is some financial or material gain compared to where it is completely voluntary.

In this chapter I presented the findings and discussed on actors' motivation for participation in Primary Health Care. In summary, I have presented that the main motivation for participation

is either for intrinsic rewards, for example, satisfaction, social recognition, religious merit or for extrinsic benefit, for example, salary, material benefit, allowances and earning livelihoods.

In next chapter, I will present the barriers to participation in PHC.

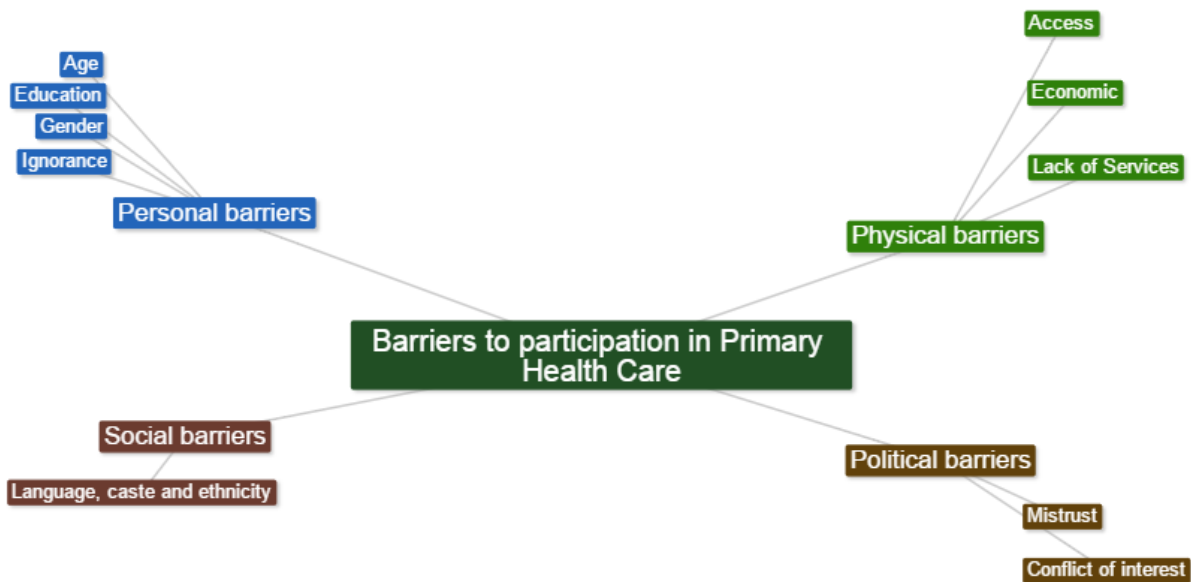
CHAPTER SEVEN

Barriers to participation in Primary Health Care

7.1 Introduction

This chapter presents the themes related to barriers to participation in PHC. The analysis in this chapter involves the results and initial discussion of barriers faced by various actors to participate in PHC or those faced in the process of participation in PHC in the village setting in Nepal. The themes identified in this regard are personal barriers, physical barriers, political barriers and social barriers (figure 7.1.). This analysis will establish why these barriers are there and how these barriers affect various actors' participation in PHC.

Figure 7.1: Barriers to participation in Primary Health Care



7.2 Personal barriers

This section discusses how personal barriers affect people's participation in PHC. People's participation in PHC is affected by their gender, age, education and actors' ignorance. Since Nepal is still a highly stratified caste-based patriarchal society, gender, education and age-based discrimination is common. Furthermore, people's lack of knowledge is common phenomena that affects their participation in PHC. This section presents a discussion about these issues and about how they affect people's participation in PHC. It demonstrates how personal barriers are equally applicable as other barriers.

7.2.1 Age

Majority of the participants expressed that a person's age significantly affects their participation in PHC. There are age-related differences in the use of different health services, as well as in higher level of participation in deciding, leading and managing the PHC (interview #4, #5). Interview participants reported that older people especially those above 50 years of age follow traditional healing practices and traditional medicines whereas the younger generation are inclined towards modern means of health services. Similarly, the older people have better knowledge of traditional and herbal remedies for various health problems whereas the younger generation rely more on Western modern medicines (interview #39).

In some villages, the younger household members – especially those from poor and uneducated segments of the society – consider old members of the family as an economic burden. This is more when the elderly are suffering from chronic health problem that require regular attention and cost money to the family. This is not expressed explicitly but it can be seen from the behaviour of family members. One of the interview participants shares a sad scenario about the effect of age as:

Age also matters in receiving the services. Let's say after a person is 60 years or more, the family thinks that it is not necessary for those old people to receive health services. They don't take him/her for health check-ups. They think that it is not necessary to treat the person who is going to die soon anyway. We have seen many of them dying in their own home due to this. They do not want to spend money in treatment but instead they want to save that for 'Ghewa' (religious ritual in Buddhist family after someone dies). The society also talks bad if one cannot perform 'Ghewa'. Because of fear of the society, they do so. The villagers' perception is that even if the older people are taken to the hospital, they will die anyway. Therefore, there will be expense in the hospital as well as in 'Ghewa'. Those who are educated take their father/mother for treatment but those who are uneducated or poor don't. They think that it's already their age to die so they let him/her die. Some also practise dhaami/jhankris (traditional healing practices) (Villager, male).

This shows how understanding about the disease and cost of health care is related. Nepal is famous for its close knit family ties, built in child care and elderly care (Goldstein and Beall, 1981). However, the economic pressure of the modern society is changing, which is reflected in the statement above. Especially the younger generation who think spending money for the

treatment of older generation is an unnecessary expense. Even though it is extreme, it shows that people have become more selfish and the society is losing the cohesiveness and promoting individualism.

I observed that educated younger people participate in modern health system more than the uneducated and the elderly. Similarly, the poor, elderly, uneducated and women participate in traditional health systems more compared to rich, educated, young and men. Therefore, people's age significantly affects their participation in PHC. Even though, people of all age participate in PHC in one or another form i.e. either in Western modern approach of health care or traditional healing, still people's age affects their participation since age affects people's mobility as well.

7.2.2 Education

Education and knowledge plays a significant role in people's participation in PHC. I observed that people think modern health is the business of educated people so people who do not have formal education hesitate to participate in it (interview #39, #40). Ordinary villagers think that not only the modern medicine practitioners but also the traditional healers, Lamas and Priests are relatively more educated and knowledgeable than themselves. This idea is continuously fed to the uneducated actors by the educated actors whether they are actors with modern Western education, for example, teachers and health workers or traditionally educated actors, for example, Buddhist Lamas, Hindu Priests and other Priests. Often these actors exploit on these beliefs of the villagers.

The ex-chairperson of the HFMC says that because of lack of education he could not participate in the maternal and child health sector:

I am not educated. If I had education, I could do more. But I don't have education so we can only inform the villagers about PHC and talk with them about how it could be made better. It is because we don't have knowledge and skill to do anything more (Villager, male).

There are still a considerable number of illiterate people in Hagam and Fulpingkot VDCs. People take their illiteracy as a handicap to participate in various activities including their participation in PHC.

One of the main thing is that I do not have education, which has stopped me from doing many things I wanted to do (Villager, male).

The importance of education has been fed into people's minds so strongly that uneducated people hesitate to participate in modern health system. A secondary school teacher in Fulpingkot shares his view that it is mainly education and people's economic condition that limits their participation in PHC.

In upper belt (where the majority of people are Tamangs), they take children for check-up to Modern health worker only if their condition gets severe; or only after they don't get well from 'fukfak' (treatment from traditional healers). But here at the lower belt (where the majority of people are Brahmins and Chhetries), if people get sick, they visit nearby places for fukfak and immediately visit to hospital for treatment. People living in upper belt visit hospital only in the condition when the patient is about to die. It is due to poor economy and less education among them (Villager, male).

The villagers have various mechanisms to address their health issues. People in the villages first try to address their health problems within their own home remedies followed by treatment from the traditional healers, herbal medicine practitioners and advice from their neighbours. One FCHV from Ryale during piloting of the interview schedule says:

We go to the dhaami/jhankri (traditional healers) for the 'jhaar-fuk' (treatment) at first and then visit to the health post. If it is not possible for treatment in the health post then we go to the hospital/medical. As far as possible, we practise treatment at home and if not then we go to the health post/hospital or medicals (medicine shops) (Volunteer, female).

This reflects two stories here, first it is more convenient to use the home remedies first, then the traditional healers, and local health workers, whereas the hospital is more inconvenient. The second it reflects the perception of risk and disease severity, i.e. for mild and minor things, they self-medicate or use traditional medicines / healers but reserve hospital care for conditions they consider to be very serious.

This shows that the education level of health systems actors and their perception about diseases and illness significantly affects their participation in PHC. Educated actors participate in PHC more willingly than those less educated even among the same group of actors. It

applies to all the actors whether it is people with modern education or those actors who are educated on their own traditional ways, for example, priests and Lamas. However, because of the current education system in Nepal – which mostly promotes Western modern health system – most of the actors who do not have access to Western education still follow the traditional healing practices. Therefore, they participate less in modern health systems compared to the educated. This is due to their understanding about the importance of health services.

7.2.3 Gender

Gender is one of the main barriers of participation in PHC. Even when women want to participate, there are other priorities they are supposed to fulfil, for example, childcare, looking after animals, working in agriculture, and completing other household chores. Especially in the villages where women are given lower priorities for health, education and other opportunities, they participate less in other aspects of life including in PHC. This has been discussed in detail in section 5.11.2. The Government of Nepal has introduced some positive discrimination to encourage women to participate in different aspects of PHC but because of social and cultural barriers women still do not participate in some aspects of PHC. Some of the main barriers are: women are not allowed to make any decisions on their own; often younger women are not allowed to walk alone; and women generally have less access to the financial and other resources. Furthermore, in many cases women are not allowed to participate in social and religious ceremonies and women are not allowed to make decisions regarding their own access to health care. These barriers lower women's decision making opportunities including their access to PHC.

The technical assistant in Hagam says that women do not visit antenatal and postnatal care because they have other priorities.

*They can't give time because of their works which are to be done compulsorily
(Government worker, male).*

For example, the Government of Nepal has introduced an incentive to women who deliver babies at a formal health institution (Ensor et al., 2009). These incentives are different in different parts of the country depending upon how remote the districts are – the more remote the area, the more incentive they get. In the case of Hagam and Fulpingkot, they get NRs 1500 (US\$ 15) for delivery attendance and NRs 400 (US\$ 4) if they attend all of the four suggested

ANCs (Ensor et al., 2009). This is to encourage the women to access safe motherhood services. However, it is often men who make decisions regarding a woman's healthcare and so women have limited say in whether or not they attend even these services.

It is not only that women cannot access health services because of other priorities, but often they do not access the services because the service provider is a male (interview #15). This applies in both traditional as well as modern health services. Women are reluctant to share their health issues with male health workers, especially any issues related to childbirth and other safer motherhood-related health problems. There are multiple reasons for women not visiting male health workers. It is cultural taboo that women do not discuss safer motherhood issues with anyone other than close female relatives because women are not supposed to talk about these things to anyone outside of the family. Since Nepalese society is very highly patriarchal society it is prohibited to discuss women's health problems openly. Therefore, women visit male health service providers only if there are no other alternatives left.

Some services are also provided by VHW but women don't come to him for services, may be because he is a male. The women may not be able to tell their problems to him so they don't go to him (Villager, male).

It is not only a gender issue, but also how society views a woman's position that affects their participation in PHC. For example, daughters-in-law are not supposed to speak in front of their fathers-in-law in many families. Similarly, there is a difference in social behaviour not only between men and women but also between daughters and daughters-in-law in both Hagam and Fulpingkot. Daughters are looked after better than daughters-in-law, and a daughter-in-law's place in the family is lower than the grandchild's position. This is because of the power structure within the family and society. Daughters-in-law have lower status in the family, whereas the grandchild – especially if it is a boy – is continuation of their lineage. Such views are strongly engrained in family practices. Often, women are not allowed to access health services whether it is modern health services or traditional healing services until they are seriously ill or cannot work in the field. Even if they are allowed, the decision is made by the male member of the family (interview #5, #41).

A teacher in Fulpingkot confirms this disparity in use of health services related to pregnancy and childbirth and child immunization:

There has been development of thinking that children should be immunized. The mothers-in-law themselves take care of their grandchildren's immunization but they do not care about their daughter-in-law's health. It may be also because of gender bias like carelessness of husbands towards women's health as well as negative attitude of family members towards check-up (Villager, male).

Women are overburdened with the household work. The male members of the family and the mothers-in-law do not prioritize women's health issues, especially those related to childbirth, so women do not participate in it.

It may be because of household work also. Especially women are involved more in household works and rearing children than men, due to which they cannot manage time for it (Teacher, female).

The society has a biased view about women's health issues which discourages women to disclose their health problems. Villagers' understanding about women's health is that women always have some problem because of their biological differences from men i.e. because of their childbirth functions and the problems related to childbirth. Mostly older women who delivered their babies without any problems or support from health workers or traditional healers discourage younger women from accessing these services even if they are available.

The family members think that women are always suffering from some diseases and they cannot be treated even by medicines. It is due to lack of knowledge and awareness. There is lack of support. The women would not know where to go, who will take them or what to tell about their own diseases when they arrive there. In these conditions, they do not visit for health services (Teacher, female).

Often women are not called for participation in any decision-making processes. It is only very recently that women are being called in various meetings and programmes to participate. However, after the democracy in Nepal in 1990, the education level of people has improved Poyck et al. (2016) and political power is decentralized to community level to a certain extent, which has helped to increase women's participation in PHC. Similarly, the Maoist's movement from 1996 to 2006 raised awareness about women's rights. This has enabled people at local level to gain awareness about women's right which has also helped to improve women's access to services in various aspects of life including their access to PHC. Therefore, women's access to health care and their participation in the health system is increasing.

However, there is still discrimination against women. For example, a female leader in Fulpingkot explains about the decision-making process for VDC budget allocation and wonders where the money allocated for women goes. At the same time she admits that women are becoming active in various aspects of life.

Representatives of political parties are there. Women aren't called for participation in it. We don't know where the money for women is being used. Women are now becoming active. We are working for it. Recently we went to Chautara (the district headquarter of Sindhupalchok district) to meet the CDO as well as the LDO. Women now are looking for their rights (Villager, female).

Furthermore, because of the patriarchal nature of the society in both VDCs women are not allowed to make independent decisions. Their decisions are often questioned by the male members of the family who often impose their own agendas. At the same time, it is not only the men but older females who also discourage their daughters-in-law and other younger women from participating in safer motherhood health programmes. For example, a FCHV in Hagam shares her experience about some of the women not participating in safer motherhood activities. She says that it is their husbands who do not let them to participate in the programme:

When I ask them they tell me that their husbands don't allow them to go for the check-up. They say that why to visit leaving all other works. Check-up doesn't do anything. Their husbands say so. Their husbands say that they could visit if the health worker can tell whether there is son or daughter in the womb. They say that without check-up also, they can deliver babies. Other women say that they can deliver babies without any medicines or receiving tt (tetanus toxoid) injection (Volunteer, female).

The decision about health services are still taken by the male members of the family which increases risks and hinders women's participation in receiving the required services. The government has recognized some of these problems but there is still gap in implementation of corrective measures. This is because of limited knowledge among villagers about various aspects of health care, for example, the safer motherhood aspect of PHC, male domination in decision making processes and slower implementation of the available laws related to women's empowerment by the government stakeholders.

In maternal health, we have three delays. Due to these three delays, problem has arisen and maternal death is not decreasing. One, delay in decision-making takes place at home. Still, when daughter-in-law or another female member of the family is in labour, her husband or father-in-law gets to take the decision whether she has to be taken to the hospital or not. What I am saying is neither husband nor father-in-law understands labour pain. They keep saying "Don't panic! Don't get afraid, don't worry, wait for little longer and others have also given birth to a baby." These things have worsened the situation (Government worker, male).

This shows that gender discrimination is still one of the main barriers for women to participate in PHC.

7.2.4 Ignorance (lack of knowledge)

To many villagers, the concept of PHC is a new thing. Most of the actors understand PHC as their actual daily experiences of available health services as well as the activities related to it. People are used to traditional healing practices but most of the people – especially the elderly – are not used to the concept of modern medicine. For them, their daily experience of PHC is more important than the concept. I observed that for the elderly the modern health services i.e. the PHC is an alien intervention that they do not always understand, might not believe in, and are sometimes fearful of. Therefore, the elderly and other people with less access to modern education, together with people living in less accessible places, hesitate to use modern PHC services and also participate less in other aspects of PHC.

People have their traditional ways of dealing with the issues related to ill health as well as childbirth. For example, in each village there used to be one or two elderly ladies who used to help new mothers during the childbirth. These are not trained traditional birth attendants (TBA) as such but they learned these skills from their own experiences and by helping others. These people understand PHC as solving their health problems themselves by using their own knowledge. If they could not solve their problems they do so by getting support from their neighbours who might be traditional healer, Priest, Lama and herbal medicine practitioners. Their health system used to be more holistic, meaning inclusive of their own community members, practices and resources. The modern Western model of PHC adopts a more disease-based approach which is distant, impersonal and does not make sense to many people, whereas the traditional healing practices take a more holistic approach. The latter describes

health problems as relating to body, mind, spirituality and feelings which have stories which people can relate to their daily lives and can trust. Therefore, the perception of PHC is one of the barriers to participation in PHC for many actors.

Before, people didn't take immunization and neither the medicines. They used to live about 100 years or even more without knowing anything about medicine. So some people now think that if their grandparents could live for so long without receiving those services then why do they need those services now (Villager, female).

Often people give lower priority to their health even if they are aware of the availability of health services because they have other immediate household chores to perform. They often try to deal with health problems themselves – only if they cannot continue to do their daily activities due to ill health they seek help from health services.

Some people even though they are informed about health issues and available services they think that it is not necessary for them to visit or access health services because of their household problems (Villager, male).

The FCHV in Ryale also expressed the same view, quoted in section 7.2.2.

Since childbirth is a natural process, often people do not take it as a health issue unless it gets complicated; pregnant women therefore do not take it seriously, especially when elderly women tell them that it is not something that requires any health care attention. This results in women not using the modern safer motherhoods health services. Similarly, some people still do not immunize their children since they cannot see any immediate benefits. On the contrary, when some children develop fever or a cold because of stress during the immunization they view it as a side effect of immunization. These concepts about different aspects of PHC are barriers to participation in PHC for some actors. When asked why pregnant women do not visit sub-health post for ANC one of the participants replies:

They may have thinking that they are well so why should they go for check-ups. (Government worker, male).

Sometimes, the actors who are promoting PHC services get frustrated due to villagers not participating in PHC activities. A FCHV in Hagam shares her experience about one family who did not immunize their children:

I mean, in the past, there was one person who had not received any immunization at all; their children even did not receive measles vaccination. They said that their children

suffer from fever due to immunization. They said that they also did not have any immunization and they are fine (Volunteer, female).

Therefore, people's understanding about different aspects of health affects their participation in PHC whether it is receiving health services or contributing to PHC through other activities. Therefore, a lack of proper knowledge about health services, their ignorance as well as how people perceive health services can prevent people from participating in PHC.

One pregnant woman had taken iron tablets during her first pregnancy. Her baby was big in size due to which it was difficult for her to deliver. She thought it is because of consuming iron tablets, therefore, she denied consuming iron tablets during her next pregnancy. We tried to make her understand and give appropriate information, but she still denied it. These types of situations are common here. I have seen and heard about it. We have to convince them in these situations (Volunteer, female).

It is not only ignorance but sometimes also the traditional beliefs about women's health that stops people from participating in PHC in these villages. For example, even though pregnancy is a natural process, some people still feel shy to access the health services.

In my view women are shy in discussing about antenatal care. Often they hide their problems related to their pregnancy. Due to this, people do not visit antenatal care services. They don't understand it as a natural process that occurs with every woman (Villager, male).

Even though pregnancy and childbirth are natural processes, modern health practices encourage regular check-ups to ensure that mother and baby are healthy. Elderly people who did not have access to modern health facilities during their own pregnancies – and also those who had babies delivered without any problems – still think that the suggestion for accessing health services during pregnancy and childbirth is a waste of time, therefore they often disagree with it and sometimes even discourage others..

Next reason is that they think pregnancy is a minor condition. Mothers-in-law tell that they delivered 8 or 10 children during their time without any check-ups so their daughters-in-law also do not need to visit for antenatal care check-up. They say that they delivered their children at home or in the field. Therefore, it may be because of the mother-in-law in some cases. In addition to this, many women also feel shy. There are

still some women who are unaware about their health issues therefore there may have been a large gap in use of safer motherhood health services (Villager, male).

Most of the people in both VDCs are used to taking care of their health themselves as part of their daily life. For example, if they have a health problem they use herbs, call their neighbours, call traditional healers and together they take care of the problem as a whole. If anything serious happens they think it is their fate, often blame themselves for upsetting a god, deities or ghosts, and sometimes blame their luck. People participate in health as part of their daily life. Therefore, when they are confronted with a modern health system different from their way of life they hesitate to participate.

It may be because of superstitious beliefs. They think that medicines cannot treat disease conditions. So they don't visit health post or don't take medicines. There are people who haven't taken any medicines all their life. There are others who bring medicines but don't take it properly. They take it one day and then leave it. They don't take medicines for the whole period it is required to be taken. Due to this, they don't get well and their diseases persist. So they say they won't visit health post because they won't get well even after visiting (Teacher, female).

How people act is shaped by how they interpret reality. For example, a teacher in Fulpingkot shares her friend's story of why she did not go for an ANC check-up. She did not go for the check-up because she already had two children and she was having a third child. She felt shy because the government states that having more than two children is not good for mother's health, children's education and family's finances. This shows how certain message in society affects people's behaviour and their participation in PHC.

She had delivered her first child in Kathmandu in a hospital. She told me that she had visited three times for antenatal check-up during her first pregnancy. I asked her why she didn't visit during her current pregnancy although she knew about it. She replied that as she already had 2 children, she felt shy because she is having too many children (Teacher, female).

Therefore in summary, different actors understand PHC differently. Some understand PHC as a modern Western health system and others understand it as their own traditional way of dealing with diseases and illnesses. Furthermore, different actors interpret health and illnesses their own way. Often the elderly and those with limited exposure to modern Western model

of health services understand PHC as a way of life where diseases, illness, life and death are all part of a greater whole. In contrast, those actors who have more exposure to modern health system and health education understand PHC as a health services to be accessed when someone is not well. Some aspects of PHC, for example, an antenatal and delivery care, the modern health system considers it something those needs some medical attention. Whereas, some people especially those elderly women who did not have such services before and had given birth without any complications think pregnancy and childbirth as natural process that does not need any especial attentions. This establishes that people's understanding as well as social construct of certain behaviour affects their participation in PHC.

7.3 Physical barriers

People's participation in PHC depends upon where they live, how busy they are and whether they can afford to participate or not. Often people do not participate in PHC because they live too far away from the community or the health centres, cannot pay for the service, or there is no service available when they need. This applies to the villagers, health service providers, policy makers, decision makers and other actors involved in PHC. A detailed discussion is presented in the following sections on how these barriers affect people's participation in PHC.

7.3.1 Access

Access in this chapter means physical access, i.e. the remoteness of the place and how far apart people live from each other and from different facilities. Though connected by fair weather roads, both Hagam and Fulpingkot VDCs are still far away from higher level primary health care facilities and hospitals. Even though basic formal health service is supposed to be available in their own village, it is not regular because of the absenteeism of staff. The only health services available to them are the basic health services provided by the health workers from respective sub-health posts and from the traditional health service providers in their villages. If these services are not locally available, the villagers have to travel further away to receive these services. This compromises the quality of the care they receive and limits their access to the required health services no matter whether it is provided by the formal health service providers or the traditional health service providers. Even within the VDC, some of the villages are 5-6 hours walk away from the available health facilities, which makes it difficult for pregnant women, children and elderly to access these facilities. This leads people to rely on the traditional health services. Some of the people in the village strongly express that distance is one of the major barriers to accessing health care in these areas:

If people who are far from the health post are sick, they cannot visit due to far distance. There are differences in participation between people who are near and those who are far (Villager, male).

The sub-health post in Hagam VDC is geographically located at the centre of the VDC but it is still 4-5 hours walk away from some of the far away villages. The elderly, sick and pregnant women try to avoid visiting this health post because it is too far away from where they live.

As I have already told you the sub-health post is far for us. Therefore, we do not visit ward number 5 (where the sub-health post is located) usually (Villager, male).

The physical distance does not only limit villagers' participation in their immediate need of health services but it also limits their involvement in health awareness programmes and other activities which help them to improve their health knowledge. This keeps them in the cycle of not participating in the health sector because they do not have the right knowledge, and vice versa. These people miss opportunities to participate in PHC because of the distance.

Some people are nomads and stay in animal shed from where they have to walk for 5-6 hours to come for the service. Therefore, they just do not come (Villager, female).

Often women and the elderly do not participate in PHC because of distance. Women are busy in their household work from which they cannot easily take time off, whereas in the case of elderly people, their health is lower priority to other members of the family.

We haven't participated in labour contribution because of the far distance (Villager, female).

Even though centrally located, the VDC Office and the secondary school are less accessed by the people from some of the wards of Hagam VDC because of the distance. The VDC technical assistant in Hagam expresses his concern about these difficulties:

Geographically, the sub-health post, which is a governmental health organization, is established at the centre of VDC. However, it is not suitable for the majority of the population. It is not situated in a place with higher population density but in a place where there is not. Since it is located in an inaccessible place, I think that there is less patient flow (Villager, male).

It shows that the distance does not only cause a physical difficulty but it also has an economic implication for people who want to participate in PHC. Villagers are less inclined to participate in PHC if it is far from them. Even if it does not cost them anything for the participation, there is cost in terms of lost opportunity, and it costs their time which they use in other essential and productive activities. Often women have multiple household responsibilities, for example, working in agriculture, looking after children, looking after animals, cleaning and cooking, which stops them from taking time away for their health issues. Therefore women do not participate in PHC.

If a pregnant woman is to take services from a health post then she won't visit Yanglakot (name of the village where PHASE Nepal runs a health clinic in Hagam VDC) to receive the services as it takes a whole day travel to arrive there. For the rich person, it's fine, they can manage. But for those who are poor, they have other work like feeding their children, managing fadders, looking after animals and work in the agriculture field. So, they won't come to receive services since it takes a whole day (Villager, male).

Therefore, distance is one of the reasons people do not participate in PHC. When it is too far away, the health service providers cannot inform everybody they want to inform to access the health services. It is mainly because of limitation of their own time as well as the distance people have to travel:

I have seen that nowadays many people visit for antenatal care check-up but there may be people who don't know about it. There are people working in cattle shed. They may not have received those services and the information about it. Tamang women here stay far away from the villages in their cattle shed. It may be the reason that they aren't informed about it. Sisters (means the ANMs) from the organization (NGO) conduct meetings and gatherings frequently. But we cannot meet those people living in the forest when we go to call them. Some people stay in shed which takes us more than 5 or 6 hours' walk if we want to meet them. Therefore, they don't come (Villager, female).

Therefore it is not only the distance but various opportunity costs attached that limit different actors' participation in PHC. There are some actors who are assigned some responsibility by the state and the society who are supposed to participate. For example, the FCHVs who do not get any regular salary except some allowances during trainings and health campaigns are

supposed to participate in most of the health-related activities. Because of their involvement in the health system as FCHV, their personal daily chores are sometimes disturbed. They do not get sufficient time to work in their home and cannot dedicate sufficient time to their children's education. These FCHVs get some financial as well as material gain for their participation in PHC. It is not material benefit but these FCHVs get social recognition which compensates their opportunity costs. However, when the opportunity costs weigh more than the material benefit and social recognition, they are reluctant to participate in PHC. Similarly, they have to prioritize their time against their more urgent and important tasks. Therefore, the barrier of participation is not a straight forward issue but often a multifaceted one.

I am feeling good about it. However, I am not getting time for it because of household works. I am alone in my house to do my housework. My working places are far away (Volunteer, female).

Some FCHVs in Hagam are not happy – they do not have sufficient time for their other activities because they have to give their time free for their FCHV work. Here, their opportunity cost overweighs the social recognition the FCHV job brings.

Sometimes I keep thinking that they should appoint someone else in my place. It is because of problem of time. I am worried about my children; if I could get time to teach them properly, they could get better education. I myself did not get to read properly, so I do not want their life to be like mine (Volunteer, female).

This shows that geographical inaccessibility hinders people's participation significantly whether it is in encouraging people to use the health services or their participation in leading, managing and implementation of PHC. Furthermore, often the opportunity cost related to the travel time also discourages people from participating in PHC.

7.3.2 Economic situation

Personal finances significantly affect people's participation in PHC in various ways. User of health services often need to pay, except for services provided by government health institutions and PHASE Nepal health clinics. Even though most of the families in Hagam and Fulpingkot have one or two of their family members working in the cities of Nepal or abroad, the majority of villagers are still subsistence farmers. They have to leave their work behind to attend the health services even if they do not have to pay, which can cost them in terms of their livelihood. If they need a higher level care they have to pay even if it is from the

government health facilities. Similarly, they need to pay for the services from the informal health service providers even if they are from the traditional health service providers. The demand for their time for participation in other aspects of PHC, for example, supporting in leading, managing and implementation often have an opportunity cost associated with it. For example, a villager complains about one private medicine shop owner and supports another because of the cost of the medicine they charge:

In private clinic, we have(names the government health worker) who is the head of the sub-health post as well. Although he is the head of the sub-health post I am not satisfied with him. It is because when patients are to be given medicines, they should be given proper medicines but he gives many unnecessary medicines that doesn't work. It is to earn money, once we visit for his services; we have to spend a lot of money. So I don't like to go there.... he takes three or four times more money (Villager, male).

Villagers' financial situation determines whether they use the health services or not, especially if those services require the user to pay a fee. People often avoid even essential surgeries because of lack of money.

We have our own weaknesses. People don't get weak only because of diseases but also because of not being able to afford the health services. For example, I had to spend about NRs 50000 (US\$ 500) for my operation which I couldn't do because I didn't have money. Because of which I am still suffering (Villager, male).

Because of the financial difficulty even the health workers who are actively involved in PHC were found to be interested in going abroad to work in a profession other than health. For example, one of the private medicine shop owners from Hagam VDC was planning to go to the Middle East for menial labour job because his private medicine shop is not paying him enough to live on (interview #2). Though it is a common phenomenon of Nepalese villages these days that most of the young people from the village go abroad to work, especially in Malaysia and Middle East, the migration of VDC level health workers will affect health services and people's participation in PHC even more.

By heart we all want to work here but sometimes due to our financial limitations we are not able to do so (Villager, male).

Even when the villagers know the consequences of not participating in the PHC, especially those related to childbirth, people often do not participate because of their poor financial

situation. They cannot afford and often they cannot also get a loan because they do not have property for collateral. This affects people's participation in PHC.

First, the reason is poor economic condition. All family members have to rely on income of only one member. They understand regarding the advice but due to lack of money they don't visit.therefore, it is because of poor economic status that they are not able to take to other hospital during delivery. However, they take the services which are provided free of cost (Villager, male).

Some actors play a greater role in facilitating people's participation in PHC compared to others. For example, because of their comfortable positionality in the community, teachers play an important role in villagers' participation. This is because people trust them and follow their advice (interview #13). Health workers request teachers to help them in various health-related activities. Often teachers expect some material benefit as well as social recognition for their additional work, therefore, they get discouraged if they do not receive this.

When teachers don't get facilities that they should get and when no one follows the things they say then teachers become fed up with them. If their profession is in danger then they can be discouraged (Teacher, male).

I observed that the health service providers complained about the villagers not participating in many activities except in those directly related to the use of the health services and when they get some sort of allowances. Even during my interviews for my research, some of the participants asked me whether they will get something for their time or not. When I said it is voluntary, some of the participants declined to be interviewed. This shows that there is a strong culture of expectation of financial benefit for participation. Government actors blamed NGOs for introducing the culture of providing allowances to various actors for their participation in different activities including PHC. I noticed that when there is no provision of allowances or other immediate benefits most of the actors seemed reluctant to participate in PHC as well as other activities. This shows that unless the villagers are convinced that the participation in PHC is for their own benefit, they do not participate.

Therefore, it can be interpreted that the participation in PHC is affected by villagers' financial situations in two different ways. First, lack of money among the villagers prohibits them from accessing the available health services no matter whether it is accessing the traditional healing practices or modern health services. This reduces their participation in other aspects of PHC as

well. Second, when there is no financial or material incentives for participation people are not interested to participate.

In both Hagam and Fulpingkot, I noticed that many people do not access higher level modern health services to treat their chronic illnesses due to their poor financial situation. Neither do they participate in other aspects of PHC, for example, leading, managing and implementation of the health services in their community. For example, a Dalit boy had a birth mark on his face which his mother has not been able to remove because she does not have money for the required operation – she thinks this is because of her poor financial condition as well as caste discrimination:

If a son of upper caste person was disabled like my son, they would have done something good for him. But they were hesitating even to register my son as disabled; even just for referring. I took a photo and requested them if they could refer then my son could get discounts in school, but they did not do it. My son complains that his brother's face is good and his is not good, I feel very sad when he says so. So I feel like if someone could help us. Since we are of lower caste and poor, they think that we cannot do anything or speak anything. I feel so (Volunteer, female).

Therefore, financial situation of people plays a significant role in their participation in PHC. Villagers can afford to give their time for volunteering for PHC if their financial situation is good. Similarly, FCHVs, health workers and other actors, for example, politicians, village heads and local youths can participate in PHC only if they can afford to take time out of their other duties to participate in PHC. Therefore, one of the barriers of participation in PHC is the chronic poverty as well as the lack of financial or other material benefit attached to it.

7.3.3 Lack of services

Potential use of health services motivates most of the actors especially the villagers to participate in PHC and other aspects of health systems. Therefore if there is not any possible personal benefit to be gained from health services, people hardly participate in any sort of health activities. I observed this in both Hagam and Fulpingkot during health advocacy campaigns, health education classes and other preventive health programmes where no curative care was provided. People said that they do not participate in PHC because they do not get any benefit out of it. Since people understand participation in health as receiving available health services, often people do not visit health facilities and do not participate in

other activities related to PHC if there is no potential personal benefit from available health services.

.....for cases like cuts/injuries/falls or accidents, treatment services are not provided from governmental health organization (Villager, male).

When asked about their participation in PHC, people complained about not getting the health services from government sub-health post. Therefore, the concept of participation among the villagers is limited to the use of the available health services. However, when there is need of free resources and a committee to be formed formal Health System Actors motivate other actors to participate in PHC.

.....(mentions the name of the VHW) is the only person who works in the governmental health organization here. We haven't received services at all from there (Villager, male).

People relate their participation in PHC to personal use of health services. People build negative ideas about the government health services because of government workers' absenteeism and lack of resources in the sub-health posts. This leads villagers not to participate in anything related to health because they participate in other health activities, for example, resource mobilization only if they can personally access the health services.

These all services are provided by nongovernmental organization otherwise we have to visit private medicine shops (Villager, male).

While discussing participation in PHC, they reflected back the situation when there was not even a current sub-health post. This implies that the health service from current sub-health post has improved the availability of health services. When prompted to discuss their participation in PHC other than the use of services they referred to their voluntary labour contribution in construction of the sub-health post building, construction of Out Reach Clinic (ORC) building, participation in health education classes and participation in open defecation free campaigns.

When there was no sub-health post here, people had to go to Chautara (district headquarter) or Jalbire (nearby VDC where there is a doctor). Those kinds of problems were prevalent. Many people, for example, those having complicated delivery cases or emergency illnesses, used to die on their way to Jalbire. Patients of diarrhoea and dysentery used to die before they reach Jalbire for treatment (Villager, male).

I noticed that negativity about available government health services, government staff and personal conflict among different health systems actors are barriers to participation for most of the actors in PHC. The caretaker in government sub-health post in Hagam questions his own institution, implying that the government has not been able to send the required staff to the post:

It has been many years that there is no AHW (Government worker, male).

Absenteeism of government health workers from their post is one of the major barriers to participate in PHC for many actors. Since one of the main objectives of PHC system is to provide health services locally, people get frustrated from the health system if that is not available. For example, a villager in Fulpingkot VDC expresses his frustration about the absenteeism of the health worker as:

We do not know anything about the health worker here. This year what I have heard is that one Chaulagain (it is family name of one of the health worker) was here and he got 1 year's salary and went back. Actually, he went to Jalbire (nearby VDC) for 2 days and then he went back. We did not know who he met, what he talked about and how he went back. Since we live far away from the sub-health post we did not meet him but people living near to the sub-health post also did not see him. If we ask them about his whereabouts they say they heard about him but have not met him. I have not seen the AHW even once in many years (Villager, male).

It is not only the villagers seeking health services that are discouraged to participate in PHC because of the lack of availability of the health services, but also other actors who participate in PHC. Sometimes it is villagers' behaviour that discourages people from participating in PHC. Villagers have some expectation from those who participate in PHC actively. For example, the villagers think the HFMC manages the sub-health post but in reality this is not so. The management committee does not have any staff management authority. Its role is to help the health staff to run the health programme smoothly.

Sometimes I think that I am involved in PHC in vain. It is because some people ask me about the kind of medicines available in the sub-health post. They think I will know because I am involved in sub-health post management committee. I tell them that I won't know such things. I support only to manage resources and help to tackle day to day management issues. I don't know about medicines or other such matters because I

haven't read about it. I tell them that I don't have right to see such information. At that time, I feel like why I got involved in it (Villager, male).

While availability of health services is one of the motivations for villagers to participate in various aspects of PHC – and lack of availability a distinct barrier to participation – there are other factors that affect participation in PHC. For example, the quality of the care, the behaviour of the health workers and the quality of the medicine also shapes people's view about the health services. One villager in Fulpingkot shares her feeling about the health services:

When we visit health institutions, if the health workers don't care about us, don't even hear what we are telling them and if they provide wrong medicine we do not visit. If we get well by taking medicines it's okay but it has happened in many places that a person is suffering from one disease and he is provided with another medicines. I have read about it in a newspaper also. A person suffering from certain disease had gone for check-up but he was given wrong medicines which caused his death. It was published in the newspaper (Villager, female).

These malpractices and sometimes even the misinformation about the health services discourage people from participating in PHC whether it is for the use of the health services or participation in health system in other ways. Similarly, repeated bad experiences of people accessing various health services forms a negative view about the health services. For example, because of the absenteeism of main government health staff in both Hagam and Fulpingkot VDCs, other actors have formed a negative view about the government health services in both VDCs. Since qualified staff are absent from respective sub-health posts, health service is provided by less qualified staff. Therefore, the villagers do not trust the services provided by these staff. This projects a negative image among other actors of available government health services as well as health system as whole.

Villagers weigh PHC in different ways before participating in it, which further shows that participation is not a simple phenomenon but a complex behaviour influenced by many factors. Villagers' participation in PHC is mostly for the use of the available health services – in other words, villagers participate in different aspects of PHC hoping that it will help to ensure the future availability of health services. I noticed that the villagers judge different aspects of

health services even when accessing the health services. A villager in Fulpingkot explains how people decide to participate in health system or not as:

After a patient arrives to the sub-health post with their sufferings, if health workers behave badly, they will hesitate to see the same health worker again. If a patient does not get well even after the treatment he visits the health institution again, doesn't he? Those people might behave rudely telling that the medicine that the health worker gave didn't work. However, the health workers shouldn't behave back rudely. Instead, if they provide good medicines or good check-up then people will feel like they can get well after visiting in that health institution and participate in the health activities more (Villager, female).

Health workers have their own reasons to complain, for example, the MCHW in Fulpingkot shares her frustration of absenteeism of her colleagues as:

Sometimes when there are not any other staff and I have to bear the entire workload of the sub-health post, I feel demotivated. When I am not well, I feel so even more. If there were all staff then I would not have felt so (Health worker, female).

Therefore, the majority of villagers related their participation in PHC as the use of the health services no matter whether it is modern health services or traditional healing practices. Often possibility of use of the health services in future motivates people to participate in PHC. Lack of health services as well as lack of such possibility is one of the main barriers to participate in PHC.

7.4 Political barriers

7.4.1 Conflict of interest

Currently, most of the villagers follow some political ideology. This also applies to most of the things they participate. Even if people are not involved in political activities directly they are influenced by various political ideologies because of their family involvement, past favours from certain political party and possible future benefits. Similarly, various actors with different political ideology involved in PHC have different motivation for their participation. Even though the expressed reason for the participation might be ensuring health services, root causes might be different. Such behaviour leads to conflict of interest among actors.

Often there is conflict for power space among the actors. For example, different private health service providers complain about each other:

It was not the case handled by me but a case which came to our clinic. There was a child who had been suffering from severe fever and cough. The child was given 'cetamol' and 'cefixime' from our clinic. The medicines didn't help to cure. Therefore, they went to a private clinic where there was a sister (ANM) from PHASE Nepal and another health worker. The health worker told them that the medicine which was given from our clinic was wrong. It was for allergy and it could even kill her child. The sister from PHASE Nepal also agreed. The mother came back to us and asked why we had given her wrong medicine. I told her that it wasn't me who gave that medicine. I had also doubt about what she was telling. The man who gave her that medicine was a CMA. When I checked the medicine properly, I found that it wasn't 'ceitrizine', it was 'cefixime'. So I went to the private clinic and asked them on what basis did they said that the medicine we gave was of allergy. After that I told the mother to continue the same medicine and she hasn't come back and I hope the child recovered well (Villager, male).

This presents a scenario of conflict of interest among the existing health service providers in Hagam VDC. The patient was not informed enough about the treatment – she did not trust the medicine therefore she went to another health worker. This shows there is a problem of trust between the health service provider and the service receiver. Because of the limited market, health service providers try to prove that they are better than others and sometimes this creates personal conflict.

However, this conflict is not only because each health service provider wants to maintain a power space. It is also because some of the people who are providing health services are not even health workers. For example, the same private medicine shop owner's wife does not have any health qualifications but she is the one who sells medicine and provides health services from his medicine shop. Other actors are not happy with this but they do not have any other alternatives.

It is his wife who works in his medicine shop to prescribe and sell medicine. She is not trained health worker and doesn't know anything about medicine. Although she is a teacher, she doesn't have knowledge regarding medicines. However, she works on the basis of what her husband tells her (Villager, male).

I observed that often there was conflict of interest among different health systems actors especially if there are financial benefits or financial contributions involved. For example, the ex-chairperson of the school and the sub-health post management committee explains in detail how the conflict of interest between the NGO health worker and the private medicine shop owner shapes their relationship with each other and affect their participation in PHC. He also expresses his doubt about the motive of the services provided by the NGOs:

Regarding the organization (he means the NGO) I have understood that if the private providers sell medicines, they get money but organization provides it free of cost. Therefore, the relation is not good between them. Since it prevents them from getting the benefit, they obviously complain about it. We have seen this many times because the organization provides free services. They may have provided for the welfare of citizens or for other reasons but there is a competition between the private medicine shops and the NGO clinic. Because they are doctor (here he means the CMA) as well as own the shop, treatment is also done by them. They take NRs 200-400 (US\$ 2-4) charge for treatment. The villagers don't know how much a medicine cost and whether it is expired or not. But, we take those medicines without knowing if they provided expired medicines. We can get such information from doctors. NGO clinic doesn't provide bad quality medicines, they provide new advanced medicines. Therefore, they personally don't have good relation (Villager, male).

Those actors who are not directly involved in health services but want to influence decision making processes are limited in their participation in PHC when these actors' personal interest do not match with the interest of the organization or the groups they represent. For example, the current chairperson of the school management committee and the political leader who used to work as a Community Nutrition Worker shares his frustration about his participation in PHC:

I feel like it is useless involving in these works sometime. There is a lot of pressure from the party. I have to manage money personally for every programme and work by myself. I have neither paid job nor income from other sources. Instead, my own money and efforts are being wasted. Therefore, sometimes I feel depressed. It is because I have to tolerate bad comments from different people despite having to spend my own resources. So I don't feel like working in this sector (Villager, male).

I observed that the conflict of interest among different actors is mainly a struggle to maintain their power space in society. This is true not only for Hagam and Fulpingkot VDCs – this was also observed during the researcher’s personal visit to Humla and Bajura in November 2014. I noticed that the political awareness level among the ordinary villagers in Bajura seemed better than in Sindhupalchok and Humla. It was also true that that people fight for positions in health management committees more for social status than for contribution in PHCs. The caste discrimination in Bajura is so rampant that the villagers from higher caste refused to visit the health clinic built by the Dalits. A similar situation was observed in Hagam, Fulpingkot and Rayale but not to such extreme.

There is conflict among the health service providers as well. For example, one of the local political party leaders in Hagam shares his view about the conflict of interest among the government, nongovernment and private health service providers as:

Nongovernmental health organizations try to make friends with governmental bodies. But the governmental health workers don’t want because if they are to work in coordination, they also have to work hard along with the nongovernmental health workers and should be sincere in their services. Since the nongovernmental organization does good work, it creates difficulty for them. The nongovernmental organization aims to provide services effectively and to develop the country and villages. However, it is not same among the government organizations (Villager, male).

Here the conflict is not for power space or financial benefit. It is a relationship issue. This also shows villagers’ perception about the government health workers’ position in PHC. Similarly, it shows that the relationship between the government and NGO actors is not good in Hagam VDC. Government health workers are supposed to provide the health services regularly from sub-health posts in both Hagam and Fulpingkot VDCs but due to their regular absence from their posts, other actors are not happy with them. This has created negativity about the government health workers and government provided health services in both Hagam and Fulpingkot VDCs. It might be equally possible that due to me being related to PHASE Nepal, most of the respondents expressed positive view about different NGOs working in these two VDCs.

Villagers suspect that private medicine shop owners do not support government health services because they will benefit if there is no other health services available. The conflict here is because of the financial benefit attached to health services.

I cannot tell about other sectors but in health sector, the private medicals (private medicine shops) think that they would benefit more if there were no nongovernmental organizations in this place. It is because the medicals (medicine shops) are often setup by the government health workers. They think that they would benefit more if their medicine shop is successful (Villager, male).

Even if it is presented differently, one of the barriers to the participation in PHC for most of the actors is their financial limitation that creates conflict among various actors. I noticed that often actors participate in PHC with a hope that their participation will attract some financial or material benefit or will at least gain them personal access to health services. When it does not, they get discouraged.

I think that in Nepal, those who do their works with sincerity, finds it difficult to earn livelihood. It has been about 24-25 years since I started working in politics. My understanding about politics is that it is for making certain development in the village and providing services. But in our place politics is for only those who does drama and violence. People like us, who are sincere and do social work, suffer. I don't want to hurt others and I don't speak lies too. I speak only if the things are correct. Let's say someone calls me for some work. I will go for it. But if I don't have time for it then I inform him in time. The person may be expecting something from you. So I tell only those things which are possible and true. Due to that I am suffering too. My economic status is also very poor. All my other friends who involved in politics with me, have now joined parties already and have earned a lot of money. They roam in car and motorcycles. But my situation is the same. Some may think that because of my honesty I may not have been able to earn. But there may be some who think that I don't have required knowledge and skill so I may not have been able to earn. Whatever others may think or tell, I won't leave my honesty (Villager, male).

The HFMC chair for the sub-health post in Fulpingkot shares his frustration about the government and political parties not helping and their contributions being ignored. Those who participate in PHC expect social recognition from government line agencies as well as the

villagers. Lack of recognition for their contribution in PHC discourages these actors from participation.

The nation doesn't care for management committees. The current political situation has messed it up. The party people are discouraging even those people who are providing services. Politics has become a means to gain personal benefits. Such behaviours are making us passive. Our services aren't valued (Villager, male).

Some of the actors have issues with accepting traditional healing practices. They want people to follow modern health practices but when that does not happen they get frustrated. I observed that often those who prefer modern health practices over traditional healing practices want other actors also to follow modern health practices. When they cannot convince other actors, they feel frustrated

It is de-motivating due to lack of education. Another thing is there is de-motivation due to dhaami/jhankris (traditional healers) practices as well. They say that diseases are due to 'deuta laageko' (due to curse from god) or 'bhoot lageko' (due to curse from the ghosts) so people shouldn't go to hospitals, this discourages people to participate in PHC. Furthermore, we are de-motivated because we also don't have all information particularly regarding health. If we had training and experiences regarding health then we could provide treatment. We are de-motivated due to the lack of awareness regarding health. It is because we don't have all knowledge regarding health (Government worker, male).

People have a very different expectation from the health service provider. They put doctors in a different position than other people. Here, they refer any health workers as a doctor. If they do not find the health workers' behaviour satisfactory, they are reluctant to participate in PHC.

Doctors should give services even if the patient's behaviour is bad. If you are a doctor for example and I am a patient, you should fulfil your duties even if I am behaving badly, I feel so (Villager, female).

Some people who are participating in PHC mostly for the benefit of other actors get demotivated if the work they are doing doesn't change what they want to change. For example, a teacher in Fulpinkot shares her frustration:

When they don't listen to me even after I have told them many times then I feel like it was waste of my time. Anyone can feel so if there is no achievement of their work as

they expected. I sometimes feel so and feel that I won't ever advise that person again (Teacher, female).

Villagers' motivation for participation in PHC is affected by available health services, staff regularity and what the villagers think about the health workers. Use of health services as well as encouragement to use available health services works as a motivating factor for most of the actors to participate in PHC. Without such factors, people feel demotivated to participate in PHC.

Talking about the government sector, it feels like something is wrong. The proposal they have submitted and the program conducted are not matching. For example, the government has established sub-health post in each VDC but when there are health workers there is no medicine and if there is medicine there are no health workers. Even if both are there they are not serious in providing the services or there are irregularity, fraud and no follow up at all. The government has invested a lot of resources in health sector, but compared to the investment, the outcome is not satisfactory (Villager, male).

There is conflict of interest when some actors assigned to one job try to get benefit from multiple sources. Similarly, there is conflict of interest when actors try to get financial gain unethically. For example, a government health worker in Hagam VDC runs his own private medicine shop and most of the government health workers are absent from their posts because they are busy in their own personal work. The private medicine shop owners prescribe more medicine than they need, to make additional profit. The educated group of villagers promote the modern Western health system which is not always followed by the villagers. This creates a conflict of interest for different Health System Actors.

7.4.2 Mistrust

I observed that there is intra- and inter-actor group conflict and mistrust among actors. The government health workers did not seem to trust each other about their own services and motivation. For example, the VHW in Hagam and the MCHW in Fulpingkot complained about the DHO for not sending the required staff for their respective sub-health posts, even after promising to do so many times (interview #3, #25, #39). Another characteristic observed among the actors was their mistrust of other actors, especially among the governmental and nongovernmental health workers. Though not directly expressed by these actors themselves

but as expressed by the villagers, the government and nongovernmental actors do not trust each other (interview #6).

Often different actors have conflicting ideas; because of which actors do not trust each other. For example, the traditional healers do not trust modern health service providers and similarly the modern health workers do not trust the treatments provided by traditional healers. This is because these two groups of health workers have different belief systems of disease and treatments due to their different understanding about these things. The private medicine shop owners do not trust the government and NGO health service providers because they are competing for the same groups of people to work with. Similarly, the villagers often do not trust only one group of health service provider because they are not sure of only one approach of treatment. They visit different health service providers – sub-health post, traditional healers, Lamas and Priests – at the same time. Furthermore, they want all of the available services to remain accessible to them so that they have a range of options if one service is not available. Some actors are competing for the same resources and others are competing for the social recognition from same community – this creates conflict among these actors.

I noticed that one of the main causes of the mistrust between the governmental health workers and other actors was related to absenteeism of the government health workers and the short nature of the NGO health services. The NGO health workers and other actors blamed the government health workers for not being regular in their posts whereas the government health workers blame the NGO health workers for disturbing the habit of the villagers by providing regular health services for a short time which is not sustainable long-term. These behaviours create mistrust among different actors. For example, a former chairperson of the sub-health post and school management committee expresses his dissatisfaction about the VHW in Hagam who is currently the head of the sub-health post:

Although there is sub-health post, the actual sanctioned post has never been filled. We don't know the reason behind it. It would be better if we could know the reason for this from the district health office. I have also felt that these organizations are run as per personal interest rather than for the benefit of the villagers (Villager, male).

I observed that some of the villagers are always suspicious about everything happening in the community including the PHC. Some of them did not approve of the health services and medicines provided by different health service providers and some did not even know about

the programme they were supposed to be involved. There were some issues where they were promised some things that were not provided. For example, they were promised some chickens for eggs by one of the NGOs (Tuki Sangh, funded by Save the Children) working in both Hagam and Fulpingkot to improve child nutrition. The villagers were not happy that they built chicken coops using their money and material but they were not provided with the chickens they were promised. I found that people often referred to the extreme cases as reason for not participating in PHC, for example, death of a woman after she was taken to the hospital, or the death of a child after immunization. Even though the actual cause of death was something else, for example, failure of treatment of certain chronic illness, such cases have created mistrust among various actors which acts as a barrier to their participation in PHC.

7.5 Social barriers

7.5.1 Language, Caste and Ethnicity

Even though discrimination against language, caste and ethnicity is a punishable act, it is still common in Nepalese society. For those whose mother tongue is not Nepali, participation in PHC is not easy. Often the modern health workers are from outside these villages, they rarely speak the local dialect. This discourages and sometimes excludes participation of villagers in PHC because some of them cannot easily express and understand or cannot communicate with health workers and other actors. Those people who do not speak the same language as the health workers, hesitate to participate in PHC because they feel inferior due to their lack of language skill (interview #5). Often there is no one to translate for them and often they are not treated well by the health workers who do not speak the local language.

Language is also a problem. Many people have difficulty in speaking Nepali. They feel shy. Since they cannot speak fluently, others cannot understand them clearly so they think that others might make fun out of them. Therefore, it is a little difficult for them (Villager, male).

Nepal is a heavily stratified caste-based society (Gellner, 2007, Subedi, 2010). Especially in rural areas, people are still judged based on their caste and ethnicity. Discrimination against ethnicity is lower than caste-based discrimination but still it affects people's participation in PHC. Though it is not always obvious, people are denied, discouraged and demotivated from participation because of their caste and ethnicity. Here are some of the views different participants expressed about language, caste and ethnicity:

Everyone receives the services but may be because of poverty or because of ethnicity; Brahmin/Chhetris receive more services. But in our VDC there aren't Brahmin/Chhetris. Those who are educated receive the services more in compared to those who work in cattle shed and those who are not educated (Villager, male).

Villagers clearly relate participation to caste, poverty and hygiene, which acts as a vicious cycle. Higher caste people do not involve Dalits in many social and cultural activities that significantly limits their participation in PHC.

The Dalits are economically backward so their hygiene is poor. This may have forced them to live isolated from a society. They don't usually involve in gatherings and discussions. Due to this, they are more isolated and they aren't informed. So they don't seek for the services. They underestimate themselves. So they are isolated from the services they should get (Villager, male).

The government has introduced a reservation system to ensure participation of people from lower strata of society in various sectors (Dhakal, 2013). There are provisions of positive discrimination for Dalits to participate in health, education as well as other developmental and social activities. However, because of the constant discrimination from higher caste people over a long period of time, Dalits are still not able to utilize such opportunities. I noticed that people still habitually practise the caste system and do not behave positively towards lower caste people even when the state has made such discrimination a punishable offence.

The VDC and the state have given more priority of services to Dalits. But I think that they are backward in seeking those services. It is due to lack of awareness and lack of education. Suaahara (it is a nutrition programme run by a local NGO Tuki Sangh and funded by Save the Children in Nepal) programmes and other programmes are here which we are advocating for poor children and disadvantaged. We are advocating scholarships for their education but the situation is like that the parents spend scholarship money on something else, husband takes away elderly allowance of his wife, Dalits have remained backward that way (Villager, male).

In addition to the Dalits being discriminated against caste, there are also social and family discriminations within and between Dalit families. One Dalit group is equally discriminated against by another Dalit group. The discrimination against women and junior members of the

family is worse in Dalit families than in higher caste. This discourages people from participating in various activities including different health services.

Another thing is people have traditional thinking that daughters-in-law are for work so there is no need for her check-up because they delivered 10 children without any problem and they were delivered in a cow shed. This is more common in Dalit community; sometimes it is because of argument between mothers-in-law and daughters-in-law (Government worker, male).

Here the issue is not only the caste but the hierarchy of the family members, their age, what they practised and finance that limits Dalit actors' participation in PHC.

I also noticed that the discrimination against caste is so internalized that even those who are discriminated against do not even realise it. This encourages the discriminators to continue discrimination, which significantly affects people's participation in various aspects of social life including their participation in PHC.

In taps or bazaar, people do not treat us badly, after all we are friends. It is not like in the past, the way our mother-in-law used to suffer. In the past, she wasn't even allowed to stay near if some upper class people are filling water in their vessels. Now it is not so. However, we aren't allowed to enter their houses. Similarly, at taps, old generation people still do not allow us to touch their pots (Volunteer, female).

This shows how the caste system is internalised even within Dalit society. However, it is not only between Dalits and upper castes; hierarchy runs through every caste and ethnicity. Even within different castes and ethnicities, there is internal hierarchy. For example, within the ethnic group Newars there is a system of higher and lower caste including Dalits and Priest class. A similar system is there even within different Dalit groups. Tamangs have relatively low discrimination, for example they do not have Dalits within their ethnicity. However, they are also divided into priest class and ordinary class, who are allowed to be Lamas, traditional healers and village heads or not respectively. These social hierarchies significantly affect people's participation in PHC.

Caste discrimination is so strong that sometimes lower caste people cannot access even basic human rights which is explained by one Dalit woman in Fulpinkot – quoted in section 7.3.2.

Similarly a Dalit teacher in Fulpinkot shared her experience about other caste's treatment towards her as untouchable. She did not explicitly say so but indicated that caste-related behaviour hinders her participation in various social activities including that in health:

Sometimes when I am walking together with my friends, it is said that they shouldn't touch me or walk with me. We all are human but in such situations some behave properly and some do badly. They treat Dalits badly when we go to a puja or 'saptaha' (religions ceremonies) or marriages in village. When we are attending marriages or other ceremony with our friends they put tika (a red mark put as a symbol of festival) on main person's forehead. However, we cannot put tika (mixed with rice, curd and vermillion) to them, instead we are supposed to give them money keeping our distance. It is said that Dalits shouldn't speak when someone dies. They shouldn't speak to the person performing ritual till 12 days are over and neither visit them. It is said that if we speak to them the spirit doesn't rest in peace and cannot enter to the heaven. There are still such practices (Teacher, female).

Therefore, participation in PHC cannot be looked on in isolation but as a part of the whole social system. People are prohibited to participate in various activities because of their caste. Discrimination takes place openly as well as discreetly. Such discrimination discourages these actors' participation in various sectors including their participation in PHC.

I observed that people from higher caste think that people from lower caste and people from ethnic groups do not care about their personal health and hygiene and neither do they care about cleanliness and sanitation. Even educated people have prejudice about the caste system.

Chhetri and Bhramin are educated, have got resources, they visit different places so they are aware about sanitation and cleanness, therefore, their health condition is good. But the Dalits and Janajatis (ethnic group) do not give much attention to the cleanness. Therefore, they suffer from lot of diseases. Even after suffering they do not think that they have to go to the hospital and neither they take any medicine (Teacher, female).

The VDC technical assistant of Hagam VDC thinks that Tamang people participate less in childbirth and immunization services because they do not prioritize health services:

There has been a good impact about receiving immunization on even those who haven't understood about it. But regarding antenatal care services, they don't give

proper attention and don't care for their own health because of work load. Tamangs do not show much interest on health issues (Government worker, male).

One of the FCHV in Hagam, who is from the so-called lower caste Kami also called Vishwokarma (blacksmith), tells me one of her many experiences of caste discrimination. She said that higher caste villagers do not allow her to go inside their houses when she goes to provide safer motherhood services during childbirth (quoted in section 4.3.1.1)

Here the bigger issue is that even an educated FCHV accepts this discrimination easily. Rather than confronting, she lets higher caste people discriminate her because it is so ingrained in the society that it feels she must take the discrimination as granted. I could see that she felt dissatisfaction with this but she did not explicitly express it, which might have been for various reasons. For example, I am from higher caste so she might have felt that there is no point complaining about it. Caste-based discrimination is decreasing so she might have thought that the situation is improving anyway, or that the discriminated are so suppressed that they are scared of the consequences of going against it. Especially for the latter reason, Dalits do not go against discrimination because they are a minority in the village and often their livelihoods depend upon works undertaken on higher caste people's land. Furthermore, they depend on higher caste people's charity for their day to day living and they are scared to break that income source. In above case, because of their minority in the villages and their social, cultural and financial positionality, if the FCHV challenges the discrimination, she might not get any support from the higher caste people or might not even be selected to be a FCHV. Therefore, she accepts such discrimination.

Therefore, the language people speak, the caste they belong and the ethnic group they belong can significantly hinder people's participation in PHC.

In addition to these barriers, sometimes affiliation to political parties hinders participation in PHC for some actors. This especially applies to those actors who are very active politically because often they are guided by who is in the government and what the governing party supports. For example, a political leader from the adjacent VDC of both Hagam and Fulpingkot shares his experience about how they are discouraged:

We are people who spend political life. The political tradition is such that if a person does good work then there are people who try to destroy them. In such situation I

become discouraged. But since our profession is that, we are discouraged sometimes and sometimes we have less energy. Still we stride those matters and keep moving forward (Villager, male).

7.6 Key issues emerged from above findings on barriers to participation:

These findings show that it is mainly lack of awareness, geography, lack of transport services, poverty, mistrust and socio-cultural factors that are the main barriers to participation in PHC. Similar findings were reported from a study about community participation in a malaria control programme in Ghana (Owusu, 2011). The following section discusses the key issues that emerged from the discussion about the barriers to participation in PHC and their implications for PHC and CP.

7.6.1 Are personal barriers the root cause of non-participation?

Most of the literature highlights financial cost as one of the main barriers to accessing health services. For example, Sato and Gilson's (2015) study in Nepal about provision of free health care reports that free health care has increased access to services because it reduced the financial barrier. Government and other organizations are investing in health to overcome such barriers (Witter et al., 2011). This research finds that it is not only the financial barrier but the opportunity cost to people's livelihoods that affects CP in PHC. Similar to what Wagle et al. (2004) report from their study in Nepal, this study also finds that poverty, low social status and long distance to the health facilities significantly reduces people's access to health care services. Furthermore, lack of knowledge and hierarchical discrimination of daughter-in-law by mother-in-law is another barrier to participation in PHC. This is common among the elderly mother-in-law that they perceive use of safer motherhood health services as unnecessary because their generation did not use such services (Simkhada et al. 2010). As a consequence, people's participation in other aspects of PHC is also automatically reduced. Lack of awareness as a result of illiteracy has also resulted in lower participation in PHC. Therefore, personal barriers, for example, age and level of education also affect people's participation in PHC.

Most people participated in various aspects of PHC to ensure their future access to available health services. This applied to both modern as well as traditional health system. The lack of services because of resource limitation as well as absenteeism of staff are some of the barriers to participation. Similarly, distance and opening time of the health facilities discouraged people from accessing health services which subsequently affected people's participation in

PHC. As highlighted by a recent systematic report about Nepal (McCoy et al., 2012), lack of time to visit health facilities was found to be another barrier to participation in PHC, with people unable to neglect their daily duties to visit medical facilities.

Increasing health literacy by running more health education campaigns, improving access and addressing social determinants of health might be some way forward to minimize these barriers to participation in PHC.

7.6.2 Can social barriers to participation be minimized?

Consistent with other literature (Ensor and Cooper, 2004, Kumar and Singh, 2015), this study also found that discrimination against gender, language, caste, ethnicity and poverty were found to be some of the barriers to participation. This was particularly true for the uneducated, poor and vulnerable segment of the population. Despite such discrimination being legally punishable it is still rampant in rural areas of Nepal. Such discrimination was less common during Maoists movement (Bennet, 2005) and to some extent it is one of the positive outcomes of the Maoist rebel movement in Nepal. Another aspect found from this research is that people with higher level of formal education and those with higher exposure to other communities were less discriminated against those compared to the less educated and those less travelled. Therefore, one of the measures to minimize such discrimination is to improve the education status of the people.

7.6.3 Can politicians minimize these barriers?

As discussed in section 7.6.2, the recent political revolution in Nepal decreased some of the discrimination. One of the main motivating factors for people from the lower strata of society, for example, the poor, Dalits and other people from lower ethnic groups – to join the Maoist movement was their ideology against various social discriminations. They advocated for equity and equality which attracted people to their movement, exploring extent of truth on that is area of another research. However, political parties also have some form of discrimination. For example, political favouritism, corruption and conflict of interest among different political parties have sometimes created discrimination against each other. This results in a certain group of people making all the decisions in the community. This has been quite a common phenomenon in Nepal. Many such incidents were reported during this study. Currently everything needs a political buy-in in Nepal, therefore it is important for political parties to advocate for PHC to reduce barriers to participation. Furthermore, it is important because the

political parties claim to represent different groups of people, they have access to decision making and they claim to work for the people in the community. Their increased involvement in PHC will reduce barriers to participation in PHC.

7.7 Conclusion

The majority of the study about community participation in PHC does not say anything about people's age as barrier to their participation in PHC. However, in the Nepalese context this research found that age is a significant factor in people's participation in PHC. Often age is associated to the distance issue, especially for elderly and those villagers who live far away from the health facilities. Often the local health system circles around where the health facilities are established. These are about 4-5 hours walk away from some of the villages in both Hagam and Fulpingkot VDCs. This walking distance for women, the elderly and children limits their participation in PHC no matter whether it is for their own personal benefit or for their family's health. In this context where people have to walk for many hours they will be less interested to participate in PHC. Therefore, old age affects people's mobility and subsequently their participation in PHC.

Nepalese society is transitioning from joint family to nuclear family. This has created social problems, that there are not many youths to take care of the elderly. This has affected old people's participation in PHC. Similarly, because of poverty people do not have time and resources to take care of the elderly– this is also affecting people's participation in PHC. Uneducated people hesitate to participate in many activities including PHC because they fear it and may have previously experienced ill-treatment from the educated health workers. Similarly, when the health workers are male, women are reluctant to participate. In addition to this, because of the social hierarchy women are discouraged to participate in any decision making positions and processes. Often people are encouraged to contribute in various aspects of PHC – both modern as well as traditional practices – because they want to ensure that health service is available when they need it. Distance and opportunity costs related to their time taken off from their regular job as well as the cost associated to the participation also affects people's participation in PHC.

Furthermore, the language difference between different actors, especially between the villagers and the higher level actors, for example, district level actors are barriers to villagers' participation in PHC. Similarly, caste, gender and age discriminations discourage women, Dalits

and the elderly from participating in PHC. Conflict of interest among different health workers, political party leaders and other actors who have multiple interests affects their participation in PHC significantly. Lack of trust among different health workers, villagers and other actors as well as villagers' ignorance are other barriers for their participation in PHC. Furthermore, political affiliation of some of the actors hinders their participation in PHC. These barriers to participation in PHC imply that there are structural barriers to participation that limit the effectiveness of participation as a policy tool. Therefore it is important to tackle some of these underlying issues to allow participation because participation by itself is not a powerful enough mechanism to address these deep-seated problems.

In the following chapter, I will present detailed discussions of the implications of these findings for our understanding of Community Participation, Primary Health Care and Nepalese health system.

CHAPTER EIGHT

Discussion

Implications for our understanding of PHC, CP and Health Systems

8.1 Introduction

This chapter discusses the findings on Health System Actor's participation in PHC in Nepal. It interprets the findings in relation to existing literature about its implication for understanding of PHC, CP and Health System Actors globally and locally. The discussions are presented in three key headings of 8.1) Implications for our understanding of PHC; 8.2) Implications for our understanding of CP and 8.3) Implications for Nepalese health system.

The findings from this research show that most people have very little understanding about PHC and CP. Even though there are many actors present and participating in PHC, they do not usually know what PHC actually involves and what participation means. Even though there is understanding that more people from the grass-root level should have a voice in PHC (Peters et al., 2008) and the existing system should be taken into account, it is rarely the case in practice. For example, the existing traditional health system in Nepal is not taken into account in the PHC and the local actors do not have any role in it. It is more of the intrinsic and extrinsic benefits for which most of the actors participate in PHC whereas the difficult geography, lack of road access, social discriminations and poverty are the barrier to their participation in PHC. These have implications for our understanding of PHC, CP and implications for the health system in Nepal. Lack of CP in PHC leads to lower use of the available services and lower feeling of ownership among the local actors. Furthermore, it leads to over reliance to the Government and underutilization of locally available human and other resources. The following sections discuss in detail these implications in relation to these findings and relevant literature:

8.2 Implications for our understanding of PHC

PHC has been promoted differently at different times. Originally the Alma Ata Declaration of PHC promoted it more as comprehensive PHC which included other sectors, for example, social determinants of health (Rohde et al., 2008). For example, water, sanitation, nutrition and agriculture sectors were supposed to be the part of overall PHC system. However, this was not followed, rather a more selective version of PHC was promoted where some diseases got higher priority over others (Lawn et al., 2008). This affected the implementation of PHC

approach in many developing countries who needed external monetary support for their health system because the major donors preferred to invest in disease specific vertical interventions, for example, Growth monitoring, Oral rehydration therapy, Breastfeeding and Immunization - GOBI (Stephen, 2008), which gave faster visible results. These vertical programmes diverted the attention away from the more comprehensive PHC and to some extent fragmented the health services as well (Dudley and Garner, 2011). This limited the idea of original comprehensive PHC to Basic PHC. Basic PHC focuses mainly on provision of treatment of basic diseases and some preventive and promotive health services with the help of community health workers. In both cases involvement of other sectors is very limited. Currently the original aim of PHC to provide basic health care service to all people is neglected because of globalization of trade and medicine, privatization and shifting priorities to disease based vertical interventions (Sambala et al., 2010, Sanders et al., 2011). This significantly limits the access of poor people to health care, especially their access to medicine because of cost and unavailability.

The findings from this research suggest that different actors understand PHC, CP and the Health System Actors differently. Often it is only the government health workers that ordinary people perceive as Health System Actors. Even though contribution of other actors, for example, traditional Health System Actors, non-health government employees, nongovernment actors and ordinary villagers contribute in PHC, they are not treated as Health System Actors. Similarly, most of the actors understand their access to available health service, resource contribution in PHC and participation in different health literacy campaigns as their participation in PHC. This has implications for their understanding about CP in PHC. Similarly, most of the actors understand PHC only as the Western model of medical care mostly promoted by the government health institutions. These limited understandings have been further discussed in following sections.

8.2.1 The multiplicity and complexity of the social actors involved

This research found twenty-six groups of actors involved in PHC in these VDCs. If we want to understand PHC it is important to understand about the roles these actors play in PHC, who is expected to participate and who participates in what. If PHC is taken as a more holistic approach i.e. participation of actors from other sectors, for example, nutrition, food supply, water, sanitation and agriculture (Unger and Killingsworth, 1986, Bryant and Richmond, 2008), this list will increase. Even though PHC is advocated for equal participation of everybody

involved in PHC it has been shown that lip service is being paid to this ideal (Lawn et al., 2008), this was seen in this research as well. For example one government official claimed that most of the PHC activities are decided with full participation of the community, but it was not found so in practice (interview #41). Originally, it was the WHO and the UNICEF who recommended a holistic approach of PHC i.e. comprehensive PHC (WHO, 1978), but later UNICEF itself promoted the selective primary health care approach as GOBI (Lawn et al., 2008).

Most of the literature (Alfaro-Trujillo et al., 2012, Abdulraheem et al., 2012) only mentions professional health workers, traditional health workers, community leaders, volunteers and higher level government and nongovernment actors as Health System Actors. They do not discuss other grass-root level actors; neither have they factored in the lower level component actors. This research finds that by treating the actors as a whole misses out the nuances of their role and their participation in PHC. For example, most of the literature refers to traditional healers as mostly herbal medicine practitioners (Gewali and Awale, 2008, Kunwar et al., 2013, Thorsen and Pouliot, 2015), but in the study area most of the traditional healers are faith healers. Neither the health policies nor various PHC interventions consider these faith healers as an important group of actors. As a result they are excluded from participation in PHC. Therefore, the current concept of PHC is too narrow, and misses out many of the other key actors involved in community health.

The PHC approach originally envisioned participation of these actors in planning, organization, operation and control of PHC (Bryant and Richmond, 2008) but this research found that this is not the case in practice. As Bender and Pitkin (1987) highlighted, it is questionable to assume that all the actors will participate in these aspects without a shift of wealth and power to these actors. Nepal was the early adopter of PHC approach; however, it followed a more selective approach of PHC until recently. In the study area none of these sectors were formally coordinated with health system. Even some of the health-related programmes, for example, the nutrition programme by nongovernmental organizations were running in parallel to PHC,, for example, the SUAHARA programme run by Save the Children in the study area. This creates suspicion that some of these vertical health interventions are run in the interest of international organizations. Some of the vertical programmes were merged in five different departments within the Ministry of Health in 1993 as directed by Nepal health policy 1991 (Shakya et al., 2012). However, there are still some vertical disease specific interventions in Nepal funded by different international and bilateral organizations which has improved some

specific health indicators, for example, mother and child health issues considerably. Nevertheless, a comprehensive health care system in Nepal, especially in a hard to reach remote areas, has not improved noticeably (Rohde et al., 2008).

Community health leader and FCHVs programme represent part of comprehensive PHC in Nepal (Lawn et al., 2008). The FCHV programme in Nepal has proved a successful community participation programme and has been credited for improved maternal and child health indices. Currently VHW, MCHW and FCHV work in the community to bridge the gap between community and the formal health system. Among these earlier two categories are paid staff, and FCHVs are volunteers. The contribution of FCHVs has been instrumental in reducing child mortality in Nepal (Malla et al., 2011, Miyaguchi et al., 2014). However, there is very limited intersectoral participation in PHC, which limits people's understanding about PHC and their participation in it.

It is not only the high number of actors but their diverse social and cultural complexity that affects their understanding and participation in PHC. Social and cultural discrimination against gender, caste, ethnicity and poverty are some of the issues which shape and limit people's understanding about PHC in both VDCs. Similarly the dichotomy between the Western modern health professionals and the traditional practitioners also play an important role in their understanding of PHC. Traditional healers in both the study VDCs try to avoid meeting with modern professional health workers. The dominating nature of modern Health System Actors' behaviour towards other actors, especially to the traditional Health System Actors, affects people's understanding about PHC and their relationship with each other. Furthermore discrimination against various social and cultural practices and complexity of caste, ethnicity and religious affiliation of actors makes it more difficult to have a common understanding of PHC, CP and health systems actors. However, if we want to ensure a basic level of health, all these actors, for example, teachers, Lamas, priests, traditional healers and modern health system workers need to work together in harmony to give consistent care and advice. It is important to work together because there is a risk that if the different actors work against each other this could undermine the population health benefit or something to that effect.

8.2.2 The critical role of teachers, education, and health literacy

It is not only because they are well respected in the community but because of the nature of their job, that teachers play multiple roles in the community. Since they are the most educated

group of people in the community, abundant in number, easily accessible and often more regularly present in the community than the health workers, they are frequently approached by other actors for advice about health and other issues. Furthermore, teachers are highly respected traditionally, which gives them the clout and influence. It is not only giving health advice but they are involved in delivering various health education campaigns, health education classes and promoting PHC among other actors. In some cases teachers are even given a role as a basic primary health care worker. Sometimes they are better than the health workers at delivering the health education message. Similar findings were reported in India, Papua New Guinea, Ghana and Tanzania (Aarons, 1983, Nayar et al., 1990, Hausman and Ruzek, 1995, Brooker et al., 2001). Since there are over 50 schoolteachers in each VDC in Hagam and Fulpingkot compared to two government health workers in each, their role in PHC is significant. The schoolteachers in Hagam and Fulpingkot run deworming programmes, health education classes and help in immunization programmes in their respective schools. Whereas, health workers also take some of the curriculum-based health education sessions in these schools to train and support the teachers. This creates better relationships among these actors and increases the health literacy for students. Therefore the teachers have a very important role in local health system, so the professional health workers and the health policy makers need to formally recognize the role of teachers in PHC.

The education level of the health systems actors significantly affects their participation in PHC. Since teachers are the most educated group of actors in the community they are believed to make rational decisions, advise others to make such decisions and motivate others to participate in PHC. Even though the educated people in both Hagam and Fulpingkot VDCs mostly follow the Western modern health system they are also positive towards the contribution of traditional health system. This shows that education not only helps to make rational choices but also helps to bring different Health System Actors together.

Currently there is a health education component within the school curriculum in Nepal. This covers the basic health education in personal health and hygiene. Since teachers are the role models in the community their involvement in health promotion is critical. They help in health literacy in two ways, by their involvement in health education campaigns and by teaching the health curriculum to the students. This has a multiplier effect in increasing the health literacy in the community. Their involvement in public health awareness campaigns attract both parents and children whereas the children who they teach can also work as health

ambassadors for their own parents (Sekhar et al., 2014). Teachers have a critical role not only in supporting others in PHC but in some cases they have a more direct role, for example, ensuring students' oral health and personal hygiene. (Sekhar et al., 2014). Furthermore, the local health workers often run school health programmes which often involves screening for basic diseases, measuring nutrition status of children and referral to further health care (de Silva and Barraclough, 2009, Abdulraheem et al., 2012) which are supported by the teachers. The intersectoral cooperation between health and education increases the health literacy and also improves relationships between teachers, health workers and the students. Therefore, the local education system and schoolteachers have a critical role in PHC.

Even though schoolteachers play a significant role in PHC delivery locally it seems more to do with the personal relationship between the schoolteachers and the local health workers. For example, participation of schoolteachers in Hagam was less compared to that among the teachers and health workers in Fulpinkot. Therefore, it may work better if their intersectoral roles were formalized in health policy so that both can contribute in each other's profession formally, which will eventually contribute in PHC. However, teachers come under a different ministry, therefore, it needs the inter-ministerial level coordination to formally give health mandate as well to the teachers and vice versa.

8.2.3 The schism between Western and traditional health systems

Even though national and international health policies have emphasized the importance of intersectoral cooperation, it rarely happens in practice; because most of the sectors have their own priorities. They plan and implement their activities independently. Furthermore, most of the nongovernmental organizations want to run their activities independently to justify their existence and sometimes government and international agencies want to implement vertical interventions for quick and focused result. At the local level those actors who have resources and want to handle the resources independently do not want to invest through government channels. For example, PHC approach originally had envisioned to integrate traditional health system into the national health system (WHO, 1978, Reissland and Burghart, 1989), it rarely happens. It was believed that it would work better if modern health workers and the traditional practitioners work together especially in those countries where health pluralism is common (Parker, 1988, Bryant and Richmond, 2008). However, in practice they rarely support each other; on the contrary in some cases they act against each other and are critical of each other.

Similar to findings from Nigeria (Abdulraheem et al., 2012), even though traditional healers are the best source of information about local diseases in the study area they are not taken into account. In fact, Reissland and Burghart (1989) in Nepal reported that modern health workers often distanced themselves from the traditional healers. This research found that the situation is even worse these days because currently the modern health system does not take the existence of a traditional health system seriously. However because of geography, poverty and other socio and cultural barriers / beliefs many people living in the remote part of Nepal have no other options but to access the traditional healing practices. In addition to this the government does not have enough resources to ensure a Western modern approach of PHC in remote areas, therefore, intersectoral cooperation including traditional health system is still important. However, the challenge is the mechanism of their involvement in health system, because the modern health system assumes traditional system as inferior, unscientific and less trustworthy.

Traditional Health System Actors and their clients treat modern health system and practitioners as a parachuted foreign approach of health care (Streefland, 1985). It is expanding even in the urban areas especially where people are not satisfied with Western medical treatment (Koirala et al., 2013). From a policy perspective, even though the 1991 National Health Policy of Nepal has recognized Ayurvedic, Unani, homeopathic, naturopathy and traditional healing practices as part of the health system (MOHP, 1991, WHO, 2007b) to some extent, traditional healing practices in the study area are different from these. These are less of local herbal medicine-based practices but mostly the faith-based spiritual healing practices. These mostly comprises chanting mantras, praying, animal sacrifices, worships and sometimes the shamans even go into trance state during the healing process. Parker (1988) also reports a similar case from her study. These are supposed to be unscientific but are still in practice and to some extent are expanding to urban areas as well.

Even though Koirala et al. (2013) claimed recognition of traditional system as the part of PHC after Alma Ata 1978 by the Government of Nepal, currently it is not the case. Indeed the traditional healing practices and practitioners are not taken into account as the part of health system. This is in contrast to the findings from Ethiopia and Ghana where the modern health workers and the traditional practitioner wanted to work together (Ragunathan et al., 2010, Gyasi et al., 2011). In Nepal they often do not want to work together. However, conflict

between the modern health system and the traditional health system is not only because of the socio-cultural practices, geography and poverty but also related to each other's livelihoods. The traditional practitioners assume that their livelihoods are challenged by introduction of modern health system. Therefore, they often oppose the modern health system.

To address such issues there have been some efforts from the government as well as nongovernment organizations to engage traditional practitioners in PHC in Nepal by providing basic health care training and basic medicines (Poudyal et al., 2003). But current efforts seem to persuade the traditional healers to accept and promote modern medicine. The question is why would they do it? They will lose their livelihoods if they do so. Their token participation in PHC does not solve the issue of their livelihoods. Therefore, a more scientific approach with alternative livelihoods opportunities is required to buy-in their participation and ensure their contribution in PHC. If so, it will eventually help the modern health system workers and traditional practitioners to work together. It is important to incorporate these traditional healers into the health system to ensure that some of the practices, for example, the faith healing, chanting and animal sacrifice, do not delay people's access to appropriate health care which might prove fatal in some cases.

This research found that there is limited PHC with shortage of staff, lack of resources and lack of CP at the decision making level. However, this is not uncommon in other developing countries, for example, in Malawi (Makaula et al., 2012). Especially the professional health workers do not involve the community in making decisions about their own health system. For example, a study in Rwanda (Freyens et al., 1993) reported that 83% of the health workers were against the community making such decisions. Therefore, it is also to do with different actors' worry about their place in PHC and share of livelihoods opportunity from providing health services. This hinders their cooperation with each other. Furthermore, it is a combination of the trust in traditional practices as well as difficulty in accessing modern health services that people still follow traditional healing practices (Troskie, 1997, Katung, 2000). There have been successful practices of training traditional healers in Ghana, Mexico and Bangladesh to deliver PHC services (Hoff, 1997). Not only the developing countries but developed countries, for example, Canada are using traditional practitioners to deliver a more holistic approach of health care (Hollenberg et al., 2013). Therefore, it is important to incorporate the traditional system in modern health system where applicable.

8.2.4 The absenteeism of government health workers

Absenteeism of health workers have been a common phenomenon in most of the developing countries (Chaudhury et al., 2006, Yamada et al., 2013, Belita et al., 2013, Morrison et al., 2015). Absenteeism often creates conflict between the health workers, community and other actors which subsequently hinders their participation in PHC. Furthermore, it compromises people's right for health care. A multi-country study in Bangladesh, Ecuador, India, Indonesia, Peru and Uganda by Chaudhury et al. (2006) found 35% of the health workers absent from their respective posts. This is also true in Nepal (Devkota et al., 2013, Gurung et al., 2015). For example, at the time of data collection for this research there were no CMAs in both Hagam and Fulpinkot, and other actors reported that they are absent from many years. Some of the absenteeism is reported to higher authorities but most of them are not reported. Villagers often do not know the reasons behind absenteeism and do not have access to higher authorities to report. This is not only the problem of health post and sub-health post level professional health staff but it is more rampant among district level doctors in Nepal. A recent study in Nepal found that 69% and 50% of the doctors were absent from their respective posts in PHCC and district hospitals respectively (Mahato et al., 2013).

Intrinsic motivations and decentralization was found to be the reasons behind high presence rate of PHC workers in Lao People's Democratic Republic (Yamada et al., 2013). Therefore this might be a way forward to reduce health workers absenteeism in Nepal as well. The Lao PDR study claims that absenteeism of the health workers was lower when they were working locally but the organization I work for; PHASE Nepal has a different experience, which I am aware that it can equally be researcher's bias. We found that local staff have more social responsibilities, family commitments and are engaged more in their agriculture and animal keeping works. This affects their presence in their posts. We found that incentive for higher attendance, competitive wage, merit based selection and decentralized hiring/firing authority reduces absenteeism. However, it is recognized that the effect of local health workers' absenteeism is not as bad as for those health workers who either never turn up or come for only a few days every 3-6 months, because the local ones can be still accessed at the time of emergencies. There is another issue of unfilled posts as well, especially in the study district, where the government has not been able to recruit for the sanctioned posts. For these sanctioned but unfilled posts, the HFMCs need to be strengthened so that they can put pressure to the higher authorities to fill these posts.

One way of reducing absenteeism is a provision of mandatory services for health workers which have been practised in many countries around the world (Frehywot et al., 2010). The Government of Nepal also has adopted this approach for newly graduated MBBS doctors (Shankar, 2010). They have to work in government assigned posts, often at a remote location for two years before they can get transferred to less remote places or places of their choice of go for higher study. However, this is not practised for health post and sub-health post level health workers, where absenteeism is more rampant (Neupane and Gulis, 2010). Absenteeism of VDC level health workers is more unrecorded absence than recorded; this might be one of the reasons for the Government not having the provision of compulsory services for these positions in Nepal.

Furthermore, since the ultimate goal of addressing absenteeism is to ensure regular health service, this might be addressed by contracting out the services to the private sector (Sanders et al., 2011). By delegation of the resources and management responsibility to the community as in CLAS (Local Health Administration Committees, in Spanish - Comunidades Locales de Administración en Salud) Peru (Cotlear, 2000). However, these approaches might not be appropriate in the rural context of Nepal, especially if the government still has to maintain their system. Because, in the absence of the monitoring and supervision from the government the private and the community-managed health professional might still be absent. As Sanders et al. (2011) point out there is very little chance that suddenly there will be a drastic economic and political change to make things more inclusive. However the national government still need to make policies for intersectoral cooperation at local level which will better support PHC.

8.2.5 The complexity of financial and personal motivations – and impacts on people's livelihoods

Lack of access to resources, power and control are some of the barriers to participation in PHC. Even though financial incentive is not the sole motivation for participation in PHC (Franco et al., 2002, Willis-Shattuck et al., 2008), it is still a fundamental requirement for health workers' livelihoods. The motivation for participation can equally be intrinsic which are self-satisfaction, social recognition and religious merit or extrinsic when it is related to monetary and material benefit. Furthermore, career prospects and relationship with other actors are other motivating factors for professional health workers (Chaulagain and Khadka, 2012). Similarly, timely payment of sufficient wage also motivates health workers to work more regularly (Peters et al., 2010).

Often people's participation in PHC is linked to some sort of incentive. These incentives can be both intrinsic as well as extrinsic benefits but without those incentives participation is not sustainable. Therefore, often those participating for material or monetary benefits end when such benefits are discontinued. This is very common with PHC activities run by NGOs because they often provide incentive to participate, but once they phase out their programme, the villagers often discontinue practising what they have learnt. Sometimes practices of incentives creates conflict between the government health workers and private / NGO workers because the government actors think it is unsustainable and others try to justify it by claiming they are paying for participants' opportunity costs.

8.2.6 Failure to address other determinants of health (sanitation, food hygiene, housing)

The Alma Ata Declaration of PHC had envisioned PHC as a holistic approach to include other non-health sector and benefit from it. The declaration had a vision to include non-health sectors, for example, safe drinking water, sanitation, agriculture, animal husbandry, nutrition and the existing health system as the part of PHC. These have been on the major health agendas of international players, for example, WHO. However, this approach never gained momentum; therefore, currently other sectors are rarely considered as part of health system. Actually lack of intersectoral approach in PHC has been noted as one of the many challenges of success of PHC (Adeleye and Ofili, 2010). At the same time it is a weakness of PHC to some extent because it is almost impossible to enforce such intersectoral cooperation in practice. Even though international commitments and national policies are in place for intersectoral partnership for delivering PHC there are problems in implementation of such commitments and policies. However, as Bhatia and Rifkin (2010) suggest that emphasis on more holistic approach of PHC that addresses wider social determinants of health is still more important than the narrow bio medical model of PHC.

Even though a systematic review by Ndumbe-Eyoh and Moffatt (2013) report that there are not many empirical studies that can provide a strong link between intersectoral cooperation in PHC and health outcomes, there are quite a few proven interventions of successful PHC with intersectoral cooperation. For example, a comparative case study in Bolivia (Gonzales et al., 1999) showed better health outcomes in a PHC intervention with intersectoral cooperation. In this study they explored difference of health outcomes of people participating in health, education and livelihoods activities and people participating only in health activities. There are

quite a few multisectoral vertical approaches in practice in Nepal to address specific diseases but intersectoral cooperation of multiple actors in PHC is not common. It is worth noting that current global economic policies are not in favour of intersectoral coordination for delivery of comprehensive PHC but favour more the selective PHC (Sanders et al., 2011). However, since social determinants of health are too complex for the health sector alone to address, intersectoral approach is a must at least for PHC at local level (Anaf et al., 2014). This is more true for the resource-poor communities in Nepal.

These examples of intersectoral cooperation, health outcomes and social determinants of health point toward very limited intersectoral cooperation in PHC. The literature is silent on whether or not there are any existing successful holistic health systems in practice. In the case of Nepal, even though policies mention the need of intersectoral cooperation (MOHP, 1991) the existing traditional health system is not considered as part of the national health system. Neither are other sectors, for example, drinking water, sanitation or agriculture considered as part of it. Therefore, currently PHC in Nepal has been de facto equated as access to the Western biomedical model of health care, which is similar to that reported by Anaf et al. (2014) in Australian PHC. Similarly, the intersectoral approach seems to be everybody's talk but it is very limited in practice. This excludes many actors from understanding, contributing and benefitting from the health system.

8.3 Implications for our understanding of CP

Ideally a community is defined as a group of people with similar characteristics living in the same place. The Alma Ata Declaration of PHC (WHO, 1978) implies a community as a homogenous mass of people as the above definition suggests. However, in practice it is rarely the case, in fact most of the communities are heterogeneous in character. Even if the group of people have some common characteristics they differ in many other aspects. Because of gender, caste, education status and poverty community fragmentation is even higher in Nepalese society. This significantly affects people's requirement, expectation and participation in PHC in Nepal and elsewhere. Furthermore, most of the literature about community participation includes a rather idealistic view about community participation. For example Draper et al. (2010) discuss about measuring CP but are silent on what community actually comprises, whether the CP they measure participation of includes marginalized groups of people or not. They mostly talk about participation of committee, groups and leaders as community participation. They imply that members of these committee, groups and leaders

are the true representatives of ordinary citizen in the community. However, this research in Nepal finds that they do not necessarily represent ordinary citizens and might not equitably represent women, Dalits and ethnic minorities. They do not represent people living in faraway isolated villages, people who speak different languages and illiterate people. It is understandable that 100% representation of the community is not possible but the question is how different they are from the community. The usual definition of community does not cover many people in the study area; therefore, these representatives should be prepared to work also for those actors who cannot participate.

This research shows that CP in Nepal can be analysed from three different angles. These are from the benefit point of view, both intrinsic as well as extrinsic benefits and from culture and facilitation point of views. Culturally there are various events where people participate for a common benefit, for example, participation in footpath construction/maintenance, irrigation channel construction and drinking water source protection. Currently some of these jobs are taken over by the state, so the social cohesion and participation in such events is decreasing. There are some practices similar to cooperatives in some ethnic communities, for example, among Thakalis and Newars. These practices are mainly to support fellow neighbour collectively at difficult times. Another form of motivation comes from people's interest in others' welfare, social respect and religious merit. Some of the actors involved in health also claim this motivation to some extent.

Most of the Nepali health professionals participate in PHC for their livelihoods. This applies to people working in both the modern as well as traditional health system. Government as well as other agencies facilitate community participation for the success of their activities. Some people participate in PHC for social recognition, respect and religious merit but most participate for material or financial benefit. There is some facilitated participation, though participation decreases once such facilitation is over. The FCHV programme in Nepal has been sustained because of the intrinsic benefit whereas the community forestry programme is sustained because of regular income from the forest. The following sections discuss the consequences of CP on various aspects of PHC in Nepal.

8.3.1 The relative success of FCHVs

The FCHV programme in Nepal is one of the most successful mechanisms of community participation in PHC in Nepal. It is so popular among women that the attrition rate is less than

5% annually among about 50,000 FCHVs (Glenton et al., 2010, Schwarz et al., 2014). Multiple reasons are given for the low attrition rate and sustainability of the FCHV programme in Nepal, mainly moral duty and social respect. Other arguments can also be presented as social benefit of being an FCHV which has helped attain this lower attrition rate. For example, since Nepal is a very gender-based closed society, being a FCHV gives an opportunity for women to come out of this social cell, which is a good motivation. Once they are out they want to continue, because it gives them some degree of freedom with increased social status. Since they are local, easily accessible and trusted members of the society they are the first point of contact in the community, this further strengthens their relationship with the community. In addition to safer motherhoods and other government assigned jobs they are even contacted for advice from other health agencies (Pant et al., 2014). Furthermore, even though the government discourages home deliveries by Traditional Birth Attendants (TBA), these FCHVs still practise TBAs in some cases because Skilled Birth Attendants (SBA) are not still available mainly in remote rural VDCs. These contributions in PHC have made FCHVs famous among other actors.

Therefore, FCHV programme has been successful even though sometimes FCHVs complain about their opportunity cost. This research also finds that FCHVs have started to ask for appropriate compensation for their lost opportunity cost. Even though there are debates for and against such incentives (Glenton et al., 2010, Maes et al., 2010), the Government of Nepal has introduced some indirect incentives to motivate these FCHVs. These incentives are in the form of partial payment for the days they work full day, frequent update training, contribution in FCHV saving fund, FCHV dress and free treatment facility in district hospital (Marie-Renée et al., 2014) for which others have to pay. However, this research finds that FCHVs are asking for more regular compensation for their time.

Despite all these successes there are some emerging challenges for sustaining the FCHV programme in Nepal. For example, because of increased demand of their time FCHVs are finding it difficult to manage their time voluntarily (Nepal Family Health Programme II, Technical Brief, 2012). Therefore they are asking for remuneration. Decreasing community ownership, over-expectation from FCHVs from the government and other organizations are some other challenges. Furthermore, increased family income because of the remittances, increased job opportunity for women, lack of time from their works might decrease the number of interested females wishing to become a FCHV to work voluntarily in future.

Furthermore, there are some arguments against incentivizing FCHVs with a regular salary. For example, Glenton et al. (2010) report that most of the higher level bureaucrats worry that regular salary to FCHVs might not create the same degree of motivation and the community might not respect FCHVs as they do currently. However, not to compensate for their time is agreeing to some extent the female exploitation in the name of social satisfaction, religious merit and the slogan of Service is Religion (Sewa nai Dharma ho), while others who are involved in health mostly receive a regular salary. Therefore, there is a need to identify a middle ground where the FCHVs will be equally motivated even with reasonable compensation for their time, so that similar approaches can be explored in other sectors, for example, water supply, sanitation, agriculture and coordinate these sectors for the benefit of people in all sectors including PHC.

8.3.2 The weaknesses of official participative channels

Currently HFMC and FCHVs are the main official mechanisms for grass-root level actors to participate in PHC in Nepal. However social inequality in the society limits equitable participation of people in the community in HFMCs (George et al., 2015). Since HFMCs are the intermediaries between the community and the health system, lack of representation of the socially discriminated group of actors automatically decrease their participation in PHC. If community participation is categorized as information sharing, consultation, collaboration and full responsibility, currently the participation is only at the information sharing level. Even that information sharing is only to the committee level i.e. to the HFMC level. Furthermore, lack of resources, lack of capacity and lack of delegation of authorities are the main barriers to participation in PHC for HFMC. A similar result was reported in Tanzania (Kilewo and Frumence, 2015). A different study in Tanzania (Kamuzora et al., 2013) reported that the Community Participation (CP) lasts till there is external facilitation. HFMCs do not have a control over any decisions in PHC. If we explore further down to the ordinary citizen level people even complain CP as a mechanism of exploitation by the professional health workers and higher level actors (Sombie, 2015). Higher level government actors contribute in decision making but the grass-root level actors are mostly token participants (Ruano, 2013, Kenny et al., 2013, Serapioni and Duxbury, 2014). This is evident in the Nepalese health system as well.

Even with all these drawbacks, currently there are no other mechanisms of CP in PHC than through HFMCs. Therefore, one of the ways of making this more inclusive might be by bringing in the mechanism of inclusion of local political party leaders in HFMC or in advisory role

formally. Even though political parties have their own limitations, assuming that the political parties represent ordinary people in the community will resolve the issue of representation of local people in PHC. Since political party leaders have their own motivation for mobilizing the community, their increased responsibility as HFMC member or advisor might help to bridge the gap between the professional health workers, policy makers and the community (Schwarz et al., 2014). This will increase CP in PHC. Another cadre of government health workers who might play a significant role to ensure CP in PHC are the VHWs and MCHWs. Currently there are 3190 MCHWs and 3985 VHWs (Statistical Pocket Book of Nepal 2014) in Nepal working as paid staff, these staff can also facilitate the process of CP. Currently they are working as service providers, therefore, if they are to be used as motivators for CP, they need to be trained differently and incentivized appropriately.

Therefore, there is need to explore other channels of participation in HFMC, for example, participation of ward citizen forum in HFMC and representation of mothers groups in HFMC. Reinstatement of local representatives through local election might solve some of these issues since local representatives will have more authority to influence such decisions at higher level.

8.3.3 Failure to consider local contexts and social realities – little use of existing social mechanisms

There are some tested and tried community participation mechanisms in Nepal both in the formal and informal sector. Sectors, for example, education and forestry have successful models of community participation. Public school management is advocated and practised to some extent as shared responsibility of central and local government but to be managed locally (Sharma, 2008). Most of the public schools in Nepal are currently managed in this model. Similarly, people's participation in VDC budget allocation, project selection and decision making is strong. People advocate, lobby and put pressure to get funding from VDC for their projects.

Indigenous people in the mountain region have their own decision-making process for community participation in different aspects of their life. They select a leader called 'Ghyapo' for their community every year in rotation from each household. When this person calls for participation in something, representatives from each household must participate. They have a certain place, a courtyard in the middle of the village to discuss and decide on some communal agendas. They all participate because others will not follow them when it is their turn if they

do not follow. Similarly, there are similar practices in Hills and Terai mostly among indigenous communities but these are less effective compared to that among Sherpas in the mountains (Bhattachan, 2010). This research found that there are certain religious and agricultural activities which have certain participatory mechanism. For example in the case of water source maintenance, foot path construction and agriculture harvest festivals, most of the people in the community participate in the discussion led by the village leaders. These leaders can be an elderly person from the community, a Lama, a priest or a political party leader. Current health systems do not use these existing mechanisms formally for collective decision making.

There is higher community participation in other sectors, for example, education and forestry compared to PHC. It is mainly because the education and forestry sectors are more decentralized and the community have more frequent use. The school management committees have higher authority compared to HFMC, for example, they are the part of the decision making process in hiring and transferring teachers and other staff. In the case of forestry management people have a higher incentive to participate because they use forest products for firewood, fodder, timber and sometimes for monetary income by selling timber and other non-timber forest products. There have been some practices of using these structures to increase CP in PHC informally. For example, they use these Ghyapos and community leaders to call community meetings but there is need to incorporate these in policies and practices formally. Therefore, it is worth exploring whether it is possible to involve existing mechanisms of CP in HFMC and other mechanism to increase CP in PHC.

8.3.4 Theories of community participation

There are a number of theories of participation. Some of these theories have already been discussed in detail in section 2.7.1. Community participation in PHC in Nepal if analysed by using Arnstein's (1969) ladder of citizen participation falls mostly to the information level. This is because most of the decisions are made at central or district level and activities and policies to be implemented are informed to the villagers by the higher level actors. Some of the actors,, for example, government health workers, higher level political party leaders and other government employees are consulted on some of activities and policies at the time of implementations but rarely during formulation of policies and design of the activities. Use of Rifkin's (Rifkin et al., 1988) framework was not possible because of time limitation and high number of actors, as this needs to measure the level participation of individual actors before and after the PHC intervention. However it was evident from the interviews with different

actors that participation of different actors on the domains of participation on Rifkin et al's (1988) framework was very low in the study area.

Irrespective of theoretical perspectives, even the limited participation in the study area was mostly dominated by the higher level actors, for example, local elites, government employees, political leaders and mostly the educated people from the community. In such case, Arnstein's (1969) and Rifkin et al.'s (1988) frameworks could not be applied because the level of participation was not measured for individual actors. For example, there might be higher level of participation in the overall programme but it will not be clear from these frameworks whether women, Dalits, marginalized people and people from ethnic minorities were equally participating or not. Furthermore, such participation was highly dependent in people's access to transport facilities and people's formal education level. In this context illiteracy and lack of transport facilities are some of the root causes of low level of participation in PHC.

Furthermore, since CP is context specific participation of some of the actors represented as higher level of participation within a theoretical framework might not always give a true picture of CP in PHC. What is more important is who really represents the participants. It might be almost impossible to involve all the actors at the highest level of participation. For example, to the citizen control level as suggested by Arnstein (1969) or to have level 5 of participation in all indicators of CP in Rifkin et al. (1988) might not be possible because the frameworks are difficult to apply as they don't take into account the extent of participation across actor groups and they assume that high participation is achievable across groups. Therefore, one approach might be to include the representative of the political parties in different committees including HFMCs. Since political parties claim to represent the ordinary citizen, this might ensure voices of ordinary people in PHC design and implementation.

Looking at these different issues of CP in PHC it seems the root cause of low participation in PHC lies more on social issues. It is discrimination against gender, caste, ethnicity and poverty that hinders CP in PHC. Therefore, it is more important to look at how these discriminations can be minimized than just forcing the CP approach in the community. This research found that the higher the education level of these actors the lower the degree of discrimination and higher the level of participation, therefore educating these actors might be one way for increasing participation. Therefore, instead of trying to increase CP by other different approaches it might be worth investing in social transformation by ensuring that everybody

gets educated, which might solve most of the CP issues. Another issue about CP in PHC is that often CP is explored at the end of a project during the evaluation or during the implementation of the project and activities. In these cases a project is designed and decided by someone else in the first place and people are mobilized to achieve project outcomes (Rosato et al., 2008). Here, the agenda for participation of the grass-root level actors come right at the end of the chain and is not seen as the fundamental aspect of how health systems work. Therefore, there is a need to fundamentally change how participation is treated, whether it is community mobilization during the implementation, token participation at the end of an intervention or community empowerment for the overall process.

Using Maslow's Theory of hierarchy of needs in analysing health system actors' motivation in participation in PHC shows that majority of the actors except who participate for social recognition, participate in PHC to fulfil their physiological needs. However, in contrary to Maslow's argument that there must be a linear progression from physiological needs towards self-actualization, this research shows that people are motivated to participate in self-esteem level even if their physiological needs are not met. For example, the FCHVs participate in PHC for benefit of other actors even if their basic needs are not fully met.

8.4 Implications for Nepalese health system.

The success of PHC with CP approach has been linked to the successful delegation of power and wealth to those who previously had least (Bender and Pitkin, 1987), which is still not the case in Nepal. Because of limited understanding of PHC, CP and Health System Actors, there are challenges for ensuring basic health care service for ordinary people in rural parts of Nepal. The planned modern health system in Nepal dates from only around 1950s even though there were some hospitals established and health services provided by missionaries before that (Dixit, 1999). Even though Nepal continued to implement the PHC approach after the 1978 Alma Ata Declaration (WHO, 1978), the international environment, for example, global inflation, structural adjustment programme forced by the World Bank and International Monetary Fund (IMF), affected it significantly. As a result even though it was mentioned in different periodic plans including in various health policies (WHO, 2007b), it never gained momentum. This is mainly because of lack of funding, limited intersectoral cooperation and a shift in international policies for health funding. However, there has been a renewed interest in PHC from 2008 as revitalization of PHC, the long term effect of which is still to come. In the

following section I will discuss on the implications of our understanding for PHC, CP and Health System Actors in Nepalese health system:

8.4.1 Can FHCV be built on? Clean water volunteers?

As explained in section 8.1.6 PHC in Nepal has been equated as a de facto Western modern health system. For PHC to be successful, intersectoral cooperation among different sectors, for example, agriculture, animal husbandry, drinking water, sanitation and currently even the climate change is important. At the policy level the intersectoral cooperation is mentioned (MOHP, 1991) but at the implementation level it is not enforced. As discussed in section 8.3.1, the success of FCHV programme in Nepal is not without controversy and has its own challenges to sustain it. Especially because of changing social, cultural, political and economic condition in Nepal it might be challenging in the future. Similarly, because of different international laws and human right issues, asking for volunteers without appropriate incentive mechanism especially if they ask for it will be difficult to continue. Therefore, to match with the changed social, cultural, political and economic balances in Nepal the issues relating to compensation of FCHVs' time must be addressed. Once such issues are addressed similar approaches could be applied to gain intersectoral support for PHC. For example, it will be worth exploring similar approaches of volunteers in other sectors, for example, safe drinking water supply and sanitation, which can be coordinated to work in PHC. Currently FCHVs are selected together by HFMC and the health post in charge. They are trained by DHO and mentored by the head of the health post, sub-health post. If this approach of volunteerism is expanded to other sectors, for example, in agriculture, water supply and sanitation, a separate approach to training and management structure is required.

Before expanding the volunteering approach to other sectors there is further need to critically analyse and ensure the sustainability of existing successful approaches like FCHV. It is important to do so because people currently participating in PHC in Nepal, for example, FCHVs and the members of HFMCs are finding it difficult to give time because they have to struggle for their livelihoods as well. Their participation in PHC has an opportunity cost. Therefore, it is a very critical issue whether to promote and encourage people to participate in PHC or let the state take care of the delivery part and create awareness among other actors to access available health services.

8.4.2 Addressing health worker absenteeism

Currently, most of the health workers are trained in the cities in Nepal even if they are from the rural part of the country. By the time they are trained they are more used to the facilities in the cities. Furthermore, the city often offers better career opportunities, education opportunities, better child care and other future benefits, that attract health workers to stay in the cities. Therefore, there is a need to find a way to train the health workers in the community they work. This approach was applied in Tanzania (Shoo, 1991) to train health workers in the community by involving the villagers. Students had to live in the community with the villagers and learn from them during their training. A similar approach is followed in Venezuela (Brouwer, 2011), where they run a medical course called the "university without walls". This university runs a course similar to comprehensive community medicine to train local youths in their own community for six years to be a medical doctor. After their graduation these doctors work in their own community or similar communities. Since these doctors are trained in their own community they are more likely to stay there than those trained in the cities. This might be one of the approaches for training health workers in Nepal to minimize the problem of absenteeism to some extent.

Furthermore, additional facilities for those who are present regularly in their posts, family support, education support for children and career development opportunities are some of the incentives that can reduce absenteeism of professional health workers (Neupane and Gulis, 2010, Ghimire et al., 2013). To address these issues, the Government of Nepal implements various programmes to encourage government health staff to work more effectively. For example, the Government of Nepal provides training to selected MCHWs to become ANMs, ANMs to become senior ANMs and AHWs (CMAs) to become senior AHWs (Senior CMAs) and promote them to higher posts to incentivise and to encourage staff to work more. With such skill upgrade and task transfer sometimes these staff are promoted even to the District Health Officer level based on their seniority even if they do not have essential academic or professional qualification. This often create problems, for example a CMA can be a line manager/supervisor of a HA or MBBS doctor which creates operational difficulty. As a result, it might increase absenteeism instead of decreasing because the HA and MBBS doctors might not be prepared to work under less qualified CMA, therefore, such approaches needs to be implemented carefully.

Recently, above issue has also attracted debates within the policy and professional circle in health sector, but more from quality of health system perspective. Some of the policy makers as well as the professionals are claiming above approach as a wrong approach and suspect that it will compromise the quality of care as well as quality of public health management. They suspect that the people trained and promoted this way will not have sufficient skill to maintain the required quality of health system. Therefore, on one hand above approach followed by the Government of Nepal might be an effective incentive to the grass-root level staff to minimize the current issues of absenteeism but on the other hand there is equal chance of deterioration of the quality of health system if they are not well trained as suspected by the health professionals, which needs to be further explored.

Another way of minimizing health workers absenteeism might be to decentralize the hiring and firing of health staff to VDC authorities and HFMC. There might be issues of nepotism, corruption and impartiality but if these could be minimized, such approach might have better chances of minimizing health workers' absenteeism. For example, the schoolteachers are less absent from their posts than the health workers. It is because theoretically the school management committee can recommend the District Education Office to dismiss the absentee teacher, they are immediately noticed if they are absent from their school and they have their head teacher as their supervisor. Even though there are some problems in school management committees as well, for example, nepotism, corruption during selection / transfer and construction, they do have a higher level of participation in decision making than that in HFMC.

There are some fundamental flaws in the Nepalese health system which needs to be improved. For example, one single CMA is responsible for the curative part of health care at sub-health post level to serve an average of 5000 population with additional responsibility of recording, reporting and updating to the DHO. This minimizes their presence in their post, because it often takes a few days walk to the DHO and back, especially in the remote areas. Another systemic problem is that once a health worker gets a permanent government job it is very rare that there will be termination of their job unless they are absent from their posts for many years. Therefore, the multiple reasons for health workers' absenteeism in Nepal need to be addressed through multiple approaches. There have been some practices of training and employing local health workers. For example, this author has found that most of the VDCs in Karnali zone of Nepal have sponsored few local men / women to be trained as CMA/ANM from Karnali Technical School, Jumla respectively. This has enabled these VDCs to hire staff from

larger pool of local candidates but absenteeism is still rampant in this area. It is mainly because there are only one or two positions in each VDC for health professionals, and those who do not get job locally move to the cities; therefore, training more local people has not solved this issue as expected.

8.4.3 Addressing the schism between Western and traditional medicine:

The Alma Ata Declaration of PHC (WHO, 1978) equally accepted the existence of health pluralism and emphasized the intersectoral approach for the success of PHC. Currently most of the government and nongovernment stakeholders promote only the biomedical approach of PHC. However, a considerable segment of population in developing countries, especially those living in the remote part of these countries still heavily rely on the traditional health system for their health care. A study in Ethiopia reported that over 80% of people in Africa still use traditional health services and some are completely dependent on it (Kandari et al., 2015). Similarly, a WHO report on traditional medicine (WHO, 2003) reports that 65% of the people in India, 40% in China and 71% in Chile access traditional health system along with the modern biomedical treatment, but still only the biomedical approach of PHC is being promoted by the government, and the international organizations. Most of the participants in this research also reported of visiting traditional healers when they needed health care.

Currently the government and nongovernmental organizations' priority lies in promoting and supporting Western medical based health care. It is mainly because the international donors and the medical professionals who are in decision making positions promote the Western medical system. Even though most of the people use both modern as well as traditional health services, if they have an equal choice people prefer Western medicine because these are believed to be more effective and different health awareness campaigns, formal education system and media promote it. Therefore, it is mainly the unavailability of the modern health service at the time of need, lack of access; cost and other social and cultural barriers people still access traditional healing practices. Furthermore, as Parker (1988) reports in her study in Nepal, the traditional health system is still in practice because it is socially and culturally ingrained in the society.

The traditional healing practices in Nepal are different from those practised in the majority of other countries. For example, a major part of the traditional system in the study area is faith based spiritual healing. This involves more of chanting mantras, praying and worship by

shamans i.e. Dhimi/Jhakri (Parker, 1988) than herbal medicine which is the major part of traditional healing practices in other developing countries. For example, in African countries and India (Banerjee et al., 2004, Kandari et al., 2015) traditional healers mainly practise herbal medicine. There are some herbal medicine practitioners in the study community but shamans highly outnumber those and professional health workers in the study area. Therefore, it needs a separate approach to address this issue in the Nepalese context. They need more training and practice than the herbal medicine practitioners to support modern health system.

Studies in Nepal have reported that participation of traditional healers in biomedical approach of PHC improves CP and people's access to available services (Oswald, 1983). It is true that training traditional healers in basic biomedical treatment procedures can improve CP and population health (Poudyal et al., 2003). However, this has negative consequences for the traditional healers because this approach does not take into account the livelihood aspect of traditional healing practitioners. Even if they are not sure of their own treatment, they still keep practising it for their livelihoods. This research found that in the study area they participated in modern health care themselves, but they were still actively providing traditional healing services to others, probably that is the reason it is still heavily present in the study area. Therefore, it is important to offer them an alternative earning methods so that they can refer people to modern PHC services and support it.

Health policies in Nepal have included Ayurveda and homeopathic treatment as traditional health system but it is silent about shamanism, faith healing and spiritual healing practitioners who claim to chase away the evil spirits. Since there are many traditional healers practising this in rural part of Nepal, it is important to understand about their system and find a mechanism to include them in the health system. It is important because, if they are not included in the main health system, it might do more damage to people's health. If not included it may affect people's health by delaying access to the service, by providing wrong treatment or by wastage of resources. Furthermore, they are the trusted practitioners in the community; therefore, their participation in modern aspects of PHC will encourage ordinary citizens to use modern health system. At the same time these traditional healers can act as the bridge between the villagers and the professional health workers. However, inclusion of these shamans in the health system is still a challenge in Nepal. Mainly because of heterogeneity of their practices, their mistrust of modern medicine and challenges in their livelihoods. This can be addressed by

providing basic health training and medicine, by providing alternative livelihood training, by providing refresher training regularly and by recognizing their contribution in health system.

Since the current health system does not take into account the existing local context and social realities, the traditional practitioners do not participate in PHC. Modern health service practitioners do not have good relationships with traditional practitioners. This has significantly affected these actors' participation in PHC. The Government needs to take concrete steps to deal the issues of practice of shamanism and faith healing. It will be difficult to stop these practices completely because of diversity in people's belief system but this must be regulated and if possible these practitioners should be trained about the pros and cons of their practices and convince them at least to refer people to modern PHC where appropriate.

8.4.4 Tackling gender, caste, and ethnic differences

Intersectoral cooperation, enforcement of the policies, alternative mechanisms of providing health services are some of the short term solutions to ensure availability of basic health care service to the people living in the remote parts of Nepal and elsewhere. A strong mechanism of law enforcement is needed to prevent discrimination against gender, caste, ethnicity, poverty and other socio cultural factors and to ensure participation of grass-root level actors. This research found that higher level of formal education and transport access are the most important factors in reducing such discriminations. Furthermore, the richer the people the less the discrimination based on such issues and the higher the participation level. Furthermore, during data collection the interview participants informally reported that such discrimination has gone down after the Maoist movement in Nepal, which proves that the political buy-in is important to minimize such discrimination. This might be possible by engaging local political leaders to make a healthy political environment in the PHC approach. Therefore, multiple approaches are needed to increase CP in PHC.

8.4.5 Promoting literacy and other determinants of health

This research found that there is a lack of health awareness and literacy among the majority of the actors especially the villagers. Level of formal education is directly related to the level of health literacy and subsequently participation in PHC. Critical participation of educated people in PHC is higher than their uneducated neighbours. Therefore, illiteracy is one of the root causes of lack of health literacy and people's participation in PHC. Most of the actors understand health as curative health service. They have little knowledge about the importance

of preventive and promotive part of the health system. Therefore, often this part of the health system is given less priority especially by the grass-root level actors even though the international actors as well as the Government of Nepal promote it. Similarly, people know little about the linkage between the social determinants of health, for example, access to education, access to health care, living environment, social situation, literacy and economic status. Even though these are important aspects of a health system there is lack of awareness about these in the community. Therefore it is more important to have more health literacy on health-related policies and programmes in community.

8.4.6 Approaches to implementation that are more sensitive to understanding and appreciating local complexities and realities

Often interventions are designed in one place, piloted in another and replicated in yet another. These interventions might be successful in the original two locations but might not necessarily be successful in the place it is replicated. This is mainly because different communities and geographies have different systems, context and requirements. Currently there is real lack of discussion and debate with the community and other actors before and during decision making processes. Rather most of the decisions are made at the central level or district level. There are diverse social and cultural realities and barriers, for example, gender, caste, ethnicity, poverty and geography. These makes each community unique, which needs to be recognized in designing, implementing and managing different PHC interventions.

There are many interventions which need local discussions and debate to work better. For example, the current provision of one CMA in a sub-health post per VDC is not sufficient. To increase access to health care these need to be discussed and contextualized. Similarly in some cases one FCHV in one ward cannot cover her ward because in some VDCs it takes one full day's walk to travel from one end of the ward to another due to the scattered settlement pattern. In some cases these have been addressed by increasing the number of FCHVs but in most of the wards in remote areas it is still a problem. Therefore, instead of having a one model fits all approach there is need to and discuss with the community before such decisions are made.

8.4.7 Is over-privatization of health system a challenge in Nepal?

There is a chance that the government health system will become similar to the government school education system in Nepal, which has mostly been taken over by the private sector.

Currently there are very few parents who will enrol their children in government school if they have a choice. Similarly, if easily available most of the relatively rich people will access private health care services even if they have to pay. Because of flow of remittances there is chance that more people will be able to pay privately for their basic health services in the remote areas as well, which will slowly increase the private health sector and decrease use of the government health services. There is a chance that eventually the government health system will focus mainly in regulating private providers, run preventive health services and other national health services, for example, immunization programme and screening. Therefore, there is a need to further explore this issue and address at policy level.

The Government of Nepal has recently started a pilot health insurance programme with the aim of ensuring a basic health care service for people who cannot usually afford it (Mishra et al., 2015). As of March 2016 the government scheme plans to raise a premium of NRs 2500 (US\$ 25) per year from each family for 5 family members (extra NRs 450 (US\$ 4.5) per year per additional family member. Each individual can claim a maximum of NRs 10,000 (US\$ 100) worth of treatment per year with a provisional list of 71 medications. The GDP per capita for Nepal is US\$ 691.7 whereas GDP per capita PPP is about 2400 USD (UN, 2014). Some of the past Community Based Health Insurance (CBHI) schemes were either externally subsidized or provider based selected care, most of them phased out once the piloting was complete (Magar, 2013). However, there are some very successful examples of such schemes if designed, decided and managed with strong CP (Dror et al., 2014). For example China currently claims that there is 97% coverage in term of Universal health coverage (UHC), and that has been possible by health insurance (Yu, 2015). China's success in UHC is mostly credited to strong public support for the government programme, strong high level political commitment, heavy government subsidies, growing state economic power, decentralization and strategic programme implementation approaches (Yu, 2015). Therefore, this might be one of the routes for the Government to ensure a basic health care service in the hard to reach areas of Nepal. However, it does not mean that what worked in China or other countries will work in Nepal. An obvious challenge for PHC in Nepal is the funding because health services costs money and poor people cannot afford it themselves, therefore combination of various alternative mechanisms need to be implemented. Other common challenges in Nepal are nepotism, corruption and bureaucratic delays. which also need to be addressed to develop a sustainable and an effective health system.

8.5 Strengths and limitations of the study

In the following sections, I have presented the strengths and limitation of my research and have discussed on how I addressed those limitations.

8.5.1 Effect of financial and geographical constraints:

Due to funding constraint, ease of access and the limited availability of fieldwork time the study was conducted only in Hagam and Fulpingkot VDCs of Sindhupalchok district. I increased the representativeness of samples as far as possible within these constraints and in my view the samples I obtained were diverse enough to cover a broad range of perspectives. Therefore, despite these constraints the selected sample of health systems actors is representative of many VDCs of hilly regions in Nepal. The research findings are internally valid for Hagam and Fulpingkot VDCs of Sindhupalchok district and Ryale VDC of Kavrepalanchok district only but it can be referenced (transferability) to similar VDCs of other hilly districts of Nepal.

8.5.2 Influence of population diversity:

Because of the nature of my research which involved semi-structured Interviews with participants representing 26 different groups of actors, despite every effort made to make the sampling as representative as possible only those people who were key players in each group were interviewed. However, I made sure to include the participants from all sectors of the community as much as possible. For example a Tamang speaking interview assistant was employed to interview women who felt uncomfortable to talk about the health issues, for example, those related to child birth and other safer motherhoods aspects of PHC with a male researcher. Similarly those who were more comfortable to be interviewed in their mother tongue were interviewed by the same interview assistant whose mother tongue was Tamang. Therefore, in conclusion I feel I managed to include most of the actors important for this research. However, I am aware that I could not interview some of the women living in the forest, children and those who were not present in these VDCs at the time of data collection.

8.5.3 Influence of researcher's positionality:

The researcher is the head of the NGO PHASE Nepal which is implementing an integrated community development programme of health, education and livelihoods improvements in both Hagam and Fulpingkot VDCs of Sindhupalchok district since last 8 years, therefore most of the actors knew the researcher. Furthermore, the researcher is an educated male civil engineer working in development sector as well as academia. This could result in the

respondents answering only the positive aspects of the community participation in PHC. This might have affected the responses mainly for the questions related to their participation in safer motherhood aspects of PHC, which is the main focus of the NGO that I am involved with.

To avoid this I clearly informed the participants through the gatekeepers, my interview assistants, the health workers and during my informal meetings with the prospective participants about the independency of my research from PHASE Nepal's work. I stayed within villages for a prolonged period in order to build the rapport. The participants were assured about the necessity of the confidentiality of the data. This helped to convince them about the use and misuse of these data for and against anyone's favour and consequences to the researcher, and the required confidentiality of the information ethically and academically. Since I stayed in the research area for four months at different times during my data collection and did not get officially involved directly or indirectly in any business of PHASE Nepal, I feel the participants were convinced about the independency of the study from PHASE's work.

3.13.4 Issues related to language and translation:

Over 90% of the population in Hagam and over 50% of the population in Fulpinkot speak Tamang language as their mother tongue. Therefore, almost 50% of the participants in my interviews and FGDs are Tamang speaking people, though majority of them speak Nepali language fluently. Since I cannot speak Tamang I interviewed the participants in Nepali and conducted FGDs in Nepali. This might have limited their understanding of my research questions and might have compromised the depth of the answer they gave. I minimized this bias by asking the participants whether they preferred to talk in Nepali with me or to talk with the Tamang speaking interview assistant. I trained the interview assistant to check with the prospective participants whether they want to talk in Nepali or in Tamang during the rapport building and appointment times. The participants were interviewed for me in Tamang language by the interview assistant when the participants opted for that.

8.5.5 Influence of gender:

Fifteen out of forty one participants for my semi-structured interviews and all the participants of two FGDs with FCHVs were women. Some of the interviews were conducted by female interview assistant and she was present in all of the interviews I conducted with females and in both of the FGDs we conducted together with the FCHVs. Still there might have been a gender bias in selecting the interview participants as well as the female participants' answers to my

questions. To avoid this bias I purposively selected my participants proportionally from different actor groups including both male and female from each groups of actors as far as possible. The female participants were asked separately by the interview assistant on whether they preferred to be interviewed by female interview assistant or male researcher, and were interviewed according to their choices. Even when the female participants opted to be interviewed by researcher, the female interview assistant was always present during the interview unless they opted for them not to be present.

8.5.6 Influences of culture and status:

As explained earlier the researcher is an employee of one of the NGOs working in both Hagam and Fulpinkot VDCs from last 8 years. Many people in the community in both VDCs know the researcher in that capacity. Most of the people in both VDCs have less access to education and other opportunities compared to the researcher which might have biased the participants' responses. Similarly, there might have been some urban rural bias, average villagers thinking of the researcher as an outsider asking the information from them for his benefit. My prolonged engagement in the area through my professional involvement and staying for a long period in the field during my data collection period helped me to gain trust from my research participants.

8.5.7 Issues related to research validity and reliability:

Quality of qualitative study can be assessed by their validity and relevance as in quantitative research but these needs to be contextualized (Mays and Pope, 2000). Because of the nature of my research, my funding constraints, confidentiality issues and limitation of time it was not possible to share the research findings to the participants to get their feedback before finalizing my thesis as member checking. However, I have increased the validity of this research by prolonged engagement with the actors, observation and use of multiple methods of data collection for triangulation (Guba, 1981, Mays and Pope, 2000). Furthermore, I have a plan to share my findings with the community, district level actors, for example, DHO and DDC and Department of Health sometime after completion of my PhD. At the same time, I will publish my research findings as articles in various academic journals to share with wider audience.

8.5.8 Issues related to data collection:

Originally, I had planned to include only the MCH aspect of PHC in my enquiry. I had planned to focus my enquiry only on participation of various actors in childbirth and child immunization. However, during my pilot study I found this aspect narrowed my actors only to those who are involved in these two aspects of PHC. For example, the VDC technical assistant, the leader of political party leader and the schoolteachers did not have a direct role in these aspects but they were actively involved in other aspects of PHC and had a significant role in it. They are involved in public awareness, resource mobilization and helping the health workers to run the PHC service smoothly. Therefore, to include these actors I widened this to participation of actors in overall PHC including the traditional approach of health care.

Similarly, my original plan to use Rifkin et al.'s (1988) framework for measuring community participation was not possible because, during my pilot study I found that it is not possible to quantify people's participation in different domains of participation as the framework suggested within a limited period of my data collection. It was not possible to get the answer for their participation in needs assessment, leadership, organization, resource mobilization and management in the scale of 1 to 5, where one being the lowest level of participation and 5 the highest. I still inquired on what they participated in but it was not possible to put those on scales. Therefore, it was not possible to produce the spider gram of people's participation as the framework suggests.

8.5.9 Strengths of methodological approach used

The interpretivist - constructionist paradigm (Bryman, 2004, Thomas, 2006, TerreBlanche and Durrheim, 2007) I followed in this study gave me flexibility to interpret the understanding of PHC, CP and the Health System Actors as the participants of this research understood. It also presented me an opportunity to explore how these understandings were constructed among various Health System Actors, rather than aiming to uncover the truth. At the same time it offered me an opportunity to understand PHC, CP and the Health System Actors from those actors' own perspective. Similarly the qualitative case study approach I followed offered me an opportunity to explore the holistic picture of PHC, CP and health systems actors in the study area in their natural setting (Guba and Lincoln, 1994, Creswell, 1994, Patton, 2002, Bassett, 2004, Hancock and Algozzine, 2006, Creswell et al., 2007, Creswell, 2009). Furthermore, the Semi Structured Interviews, Focus Group Discussions and Observation methods I used for my data collection provided me opportunity with sufficient flexibility to seek answers for my

research questions and to validate the data obtained from these different methods (Kitzinger, 1995, Bryman, 2004, Pope and Mays, 2006, Gibson and Brown, 2009). Therefore, it can be safely claimed that the methodological approach I followed in this research is an appropriate approach to study PHC, CP, Health System Actors and health system as a whole in a similar context in other parts of Nepal and elsewhere.

8.6 Reflection

Community participation in PHC has been incorporated in most of the health policies in Nepal especially after Declaration of Alma Ata 1978 (Shrestha and Pathak, 2012). However, it has not fully reached the targeted segments of the population in Nepal despite some successful examples of its benefit. For example, the FCHV programme shares most of the credit for Nepal's success of attaining some of the MDGs related to women and children. This is claimed to be a result of effective participation of FCHVs in safer motherhood programmes (Nepal, 2015). Therefore, it can be safely implied that community participation is important for the success of PHC in Nepal. Therefore, it is important to ensure full community participation in PHC in Nepal.

Even though Howard and Wheeler (2015) argue that citizen participation during the process of formulating UN Sustainable Development Goal was tokenistic, at broad level the SDG has strongly emphasized participation of all countries, stakeholders and all people (United Nations 2015). SDG target 5.5 emphasizes for full participation of women all levels of decision making processes and whereas SDG target 6.b is about participation of communities in management of water and sanitation. Similarly, SDG target 16.7 aims for inclusive and participatory decision making processes at all levels. SDG plans to achieve these through partnership of major groups and relevant stakeholders as all level. Therefore, it is evident that people's participation is a cross cutting phenomena on many SDGs and targets. SDG devotes 13 health related targets and SDG 3 specially relates to health to "Ensure healthy lives and promote well-being for all at all ages" (Pettigrew et al. 2015). Furthermore, since SDG target 3.8 is to "Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all", it is very important for all the health system actors to participate to achieve this, mainly because CP is one of the indicators of successful PHC (Pettigrew et al. 2015) which is important to achieve UHC. CP is important to achieve many SDG targets and to achieve UHC as

targeted by SDG 3.8. Therefore, it is important to ensure CP in PHC to achieve UHC and other health related and other SDG targets.

Insufficient resources and scattered settlements, especially in the hills and mountains of Nepal, will prohibit the Government of Nepal to place trained health workers below VDC level for several years yet, as highlighted by (Sato and Gilson, 2015) on Nepal's free health services. Similarly, it will not be easy to build all weather motorable roads to every village any time soon to facilitate people's access to health services from faraway places. Therefore, there is no choice but to promote community participation similar to FCHVs to increase awareness and access to some aspects of PHC in Nepal.

Community participation is still a top down approach and externally facilitated by the health workers and other stakeholders. This is being promoted when there is need of contribution from the villagers. These contributions are in the form of free labour, free resources and moral support for activities they implement. This gives the impression that the higher level actors do not want the villagers to participate in PHC, especially not in decision making, management and leadership of the health system. This needs to be changed by the higher level actors through change of their behaviour by improving their relationship by engaging other actors more in above processes.

Barriers to participation still outweigh motivations for participation in PHC in Nepal. Because of the patriarchal nature of society, illiteracy and discrimination, people from the disadvantaged strata of society often do not participate in PHC. Therefore, there is a need to promote the motivating factors and minimize the discouraging factors to increase community participation.

Government and other actors who promote community participation need to change their position and let other actors, mainly the villagers, to determine their participation by facilitating them to decide on, manage and lead their health care themselves. However, looking at the current health system where most of the major decisions are made centrally, there is a minimal chance that this will change in the near future.

Often actors are presented as those directly involved in primary health care, for example, frontline health workers, senior health workers, policy makers, managers, health officers and NGOs (Schneider et al., 2014). However, other actors, for example, the traditional healers,

village leaders, political party leaders and most importantly the villagers also have an important role in PHC, which is not fully considered and needs to be taken into account for the success of PHC in the future. Similarly, the role of offstage actors in PHC is equally significant as that of those directly and formally involved, if not more, therefore their participation should be ensured. Furthermore, there is still a lack of frameworks and mechanisms to involve communities at the peripheral and operational decision making level of health systems (Makaula et al., 2012), this needs to be addressed.

Based on this study from these two VDCs leaving PHC in the hands of the community to decide, plan, manage and implement themselves did not seem suitable in this setting in the context of Nepal. However, as Gish (1979) suggested, it cannot be either “Health for the People” or “Health by the people” but there should be combination of both because one cannot work without others’ support. Furthermore, community participation should not be left just as sharing of resources by other actors with the state but also empowerment of the actors to participate in decision making, planning, implementing and evaluation of their health system themselves (De Vos et al., 2009). From my study financial and human resources were found to be two main constraints in delivery of PHC, which the average villagers have least access. Whereas, community participation was used by the government to divert people’s attention from people demanding health care services to exploring their own ways of managing them. This was not possible because of lack of skills, capacity, authority and resources. Both PHC and community participation seem to have a focus on people’s perceived need rather than their real demand (WHO, 2000). Therefore, PHC is not fully functioning and neither is there full community participation. Therefore, for effective community participation the health system should be fully decentralized to the level of full access and control of the resources together by the community and the government with appropriate capacity development of the participating actors.

This study implies that the PHC and community participation promoted in the last 35 years by Nepal needs to be revisited. It was appropriate to promote PHC approach as it is when there was not any form of health services available but the context has changed in the last few decades. Political change, economic change and improvement in people’s education level have presented a different context of people’s expectation from the state, expectation of health service as human right and the role of the state. Because of improved health awareness levels and the need for improved health services, PHC cannot be provided only by volunteers and

community health workers. People expect health services provided by the right professionals at the right place when they need them. Therefore, the concept of community participation in PHC needs to be changed. The state needs to change the approach to participation. The villagers should have access to resources, the right to monitor and supervise the health staff for regular attendance.

Furthermore, the current allocation of only one paramedic staff who is allowed to prescribe medicine and one midwifery staff for an average of 5000 people in rural part of Nepal is very conservative, this needs to be increased. In addition to this, the health staff should be provided with additional facilities for their professional development, peer support and sufficient resources to perform their job satisfactorily. These need to be ensured by the government for the success of PHC. As for the community participation, it will need to have a clear definition of who, where, how and when the participation is needed rather than its vague generalization.

At the same time, another emerging issue in current health system in Nepal is the effect of staff promotion mechanism explained in section 8.4.2. Incentivising staff for their good work and long services is important to motivate staff in long run. However, the current approach of promoting the staff with limited skill and qualification to a higher posts might demotivate people with higher qualification to join public health sector and negatively affect the quality of health system as a whole, i.e. not only in the curative part but also in the quality of over all public health sector in Nepal. Therefore, this task transfer with skill upgrade approach needs a careful rethinking and alternative approach to minimize current conflict, so that incentivising staff can be maintained without compromising quality of care and attraction to the public health sector.

8.7 Dissemination

To disseminate the findings from my PhD, in addition to this PhD thesis I have planned to publish five peer reviewed journal articles from this PhD research, i.e. one article from each of my discussion chapter and one from the whole PhD research. Furthermore, I presented the initial findings from this research in different academic conferences and have published abstracts (details in appendix IX).

8.8 Conclusion

In conclusion, to succeed, the health system needs to consider local complexities and sensitivities carefully when planning and implementing PHC. Furthermore, there is a need to promote and increase health literacy mainly among grass-root level actors and higher level actors need to understand that without full participation of grass-root level actors the path to a successful PHC is difficult if not impossible.

In chapter nine I will present the conclusion of this research along with my recommendations for policy implications and future research.

CHAPTER NINE

Conclusions and Recommendations

9.1 Conclusion

9.1.1 Overview of the findings

This study found that most of the previous studies on participation in primary health care focus mostly on the higher level community participation. As we saw in chapter two almost all of the studies consider that the participation of selected community members in various management committees and groups are considered as community participation in PHC. Their assumption is that the community is represented by these committees and groups, which was found not to be the case in Hagam and Fulpingkot VDC of Sindhupalchok district in Nepal. This study challenges this assumption and includes all twenty-six groups of actors including the villagers as actors in this context. This study concludes that, for successful community participation there should be an approach where ordinary people from the usually excluded layers of society should have a much greater role to contribute to manage their health systems themselves. There is still discrimination based on class, caste, ethnicity and religion of actors hindering the participation of actors in PHC, such discrimination should be minimized. The main motivations for community participation are enlightened self-interest, social recognition and religious or spiritual merit. Similarly personal, physical, political and social barriers are the main barriers to participation in PHC. Positive aspects of motivations for participation need to be promoted and the barriers to participation need to be addressed for better community participation in PHC in Nepal and other developing countries. These have implications on our understanding about PHC, CP and the health systems actors and consequently about health systems in Nepal and elsewhere.

9.1.2 Introduction

This qualitative research explored community participation in Primary Health Care in Nepal. In this process, this study identified and classified the wide range of actors present in a Primary Health Care setting in rural Nepal and their relationships with each other. It investigated how these relationships affect their participation in PHC, what motivates them to participate and what stops them to do so. Similarly, it discusses the implications of these for our understanding of PHC, CP and Actors in Nepal and elsewhere. This chapter presents the conclusions of this research and some recommendations on how the gap in understanding of community participation and implementation of community participation can be minimized.

Furthermore, this chapter elaborates the policy and practical implications of this study in community participation in health systems in general and in PHC in Nepal in particular.

9.1.3 Contribution to knowledge of community participation in PHC

This study has made some contributions to the existing body of knowledge regarding community participation in Primary Health Care in general and PHC in Nepal in particular. The contributions from the literature review, methodological approach and from the empirical research have been presented in the following sections separately.

9.1.3.1 Contribution from the literature review

The concept of delivering primary health care with community participation has been around since the early 1970s. Especially after the Declaration of Alma-Ata for Primary Health Care in 1978 Community Participation has been at the fore front of the discourse about health systems, mainly in PHC. This declaration had envisioned community participation in PHC as a way forward for the success of health systems mainly to narrow the quality and access gaps between the people of developing and developed countries. It emphasized that the people have a right and a duty to participate individually and collectively in planning and implementing their health care themselves (WHO, 1978). From the literature review, it was found that there is significant confusion about whether community participation is an intervention or a process.

Originally, the major advocates of community participation in PHC have been WHO and other UN sister organizations (WHO, 1978). Later, most of the developing countries around the world and few developed countries adopted community participation in PHC in their health systems. Once included in international health policies, community participation approaches seemed to be imposed by international agencies in developing countries and at the community level by the national governments of developing countries (Zakus and Lysack, 1998). There was no apparent uniformity in the model and approach of community participation (Hossain et al., 2004). There were not many comparative case studies of community participation in PHC. Rather most of the studies focused on the study of one or another vertical component of PHC, for example, community participation in malaria control programmes, community participation in maternity health care and community participation in HIV/AIDs control programmes.

Most studies in participation in PHC seem to focus mainly on the broad participation, meaning participation only at committee and group level. There are hardly any studies that consider individuals' participation in PHC as participation. In contrast to this, my study finds that the success of community participation is higher if there is individual buy-in and a personal benefit attached to it. These benefits do not necessarily need to be direct financial or material benefit. It can be social recognition, a feeling of religious merit or spiritual satisfaction. For example, the success of the FCHV programme in Nepal is mainly due to their participation in PHC as individuals rather than a group, their social recognition and their feeling of being useful to their community.

Most studies on community participation have tried to quantify community participation in PHC. For example, most studies by Rifkin et al. (1988) try to measure community participation in PHC as a quantifiable item using the spider gram diagram they developed. It is mostly used as an evaluation tool to measure community participation before and after an intervention. This approach does not seem sufficient to assess community participation in PHC because it is not always possible to quantify participation. This has led to passive participation or a top down approach of participation rather than the bottom up community participation as envisioned by the Declaration of Alma Ata for PHC in 1978. In contrast, this investigation has studied the actors involved in PHC, the process of their participation in PHC, their relationship with each other, the factors that motivate them to participate and the factors that hinder their participation in PHC, which is a new way of considering the dynamics of community participation in PHC.

9.1.3.2 Contribution from the methodological approach

As presented in section 3.14 the interpretivist - constructionist paradigm followed in this research was an appropriate approach for exploring the PHC, CP and Health System Actors in rural setting,, for example, this study location in Nepal, because it offered an opportunity to explore the way the Health System Actors understood it themselves. Similarly the qualitative case study approach applied provided a flexible process to look for the rich descriptions and insightful explanation of PHC, CP and Health System Actors in natural setting. Furthermore, the SSI, FGD, observation and research diary methods used for the data collection were flexible enough to gather meaningful trustworthy data. Therefore, the methodological approach applied in this research can be safely followed in similar health systems research in future.

9.1.3.3 Contribution from empirical research

Previous studies have considered health systems actors only at the committee or group level. This study considered individual villagers as the main actors of community participation in PHC. It has also established that community participation is not a straightforward phenomenon that has one fit for all. It is a complex phenomenon which is a function of actors' social, political, financial, cultural and geopolitical position. People's participation in PHC differs based on where they live, their education level, their financial situation, where they fall in the social hierarchy, their caste and ethnicity, which political ideology they follow and their felt interest to participate for enlightened self-interest. The interrelationship of these actors also shapes their participation in PHC and vice versa. Often most of the participation comes down to various actors' interrelationships with the actors who are promoting the activity including PHC.

This research made it clear that for successful community participation in PHC all the actors who have a role in PHC, one way or another should be involved in it. Most importantly, participation of local level actors, especially of villagers, should be ensured for the success of PHC. Social, cultural and political factors should be taken into account in this process. Factors, for example, caste, ethnicity, financial situation of the actors and their political ideology should be taken into consideration. Actors' interrelationship plays an important role in people's participation in PHC. Since their relationship depends upon mutual trust, transparency, respect and mutual care, these need to be taken into consideration for effective community participation. Because of recent socio political changes in Nepal, individual identity is important even to get involved in groups. Therefore, individual's recognition should be considered in participation in PHC as well.

So far community participation in Nepal is imposed upon the actors especially upon the villagers as a top down intervention by the government, NGOs and any other stakeholders active in PHC. Therefore, even where there is participation it is not fully owned by the actors. This needs to change and a possible degree of participation should be ensured from all levels of actors so that these actors own such participation. This study found that the motivation for participation in PHC is not always an interest to contribute voluntarily as envisioned by the Alma Ata Declaration for PHC in 1978. It has other more pressing facets, some of which are means of livelihoods, additional financial benefit, unethical material benefit, spiritual benefit, social recognition, religious merit and exercise of power over other actors. The positive and socially accepted aspects of these motivating factors need to be promoted and the unethical

aspects need to be discouraged to increase effective community participation in PHC. Similarly, barriers to participation, for example, discrimination based on caste, ethnicity and gender should be made punishable. Even though some of the barriers, for example, distance, level of education and poverty are beyond the scope of PHC, these need to be addressed in coordination with relevant stakeholders to minimize their effect and ensure effective community participation.

In conclusion, this study establishes that even though the discourse about community participation in PHC usually considers only higher levels of participation, mainly broad level participation, for example, participation of committees and groups, individual level participation is more important for genuinely successful community participation in PHC. For example the FCHV approach in Nepal is more successful because it has assigned a well-defined role to individual FCHV for a ward and gives individual credit for their work which brings collective benefit to the VDC and eventually to the country. In contrast, the HFMC have been given responsibility without proper authority, which makes their participation in PHC less effective. Therefore, the existing successful models need to be analysed and replicated in other aspects of PHC as well. Furthermore, the existing top down approach of community participation does not recognize and learn from existing successful traditional practices, for example, Sareli system (this is an agriculture system where the farmers complete their agricultural activities for the whole village one by one). The reasons for success of such practices should be further explored to see whether similar approaches can be applied for effective participation in PHC as well.

As discussed in chapter five, good relationships among different actors are very important for successful community participation of various actors in PHC. Therefore, factors affecting the relationships of various actors in the process of their participation in PHC need to be analysed. Furthermore, issues related to lack of transparency, corruption, favouritism and exercise of power should be carefully analysed and addressed to encourage fruitful interrelationships among the actors. The motivating factors, for example, feeling of enlightened self-interest, social recognition and importance of voluntarism should be promoted among the actors to increase community participation in PHC. Similarly, the barriers to participation, for example, discrimination against gender, caste, ethnicity, social status, financial status, age, distance and politics based discrimination should be addressed to increase effective community participation in PHC.

Therefore, based on this research in Hagam and Fulpingkot VDCs in Sindhupalchok in Nepal there is limited community participation in Primary Health Care in Nepal. The participation takes place only at the committee or group level, but not at the individual villagers' level as envisioned by the Declaration of Alma Ata for PHC in 1978. Actors' participation in PHC highly depends on their relationships on a personal level. These relationships are affected by people's ethnicity, caste, social status, political ideology and their financial situation. It is the expectation of some sort of benefit, whether it is enlightened self-interest, means of livelihoods, means of getting additional material benefit, social recognition or spiritual or religious benefit that are the main motivations for most of the actors to participate in PHC. Similarly, age, distance, discrimination and difference in political ideologies are the main barriers to participation for most of the actors in PHC in Nepal in general and in Hagam and Fulpingkot in particular.

9.2 Recommendations

9.2.1 Recommendations and practical implications for community participation in PHC

National and international Health System Actors have promoted the importance of community participation in PHC (Hossain et al., 2004, Shrestha and Pathak, 2012). The Government of Nepal has included community participation in its health policies since the Alma Ata Declaration (GoV-Nepal, 2010, Shrestha and Pathak, 2012, DoHS-Nepal, 2013, Nepal, 2014). Considering this and based on success stories of community participation in PHC in different countries and contexts it is important to seek and embrace successful approaches of community participation in Nepal for the success of PHC. This study has shown that the community participation in PHC in Nepal needs to be revisited. The success of community participation depends strongly on the commitment of the individual actors for the collective benefit. For example, one of the reasons for the success of FCHVs in Nepal is a clearly defined, simple job description and recognition for the contribution they make in the health system as individuals. Therefore, an approach with a system of individual recognition should be explored to systematize the community participation in PHC.

Community participation needs to be considered as more than free labour, free cash donations or free resources which the villagers provide for the activities in response to calls from the government and other actors whether it is in health or other sector. Community participation should be an opportunity for community members to make their voices heard to ensure that

the state meets their health needs (LeBan et al., 2014). Currently there is no community ownership of the participation in PHC in Nepal. The government's approach of considering participation only at the committee level needs to be changed and individual villagers or their true representatives need to be involved for the success of community participation in PHC.

The actors who participate with an interest of serving the community participate longer than those who have value laden interests for other material benefits. This is because once the material benefit runs out there is a high risk that these actors discontinue their participation, whereas those who participate for altruistic reasons to serve the community are more likely to participate for a longer time. This aspect of motivation needs to be promoted more to increase community participation. Furthermore, in the context of Nepal the practitioners of Western model of modern health systems need to appreciate the fact that practitioners who follow traditional and spiritual healing approaches have a far stronger influence among the villagers. Therefore, due consideration should be given to including these actors in the main stream health system for more inclusive participation of the Health System Actors in PHC. Treating the consumers poorly (Berlan and Shiffman, 2012) and “playing god” by the Western model modern health system practitioners should be addressed and equal value should be given to other actors for the success of PHC in Nepal. Furthermore, the government should have an official community participation mechanism built in the health system for access to government resources and decentralized power (Berlan and Shiffman, 2012). This will increase the ownership of the health system among the actors.

9.2.1.1 Lower level actors are equally important for a successful health system

Community participation should not be limited only to the committees and groups level but it should be promoted to the individual level. It should be included not only in the policy level but needs careful feedback mechanism on how it is happening in practice. Furthermore, community participation should be entirely devoid of discrimination against gender, caste, ethnicity, social status, financial situation and political affiliation of actors. The participants should be given equal opportunity to participate at all levels of participation in equal terms irrespective of their gender, caste, ethnicity and social status, where it is practical. This can be achieved by creating awareness of health rights, through government regulation, positive discrimination and feedback mechanisms by the government to ensure community participation.

The success of community participation in PHC equally depends upon the participation of currently neglected actors, for example, women, elderly, people from lower caste and others who need health services more than just the participation of active groups of actors in the society. Some of these types of discrimination will take time to change but actions should be taken to minimize them (Bennett et al., 2008). People from Dalit and ethnic minority groups should be encouraged to participate in PHC to ensure that they benefit from the available health services and feel they are part of the system. Currently the Government of Nepal encourages participation of Dalits in different aspects of community activities but in practice either it rarely happens or happens just for a formality. For example, the government has made it mandatory that there should be at least one representative from Dalits in the HFMC and other committees. However, often their voices are not included even if they are nominally members of these committees. Therefore, community participation needs to be made more inclusive in real terms. This can be achieved by enforcing the policies into practice effectively with a transparent feedback mechanism.

The government and other actors should move beyond the concept of community mobilization, rather they should put more emphasis on community participation. Community mobilization is a top down approach imposed by external actors for the success of a certain programme, ideology or activity. Community participation can also be promoted by outside actors but the decision to participate or not is entirely up to the local actors. Community participation is long lasting whereas participation due to community mobilization might end once the promotional activity is over.

The pluralism of health practices is clear from this study. Villagers used government health services, health services provided by the NGOs, visited traditional healers, consumed herbal medicine and got private health services. It came out strongly in this research that the average villagers' participation in traditional healing practices was more active compared to their participation in Western modern health services. This highly influences community participation in PHC. Therefore, an inclusive approach for participation of all these actors needs to be considered in PHC interventions.

9.2.1.2 Understanding actors' relationship as a function of trust, gender, caste and ethnicity

Community participation in PHC is highly affected by the relationship of different actors among themselves. Their participation in PHC is the function of their relationship with each other. It is

natural for actors who have good relationships with each other to participate in each other's activities more than of those with whom they do not have a good relationship. Better relationships help actors to increase their participation and eventually increase their access to PHC. Since the Government of Nepal has declared free basic health care service to its population (RTIInternational, 2009, Witter et al., 2011, Sato and Gilson, 2015), it is fair to assume that it is the state's responsibility to ensure health services to its population. However, because of lack of material and human resources there are still areas where the state needs other actors' contribution to provide health care services. For which the government needs to maintain positive and productive relationships with other actors and vice versa. Therefore, government actors should initiate and build good relationships with other actors.

9.2.1.3 Over-politicization of community participation in PHC should be minimized.

It is a common phenomenon in Nepal that most interventions need to have full political acceptance before they can be launched in the community. Therefore, it is very important to achieve buy-in and support from the local political party leaders for the success of any activities including participation in PHC. Because of the participation of high numbers of people in PHC, politicians have a higher interest and often are suspicious of active participation by off-stage actors. Therefore, political representation should be ensured in health systems for effective community participation in PHC.

9.2.1.4 Replication of successful community participation models.

Participation of FCHVs in PHC is a successful programme in Nepal, remarkable for their continuity in participation in PHC (New-ERA, 2007). It is so because it has cashed in on people's interest to serve the community voluntarily and on individual recognition for their contribution as FCHV. Furthermore, FCHVs are successful because of their enhanced social recognition, their religious satisfaction and their feeling of moral duty which is a matter of pride for them (Glenton et al., 2010). This programme can be used as a platform or catalyst for successful community participation (LeBan et al., 2014). Therefore, this success needs to be replicated in other PHC interventions in Nepal and elsewhere. However, at the same time a proper mechanism of compensation for volunteers' time for lost opportunity cost needs to be explored for the long-term sustainability of community participation in PHC (Singh et al., 2015), and the professional support to FCHVs needs to be increased with more recognition, training and resources. Care should be taken to do so because the cash compensation system will bring other issues, for example, selection and nepotism and the volunteers will mostly lose the social

recognition part. Furthermore, a co-partnership model of decision making and resource mobilization should be developed between the government and the community (Labonté et al., 2014).

9.2.1.5 Systematic discouragement of discrimination against gender, caste and ethnicity.

Discrimination against gender, class, caste and ethnicity is still rampant in the study area and in general all over Nepal. Women are not included in decision making processes and positions, their suggestions are not taken seriously and they are mostly included only in voluntary work. The FCHV programme is working because they are local, their main work is related to women and children's health and volunteerism is socially respected. When there are any financial or material benefits involved it is often men who participate in such activities. These behaviours sometimes hinder women's participation in PHC. Furthermore, because of caste and ethnicity people are discouraged from participation in PHC (Gurung and Tuladhar, 2013) and are not selected as volunteers, for example, FCHV (UNICEF, 2004, New-ERA, 2007). This is common in both higher level and community level participation. Even though the Nepalese government has policies against such discrimination for inclusive participation, there is still discrimination in practice. Mechanisms for guaranteeing participation of these groups of people should be ensured in the health policy. Most importantly, policies need to be translated into practice for the participation of grass-root level actors in PHC.

9.2.1.6 Positive discrimination to ensure participation of people that normally do not participate.

There are some provisions in various policies in Nepal to ensure participation of people from vulnerable parts of society. These include provisions like mandatory representation from Dalits, ethnic groups and women in the committees. However, these are treated either as mechanism of token representation or not implemented at all in practice. This is often due to lack of awareness about the policy among these actors in the community level, lack of monitoring, lack of interest among the implementing actors and lack of understanding about community participation among the actors. Often community participation is understood by the villagers as a by-product of the government's health system (Lehmann and Sanders, 2007). Therefore, since community participation in PHC is minimal among the actors from the disadvantaged strata of society, the government should ensure a mechanism of positive discrimination for their effective participation. There have been some complaints from people from higher class, caste and higher strata of society against such reservations but the government should

discourage such complaints from those actors and address such issues and continue to ensure everyone's participation.

9.3 Suggestions for future research

This study presents community participation of Health System Actors in two heterogeneous middle hill communities of Nepal. Here, discrimination against caste, gender, class and ethnicity is higher than in the mountain area but it is lower than in the Southern Terai (Southern flat land of Nepal) regions of Nepal. Therefore, a comparative case study of a few VDCs from each region would give a better picture of community participation in PHC in Nepal. Such a study will help to increase the knowledge base on community participation in PHC.

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Appendixes

Appendix I: Data collection tool – semi structured interview schedule

Appendix I - 1

Health System Actors' Participation in Primary Health Care in Nepal Interview schedule for Semi structured interview with Government Health Workers

1. Please tell me who are the health service providers in this VDC? Please tell me about both formal and informal service providers.
2. Please tell me about a most recent noticeable service you provided in your community related to child birth and immunization.
3. Please tell me about your role on child birth and immunization service in this VDC.
4. Please tell me about your relation with other actors and how do you build this relation, mainly in the issues of child birth and immunization.
5. If you have to rank your participation in child birth and immunization issues in the scale of 1 to 5, please tell me where do you put yourself in Leadership, Resource mobilization, Needs assessment, Organization and Management?
6. Please tell me why do you put yourself in these scales? Why same or different in different domains?
7. Please tell me about things that encourage or discourages you in providing services related to child birth and immunization.
8. Please tell me the benefits of your participation in child birth and immunization programmes or issues.

Appendix I - 2

Health System Actors' Participation in Primary Health Care in Nepal Interview schedule for Semi structured interview with Non Governmental Organization workers / members

1. Please tell me about the formal and informal health service providers in this area and those who have influence in health services.
2. Please tell me about child birth and immunization service available in the community or if you are directly involved about your last case or service about it.
3. Please tell me about your role on child birth and immunization related health services in this VDC.
4. Please tell me about your relation with other actors and how you build that relation, mainly in the issues of child birth and immunization.
5. If you have to rank your participation in child birth and immunization issues in the scale of 1 to 5, please tell me where do you put yourself in Leadership, Resource mobilization, Needs assessment, Organization and Management?
6. Please tell me why do you put yourself in these scales? Why same or different in different domains?
7. Please tell me what facilitate or hinders your participation in services or programmes related to child birth and immunization.
8. Please tell me the benefits of your participation in child birth and immunization programmes or issues.

Appendix I - 3

Health System Actors' Participation in Primary Health Care in Nepal Interview schedule for Semi structured interview With Community leaders and local political party leaders

1. Please tell me who provides health services in this area and those who have influence on those services.
2. Please tell me about child birth and immunization services in your area.
3. Please tell me about your role on MCH service in this VDC.
4. Please tell me about your relation with other actors and how you build that relation, mainly in the issues of child birth and immunization.
5. If you have to rank your participation in child birth and immunization issues in the scale of 1 to 5, please tell me where do you put yourself in Leadership, Resource mobilization, Needs assessment, Organization and Management?
6. Please tell me why do you put yourself in these scales? Why same or different in different domains?
7. Please tell me about the things that help or hinders you to ensure services or programmes related to child birth and immunization in your area.
8. Please tell me the benefits of your participation in child birth and immunization programmes or issues.

Appendix I - 4

Health System Actors' Participation in Primary Health Care in Nepal Interview schedule for Semi structured interview with Ordinary citizen from the community

1. Please tell me where do you go for advice or treatment for your health when you or someone in your family needs?
2. Please tell me about the last child birth in your family.
3. Please tell me about how you deal with MCH and how you get services if you need.
4. Please tell me about your relation with other actors and how you build that relation, mainly in the issues of child birth and immunization.
5. If you have to rank your participation in child birth and immunization issues in the scale of 1 to 5, please tell me where do you put yourself in Leadership, Resource mobilization, Needs assessment, Organization and Management?
6. Please tell me why do you put yourself in these scales? Why same or different in different domains?
7. Please tell me about your last visit to the health service provider and one about you wanted to visit but could not make.
8. Please tell me the benefits of participating in services or programmes related to child birth and immunization.

Appendix I - 5

Health System Actors' Participation in Primary Health Care in Nepal Interview schedule for Semi structured interview with Informal health service providers

1. Please tell me about health service providers in this area and those influence the services
2. Please tell me about the last case you dealt related to child birth.
3. Please tell me about your role on MCH service in this VDC.
4. Please tell me about your relation with other actors and how you build that relation, mainly in the issues of child birth and immunization.
5. If you have to rank your participation in child birth and immunization issues in the scale of 1 to 5, please tell me where do you put yourself in Leadership, Resource mobilization, Needs assessment, Organization and Management?
6. Please tell me why do you put yourself in these scales? Why same or different in different domains?
7. Please tell me about things that encourage or discourages you in providing services related to child birth and immunization.
8. Please tell me the benefits of your participation in child birth and immunization programmes or issues.

Appendix II: Data collection tool – focus group discussion schedule

Appendix II - 1

Health System Actors' Participation in Primary Health Care in Nepal Focus group discussion schedule for FCHVs

1. Let us talk about who are the people and organization who provide health services in this VDC, especially that related to Child birth.
2. Please tell me about child birth and immunization services in your area.
3. Let us discuss how different people and organizations participate in MCH in this community.
4. Let us discuss how different people and organizations related to health interact with each other.
5. Let us work out how where participation of different group of actors lie in different domains of participation.
6. Why do you put different actors in these scales? Why same or different in different domains?
7. Let us discuss about the things that help or hinder different people and organization's participation in the services or programmes related to child birth and immunization this area.
8. What will happen if people participate in these programmes or not?

Appendix II - 2

Health System Actors' Participation in Primary Health Care in Nepal Focus group discussion schedule for ordinary citizens in the community

1. Let us talk about who are the people and organization who provide health services in this VDC, especially that related to Child birth.
2. Please tell me about child birth and immunization services in your area.
3. Let us discuss how different people and organizations participate in MCH in this community.
4. Let us discuss how different people and organizations related to health interact with each other.
5. Let us work out how where participation of different group of actors lie in different domains of participation.
6. Why do you put different actors in these scales? Why same or different in different domains?
7. Let us discuss about the things that help or hinder different people and organization's participation in the services or programmes related to child birth and immunization this area.
8. What will happen if people participate in these programmes or not?

Appendix III: Nepal Health Research Council ethical clearance letter



Nepal Health Research Council

Estd. 1991

Ref. No. : 1182

21 April 2014

Mr. Jiban Kumar Karki
Principal Investigator
University of Sheffield, UK

Ref: **Approval of Research Proposal** entitled **Health System Actors' Participation in Primary Health Care Case Studies from Hagam and Fulpingkot VDCs of Sindhupalchok district of Nepal**

Dear Mr. Karki ,

It is my pleasure to inform you that the above-mentioned proposal submitted on 18 February 2014 (**Reg. no.32/2014** please use this Reg. No. during further correspondence) has been approved by NHRC Ethical Review Board on 17 April 2014 (2071-1- 4).

As per NHRC rules and regulations, the investigator has to strictly follow the protocol stipulated in the proposal. Any change in objective(s), problem statement, research question or hypothesis, methodology, implementation procedure, data management and budget that may be necessary in course of the implementation of the research proposal can only be made so and implemented after prior approval from this council. Thus, it is compulsory to submit the detail of such changes intended or desired with justification prior to actual change in the protocol.

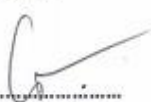
If the researcher requires transfer of the bio samples to other countries, the investigator should apply to the NHRC for the permission.

Further, the researchers are directed to strictly abide by the National Ethical Guidelines published by NHRC during the implementation of their research proposal and submit progress report and full or summary report upon completion.

As per your research proposal, the total research amount is **US\$ 5,847.00** and accordingly the processing fee amounts to **NRS- 9,925.00**. It is acknowledged that the above-mentioned processing fee has been received at NHRC.

If you have any questions, please contact the research section of NHRC.

Thanking you.


.....
Dr. Guna Raj Lohani
Executive Chief

Appendix IV: Consent forms

Appendix IV - 1

Consent Form for participant for Semi Structured Interview

Namaskar,

I am Jiban Kumar Karki, a PhD student from the School of Health and Related Research in The University of Sheffield, UK. I am conducting a research about how different health systems actors participate in Primary Health Care. My research topic is "Health System Actors' Participation in Primary Health Care in Nepal". I would like to request you take part in this research and provide your invaluable view about the topic I would like to talk with you if you agree to take part.

We hope the findings from this study will be useful in Primary Health Care in Nepal. Your participation in this research is entirely voluntary, it is your right to not to take part or withdraw from it any time during the interview or not to answer if you do not want to answer certain questions. All your responses will be confidential and anonymous.

Health System Actors' Participation in Primary Health Care in Nepal

Name of Researcher: Mr Jiban Kumar Karki

Participant Identification Number for this research:

Please initial box

1. I confirm that I have read and understand the information sheet dated explaining the above research project and I have had the opportunity to ask questions about the research.
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and without there being any negative consequences. In addition, should I not wish to answer any particular question or questions, I am free to decline.
3. I understand that my data will be kept strictly confidential. I give permission for members of the research team to have access to my anonymised data during the lifetime of the project. I understand that my name will not be linked with the research materials, and I will not be identified or identifiable in the report or reports that result from the research.
4. I agree for the data collected from me to be used in future research
5. I agree to take part in Semi Structured Interview in the above research and for my involvement to be recorded by digital audio recorder.

.....
Name of Participant Date ...
(or legal representative) Signature

.....Dat
Name of person taking consent e ... Signature
(if different from lead researcher)
To be signed and dated in presence of the participant

.....
lead researcher Date Signature
To be signed and dated in presence of the participant

Appendix V: Ovid_ Search record for article search

1/15/14

Ovid: Search Form



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<input type="checkbox"/>	#	Searches	Results	Search Type	Actions
<input type="checkbox"/>	65	24 and 38	158	Advanced	Display More >
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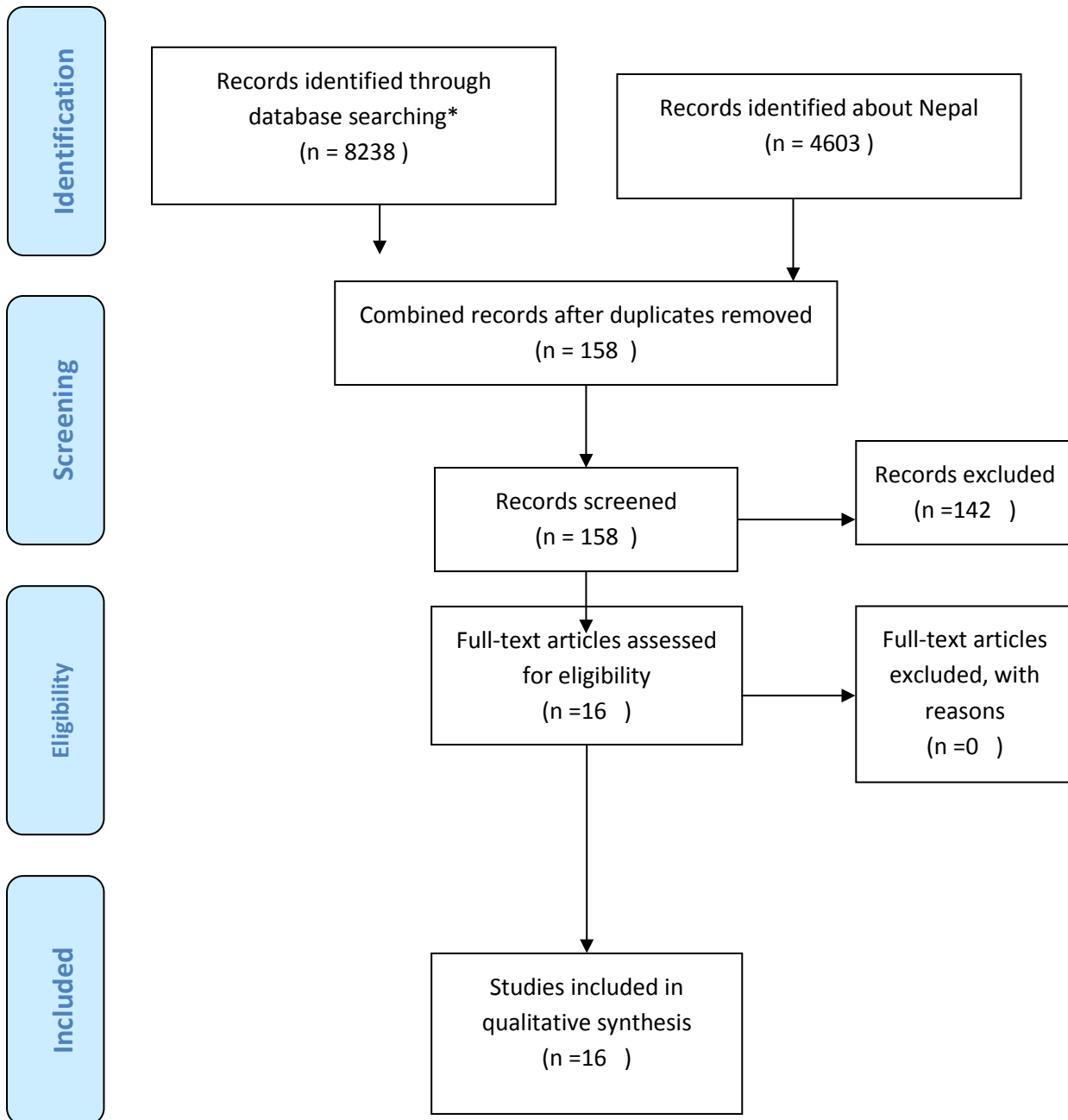
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- Search terms used:
access
action
approach*
barriers
building
capacity
capacitybuilding
capital
collaborat*

101. Caries experience of 5-6-year-old and 12-13-year-old schoolchildren in central and western Nepal.
Yee R. McDonald N.
International Dental Journal. 52(6):453-60, 2002 Dec.
[Journal Article]
UI: 12553401
Authors Full Name
Yee, R. McDonald, N.
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AB OBJECTIVE: To describe and analyse the caries experience and caries prevalence in the

Appendix VI: PRISMA 2009 Flow Diagram for article search



Appendix VII: Details of the articles searched from Ovid Search:

1

Title of the article	Towards the measurement of community participation
Date published	1989
Publisher	World Health Forum (WHO) (Vol. 10, No. 3/4, pp. 467-72).
Authors	Wolfgang Bichmann, Susan B. Rifkin, & Mathura Shrestha
Country of Study	Nepal
Key Words	Primary Health care, community participation
Methodology applied	Review
Main points from the article	<p>Community participation has been looked as the number of events people took part rather than looking into the process of their involvement in decision making about such activities.</p> <p>This article aims to propose a framework of measurement of community participation based on over 200 case studies.</p> <p>People's participation in needs assessment, leadership, organization, resource mobilization and management are taken as the five domains of participation.</p> <p>Community is the group of people living in a same area, sharing same value and having fairly same basic interest.</p> <p>Community participation is a social process where a specific groups living in a shared area participate in making decisions about their needs.</p> <p>People's level of participation in different domain of participation mentioned above is plotted as before and after intervention of some of the PHC interventions in Nepal in experimental basis. This framework still needs further testing but will be useful for planners and policy makers to evaluate the community participation in PHC activities in Nepal.</p>
Relevance	Study of community participation in PHC in Nepal.

2

Title of the article	Are large-scale volunteer community health worker programmes feasible? The case of Sri Lanka
Date published	1989
Publisher	Social Science & Medicine, Volume 29, Issue 5, Pages 599-608
Authors	Gill Walt, Myrtle Perera, Kris Heggenhougen
Country of Study	Sri Lanka
Key Words	Volunteers; Community Health Worker Programmes; Sri Lanka
Methodology applied	Questionnaire, In depth interviews (mixed method study).
Main points from the article	<p>It is the review of the CHW programme in Sri Lanka.</p> <p>There are both paid and unpaid Community health workers working in PHC.</p> <p>Most of the small scale volunteer CHW programme are successful but when they are large scale it is difficult to sustain.</p> <p>Volunteers were provided with only allopathic trainings whereas most the people served followed more holistic approach of treatment.</p> <p>Volunteer programme are sustained where more literate people do not have jobs, volunteers have high social and cultural recognition,</p>

	societal expectation of volunteerism, political commitment.
Relevance	Important because of the similarity of FCHV programme in Nepal.

3

Title of the article	Why health improves: Defining the issues concerning 'comprehensive primary health care' and 'selective primary health care'
Date published	1986
Publisher	Social Science & Medicine, Volume 23, No. 6, pp. 559-566
Authors	Susan B. Rifkin, Gill Walt
Country of Study	Worldwide significance but mostly the developing countries.
Key Words	Comprehensive PHC; selective PHC; health policy; health interventions
Methodology applied	Review
Main points from the article	Immediately after Declaration of Alma Ata there the comprehensive Vs selective PHC debate started. PHC approach is built on equity, community participation, involvement of multiple sector I health, Selective PHC neglected concept of community participation in PHC, offered service to selected disease but left others behind and it is imposed by the external agencies. Both selective as well as comprehensive PHC are part of each other so should not be looked these as replacement for each other.
Relevance	Community participation in PHC is one of the components of comprehensive PHC.

4

Title of the article	Primary health care for whom? Village perspectives from Nepal
Date published	1986
Publisher	Social Science & Medicine Volume 22 no. 3 293-302.
Authors	Linda Stone
Country of Study	Nepal but worldwide significance for developing countries
Key Words	Primary Health Care,
Methodology applied	Qualitative study, caste study
Main points from the article	Villagers understand PHC only as the allopathic curative treatment as PHC Traditional health system has its own place in Nepalese society, this need to take into account into modern PHC. More important is how PHC is achieved. The PHC emphasizes community participation which is alien from earlier approaches of health care delivery. The PHC implementation in Nepal did not take into account the existing socio cultural aspects. Minimum value to the health education True community participation is rare. This study suggests not to force community participation in PHC in the rural community without broader participatory development intervention
Relevance	Study of PHC intervention in Nepal, therefore, very relevant.

5

Title of the article	Improving skills and utilization of community health volunteers in Nepal
Date published	1995
Publisher	Social Science & Medicine Volume 40, no. 8: 1117-1125.
Authors	Curtale, Filippo, Bhola Siwakoti, Cecilia Lagrosa, Massimo LaRaja, and Ranieri Guerra.
Country of Study	Nepal
Key Words	Nepal, Community Health Volunteer, primary health care, nutrition education
Methodology applied	Survey, Intervention and control operational research, Review
Main points from the article	<p>This study evaluated a child nutrition programme. FCHVs were mobilized to deliver this intervention for which they were provided some additional training.</p> <p>Lack of motivation and high attrition rate among the FCHVs. Additional responsibility increased FCHV motivation.</p> <p>FCHVs were found to be the first contact point for the women. FCHVs programme increased the child immunization and ORS coverage.</p> <p>Financial incentive to FCHVs is also one of the motivations that helped.</p>
Relevance	Relevant because of the participation of FCHVs in the programme and their motivation to participate in this programme.

6

Title of the article	Cultural influences in community participation in health
Date published	1992
Publisher	Social Science and Medicine. Volume 35(4): 409-17
Authors	Linda Stone
Country of Study	Developing countries, Nepal
Key Words	Community participation, Primary Health Care, culture
Methodology applied	Review
Main points from the article	<p>The role of culture in community participation in health care is significant</p> <p>Volunteer local midwives was seen as the part of community participation in PHC</p> <p>Traditional system is not accepted but traditional birth attendants are used.</p> <p>The traditional system has been portrayed as an obstacle to the modern health system.</p> <p>Health education and preventive services are equally important for delivering PHC.</p> <p>The prescribed mode of PHC is contradictory to the value of community participation.</p> <p>Community participation is criticized to shield the disparities between the health facilities among the rich and poor people.</p>

	Power relationship, conflicting interests and inequity are the barriers successful community participation in PHC.
Relevance	

7

Title of the article	The organisationsss of health care in Nepal
Date published	1995
Publisher	International Journal of Nursing Studies Volume 32, no. 3: 260-270
Authors	Bentley, Helen
Country of Study	Nepal
Key Words	PHC, community participation
Methodology applied	Review
Main points from the article	<p>There is confusion whether to use the resources to cure existing ill health or more long term health interventions.</p> <p>Nepal has chosen PHC as the basis for organization of its health care. PHC approach is supposed to be more equitable than the hospital based health care.</p> <p>Presence of medical pluralism.</p> <p>Poverty, gender discrimination, and remoteness hampers access to PHC.</p> <p>Socio cultural factors needs to be considered while implementing PHC. Though the lowest level of staff peons still deliver the health services in most of the rural health posts because they are local, speak their language and act at the same level as the villagers.</p> <p>Reports that it is the women who make decision which contradicts with others' findings.</p> <p>Existing situation of water supply needs to improve along with the production of food.</p> <p>Training local staff might be one way to deliver PHC locally.</p>
Relevance	Study of the Nepalese health system and implementation of PHC approach

8

Title of the article	Nepal: integrating traditional and modern health services in the remote area of Bashkharka
Date published	1990
Publisher	International Journal of Nursing Studies, Volume 27, no. 4: 343-353.
Authors	Sharma, Anju, and Jane Ross
Country of Study	Nepal
Key Words	PHC, traditional health services, Health Promotion
Methodology applied	Review
Main points from the article	<p>Health pluralism is common in Nepal (ayurvedic, dhami-jhakri and modern)</p> <p>One HA/CMA, one ANM and one peon in each post to deliver PHC</p> <p>Peon providing the health services</p> <p>Lack of monitoring and supervision in PHC</p>

	<p>Modern health system does not appreciate the existing traditional approach of health care, ill practices, for example, not giving fluid to the child during diarrhoea, treating fever by throwing rice grain and turmeric powder around the houses exist in many part of the country.</p> <p>People have greater faith in traditional healing than the modern health services.</p> <p>People's knowledge has not been included in health planning.</p> <p>PHC is not available to all people.</p> <p>Difficulty geography, lack of transport, low literacy rate, religious and cultural beliefs are some of the barriers to provide health service in Nepal.</p>
Relevance	

9

Title of the article	Paradigms lost: toward a new understanding of community participation in health programmes
Date published	1996
Publisher	Acta Tropica 61, no. 2, 79-92.
Authors	Rifkin, Susan B
Country of Study	Developing countries
Key Words	Community participation; Paradigm shift; Community health workers; Rapid appraisal
Methodology applied	Review
Main points from the article	<p>Community participation was emphasized because it is assumed that once the community is engaged in decision making they will follow those decisions, contribution of local resources, change in their poor health behaviour, people will challenge the status quo which has deprived them from making any decisions.</p> <p>There is still no community participation in PHC because there no agreed framework of successful community participation</p> <p>Top down approach of community participation i.e. people are asked to support in the implementation of already decided projects / programmes.</p> <p>Community participation is often treated as a product, i.e. it is tried to quantify the community participation</p> <p>Community Health Worker programme are treated as the mechanism of community participation</p> <p>This study claims that large scale voluntary CHP was not successful</p> <p>There is no absolute reality about community participation but it is context specific.</p>
Relevance	Community participation in Primary health care

10

Title of the article	Community Participation and Mobilization in Community-Based Maternal, New-born and Child Health Programmes in Nepal
Date published	2011
Publisher	Journal of Nepal Health Research Council, Nepal
Authors	Kc, N. P., A. Kc, N. Sharma, H. Malla, N. Thapa, K. Aryal, R. Vitrakoti,

	and R. M. Bhandari
Country of Study	Nepal
Key Words	Nepal, community mobilization, participation, community based maternal, new-born and child health programmes, mother's group, female community health volunteer
Methodology applied	Qualitative study, FGD
Main points from the article	<p>Community participation is important in community based interventions.</p> <p>This study reported a minimum level of community participation in decision making level. Community was not involved in identifying and solving the problems.</p> <p>Six point scale of community participation, co-option, compliance, consultation, cooperation, co-learning and collaborative actions are used to measure the community participation in maternal, new-born and child health programme.</p> <p>FCHVs are the drivers of change</p> <p>Community participation is one of the main components of any health intervention in Nepal which should be built into the PHC interventions.</p>
Relevance	Study of community participation in PHC intervention

11

Title of the article	Primary Health Care Development: Where is Nepal after 30 years of Alma Ata Declaration
Date published	2010
Publisher	Journal of Nepal Medical Association 49, no. 178
Authors	Karkee, Rajendra, and N. Jha
Country of Study	Nepal
Key Words	PHC, Nepal, constraint, progress
Methodology applied	Review
Main points from the article	<p>Nepal has made impressive achievements in selective interventions, for example, reduction in maternal mortality, reduction in child mortality but access to health care is still very are satisfactory.</p> <p>Health strategies are focused more on selective intervention rather than a holistic PHC approach.</p> <p>Nepal is one of the early adopters of the PHC approach put forward by the WHO</p> <p>Because of the remoteness of most of the areas in Nepal the PHC delivery has been a challenge, especially to retain the health workers.</p> <p>PHC is more relevant in changed context because there is more need to engage the community in deciding their health systems themselves.</p> <p>Training the health workers from rural area, reservation of seats for the candidates from poorer community, regular supervision and monitoring of staff are some of the necessary steps to increase staff retention.</p> <p>Compulsory service after graduation might be another way of</p>

	<p>retaining staff.</p> <p>Empowerment of the community to decide about their health system themselves is one of the ways forward for higher community participation in PHC. Use of FCHVs and mothers' groups as active agents for this purpose is a way forward.</p> <p>Intersectoral coordination is important to have a synergetic effect in PHC and to increase community participation.</p> <p>Nepal has adopted the PHC approach in health policies and strategies but there is need to translate into practice. Therefore, revitalizing PHC approach is important.</p>
Relevance	It is about PHC revitalization in Nepal.

12

Title of the article	Community participation in health: A brief review and the experience of Kathmandu Medical College with the Duwakot community
Date published	2008
Publisher	Kathmandu University Medical Journal, Vol. 6, No. 4, Issue 24, 526-532
Authors	Vaidya A , Pradhan B
Country of Study	Nepal
Key Words	Primary Health Care, Community Participation
Methodology applied	Review Qualitative research
Main points from the article	<p>Factors leading to successful community participation are commitment, continuity, intersectoral collaboration, trust, recognition of community authority.</p> <p>Factors that diminish community participations are threat to established power structure, benefit seeking from participation, community unwillingness and bureaucratic unwillingness.</p> <p>Level of community participation is ranked as community contact, involvement, collaboration, community participation and community control.</p> <p>Community participation in Nepal is practised in community forestry, cooperatives and small farmers' bank, school management committees (community schools) and community participation in PHC (FCHVs, HFMCs).</p> <p>Community participation depends on how much resources the community can borne without further aid to maintain the participation.</p> <p>Intersectoral coordination is important to maintain the community participation.</p>
Relevance	Study of community participation in PHC in Nepal.

13

Title of the article	Early Initiation of Community-based Programmes in Nepal: A Historic Reflection
Date published	2012
Publisher	Journal of Nepal Health Research Council, 10(21): 82-87
Authors	Houston R, Acharya B, Poudel D, Pradhan S, Singh S, Manandhar M, Pokhrel RK, Shrestha PR
Country of Study	Nepal

Key Words	ARI programme; community-based integrated management of childhood illness; female community health volunteers; national vitamin A programme; Nepal
Methodology applied	Review
Main points from the article	<p>FCHV programme is one of the largest community volunteer programme in Nepal. This was originally initiated in 1988 to work in maternal and child health sector.</p> <p>FCHV programme is one of the successful community participation programme in Nepal.</p> <p>Government's ownership of the programme and social recognition are the most important factors for success of FCHV programme in Nepal.</p> <p>FCHVs are the primary bridge between the health system and the community in Nepal.</p>
Relevance	

14

Title of the article	Strengthening National Health Systems for Improving Efficiency of Health Service Delivery in Nepal
Date published	2012
Publisher	Journal of Nepal Health Research Council. 10(21): 101-7
Authors	Shakya HS, Adhikari S, Gurung G, Pant S, Aryal S, Singh AB, Sherpa MG
Country of Study	Nepal
Key Words	Facility-based maternal and neonatal health services; health logistics system; local health governance
Methodology applied	Review
Main points from the article	<p>Decentralization of health management is a key to success of many PHC interventions in Nepal.</p> <p>As a signatory of the Alma Ata Declaration of PHC (WHO 1978), Nepal has adopted the PHC with community participation approach to deliver health services efficiently and effectively.</p> <p>Health Facility Management Committees are the mechanism of people managing their health systems themselves. The members of HFMC are the VDC personnel, teachers, FCHV, representatives from Dalit and women. HFMC is the bridge between the health system and the community.</p> <p>Community engagement, social inclusion and local governance are significant factors for the success of PHC in Nepal.</p> <p>The role of HFMC in PHC is supposed to be supervision of health facilities, inform people about the available health services and social audits, these leads to responsive and efficient health services.</p> <p>Still the financial and administrative decision making is centralized that limits the scope of community making a decision as such.</p> <p>At changed political dynamics in Nepal, decentralization and community participation is even more important.</p>
Relevance	It is about the decentralization of health system in Nepal.

15

Title of the article	The female community health volunteer programme in Nepal: Decision makers' perceptions of volunteerism, payment and other incentives
Date published	2010
Publisher	Social Science & Medicine 70, 1920 - 1927
Authors	Claire Glenton, Inger B. Scheel, Sabina Pradhan, Simon Lewin, Stephen Hodgins, Vijaya Shrestha
Country of Study	Nepal
Key Words	Nepal, Community health workers, Incentives, Volunteerism, Women
Methodology applied	Qualitative research, Semi structured interviews
Main points from the article	<p>Sustainability of long term volunteerism is questionable. There is very limited evidence in relationship of incentive and the attrition rate of volunteers.</p> <p>South African experience of attrition of 22% of volunteers in one year. Volunteerism incurs significant opportunity cost</p> <p>Motivation for volunteerism can be desire to serve the community, to gain knowledge, develop skills and to boost self-esteem. Different motivating factors work for different people.</p> <p>FCHV programme has only 4% annual attrition rate, which is impressive despite various stakeholders advocating for compensation for these FCHV's lost opportunity cost.</p> <p>Earning religious merit, sense of obligation for community service, recognition from the community, gaining health knowledge are some of the motivation for FCHVs.</p> <p>Introducing salary for FCHVs is not only financially not viable it might also decrease their volunteering spirit similar that to the negative attitude towards the salaried VHW.</p> <p>Even if regular salary for FCHVs is difficult, it is still important to compensate for their lost opportunity costs and to appreciate their contribution in Nepalese health system. Therefore, a context specific incentive system is necessary.</p>
Relevance	Study of FCHV in Nepal

16

Title of the article	Culture, status and context in community health worker pay: pitfalls and opportunities for policy research. A commentary on Glenton et al.(2010)
Date published	2010
Publisher	Social Science & Medicine Volume 31; 71(8): 1375-8
Authors	Maes KC, Kohrt BA, Closser S.
Country of Study	Nepal
Key Words	Volunteerism' Nepal, Community health workers, Sustainability, Mixed methods Inequality, Livelihoods, Motivation, Women
Methodology applied	Commentary
Main points from the article	This article critically reviews the findings from another article (The female community health volunteer programme in Nepal: Decision

	<p>makers' perceptions of volunteerism, payment and other incentives. <i>Social Science & Medicine</i>, 70(12), 1920e1927.).</p> <p>The suggestion of discouraging payment to FCHVs is not backed up by sufficient input from the FCHVs themselves, but rather based on the input from the people in high positions in the Ministry of Health of Nepal.</p> <p>There is gendered view about religious merit. For example how to justify the claim that women taking wages compromises their religious merit whereas men doing so does not. Failed to justify why it is detrimental to pay FCHVs who are already discriminated as women.</p> <p>Challenges the claim that paying FCHVs is not financially sustainable and suggests it can be done by reducing the number of expatriate staff.</p> <p>There should be a way to incentivise the volunteers for their time and still keeping the social recognition and respect.</p> <p>A more robust research with involvement of larger sample of FCHVs employing multiple methods is needed to make such claim of incentivising volunteers diminishes their motivation to work and loss of respect from the community.</p>
Relevance	Commentary on the article published about the success of FCHV in Nepal

17

Title of the article	Financial incentives for maternal health: impact of a national programme in Nepal.
Date published	2012
Publisher	<i>Journal of Health Economics</i> , 31(1), pp.271-284.
Authors	Powell-Jackson, T. and Hanson, K.
Country of Study	Nepal
Key Words	Impact evaluation, Financial incentives, Demand for health care, Maternal health, Nepal
Methodology applied	Survey and qualitative study
Main points from the article	<p>Financial reward for using the health service is one of the tested approaches of increasing the uptake of available services especially if it is a new intervention.</p> <p>Very few women in Nepal make their health decisions themselves. Financial incentives attract women to deliver at the institution but the distance and inadequate infrastructure discourages them to do so.</p>
Relevance	This study is about increasing the access to health care with appropriate incentive to motivate women to participate in attended delivery.

18

Title of the article	A Conceptual Model for Empowerment of the Female Community Health Volunteers in Nepal
Date published	2003
Publisher	<i>Education for Health</i> , Vol. 16, No. 3, November 2003, 318 – 327
Authors	Sarala Shrestha

Country of Study	Nepal
Key Words	Empowerment, community health volunteer, participatory action research, contraceptive acceptance
Methodology applied	Review
Main points from the article	Community Health Volunteers are one of the main workforce to deliver basic health service in many countries. These are taken as best alternative where skilled health workers are scarce. FCHV programme is treated as one of the mechanism of community participation in PHC in Nepal. FCHVs are the change agents in the community. Therefore, empowering FCHVs is important to bring sustainable change in their job performances.
Relevance	FCHV programme is one of the community participation mechanisms in Nepalese health system.

19

Title of the article	Local governance and community financing of primary care: evidence from Nepal
Date published	2002
Publisher	Health Policy and Planning 17.2: 202-206
Authors	Bishai, David, Louis W. Niessen, and Mohan Shrestha
Country of Study	Nepal
Key Words	Nepal, community empowerment, equity, primary health care, health care financing
Methodology applied	Survey
Main points from the article	Community financing is important for sustaining health services in developing countries. Community participation can be in the form of giving free time as well as donating money or other resources. Quality and sustainability of PHC services increases with increased community involvement in financial and operational support. Increased community participation results in effective curative services and decreases international donor dependency. This paper mentions participation of lower caste but does not elaborate in detail about barriers to their participation. This paper suggests that VDC with higher proportion of lower caste members contribute higher in the health facility, which shows that the financial contribution is inversely proportional to socio economic status of the population. This is related to VDC funding.
Relevance	Study on the local financing of PHC in Nepal

20

Title of the article	Primary health care, community participation and community-financing: experiences of two middle hill villages in Nepal
Date published	1996
Publisher	Health Policy and Planning 11, no. 1: 93-100
Authors	Sepehri, Ardeshir and Judith Pettigrew

Country of Study	Nepal
Key Words	
Methodology applied	Qualitative study, SSIs and observation
Main points from the article	<p>Study of two health posts one government controlled and financed and another community controlled and financed. It is a qualitative study which used SSIs and observation methods to collect data.</p> <p>Pluralism of health system exists in both the study areas. Illness is believed to be the causes of soul loss, witchcraft, attacks by spirits, deities and unfavourable astrological positions. Whereas the modern health workers understand it differently.</p> <p>Community financing in one of the health post is reported as the sign of community participation.</p> <p>Even though people were aware about the curative part of health service available over 90% of the people were not aware about the health committees and their role in PHC. Health volunteers were more known to the community than the health workers and the committee.</p> <p>Community participation in these two communities was very little beyond the use of the health services.</p> <p>Community financing did not increase participation.</p>
Relevance	Study of community participation in PHC
Relevance	

Appendix VIII: Published abstracts

Appendix: VIII-1 Health System Actors' Participation in Primary Health Care in Nepal (abstract) – poster presentation ((<http://onlinelibrary.wiley.com/doi/10.1111/tmi.12574/epdf>) Page 373-374)

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Health system actors' participation in primary health care in Nepal

J. K. Karki¹, A. Lee¹, M. Johnson¹, P. Simkhada², M. R. Chhetri³ and G. Jones¹
¹School of Health and Related Research, University of Sheffield, Sheffield, UK; ²Liverpool John Moores University, Liverpool, UK; ³Chitwan Medical College, Bharatpur, Nepal

BACKGROUND Community participation in Primary Health Care (PHC) has been a major theme in health system debates since the declaration of Alma Ata on PHC in 1978. The government of Nepal and other health providers have

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incorporated community participation into their health policies and programme. However, community participation has mostly been understood as villagers using available services and not as active contributors to their design, delivery and local appropriateness.

METHOD A qualitative study was conducted to understand community participation in PHC in Nepal. Forty-one semi-structured interviews and four focus group discussions were conducted with different stakeholders from 21 groups of health systems actors in two Village Development Committees (VDCs). Interviews were transcribed and translated, then coded using NVivo10. Themes and subthemes were developed from these codes using an inductive approach, before a thematic framework was applied for analysis.

FINDINGS Financial benefit, social power and spiritual gains are the main motivators for participation, however, there is limited understanding of what participation means amongst key actors. There are not enabling relationships between actors to facilitate community participation, whilst poverty, gender, caste and social hierarchy were found to be the main barriers for community participation in PHC. Contrary to high community engagement in socio-cultural activities in the villages, there is less participation in PHC than the government and some outside agencies claim, with village members still only engaging with PHC as service users.

CONCLUSION Community participation in the two VDCs remains low. Levels of engagement are influenced by factors including; local context, socio-economic status, gender, ethnicity, caste, politics and ease of access to services. If communities are to be engaged with all aspects of PHC delivery, a greater understanding of what participation means is required as well as a focus upon the root causes of peoples' participation and non-participation.

DISCLOSURE Nothing to disclose.



Britain - Nepal
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14th BNAC Nepal Study Days

14-15 April 2016

Redmonds Building, Brownlow Hill,
Liverpool John Moores University, Liverpool L3 5UG

ABSTRACTS OF PRESENTATIONS

Theme 5: Health

Paper 13

Health System Actors' Participation in Primary Health Care in Nepal

Jiban Karki^{a*}, Padam Simkhada^b, Andrew Lee^a, Maxine Johnson^a, Muni Raj Chhetri^c,
Graham Jones^a

^a The University of Sheffield ^b Liverpool John Moores University ^c Chitwan Medical
College, Bharatpur-13, P.O.Box No. 42, Chitwan, Nepal

Background

Nepal has theoretically been an early adopter of WHO's Primary Health Care (PHC) with a Community Participation (CP) approach. However, it has struggled with its implementation mainly because of its developmental challenges such as poverty, civil war, geography, etc. It is still important to understand CP and PHC because the current context in Nepal demands people's involvement in every aspect of public affairs.

Methodological approach

A qualitative study was conducted to understand CP in PHC in Nepal. Forty-one semi-structured interviews and four focus group discussions were conducted with 26 groups of health system actors in two VDCs of Sindhupalchok district in 2014. Interviews were transcribed and translated, then coded using NVivo10. Categories, themes, and subthemes were developed from these codes using a general inductive approach before a thematic framework was applied for analysis.

Findings

There was very minimal understanding about PHC and CP among the actors. CP was limited to token participation and token resource contribution. Decisions were imposed in a top-down way without considering local context, practices, or actors. The main motivations for participation in PHC were material benefits, social recognition, and religious merit, whereas geography, opportunity cost, lack of awareness, and socio-cultural discrimination were barriers to participation.

Conclusion

PHC with CP is still important for Nepal but it need to be contextualized to accommodate, learn, and benefit from the existing traditional health system. Similarly, stronger policy measures are needed to minimize, if not to eradicate, discrimination on grounds of gender, caste, ethnicity and class to increase CP in PHC. In the current socio-political situation of Nepal, neither the government nor the

non-governmental and private sector alone are able to address increasing healthcare needs in Nepal. Therefore, a wider broad partnership based PHC with CP is the recommended way forward to ensure basic health care service.

Appendix IX: Translated copies of consent forms and research tools

अनुसूची 4-1

अन्तर्बातामा सहभागिताको लागि सहमती फाराम

नमस्कार

म जीवन कुमार कार्की, बेलायत को शेफिल्ड विश्वविद्यालयको पि एच डि विद्यार्थी हुँ । म नेपालको प्राथमिक स्वास्थ्य सेवामा स्वास्थ्य प्रणालीसंग सम्बन्धित बिभिन्न ब्यक्ति र संस्थाहरू कसरी सहभागि हुन्छन् भन्ने बारेमा अनुसन्धान गरिरहेको छु । मेरो अनुसन्धानको विषय "नेपालको प्राथमिक स्वास्थ्य सेवामा बिभिन्न स्वास्थ्य प्रणालीसंग सम्बन्धित ब्यक्ति र संस्थाहरूको सहभागिता" हो। म तपाईंलाई यो अनुसन्धानमा भाग लिई आफ्नो अमूल्य बिचार प्रदान गरी मेरो अनुसन्धानमा सहयोग गरिदिनुहुन हार्दिक अनुरोध गर्न चाहन्छु । मेरो यस अध्ययनले नेपालको प्राथमिक स्वास्थ्य सेवाको क्षेत्रमा योगदान पुग्नेछ भन्ने आशा राखेको छु । यस अनुसन्धान मा तपाईंको संलग्नता स्वैच्छिक हो । यसमा भाग लिन नचाहनु वा कुनै प्रश्नको जवाफ दिन नचाहेमा त्यो तपाईंको अधिकार हो । तपाईं कुनै पनि समय यस अन्तर्बाताबाट बाहिरिन सक्नुहुनेछ र यो पुरै तरिकाले स्वैच्छिक हो । तपाईंका सबै उत्तरहरू गोप्य राखिनेछ र पहिचान गर्न नसक्ने बनाईनेछ । यदि तपाईं यस अनुसन्धानमा भाग लिई मलाई सहयोग गर्न चाहनु हुन्छ भने तलको प्रत्येक बुदाहरूमा चिन्ह लगाई सहिछाप गरिदिनुहुन हार्दिक अनुरोध गर्दछु ।

अनुसन्धानकर्ता को नाम: जीवन कुमार कार्की

सहभागीको पहिचान

कोठामा √ चिन्ह लगाउनुहोस्

संख्या:

- १ मलाई यस अनुसन्धानको बिषयमा पूर्ण रुपमा जानकारी दिइएको छ र मलाई आफुलाई लागेको प्रश्नहरू सोध्ने मौका दिइएको छ ।
- २ म मेरो सहभागिता स्वैच्छिक हो भन्ने थाहा छ । म कुनै पनि कारण नदिई यसबाट बाहिरिन सक्छु र यसले मलाई कुनै असर गर्नेछैन भन्ने मलाई थाहा छ । यसको साथै मलाई कुनै पनि प्रश्नको पूर्ण वा आंशिक उत्तर नदिने पूर्ण अधिकार छ ।
- ३ मसंग लिइएको तथ्यांकहरू गोप्य राखिन्छन् भन्ने मलाई थाहा छ । मैले दिएको तथ्यांकहरूमा यस अनुसन्धानको जीवनकालमा अनुसन्धान दलका सदस्यहरूको पहुचको लागि म अनुमति दिन चाहन्छु । मेरो नाम कुनै पनि प्रतिबेदन र अनुसन्धान सामाग्रिहरूमा आउने छैन र यीनीहरूमा मेरो पहिचान पनि खुल्ने छैन ।
- ४ मसंग संकलन गरीएका तथ्यांकहरू भविष्यका अनुसन्धानहरूमा प्रयोगको लागि मेरो सहमती छ
- ५ म यस अनुसन्धानको अन्तर्बातामा भाग लिन मन्जुर छु र मेरो अन्तर्बाता डिजिटल ध्वनि रेकर्डरले रेकर्ड गर्न मन्जुरि दिन्छु ।

..... सहभागिको नाम मिति सहिछाप
(वा कानुनि प्रतिनिधि)

..... सहमति लिनेको नाम मिति सहिछाप
(यदि मुल अनुसन्धानकर्ता नभएमा)

सहभागिको सामुन्नेमा सहिछाप गरि मिति लेख्ने

..... मुल अनुसन्धानकर्ता मिति सहिछाप
सहभागिको सामुन्नेमा सहिछाप गरि मिति लेख्ने

अनुसूची 4-2

सामुहिक छलफलमा सहभागिताको लागि सहमती फाराम

नमस्कार

म जीवन कुमार कार्की, बेलायत को शेफिल्ड विश्वविद्यालयबाट पि एच डि गर्दै गरेको विद्यार्थी हुँ । म नेपालको प्राथमिक स्वास्थ्य सेवामा स्वास्थ्य प्रणालीसंग सम्बन्धित बिभिन्न ब्यक्ति र संस्थाहरू कसरी सहभागि हुन्छन् भन्ने बारेमा अनुसन्धान गरिरहेको छु । मेरो अनुसन्धानको विषय "नेपालको प्राथमिक स्वास्थ्य सेवामा बिभिन्न स्वास्थ्य प्रणालीसंग सम्बन्धित ब्यक्ति र संस्थाहरूको सहभागिता" हो। म तपाईंलाई यो अनुसन्धानमा भाग लिई आफ्नो अमूल्य बिचार प्रदान गरी मेरो अनुसन्धानमा सहयोग गरिदिनुहुन हार्दिक अनुरोध गर्न चाहन्छु । मेरो यस अध्ययनले नेपालको प्राथमिक स्वास्थ्य सेवाको क्षेत्रमा योगदान पुग्नेछ भन्ने आशा राखेको छु । यस अनुसन्धान मा तपाईंको संलग्नता स्वैच्छिक हो । यसमा भाग लिन नचाहनु वा कुनै प्रश्नको जवाफ दिन नचाहेमा त्यो तपाईंको अधिकार हो । तपाईं कुनै पनि समय यस अन्तर्बाताबाट बाहिरिन सक्नुहुनेछ र यो पुरै तरिकाले स्वैच्छिक हो । तपाईंका सबै उत्तरहरू गोप्य राखिनेछ र पहिचान गर्न नसक्ने बनाईनेछ । यदि तपाईं यस अनुसन्धानमा भाग लिई मलाई सहयोग गर्न चाहनु हुन्छ भने तलको प्रत्येक बुदाहरूमा चिन्ह लगाई सहिछाप गरिदिनुहुन हार्दिक अनुरोध गर्दछु ।

अनुसन्धानकर्ता को नाम: जीवन कुमार कार्की

सहभागीको पहिचान

कोठामा √ चिन्ह लगाउनुहोस्

संख्या:

- १ मलाई यस अनुसन्धानको बिषयमा पूर्ण रुपमा जानकारी दिइएको छ र मलाई आफुलाई लागेको प्रश्नहरू सोध्ने मौका दिइएको छ ।
- २ म मेरो सहभागिता स्वैच्छिक हो भन्ने थाहा छ । म कुनै पनि कारण नदिई यसबाट बाहिरिन सक्छु र यसले मलाई कुनै असर गर्नेछैन भन्ने मलाई थाहा छ । यसको साथै मलाई कुनै पनि प्रश्नको पूर्ण वा आंशिक उत्तर नदिने पूर्ण अधिकार छ ।
- ३ मसंग लिइएको तथ्यांकहरू गोप्य राखिन्छन् भन्ने मलाई थाहा छ । मैले दिएको तथ्यांकहरूमा यस अनुसन्धानको जीवनकालमा अनुसन्धान दलका सदस्यहरूको पहुचको लागि म अनुमति दिन चाहन्छु । मेरो नाम कुनै पनि प्रतिबेदन र अनुसन्धान सामाग्रिहरूमा आउने छैन र यीनीहरूमा मेरो पहिचान पनि खुल्ने छैन ।
- ४ मसंग संकलन गरीएका तथ्यांकहरू भविष्यका अनुसन्धानहरूमा प्रयोगको लागि मेरो सहमती छ
- ५ म यस अनुसन्धानको सामुहिक छलफलमा भाग लिन मन्जुर छु र मेरो अन्तर्बाता डिजिटल ध्वनि रेकर्डरले रेकर्ड गर्न मन्जुरि दिन्छु ।

..... सहभागिको नाम मिति सहिछाप
(वा कानुनि प्रतिनिधि)

..... सहमति लिनेको नाम मिति सहिछाप
(यदि मुल अनुसन्धानकर्ता नभएमा)
सहभागिको सामुन्नेमा सहिछाप गरि मिति लेख्ने

..... मुल अनुसन्धानकर्ता मिति सहिछाप
सहभागिको सामुन्नेमा सहिछाप गरि मिति लेख्ने

अनुसुचि 1- 1

नेपालको प्राथमिक स्वास्थ्य सेवामा बिभिन्न स्वास्थ्य प्रणालीसंग सम्बन्धित ब्यक्ति र संस्थाहरूको सहभागिता

सरकारी स्वास्थ्यकर्मीहरूसंगको अन्तर्बाताको लागि प्रश्नवली

- 1 यस गाविसमा औपचारिक तथा अनौपचारिक तवरले स्वास्थ्य सेवा प्रदान गर्ने सेवा प्रदायकहरू को को छन् कृपया बताउनुहोस् ।
- 2 कृपया तपाईंले हालसालै पुर्याउनु भएको मातृस्वास्थ्य, गर्भवति सेवा, सुत्केरि सेवा, खोप वा सो सम्बन्धि कुनै सेवाको बारेमा बताउनुहोस् ।
- 3 आमा तथा बच्चाको स्वास्थ्य सम्बन्धमा खासगरी यस गाविसमा तपाईंको भूमिकाको बारेमा बताउनुहोस् ।
- 4 कृपया बिभिन्न सेवा प्रदायकहरू, सेवाग्राहीरू, सो सम्बन्धि चासो राख्ने ब्यक्तिहरू तथा संघ संस्थाहरूसंगको तपाईंको सम्बन्धको बारेमा बताउनुहोस् (खासगरी मातृस्वास्थ्य, गर्भवति सेवा, सुत्केरि सेवा, खोप वा सो सम्बन्धि) ।
- 5 यदि मातृस्वास्थ्य, गर्भवति सेवा, सुत्केरि सेवा, खोप वा सो सम्बन्धि सेवामा आवश्यकता पहिचान, नेतृत्व, संगठन, स्रोत परिचालन र व्यवस्थापनमा तपाईंको सहभागितालाई १ देखि ५ सम्म (१ कम सहभागिता, ५ सकृय सहभागिता) अंक दिनु पर्यो भने तपाईं कुन प्रकृत्यालाई कति अंक दिनुहुन्छ, कृपया बताउनुहोस् ?
- 6 तपाईंले आफुलाई यी बिभिन्न स्तरहरूमा किन राख्नुभयो कृपया बताउनुहोस् । किन फरक फरक प्रकृत्यामा फरक वा उस्तै?
- 7 मातृस्वास्थ्य, गर्भवति सेवा, सुत्केरि सेवा, खोप वा सो सम्बन्धि सेवामा सहभागिताको लागि तपाईंलाई प्रोत्साहन वा निरुत्साहित गर्ने चिजहरू के के हुन् कृपया बताउनुहोस् ।
- 8 मातृस्वास्थ्य, गर्भवति सेवा, सुत्केरि सेवा, खोप वा सो सम्बन्धि सेवामा तपाईंको सहभागिताले के प्रभाव पार्दछ कृपया बताउनुहोस् ।

अनुसुचि 1-2

नेपालको प्राथमिक स्वास्थ्य सेवामा बिभिन्न स्वास्थ्य प्रणालीसंग सम्बन्धित ब्यक्ति र संस्थाहरूको सहभागिता

गैहसरकारी संस्थाका कर्मचारिहरू वा पदाधिकारिहरू संगको अन्तर्बाताको लागि प्रश्नवली

- 1 यस गाविसमा औपचारिक तथा अनौपचारिक तवरले स्वास्थ्य सेवा प्रदान गर्ने सेवा प्रदायकहरू को को छन् कृपया बताउनुहोस् । साथै यस क्षेत्रमा स्वास्थ्यमा कसको प्रभाव बढि छ बताउनुहोस् ।
- 2 यस गाविसमा उपलब्ध मातृस्वास्थ्य, गर्भवति सेवा, सुत्केरि सेवा, खोप वा सो सम्बन्धि कुनै सेवाको बारेमा बताउनुहोस् । साथै तपाईं यसमा प्रत्येक्ष सहभागि हुनुहुन्छ भने तपाईंले सबै भन्दा पछिल्लो पटक सहभागि हुनुभएको केस को बारेमा बताउनुहोस् ।
- 3 आमा तथा बच्चाको स्वास्थ्य सम्बन्धमा खासगरी यस गाविसमा तपाईंको भुमिकाको बारेमा बताउनुहोस् ।
- 4 कृपया बिभिन्न सेवा प्रदायकहरू, सेवाग्राहीरू, सो सम्बन्धि चासो राख्ने ब्यक्तिहरू तथा संघ संस्थाहरूसंगको तपाईंको सम्बन्धको बारेमा बताउनुहोस् (खासगरी मातृस्वास्थ्य, गर्भवति सेवा, सुत्केरि सेवा, खोप वा सो सम्बन्धि) ।
- 5 यदि मातृस्वास्थ्य, गर्भवति सेवा, सुत्केरि सेवा, खोप वा सो सम्बन्धि सेवामा आवश्यकता पहिचान, नेतृत्व,संगठन,स्रोत परिचालन र व्यवस्थापनमा तपाईंको सहभागितालाई १ देखि 5 सम्म (1 कम सहभागिता, 5 सकृय सहभागिता) अंक दिनु पर्यो भने तपाईं कुन प्रकृत्यालाई कति अंक दिनुहुन्छ, कृपया बताउनुहोस् ?
- 6 तपाईंले आफुलाई यी बिभिन्न स्तरहरूमा किन राख्नुभयो कृपया बताउनुहोस् । किन फरक फरक प्रकृत्यामा फरक वा उस्तै?
- 7 मातृस्वास्थ्य, गर्भवति सेवा, सुत्केरि सेवा, खोप वा सो सम्बन्धि सेवामा सहभागिताको लागि तपाईंलाई प्रोत्साहन वा निरुत्साहित गर्ने चिजहरू के के हुन् कृपया बताउनुहोस् ।
- 8 मातृस्वास्थ्य, गर्भवति सेवा, सुत्केरि सेवा, खोप वा सो सम्बन्धि सेवामा तपाईंको सहभागिताले के प्रभाव पार्दछ कृपया बताउनुहोस् ।

अनुसुचि 1-3

नेपालको प्राथमिक स्वास्थ्य सेवामा बिभिन्न स्वास्थ्य प्रणालीसंग सम्बन्धित ब्यक्ति र संस्थाहरूको सहभागिता

स्थानिय अगुवा तथा स्थानिय राजनैतिक पार्टिका नेताहरूसंगको अन्तर्बाताको लागि प्रश्नवली

- 1 यस क्षेत्रमा स्वास्थ्य सेवा प्रदान गर्ने सेवा प्रदायकहरू को को छन् कृपया बताउनुहोस् । साथै यस क्षेत्रमा स्वास्थ्यमा कसको प्रभाव बढि छ बताउनुहोस् ।
- 2 कृपया यस क्षेत्रमा उपलब्ध मातृस्वास्थ्य, गर्भवति सेवा, सुत्केरि सेवा, खोप वा सो सम्बन्धि सेवाहरू सम्बन्धमा बताउनुहोस् ।
- 3 कृपया आमा तथा बच्चाको स्वास्थ्य सम्बन्धमा खासगरी यस क्षेत्रमा तपाईंको भुमिकाको बारेमा बताउनुहोस् ।
- 4 कृपया बिभिन्न सेवा प्रदायकहरू, सेवाग्राहीरू, सो सम्बन्धि चासो राख्ने ब्यक्तिहरू तथा संघ संस्थाहरूसंगको तपाईंको सम्बन्धको बारेमा बताउनुहोस् (खासगरी मातृस्वास्थ्य, गर्भवति सेवा, सुत्केरि सेवा, खोप वा सो सम्बन्धि) ।
- 5 यदि मातृस्वास्थ्य, गर्भवति सेवा, सुत्केरि सेवा, खोप वा सो सम्बन्धि सेवामा आवस्यकता पहिचान, नेतृत्व, संगठन, स्रोत परिचालन र व्यवस्थापनमा तपाईंको सहभागितालाई १ देखि 5 सम्म (1 कम सहभागिता, 5 सकृय सहभागिता) अंक दिनु पर्यो भने तपाईं कुन प्रकृत्यालाई कति अंक दिनुहुन्छ, कृपया बताउनुहोस् ?
- 6 तपाईंले आफुलाई यी बिभिन्न स्तरहरूमा किन राख्नुभयो कृपया बताउनुहोस् । किन फरक फरक प्रकृत्यामा फरक वा उस्तै?
- 7 मातृस्वास्थ्य, गर्भवति सेवा, सुत्केरि सेवा, खोप वा सो सम्बन्धि सेवामा कार्यक्रममा सहभागिताको लागि तपाईंलाई प्रोत्साहन वा निरुत्साहित गर्ने चिजहरू के के हुन् कृपया बताउनुहोस् ।
- 8 मातृस्वास्थ्य, गर्भवति सेवा, सुत्केरि सेवा, खोप वा सो सम्बन्धि सेवामा तपाईंको सहभागिताले के प्रभाव पार्दछ कृपया बताउनुहोस् ।

अनुसुचि 1-4

नेपालको प्राथमिक स्वास्थ्य सेवामा बिभिन्न स्वास्थ्य प्रणालीसंग सम्बन्धित ब्यक्ति र संस्थाहरूको सहभागिता

सर्वसाधारण नागरिकहरूसंगको अन्तर्बाताको लागि प्रश्नवली

- 1 तपाईंलाई कुनै पनि स्वास्थ्य सेवा आवश्यक परेमा कहाँ जानुहुन्छ, र को को संग सल्लाह लिनुहुन्छ, कृपया बताउनुहोस् ।
- 2 कृपया तपाईंको परिवारमा वा नातामा पछिल्लो पटक जन्मेको बच्चाको बारेमा बताउनुहोस् ।
- 3 कृपया तपाईं मातृस्वास्थ्य, गर्भवति सेवा, सुत्केरि सेवा, खोप वा सो सम्बन्धि सेवा कहाँबाट कसरी लिनुहुन्छ बताउनुहोस् ।
- 4 कृपया बिभिन्न सेवा प्रदायकहरू, सेवाग्राहीरू, सो सम्बन्धि चासो राख्ने ब्यक्तिहरू तथा संघ संस्थाहरूसंगको तपाईंको सम्बन्धको बारेमा बताउनुहोस् (खासगरी मातृस्वास्थ्य, गर्भवति सेवा, सुत्केरि सेवा, खोप वा सो सम्बन्धि) ।
- 5 यदि मातृस्वास्थ्य, गर्भवति सेवा, सुत्केरि सेवा, खोप वा सो सम्बन्धि सेवामा आवश्यकता पहिचान, नेतृत्व, संगठन, स्रोत परिचालन र व्यवस्थापनमा तपाईंको सहभागितालाई १ देखि 5 सम्म (1 कम सहभागिता, 5 सकृय सहभागिता) अंक दिनु पर्यो भने तपाईं कुन प्रकृत्यालाई कति अंक दिनुहुन्छ, कृपया बताउनुहोस् ?
- 6 तपाईंले आफुलाई यी बिभिन्न स्तरहरूमा किन राख्नुभयो कृपया बताउनुहोस् । किन फरक फरक प्रकृत्यामा फरक वा उस्तै?
- 7 मातृस्वास्थ्य, गर्भवति सेवा, सुत्केरि सेवा, खोप वा सो सम्बन्धि सेवामा सहभागिताको लागि तपाईंलाई प्रोत्साहन वा निरुत्साहित गर्ने चिजहरू के के हुन् कृपया बताउनुहोस् ।
- 8 मातृस्वास्थ्य, गर्भवति सेवा, सुत्केरि सेवा, खोप वा सो सम्बन्धि सेवामा तपाईंको सहभागिताले के प्रभाव पार्दछ कृपया बताउनुहोस् ।

अनुसुचि 1-5

नेपालको प्राथमिक स्वास्थ्य सेवामा बिभिन्न स्वास्थ्य प्रणालीसंग सम्बन्धित ब्यक्ति र संस्थाहरूको सहभागिता

अनौपचारिक स्वास्थ्यकर्मीहरूसंगको अन्तर्बाताको लागि प्रश्नवली

- 1 यस गाविसमा औपचारिक तथा अनौपचारिक तवरले स्वास्थ्य सेवा प्रदान गर्ने सेवा प्रदायकहरू को को छन् कृपया बताउनुहोस् ।
- 2 कृपया तपाईंले हालसालै पुर्याउनु भएको मातृस्वास्थ्य, गर्भवति सेवा, सुत्केरि सेवा, खोप वा सो सम्बन्धि कुनै सेवाको बारेमा बताउनुहोस् ।
- 3 आमा तथा बच्चाको स्वास्थ्य सम्बन्धमा खासगरी यस गाविसमा तपाईंको भुमिकाको बारेमा बताउनुहोस् ।
कृपया बिभिन्न सेवा प्रदायकहरू, सेवाग्राहीरू, सो सम्बन्धि चासो राख्ने ब्यक्तिहरू तथा संघ संस्थाहरूसंगको
- 4 तपाईंको सम्बन्धको बारेमा बताउनुहोस् (खासगरी मातृस्वास्थ्य, गर्भवति सेवा, सुत्केरि सेवा, खोप वा सो सम्बन्धि) ।
यदि मातृस्वास्थ्य, गर्भवति सेवा, सुत्केरि सेवा, खोप वा सो सम्बन्धि सेवामा आवश्यकता पहिचान, नेतृत्व, संगठन, स्रोत परिचालन र व्यवस्थापनमा तपाईंको सहभागितालाई १ देखि 5 सम्म (1 कम सहभागिता, 5 सकृय सहभागिता) अंक दिनु पर्यो भने तपाईं कुन प्रकृत्यालाई कति अंक दिनुहुन्छ, कृपया बताउनुहोस् ?
- 6 तपाईंले आफुलाई यी बिभिन्न स्तरहरूमा किन राख्नुभयो कृपया बताउनुहोस् । किन फरक फरक प्रकृत्यामा फरक वा उस्तै?
- 7 मातृस्वास्थ्य, गर्भवति सेवा, सुत्केरि सेवा, खोप वा सो सम्बन्धि सेवामा सहभागिताको लागि तपाईंलाई प्रोत्साहन वा निरुत्साहित गर्ने चिजहरू के के हुन् कृपया बताउनुहोस् ।
- 8 मातृस्वास्थ्य, गर्भवति सेवा, सुत्केरि सेवा, खोप वा सो सम्बन्धि सेवामा तपाईंको सहभागिताले के प्रभाव पार्दछ कृपया बताउनुहोस् ।

नेपालको प्राथमिक स्वास्थ्य सेवामा बिभिन्न स्वास्थ्य प्रणालीसंग सम्बन्धित ब्यक्ति र संस्थाहरूको सहभागिता

महिला स्वयंसेविकाहरूसंगको सामुहिक छलफलको लागि प्रश्नावली

- 1 यस गाबिसमा उपलब्ध स्वास्थ्यसेवा, सेवा प्रदायकहरू तथा सम्बन्धित ब्यक्ति तथा संघ संस्थाहरूको बारेमा छलफल गरौं ।
- 2 तपाईंहरू मातृस्वास्थ्य, गर्भवति सेवा, सुत्केरि सेवा, खोप वा सो सम्बन्धि सेवा भन्नाले के बुझ्नुहुन्छ छलफल गरौं ।
- 3 तपाईंहरू मातृस्वास्थ्य, गर्भवति सेवा, सुत्केरि सेवा, खोप वा सो सम्बन्धि सेवा कहाँबाट कसरी लिनुहुन्छ र कसरि यसमा संलग्न हुनुहुन्छ छलफल गरौं ।
- 4 कृपया तपाईंहरू बिभिन्न सेवा प्रदायकहरू, सेवाग्राहीरू, सो सम्बन्धि चासो राख्ने ब्यक्तिहरू तथा संघ संस्थाहरूसंग कसरि सम्बन्ध बनाउनुहुन्छ भन्ने बारेमा छलफल गरौं (खासगरी मातृस्वास्थ्य, गर्भवति सेवा, सुत्केरि सेवा, खोप वा सो सम्बन्धि) ।
- 5 मातृस्वास्थ्य, गर्भवति सेवा, सुत्केरि सेवा, खोप वा सो सम्बन्धि सेवामा सहभागि हुनको लागि तपाईंहरूलाई प्रोत्साहन वा निरुत्साहित गर्ने चिजहरू के के हुन् छलफल गरौं।
- 6 मातृस्वास्थ्य, गर्भवति सेवा, सुत्केरि सेवा, खोप वा सो सम्बन्धि सेवामा तपाईंहरूको सहभागिताले के प्रभाव पार्दछ छलफल गरौं ।

अनुसुचि 2-2

नेपालको प्राथमिक स्वास्थ्य सेवामा बिभिन्न स्वास्थ्य प्रणालीसंग सम्बन्धित ब्यक्ति र संस्थाहरूको सहभागिता

सर्वसाधारण नागरिकहरूसंगको सामुहिक छलफलको लागि प्रश्नावली

- 1 यस गाबिसमा उपलब्ध स्वास्थ्यसेवा, सेवा प्रदायकहरू तथा सम्बन्धित ब्यक्ति तथा संघ संस्थाहरूको बारमा छलफल गरौं ।
- 2 तपाईंहरू मातृस्वास्थ्य, गर्भवति सेवा, सुत्केरि सेवा, खोप वा सो सम्बन्धि सेवा भन्नाले के बुझ्नुहुन्छ छलफल गरौं ।
- 3 तपाईंहरू मातृस्वास्थ्य, गर्भवति सेवा, सुत्केरि सेवा, खोप वा सो सम्बन्धि सेवा कहाँबाट कसरी लिनुहुन्छ छलफल गरौं ।
- 4 कृपया तपाईंहरू बिभिन्न सेवा प्रदायकहरू, सेवाग्राहीरू, सो सम्बन्धि चासो राख्ने ब्यक्तिहरू तथा संघ संस्थाहरूसंग कसरी सम्बन्ध बनाउनुहुन्छ भन्ने बारेमा छलफल गरौं (खासगरी मातृस्वास्थ्य, गर्भवति सेवा, सुत्केरि सेवा, खोप वा सो सम्बन्धि) ।
- 5 मातृस्वास्थ्य, गर्भवति सेवा, सुत्केरि सेवा, खोप वा सो सम्बन्धि सेवामा वा कार्यक्रममा सहभागि हुनको लागि तपाईंहरूलाई प्रोत्साहन वा निरुत्साहित गर्ने चिजहरू के के हुन् छलफल गरौं।
- 6 मातृस्वास्थ्य, गर्भवति सेवा, सुत्केरि सेवा, खोप वा सो सम्बन्धि सेवामा तपाईंहरूको सहभागिताले के प्रभाव पार्दछ छलफल गरौं ।