प्रदेश लोक सेवा आयोग
कर्णाली प्रदेश
स्वास्थ्य सेवा, हेल्थ इन्सपेक्सन समूह, अधिकृतस्तर सातौं तह, जनस्वास्थ्य अधिकृत पदको खुला प्रतियोगितात्मक लिखित परीक्षा
(२०८१/०५/२२)

चरण : प्रथम — समय : ३ घण्टा
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सबै प्रश्नहरु अनिवार्य छन् । प्रत्येक खण्ड (**Section**) को उत्तर छुट्टाछुट्टै उत्तरपुस्तिकामा लेख्नुपर्नेछ अन्यथा उत्तरपुस्तिका रद्द हुनेछ ।

Section-(A)

1. What are the salient features of Karnali Province Health Policy, 2076? What other changes would you suggest for positive health reforms in Karnali Province? (5+5)

Answer:

Part 1: Salient Features of Karnali Province Health Policy, 2076 (5 Marks)

Introduction

The Karnali Province Health Policy, 2076 (2019) is the province's foundational health policy document, formulated in alignment with Nepal's Constitution, the National Health Policy 2076, and the federal structure. Its primary goal is to address the unique and significant health challenges of Karnali—a province known for its geographical remoteness, high levels of poverty, and health indicators that are often lower than the national average. The policy's vision is to ensure the "realization of the right to health of the people of Karnali province by ensuring quality health services" and to move towards "Healthy and Prosperous Karnali Citizens".

Salient Features

1. Commitment to Universal Health Coverage (UHC): The policy emphasizes improving access to and utilization of quality healthcare for all citizens, regardless of their economic or social status. This includes strengthening the Social Health Insurance program, which has particularly low enrollment in the province.
2. Strengthening Provincial and Local Health Systems: A core feature is the development of a robust, decentralized health system. This involves enhancing the capacity of the Ministry of Social Development (MoSD), the Health Service Directorate, and local-level health facilities to plan, manage, and execute health programs tailored to local needs.
3. Focus on Service Integration and Specialization: The policy identifies the need to move beyond basic services. A key example is its identification of rehabilitation as an essential health service. It

designates the Provincial Hospital in Surkhet as a referral center and promotes a strategy to integrate rehabilitation services into the Primary Health Care (PHC) level.

4. Health Workforce Development and Management: Recognizing the severe shortage and maldistribution of health workers, the policy prioritizes the development of a "skill-mixed" health workforce. This includes creating strategies for attracting, managing, and retaining staff in remote areas, as well as investing in local training institutions like the Karnali Academy of Health Sciences (KAHS).
5. Evidence-Based Planning: The policy underscores the importance of a strong Health Management Information System (HMIS) and the promotion of provincial health research. This is crucial for making data-driven decisions and allocating resources effectively in a challenging context.
6. Multi-sectoral Collaboration: The policy acknowledges that health is determined by many factors outside the health sector. It calls for strong collaboration with other sectors (e.g., education, WASH, transport, agriculture) to address the social determinants of health.

Part 2: Suggested Changes for Positive Health Reforms in Karnali (5 Marks)

Introduction

While the Karnali Health Policy 2076 provides a strong framework, its implementation is hindered by deep-seated challenges. To achieve positive health reforms, the province must adopt bold, innovative, and context-specific strategies that go beyond conventional approaches.

Suggested Reforms

1. Radical HRH Incentivization and Retention Model: The single greatest challenge is the lack of health workers.
    - Suggestion: Create a "Karnali-specific" incentive package that is *significantly* higher than federal incentives. This should include substantial financial bonuses, guaranteed fast-track promotions, and high-quality residential and educational (for children) facilities for staff serving in remote districts.
    - Suggestion: "Build and Retain" by massively investing in KAHS, with a legal "service bond" requiring graduates to serve within Karnali's public health system for a minimum of 3-5 years.
2. Technological Leapfrogging (Telemedicine & Digital Health): Given the geography, building hospitals everywhere is not feasible.
    - Suggestion: Establish a Provincial Telemedicine Hub at the Surkhet Provincial Hospital and KAHS. This hub would connect all remote Health Posts and Basic Health Service Centers (BHSCs) via robust satellite internet, providing specialist consultations (e.g., for radiology,

dermatology, and mental health) and virtual training for on-site (e.g., ANM, CMA) staff. This directly addresses the workforce shortage.

3. Specialized Logistics and Outreach: Standard logistics and outreach models fail in Karnali.
    - Suggestion: Develop a specialized "Air-Lift" Logistics and Emergency Team. This team would use helicopters (or drones for smaller packages) for the timely supply of essential

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medicines/vaccines to cut-off areas and for conducting emergency evacuations or "Aakash-e-Doctor" (Doctor from the Sky) specialized outreach camps.

4. Strengthening Governance and Coordination: Poor coordination between government tiers and delayed budgets are major bottlenecks.
   - Suggestion: Create a high-level "Provincial Health Reform Taskforce" with representatives from the MoSD, local-level mayors/chairs, and KAHS. This taskforce's sole mandate would be to identify and resolve inter-governmental bottlenecks (e.g., in procurement, fund release, and staff deployment) in real-time.
5. Targeted Public-Private Partnerships (PPPs):
   - Suggestion: Instead of focusing on traditional curative PPPs, the province should partner with private/non-profit organizations to manage non-clinical services, such as the entire supply chain, health infrastructure maintenance, or the telemedicine digital infrastructure, allowing the government to focus purely on service delivery and governance.

Conclusion

The Karnali Health Policy 2076 is a vital document, but its success hinges on its implementation. Standard reforms will yield standard (and insufficient) results. Karnali requires a radical, technology-driven, and human-resource-centric approach to overcome its formidable geographical and systemic barriers and truly realize its vision of health for all its citizens.

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2. What are the opportunities and challenges in implementing federalism in the Health System of Nepal? (10)

Answer:

Introduction

Federalism in Nepal, institutionalized by the 2015 Constitution, fundamentally restructured the state, transitioning the health system from a centralized, unitary model to a three-tier governance system (Federal, Provincial, and Local). This reform devolved significant power, resources, and responsibilities, creating a landscape of both unprecedented opportunities and formidable challenges for achieving Universal Health Coverage (UHC) and the Sustainable Development Goals (SDGs).

Opportunities of Health Federalism

1. Local Accountability and Ownership: Local governments (753 Palikas) are now primarily responsible for basic health service delivery. This proximity brings decision-making closer to the people, theoretically making health workers and elected officials more accountable to community needs.
2. Context-Specific Planning and Policy: Provinces and local levels can develop policies and plans tailored to their specific epidemiological, geographical, and cultural contexts. For example, a municipality in the Terai can prioritize dengue control, while a Himalayan municipality can focus on mobile clinics and birthing center equipment.

3. Resource Mobilization and Flexibility: Local governments have constitutional authority to allocate their own budgets for health, mobilize local resources, and hire required health staff on contract. This flexibility allows for rapid responses to local issues, such as hiring extra staff during an outbreak.
4. Strengthened Primary Health Care (PHC): The new structure mandates the establishment of Basic Health Service Centers (BHSCs) in every ward, expanding the PHC network to improve access to essential services and fulfill the constitutional "right to health".
5. Innovation in Service Delivery: Federalism creates "laboratories of democracy" where provinces and palikas can pilot new health models. This was evident during the COVID-19 pandemic, where local governments led on-the-ground responses, set up quarantines, and conducted contact tracing.

Challenges of Health Federalism

1. Poor Inter-governmental Coordination: This is a paramount challenge. Conflicting policies, unclear roles, and weak communication channels between the three tiers of government lead to duplication of efforts, gaps in service, and confusion.
2. Human Resource for Health (HRH) Management: The federal transition has exacerbated HRH issues. These include:
    - Maldistribution: A severe shortage of skilled staff (doctors, specialists, PHOs) in remote provinces and palikas, with an over-concentration in urban centers.
    - Staff Adjustment (Samayojan): Lingering issues from the initial staff adjustment process, low morale, and resistance from staff to be posted to peripheral areas.
    - Retention: High turnover and "brain drain" due to a lack of incentives, poor living conditions, and unclear career paths.
3. Capacity Gaps (Technical and Managerial): Many newly elected local officials and administrative staff lack the technical capacity for health sector planning, budgeting, procurement, and monitoring. This hinders their ability to effectively manage the devolved health functions.
4. Health Financing and Procurement: While budgets are devolved, local levels face significant challenges. These include delayed release of funds from the federal level, insufficient conditional grants, and difficulties navigating the complex Public Procurement Act, 2063, leading to delays in purchasing essential medicines and equipment.
5. Quality Assurance and Regulation: With 753 local governments and 7 provinces, ensuring a uniform national standard of care, regulating the private sector, and maintaining the quality of data in information systems (HMIS/LMIS) is incredibly complex.

Conclusion

Federalism has successfully brought health governance closer to the people, creating immense opportunities for a more responsive and equitable system. However, realizing this potential is contingent on resolving the critical challenges of inter-governmental coordination, HRH maldistribution, and the technical capacity of sub-national governments. A long-term commitment to strengthening these areas is essential for the success of Nepal's health system reform.

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3. a) Based on the Local Government Operation Act, 2074 what are the health related responsibilities of local government? (5)

Answer:

Introduction

The Local Government Operation Act, 2074 (2017) is the primary legal framework that details the functions, duties, and powers of Nepal's 753 local governments (Rural Municipalities and Municipalities). It operationalizes the constitutional mandate of federalism, assigning 22 specific functions to local levels, including a comprehensive set of responsibilities for managing basic health services.

Health-Related Responsibilities of Local Government (as per LGOA, 2074)

The Act outlines the following key health responsibilities for local governments:

1. Basic Health Service Delivery: Planning, operation, management, and monitoring of all basic health services, including Primary Health Care Centers (PHCCs) and Health Posts (HPs) (now often referred to as Basic Health Service Centers - BHSCs).
2. Infrastructure Development: Construction, management, and maintenance of local-level health institutions (e.g., BHSCs).
3. Preventive, Promotive, and Curative Services:
    - Immunization & Nutrition: Conducting national immunization programs and nutrition programs (e.g., Vitamin A, deworming, malnutrition management).
    - Maternal & Child Health: Running programs for safe motherhood, neonatal and child health (e.g., CB-IMNCI).
    - Family Planning: Management of family planning and reproductive health services.
4. Health Promotion and Awareness: Conducting health education, information, and communication (IEC) campaigns, and sanitation and hygiene (WASH) programs.
5. Human Resource Management: Management (including recruitment on contract and deployment) of health personnel at the local level health facilities.
6. Supply Chain Management: Ensuring the procurement, storage, and distribution of essential medicines, equipment, and logistics at the local level.
7. Data Management and Reporting: Collection, management, and reporting of health information (HMIS/LMIS) to district/provincial/federal levels.
8. Program Management: Implementation and management of national health programs related to communicable diseases (e.g., TB, HIV, vector-borne diseases) and basic management of non-communicable diseases.
9. FCHV Program Management: Managing and mobilizing Female Community Health Volunteers (FCHVs) and other local health volunteers.
10. Regulation and Monitoring: Monitoring and regulation of private health facilities (within their jurisdiction), and ensuring quality control in local health services.

Conclusion

The LGOA, 2074, effectively makes the local government the primary steward and provider of basic health care in Nepal. It empowers them with the legal authority to manage nearly all aspects of the local health system, from building infrastructure to managing personnel and delivering services.

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3. b) What are the provisions for punishment and appeal for a government employee? (5)

Answer:

Introduction

Provisions for punishment and appeal for government employees in Nepal are primarily governed by the Civil Service Act, 2049 (Nijamati Sewa Ain) and the Civil Service Regulations, 2050 (Nijamati Sewa Niyamawali). These legal documents establish a disciplinary framework to maintain good conduct, integrity, and efficiency in the civil service, while also providing a mechanism for employees to appeal against perceived injustices.

Provisions for Punishment (Disciplinary Actions)

The Act defines two main categories of punishment:

1. Minor Punishments (Samaanya Sajaya):

These are imposed for minor misconduct, such as negligence, non-compliance with orders, or repeated delays.

- Warning (Nasihat Dine): A formal written warning.
- Withholding of Promotion (Baduwa Rokka): Withholding a promotion for a period of one to five years.
- Withholding of Salary Increment (Talab Briddhi Rokka): Withholding grade (salary) increments for a period of one to five years.

2. Major Punishments (Bishes Sajaya):

These are imposed for serious misconduct, such as corruption, gross violation of conduct, continuous unauthorized absence, or conviction for a criminal offense involving moral turpitude.

- Demotion (Ghatam-Baduwa): Demotion to a lower position, lower time-scale, or lower grade.
- Dismissal from Service (Bhakhasst): Removal from the position. This is further divided into:
    - Removal from Service (Sewa bata Hataune): Dismissal that does not disqualify the employee from future government employment.
    - Dismissal from Service (Sewa bata Barkhasta): Dismissal that *disqualifies* the employee from holding any future government position. This is the most severe punishment.

Procedure: Before imposing any punishment, the employee must be given a chance to clarify (Spashtikaran). They must be provided with a written explanation of the charges against them and a reasonable timeframe to submit their defense.

Provisions for Appeal (Punarabedan)

An employee who is not satisfied with the punishment imposed by the authorities has the right to appeal.

1. Appellate Authority: The appeal is typically made to the authority one level higher than the one that issued the punishment.
2. Administrative Court: For major punishments (like removal or dismissal) imposed by higher authorities (e.g., a Secretary), the employee has the right to appeal to the Administrative Court (Prashasakiyya Adalat).
3. Timeframe: The appeal must be filed within a specific timeframe (usually 35 days) from the date of receiving the punishment order.

Conclusion

The disciplinary framework in Nepal's civil service is designed to balance accountability with employee rights. It provides a structured process for imposing penalties based on the severity of the offense while ensuring the principle of natural justice by granting the employee the right to defend themselves and appeal the decision.

Section-(B)

1. Why FCHV program has been a major success in Nepal? Discuss the major changes made in FCHV program over the last few years. (5+5)

Answer:

Part 1: Reasons for the Success of the FCHV Program in Nepal (5 Marks)

Introduction

The Female Community Health Volunteer (FCHV) program, established in 1988, is widely recognized as one of the cornerstones of Nepal's public health success. This volunteer-based program has been instrumental in extending basic health services to the "last mile," especially in remote and rural communities, and has significantly contributed to the nation's remarkable improvements in maternal and child health indicators.

Key Reasons for Success

1. Community-Based and Embedded: FCHVs are selected from *within* their own communities. This ensures they are trusted, culturally accepted, and have a deep understanding of local social dynamics, norms, and health issues.
2. Bridge to the Health System: FCHVs act as the critical link between the formal health system (Health Posts/BHSCs) and individual households. They motivate families to use facility-based services (e.g., ANC, institutional delivery, immunization) while also providing basic services at the doorstep.
3. Effective Service Delivery Model: The program has been highly effective in rolling out high-impact, low-cost interventions. Key examples include:
    - Vitamin A & Deworming: FCHV-led distribution of Vitamin A capsules and deworming tablets, achieving consistently high coverage.

- CB-IMNCI: Distributing essential child health commodities like zinc and oral rehydration salts (ORS) for diarrhea management, and identifying danger signs.
- Family Planning: Community-based distribution of condoms and counseling.

4. Volunteerism and Motivation: The spirit of volunteerism, combined with social recognition and non-financial incentives (e.g., FCHV Fund, free healthcare access at local facilities, celebration of FCHV Day), has sustained the program's motivation and low attrition rate for decades.
5. Adaptability and Expansion: The FCHV network has proven to be incredibly adaptable. It has successfully integrated new programs over time, from MCH and immunization to NCDs (screening for hypertension) and responding to emergencies like the 2015 earthquake and the COVID-19 pandemic (contact tracing, awareness).

Part 2: Major Changes in the FCHV Program Over the Last Few Years (5 Marks)

Introduction

In recent years, especially post-federalism and with an evolving epidemiological landscape, the FCHV program is undergoing significant changes. These changes aim to adapt the program to new health challenges, a decentralized governance structure, and the changing socio-economic status of the volunteers themselves.

Major Recent Changes

1. Governance and Management in Federalism: The biggest change has been structural. Under the Local Government Operation Act, 2074, the responsibility for managing, mobilizing, and supporting the FCHV program has been devolved from the central government to the local governments (palikas). Palikas are now responsible for FCHV record-keeping, providing incentives, and integrating them into local health plans.
2. Shift from MCH to NCDs: While MCH remains a core function, the program is increasingly being used to tackle the rising burden of Non-Communicable Diseases (NCDs). Many palikas have trained FCHVs to conduct basic screening for hypertension (blood pressure measurement) and diabetes (blood sugar testing) at the community level and refer suspected cases to health facilities.
3. Technological Integration (mHealth): There is a growing trend of equipping FCHVs with mobile technology. This includes using dedicated apps for:
    - Reporting: Replacing paper-based records with real-time digital reporting (e.g., for MCH or immunization tracking).
    - Decision Support: Using mobile health (mHealth) tools to guide them through counseling protocols (e.g., for ANC/PNC) or danger sign identification.
4. Enhanced Incentives and "Retirement" Packages: Recognizing the long service of many volunteers and the need to attract new ones, there is a shift from purely non-financial incentives.
    - Federal Level: The federal government has established an "FCHV Retirement Fund" providing a one-time gratitude payment (e.g., NPR 20,000) for volunteers who retire.

  - Local Level: Many palikas are providing additional monthly financial incentives, travel allowances, and improved health and social security benefits, moving towards a "quasi-paid" model in some areas.

5. Strengthened Role in Emergency Response: The COVID-19 pandemic firmly established the FCHV network as a critical part of the public health security infrastructure. Their roles were formalized in contact tracing, community surveillance, promoting vaccination, and disseminating risk communication, a change from their ad-hoc role in past emergencies.

Conclusion

The FCHV program is evolving from a purely MCH-focused volunteer network to a more professional, multi-skilled, and digitally-enabled community health workforce. Its successful adaptation to federalism and new health threats like NCDs will be crucial for sustaining Nepal's public health gains.

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2. What are the common mental health issues in Nepal? Explain, how Psycho-social support can prevent distress and suffering from turning into more severe mental problem. What system will help in providing mental health services? (3+3+4)

Answer:

Part 1: Common Mental Health Issues in Nepal (3 Marks)

Introduction

Nepal faces a significant and growing burden of mental health issues, which are often under-recognized and under-treated due to stigma, a lack of services, and a severe shortage of specialists. These issues are exacerbated by poverty, social-political instability, and the high rate of labor migration.

Common Mental Health Issues

1. Depressive Disorders: Depression is one of the most common mental health problems, affecting a large portion of the population. It is often linked to economic hardship, social isolation, and chronic physical illness.
2. Anxiety Disorders: This includes Generalized Anxiety Disorder (GAD), panic disorder, and phobias. These are highly prevalent, particularly in the context of uncertainty and stress.
3. Alcohol Use Disorder: Due to cultural norms and stress, alcohol abuse and dependence are major public health problems, particularly among males, leading to other health and social problems.
4. Suicide: Nepal has an alarmingly high suicide rate, especially among women of reproductive age. It is a leading cause of death in this demographic, highlighting a crisis in mental health and psychosocial support.
5. Post-Traumatic Stress Disorder (PTSD): The decade-long armed conflict, recurrent natural disasters (like the 2015 earthquake), and other traumatic events have left a significant portion of the population with PTSD.
6. Psychotic Disorders (e.g., Schizophrenia): While less common, these severe mental illnesses place a heavy burden on families due to a near-total lack of community-based care and support.

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Part 2: How Psycho-social Support Prevents Severe Mental Problems (3 Marks)

Introduction

Psycho-social support (PSS) refers to actions that address both psychological and social needs of individuals and communities. It is a non-specialist approach that aims to build resilience and help people cope with adversity. PSS acts as a critical "first-line" defense, preventing initial distress from escalating into more severe, chronic, or clinical mental health disorders.

Mechanisms of Prevention

1. Normalizes Distress and Reduces Stigma: PSS, often delivered by trained counselors or community workers, helps individuals understand that their feelings of stress, anxiety, or sadness are a *normal reaction* to an *abnormal situation* (e.s., a disaster, a death). This validation reduces self-stigma and encourages help-seeking.
2. Provides "Psychological First Aid" (PFA): In acute situations (e.g., after a disaster), PSS provides a humane, supportive, and practical response. This involves active listening, providing comfort, helping people meet their basic needs, and protecting them from further harm. This immediate stabilization prevents the consolidation of traumatic stress.
3. Strengthens Coping Mechanisms: PSS teaches practical coping strategies (e.g., relaxation techniques, problem-solving skills) and helps individuals identify and activate their existing support networks (family, friends, community groups). This builds resilience, allowing them to manage their distress without resorting to negative coping mechanisms like alcohol use.
4. Links to Services: A key function of PSS is to identify individuals whose distress is not resolving (the "red flags") and refer them to more specialized mental health services (e.g., clinical psychologists, psychiatrists) before their condition becomes severe and entrenched.

Part 3: System for Providing Mental Health Services (4 Marks)

Introduction

To address Nepal's mental health gap, a multi-layered, decentralized system is required, as outlined in Nepal's National Mental Health Strategy and Action Plan (2020). This system must move beyond the current model (which is heavily centralized in urban hospitals) and integrate mental health into all levels of the health system.

A Multi-Layered System

1. Policy and Governance (Federal Level): The Ministry of Health and Population (MoHP) is responsible for:
    - Developing national policies, strategies, and standards (e.g., the National Mental Health Strategy).
    - Allocating budgets for mental health.
    - Procuring and supplying essential psychotropic medicines.

- Managing central-level psychiatric hospitals (e.g., Mental Hospital, Lagankhel).

2. Specialized Care (Provincial Level):
   - Provincial and former regional hospitals should serve as specialized referral centers.
   - These hospitals should have dedicated psychiatric inpatient units and specialist outpatient clinics (OPDs) staffed with psychiatrists, clinical psychologists, and psychiatric nurses.
   - They would also serve as a hub for training and supervising lower-level health workers.
3. Integrated Service Delivery (Local Level - Palika): This is the most critical part of the system.
   - Integration into PHC: Mental health services must be integrated into all Primary Health Care Centers (PHCCs) and Health Posts. This involves training general health workers (doctors, HAs, ANMs) to identify, manage, and treat common mental disorders (like depression and anxiety) using WHO's Mental Health Gap Action Programme (mhGAP) protocols.
   - Referral System: A clear referral pathway must exist, allowing PHC workers to refer complex cases to the provincial hospital while managing common cases locally.
4. Community-Based Support (Ward Level):
   - Psycho-social Support: Trained Psychosocial Counselors should be deployed at the Palika or PHC level to provide PSS and counseling.
   - FCHV Role: FCHVs can be trained to identify signs of severe mental distress, provide basic emotional support, destigmatize mental illness in the community, and encourage families to seek care.
   - Community Mental Health Centers: Establishment of community-based day-care centers and rehabilitation programs for people with severe and chronic mental illness.

Conclusion

An effective mental health system for Nepal is not just about building more psychiatric hospitals. It is about a stepped-care model that integrates mental health into PHC, utilizes non-specialist workers for psycho-social support, and leverages the new federal structure to build a robust, decentralized, and stigma-free service network.

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3. What are the health effects of natural disasters? Discuss the important measures to be taken in community and province level for disaster preparedness. (3+4+3)

Answer:

Part 1: Health Effects of Natural Disasters (3 Marks)

Introduction

Natural disasters, such as earthquakes, floods, landslides, and epidemics, have devastating and multi-faceted impacts on public health. These effects are not limited to the immediate trauma but extend to long-term physical, mental, and social consequences that can cripple a health system.

Key Health Effects

1. Immediate Mortality and Morbidity:
   - Deaths and Injuries: The most direct effect is mass casualties from the event itself (e.g., trauma, fractures, and crush injuries from an earthquake; drowning from a flood).
   - Exacerbation of Chronic Illness: Interruption of care and lack of access to medication (e.g., for diabetes, hypertension, renal failure) leads to acute complications and death.
2. Increased Risk of Communicable Diseases:
   - Water-borne Diseases: Destruction of sanitation systems (toilets) and contamination of water sources leads to outbreaks of cholera, typhoid, dysentery, and hepatitis.
   - Vector-borne Diseases: Stagnant water after floods creates breeding grounds for mosquitoes, increasing the risk of malaria and dengue fever.
   - Crowding-related Diseases: Displacement of populations into temporary shelters with poor ventilation leads to the rapid spread of acute respiratory infections (ARI) and measles.
3. Mental and Psycho-social Impacts:
   - Disasters cause widespread Post-Traumatic Stress Disorder (PTSD), anxiety, and depression due to loss of life, livelihood, and homes.
4. Damage to Health Infrastructure and Disruption of Services:
   - Hospitals and health posts are often damaged or destroyed, rendering them non-functional.
   - This leads to the complete breakdown of routine services like immunization, maternal and child health (MCH), and family planning, often resulting in secondary increases in maternal and child mortality.
5. Malnutrition: Destruction of crops, food stocks, and livelihoods leads to food insecurity and a subsequent increase in acute malnutrition, especially among children and pregnant women.

Part 2: Disaster Preparedness Measures at the Community Level (4 Marks)

Introduction

At the community level, disaster preparedness focuses on building local resilience, ensuring that communities can respond effectively in the critical first hours of a disaster *before* external help arrives.

Important Measures

1. Formation and Training of Community-Level Task Forces:
   - Form a Community Disaster Management Committee (CDMC) at the ward level, including local leaders, FCHVs, teachers, and youth.
   - Train this team in First Aid, Light Search and Rescue, and Psychological First Aid (PFA).
2. Vulnerability and Resource Mapping:

- The community should conduct a Hazard, Vulnerability, and Capacity Assessment (HVCA).
- This involves identifying high-risk areas (e.g., landslide-prone slopes), vulnerable households (e.g., elderly, disabled), and local resources (e.g., safe open spaces, health workers, available tools).

3. Community-Based Early Warning System (EWS):
    - Establish simple, locally understood warning systems (e.g., sirens, flags, megaphones) for floods or landslides, and train everyone on what to do when the warning is given.
4. Stockpiling and Resource Management:
    - Encourage households to prepare "Go-Bags" with essential items (water, dry food, first aid, documents).
    - Establish a community-managed stockpile of essential supplies like ORS, chlorine tablets, first aid kits, ropes, and tarpaulins at a safe location (e.g., a school or health post).
5. Awareness and Drills:
    - Conduct regular awareness programs on local hazards.
    - Organize simple evacuation drills (e.g., "drop, cover, hold on" for earthquakes; moving to high ground for floods) to practice and refine the community response plan.

Part 3: Disaster Preparedness Measures at the Province Level (3 Marks)

Introduction

The provincial level acts as the main coordination and resource hub. Its role is to support and coordinate the local-level response, manage large-scale resources, and handle complex medical and logistical needs that are beyond the capacity of individual communities.

Important Measures

1. Provincial Health Emergency Operation Center (PHEOC):
    - Establish and maintain a fully functional PHEOC at the Ministry of Social Development (MoSD).
    - This center must have redundant communication systems (satellite phones, high-frequency radio) and trained staff to act as the 24/7 "command center" for health response, coordinating all data and resources.
2. Resource Stockpiling and Logistics Management:
    - Maintain a large provincial-level stockpile of essential medical supplies, medicines, tents, and equipment in a secure warehouse (e.g., the Provincial Medical Store).
    - Develop a clear logistics plan for rapidly deploying these resources to affected districts and palikas.
3. Specialized Team and Hospital Preparedness:

- Develop and train a Rapid Response Team (RRT) at the provincial level, consisting of public health experts, epidemiologists, and clinicians, ready for immediate deployment.
- Designate provincial and hub hospitals as referral centers for mass casualties, ensure their own structural safety (seismic retrofitting), and test their "Mass Casualty Incident (MCI)" plans regularly.

4. Coordination and Planning:
    - Develop and update the Provincial Health Sector Disaster Preparedness and Response Plan.
    - This plan must clarify the roles and responsibilities of all stakeholders: MoSD, Health Directorate, palikas, security forces (Nepal Army, Police), and I/NGO partners, ensuring a coordinated, not chaotic, response.

Conclusion

Disaster preparedness in a federal context requires a "whole of society" approach. Communities must be empowered as first responders, while the province provides the critical technical, logistical, and specialized support to manage the large-Fscale health consequences.

Section-(C)

1. What are the health education information and communication activities run by Karnali Province and local level describe and how to improve effectively? (5+5)

Answer:

Part 1: Health Education, Information, and Communication (HEICC) Activities in Karnali (5 Marks)

Introduction

Health Education, Information, and Communication (HEICC) activities are a cornerstone of public health, aimed at promoting healthy behaviors, increasing health literacy, and driving demand for health services. In a province like Karnali, with its challenging geography and socio-cultural context, these activities are run by both the provincial government (Ministry of Social Development/Health Directorate) and local governments (Palikas), often in coordination.

HEICC Activities

1. Broadcast Media (Provincial Level):
    - Radio Programs: This is the most effective medium in Karnali. The provincial government and partners sponsor and broadcast radio jingles and programs (e.g., *Swasthya Chautari*) on local FM stations. These cover topics like immunization, safe motherhood, nutrition, and sanitation.
    - Television: Limited use of TV spots on provincial or local cable networks, especially for major campaigns like vaccination or dengue control.
2. Print Media and Materials (Provincial and Local Level):

- IEC Materials: The province is typically responsible for the design, procurement, and supply of standardized IEC materials (posters, pamphlets, flipcharts) to health facilities.
- Local Level Distribution: Local governments (Palikas) and health facilities are responsible for distributing these materials to community gathering spots, schools, and during clinics.

3. Community-Level Interpersonal Communication (IPC) (Local Level):
    - FCHV Mobilization: This is the most critical HEICC activity. FCHVs conduct household visits and mothers' group meetings to counsel pregnant women, new mothers, and families on key health behaviors (ANC, delivery, nutrition, hygiene).
    - Health Worker Counseling: Health workers at BHSCs and HPs provide one-on-one counseling to patients during clinic visits (e.g., at immunization clinics, ANC check-ups, or family planning consultations).
4. Campaigns and "Days" (Joint Effort):
    - National Campaigns: Both province and local levels cooperate to run HEICC activities for national campaigns like the National Immunization Program (NIP), Vitamin A (Susthara) Program, and Family Planning Day.
    - Outbreak Response: During outbreaks (e.g., cholera, COVID-19), coordinated "miking" (using loudspeakers) in jeeps and community announcements are heavily used.
5. School Health Programs (Local Level):
    - Local governments coordinate with schools to conduct health education sessions on topics like handwashing, menstrual hygiene, and nutrition, often using school nurses or health workers.

Part 2: Strategies for Effective Improvement (5 Marks)

Introduction

While HEICC activities are ongoing, their effectiveness in Karnali is often hampered by the difficult terrain, low literacy rates, diverse languages, and a reliance on traditional (and sometimes passive) methods. A more strategic, targeted, and modern approach is needed.

Strategies for Improvement

1. Embrace Digital and Mobile Technology (mHealth):
    - Given the high mobile phone penetration (even if it's basic "feature" phones), mass SMS/voice messaging in local dialects can be used for public health alerts, reminders (e.g., for immunization), and key messages.
    - Utilize social media platforms (like Facebook and TikTok), which are increasingly popular even in rural areas, for targeted health promotion campaigns aimed at youth.
2. Strengthen Inter-Personal Communication (IPC) Skills:
    - Move beyond simple "message-giving." Train FCHVs and health workers in behavioral change communication (BCC) and empathetic counseling skills. This involves teaching them

to *listen* to community concerns and *co-develop* solutions, rather than just "telling" people what to do.

3. Contextualize and Localize Content:
    - Standard federal-level IEC materials are often not effective. The province and local levels must co-develop materials that reflect local culture, use local languages/dialects (e.g., Khas), and feature relatable images.
    - "Edutainment" (Entertainment-Education): Use local art forms like *Deuda* songs, street theatre (*Kachahari*), and storytelling to convey health messages in an engaging and culturally resonant way.
4. Targeted, Audience-Segmented Communication:
    - Stop using a "one-size-fits-all" approach. Develop specific communication strategies for different audiences.
    - Example: A different message and channel is needed for a new mother (via FCHV), an adolescent girl (via school or social media), and an elderly man (via radio or a male community group).
5. Multi-Sectoral and Community-Leader Engagement:
    - HEICC is not just a health sector job. Engage other sectors:
        - Education: Formally integrate practical health education into the school curriculum.
        - Community Leaders: Actively involve and orient local political leaders, religious leaders (*Dhami/Jhankri*), and teachers, as their endorsement is critical for changing social norms (e.g., ending *Chhaupadi*, promoting institutional delivery).

Conclusion

To make HEICC effective in Karnali, the approach must shift from passively "distributing" information to actively "engaging" communities. This requires investing in modern technology, building local communication capacity, and respecting local culture, all led and coordinated by the local and provincial governments.

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2. What health related training programs are being carried out in Karnali Province? What gaps are still observed? Make out a plan to fill the gaps. (3+3+4)

Answer:

Part 1: Health-Related Training Programs in Karnali Province (3 Marks)

Introduction

Health-related training programs in Karnali Province are essential for building the capacity of the health workforce to deliver quality services. These trainings are typically a mix of national programs (cascaded down from the federal level) and provincially-initiated programs, managed by the Provincial Health Directorate and/a

or the Provincial Health Training Center (PHTC).

Common Training Programs

1. Maternal and Child Health (MCH) Trainings:
    - CB-IMNCI/IMCI: Community-Based Integrated Management of Newborn and Childhood Illness (for FCHVs/HAs) and Integrated Management of Childhood Illness (for clinicians).
    - Skilled Birth Attendant (SBA): A long-term, intensive training for nurses and ANMs to manage normal deliveries and identify complications.
    - Basic Emergency Obstetric and Newborn Care (BEONC): Training for health workers at PHCCs to manage common obstetric complications.
2. Disease-Specific Programmatic Trainings:
    - Tuberculosis: Trainings on Direct Observed Treatment, Short-course (DOTS), and management of TB (including MDR-TB) for health workers.
    - Immunization: Trainings for health workers (VHWs/MCHWs) on vaccine management, cold chain, and the National Immunization Program (NIP) schedule.
3. Public Health and Management Trainings:
    - HMIS/LMIS: Trainings on the Health Management Information System (HMIS) and Logistics Management Information System (LMIS) to improve data reporting and commodity management.
    - Micro-planning: Trainings for local-level health managers on how to plan and budget for local health programs (e.g., for immunization or outreach clinics).
4. New and Emerging Area Trainings:
    - mhGAP: The Mental Health Gap Action Programme (mhGAP) training to enable PHC workers to manage common mental health issues.
    - Basic Life Support (BLS) and Infection Prevention and Control (IPC), which became prominent during the COVID-19 pandemic.

Part 2: Observed Gaps in Training (3 Marks)

Introduction

Despite these efforts, the training system in Karnali faces significant gaps that hinder its impact, often stemming from resource constraints, geography, and systemic weaknesses.

Observed Gaps

1. "Training for Training's Sake" vs. Needs-Based: Trainings are often supply-driven (i.e., a national program dictates a training) rather than based on a Training Needs Assessment (TNA) of the actual skill gaps at the health facility level.

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2. Lack of Post-Training Follow-up and Mentorship: This is a critical gap. Health workers are trained (e.g., in BEONC or SBA), but there is no system for on-site coaching, mentorship, or supportive supervision to ensure they are actually applying their new skills correctly and confidently.

3. High Staff Turnover and Mis-matching: The "revolving door" of staff in Karnali is a major problem. A health worker is trained, and then within months, they are transferred (or leave). The new person who replaces them is often untrained, and the trained person is posted where their new skills are not used.

4. Gaps in Non-Clinical and Management Skills: There is a heavy focus on clinical/programmatic training, but a significant gap in management and leadership skills for health post in-charges, municipal health coordinators, and hospital administrators. They are often not trained in financial management, procurement, human resource management, or planning.

Part 3: Plan to Fill the Gaps (4 Marks)

Introduction

A strategic plan to fill these training gaps must focus on creating a sustainable, systematic, and impactful training system, rather than just conducting more one-off workshops.

A 4-Point Plan to Fill the Gaps

1. Establish a Provincial Training Information System (PTIS):
   - Action: Develop a simple, digital database of all health workers in the province, tracking their posting, and *all* trainings they have completed.
   - Impact: This stops "re-training" the same person and allows for rational, data-driven selection. It helps managers identify *who* is untrained and *where* they are. This directly addresses the mismatch and turnover problem.
2. Implement a Post-Training Follow-up (PTF) and Mentorship Program:
   - Action: Mandate that no major clinical training (e.g., SBA, BEONC, IMCI) is "complete" without a 3-month post-training follow-up.
   - Mechanism: Use provincial hospital specialists, district health officers, and senior HAs to conduct on-site coaching visits (supportive supervision). This PTF component must be included in the training budget.
3. Develop a Core Curriculum for Health Managers:
   - Action: The Provincial Health Training Center (PHTC), in collaboration with KAHS, must design and roll out a mandatory "Health Management Package" for all health post in-charges and municipal health coordinators.
   - Content: This package must focus on the identified gaps: Public Procurement, HRH management (at local level), financial management (F-CITRA), and leadership & planning.
4. Strengthen In-House and On-Site Training (Decentralization):

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- Action: Instead of pulling staff out of remote HPs for long trainings in Surkhet, deploy mobile training teams (based out of PHTC or hub hospitals) to conduct on-site, short-duration, high-intensity trainings *at* the health facility.
- Impact: This is less disruptive, more cost-effective, and allows for training that is highly relevant to the facility's actual equipment and patient load. It also builds the capacity of hub hospitals (like the provincial hospital) as training centers.

Conclusion

The solution to Karnali's training gaps is not just *more* training, but *smarter* training. By building a system that tracks, mentors, and provides the right non-clinical skills, the province can maximize the return on its training investments and build a truly competent health workforce.

Section-(D)

1. a) Differentiate between supervision, monitoring and evaluation with examples. (5)

Answer:

Introduction

Supervision, monitoring, and evaluation (M&E) are three distinct but interrelated management functions that are essential for the successful implementation and improvement of any health program. While they all involve observing and assessing performance, they have different objectives, timing, and methodologies.

Differentiation

Feature	Supervision	Monitoring	Evaluation
Primary Purpose	To improve performance and develop staff skills through supportive guidance, coaching, and joint problem-solving.	To track progress and check compliance against planned activities and targets. It asks, "Are we doing things right?"	To assess impact and determine the value or worth of a program. It asks, "Did we do the right thing?" and "Did it work?"
Timing	Continuous and routine (e.g., monthly, quarterly). It is an ongoing management process.	Continuous and routine (e.g., daily, weekly, monthly). It is a part of day-to-day program management.	Episodic (e.g., mid-term, end-of-project, or 3-5 years). It is done at specific, planned intervals.
Focus	People-focused. Looks at the *quality* of work,	Activity-focused. Looks at *inputs, activities, and*	Outcome & Impact-focused. Looks at *outcomes and*

Feature	Supervision	Monitoring	Evaluation
	skills of health workers, and solving immediate problems.	*outputs*. Tracks indicators, spending, and timelines.	*impact*. Assesses effectiveness, efficiency, relevance, and sustainability.
Key Question	"How can I help you do your job better?"	"Is the program on track? Are activities being completed as planned? Are we reaching our targets?"	"Did the program achieve its intended goals? What was the impact? Why did it succeed or fail?"
Example in Nepal's Health System	A Health Post In-charge conducts a supportive supervision visit to a Basic Health Service Center (BHSC), observes an ANM's counseling session, and provides constructive feedback.	A municipal health coordinator monitors the monthly HMIS report to check if the immunization target (e.g., 15 new babies to be vaccinated) was met for that month.	The Ministry of Health and Population commissions an evaluation of the "Safe Motherhood Program (Aama Surakshya)" to determine if the program *caused* a measurable reduction in the maternal mortality ratio over the past five years.

Conclusion

In summary, monitoring is like looking at the dashboard of a car to check the speed and fuel. Supervision is like a driving instructor sitting next to you, providing real-time feedback to improve your driving. Evaluation is like looking back at the entire journey to decide if the trip was worthwhile, efficient, and if it took you to your desired destination. All three are essential for managing a health system effectively.

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1. b) Outline the structure of Ministry of Health and Population and Ministry of Social Development. (5) **

Answer:

Introduction

In Nepal's federal structure, the Ministry of Health and Population (MoHP) is the federal (national) body, while the Ministry of Social Development (MoSD) is the provincial body responsible for health (and often other sectors like education and social welfare). Their structures reflect their distinct roles in policy-making, regulation, and service delivery.

Outline: Ministry of Health and Population (MoHP) - Federal

The MoHP is the apex body responsible for national-level health policy, planning, regulation, and coordination. Its structure is designed to manage large-Cscale national programs, specialized services, and regulatory bodies.

- Political Leadership: Minister, State Minister
- Administrative Leadership: Chief Secretary (at the ministry level), Secretary (Health)
- Key Divisions (महाशाखा):
    1. Policy, Planning, and Monitoring Division: Responsible for developing national health policies (e.g., NHP 2076), strategic plans (e.g., NHSS), and coordinating with provincial/I-NGO partners.
    2. Health Coordination Division: Manages coordination between federal, provincial, and local governments, and handles international health relations (e.g., with WHO).
    3. Health Services Division: Focuses on curative services, hospital management, and quality standards.
    4. Population Management Division: Manages population-related policies and programs.
    5. Administration, Finance, and Management Division: Handles all internal administrative, financial, and HR matters.
- Key Departments (विभाग):
    1. Department of Health Services (DoHS): This is the main technical and implementation arm. It is structured into several Centers/Divisions that manage all vertical/programmatic public health services:
        - National Health Education, Information and Communication Center (NHEICC)
        - National Center for Communicable Diseases and Control (NCCDC) - *a new structure evolving from EDCD, NTC, etc.*
        - Family Welfare Division (FWD)
        - Management Division (LMD - for Logistics)
        - National Public Health Laboratory (NPHL)
    2. Department of Ayurveda and Alternative Medicine
    3. Department of Drug Administration (DDA): The national drug regulatory body.
- Professional Councils (e.g., NHPC, NMC): Autonomous regulatory bodies for health professionals.
- National Level Hospitals: Specialized central hospitals (e.g., Bir Hospital, Mental Hospital, Kanti Children's Hospital).

Outline: Ministry of Social Development (MoSD) - Provincial (e.g., Karnali)

The MoSD is the provincial-level ministry. Its structure is smaller and focused on implementing national policies in the provincial context, managing provincial-level institutions, and providing technical support to local governments.

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- Political Leadership: Minister
- Administrative Leadership: Secretary (Provincial Civil Service)
- Key Divisions (महाशाखा): (Structure varies slightly by province)
    1. Planning and Administration Division: Handles provincial-level planning, budgeting, HR management, and coordination.
    2. Social Development Division: Manages other social sectors (e.g., Education, Women & Children, Labor).
    3. Health and Population Division: This is the main health wing, responsible for adapting national health programs to the provincial context.
- Key Directorates and Offices (Under the MoSD):
    1. Health Directorate (स्वास्थ्य निर्देशनालय): This is the technical arm of the MoSD (analogous to the DoHS). It is responsible for *executing* and *monitoring* all health programs within the province.
    2. Provincial Health Training Center (PHTC): Manages all provincial-level health training.
    3. Provincial Health Laboratory: The provincial-level referral lab.
    4. Provincial Medical Store: Manages the provincial logistics and supply chain.
    5. Health Office (स्वास्थ्य कार्यालय): One in each district. This is a critical office under the provincial directorate. It does not deliver services but acts as a technical support and coordination hub for all the local governments (Palikas) within that district.
- Provincial Level Hospitals: Managament of the Provincial Referral Hospital and other provincial/district-level hospitals.

Conclusion

The MoHP's structure is vast, focusing on national policy, regulation, and specialized services. The MoSD's structure is leaner, acting as the provincial health manager, technical support hub for local levels, and operator of provincial-level hospitals and institutions.

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2. What is human resource management and its objectives? Clearity seven major functions of human resource management in Nepal. (5+5)

Answer:

Part 1: Human Resource Management and Its Objectives (5 Marks)

Introduction

Human Resource Management (HRM) is the strategic and coherent approach to the effective and efficient management of an organization's most valuable asset: its people. In the context of Nepal's health sector,

Human Resource for Health (HRH) Management involves the planning, production, deployment, and retention of health workers to ensure the delivery of quality health services to the entire population.

Objectives of Human Resource Management

The primary objective of HRM is to ensure the organization can achieve its goals through its people. This includes:

1. To Acquire the Right Workforce: To recruit and select the right number of people with the right skills, knowledge, and attitude for the right jobs.
2. To Develop the Workforce: To enhance the skills and competencies of employees through training, development, and performance management, enabling them to meet new challenges.
3. To Motivate and Retain the Workforce: To create a positive work environment and implement policies (e.g., fair compensation, incentives, good working conditions, clear career paths) that motivate employees and ensure their retention.
4. To Optimize Performance: To manage performance effectively, aligning individual goals with organizational objectives (e.g., improving health indicators).
5. To Ensure Compliance: To ensure all HR practices comply with the country's legal and ethical standards (e.g., Civil Service Act, Labor Act).

Part 2: Seven Major Functions of Human Resource Management in Nepal (5 Marks)

Introduction

In Nepal's public health system, HRH management functions are critical but complex, especially in the federal context. These functions are shared between the Federal (MoHP, PSC), Provincial (MoSD, PPSC), and Local governments.

Seven Major Functions

1. HRH Planning and Forecasting:
    - Function: This involves analyzing the current health workforce (who we have, where they are) and forecasting future needs (who we need, what skills) based on population needs, disease burden, and health policy goals (e.S., NHSS).
    - Nepal Context: This is a major challenge, leading to the maldistribution and shortage of staff in remote areas.
2. Recruitment and Selection:
    - Function: The process of attracting a pool of qualified candidates and selecting the best ones.
    - Nepal Context: This is formally done by the Public Service Commission (Lok Sewa Aayog) and Provincial PSCs for permanent positions. Local governments also recruit temporary/contract staff to fill urgent gaps.
3. Deployment and Staff Adjustment (Samayojan):
    - Function: Placing the right health worker in the right health facility at the right time.

- Nepal Context: This has been a major challenge post-federalism. The "Samayojan" process of adjusting existing staff into the three tiers was complex, and ensuring staff (especially doctors) go to and *stay* in remote palikas is a persistent problem.

4. Training and Development:
   - Function: Providing orientation, in-service training, and professional development opportunities to upgrade employee skills (e.g., SBA training, mhGAP training).
   - Nepal Context: This is a key function of Provincial Health Training Centers (PHTCs). A major gap is the lack of post-training follow-up and mentorship.
5. Performance Management (Performance Appraisal):
   - Function: The process of evaluating an employee's job performance, providing feedback, and linking it to promotions or rewards.
   - Nepal Context: In the civil service, this is often a ritualistic, form-filling exercise (*Karya Sampadan Mulyankan*) rather than an effective tool for performance improvement.
6. Compensation, Benefits, and Incentives:
   - Function: Designing and managing salaries, allowances, and other benefits (e.g., health insurance, provident fund).
   - Nepal Context: A critical challenge is designing effective incentive packages (both financial and non-financial, like better housing or promotion opportunities) to attract and retain health workers in "difficult" or remote areas like Karnali.
7. Employee Relations and Retention:
   - Function: Maintaining a positive, safe, and motivating work environment, managing grievances, and implementing policies to reduce staff turnover.
   - Nepal Context: Low retention and high "brain drain" (doctors and nurses leaving for abroad) are critical issues. This function involves trying to improve working conditions, ensuring staff safety (e.g., from violence), and creating a clear career path.

Conclusion

Effective HRH management is arguably the most critical determinant of health system performance in Nepal. While formal structures for these functions exist, systemic weaknesses in planning, deployment, and retention continue to be the biggest bottleneck in delivering equitable health services.

The End

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