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नेपाल स्वास्थ्य सेवा, हेल्थ इन्स्पेक्सन समूह,
सातौं तहको प्रतियोगितात्मक लिखित परीक्षा
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तलका प्रश्नहरूको उत्तर Section अनुसार छुट्टाछुट्टै उत्तरपुस्तिकामा लेख्नुपर्नेछ।

Section 'A'

1. What do you mean by National Health Policy? Describe briefly the areas addressed by National health policy 1991 and the national policy 2015. (2+8=10)

Answer:

Part 1: What is a National Health Policy? (2 Marks)

A **National Health Policy (NHP)** is the supreme, high-level strategic document that defines a government's **vision, goals, priorities, and guiding principles** for the health sector.

It is the foundational "umbrella" that provides the *long-term direction* for improving the health of the population. It acts as the basis for all other health-related laws, strategic plans (like the NHSS), programs, and budgets. Its primary purpose is to identify the nation's health problems and challenges and to outline the government's commitment and strategies to address them, ensuring the progressive realization of the "right to health."

Part 2: Areas Addressed by NHP 1991 and NHP 2015 (8 Marks)

National Health Policy, 1991 (2048 BS)

- **Context:** This was a landmark policy, formulated just after the restoration of democracy in 1990. It was the first policy to strategically shift Nepal's health system away from an urban-centric, hospital-based model to a **Primary Health Care (PHC)** model.
- **Major Areas Addressed:**

1. **Massive PHC Infrastructure Expansion:** This was its most famous feature. It set the target of establishing one **Sub-Health Post (SHP)** in every VDC, a **Health Post (HP)** in every Ilaka (electoral constituency), and a **Primary Health Care Center (PHCC)** in every constituency. This created the "hardware" of Nepal's rural health system.

2. **Community-Based Health Workforce:** It laid the foundation for the community health workforce, most notably by establishing the **Female Community Health Volunteer (FCHV)** program (in 1988, but massively scaled up by this policy) and the **Maternal Child Health Worker (MCHW)** cadre.

3. **Preventive and Promotive Health:** It prioritized preventive and promotive programs, leading to the strengthening of the **National Immunization Program (NIP)** and **Family Planning** services.

4. **Decentralization (Deconcentration):** It was the first policy to champion "decentralization," giving more implementation authority to the district level (DHO/DPHO) and establishing Health Facility Management Committees.

5. **Public-Private Partnership:** It was the first policy to formally recognize the role of the private sector ("NGOs/INGOs") and promote public-private partnerships.

National Health Policy, 2015 (2071 BS) - *(Note: Often called NHP 2014, or NHP 2071 BS)*`

- **Context:** This policy was formulated just before the 2015 earthquake and the new constitution. Its goal was to *update* the 1991 policy, address new challenges, and move towards **Universal Health Coverage (UHC)**. It acted as a bridge between the 1991 policy and the new 2019 (2076 BS) federal policy .

- **Major Areas Addressed:**

    1. **Commitment to Universal Health Coverage (UHC):** This was its central theme. It explicitly aimed to ensure all people receive quality health services *without suffering financial hardship*.

    2. **Introduction of Social Health Insurance:** To achieve UHC, this policy was the one that formally *conceptualized and mandated* the creation of the **Social Health Insurance (SHI)** program, which was subsequently piloted.

    3. **Addressing the "Double Burden" of Disease:** While NHP 1991 focused on MCH/communicable diseases, NHP 2015 was the first to *formally recognize* the rising epidemic of **Non-Communicable Diseases (NCDs)** (like diabetes, hypertension, cancer) and called for integrating NCD prevention and management into the PHC system.

4. **Quality of Care and Regulation:** It shifted the focus from just "access" (building HPs) to the **"quality"** of services. It emphasized the need to strengthen quality assurance, accredit health facilities, and better regulate the booming, but uneven, private sector.

5. **Health System Strengthening:** It addressed the "software" of the health system, including the need for better **HRH management**, strengthening the health information system (HMIS), and improving the logistics and procurement system.

Conclusion

The **NHP 1991** was a revolutionary policy that *built* Nepal's entire rural PHC infrastructure. The **NHP 2015** was an *evolutionary* policy that built upon that infrastructure, shifting the national focus to new challenges: **UHC, Social Health Insurance, and the NCD epidemic.**

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2. Explain in role of Nepal Health Professional Council (NHPC) to improve the quality of health services in Nepal. (10)

Answer:

Introduction

The **Nepal Health Professional Council (NHPC)** is a statutory, autonomous regulatory body established under the **NHPC Act, 2053 (1997)**. It is one of Nepal's key professional councils, alongside the Nepal Medical Council (NMC), Nepal Nursing Council (NNC), etc.

NHPC's primary mandate is to **regulate the training, registration, and professional conduct** of a diverse range of allied health professionals (e.g., Public Health Officers, HAs, Lab Technicians, Radiographers, Physiotherapists). Its role is *not* to deliver services, but to act as the "gatekeeper" and "watchdog" to ensure that the professionals *providing* those services are competent and ethical.

Role of NHPC in Improving Quality of Health Services

NHPC improves quality by acting on the *inputs* (the professionals) of the health system.

The 4 Pillars of NHPC's Quality Control Role

1. Setting and Regulating Educational Standards:

- **Role:** NHPC's first role is to ensure quality *before* a professional even graduates. It inspects, monitors, and **provides accreditation** to the academic institutions and colleges that run allied health programs.

- **Impact on Quality:** It sets the **minimum standards for curriculum**, faculty, and infrastructure. By refusing to accredit "low-quality" or "shop-like" colleges, it ensures that new graduates entering the health system have a baseline level of knowledge, which is the *first step* to quality service.

2. **Ensuring Minimum Competence (Licensing):**

- **Role:** NHPC is the "gatekeeper." It is illegal to practice as a health professional in Nepal without being **registered with NHPC**.

- **Impact on Quality:** To get registered, a graduate must pass the **"Licensing Examination."** This exam tests for minimum competence. This process *directly improves quality* by **filtering out unqualified individuals** and "quacks" from the health system, ensuring that the person treating a patient is verifiably competent.

3. **Enforcing Professional Conduct and Ethics:**

- **Role:** NHPC is the "police" and "court" for professional ethics. It has a **Code of Ethics** that all registered professionals must follow.

- **Impact on Quality:** If a health professional acts unethically or negligently (e.g., a PHO is involved in corruption, a Lab Tech gives a false report), a member of the public can file a *complaint* with the NHPC. The NHPC has the legal power to **investigate, summon the professional, and (if guilty) take disciplinary action**—from a warning, to suspension, to *permanently revoking their license* (removing them from the profession). This accountability is a powerful tool for maintaining quality.

4. **Promoting Continuing Professional Development (CPD):**

- **Role:** NHPC recognizes that "quality" is not static; medicine and public health are always evolving. It is responsible for promoting "lifelong learning."
- **Impact on Quality:** It has implemented a **Continuing Professional Development (CPD)** system, which *requires* health professionals to earn a certain number of "credit hours" (by attending workshops, trainings, seminars) to be eligible for their **license renewal** (every 5 years). This *forces* professionals to stay updated with the latest knowledge and skills, directly improving the quality of care they provide.

Conclusion

The NHPC's role is foundational to quality. It cannot *guarantee* that every patient interaction is high-quality, but it *creates the system* for it. By **controlling the *entry* into the profession (licensing)**, **regulating the *standards* of education**, and **policing the *conduct* of professionals (ethics)**, the NHPC ensures that the health workforce as a whole is competent, qualified, and accountable, which is the essential prerequisite for a quality health system.

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3. What do you mean by decentralization? What is the role of local government in effective health services delivery? Describe in present context. (10)

Answer:

Part 1: What is Decentralization? (3 Marks)

Decentralization is the systematic process of transferring authority, responsibility, resources, and administrative power from a *central government* (like in Kathmandu) to *sub-national governments* (like provinces, districts, or local municipalities).

It is not one single thing, but a spectrum:

1. **Deconcentration:** The *weakest* form. The central government simply moves its staff or offices to a local area, but they still report to the center (e.g., the old District Health Office).
2. **Delegation:** The central government "lends" responsibility for a specific task to a sub-national body, but can take it back (e.g., "delegating" hospital management to a committee).
3. **Devolution:** The *strongest* and *truest* form. This is what Nepal has done. It is the *irreversible, constitutional transfer* of power to autonomous, *elected* local

governments. The central government "gives away" the power, and the local government is now *accountable to its local citizens*, not to the central ministry.

Part 2: Role of Local Government in Effective Health Service Delivery (7 Marks)

Introduction

In the "present context" of Nepal's 2015 Constitution and the Local Government Operation Act (LGOA), 2074 , decentralization has taken the form of devolution.

This has completely transformed the role of the **Local Government (Palika)**. The Palika is no longer a *passive implementer* of central programs; it is now the **primary "steward" and "provider"** of basic health services.

Role of Local Government in the Present Context:

1. **Provider and Manager of Basic Health Services:**
   - This is their *number one* role. The LGOA, 2074, gives them full responsibility for the **operation, management, and monitoring** of all local-level health institutions, including **Basic Health Service Centers (BHSCs)**, **Health Posts (HPs)**, and (in many cases) **Primary Health Care Centers (PHCCs)** .
2. **Local-Level Health Planning and Budgeting:**
   - The Palika is now its *own* planning and budgeting authority. They are responsible for conducting **local health needs assessments** and formulating their *own* **annual health plan and budget**.
   - **Example:** A Palika in Madhesh can decide to *prioritize* and *budget* extra local funds for a Dengue control program, even if it's not a federal priority.
3. **Local HRH Management:**
   - The Palika is now the *direct supervisor* of all health staff in its health facilities.
   - Crucially, it has the power to **hire its own contract staff** (e.g., Medical Officers, ANMs, HAs) to fill the gaps left by the federal/provincial adjustment, which is a vital tool for ensuring services are not interrupted.
4. **"Last-Mile" Logistics and Procurement:**
   - The Palika is responsible for ensuring its health facilities *do not* have stock-outs.

- This includes managing the **local-level store**, collecting commodities from the Health Office, and **procuring essential drugs and equipment** that are not supplied by the federal/provincial system (using its own budget).

5. **Community Mobilization and Health Promotion:**

   - The Palika is now the *sole manager* of the **Female Community Health Volunteer (FCHV) program** .

   - It is responsible for all local **health promotion (HEICC)** activities, such as "miking" (loudspeaker announcements) for a vaccine campaign or running school health programs.

6. **Surveillance and Local Outbreak Response:**

   - The Palika (specifically its Health Section) is the **"first responder"** to a local public health event.

   - They are responsible for **collecting and reporting HMIS/EWARS data** and, in the event of an outbreak (e.g., cholera), for leading the *initial* investigation and response.

7. **Quality Assurance and Regulation:**

   - The LGOA gives local governments the power to **monitor and regulate** local-level private health facilities (e.g., clinics, pharmacies), ensuring they meet standards.

Conclusion

In Nepal's "present context" , the role of the local government is total in basic health. They are the planners, funders, managers, and monitors of the entire local health system. This "devolution" has created 753 autonomous health systems, presenting a huge opportunity for "bottom-up" governance but also a massive challenge in capacity and coordination.

Section 'B'

1. Critically analyze the performance and status of primary health care out-reach clinic (PHC- ORC) in remote rural setting of Nepal. What are the major challenges and how could they challenges be overcome? (5+5=10)

Answer:

Part 1: Critical Analysis of PHC-ORC Performance and Status (5 Marks)

Introduction

The Primary Health Care Outreach Clinic (PHC-ORC) is a monthly, community-based clinic designed to deliver a package of high-impact MCH and Family Planning services. In the remote rural settings of Nepal (e.g., high hills, mountains), the PHC-ORC is not just an "add-on"; it is often the only functional and accessible health service for the community.

Critical Analysis of Performance:

Positive Performance ("The Success"):

- **Backbone of Immunization:** The program has been *exceptionally successful* as the primary delivery platform for the **National Immunization Program (NIP)**. The NIP's high, equitable coverage—which is Nepal's biggest PHC success—is *directly attributable* to the reliable, monthly schedule of the PHC-ORC.
- **MCH Commodity Distribution:** It has been highly effective in distributing "vertical" MCH commodities, such as **Vitamin A & Deworming** (during campaigns) and **Family Planning** methods (Depo, pills, condoms) .
- **Equity and Access:** It has been the *most pro-poor and equitable* service delivery model, successfully **removing the "geographical barrier"** for remote communities.

Negative Performance ("The Failure"):

- **"Clinic Creep" - From PHC to "II" Clinic:** The PHC-ORC was designed to be a *Primary Health Care* clinic, but its status has "crept" (shrunk) over time. It is now, in many places, just an **"Immunization and Injection" (II) Clinic**.
- **Neglect of "PHC" Components:** The "PHC" components are very weak.
    - ✓ **Growth Monitoring** is often not done, or the scale is broken.
    - ✓ **ANC check-ups** are "rushed" (e.g., just giving IFA, not a real check-up).
    - ✓ **Health Education** is minimal or non-existent.
    - ✓ **Curative Care:** While not its "main" role, the ORC is often the *only* time a health worker is present, but they are often not equipped (or trained) to manage simple childhood illnesses (IMCI) during the clinic.
- **Poor Quality and Reliability:** In many remote settings , the clinic is unreliable. The health worker may not show up (due to staff vacancies, bad weather), the cold chain (vaccine carrier) may be compromised, or the clinic is rushed and of poor quality.

Part 2: Major Challenges and How to Overcome Them (5 Marks)

Major Challenges:

1. **Human Resource Gaps:**
    - **Challenge:** The PHC-ORC is run by a *single health worker* (e.g., ANM/MCHW). In remote HPs with high staff vacancies, if that *one* ANM is on leave, sick, or at a training, the ORC is **cancelled**, often for months, crippling the immunization schedule.
2. **Over-Burdened Staff and "Vertical" Focus:**
    - **Challenge:** The ANM is under *immense pressure* to meet **immunization targets**. This forces them to *only* focus on giving vaccines, leading to the "clinic creep" and the neglect of all other services (ANC, counseling, nutrition).
3. **Logistical and Cold Chain Barriers:**
    - **Challenge:** In remote rural settings , the ANM must *walk 3-4 hours* carrying a heavy vaccine carrier. This is physically demanding, and it is very difficult to *maintain the cold chain*, leading to (potentially) non-potent vaccines.
4. **Weak Supervision and Monitoring:**
    - **Challenge:** Because ORCs are "remote," they are almost *never* supervised. The Health Post In-charge or Palika coordinator rarely visits the ORC site, so there is no accountability, no on-site coaching, and no problem-solving.

How to Overcome These Challenges:

1. **Overcome HRH Gaps (The "Team" Approach):**
    - **Solution:** Never rely on a single person. The Palika must ensure the ORC is run by a **team of two** (e.g., ANM + another staff member, or a paid, trained local volunteer). This provides a "backup" and allows for a "division of labor" (one gives vaccines, the other does counseling/ANC).
2. **Overcome "Vertical Focus" (The "Integrated" Approach):**
    - **Solution:** Re-brand and re-train the PHC-ORC as an **"Integrated MCH-N Clinic"**. The *supervision checklist* and *HMIS reporting forms* must be modified to give *equal weight* to **Growth Monitoring, ANC, and IYCF Counseling**, not just "vaccines given."

3. **Overcome Logistics (The "Local Depot" Approach):**

    - **Solution:** Instead of the ANM carrying vaccines 4 hours from the HP, establish **local "Cold Chain Points"** (e.g., a solar-powered fridge at a teacher's house or a local shop) near the ORC site, with a trained local "Cold Chain Manager." This protects the vaccine potency.

4. **Overcome Supervision Gaps (The "FCHV Feedback" Approach):**

    - **Solution:** Use the **FCHVs and Mothers' Group** as a "community monitoring" system. Equip them with a simple checklist: "Did the ANM come on time? Did she weigh the babies? Was she respectful?" This "bottom-up" accountability can be reviewed monthly at the HP.

Conclusion: The PHC-ORC is one of Nepal's best equity-focused strategies . To save it from becoming just an "injection clinic," we must re-invest in it by ensuring it is run by a **team**, is truly **integrated**, and is **monitored by the community** it serves.

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2. What is a Logistic Management Information System (LMIS)? How this information system contributes to dynamics of overall health care system? Explain. (10)

Answer:

Introduction

A **Logistic Management Information System (LMIS)** is a specialized information system (of people, processes, and technology) designed to manage the **health commodity supply chain**.

Its sole purpose is to **collect, analyze, and use data** on health commodities to ensure that the *right products* (e.g., drugs, vaccines, test kits) are available in the *right quantity*, in the *right condition*, at the *right place*, and at the *right time*.

It is the "information backbone" for all "logistics." While HMIS tracks *patients and diseases*, LMIS tracks *products and supplies* .

Contribution of LMIS to the Dynamics of the Overall Health Care System

An effective LMIS (like Nepal's eLMIS) is not just a "warehouse tool"; it is a *dynamic management system* that fundamentally *improves the entire health system's performance* .

1. **Prevents Stock-Outs (Ensures Service Availability):**

- **Contribution:** This is its most critical function. An LMIS provides *early warning* to managers when a health post is running *low* on a drug (e.s., Amoxicillin).

- **Dynamic Impact:** This allows the manager to "push" an emergency supply or move stock from an over-stocked facility. This *directly* ensures **service continuity**. A health system with no drugs is a "dead" system. LMIS keeps it "alive."

2. **Enables Data-Driven "Pull" Logistics (Improves Efficiency):**

    - **Contribution:** An LMIS provides *consumption data* (how much was used).

    - **Dynamic Impact:** This allows the system to shift from an inefficient **"Push"** model (where the center "guesses" and sends a standard kit) to an efficient **"Pull"** model (where the health post "requests" *only* what it needs, based on its *actual* consumption data). This *prevents waste* and *reduces costs*.

3. **Reduces Waste (Ensures Financial Sustainability):**

    - **Contribution:** The LMIS tracks **batch numbers** and **expiry dates**.

    - **Dynamic Impact:** The system can automatically "flag" drugs that are *nearing expiry*. This allows a manager to quickly *redistribute* those drugs to a high-demand facility, ensuring they are *used* before they *expire*. This *saves millions of rupees* and prevents the "double tragedy" of having "expired drugs in one district, and stock-outs in another."

4. **Strengthens Accountability and Transparency:**

    - **Contribution:** The LMIS tracks every single commodity, from the central warehouse to the health post.

    - **Dynamic Impact:** It creates a **transparent audit trail**. This makes it much harder for supplies to be "leaked" or "diverted" (stolen or sold). If the LMIS shows 1,000 tablets were sent but the HMIS shows only 100 patients were treated, it "flags" a problem for the manager to investigate.

5. **Improves Data Quality and Forecasting (Improves Planning):**

    - **Contribution:** An effective LMIS provides high-quality data on *how fast* the health system is *consuming* supplies.

    - **Dynamic Impact:** This consumption data is the *only* accurate way for the MoHP to **forecast national-level demand**. This allows them to procure the *correct amount* of drugs for the *next year*, preventing massive national-level shortages or over-stocks.

- **Example:** By linking HMIS (e.g., "100 TB cases diagnosed") to LMIS (e.g., "100 TB drug kits consumed"), we can *validate* the data from *both* systems.

Conclusion

The LMIS is far more than a "stock-keeping" tool . It is the engine of an efficient health system. By providing real-time data on commodities, the LMIS dynamically links the clinical side (patients) with the management side (supplies), ensuring that when a patient arrives at a health post, the medicine they need is actually on the shelf.

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3. Describe the Tuberculosis National health program and critically review the current status of this program. (10)

Answer:

Introduction

The **National Tuberculosis Program (NTP)**, now under the National Tuberculosis Control Center (NTCC), is one of Nepal's oldest, most structured, and highest-priority "vertical" public health programs.

Description of the Program:

Its goal is to "End TB" in Nepal by 2035 (in line with SDG targets). The program is built on the global "End TB Strategy", which involves a comprehensive package of interventions provided free of cost to the patient:

1. **Case Finding (Detection):**
    - ✓ **Passive:** Patients who self-present at a health facility with a cough (suspects).
    - ✓ **Active:** Proactively screening high-risk groups (e.g., prisoners, contacts of TB patients, HIV-positive).
    - ✓ **Diagnosis:** Using Sputum Microscopy at PHC centers and **GeneXpert** (a rapid molecular test) at hub centers for rapid diagnosis and detection of drug resistance.
2. **Standardized Treatment (Cure):**
    - ✓ Providing free, high-quality **"first-line" anti-TB drugs** for 6 months.

- ✓ Providing specialized, complex **"second-line" drugs** for patients with **Multi-Drug Resistant TB (MDR-TB)**.

3. **Patient Support (Adherence):**

   - ✓ This is the cornerstone of the program. It uses the **DOTS (Directly Observed Treatment, Short-course)** model, where a health worker or FCHV *directly watches* the patient swallow their medicine every day.

   - ✓ Providing patient support, including counseling and (in some cases) nutrition/transport allowances.

4. **Surveillance and M&E:**

   - ✓ Maintaining a meticulous **TB Register (and e-TB system)** to track every patient, monitor their treatment progress, and ensure a high "Treatment Success Rate."

Critical Review of the Current Status (Strengths and Weaknesses)

Strengths (Positive Status):

1. **High Treatment Success Rate:** This is the program's greatest strength. For new "drug-sensitive" TB cases, the treatment success rate is consistently **above 90%**, which is a world-class achievement. This is a direct result of the well-managed DOTS model.

2. **Nationwide DOTS Network:** The program has a remarkable "reach." The DOTS strategy is implemented through *every single* public health post and by thousands of FCHVs, ensuring that treatment is available "at the doorstep" for free, all over the country.

3. **Modern Diagnostics (GeneXpert):** The program has successfully rolled out **GeneXpert** machines to centers in every district. This technology has *revolutionized* case-finding by:

   - ➢ (a) Providing a diagnosis in *2 hours* (vs. 2 days for microscopy/culture).

   - ➢ (b) *Simultaneously* detecting **Rifampicin resistance** (MDR-TB).

4. **Managing MDR-TB:** The program has successfully decentralized **MDR-TB treatment** from a few "hostels" to "treatment centers" across the country, using new, shorter, all-oral drug regimens.

Weaknesses (Critical Challenges - The "Current Status"):

1. **Massive "Case-Finding Gap" (The "Missing Million"):**
    - ✓ This is the *biggest failure* of the current program.
    - ✓ The WHO estimates that Nepal has ~69,000 new TB cases *per year*.
    - ✓ The NTP, however, only *finds and registers* ~28,000 cases per year.
    - ✓ This means there is a **massive gap of ~41,000 "missing" TB cases** *every year*. These are people who are *in the community*, *undiagnosed*, *untreated*, and *actively spreading* the disease.
2. **Over-reliance on "Passive" Case Finding:**
    - ✓ The "missing case" gap is caused by the program's *over-reliance* on "passive" case finding (waiting for sick patients to come to a *public* health post).
    - ✓ A large number of patients (up to 50%) *first go to the private sector* (private clinics, pharmacies). The NTP has a very *weak* mechanism (**PPM - Public-Private Mix**) to get these private doctors to *report* TB cases or *use* the free government drugs.
3. **Fragmented Federal Structure:**
    - ✓ Post-federalism, the "vertical" NTP program has been *fragmented*. The local governments (Palikas) are now *responsible* for TB control, but often lack the *technical capacity*, *budget*, and *ownership* to manage the program effectively. Coordination between the NTCC (federal) and the Palikas (local) is weak.
4. **Inadequate Patient Support:**
    - ✓ While DOTS is good, TB is a "social disease" linked to poverty. The *cost of travel* to the DOTS center and the *cost of food* (malnutrition) are major barriers to treatment completion. The program's "patient support" package is still too weak to address these social determinants.

Conclusion

The NTP is a "paradox." It is brilliant at treating the patients it finds (90%+ success). But it is failing at finding the majority of patients who have the disease. The future of "End TB" in Nepal depends 100% on closing this "case-finding gap", which requires a radical new strategy focused on active case finding, private sector engagement (PPM), and empowering local governments.

Section 'C'

1. What are the major nutritional disorders among the under five children in Nepal? Describe in brief that the difference efforts being launched to correct those disorders by Government of Nepal. How could the problem of over nutrition be overcome? (3+3+4=10)

Answer:

Part 1: Major Nutritional Disorders (<5 Children) (3 Marks)

Introduction

Nepal's under-five children suffer from a "triple burden" of malnutrition , meaning different forms of under-nutrition co-exist, and over-nutrition is emerging.

Major Nutritional Disorders (based on NDHS 2022):

1. **Stunting (Chronic Malnutrition):**
    - (Low Height-for-Age). This is the **largest nutritional problem** in Nepal.
    - **Status: 25%** (1 in 4) of all children <5 are stunted. This is a sign of long-term, chronic deprivation.
2. **Wasting (Acute Malnutrition):**
    - (Low Weight-for-Height). This is the *most life-threatening* form of malnutrition.
    - **Status: 8%** of children <5 are wasted, with **2%** suffering from *Severe Acute Malnutrition (SAM)*.
3. **Underweight:**
    - (Low Weight-for-Age). This is a composite measure of both stunting and wasting.
    - **Status: 19%** of children <5 are underweight.
4. **Micronutrient Deficiencies ("Hidden Hunger"):**
    - **Anemia:** This is a massive problem. **43%** of children (6-59 months) are anemic (iron-deficient).

- **Vitamin A Deficiency:** This is well-controlled but remains a threat.

Part 2: Government Efforts to Correct These Disorders (3 Marks)

The Government of Nepal (GoN) implements a **Multi-Sectoral Nutrition Plan (MSNP)**, with the health sector running the following "nutrition-specific" interventions:

1. **Community-based Management of Acute Malnutrition (CMAM):**
    - **To correct Wasting:** FCHVs and health workers screen children (with MUAC tape).
    - **OTP (Outpatient Therapeutic Program):** Provides **Ready-to-Use Therapeutic Food (RUTF)** to children with Severe Acute Malnutrition (SAM) to treat them at home.
    - **NRH (Nutrition Rehabilitation Homes):** Provides inpatient care for SAM cases with medical complications.
2. **Micronutrient Supplementation Programs:**
    - **To correct "Hidden Hunger":**
        - **National Vitamin A Program (Susthara):** Bi-annual distribution of **Vitamin A capsules** (to prevent blindness) and **Deworming tablets**.
        - **Iron (IFA):** Distribution of **Iron-Folic Acid (IFA)** to pregnant women (to prevent maternal anemia and low birth weight).
        - **Bal-Vita (MNP):** Distribution of **Multiple Micronutrient Powder (MNP)** to children 6-23 months to sprinkle on their food.
3. **Infant and Young Child Feeding (IYCF) Promotion:**
    - **To prevent Stunting and Underweight:** This is the *primary* preventive strategy.
    - It involves counseling mothers on the "First 1000 Days": **early initiation of breastfeeding**, **exclusive breastfeeding for 6 months**, and timely introduction of diverse and adequate **complementary foods**.

Part 3: How to Overcome the Problem of Over-nutrition (4 Marks)

Introduction

Over-nutrition (overweight and obesity) is the other side of malnutrition. It is a rapidly emerging "double burden" in Nepal, especially in urban areas. It is the primary risk factor for NCDs (diabetes, hypertension).

Overcoming it requires a *multi-sectoral* approach focused on *preventing* the "obesogenic environment."

Strategies to Overcome Over-nutrition:

1. **Strong Public Policy and Regulation (Fiscal Measures):**
    - This is the most effective approach.
    - **Action:** The government must implement high **"Sin Taxes" (Excise Duty)** on **Sugar-Sweetened Beverages (SSBs)** (like Coke, Fanta) and all "ultra-processed" junk foods (e.g., chips, instant noodles). This "makes the unhealthy choice the expensive choice."
    - **Action:** Legally **ban all "junk food" advertising** that targets children.
2. **Creating a "Healthy School Environment":**
    - **Action:** The Ministry of Education must *ban* the sale of all junk food and sugary drinks *in and around* school premises.
    - **Action:** Mandate and re-introduce **mandatory physical education (sports)** classes in all schools to combat sedentary lifestyles.
3. **Mass Media and Public Awareness (HEICC):**
    - **Action:** The NHEICC must run national-level campaigns on the *dangers* of junk food and sugar, just as it does for tobacco.
    - **Action:** Implement mandatory, clear **"Front-of-Pack Labeling"** (e.g., "Red Light" for high sugar/salt/fat) on all packaged foods so consumers can make an informed choice.
4. **Promoting Healthy Urban Environments:**
    - **Action:** This is a multi-sectoral role for Palikas (municipalities). They must **invest in "built environments"** that promote activity.
    - **Example:** Building safe **walking paths, bicycle lanes, and public parks** to make physical activity easy, safe, and free.

Conclusion

The nutritional landscape has changed . While Nepal must continue to fight stunting and wasting, it must simultaneously start a new fight against over-nutrition. This new fight requires strong political will to regulate the "junk food" industry and build healthier urban environments.

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2. Explain the different types of training needed to organize in a district to manage the district health programs smoothly. (10)

Answer:

Introduction

In Nepal's federal system, the "district" is the key "coordination level," managed by the (Provincial) Health Office (HO). To ensure all health programs run "smoothly," the HO (or the Provincial Health Training Center - PHTC) must organize and coordinate a wide variety of training types.

These trainings are not just for *clinical skills*; they must also cover *management, programmatic, and community* skills to build a well-rounded and competent health workforce across all the Palikas in the district.

Types of Training Needed at the District Level

1. **Programmatic "Cascade" Trainings (Vertical Programs):**
    - **Description:** These are the most common trainings, where national-level programs (under DoHS) "cascade" new policies, protocols, or guidelines.
    - **Examples:**
        - **CB-IMNCI:** Refresher training for health workers on the protocol for childhood illness.
        - **Immunization (NIP):** Training on a *new vaccine introduction* (e.g., HPV), or annual "micro-planning" workshops.
        - **TB/Leprosy:** Training on new treatment regimens or how to use the "e-TB" reporting system.
        - **Family Planning:** Training on counseling or providing new methods (e.g., "Implants").
2. **Clinical Skill-Building Trainings:**

- **Description:** These are intensive, "hands-on" trainings designed to build a *specific, high-level clinical competency*.
- **Examples:**
    - **Skilled Birth Attendant (SBA):** A long-term, intensive training for ANMs/Nurses to manage deliveries.
    - **BEmONC/CEmONC:** Training the *team* at a PHCC or hospital to manage Basic Emergency Obstetric and Newborn Care.
    - **IMCI:** The full (multi-week) *Integrated Management of Childhood Illness* training.

3. **Health Management and Governance Trainings:**
    - **Description:** This is a *critical* but often *neglected* area. These trainings are for *managers* (Health Post In-charges, Palika Health Coordinators) on *how to run the system*.
    - **Examples:**
        - **Health Management Information System (HMIS/DHIS2):** Training on data entry, analysis, and *data use for decision-making* .
        - **Logistics Management (LMIS):** Training on how to use the eLMIS, manage a store, and prevent stock-outs.
        - **Planning and Budgeting:** Training Palika coordinators on how to prepare their *annual health plan and budget*.
        - **Public Procurement:** Training on the (very complex) PPA/PPR so they can legally *buy* medicines and equipment.
4. **Supportive Supervision and Quality Improvement Trainings:**
    - **Description:** "Training the trainers/supervisors." This is training for *managers* on *how to supervise* their staff.
    - **Example:** Training a Health Post In-charge on the **"Supportive Supervision"** model—how to use a checklist, give constructive feedback, and be a *mentor*, not an *inspector*.
5. **Community-Level and FCHV Trainings:**
    - **Description:** These are trainings coordinated *by* the district/Palika but *for* the community-level workforce.

- **Examples:**
    - **FCHV Refresher Training:** Updating FCHVs on their core modules (MCH, FP, nutrition).
    - **FCHV New Program Training:** Training FCHVs on a *new* role, such as **NCD screening** (e.g., how to measure Blood Pressure) or the **CMAM** protocol (how to use a MUAC tape).

6. **Emergency Preparedness and Response Trainings:**
    - **Description:** Trainings to prepare the district/Palika to respond to emergencies.
    - **Example:**
        - **Rapid Response Team (RRT) Training:** Training a designated district/Palika RRT on how to *investigate and manage* an outbreak (e.g., of cholera or dengue).
        - **Mass Casualty Incident (MCI) Drill:** Conducting a "drill" or simulation at the District Hospital.

Conclusion

A "smoothly" managed district health system requires a balanced training portfolio. A system that only does clinical training (SBA/IMCI) but fails to do "management training" (HMIS/Procurement) will result in highly-skilled doctors who have no drugs, no data, and no budget. A comprehensive training plan must address all these different needs.

Section 'E'

1. Critically analyze the existing HRH planning in National Health System of Nepal. How could the restructuring of HRH be done to address the transit to federalism in Nepal? (5+5=10)

Answer:

Part 1: Critical Analysis of Existing HRH Planning (5 Marks)

Introduction

Human Resources for Health (HRH) Planning is the process of estimating how many health workers, with what skills, are needed where and when, and then creating a plan to produce, recruit, and retain them.

In Nepal, HRH planning has historically been, and remains, the **single greatest weakness of the health system**.

Critical Analysis of its Failures:

1. **Reactive, Not Proactive:**
   - **Critique:** HRH planning is *reactive*. We wait for a "crisis" (e.g., a massive shortage of anesthetists) and then try to "fix" it. There is **no long-term, 10-20 year "Master Plan"** that *forecasts* future needs (e.g., "We will need 5,000 geriatricians by 2040") and aligns "production" (universities) with those needs.
2. **Complete Mismatch of Production vs. Need:**
   - **Critique:** The "production" of HRH (led by the private sector) is *de-linked* from the "need" of the public system.
   - **Example:** We *over-produce* Medical Officers who want to work in urban hospitals, but we *critically under-produce* public health specialists (PHOs), clinical-epidemiologists, and mid-level workers who are *trained and willing* to manage the rural, primary care system .
3. **Failure of "Workload-Based" Planning (The "O&M" Failure):**
   - **Critique:** Staffing norms are based on outdated "Organization & Management (O&M)" surveys that are *not* based on **patient load or workload**.
   - **Example:** A remote mountain Health Post (with 10 patients/day) has the *same* staff "darbandi" (quota) as a Terai Health Post (with 100 patients/day). This is a *total failure* of planning, leading to "ghost staff" in one place and "burnout" in another.
4. **No "Retention Plan":**
   - **Critique:** HRH "planning" in Nepal focuses 90% on "recruitment" and 0% on **"retention."** We have *no effective national plan* to *keep* the staff we have. We do not plan for incentives, career paths, or good working conditions, which is the direct cause of the massive "brain drain" .

Part 2: Restructuring HRH to Address Transit to Federalism (5 Marks)

Introduction

The "transit to federalism" was a massive shock to the HRH system. It took a single, unified workforce and tried to "adjust" (Samayojan) it into 761 different governments (1 federal, 7 provincial, 753 local). The "Samayojan" was chaotic .

To "address" this new reality, the *entire* HRH structure must be re-built.

Restructuring Strategies:

1. **Create 3 "Accountable" HRH Management Tiers:**
    - ✓ **Restructuring:** The *single* "Health Service" must be *formally* unbundled into three.
        - **Federal Health Service:** Manages *only* federal staff (at MoHP, central hospitals).
        - **Provincial Health Service (PHS):** A *strong, independent* PHS for each province, managed by the Provincial PSC . This service manages *all* staff from the Provincial Ministry down to the District Hospitals and Health Offices.
        - **Local Health Service (LHS):** A *separate* LHS for each Palika, allowing them to *recruit and manage* their own permanent PHC staff.
2. **Implement a National "Mandatory Service" Bond:**
    - ✓ **Restructuring:** To address the "equity" failure of federalism (no one wants to go to remote palikas) , we must fix it at the "production" source.
    - ✓ **Action:** All "scholarship" *and* "private" medical/nursing graduates must be *required* to complete **2 years of mandatory, paid service** in a Palika/Hospital designated by the government *before* they are eligible for their *full* professional license (e.g., from NHPC/NMC) .
3. **Shift from "Salary" to "Total Compensation" (Incentives):**
    - ✓ **Restructuring:** We must *stop* pretending that a "remote area allowance" of a few thousand rupees is an "incentive."
    - ✓ **Action:** Create a **"Total Compensation Package"** for remote/provincial service. This package, managed by the Province, must be *at least 50-100% higher* than a federal job in Kathmandu and must include non-financial incentives like:
        - **Better Housing & Child Education.**
        - **"Fast-Track" Promotion:** (e.g., 1 year of remote service = 2 years of "seniority").

4. **A "Federal HRH Equalization Fund":**

   - ✓ **Restructuring:** A rich Palika (like in Pokhara) can *afford* to hire 10 doctors. A poor Palika (in Mugu) cannot. This is the "equity gap" of federalism.
   - ✓ **Action:** The Federal MoHP must create a **"HRH Equalization Grant"**. This is a *conditional grant* given *directly* to poor/remote Palikas with the *sole purpose* of allowing them to hire and incentivize their *own* local health workforce.

Conclusion

The old, centralized HRH planning is dead. The "Samayojan" failed. The only way forward is to fully embrace federalism by building three distinct, accountable health services (Federal, Provincial, Local) and using strong federal-level interventions (like "mandatory service" and "equalization funds") to guarantee that no remote Palika is left without a health worker.

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2. What is supervision? how supervision can be differentiate with monitoring? Describe the role of supervision in improving health care system in a country? (2+4+4=10)

Answer:

(Note: This question is a repeat of Madhesh 2080 Q.D2 , but with a different mark allocation. The answer is structured to fit the new allocation.)

Part 1: What is Supervision? (2 Marks)

Supervision is an ongoing, "people-focused" management process where a senior staff member (supervisor) provides face-to-face guidance, support, and coaching to a junior staff member (supervisee) .

Its primary goal is *not* to "inspect" or "find faults," but to **improve the *quality* of performance**, **build staff skills**, **solve on-site problems**, and **increase motivation**.

Part 2: Differentiation of Supervision from Monitoring (4 Marks)

Supervision and Monitoring are often confused, but they are *different* management functions .

Monitoring is a **"data-focused"** process of *tracking progress*.

- **What it is:** It is the *routine collection and analysis of quantitative data* (from systems like HMIS/LMIS) to compare "what was planned" versus "what was achieved."
- **Key Question:** "Did we meet our targets?" (e.g., "Did we vaccinate 100 children this month?").
- **Method:** "Desk-based" (reviewing reports, registers, dashboards).

Supervision is a **"people-focused"** process of *improving quality*.

- **What it is:** It is the *qualitative, face-to-face interaction* to observe *how* the work is being done.
- **Key Question:** "Are we doing the job *correctly*?" (e.g., "Is the vaccinator *using the correct technique* and *counseling the mother* properly?").
- **Method:** "Field-based" (observation, on-site coaching, joint problem-solving).

In short: Monitoring uses *data* to find a *problem* (the "WHAT"). **Supervision** uses *observation* to find the *reason* for the problem and *fix it* (the "WHY" and "HOW").

Table: Supervision vs. Monitoring

Feature	Monitoring	Supervision
Focus	Data, Quantity, Targets	People, Quality, Skills, Process
Goal	Track Progress	Improve Performance
Method	Desk Review (HMIS)	Field Visit (Observation)
Example	Reading a report that says "ORS stock is 0."	Visiting the HP to find out *why* (e.g., "The in-charge doesn't know how to order") and *teaching them* how.

Part 3: Role of Supervision in Improving Health Care System (4 Marks)

Supervision is a *critical action* that directly *improves* the health system's performance and quality .

1. **Ensures Quality of Care and Technical Competence:**

- ✓ **Role:** This is the most important role. A supervisor *observes* the health worker providing a service (e.g., ANC, IMCI) and provides *immediate, constructive feedback*.
- ✓ **Impact:** This corrects technical errors, ensures national protocols are being followed, and improves the *safety and quality* of care the patient receives.

2. **Provides On-the-Job Training and Mentorship:**
   - ✓ **Role:** Supervision is the *most effective* form of "Post-Training Follow-up." A health worker who attended a training will only *use* those new skills if a supervisor *mentors* and *coaches* them at their own facility.
   - ✓ **Impact:** It builds the *long-term capacity* and *competence* of the workforce.
3. **Solves "Last-Mile" System Bottlenecks:**
   - ✓ **Role:** The supervisor is the "problem-solver" who links the "front line" (HP) to the "management" (Palika).
   - ✓ **Impact:** When a health worker has a problem (e.g., "The vaccine fridge is broken," "The HMIS report won't upload"), the supervisor's job is to *facilitate a solution*, thereby "unblocking" the system and making it functional.
4. **Improves Staff Motivation, Morale, and Retention:**
   - ✓ **Role:** A *supportive* supervisor (one who listens, appreciates, and supports) reduces the professional *isolation* and *demotivation* of staff in remote posts.
   - ✓ **Impact:** By making staff feel *heard* and *valued*, supervision *improves job satisfaction*, *reduces absenteeism*, and *helps retain* the health workforce—which is the "backbone" of the entire system.

The End