**A Participatory Assessment of Anandaban Hospital**

**Situation, Effectiveness and Way-forward**



**Submitted by**

**Nepal participatory action network (NEPAN)**



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Abbreviations

AH Anandaban Hospital

AHW Assistant Health Worker

ANM Auxiliary Nurse Midwife

ATS Additional Technical Support

CDR Central Development Region

CEDAR Community Empowerment, Development, Disability & Rehabilitation

CMA Community Medical Auxiliary

DDC District Development Committee

DHO District Health Office/Officer

DOHS Department of Health Services

DRL Diagnostic Research Lab

DTLA District TB/Leprosy Assistant

FGD Focus Group Discussion

GO/N Government of Nepal

HA Health Assistant

IDI In-depth Interview

IPD Inpatient Department

KIs Key Informants

LCD Leprosy Control Division

LSS Leprosy Support Services

MOH Ministry of Health

NLRP Netherland Leprosy Relief Project

OPD Outpatient Department

OPD Outpatient Department

PCR Polymerase Chain Reaction

PHC Primary Healthcare Centre

PRA Participatory Rural Appraisal

RTLO Regional TB/Leprosy Officer

S/HP Sub/Health Post

SER Socio Economic Rehabilitation Project

SER Socio-economic Rehabilitation

SHG Self-help Group

TLM/I The Leprosy Mission International

LM/N The Leprosy Mission Nepal

TOR Terms of Reference

TU Training Unit

VDC Village Development Committee

WHO World Health Organisation

Acknowledgement

First of all, we would like express our sincere appreciation to the leprosy patients met during this study period in the Anandaban hospital, former patient in the field and the community people in VDCs of Lalitpur districts for providing honest and frank views and sharing their experiences and observations regarding the leprosy services with us. Without their information the study would not have come to this shape.

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Our sincere thank goes to all those staff members for arranging field work and accompanying the study team in the field trips. We deeply appreciate Anandaban Hospital staff, DHOs/DTAs/Os, district staff, SHG members of Lalitpur, Kavre, Chitwan, Parsa and Bara for their support during the field studies. We would like to acknowledge the supports and co-operations received from various organizations particularly Leprosy Control Division, Teku Kathmandu, Regional Director, Regional Health Directorate, Central Development Region and Netherlands Leprosy Relief Association.

Executive summary

This study was conducted to assess the overall situation, effects of Anandaban Leprosy Hospital and exploration of options for future programming to improve the current implantation.

The study was carried out using participatory methods and approaches. Six districts were visited where 14 focused group discussions, 39 key informants were interviewed and other participatory tools used as well. The respondents were from wide range of location, organisation, community and clients/beneficiaries.

Anandaban Hospital is working with the support of The Leprosy Mission International under Tripartite Project Agreement with the Government of Nepal, Social Welfare Council, primarily in the field of leprosy in Nepal since 1957. Basic general medical services were started in 1980 for people of southern parts of Lalitpur district of Nepal.

Leprosy Mission Nepal has been gradually increasing their programme over the past 57 years. Programs now include (1) Hospital, (2) Training and Technical Support program, (3) Mycobacterial Research Laboratory, and two community based programs encapsulating the prevention of disability, social and economic activities and known as (4) Socio-Economic Rehabilitation (SER) Project and (5) Community Empowerment, Development, Disability and Rehabilitation (CEDAR) Project.

Anandaban Hospital is considered a central referral hospital for leprosy affected people, where a high standard of services is expected for tertiary care of Leprosy cases. Anandaban Hospital provides outpatient and inpatient services with 110-beds (30 beds for general patient) to take care of leprosy referrals from all over the country and India.

Specialist services in AH include reaction management, wound care and reconstructive surgery. AH has one of the two prostheses and orthoses departments in Nepal. The department is highly regarded in Nepal and serves the requirements of leprosy affected clients from the entire country. There are no referral facilities in the government system for the treatment of complications of leprosy.

**Key Findings and Recommendations**

Leprosy service is a flag mast of Anandaban Hospital, and the sole purpose of being in Nepal as well as main element of agreement with government of Nepal. The contribution of Anandaban Hospital in leprosy control programme in Nepal is well appreciated by government officials and other partners working in the field. There are no specific leprosy hospitals in the government setting. **The government’s strategy to include leprosy in the national integrated health system is a welcoming move but initiation of admission/treatment for the leprosy affected patients with ulcer/reaction is a big challenge. Anandaban Hospital along with other partners is expecting support in implementing this strategy.**

Reducing leprosy burden, preventing disability, reducing stigma are other critical remaining challenges in leprosy control in Nepal. **It is a disease with long term effects and likely to remains for long time, therefore services of Anandaban Hospital is crucial in the days to come for care after cure.**

Though the overall new case detection in AH is slowly declining as the initial detection/diagnosis is now available in government health facility all over the country, **the overall need of OPD service and in patient service is in increasing trend**. Clearly, AH management needs to constantly upgrade its facility and services to meet the increasing needs of Leprosy Affected People in particular and other public in general.

In its inpatient department, AH, being a referral hospital for tertiary care for Leprosy Affected People, it receives referrals from all over the country and India. The data from 2006 to 2011 indicate that nearly 5% referral is from India. And most referrals in Nepal are from central region.

Every year AH receives, in its OPD, over 4,000 visits from Leprosy Affected People for various complication and simple routine check up. Almost one third of cases are MDT. Ulcer and reaction are other major reasons for people visiting OPD

Outreach clinic, apart from offering routine check up and follow-up, is also an opportunity for case finding. The outreach clinics have contributed to diagnosis of leprosy cases missing and unidentified for long time.

Basic leprosy and refresher training on leprosy has been provided to health workers in the districts of central region consistently for last many years. **High number of training offered in the district with high case reporting is a congruent pattern observed in few districts, but many districts do not show comparable consistency**.

While the need for leprosy related training will continue for government staff though likely to be at reduced frequency, optimizing the training facility is crucial for sustainability of the centre. Along with existing hospital facility and its field presence, potentially training unit can be expanded to include other training courses of long or short duration. While there are wild suggestions from staff and others alike (setting up nursing college, marketing training facility to other agencies), **AH needs to make need assessment and a business plan for training unit.**

In the context where leprosy is in “post elimination stage” where focus of leprosy related services is likely to change, current resource spending pattern needs to be carefully assessed by the AH management. **Moreover, Anandaban as referral hospital which take care of leprosy affected people and provides training to government health workers, do not receive funding support from government of Nepal despite previous efforts in past. It is noted that government budget for leprosy programme has increased many fold over the period. Advocacy and lobbying with government is suggested to obtain government grant to manage tertiary care.**

Keeping in view of local people’s high expectations/need, Leprosy Mission Nepal management needs to decide the level of services (i.e. Primary healthcare centre, District hospital level or higher) it will provide in future. While so doing, it is recommended to take into account **community’s willingness to pay more** and views on additional services needed e.g. need of a full fledge maternity services, x-ray facility, ambulance service, etc. **Furthermore, regular communication with community people regarding the available facility and services at Anandaban is expected by the community**. If flow of information about its facilities and expertise is improved, the Anandaban will be the first choice of the community because of its infrastructure and affordable service charge.

Available information shows that there is more expenditure than income generated for general health services to local community. Though the deficit is narrowing from 2008 to 2010, there is a deficit of approximately 14% in 2009 and 2010. To recover the cost of general health services, AH needs to take into consideration the local community’s willingness to pay more for better and additional services.

There are opportunities to mobilise local resources from VDC and DDC in the areas where AH has programme and services. The possibility was expressed by the local community as well as field-based stakeholders. AH should proactively explore this opportunity along with the community it serves.

The SER/CEDAR Self-help group programmes need to be more flexible in its group formation and mobilisation approach. Moreover, with proper social mobilisation approach and investment on social intermediation, appropriate training, linkage and network development activities (local NGOs, govt. institutions), potentially the group/s can be developed into institution like co-operatives or other organizations where they can develop/ manage/organize their needs.

AH Mycobactrial research facility (Laboratory) is reported as one of the best in South Asia. Some of the important researches that were carried out were in the area of reaction, diagnosis, and drug resistance including surveillance monitoring in collaboration with WHO. The finding of this research is expected to contribute in this critical aspect particularly in policy development and changing treatment regimen. However, the government officials were critical on lack of coordination and communication regarding ongoing research activity and its effectiveness as well as benefit to Nepal.

# Introduction

## Leprosy context in Nepal

Nepal is a known leprosy endemic country. With an estimated number of 100,000 Leprosy cases, in the year 1966, leprosy control program using Dapsone mono therapy was started as a pilot project in Nepal. This project was gradually expanded as a vertical program and remained so till 1987 when it was integrated into general health services. Multi Drug Therapy (MDT) was introduced for the first time in Nepal in the year 1982/83 in selected areas and hospitals. By that time number of registered cases had come down to 31537 (PR of 21 per 10,000). There was a gradual and steady expansion of MDT services and by the year 1996 MDT coverage was extended to all the 75 districts of the country[[1]](#footnote-2).

Leprosy control programmes have changed significantly since 1980s following the introduction of MDT and global strategy to eliminate leprosy as a public health problem. It was concluded by many that the integration of leprosy services into general health services was the most effective and sustainable approach to leprosy control. The conclusion was based on the key benefits of an integrated approach[[2]](#footnote-3). In 2009, Leprosy Control Division, Nepal reported that leprosy prevalence had been reduced to 0.89/10,000 population, below the target of 1/10,000 population considered by the World Health Organisation (WHO) as sufficient to declare elimination[[3]](#footnote-4).

The Leprosy Mission International (TLMI), a non-profit international non-government organisation (INGO), started work in Nepal in 1957. In July 2005 the Leprosy Mission Nepal (LMN) took over responsibility for the work of The Leprosy Mission International in Nepal. The Leprosy Mission International established the Anandaban Leprosy Hospital (now called Anandaban Hospital) in Lalitpur district, South of Kathmandu. Anandaban Hospital soon became the major referral centre in Nepal for tertiary level leprosy care. Since that time activities and services have been carried out in close coordination with the Central Region Health Directorate, the Leprosy Control Division and District Development Committees, in accordance with the policies of the Ministry of Health.

In 1993, the Social Welfare Act, Government of Nepal, and subsequent guidelines encouraged international organisations working in Nepal to implement the programs only through national bodies in the country. The Leprosy Mission International established a partnership relationship with the LMN, a non-profit non-government organisation (NGO).

Approximately 165,000 patients all over the country are RFT and significant numbers of those patients have deformities. In addition 3.47% (2010/2011 national data) among new cases are developing deformities each year because of leprosy. More new cases are being detected each year (1.12/10,000 population – 2010/2011 national data).

There are no specific leprosy hospitals in government setting. The government’s strategy to include leprosy in the national integrated health system has been introduced but admission/treatment for the leprosy affected patients with ulcer/reaction is a big challenge.

Besides, reducing leprosy burden, preventing disability, reducing stigma are other critical challenges in leprosy control in Nepal.

# Objective and methodology of assessment

The objective of the study was refined in participatory workshops with AH management, which is as follows.

* To assess how effectively Anandaban Hospital is delivering its services to the local community?
* To assess how Anandaban Hospital is working as a national referral hospital in terms of delivering comprehensive leprosy service
* To assess how it can make that delivery more effective?
* To assess how the Hospital should be adapting to meet the challenges of the future?
* Explore the views and opinions of existing and former clients on the services they received and whether the Hospital could offer additional services or support that they would have found helpful. A detail TOR of the study is given in *Annex 1: TOR*.

The assessment was carried out using participatory methods. As such, a total of 14 focused group discussions along with venn diagram and preference ranking were conducted. Similarly, 39 key informants’ interviews were conducted as well as other participatory tools (i.e. group discussion, personal observation and participatory workshops) were also used. The six sample districts (Lalitpur, Kathmandu, Kavre, Chitwan, Bara and Parsa), Village Development Committee (VDC), Self-help groups were selected purposively so that teraiand the hills are represented in the assessment. Following FGD and IDI were conducted.

|  |  |
| --- | --- |
| Tools | Numbers |
| FGD | 14 (182 participants) |
| IDI (Leprosy clients) | 22 |
| IDI (AH, govt, stakeholders) | 17 |
| AH Staff (workshop) | 2 (15 participants) |

Tools and source of information (Table 1), FGD and IDI checklist (), was finalized with participatory approach at plenary session with Executive Director and staff (technical and admin/management) of Anandaban Hospital.

Staffs were involved in the study process wherever possible/as and when needed. Process and findings were shared with AH staff regularly through participatory workshops at Anandaban. Comments, suggestions and options were also discussed and incorporated.

Available literature of recently published reports was also reviewed to obtain additional insights and information.

Table 1: Tools and source of information

| **Key areas** | **Tools** | **Source of informants** | **District** |
| --- | --- | --- | --- |
| * Effectiveness * Way forward * Community * Expectations * Strengths & weaknesses | Focus group discussion,  Venn diagram,  Preference ranking,  Participatory workshops,  SWOT/C | * Beneficiaries of general health services * Self help groups * Health Post Management Committee * all political party representatives * Staff of Anandaban Hospital * Documents, hospital data, progress reports | Lalitpur, Kavre, Chitwan, Bara |
| * Effectiveness * Service charges & sustainability * Social stigma * Expansion services * Self-help group * Programme coordination * Future role | In-depth interview | * Local influential people (social workers, senior citizens, school teachers) * Leprosy clients (existing and former) * OPD patients (general) * IPD (Leprosy and other patients) * Existing and former leprosy clients * Self-help Group/coordinator/ mobilizer * DHOs * DTLO/RTLO * Medical Officer/Medical college * Health Post in charge * Local key informants (social worker, school teachers, community leaders, AH staff) | Lalitpur, Kathmandu, Kavre, Chitwan, Bara, Parsa, Leprosy In-patient from Morang, Jhapa, Parsa, Sunsari, Dhanusa, Kanchanpur, Ramechhap |
| * Leprosy Policy * Coordination (Govt. I/NGOs) * Way forward | In-depth interview | * Ministry of Health * Leprosy Control Division * Regional Health Director * INGOs * Document review |  |
| * Additional insights | Personal observation | * Self help groups * Beneficiaries |  |

The field work was conducted between 4 - 25 September. Additional consultation was done in Kathmandu before and after field visit. The detail itinerary and list of places/visited and a person consulted is given in *Annex 3: Field visit schedule*; and .

## Limitations

Among 15 districts covered under the LMN/AH program (five key programmes – please refer below) in the central region, only six districts (two from Terai one from inner terai and three from mid hill) were visited for the study. Only two to three sites in each selected district were visited. The field findings and conclusions are based on the data and information from those districts and sites only, therefore cannot be generalised to other settings or other rehabilitation activities as it was conducted for specific purpose and objective.

Though AH receives referral from all over the country, the medical data from AH only was reviewed therefore it reflects the picture of AH and not the overall treatment picture of the country or other hospital. Some additional information (both quantitative and qualitative) was from the secondary sources.

Since the field work was completed in tight schedule, there was limited communication and coordination in the field as well as only small number of sites and groups were feasible for visit and consultation.

# Findings

## Respondents’ profile

A total of 199 clients and 42 AH, Government officials and I/NGOs persons were contacted to obtain information through participatory workshops, in-depth interview, focus group discussion, venn diagram, preference ranking. The respondents were from wide range of location, organisation, community and clients/beneficiaries mostly from agriculture and small business profession.

The age of the participants ranged from 15 years to 60 years in female (48%) and 16 years to 78 years old male (52%). Most of the participants (75%) were literate (ranging from school to masters level education) and rest were illiterate (for detail please refer to ).

Table 2: Respondents by education and sex

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Bara** | **Chitwan** | **Jhapa** | **Kan/pur** | **Kavre** | **Lalitpur\*** | **Morang** | **R/chhap** | **Sunsari** | **Total** |
| **Education** |  |  |  |  |  |  |  |  |  |  |
| Illiterate | 10 | 1 |  |  | 11 | 27 | - | - | - | 49 |
| Literate | 21 | 4 | 2 | 1 | 10 | 58 | - | - | - | 96 |
| School | 3 | 3 |  |  |  | 26 | - | - | - | 32 |
| Plus 2 | - | - | - | - | - | - | 1 | 1 |  | 11 |
| Bachelor | - | - | - | - | - | 6 | - | - | 1 | 7 |
| Master | - | - | - | - | - | 4 | - | - | - | 4 |
| **Sex of respondents** | | |  |  |  |  |  |  |  |  |
| Female | 22 | 4 | - | - | 7 | 61 | - | - | 1 | 95 |
| Male | 12 | 4 | 2 | 1 | 14 | 69 | 1 | 1 |  | 104 |
| **Total** | **34** | **8** | **2** | **1** | **21** | **130** | **1** | **1** | **1** | **199** |
| \* VDCs of Lalitpur were selected for obtaining information regarding general health services provided by AH | | | | | | | | | | |

Among the respondents about one fourth (26%) were leprosy clients where 37% were female and 63% were male (Refer to Figure 1).

Figure 1: Sex and age of respondents

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## Leprosy services

Leprosy service is flag mast of AH, and the purpose of being in Nepal as well as main element of agreement with government of Nepal. The contribution of AH in leprosy control programme in Nepal is well appreciated by government officials and other partners working in the field. **It has received patients from all over the country and quite a number of cases from India as well**. Besides, other leprosy hospitals like INF Pokhara, Lalgadh hospital Siraha, NLR clinic in Biratnager refer the cases to Anandanben for tertiary care and management of complication.

Government officials and other stakeholders expressed that since leprosy is slow progressing disease, delivering current level of services is required for another 30 years. It is a disease with long term effects and likely to remain for long time. Leprosy programme was donor driven for long time, but now it is within government strategy. Government budget has also increased over the period from about Rs 20 million to now Rs 45 million to cover additional programme activities like transportation support of Rs 1000 (Approx US$ 15) and equal amount for patient completing the treatment, expansion of Information Education and Communication activities etc. **Cost of tertiary care (including reconstructive surgery and other associated costs) is neither budgeted in LCD nor directly made available to hospital like Anandaban**.

It is also expressed by many that despite Nepal being one of the best performing countries in Leprosy control, next five year is critical, as it (the disease level) is in boarder line. If effort is lessened, the prevalence may go up.

### Anandaban Hospital

Anandaban Hospital provides a wide range of services with its capacity of 110 beds (30 beds for general patients) and other specialised services – reconstructive surgery, general surgery, dermatology, obstetrics and gynaecology, physiotherapy, and artificial limbs including foot ware. Specialist services in AH include reaction management, wound care and reconstructive surgery. AH has one of the two prostheses and orthoses departments in Nepal (the other is at Green Pastures Hospital in Pokhara). This department is highly regarded within Nepal. There is no referral facility in the government system for the treatment of complications of leprosy though government in its strategy aim to set up referral hospital. Hospital also has a well established research facility and laboratory capable of handling PCR and mouse colony facility.

Additional technical support is also provided for leprosy control work in 15 districts of central development regions (excluding 4 districts - Sindhuli, Sarlahi, Mahottari and Dhanusa). The hospital services are also accessed by patients from bordering towns from India. All leprosy services are free but subsidised fee is charged for general health services in AH.

LMN now include five key programmes

1. Anandban Hospital (leprosy and general services)
2. Training and Technical Support program,
3. Mycobacterial Research Laboratory, and

Community based programs for preventing disability due to leprosy, social and economic activities, known as the

1. Socio-Economic Rehabilitation (SER) Project. These projects aims to empower increase the capacity and improve the quality of life of people affected by leprosy and people with physical disabilities.
2. Community Empowerment, Development, Disability and Rehabilitation (CEDAR – in Rautahat and Ramechhap with support from the Leprosy mission Australia) Project and the

### Inpatient services

AH, being a referral hospital for tertiary care for Leprosy Affected People, it receives referrals from all over the country and India. The data from 2006 to 2011 indicates that **nearly 5% referral is from India.**

Figure : Admission of Leprosy Affected People

Highest number of referral is received from central region where case reporting is also high (Figure 3). From other regions referral is relatively low compared to case reporting. It appeared and was also explained to the study team that the referral from other regions is made to other hospitals nearby like Lalgadh hospital from Eastern region. It was also noted that referral from central region is not just for tertiary care but for other complications also, whereas referrals from other regions is only for complicated case for tertiary care. Being based in strategic location at Kathmandu valley, AH has location specific advantage also as people visiting AH can do many other personal activities in Kathmandu.

Box : Story of an inpatient at AH

**An in-patient at Anandaban Hospital**

Urmila Khatri- 27, married women, from Chalal, Kavre is an in-patient client at Anandaban hospital for last 11 months. She had spent two years in several places i.e. local health post, Banepa hospital, Dhulikhel hospital and Bir hospital before finally ending up at AH. She was treated eight months in Bir hospital saying that her problem will be solved soon but did not happen so. Finally, she was advised to visit Patan outreach clinic where she was diagnosed as leprosy patient and referred to Anandaban. During those periods she had to suffer a lot and spent a lot of money too. Innocently she said, why did not they advise to go directly from Banepa Dhulikhel to Anandaban hospital in first place? She had to face a lot of problem. She is already left by her husband and now helped by father and brother. She thinks if she was not brought here at Anandaban, she would have been disabled and would not have been able to work work for her daily life. Due to timely treatment by experience doctors and technician at Anandaban, now she has courage to live and maintain her life herself. She now would advise anyone with suspects of Leprosy directly go to Anandaban Hospital.

The inpatient service of AH appeared heavily used both of Leprosy Affected People and general public. The beds allocated for Leprosy Affected People is 80 and 30 beds are set aside for general people of the surrounding area. Though the overall new case detection in AH is slowly declining as the initial detection/diagnosis is now done in government health facility all over the country, **the overall need of OPD service and in patient service is in increasing tread**. Clearly, AH management needs constantly upgrading and maintaining its facility and current level of services to meet the increasing need of LAP in particular and other public in general.

Figure : Leprosy case referrals to AH

|  |  |
| --- | --- |
|  |  |

### Outpatient Services

OPD services are provided six days a week for general services but leprosy patients and general emergencies are taken care any time of the day or night and a doctor is always on call. In general, outpatient facilities and environment are well managed and maintained. Emergency services are well kept with full range of staff. Most related departments/sections/units are located conveniently.

Every year AH receives over 4000 visits from Leprosy Affected People for various complication and simple routine check up. Almost one third of cases are MDT. Ulcer and reaction are other major reasons for people visiting OPD.

Figure : OPD visits of Leprosy Affected People (2007 – 2010)



### Outreach clinic

Box : benefit of outreach clinic

AH also provides outreach clinical services for leprosy patients every week (Wednesday) in Patan Hospital and once in a month in Chandranigahapur, Rautahat. Outreach clinic apart from offering routine check up and follow-up is also an opportunity for case finding. The outreach clinics have contributed to diagnosis leprosy cases which are missing and unidentified for long time. Many patients were found to visit the clinic from across the country. Most of them were referred or advised from hospitals, relatives and friends. It is found that the **Patan outreach clinic has been regarded as a main referral clinic of leprosy**.

**Benefit of outreach clinic**

As expressed by existing clients who visited AH run Patan outreach clinic that the health posts and district hospitals could not diagnose her diseases for long time and was treated as general health problem with huge cost to her. Pasupati Rai, 25, had to visit various hospitals to be properly diagnosed for six years. During those years she was treated for skin, orthopedic and neurological problems in different hospitals. Finally, as advised by her friends, she arrived at Patan outreach clinic and was diagnosed as leprosy. Now she is being treated as a primary patient.

**While asking about the benefit of outreach clinic, some were of view that they hesitate to visit AH because of fear of stigma as AH is known as leprosy hospital. To maintain confidentiality, they prefer to visit Patan clinic as general patient even when they know they have leprosy**.

## Hospital services (General)

General OPD (six days a week) and 24 hrs emergency services are offered mainly for the communities in southern part of Lalitpur district (19 VDCs – Chhampi, Lele, Jharuwarasi, Devichaur, Nallu, Bhattedanda, Gotikhel, Asrang, Gimdi, Bhardev, Dalchoki, Devichaur, Ikudol, Malta, Sankhu, Kaleswor, Ghusel, Durlung and Thulodurlung) which is approximately in the radius of 60 KM.

Figure 5 shows the trend of four years’ service attendance pattern of in/out-patient and leprosy and general clients. While both in and out-patient of general attendance is in increasing trend, though not significant, the attendance of leprosy in/out-patient is in decreasing trend probably due to declining national prevalence of leprosy.

Figure : Trend of service attendance pattern in last four years (2007-2010)

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The number of general patient attendance is in an increasing trend despite the poor access of transportation to AH. However, available data indicate that people from Lele VDC are accessing the service more than people from other VDCs probably due to proximity of the VDC to the hospital (Figure 6).

Interviewed clients expressed their satisfaction with the OPD/general services. It was also expressed that the main reasons for coming to AH was because of timely care, good environment and reasonable cost. The reason for not going to Sub/Health Post and PHC was the unavailability of technicians, doctors and poor service quality and facility.

Figure : OPD service attendance by VDC



## Nallu_Venn D Female8.JPGEffectiveness of AH hospital

The women group in south of Lalitpur expressed Anandaban Hospital as their preferred service provider after health post. Majority of people visit local health post and AH in minor health problem. They do not go to other specialized hospital such as Patan hospital or other private hospital unless the AH refers them to such hospitals. They have strong feeling that the AH has contributed to improve health status of the community. Being the local residents they have easy access to hospital service. They also appreciate the behavior of doctors, nurses and other staff and their referral system to other hospital. The main reason behind the appreciation of the hospital is physical access, quick responses from the staff, low cost service and easy access to doctor and staff. Although the local people are satisfied with the service of the hospital, some of them think that ‘‘**the hospital should have highly experience doctors**’’. However, it was also said that the beneficiaries **do not know about the type of services and expertise available and the system of AH for utilizing those services**. They further expressed that **it would be convenient if the AH provides all the information about the hospital through wall paper and leaflets/brochures etc**.

The women groups have similar opinion that the **hospital has contributed to minimize health risks of children because of immunization service**. The general perception of the group was that the child mortality rate has been remarkably reduced in the community with the contribution of local health posts as well as AH. As expressed by the women group **the hospital is one of the important health institutions for poor people of the community who cannot afford the hospital fee and other expenditures in the city.**

The male group has similar view with that of female group regarding the expertise of the doctors. **However, they prefer AH in place of health post and Primary Healthcare Center. The group also suggested that the hospital should have ambulance, ultrasound and x-ray for effective service**.

Figure : Total AH spending by category (2008 – 2010)

From spending point of view (pie graphs) leprosy related expenses including disability management cost is about 79% and 21% cost is spent on non-leprosy related services. This cost does not include cost of SER/CEDAR.

The beneficiaries are **ready to pay more if the hospital increases service charges** provided that the standard of service also improves. The increased fee is also expected to contribute in continuing the hospital service to some extent. They are also of view the possibility of the VDCs and DDC financial contribution to sustain the hospital services. **For this hospital management should proactively explore this possibility**.

**In the context where leprosy is in “post elimination stage” where focus of leprosy related services is likely to change, current resource spending pattern needs to be carefully assessed by the AH management**.

Box : Quality of life – former client

**Quality of life – former client**

The AH has contributed in changing the life of leprosy patients. Some former client said that before treatment, they were unable to work “but just eat and stay”, but now they do both “eating and working”. The AH transformed them from a “dependent and burden” to an active earning member of their family. Support from SHG, scholarship, low cost housing, micro credit improved economic condition. Unlike earlier days now they are not humiliated in public places such as tea shop and hotels. **They run tea shop and hotels of their own.** A former patient said "if there was no AH, I would have died long ago, but today I can work in field, my life has been saved”.

Furthermore, 21% spending in general OPD/IPD services raises a question whether this spending is adequate in meeting the expectation of the local people seeking general health services, though the cost of general services is subsidized through ‘poor fund’. Keeping in view of local people’s higher expectations/need, AH management needs to decide the level of services (i.e. PHC, District hospital level or higher) it will provide in future.

### Relative proximity of AH

Through the Venn diagram, women were able to express and visualise the relative proximity and relationship with the health facilities in relation to level of satisfaction from services and interaction with them.

Figure : Relative proximity (venn diagramme)

The Venn diagramme shows that the closest health support the community gets is from sub- health post and next closest provider is health post and Anandaban Hospital. The position of Anandaban Hospital in relation to the closeness with community as perceived by women and men group is near. Some of the reasons expressed are, AH and its officials are easily accessible, positive behavior, quick response and low cost services.

They were of view that **if the hospital flows information about its facilities and expertise, the AH will be the first choice of the community because of its infrastructure and affordable service charge**. The community member also expressed their views that although they have less information about the AH, most of the people visit the hospital after getting primary treatment from local health facility.

### Additional services

Participants in all the visited VDCs in Lalitpur district were asked about the additional services in AH. They wish to have a **separate maternity department in the hospital**

so that many lives of mother and child can be saved. Because of low capacity, PHCs and

HPs are not capable in handling the delivery cases. They also said that **if the hospital manages basic medical equipments such as ultra sound and general x-ray, the people need not to go to other hospital in the city** and they will have access to effective health services in minimum cost. As a result of this gap of information, the number of patient is low from the surrounding VDCs.

Figure : Preference ranking for additional services

The need for additional services were further triangulated by using preference ranking tool (Figure 9) where both men and women groups unanimously **ranked maternity service as their first** **priority need followed by orthopaedic, eye and ENT**.

In addition to this, community also **preferred 24 hour emergency service and ambulance** service at AH. The reasons for prioritizing maternity service are; the very high numbers of unsafe delivery cases in the area, lack of expertise in handling delivery case in the local health post and PHC and poor condition of road to reach hospital in city center. **They want continuation of existing services including skin and TB services.**

### Revenue and expenditure

Available information shows that there is more expenditure than income generated. Though the deficit is narrowing from 2008 to 2010, there is deficit of approximately 14% in 2009 and 2010; extra effort is required to reach the breakeven point.

The data would not allow for further projection except that fact that that rate of income is higher than rate increment in client attendance (Refer to Figure 11). AH needs to take into consideration that **local community’s willingness to pay more for better and additional services** as well as possibility of mobilising local resources with VDC and DDC.

Figure : Income and expenditure (general service)



**It is however important to note that since the leprosy service is free, in order to continue the current level of leprosy service AH needs sustained support from donor or government.**

Figure : Client attendance and rate of income



## Training

AH have a good training facility with dormitory, training equipments and other facility. It can accommodate up to 40 participants in its facility. Training unit primarily aims to train Health Staff from government and other partners in various aspects of leprosy. But it is open and flexible to meet other training need of government and partners. Leprosyrelated training curricula are approved by Leprosy Control Division (LCD). Apart from specific basic and refresher trainings to paramedical staff and doctors, training centre also provides one day orientation to medical students (MBBS, Staff nurse, B PH, Lab) as well as orientation to NGO workers and other (lawyers) on Leprosy.

Figure : Total trained from Training Centre

Data trend indicates that training unit has been consistently providing training on basic leprosy and refresher both at field and at the AH. It was reported that most of the participants are government health workers mainly from central region.

However, if training report is compared with cases referred to AH for complication management from different districts, number of basic training provided to district health staff and the case referred shows wide variations. For example, from Bara district total case reported to AH is only 5 whereas the total number of training is more than 120 persons. Similarly, from Makwanpur the case reported is nearly 140, but training is less than that of Bara district. The reasons for such wide variations could not be identified or explained; training centre is expected to constantly monitoring case reporting from districts and intensify its training activities in those districts where case reporting is higher (Figure 13).

However, while comparing number of person trained against district case reporting (national data), a congruent pattern is observed for Chitwan, Parsa, Rautahat and Bara district where case reporting is also very high. For other districts where large numbers of people were trained such congruent pattern is not seen.

Figure : Training to health workers vs case referred to AH



## Mycobacterial research laboratory (MRL)

**AH Mycobacterial research facility (Laboratory) as one of the best in South Asia** and reportedly one among 10 WHO recognised leprosy research facility. Over the period it has carried our various research activities some of which is already published for wider benefit, though dissemination/sharing within the country reported to have not done. Some of the important researches that were carried out were in the area of reaction, diagnosis, and drug resistance including surveillance monitoring in collaboration with WHO. Interestingly the medical records of the hospital indicates the increasing number of reaction cases, therefore the finding of this research (particularly the reaction predication, diagnosis and treatment) is expected to contribute in this critical aspects particularly in policy development and changing treatment regimen. Please refer to - for detail research activities.

Among the collaborating partners in the research activities, most are international laboratories and universities in US, UK, Netherlands. **Government officials were critical on lack of coordination and communication regarding ongoing research activities and its effectiveness and benefit**.

## Community rehabilitation programme

It is one of the major programmes directly reaching leprosy clients in the field and remote villages. Leprosy outreach and self-help group program is being implemented as a SER/CEDAR project in 15 districts (excluding 4 districts of Sindhuli, Sarlahi, Mahottari and Dhanusa) of Central Development Region.

The goal of the project is to empower and increase the capacity of people affected by leprosy and or with physical disabilities. Special attention is given to women and people who are marginalised. The main objectives of the SHG are;

1. to train the person affected by leprosy in performance of self care activities, enabling the person to care for themselves within their own community

1. to prevent the person affected by leprosy from sustaining any new impairment.
2. to empower the person affected by leprosy and encourage them to take responsibility for management and prevention of disability and
3. to develop strategies for overcoming issues related to activity limitation and community participation restriction.

The SHG programme ultimately aims to transform the group into a “co-operative” like institution. The SER has a plan of total of 40 SHG by 2013 and so far it has formed 36 SHG in 12 districts. This project also provides financial support for school/college going boys and girls to pursue their studies.

**Situation of Self-help Group**

The study team visited 4 SHG groups in teraiand 2 SHG groups in hill districts. Normally 12-20 members made up a group. The composition of the group is expected to be with 60% leprosy patients, 25% disable and 15% marginalised. However, **this representation ratio was not found in the visited groups** (Figure 14)**. Interestingly, one group was found to have 63% representation from marginalised household instead of 15%**.

In most of the visited district, the status of the groups was in preliminary stage. Most of the groups were not sure why they are in the group and not aware of objectives and group operating guideline/ norms. All the SHG are being assisted and monitored by the head office (one coordinator and four social mobilizers). They are also responsible to implement/manage other activities in SHGs in the community. Only one district (Bara) does have Group facilitator/volunteer who is responsible for mobilising and managing groups’ fund/seed money activities and arranging non-formal literacy class. Group facilitator/volunteer regularly visits the groups and attends meetings and inform/collect savings, and also to educate on health related programs and group’s activities.

Figure : Composition of SHG



In the district **where there is full time Group facilitator/volunteer, the overall group’s activities are better managed** (very impressive group development/mobilization in just 4 months old group). It was observed that as the **targeted beneficiaries are widely scattered particularly leprosy affected members, are spending more time on travel for attending the group meeting**.

The level of participation normally starts with passive receptiveness, gradually evolving to making demands and giving suggestions to address the demands, and finally to be able to identify problems and plan and manage the group activities by themselves. The level and the kind of participation that the beneficiaries have during the group building and institutional building processes determine if they will be able to plan; manage and monitor their activities later. It has been evident that even with careful and dedicated efforts by development agents and social mobilizers, it takes long time (at least more than 5/6 years) to move the groups and communities from the initial stages to the final stages of institutional growth.

While assessing the groups’ stages of participation according to a participatory ladder model[[4]](#footnote-5), wide variation was noticed among the groups visited. Some are at very preliminary stage whereas others are at higher stage of development (Figure 15).

Figure : Stages of participation of SHG



The age of the groups varied from four months old to five years old. Therefore, it was not surprising that most have not yet reached the mature stage. Nonetheless, some had already been in higher stage particularly in reducing social stigma, promoting community awareness and women empowerment. They had come a steps forwards from being passive recipients to a stage where they can now articulate their needs and priorities. It was quite **motivating to observe that the group members who could not even speak out their names in public gatherings were able to narrate their success stories and ask for clarification or make some demands according to their needs.**

The majority of the group members mentioned that **the most important reason for staying in a group was to be able to access the seed money (Rs 20,000) and loan**. **The groups’ meetings were only held during the visit (monthly) of social mobilizer from the head office**. The meeting discusses mainly clinical/health and monthly saving collection. Other social and economic issues are not often discussed at length in those group meetings. The decisions made during the meetings were normally not recorded as minutes. Group activities like loan transactions as seed money, communications among the members takes place more often where clinical and project activities exist. Interestingly, some group members stated that they maintain meeting minutes and records of group activities in other similar group (i.e. saving credit group) where they are member.

**The motivation, skills and learning environment in the groups is very low. With this level of group dynamics and effort in group mobilization, developing the group into a cooperative will be a challenging task**.

The groups had also not been aware of and linked with or networked with the services provided by other service providers (e.g. Health post, VDCs agriculture/livestock/women development offices, local NGOs) in the districts. They had not been properly oriented towards mission and vision of the groups.

**The group members highly appreciated the AH for bringing them in group and their regular visit to assist them for self care and financial support through seed money and direct credit from the head office**. Group also highlighted that the income generation activities like small livestock rearing/buying and selling, (goat, pigs and poultry), grocery shop, vegetable farming and tea shop/small business etc has improved their financial status which has also helped reduce stigma in household because of being earning member of the family. The group concepts and group dynamics has also helped improving household relation with family and other people, raised their confidence level and improved their communication skills. Personal hygiene, self care, guiding and motivating new patient for treatment are other impressive achievements.

**No training on group management/social mobilization and skill trainings were provided to date. They expressed that such trainings would have been very useful for addressing their practical and strategic needs.**

Government official appeared less knowledgeable about community work as this activity is often not communicated formally with local and central level officials therefore did not appraise it critically during meetings.

## Views of Anandaban staff

During the field study a half-day participatory workshop was organised with the objective of sharing of AH staffs’ views and experience on strengths, weaknesses, opportunities and threats/constraints of AH at Anandaban. At the same time how AH can be made towards self sustainable and its way forward was also discussed and finalised their views through the participatory workshop. The participants were Executive Director, Admin and Finance staff, Medical doctors/nurse staff, Research laboratory, Trainer, and other general staffs of AH. While reviewing the AH existing work/programme and situation assessment and effect of AH and way forward a SWOT/C analysis was conducted involving all participants in two groups (see Table 3 and detail output in Annex 6: SWOT/C Analysis of Anandaban Hospital with staff).

Table : SWOT/C analysis output (AH staff)

|  |  |
| --- | --- |
| **Strengths:**   * Reaction management, Reconstructive surgery, special footwear and prosthesis * Ulcer management * Separate self care unit of prevention of disability (POD) * Research (Mycobacterial) and clinical lab * Training unit * Infrastructure (well established hospital buildings, land) * Well trained and dedicated staff * Orthopedics, dermatological services * Outreach services/Special camps * Good Networking/coordination with Leprosy Network NGO/INGO and Government * Donor’s commitment * Moral support and goodwill of community | **Weaknesses:**   * Poor road access * Poor communication network (telephone, internet and electricity) * Insufficient trained staff and specialized services (eye, gynecology/obstetrics) * Weak in causality service (No lab services) * No blood bank, no digital X-ray * No hospital protocols * Rapid turnover of staff (medical), not enough human power * No ambulance service * No reliable and frequent transport service (for staff and clients) * Frequent change of policy * Low revenue collection from general services from local clients * Completely dependent on donor |
| **Opportunities:**   * Leading health institution in southern part of Lalitpur district * Upgrading specialized services (gynecology/obstetrics, surgical) * Training/seminar centre, nursing college * Ortho appliance centre * Trauma centre * Potentiality of generating income by expanding specialize services | **Threats/Constraints:**   * Internal mission’s policy/priority * Frequent changed policies of government and donors * Government policy * No back-up services (No second person cadre) |

# Recommendations

1. Since AH is considered as a national leprosy referral hospital for management of reaction and tertiary care, AH needs to maintain this service along with other routine leprosy related services. Besides, as government strategy plans to establish at least a government hospital for leprosy referral cases, AH along with other partners should support in implementing this strategy. Since AH is working as referral hospital for tertiary care in the country and it does not receive any financial support from government, an advocacy and lobbying is suggested to obtain government grants to manage tertiary care in the hospital.
2. In the context where leprosy is in “post elimination stage” where focus of leprosy related services is likely to change, current resource spending pattern needs to be carefully assessed by the AH management.
3. Current expertise and facility in skin and orthopedic is well acknowledged both by government and community people. While continuing the current level of services, it is recommended to expand and ‘fine tune’ skin and other services to meet the community need.
4. Despite appreciation of research facility and work, concerns were expressed on lack of coordination and cooperation particularly by the government staff. A proper coordination and communication is expected from AH on this regards. It is also recommended to broaden the scope of research by including other biomedical researchers, and collaborating with other similar research institutions within the country and outside.
5. 21% spending in general OPD/IPD services raises a question whether this spending is adequate in meeting the expectation of the local people seeking general health services. Keeping in view of local people’s higher expectations/need, AH management needs to decide the level of services (i.e. PHC, District hospital level or higher) it will provide in future. While so doing, it is recommended to take into account of community’s willingness to pay more and views on additional service need e.g. need of a full fledge maternity services, x-ray facility, ambulance service etc. Furthermore, regular communication with community people regarding the available facility and services at AH is expected by the community. If flow of information about its facilities and expertise is improved, the AH will be the first choice of the community because of its infrastructure and affordable service charge.
6. While the need for leprosy related training will continue for government staff though likely to be at reduced frequency, optimizing the training facility is crucial for sustainability of the centre. Along with existing AH hospital facility and its field presence, potentially training unit can be expanded to include other training courses of long or short duration. While there are wild suggestions from staff and others alike (setting up nursing college, marketing training facility to other agencies), AH needs to make need assessment and a business plan for training unit.

*Community rehabilitation activities*

1. AH need to be more flexible in its self help group approach. Instead of having rigid rule of 60% of Leprosy clients, they can be more flexible including general disable with priority to Leprosy. Moreover, with proper social mobilisation approach and investment on social intermediation, appropriate training, linkage and network development activities (local NGOs, govt. institutions), potentially the group/s can be developed into institution like co-operatives or other organizations where they can develop/manage/organize their needs.
2. The groups are not aware of and linked with or networked with the services provided by other service providers (e.g. Health post, VDCs agriculture/livestock/women development offices) in the districts. Other short comings in the group management were also observed. Effort should be made to establish linkage with other groups and services at the local level. As such, the current limited number of facilitator/volunteer should be revisited.

*Additional points*

1. Language and associated factors could be a barrier in accessing health services as most of the women in catchment area speak their own mother tongue, Tamang (Lalitpur), Bhojpuri (Bara, Parsa)
2. There are opportunities to mobilise local resources from VDC and DDC in the areas where AH has programme and services. AH should proactively explore this opportunity.

**Annexes**

Annex 1: TOR

Terms of Reference

for a Participatory Rural Appraisal of the services of Ananadaban Hospital, Nepal

Leprosy Mission Nepal supported by The Leprosy Mission International

1. **Aims**

The 10 year Strategic Plan drawn up for Anandaban Hospital in 2009 recommends that an Organisational Assessment should be carried out to determine how well-placed the Hospital currently is to develop in the manner envisaged by that Plan. As part of that Organisational Assessment, a review of current standards and protocols is to be undertaken to measure how effectively Anandaban Hospital is delivering its services to the local community, how it can make that delivery more effective, and how the Hospital should be adapting to meet the challenges of the future.

1. **Objectives**

A Participatory Rural Appraisal (PRA) will be conducted by a firm of independent consultants to ensure that its conclusions are free from Hospital influence. These consultants will undertake a comprehensive field study to discover the views and opinions of existing and former clients on the services they received and whether the Hospital could offer additional services or support that they would have found helpful. They will also consult with external stakeholders, Government departments and leprosy NGOs.

1. **Methods**

The following questions and issues should be addressed by the PRA:

3.1 External stakeholders, Government departments and leprosy NGOs (specific details to be agreed):

* Will Anandaban Hospital be needed in future to provide secondary and tertiary level health care (primary level care is provided at Government-run Health Posts).
* What are the gaps in Government provision for leprosy services that the Hospital could fill?
* Should Anandaban Hospital move towards developing as a national leprosy referral hospital for leprosy reaction and reconstructive surgery?
* Should the Hospital develop its services for trauma related injuries, in addition to maintaining its expertise in leprosy diagnosis, treatment and management. Is such a development feasible? Is it a good idea?

3.2 Existing and former clients of Anandaban Hospital (these must be a mixture of leprosy-affected and non-leprosy-affected people, both male and female, disabled and able-bodied):

* To what extent is Anandaban Hospital contributing to people’s quality of life?
* Do leprosy-affected people feel that they have a dignified life? Has the Hospital contributed towards this?
* Is there anything else that the Hospital could do to give them a better quality of life?
* How do leprosy-affected and non-leprosy-affected people feel about being treated together in the Hospital?

3.3 A separate section of the PRA should consider the sustainability of the Hospital’s services, both current and proposed, from the point of view of finances and manpower.

3.4 The following PRA tools will be applied during the study :

* Focus group discussions in the field and at Anandaban Hospital
* Views of external agencies obtained via Interview or questionnaires
* Other PRA tools to be agreed

1. **Selection of Districts for Field Visits**

The number of field visits undertaken will take account of the number of patients registered in a particular area to ensure that a full cross-section of client groups is included in each visit. The VDCS to be covered are 3 VDCS of Lalitpur district, 1 VDC of Bara or Parsa district and 1 VDC of Sindhupalchowk or Kavre (total 5 VDCs). There has to be an interview with the patients who are currently under treatment at Anandaban, who are from the other parts of Nepal (beyond Central region).

1. **Report and Schedule**

The PRA should be produced to international standards, written in a straightforward manner in English, and is to begin with a tightly focused summary of the study findings. The draft report will be presented to the Hospital by the first week in October for review and the final report submitted by the second week in October.

1. **Responsibilities**

All logistics, transportation and manpower required to conduct the field study will be provided by Anandaban Hospital at its own cost, as will accommodation and subsistence for the team in the field.

The firm of consultants will be responsible for the remaining costs of compiling and producing the PRA.

**Payment Procedures:**

Once we receive the quotations, the amount and the procedure will be finalized.

Annex 2: Check list - FGD and IDI

**Check List for Participatory Assessment of Anandaban Hospital: Situation, Effectiveness and Way-forward**

**(Focus Group Discussion)**

**Beneficiary Group:** Beneficiaries General Health (Community), Health Post Management Committee, All Party Political Representatives, OPD clients and Social worker/Community Leader

* Introduction and climate setting
* What do they know about AH?
* Types of services they are getting from AH (free and paid services)
* How easy/difficult to get service from AH
* Health services different from other hospitals (venn diagram)
* Why they come to AH? instead of local Sub/health post and other hospital
* Difference between other hospitals and AH in terms of services
* Services/facilities for disables in AH
* What other better services can be expected from AH
* Communities’ need/expectation of additional services/facilities in future (preference ranking)
* Willingness to pay for better additional services
* Contribution/improvement for local community and human health
* Feeling about treating together with leprosy-affected person in same place/hospital
* Making community hospital to AH and suggestions
* Communities’ feelings if services are discontinued at AH
* Most liked things/aspect of AH (at least 3)
* Suggestions for making more effective to AH

**Beneficiary Group**: Self-help Groups

* Criteria of group formation
* Objective of group formation, Is the group inclusive (other than Leprosy disable and poor)
* Group’s work plan, (activities, record keeping)
* Group meeting and minute maintaining system
* Group's rules and regulations (who develop it?)
* Size of seed money provided by ABH (procedure)
* Awareness on group's saving scheme
* Use of saving scheme( if exist objective, procedure?, rules and regulation of scheme and priority areas)
* Credit facilities centres in local area (bank, micro finance institution cooperative)
* Size of the credit, interest rate, management capacity
* Opportunities to develop cooperative/organization
* Presence of other institutions (Venn diagram)
* Social stigma
* How the group members perceive the contribution of ABH
* What the AH staffs do during group's monthly meeting?
* Facilitation process of group (What do they do)

**In-depth Interview**

**Beneficiary Group:** Existing/in and outpatient/outreach clients

* Area/location of client
* How did they came to AH/Outreach clinic and why not other hospital
* Did they came first to AH or gone somewhere else?
* Services/facilities they are getting from AH
* Behaviour of Doctors/staff of AH
* Expectation of additional services/facilities in future
* Three most liked things/aspects of AH
* Suggestions for persons like them (leprosy affected)
* Suggestions for making more effective to AH
* If services are discontinued at AH

**Beneficiary Group:** Former leprosy clients

* Present life/conditions and business
* Behaviour of family/society while suffering from leprosy
* Why did they prefer to go to AH?
* The changes made by AH to their life
* Clients’ situations in the society/community/home (before and after treatment)
* Economic condition/changes after treatment.

**Beneficiary Group:** Social worker/community leader

* Introduction and brief objective of study
* Distance to travel (on foot/by public transport and hrs)
* How do they perceive the services of AH
* What do they know about AH?
* Types of services they are getting from AH (free and paid services)
* How easy/difficult to get service from AH
* Health services different from other hospitals
* Why they come to AH? instead of local Sub/health post and other hospital
* Difference between other hospitals and AH in terms of services
* What other better services can be expected from AH
* Additional services/facilities in future
* Willingness to pay for better additional services
* Contribution/improvement for local community and human health
* Feeling about treating together with leprosy-affected person in same place/hospital
* Making community hospital to AH and suggestions
* Feelings if services are discontinued at AH
* Most liked things/aspect of AH (at least 3)
* Suggestions for making more effective to AH

**Beneficiary Group:** Private Medical College/Medical Officer

* What do they know about AH?
* Relation with local leprosy clinic
* Relation with DHO
* Do they have leprosy treatment facility/department
* How the patient comes to them (direct or after referring)
* Leprosy diagnosis and referral system
* Situation of stigma in the locality

**Beneficiary Group:** Health post/DHO/DTLA/RTLO

* Information/knowledge about AH
* How do they perceive the AH services
* Programme coordination/linkage with AH
* Referral system of Leprosy client
* Why AH general service should be continued in South of Lalitpur?
* Most positive aspects of AH (at least three)
* Effect in the community if TLM’s fund is discontinued
* Suggestion/options if AH service is discontinued

Beneficiary Group: RD/LCD/NGO/INGO

* Government’s leprosy treatment/working systems
* Government’s leprosy referral system
* Status of referral hospital and AH
* Programme coordination/linkage with DHOs
* Relation/coordination with AH and other NGOS on leprosy programme
* Working policy/programme on tertiary and rehabilitative care
* Future role of AH in the context of leprosy elimination
* Role of AH if leprosy treatment/programme is manage by the Government
* Programme/policy and future role of AH in general health services in south of Lalitpur district
* AH’s role for national leprosy referral hospital
* AH/SER Self-help group programme and linkages
* Situation if AH services fund is reduced/discontinued
* AH’s way forward and options for sustainability
* DTLA’s views on leprosy treatment/work in Nepal

Annex 3: Field visit schedule

**Field Visit Program**

**Field Visit Team:**

* Purna Bahadur Chemjong, Team Leader, AH study team
* Dipak Timsina, Member, PRA Field Research and Supprt Specialist
* Mahesh Sharma, Member, Policy analyst/health system Specialist
* Ram Babu Bista, Physiotherapy Supervisor, Anandaban Hospital
* Iswor Shrestha, Lab Supervisor, Anandaban Hospital
* Indra Bahadur Tamang, Training Supervisor, Anandaban Hospital
* Kashi Nath Aryaal, Social Mobilizer, Anandaban Hospital
* Chandra Bahadur Thapa, Social Mobilizer, Anandaban Hospital
* Badri Kathait, Social Mobilizer, Anandaban Hospital

**Mode of Transportation:** Office Vehicle

|  |  |  |  |
| --- | --- | --- | --- |
| **Date** | **Day** | **Venue** | **Program Activities** |
| 06 Sep 2011 | Tuesday | Capaganu & Chhampi, Lalitpur | * FGD with community group (male/female) and IDI |
| 07 Sep 2011 | Wednesday | Patan Clinic, DHO, Lalitpur | * IDI with OPD clients and DHO/DTA |
| 08 Sep 2011 | Thursday | Kavre & Panauti | * FGD with self-help groups and IDI |
| 09 Sep 2011 | Friday | Nallu, Lalitpur | * FGD with community group (male/female) and IDI |
| 11 Sep 2011 | Sunday | Gotikhel, Lalitpur | * FGD with community group (male/female) and IDI |
| 21 Sep 2011 | Wednesday | Miadi, Chitwan | * FGD with self-help groups and IDI |
| 22 Sep 2011 | Thursday | DHO, Bharatpur, Bhandara, Chitwan | * FGD with self-help groups and IDI |
| 23 Sep 2011 | Friday | National Medical College, DHO, Birgunj | * IDI with Dermatologist, DTA & Medical Officer, PHC Bagaiya, Parsa |
| 24 Sep 2011 | Saturday | Parsurampur, Kalaiya, Bara | * FGD with self-help groups and IDI |

Annex 4: List of people consulted (FGD, SHG, Workshop and in depth interview)

**Female Focus Group Discussion, Chapagaun**

| SN | **Name** | **Age** | **Education** | **Marital**  **Status** | **Beneficiaries** | **District** | **VDC** | **Sex** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1 | Sainli Tamang | 60 | Illiterate | Married | Beneficiaries GH | Lalitpur | Chapagaun | Female |
| 2 | Sunita Thapa Magar | 27 | Illiterate | Married | Beneficiaries GH | Lalitpur | Chapagaun | Female |
| 3 | Suntali Magar | 60 | Illiterate | Married | Beneficiaries GH | Lalitpur | Chapagaun | Female |
| 4 | Pyari Tamang | 38 | Illiterate | Married | Beneficiaries GH | Lalitpur | Chapagaun | Female |
| 5 | Maiya Tamang | 36 | Illiterate | Married | Beneficiaries GH | Lalitpur | Chapagaun | Female |
| 6 | Thuli Waiba | 50 | Illiterate | Married | Beneficiaries GH | Lalitpur | Chapagaun | Female |
| 7 | Man Maya Tamang | 65 | Illiterate | Married | Beneficiaries GH | Lalitpur | Chapagaun | Female |
| 8 | Mithu Tmang | 50 | Illiterate | Married | Beneficiaries GH | Lalitpur | Chapagaun | Female |
| 9 | Thuli Tamang | 50 | Illiterate | Unmarried | Beneficiaries GH | Lalitpur | Chapagaun | Female |
| 10 | Sunita Tamang | 16 | School | Married | Beneficiaries GH | Lalitpur | Chapagaun | Female |
| 11 | Lakshmi Tamang | 17 | School | Married | Beneficiaries GH | Lalitpur | Chapagaun | Female |
| 12 | Sarmila Tamang | 24 | School | Married | Beneficiaries GH | Lalitpur | Chapagaun | Female |
| 13 | Sanu Thapa | 30 | Plus 2 | Married | Beneficiaries GH | Lalitpur | Chapagaun | Female |
| 14 | Rasmi Tamang | 28 | Bachelor | Married | Beneficiaries GH | Lalitpur | Chapagaun | Female |
| 15 | Uma Tamang | 25 | Plus 2 | Married | Beneficiaries GH | Lalitpur | Chapagaun | Female |
| 16 | Maya Tamang | 35 | Literate | Married | Beneficiaries GH | Lalitpur | Chapagaun | Female |
| 17 | Goma Tamang | 47 | Literate | Married | Beneficiaries GH | Lalitpur | Chapagaun | Female |
| 18 | Sarswoti Tamang | 37 | Literate | Married | Beneficiaries GH | Lalitpur | Chapagaun | Female |
| 19 | Anju Tamang | 27 | Literate | Married | Beneficiaries GH | Lalitpur | Chapagaun | Female |
| 20 | Urmila Tamang | 30 | Literate | Married | Beneficiaries GH | Lalitpur | Chapagaun | Female |
| 21 | Lakhmi Tamang | 30 | Literate | Married | Beneficiaries GH | Lalitpur | Chapagaun | Female |
| 22 | Goma Tamang | 35 | Literate | Married | Beneficiaries GH | Lalitpur | Chapagaun | Female |
| Male Focus Group Discussion, Chapagaun, Lalitpur | | | | | | | | |
| 1 | Jaya Kumar Tamang | 30 | School | Married | Beneficiaries GH | Lalitpur | Chapagaun | Male |
| 2 | Manoj Tamang | 32 | School | Married | Beneficiaries GH | Lalitpur | Chapagaun | Male |
| 3 | Santosh Tamang | 32 | School | Married | Beneficiaries GH | Lalitpur | Chapagaun | Male |
| 4 | Kanchha Tamang | 30 | School | Married | Beneficiaries GH | Lalitpur | Chapagaun | Male |
| 5 | Kamal Tamang | 36 | School | Married | Beneficiaries GH | Lalitpur | Chapagaun | Male |
| 6 | Umesh Tamang | 26 | School | Married | Beneficiaries GH | Lalitpur | Chapagaun | Male |
| 7 | Gyan Bdr Tamang | 36 | Literate | Married | Beneficiaries GH | Lalitpur | Chapagaun | Male |
| 8 | Chalitra Tamang | 45 | Literate | Married | Beneficiaries GH | Lalitpur | Chapagaun | Male |
| 9 | Rakcha Tamang | 36 | Literate | Married | Beneficiaries GH | Lalitpur | Chapagaun | Male |
| 10 | Chandra Bdr Tamang | 63 | Illiterate | Married | Beneficiaries GH | Lalitpur | Chapagaun | Male |
| 11 | Man Bdr Tamang | 70 | Illiterate | Married | Beneficiaries GH | Lalitpur | Chapagaun | Male |
| 12 | Purna Bdr Tamng | 50 | Illiterate | Married | Beneficiaries GH | Lalitpur | Chapagaun | Male |
| 13 | Ram Bdr Tamang | 60 | Illiterate | Married | Beneficiaries GH | Lalitpur | Chapagaun | Male |
| 14 | Chandra B Magar | 60 | Illiterate | Married | Beneficiaries GH | Lalitpur | Chapagaun | Male |
| 15 | Amar Tamang | 27 | Plus 2 | Unmarried | Beneficiaries GH | Lalitpur | Chapagaun | Male |
| 16 | Dinesh Tamang | 16 | School | Unmarried | Beneficiaries GH | Lalitpur | Chapagaun | Male |
| 17 | Raju Thapa Magar | 20 | School | Unmarried | Beneficiaries GH | Lalitpur | Chapagaun | Male |
| 18 | Man Kaji Tamang | 27 | School | Unmarried | Beneficiaries GH | Lalitpur | Chapagaun | Male |
| 19 | Hem Raj Tamang | 30 | Bachelor | Unmarried | Beneficiaries GH | Lalitpur | Chapagaun | Male |
| Female Focus Group Discussion, Chhampi, Lalitpur | | | | | | | | |
| 1 | Maiya Baniya | 35 | Literate | Married | Beneficiaries GH | Lalitpur | Chhampi | Female |
| 2 | Ratna Khadka | 50 | Literate | Married | Beneficiaries GH | Lalitpur | Chhampi | Female |
| 3 | Sita Nagarkoti | 22 | Literate | Married | Beneficiaries GH | Lalitpur | Chhampi | Female |
| 4 | Sarmila Khadka | 27 | Literate | Married | Beneficiaries GH | Lalitpur | Chhampi | Female |
| 5 | Gayatri Khadka | 40 | Literate | Married | Beneficiaries GH | Lalitpur | Chhampi | Female |
| 6 | Maya Neupane | 54 | Literate | Married | Beneficiaries GH | Lalitpur | Chhampi | Female |
| 7 | Manju Khadka | 40 | Literate | Married | Beneficiaries GH | Lalitpur | Chhampi | Female |
| 8 | Sarita Khadka | 35 | Literate | Married | Beneficiaries GH | Lalitpur | Chhampi | Female |
| 9 | Nani Khadka | 28 | Literate | Married | Beneficiaries GH | Lalitpur | Chhampi | Female |
| 10 | Sarju Khadka | 31 | Literate | Married | Beneficiaries GH | Lalitpur | Chhampi | Female |
| 11 | Sumitra Khadka | 35 | School | Married | Beneficiaries GH | Lalitpur | Chhampi | Female |
| 12 | Ruku Khadka | 25 | Plus 2 | Married | Beneficiaries GH | Lalitpur | Chhampi | Female |
| 13 | Susma Khadka | 21 | Plus 2 | Unmarried | Beneficiaries GH | Lalitpur | Chhampi | Female |
| Male Focus Group Discussion, Chhampi, Lalitpur | | | | | | | | |
| 1 | Krishna Hari Khadka | 50 | Master | Married | Beneficiaries GH | Lalitpur | Chhampi | Male |
| 2 | Chandra Hari Khadka | 52 | SLC | Married | Beneficiaries GH | Lalitpur | Chhampi | Male |
| 3 | Ram Hari Khadka | 60 | SLC | Married | Beneficiaries GH | Lalitpur | Chhampi | Male |
| 4 | Basudev Khadka | 40 | School | Married | Beneficiaries GH | Lalitpur | Chhampi | Male |
| 5 | Bhimsen Nagarkoti | 30 | SLC | Married | Beneficiaries GH | Lalitpur | Chhampi | Male |
| 6 | Amrit Baniya | 38 | School | Married | Beneficiaries GH | Lalitpur | Chhampi | Male |
| 7 | Arjun Khadka | 36 | Plus 2 | Married | Beneficiaries GH | Lalitpur | Chhampi | Male |
| 8 | Mdhusudan Ngarkoti | 35 | School | Married | Beneficiaries GH | Lalitpur | Chhampi | Male |
| 9 | Biswa Ghimire | 30 | Plus 2 | Married | Beneficiaries GH | Lalitpur | Chhampi | Male |
| 10 | Raj Kumar Nagarkoti | 33 | SLC | Married | Beneficiaries GH | Lalitpur | Chhampi | Male |
| 11 | Kedar Nagarkoti | 42 | School | Married | Beneficiaries GH | Lalitpur | Chhampi | Male |
| 12 | Kesab Ngarkoti | 40 | School | Married | Beneficiaries GH | Lalitpur | Chhampi | Male |
| 13 | Shyam Bdr Khadka | 50 | School | Married | Beneficiaries GH | Lalitpur | Chhampi | Male |
| 14 | Prem Bdr Khadka | 65 | Literate | Married | Beneficiaries GH | Lalitpur | Chhampi | Male |
| 15 | Dambar Ngarkoti | 40 | Literate | Married | Beneficiaries GH | Lalitpur | Chhampi | Male |
| 16 | Santa B Nagarkoti | 48 | Literate | Married | Beneficiaries GH | Lalitpur | Chhampi | Male |
| Female Focus Group Discussion, Nallu, Lalitpur | | | | | | | | |
| 1 | Meera K.C. | 20 | Literate | Married | Beneficiaries GH | Lalitpur | Nallu | Female |
| 2 | Seeta Ghalan | 24 | Illiterate | Married | Beneficiaries GH | Lalitpur | Nallu | Female |
| 3 | Anita Ghalan | 20 | Illiterate | Married | Beneficiaries GH | Lalitpur | Nallu | Female |
| 4 | Sahili Thing | 60 | Illiterate | Married | Beneficiaries GH | Lalitpur | Nallu | Female |
| 5 | Sarmila Ghalan | 18 | Literate | Married | Beneficiaries GH | Lalitpur | Nallu | Female |
| 6 | Srijana Yonjan | 23 | Illiterate | Married | Beneficiaries GH | Lalitpur | Nallu | Female |
| 7 | Mahili Ghalan | 60 | Illiterate | Married | Beneficiaries GH | Lalitpur | Nallu | Female |
| 8 | Kanchhi Ghalan | 39 | Literate | Married | Beneficiaries GH | Lalitpur | Nallu | Female |
| 9 | Dhan Maya Tamang | 27 | Literate | Married | Beneficiaries GH | Lalitpur | Nallu | Female |
| 10 | Mahili Ghalan | 50 | Illiterate | Married | Beneficiaries GH | Lalitpur | Nallu | Female |
| 11 | Sabitri Khatri | 25 | Literate | Married | Beneficiaries GH | Lalitpur | Nallu | Female |
| 12 | Anjali Syangtan | 22 | Illiterate | Married | Beneficiaries GH | Lalitpur | Nallu | Female |
| 13 | Rasmita Bal | 38 | Literate | Married | Beneficiaries GH | Lalitpur | Nallu | Female |
| Male Focus Group Discussion, Nallu, Lalitpur | | | | | | | | |
| 1 | Bhim Bdr Ghalan | 24 | Literate | Married | Beneficiaries GH | Lalitpur | Nallu | Male |
| 2 | Badri Bdr Syangtan | 50 | Literate | Married | Beneficiaries GH | Lalitpur | Nallu | Male |
| 3 | Karna Ghalan | 40 | Literate | Married | Beneficiaries GH | Lalitpur | Nallu | Male |
| 4 | Ale Ghalan | 30 | Illiterate | Married | Beneficiaries GH | Lalitpur | Nallu | Male |
| 5 | Bhim Bahadur Ghalan | 42 | Literate | Married | Beneficiaries GH | Lalitpur | Nallu | Male |
| 6 | Prem lal Syangtan | 60 | Literate | Married | Beneficiaries GH | Lalitpur | Nallu | Male |
| 7 | Prakash Tamang | 23 | Literate | Married | Beneficiaries GH | Lalitpur | Nallu | Male |
| 8 | Bijaya Syangtan | 29 | Literate | Married | Beneficiaries GH | Lalitpur | Nallu | Male |
| 10 | Basanta Tamang | 39 | Literate | Married | Beneficiaries GH | Lalitpur | Nallu | Male |
| 11 | Keshar Thing | 24 | Literate | Married | Beneficiaries GH | Lalitpur | Nallu | Male |
| 12 | Sukulal Thing | 22 | Literate | Married | Beneficiaries GH | Lalitpur | Nallu | Male |
| 13 | Kanchha Singh | 78 | Literate | Married | Beneficiaries GH | Lalitpur | Nallu | Male |
| Female Focus Group Discussion, Gotikhel, Lalitpur | | | | | | | | |
| 1 | Chahana Lama | 19 | Plus 2 | Unmarried | Beneficiaries GH | Lalitpur | Gotikhel | Female |
| 2 | Parbati Mahat | 39 | Illiterate | Married | Beneficiaries GH | Lalitpur | Gotikhel | Female |
| 3 | Prava Lama | 27 | Literate | Unmarried | Beneficiaries GH | Lalitpur | Gotikhel | Female |
| 4 | Pratima Chaulagain | 22 | Bachelor | Unmarried | Beneficiaries GH | Lalitpur | Gotikhel | Female |
| 5 | Sunita Sigdhan | 22 | Illiterate | Married | Beneficiaries GH | Lalitpur | Gotikhel | Female |
| 6 | Dil Kurmari Shrestha | 40 | Literate | Married | Beneficiaries GH | Lalitpur | Gotikhel | Female |
| 7 | Purnakumari Ghimire | 55 | Illiterate | Married | Beneficiaries GH | Lalitpur | Gotikhel | Female |
| 8 | Sabitri Dahal | 41 | Illiterate | Married | Beneficiaries GH | Lalitpur | Gotikhel | Female |
| 9 | Beli Syangtan | 30 | Literate | Married | Beneficiaries GH | Lalitpur | Gotikhel | Female |
| 10 | Kabita Pariyar | 28 | Literate | Married | Beneficiaries GH | Lalitpur | Gotikhel | Female |
| 11 | Sushila Timilsina | 34 | Literate | Married | Beneficiaries GH | Lalitpur | Gotikhel | Female |
| Male Focus Group Discussion, Gotikhel, Lalitpur | | | | | | | | |
| 1 | Rajendra K Adhikari | 37 | SLC | Married | Health Post MC | Lalitpur | Gotikhel | Male |
| 2 | Tanka Lama | 35 | Master | Married | Health Post MC | Lalitpur | Gotikhel | Male |
| 3 | Ram Hari Dulal | 37 | Master | Married | Health Post MC | Lalitpur | Gotikhel | Male |
| 4 | Tanka B Ghimire | 67 | Literate | Married | Health Post MC | Lalitpur | Gotikhel | Male |
| 5 | Sagar Pariyar | 27 | Literate | Married | Health Post MC | Lalitpur | Gotikhel | Male |
| 6 | Bal Ram Ghimire | 43 | SLC | Married | Health Post MC | Lalitpur | Gotikhel | Male |
| 7 | Mukunda P Parajuli | 56 | SLC | Married | Health Post MC | Lalitpur | Gotikhel | Male |
| 8 | Tej B Syangtan | 51 | Bachelor | Married | Health Post MC | Lalitpur | Gotikhel | Male |
| 9 | Ramesh Ghimire | 35 | Literate | Married | Health Post MC | Lalitpur | Gotikhel | Male |
| 10 | Sitaram Banjara | 48 | Plus 2 | Married | Health Post MC | Lalitpur | Gotikhel | Male |
| 11 | Narayan P Sharma | 43 | Bachelor | Married | Health Post MC | Lalitpur | Gotikhel | Male |
| Self-help Group: Pancha Kanya Devi Samuha, Panchkhal, Kavre 2062/63) | | | | | | | | |
| 1 | Gyanendra Mijar | 29 | Literate | Married | Leprosy | Kavre | Panchkhal | Male |
| 2 | Kishna B Mijar | 60 | Illiterate | Married | Leprosy | Kavre | Panchkhal | Male |
| 3 | Mache Danubar | 60 | Illiterate | Married | Leprosy | Kavre | Panchkhal | Male |
| 4 | Kanchi Danubar | 62 | Illiterate | Married | Leprosy | Kavre | Panchkhal | Female |
| 5 | Laldhoj Tamang | 69 | Literate | Unmarried | Leprosy | Kavre | Panchkhal | Male |
| 6 | Suntoli Mijar | 34 | Illiterate | Married | Leprosy | Kavre | Panchkhal | Female |
| 7 | Santa Mijar | 31 | Illiterate | Married | Leprosy | Kavre | Panchkhal | Female |
| 8 | Bir Bahadur Tamang | 64 | Illiterate | Married | Leprosy | Kavre | Panchkhal | Male |
| 9 | Meghnath Timalsina | 68 | Illiterate | Married | Leprosy | Kavre | Panchkhal | Male |
| 10 | Chandra P Danuwar | 62 | Illiterate | Married | Leprosy | Kavre | Panchkhal | Male |
| 11 | Santamatha Mijar | 35 | Illiterate | Married | Leprosy | Kavre | Panchkhal | Female |
| 12 | Muna Mijar | 17 | Literate | Unmarried | Leprosy | Kavre | Panchkhal | Female |
| 13 | Megh Nath Accharya | 65 | Illiterate | Married | Leprosy | Kavre | Panchkhal | Male |
| 14 | Dirgha Lamichhane | 66 | Illiterate | Married | Leprosy | Kavre | Panchkhal | Male |
| Self-help Group: Gorkhanath Samuha, Panauti, Kavre (2060) | | | | | | | | |
| 1 | Krishna Bahadur Rai | 55 | Literate | Married | Leprosy | Kavre | Panauti | Male |
| 2 | Ganesh Mijar | 40 | Literate | Married | Leprosy | Kavre | Panauti | Male |
| 3 | Bidur P Acharya | 61 | Literate | Married | Leprosy | Kavre | Panauti | Male |
| 4 | Ganesh Man Duwal | 72 | Literate | Married | Leprosy | Kavre | Panauti | Male |
| 5 | Bal Krishna B.K. | 57 | Literate | Married | Leprosy | Kavre | Panauti | Male |
| 6 | Ganga Deula | 30 | Literate | Married | Leprosy | Kavre | Panauti | Female |
| Self-help Group: Dayalu Swayam Sahayata Samuha, Parshurampur, Bara (2068) | | | | | | | | |
| 1 | Sikhan Khatun | 45 | Literate | Married | Leprosy | Bara | Parshurampur | Male |
| 2 | Bajul Miya | 25 | School | Married | Leprosy | Bara | Parshurampur | Male |
| 3 | Amina Khatun | 16 | Literate | Unmarried | Other | Bara | Parshurampur | Female |
| 4 | Majiran Khatun | 55 | Literate | Unmarried | Leprosy | Bara | Parshurampur | Female |
| 5 | Jiya Lal Saha | 22 | School | Married | Leprosy | Bara | Parshurampur | Male |
| 6 | Ujrali Miya | 60 | Illiterate | Married | Leprosy | Bara | Parshurampur | Male |
| 7 | Majrun Nisha | 50 | Illiterate | Married | Leprosy | Bara | Parshurampur | Female |
| 8 | Manjur Alam | 60 | Illiterate | Married | Leprosy | Bara | Parshurampur | Female |
| 9 | Gairi Khatun | 50 | Literate | Married | Poverty | Bara | Parshurampur | Female |
| 10 | Kalamun Nisha | 25 | Literate | Married | Poverty | Bara | Parshurampur | Female |
| 11 | Tairun Nesha | 35 | Literate | Married | Poverty | Bara | Parshurampur | Female |
| 12 | Maimul Khatun | 32 | Literate | Married | Poverty | Bara | Parshurampur | Female |
| 13 | Jarina Khatun | 28 | Literate | Married | Poverty | Bara | Parshurampur | Female |
| 14 | Tarabun Khatun | 25 | Literate | Married | Poverty | Bara | Parshurampur | Female |
| 15 | Sakina Khatun | 36 | Literate | Married | Poverty | Bara | Parshurampur | Female |
| 16 | Hyatun Khatun | 40 | Literate | Married | Poverty | Bara | Parshurampur | Female |
| 17 | Sahima Khatun | 15 | Literate | Unmarried | Poverty | Bara | Parshurampur | Female |
| 18 | Seikh Utijula | 35 | Literate | Married | Poverty | Bara | Parshurampur | Male |
| 19 | Lal Bibid Khatun | 45 | Illiterate | Married | Poverty | Bara | Parshurampur | Male |
| 20 | Kabirat Khatun | 25 | Illiterate | Married | Poverty | Bara | Parshurampur | Female |
| 21 | Tetari Khatun | 25 | Illiterate | Married | Poverty | Bara | Parshurampur | Female |
| 22 | Sarpun Khatun | 40 | Illiterate | Married | Poverty | Bara | Parshurampur | Female |
| 23 | Maimul Khatun | 45 | Illiterate | Married | Poverty | Bara | Parshurampur | Female |
| 24 | Rokaiya Khatun | 30 | Illiterate | Married | Other | Bara | Parshurampur | Female |
| Self-help Group: Bauddhimai Swayam Sahayata Samuha, Kalaiya, Bara (2068) | | | | | | | | |
| 1 | Chhathuk Pandit | 42 | Literate | Married | Leprosy | Bara | Kalaiya | Male |
| 2 | Shiba B Thapa | 48 | Literate | Married | Leprosy | Bara | Kalaiya | Male |
| 3 | Fani Raj Pathak | 55 | Illiterate | Married | Leprosy | Bara | Kalaiya | Male |
| 4 | Ramautar Mahato | 60 | Literate | Married | Leprosy | Bara | Kalaiya | Male |
| 5 | Kanta Chaudhari | 70 | Literate | Married | Leprosy | Bara | Kalaiya | Male |
| 6 | Khovari Ram | 68 | Illiterate | Married | Leprosy | Bara | Kalaiya | Male |
| 7 | Rishi Giri | 17 | SLC | Unmarried | Observer | Bara | Kalaiya | Male |
| 8 | Pramila Giri | 35 | Literate | Married | Leprosy | Bara | Kalaiya | Female |
| 9 | Premadevi Chaudhari | 50 | Literate | Married | Leprosy | Bara | Kalaiya | Female |
| 10 | Nimuniya Mandal | 30 | Illiterate | Married | Leprosy | Bara | Kalaiya | Female |
| Self-help Group: Madi Swayam Sahayta Samuha, Madi, Chitwan (2064/65) | | | | | | | | |
| 1 | Sita BK | 33 | School | Married | Leprosy | Chitwan | Gardi | Female |
| 2 | Bishnu P Dulal | 35 | School | Married | Leprosy | Chitwan | Bagauda | Male |
| 3 | Om B Nepali | 50 | School | Married | Leprosy | Chitwan | Kalyanpur | Male |
| 4 | Bhagwat Mahato | 36 | Literate | Married | Leprosy | Chitwan | Kalyanpur | Male |
| Self-help Group: Bhandara Swayam Sahayta Samuha, Bhandara, Chitwan (2064/65) | | | | | | | | |
| 1 | Charimaya Pariyar | 60 | Illiterate | Married | Leprosy | Chitwan | Bhandara | Female |
| 2 | Tikamaya Pariyar | 45 | Literate | Married | Leprosy | Chitwan | Bhandara | Female |
| 3 | Thulimaya Pariyar | 35 | Literate | Married | Leprosy | Chitwan | Bhandara | Female |
| 4 | Ram P Chaudhari | 55 | Literate | Married | Leprosy | Chitwan | Bhandara | Male |

**List of participants in In-depth Interview (Clients)**

| SN | **Name** | **Age** | **Education** | **Marital**  **Status** | **Beneficiaries** | **District** | **VDC** | **Sex** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1 | Urmila Khatri | 28 | Literate | Married | In-patient Leprosy | Kavre | Chalal | Female |
| 2 | Sagar Jha | 27 | IA | Married | In-patient Leprosy | Morang |  | Male |
| 3 | Karna B Chanda | 52 | Literate | Married | In-patient Leprosy | Kanchanpur |  | Male |
| 4 | Palanu Rajbansi | 57 | Literate | Married | In-patient Leprosy | Jhapa |  | Male |
| 5 | Som Saran | 40 | Literate | Married | In-patient Leprosy | Jhapa |  | Male |
| 6 | Prem B Tamanag | 38 | Literate | Married | In-patient General | Lalitpur | Dalchoki | Male |
| 7 | Beni B Nagarkoti | 42 | Literate | Married | In-patient General | Lalitpur | Chhampi | Male |
| 8 | Shiva P Neupane | 56 | Literate | Married | In-patient General | Lalitpur | Ghusel | Male |
| 9 | Rita Marap | 55 | Illiterate | Married | Out-patient General | Lalitpur | Lele | Female |
| 10 | Thulimaya Bamjan | 54 | Literate | Married | Out-patient General | Lalitpur | Devichaur | Female |
| 11 | Ramu Gole | 36 | Literate | Married | Out-patient General | Lalitpur | Bharde | Male |
| 12 | Navaraj Ghimire | 22 | BSc | Unmarried | Out-patient General | Lalitpur | Sankhu | Male |
| 13 | Madhab Sanjel | 23 | MSc | Unmarried | Outpatient General | Lalitpur | Sankhu | Male |
| 14 | Chadra Bd. Ghalan | 55 | Literate | Married | Outpatient General | Lalitpur | Nallu | Male |
| 15 | Tikaram Neupane | 53 | Literate | Married | Outpatient General | Lalitpur | Chhampi | Male |
| 16 | Netra P Sapkota | 70 | Literate | Married | In-patient General | Lalitpur | Devichaur | Male |
| 17 | Surendra Sapkota | 40 | Literate | Married | Outpatient General | Lalitpur | Devichaur | Male |
| 18 | Loknath Humagain | 62 | Literate | Married | Former Client Lepro | Lalitpur | Chhampi | Male |
| 19 | Ananda Sunuwar | 24 | Plu2 | Unmarried | Patan Clinic | Ramechhap | Saipu, | Male |
| 20 | Indradevi Saha | 26 | Literate | Married | Patan Clinic | Bara | Sukhitra | Female |
| 21 | Som Saran | 40 | Literate | Married | Patan Clinic | Jhapa |  | Male |
| 22 | Pasupati Rai | 25 | BA | Unmarried | Patan Clinic | Sunsari |  | Female |

**List of participants at Participatory Workshop, Anandaban**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| SN | Name | Designation | Department/Unit | Remarks |
| 1 | Mr Shovakhar Kandel | Executive Director | AH Management |  |
| 2 | Mr Kul P Adhikari | Admin Officer | Administration |  |
| 3 | Mr Shusil Khatiwada | Finance Manager | Admin/Finance |  |
| 4 | Dr Mahesh Saha | Skin Specialist | Medical |  |
| 5 | Dr Indra Napit | Orthopaedist | Medical |  |
| 6 | Dr Pankaj Awale | MDGP | Medical |  |
| 7 | Ms Nirmala Shrestha | Matron | Medical/Nursing |  |
| 8 | Mr Ram B Khadka | Nursing Tech | Medical/Nursing |  |
| 9 | Mr Kanchha Shrestha | Medical record | Medical, OPD |  |
| 10 | Mr Yadav Raj Chalise | Social Mobiliser | AH |  |
| 11 | Ms Ruth Shrestha | Councillor | Medical |  |
| 12 | Mr Gopal Pokharel | Training Officer | Training & Tech. Support |  |
| 13 | Mr Indra B Tamang | Training Supervisor | Training & Tech. Support |  |
| 14 | Mr S P Ruchal | Prosthetic Officer | Prosthetic |  |
| 15 | Mr Ram Babu Bista | Physio Supervisor | Physiotherapy |  |
| 16 | Mr Kapil Neupane | Lab Manager | Laboratory |  |
| 17 | Mr Iswar Shrestha | Lab Supervisor | Laboratory |  |
| 18 | Mr Badri Kathait | Social Mobilizer | AH |  |
| 19 | Mr Kanshi | Social Mobilizer | SER |  |
| 20 | Mr Chandra Thapa | Social Mobilizer | SER |  |
| 21 | Mr Balram Neupane | Medical Nurse | AH |  |
| 22 | Ms Chandra Dahal | Medical Nursae | AH |  |

Annex 5: AH Staff, Social workers, Government/NGO/INGO, Officials

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| SN | Name | Designation | Office | Remarks |
| 1 | Dr GD Thakur | Director | EDCD/Leprosy Divi | Dept of Health |
| 2 | Dr KP Dhakal | Country Director | Netherland Leprosy Relief Project | Chairperson, Leprosy NGO |
| 3 | Mr Sagar Ghimire | Regional Director | Central Dev Region |  |
| 4 | Mr Bishnu Jaishi | Regional TB/Leprosy Offr | '' '' |  |
| 5 | Mr Balkrishna Bhusal | District Health Officer | DHO, Lalitpur | Chief, DOH |
| 6 | Ms Devi Gurung | District TB/Leprosy Asst | DHO, Lalitpur |  |
| 7 | Mr Jayaram Duwadi | District TB/Leprosy Asst | DHO, Chitwan |  |
| 8 | Mr Sahabuddin Mikrani | District TB/Leprosy Asst | DHO, Parsa |  |
| 9 | Dr Atulesh K Chaurasiya | Dermatologist | National Med College | Birgunj |
| 10 | Dr Rakesh Tiwari | Medical Officer | PHC, Bagaiya , Parsa |  |
| 11 | Mr Santaman Manandhar | In-charge | Health Post, Nallu |  |
| 12 | Mr Sushil Bhattarai | Former WHO Staff | WHO/Nepal |  |
| 13 | Ms Sangita Silwal | School Teacher | Shree Devi Nallu | Lower secondary |
| 14 | Mr Narayan P Shaarma | Incharge | Health Post, Gotikhel |  |
| 15 | Mr Sitaram Banjara | AHW | Health Post, Gotikhel |  |
| 16 | Mr Balram Neupane | Medical Nurse | AH Anandaban |  |
| 17 | Ms Chandra Dahal | Medical Nursae | AH Anandaban |  |
| 18 | Ms Sulochana Shrestha | SER, Coordinator | AH Anandaban |  |
| 19 | Ms Pradipa Adhikari | SER, Social Mobilizer | AH Anandaban |  |

Annex 6: SWOT/C Analysis of Anandaban Hospital with staff

Prepared by AH's staff with facilitation of the study team, at situation assessment and effect of AH and way forward;

**Group 1: Technical Staff**

|  |  |
| --- | --- |
| **Strengths** | **Weaknesses** |
| * Leprosy Hospital as tertiary centre: | * Physical |
| * Reaction management | * Road access |
| * Reconstructive surgery | * Land (Topography) |
| * Ulcer management | * Communication (Telephone, internet and electricity) |
| * Separate self care unit of POD | * Poor internal communication |
| * Special footwear and prosthesis |  |
| * Research (Mycobacterial) and clinical lab | * Lack of specialized services (Eye, gynecology/obstetrics) |
| * Training unit | * Weak in causality service ( No lab services) |
| * Infrastructure (Land, building) | * No blood bank |
| * General services: | * No digital X-ray * No microbiology lab services |
| * Orthopedics | * No hospital protocols |
| * Skin | * Rapid turnover of staff (Medical) |
|  | * Less opportunity in further training |
| * Outreach services | * No ambulance service |
| * Special camps | * No reliable and frequent transportation service (Staff and clients) |
|  | * Not enough human power |
| * Good Networking |  |
| * NGO/INGO and Government |  |
| **Opportunities** | **Threats/Constraints** |
| * Leading health institution in Southern part of Lalitpur district | * Internal mission policy |
| * Upgrading specialized services (Gynecology/obstetrics, surgical) | * Frequent changed policies of govt and donors |
| * Training/seminar centre | * Donor's priority |
| * Ortho appliance centre | * No back-up services (No second person) |
| * Trauma centre |  |
| * Nursing college |  |
|  |  |

**Group 2: Administration & Management**

|  |  |
| --- | --- |
| **Strengths** | **Weaknesses** |
| * Financial | * Obstacle for effective service |
| * Donor's commitment | * Road access |
|  | * Communication and Transport (Email, internet, phone) |
| * Specialization | * Capacity |
| * Orthopedics | * Insufficient trained staff for general service |
| Dermatological service | * Fast staff turnover (Medical staff) |
| * Reconstructive surgery | * Less staff (as per require) |
| * Reaction management for lep |  |
| * Coordination | * Existing policy |
| * Government | * Frequent change of policy |
| * Social Welfare Council | * Renewal of staff contract (every year) |
| * Ministry of health |  |
| * NGO |  |
| * Leprosy Network |  |
| * The Leprosy Mission International |  |
| * Leprosy Mission Nepal |  |
| * Community | * Financial |
| * Moral support | * Low revenue collection from general services from local clients |
| * Good will | * Completely dependent on donor |
| * Infrastructure |  |
| * Well established hospital building |  |
| * Well trained and dedicated staff |  |
| **Opportunities** | **Threats/Constraints** |
| * Sustainability | * Policies |
| * Possibility of generating income | * Donor's priority and policy |
| * Marketing opportunities | * Frequent changed Government policy (political change) |
| * Service expansion (specialization services) |  |

Annex 7: AB Research and collaborators

**MRL Current Project Profile and Collaborators (2011)**

|  |  |  |  |
| --- | --- | --- | --- |
| Research Issues | Question | Status | Collaborators |
| **Diagnostics** | Can preclinical leprosy be detected? (2000-2010) | Manuscript writing | National Institutes of Health (NIH)  Dr. Pat Brennan’s Laboratory  Colorado State University (USA) |
| **Prediction of Reactions** | Can we predict which patients will have reaction? (2007-2011) | data analysis | Dr. Annemiek Geluk and Dr. Linda Oskam  Leiden University and KIT, The Netherlands |
| **Reaction Diagnosis** | How effective is reaction treatment in Nepal’s Integrated Care System? Summer 2010 | Manuscript writing | Dr Diana Lockwod and Dr. Sonia Raffe, MSc Thesis project, London School of Hygiene and Tropical Medicine, UK |
| **Treatment of Reactions** | Can reaction treatment be improved with Methylprednisolone? | 1 published;  another submitted | Dr. Diana Lockwood and Dr. Steve Walker, London School of Hygiene and Tropical Medicine, UK |
| **Host Genetics** | Are leprosy patients genetically different from those who do not develop disease? | 4 published;  ongoing | Dr. Tom Hawn, Dr. William Berrington, University of Washington, USA |
| **Molecular Epidemiology** | Can strains be connected or tracked within a family, village or region for transmission studies? | Manuscript submitted; ongoing | Dr. Vara Lakshmi Vissa, Colorado State, University, USA |
| **Drug Resistance** | What are the levels of leprosy drug resistance in Nepal? | Ongoing | TLM and WHO Surveillance program |
| **Neuropathy** | Trial 1: Can preclinical neuropathy be detected and treated? | Initiation | Dr. Erik Post and Dr. Wim Brandsma, Lalgadh Hospital; TURING Foundation, KIT, ALM; multicentric trial being performed in Nepal, India, Bangladesh, Brazil and Indonesia |
| Trial 2: Is 20-32wks prednisolone treatment better for early neuropathy? |

1. Leprosy Control Division, Department of Health Services, than His Majesty’s Government of Nepal Ministry of Health and Population. Annual report 2063/2064 (2006/2007) 1st Draft. Kathmandu: Leprosy Control Division; 2007. 30p. [↑](#footnote-ref-2)
2. Situation analysis of the integration of leprosy control services in Nepal, October 2010. [↑](#footnote-ref-3)
3. Nov 2009, Leprosy Control Division) [↑](#footnote-ref-4)
4. Adapted from Arnstein, Sherry R (1969), Journal of the American Institute of Planner Vol. 35 pp 216-224 [↑](#footnote-ref-5)