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EXECUTIVE SUMMARY

Chronic Kidney Disease (CKD) is defined as renal damage or decreased renal function for three or more months along with progressive destruction of renal mass with irreversible sclerosis and loss of nephrons. CKD is a global epidemic which is associated with high cost and financial burden to patients, families and health system of any country. The Government of Nepal, Department of Health Services (DoHS) through its special program on chronic diseases - 'Bipanna Nagarik Sahayata Kosh' has been supporting the people with a number of enlisted chronic diseases for their treatment and care. CKD and heart diseases are some of the conditions included in the program. This study aimed to comprehend the current scenario of on-going chronic disease support program of the government of Nepal with special focus on CKD.

It was a qualitative study conducted in four different development regions. Chronic Kidney Diseases patients, representatives of central government institutions (MoH, DoHS), representatives from hospital management committee of different hospitals, and representatives of municipal governments from these development regions were purposively chosen for the study. Information was collected from 18 patients; five District Public Health Officers, eight hospital managers and one policy level officer of DoHS using in-depth interview, key informant interview and record review. Data was analysed using a qualitative content analysis approach.

Findings from the study revealed that there is no clear definition of bipanna and thus it is difficult to ensure that the service is being utilized by the real needy ones. Participants also shared that the numbers of patients beyond the capacity of the health facilities has been a factor for delayed service delivery to the patients. Participants who were getting the service complained of less number and shorter session of dialysis than prescribed.

Furthermore, the participants expressed about the high non-medical costs such as travel cost, lodging and fooding costs due to centralization of health facilities. They shared that even though the program has proven to be great support to those who cannot afford the treatment on their own, the associated non-medical costs and problems with services has decreased the value.

Service providers expressed their realization about lack of coordination among the different concerned authorities as a major barrier to ensure proper utilization of the fund under the program. They also shared lack of authority within District Health Office / District Public Health Office (DHO/DPHO) to verify the status of the service seekers sometimes leads to recommendation for those who are not the actual bipanna.

Regarding the sustainability of the program, participants suggested focusing on preventive measures and community awareness program rather than putting all the effort on curative services only. Besides, participants suggested on conducting screening programs such as creatinine test, blood urea test to identify the disease in the early stage.

Participants opined that monitoring and supervision of the program should be strengthened to ensure that the needy ones are getting the services and the fund is not misused. They further suggested for coordination and communication among the hospital, DHO/DPHO and DoHS to identify the loop holes and hence improve the program implementation.

Thus, the study shows that the guideline for the program needs revision in order to clarify the eligibility criteria for the patients to receive support. It also highlights the need for development of a mechanism that could be implemented nationwide to ensure the real needy ones are getting the service and the fund is not misused. Furthermore, the challenges faced by patients and hospitals should be addressed through decentralized service provision and capacity of the hospitals designated for these service, should be strengthen in order to provide quality service for the people. In addition, concerns for the preventive aspect and early identification of the disease should be taken into consideration and alternative approaches like insurance system need to be focused for reducing the cost of the program and make it sustainable.
ACKNOWLEDGEMENT

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Professor Dr. Anjani Kumar Jha
Executive Chairman
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<th>Abbreviation</th>
<th>Explanation</th>
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<tbody>
<tr>
<td>CDO</td>
<td>Chief District Officer</td>
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<td>CKD</td>
<td>Chronic Kidney Disease</td>
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<td>DALY</td>
<td>Disability Adjusted Life Year</td>
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<td>DHO</td>
<td>District Health Office</td>
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<td>DoHS</td>
<td>Department of Health Services</td>
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<td>DPHO</td>
<td>District Public Health Office</td>
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<td>FCHV</td>
<td>Female Community Health Volunteer</td>
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<td>GBD</td>
<td>Global Burden of Disease</td>
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<td>LDO</td>
<td>Local Development Officer</td>
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<td>MoH</td>
<td>Ministry of Health</td>
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<td>NCD</td>
<td>Non-communicable Disease</td>
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<td>NHRC</td>
<td>Nepal Health Research Council</td>
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<tr>
<td>PHCRD</td>
<td>Primary Health Care Revitalization Division</td>
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<td>RRT</td>
<td>Renal Replacement Therapy</td>
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<td>VDC</td>
<td>Village Development Committee</td>
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Chronic Kidney Disease (CKD) is defined as renal damage or decreased renal function for three or more months along with progressive destruction of renal mass with irreversible sclerosis and loss of nephrons (6). CKD is a global epidemic which is associated with high cost and financial burden to patients, families and health system of any country (6, 7, 10). At the same time, CKD is also associated with increased risks of cardiovascular diseases, premature deaths and decreased quality of life (8). It has been found that identifying CKD in its earliest stage could prevent disease progression and can lessen high medical costs (9).

Chronic Kidney Disease (CKD) is not identified as a separate entity in World Health Organization (WHO) reports and has been covered under the genitourinary disease. WHO Global Burden of Disease (GBD) Report 2004, estimates genitourinary diseases responsible for 928,000 deaths or 1.6% of the total number of global deaths and 14,754,000 DALYs, 1% of all global DALYs (1, 2). Worldwide prevalence of CKD has been estimated to be 8-16% (3) whereas the community prevalence of CKD in eastern Nepal was found to be 10.6% (4). Different countries follow different types of funding model to provide patients free services to some extent. For example, in Indonesia, CKD patients receive financial assistance for dialysis performed in government and private health centres. Similarly, not-for-profit organizations, which are led by the respective kidney foundation in each country, set up haemodialysis service centres to assist in complementing government’s Renal Replacement Therapy (RRT) program in Singapore and Malaysia. The public-private funding model has been popular and efficient in many countries to treat CKD patients, where patients receive twice to thrice dialysis service weekly. Also, kidney foundations work on public education program, training of allied health staffs and health screening programs about CKD. On the other hand, Brunei has comprehensive Renal Replacement Therapy program, which is fully funded by government (11).

The Government of Nepal (DoHS) through its special program on chronic diseases - ‘Bipanna Nagarik Sahayata Kosh’ has been supporting the people with a number of enlisted chronic diseases for their treatment and care. CKD and heart diseases are some of the conditions included in the program (5). Bipanna nagarik ausadhi upachar kosh was started in 2066/67 BS to increase access in health services by providing support to the bipanna (impoverished people) for the treatment of selected chronic diseases. The guideline for the program was developed in 2067 and was implemented from the same year under the name bipanna nagarik aushadhi upchar kosh nirdeshika. According to the guideline, support is available for eight different types of diseases namely: Heart disease, Kidney disease, Cancer, Spinal injury, Head injury, Parkinson, Alzheimer’s disease and Sickle Cell Anemia. The service equivalent to the support amount could be accessed through the 32 health facilities listed by Ministry of Health. The guideline also clarifies, the listed health facility would provide service equivalent to the amount entitled by the government to the identified bipanna patients and the amount shall be reimbursed to health facilities by Ministry of Health. It also states that any
person should be recommended by the committee (consisting of Chief District Officer as chairperson, Local Development Officer, Medical Superintendent of District Hospital, Chief of Financial Controller General Office and head of DHO/DPHO as member secretary) as bipanna nagarik to be eligible for the service. Following the guideline, each of the listed health facility has set up an information center from where people can get the information about the free service and the related process. Although some reports from the concerned division have highlighted that the amount being used for these disease conditions have been increasing in geometrical ratio every year leaving the threat for government effort in treating NCDs-being unsustainable, there is need of population based scientific evidence to evaluate the real scenario. The fact that Government has also realized the increasing expenditure for the free medication and treatment of enlisted NCDs further signifies the need of the studies aimed at providing insight into utilization and effectiveness of the program. This study helps us to comprehend the current scenario of on-going chronic disease support program of the government in Nepal.

1.2 Objectives of the Study

1.2.1 General objective

To find out the utilization pattern of the Chronic Kidney Disease support program, associated challenges, issues with sustainability and to describe the perceived effectiveness of the patients of Chronic Kidney Disease support program.

1.2.2 Specific Objectives

• To assess the utilization pattern of the Chronic Kidney Disease support program.
• To explore the challenges and sustainability issues regarding Chronic Kidney Disease support program.
• To describe the perceived effectiveness of the patients of Chronic Kidney Disease support program.
2.1 Study design
Qualitative study design was used for this study.

2.2 Study population
Chronic Kidney Diseases patients from four development regions (except far western development region), representatives of central government institutions (MoH, DoHS) that oversee the operations of the funds, representatives from hospital management committee of different hospitals in the four development regions committed to this service (refer to Annex for the list of hospital selected) and representatives of municipal governments from these development regions who are involved in the selection of eligible candidate were chosen to be the study population.

2.3 Sampling procedure and sample size
Patients, representatives and the personnel affiliated with the hospitals providing the services were chosen purposively. Information was collected from 18 patients, five District Public Health Officers, eight Hospital Managers and one policy level officer of DoHS.

2.4 Data collection technique and tools
Data was collected using in-depth interview, Key Informant Interview and record review. Open ended semi-structured interviews were used to collect information on medical history of patient, role of government officials, current financial status, strengths of the program, challenges of the program and recommendations from the participants. Key informant interviews were conducted with representatives of central government institutions, representative of hospital management committee and representatives of municipal governments. Similarly, in-depth interviews were conducted with patients who had received or were receiving the free services from those selected hospitals. Besides, record review was done to have an overview of the total number of patients getting services for different diseases under Bipanna Nagarik Sahayata Kosh in F/Y 2072/73. Recorded data was taken from Bipanna Nagarik Sahayata section in Department of Health Services (DoHS), Teku, Kathmandu.

2.5 Duration of data collection
The interviews were conducted during the month of June and July 2016. And the record review was done during the month of July 2016.

2.6 Data management and analysis
Data was analysed using a qualitative content analysis approach. Initially, the interviews were transcribed in Nepali from field notes and audio records. Nepali transcript was then translated into English before further processing. All the information including incomplete sentences, interrupted conversations, agreements, pause and non-verbal behaviours were recorded to provide the real field scenario of interview.
Interview transcripts were then subjected to open coding. They were reviewed and initial
codes were generated. Further, they were categorized into the preliminary thematic areas. After
continuous reading, categorization and sub-categorization, information were fitted under the
identified thematic areas. The process was repeated until all information was grouped under the
themes that addressed similar ideas. Verbatim justifying the individual themes was also picked
up during the process.

2.7 Ethical clearance

Ethical clearance for the study was obtained from Ethical Review Board of Nepal Health Research
Council (NHRC) and written informed consent was taken from each of the participants.
This chapter deals with the findings from the record review and interviews with the study participants. The findings from interviews have been presented under different thematic areas.

3.1 Participants understanding about Bipanna nagarik ausadhi upachar kosh

3.1.1 Reason for initiating Bipanna nagarik ausadhi upachar kosh

General managers and high level staffs from hospitals and participants from DHO/DPHO defined it as a program initiated by the government from 2009/10 AD to help the disadvantaged citizens for the treatment of eight diseases; Kidney Disease, Heart Disease, Cancer, Parkinson’s, Alzheimer, Neuro (head and spinal injury) and Sickle Cell Anaemia. They shared that this program aims to help those people who cannot afford the lifelong treatment for the listed chronic diseases. Further, the personnel from the policy level clarified that the program was initially started for five diseases; Head and Spinal Injury and Sickle Cell Anaemia were added later. Head and Spinal Injury were added in 2013 AD and Sickle Cell Anaemia was added in 2015 AD.

“Those citizens who are suffering from chronic disease and who cannot afford the treatment are provided support under the social security program.” Representative of District Level Management Committee, Mid-Western Development Region

“The treatment subsidy for bipanna nagarik was started after the people’s movement of 2062/63 and especially after the establishment of PHCRD. Though it is targeted for bipanna, others who have the recommendation letter have also got the services.” Representative of District Level Management Committee, Western Development Region

3.1.2 Definition of bipanna

The managers and hospital staffs expressed that though the program is aimed to bipanna, there is no clear definition for bipanna. Identifying any citizen as bipanna solely depends upon the local authorities and those who get the recommendation are entitled bipanna regardless of whether the identification is based on reality or not. They further shared that some elite group of people claim to be bipanna since the nature of disease makes them poor anyway and they also have views that paying tax makes them eligible for utilizing bipanna fund.

“The letter from the VDC/municipality is the only authorized document to specify anyone as bipanna. We do not further enquire about their economic status.” Representative of Hospital Management Committee, Central Development Region

“Some patients come to the hospital in car and wearing gold necklace and ask for free service showing the recommendation of disadvantaged. In such case even if their status is clearly reflected,
we cannot deny the free service as they have authorized letter of recommendation. We don’t have authority.” Representative of Hospital Management Committee, Central Development Region

“When the hospital gets the recommended letter from the DHO/DHPO approved by the local authority, the hospital does not inquire about the status of the service seeker. We give service regardless of whether the person comes in a pajero or in helicopter.” Representative of Hospital Management Committee, Eastern Development Region

Furthermore, the respondents from policy level explained that bipanna refers to those who are below the poverty line. However, there is no authorized definition.

“In our context, they are the people who cannot afford food for more than 3 months a year but we do not have formal document defining this.” Representative of Department of Health Services, Central Development Region

3.2 Process for getting service
3.2.1 Eligibility criteria
Representatives from hospital management committees shared that any person with the recommendation letter from VDC/municipality, identifying him/her as bipanna, recommendation letter from DHO/DPHO, prescription of the medical personnel clearly mentioning the diagnosis and having the citizenship certificate are eligible for the service under this kosh.

“We give free service to those who have the recommendation letter from the DHO/DPHO and have been certified as bipanna by the VDC/municipality. In addition to these, the service seekers should present their citizenship certificate, photo and they should also submit the application letter through social security unit of the hospital.” Representative of Hospital Management Committee, Central Development Region

3.3 Process of verification and selection of eligible person
Health personnel’s from different hospitals shared that the process is clearly mentioned in bipanna nagarik ausadhi upachar kosh guideline. Participants shared that applicants should first get diagnosis verified by the doctor and should have prescription. After having prescription, applicants need to obtain recommendation letter from the VDC/municipality recognizing them as bipanna and present it to DHO/DPHO along with other documents including medical reports and citizenship certificate. There is a district level committee named, Bipanna Nagrik Ausadhi Upachar management committee with CDO as the chairperson, chief of DHO/DPHO as secretary general and medical superintendent, local development officer and representative from peace society as general members. The medical documents are verified by the Medical Superintendent in the committee and if the disease is not clearly mentioned, application is sent back for clarification. Further, his/her citizenship and recommendation from local authority are verified and then the decision on whether or not to recommend for free service is made. In case if the committee decides to recommend for the service, DHO/DPHO writes letter to the hospital asking to provide free service to the patient. It was reported that the process is completed within a day or two.

“Hospital gives the letter to the patient verifying his/her diagnosis which s/he has to take to the VDC/ Municipality of his/her residence. The local authority gives the letter specifying him/her as bipanna. Then along with those two documents, the patient has to submit application to the DHO/DPHO requesting for free service. A committee comprising of 7 members in chairmanship of CDO verifies the documents and gives the recommendation letter stating the name of the hospital from which the
3.4 Subsidy for kidney disease under the KOSH and fund regulation

3.4.1 Subsidy for kidney disease

Research participants from the policy level stated that a patient with kidney disease receives 208 episodes of dialysis free of cost equivalent to 5 lakhs 20 thousand Nepali rupees from the hospital. Furthermore, patients undergoing transplantation receive discount of 2 lakhs in the total cost if the transplantation service is carried out within the country. If the patient has undergone transplantation service outside country, he/she receives 1 lakh to cover expenses on medicine regardless. For other listed diseases, patients get service equal to the amount of 1 lakh. Hospital managers shared that the subsidy for dialysis which is equal to NRs. 2500 for a session is not sufficient to cover the cost and emphasized that it should be at least NRs. 3500-4000.

“We give 208 sessions of dialysis free of cost to the patients with the recommendation letter from the VDC/municipality and DHO/DPHO. Further if the patient wants to undergo transplant, s/he gets 3 lakhs in total including 1 lakh for medicine and 2 lakhs for transplant process.” Representative of Hospital Management Committee, Central Development Region

“Government has allocated 2500 for each session of dialysis which is very minimal. There are so many indirect costs like those of maintenance, which is difficult to cover with the subsidy. In an average, government should provide at least 3500-4000 per session of dialysis.” Representative of Hospital Management Committee, Central Development Region

3.4.2 Fund regulation

Participants shared that patients get the service from the hospital not exceeding to the amount entitled and the amount is later reimbursed by DoHS to the hospital on submission of medical bills. In case the patients have to be referred to another hospital for dialysis services, the detail information on remaining dialysis sessions is provided to the patients. Referred patients then receive further sessions equal to the remaining amount from referred hospital. Further, participants shared that even if the hospitals send the reports timely the reimbursement is delayed most of the time.

“Once the hospitals send the bills to DoHS claiming for reimbursement, the committee comprised of secretaries of health ministry, home ministry and finance ministry holds meeting, approves the bills and forwards it to the central board which gives the final approval after cross checking and verification of all the documents.” Representative of Department of Health Services, Central Development Region

“Patient gets the service equal to the subsidy amount from the hospital and the fund is later reimbursed form government to the hospital.” Representative of District Level Management Committee, Mid-Western Development Region

“We only provide the recommendation. Regulation of the fund is done by the ministry and we have no role in it.” Representative of District Level Management Committee, Central Development Region

“We make the reports according to the format provided by the ministry. The report contains all the details of the patients and the service provided which is sent monthly to DOHS. Although the reimbursement is said to be provided in quarterly basis, most often we get it once in 8-9 months.” Representative of Hospital Management Committee, Eastern Development Region

“We send a monthly report containing every detail of the services and expenses to the DOHS. On the
basis of the report, we get the reimbursement half yearly.” Representative of Hospital Management Committee, Central Development Region

3.4.3 Mechanism to prevent misuse of the fund

The hospital managers reported lack of any mechanism to ensure that the service is received only by eligible person. They shared that all the people who have the recommendation from DHO/DWHO are provided the service. Even though some hospitals have developed software to record the information to ensure that the person gets the allocated service with no misuse, there are chances that a person might be taking service from two hospitals (patient duplication). Furthermore, the personnel from DHO/DWHO also shared that there is no mechanism to prevent misuse and the monitoring and supervision of the program that is supposed to control misuse of fund is weak. Thus, to control misuse of fund, the participants highlighted the necessity of a system that can be implemented throughout the country. However, the respondent from policy level reported that supervision is done by the DoHS to prevent misuse of the fund. The bills sent by the hospitals are cross checked for accuracy and continue interactions with the hospital directors and experts are also carried out.

“There is a chance that the a patient receives the free service twice from two different hospitals as there is no mechanism in the national level to control this and the hospital does not have the means of information to ensure whether the service seeker has already taken the service from other hospital or not.” Representative of Hospital Management Committee, Eastern Development Region

“There is no any mechanism till now to make sure the service is received by the real bipanna. In my point of view, the social service unit should take this responsibility.” Representative of Hospital Management Committee, Central Development Region

“Our hospital has developed software to keep the details of all the patients and the service received by them. We get information on how many sessions the patients have received on which dates. This kind of software should be developed and implemented nationwide.” Representative of Hospital Management Committee, Central Development Region

“There should be clear guideline to certify a person as bipanna and the government should start the card system for those identified. This is help to some extent to prevent the misuse.” Representative of Hospital Management Committee, Central Development Region

“I cannot say about the misuse as we do not have authority to monitor and the hospitals also do not report us.” Representative of District Level Management Committee, Mid-Western Development Region

“There is no chance for patient duplication as we have the record of the patients who are recommended for the service. However, if the person goes to another district, then there are chances that he may take the service again. So there should be system in the national scale to keep and retrieve the information about the service taken by the citizen.” Representative of District Level Management Committee, Central Development Region

“There is no mechanism as such in the district and I don’t think it is in the division either.” Representative of District Level Management Committee, Central Development Region

3.5 Record and report about the service users

According to the records available at the health facilities, highest amount has been spent for cancer followed by kidney and then heart disease. There is disaggregated data available for each.
Hospitals have the information regarding age, sex, ethnicity of the patients in the medical records but they do not have the disaggregated data compiled in one place in the form of soft copy or hard copy. According to the hospital managers and staffs, the reporting format by the ministry does not require such data and thus the data are not disaggregated.

“We keep the data and report according to the provided format under the guideline. We have the district wise data or the disease wise data but we don’t have segregated data on the basis of age, sex or case. However, we can get the data in these formats on the basis of the medical records.”
Representative of Hospital Management Committee, Eastern Development Region

“We have the detail information of all the patients but we have not maintained the data on the basis of age or ethnicity.”
Representative of Hospital Management Committee, Central Development Region

**Number of service users in year 2072/73**

Record review revealed that a total of 36,039 people obtained free service in the F/Y 2072/73. According to DOHS record, majority of the patient utilizing the services were cancer patient. A total of 20,445 cancer patients received the treatment under *Bipanna Nagarik Sahayata Kosh* in F/Y 2072/73 among which 3889 patients were newly registered in the fiscal year and 16,556 were old patients. After cancer, the highest numbers of service users were the CKD patients. In the F/Y 2072/73, a total of 12,574 people obtained free service for chronic kidney disease under *Bipanna Nagarik Sahayata Kosh*. Among them, 11,648 received haemodialysis service, 148 received support for kidney transplantation and 818 people received peritoneal hemodialysis.

3.6 **Role of DHO/DPHO in District Level Management Committee**

The personnel from DHO/DPHO expressed that DHO/DPHO is only limited to preparing the recommendation letter to the hospital based on the documents submitted by the patient. DHO is not involved in funding and other process. Since the hospitals do not report to DHO and communicate directly with ministry, there is even no mechanism to cross check if the patient with the recommendation letter received the service. Further, DHO/DPHO does not have the authority to assess the economic status of patient seeking recommendation as bipanna as the sole responsibility of assessment lies on local authority. Furthermore, participants shared that even if the patients are not poor at the beginning, they become impoverished because of medical expenses and thus shared their understanding that the name of program be changed to “kada rog ausadhi upachar kosh”.

“We only verify about the reported disease. Identification of the bipanna person is the responsibility of the local authorities and we do not cross check on that.”
Representative of District Level Management Committee, Eastern Development Region

“We do not verify whether the person with the recommendation from the local authority is the real bipanna or not as any person who is suffering from chronic disease will become impoverished sooner or later due to the medical expenses. We have even suggested changing the name of the fund to kada rog ausadhi upachar kosh from bipanna nagarik ausadhi upachar kosh.”
Representative of District Level Management Committee, Central Development Region

“We have no information on how many people among those who get the recommendation from DHO/DPHO get the service from the hospital. There should be mechanism for the monitoring, supervision
by the DHO/DPHO and reporting of the service provided by the hospital.” Representative of District Level Management Committee, Mid-Western Development Region

3.7 Steps taken to increase access to the program
Personnel from the DHO/DPHO shared that awareness program has been the major approach to increase access and they emphasized on its continuation with more focus in the hard to reach areas. They shared that they spread the message about free health service through health posts and local clinics. Participants also shared the need of targeting the awareness program to rural areas. Hospital managers and staffs further shared that the information should be given to the community through media, FCHVs, schools, outreach clinics and health camps and suggested to decentralize the service itself. Respondent working at policy level shared that interaction programs and meetings are being held to design the effective programs to increase awareness in the community.

“We have given information to all the health service providers and community people. Most of the people are aware about the service.” Representative of District Level Management Committee, Mid-Western Development Region

“Awareness programs should be targeted to remote areas as the trend of service users shows that those from the urban areas and nearby rural areas are getting the service and the real needy ones are left out.” Representative of District Level Management Committee, Western Development Region

“The service is available only in the urban areas and especially in Kathmandu and is out of reach of the people who reside in the rural areas. Thus, the service should be available at the district level.” Representative of Hospital Management Committee, Mid-Western Development Region

“Awareness programs should be conducted in the community level through different personnel like health service providers and also through radio, television. Schools could also be a good platform to disseminate the message. Further, screening camps should be conducted to identify the patients in initial stage.” Representative of Hospital Management Committee, Central Development Region

“The service should be decentralized and there should be placement of human resources in the rural areas of the country.” Representative of Hospital Management, Central Development Region

3.8 Information regarding Bipanna Nagarik Ausadhi Upachar Kosh among the service users
Most of the service users were aware of the free dialysis for 208 episodes under the bipanna nagarik ausadhi upachar kosh and recently announced – lifetime free dialysis. The major sources of information were family, relatives, friends, neighbours, health service providers, media (TV, radio), mrigaula rog pidit sangh and other kidney patients. Participants opined that the total cost of the subsidy is 2 to 3 lakhs.

“I got the information about this program from one of my neighbour who was receiving the free service. Besides, I had also heard about this from radio.” Patient with CKD, Western Development Region

“Previously the program supported for 208 episodes of dialysis but recently free service for the life time has been announced but I don’t know if it will be implemented.” Patient with CKD, Western Development Region

Participants were aware about the process of getting free service. They shared that they need to get the recommendation from their VDC/municipality identifying them to be bipanna. They further
added that they need the document from the hospital explaining the diagnosis. On the basis of diagnosis, they get the recommendation from DHO/DPHO for the free service at the hospital. For most of the participants, the time to complete all these formalities ranged from 2-5 days. However, participants shared that it takes more than a month to take the free service after completing the formalities.

“VDC gives letter stating the person is bipanna and he/she needs support for his treatment. Then we have to take the letter to the DHO along with the document from the doctor verifying the diagnosed CKD. Then the DHO writes the letter to the hospital on the basis of which we get free dialysis service. It took me 5 days to collect all the documents.” Patient with CKD, Central Development Region

3.9 Experiences of service users

The participants felt that the program is good for those who cannot afford the dialysis on their own. Participants suggested that other expenses besides the cost for dialysis should also be covered by the program and specially the cost of medicine and diagnostic tests. Most of the patients were satisfied because they were getting financial assistance from the government to some extent. Some participants further elaborated that there should be free services in transportation, medication and transplantation service.

“It is a great support for those like us who cannot afford the service on their own. We have got chance to live little longer.” Patient with CKD, Mid-Western Development Region

“The amount is not enough. We have to bear for some of the things. So, if extra subsidy is added, it would be better. For example, we are testing blood in labs. Government also needs to bear that fully.” Patient with CKD, Western Development Region

“I am very satisfied (with the program)... paying 6 thousand (Nepali Rupees) is very big thing for us. Getting that much subsidy from government as a help makes me satisfied.” Patient with CKD, Central Development Region

3.9.1 Experience relating to health personnel

Most of the participants had opined that the behaviour of service providers was good although some participants shared about difficulties faced due to unavailability of health personnel in some instances. They shared that they were explained about all the procedures, the services and the expenses that they had to bear. They were explained that those who are undergoing dialysis should ultimately have transplantation which could bring them back to their normal life. However, they would have to take medicine for their life time and they would not be able to do heavy works.

“The staffs here are very good. They explain about all the things we ask.” Patient with CKD, Mid-Western Development Region

“The behaviour (of health personnel’s) is good. They are friendly and are service oriented. The dialysis is usually performed till 6 pm but in case required for the patient they give the service even in the midnight.” Patient with CKD, Central Development Region

3.9.2 Difficulties faced by the patients while seeking the service

The patients shared that they had to seek service from the private centres at their own expenses when the machines at the service providing hospitals, were under maintenance or were not working. Some of the participants reported that the hospitals took long time to repair the machine and the responsible person did not respond when asked about the delay in the process.
“The machines are often under maintenance and we have to go to private centres paying 6000-7000. Hospital takes at least 2 weeks to repair the machine due to which we have to face difficulty. And if we inquire about the process, the responsible persons do not answer.” Patient with CKD, Central Development Region

Participants shared about difficulties associated with lack of doctors and specialist in the government hospitals. Moreover, they reported lack of technicians who can repair the machines within short time so that patients do not have to go to other service centres.

“Doctors and engineers who can repair the machine are available all the time in private hospitals but in government hospitals, the doctors come only to show their face.” Patient with CKD, Central Development Region

In addition, some patients reported that they were getting dialysis service once/twice a week even when they were prescribed to do it twice/thrice due to overflow of patients and lack of adequate machines at the hospital. Further, they shared that they were getting the dialysis for shorter duration due to the long queue of the patients and a limited number of machines.

“I was prescribed by the doctor to undergo dialysis three times a week but the hospital administration said that managing three sessions of dialysis for a person would not be possible due to the long list of patients. So I am undergoing dialysis only two times a week.” Patient with CKD, Central Development Region

“It is very difficult to get the time. There are only two machines and the queue is long. Previously we used to get dialysis for up to four hours but nowadays it is done for hardly 2 hours.” Patient with CKD, Western Development Region

Furthermore, some reported about the lack of donor for transplant and person accompanying them to health facilities for service utilization.

“The main difficulty is the restriction by the government on donor for kidney transplant. As people other than blood relations cannot donate kidney and there is problem in getting donor within my family. So I am unable to undergo transplant.” Patient with CKD, Central Development Region

Some patients shared that immediate service utilization was difficult in case of emergency as the hospitals have the scheduled sessions for other patients that could not be disturbed. In such cases patients had no other option than visiting private service centres that charge about 5000-6000 for a session. Furthermore, some patients who came from distant places to get the service had faced difficulties in arranging for accommodation.

“If we have to undergo dialysis in the emergency condition, hospitals do not give the service. I came here last Saturday in emergency but I had to go to private centre when the hospital denied of the service. I have to pay 6000 for the session.” Patient with CKD, Central Development Region

“It takes 4 hours to reach here. I have to take three different buses. Sometimes there is no seat and have to travel standing all the way which is very difficult.” Patient with CKD, Western Development Region

Some of the participants shared that even after getting the recommendation from DPHO for free service, the hospital made them pay for initial 5 sessions saying that it is the rule of hospital.
“They said that it was the rule of hospital. Whoever pays for the first 5 dialysis is only eligible to get the free service. And they asked me to go to another hospital if I do not pay for the initial episodes.”
Patient with CKD, Central Development Region

3.9.3 Costs to be borne by the patients
Participants who were undergoing treatment for CKD shared about the medical and non-medical costs which included cost for diagnosis, treatment, laboratory tests, dialysis, transplant, transportation, lodging and fooding. Depending on whether the patients were under the free service or not, the cost of service differed. Cost of one time treatment immediately after diagnosis was as high as 3 lakhs. Although, the patients under the *bipanna nagarik ausadhi upachar kosh* were getting the dialysis service for free, they had to bear the medication cost and other direct non-medical costs such as cost for foods, accommodation and transportation. The expenses of those who were getting the free dialysis service ranged from NRs. 20,000-25,000 per month and in case of those who were paying for the dialysis, the cost ranged from NRs 48,000-53,000 as the dialysis cost around NRs 3500 per session.

“Only the dialysis is free here. I have to take medicines of Rs.1500 per month and undergo regular tests that cost Rs.1400. Besides, Rs.400 for one injection and Rs.800 for blood per week. In addition, there are expenses on fooding and transportation.” Patient with CKD, Central Development Region

“There is one small injection of size that of the ball pen which is very costly. I have to take it every time I undergo dialysis. If we get discount in these medicines we could afford for more sessions of dialysis and prolong life.” Patient with CKD, Mid-Western Development Region

Most of the participants reported they had to take loans from their relatives, neighbour and friends and also had to sell their properties including their land and house to bear the expenses for lodging, fooding, transportation and medicines. A few had got donations after publishing about their status in the newspaper. In addition, some were doing job or doing their own business like poultry to support their expenses.

“I have taken loans from my relatives to cover the expenses. Furthermore, I have taken the medicines equivalent to 2.5 lakhs on credit. I am under very much difficult condition to sustain this treatment.” Patient with CKD, Eastern Development Region

“Including medicines, we have to spend around 20 thousand Nepali rupees from our pocket as we have to come from distant places. We have to bring our own vehicle.... We have to come from far and often we cannot predict might happen in Nepal...Strikes always happen...can’t get the vehicle as per our need...Often, there is scarcity of fuel so we bring our own vehicle that makes the cost higher. Everyone’s financial status is not same, isn’t it? It’s hard...” Guardian of a Patient with CKD, Eastern Development Region

3.10 Strengths and Challenges of the program
3.10.1 Strengths
The participants shared that the program has proven to be a great support to those who cannot afford the treatment on their own. The hospital managers and personnel from DHO/DPHO shared that the program is a good approach to help those who cannot afford for the treatment. They also expressed that when a person suffers from chronic disease, sooner or later even the elite ones can fall below poverty, so the program is a great relief to the patients. Besides, the participants perceive this program as a step of the government to ensure its citizens right to live.
“Once a person gets the chronic disease, he will get impoverished sooner or later. So this program is a great support to people.” Representative of Hospital Management Committee, Western Development Region

“Helpful...It is very helpful for us because this (to afford the treatment cost) is so hard...medicines are very expensive to buy. So it is very helpful.” Patient with CKD, Central Development Region

“The strong point of this program is that people do not have to die because of lack of service just because they do not have strong financial background. There are so many who cannot afford the treatment. As chronic disease stays forever, people like that do not have to die.” Representative of District Level Management Committee, Western Development Region

“One of the advantages of this (program) is that they (CKD patient) can prolong their life as soon as they are diagnosed with CKD.” Representative of Department of Health Services, Central Development Region

3.10.2 Challenges
Personnel from the DHO/DPHO also expressed that the political pressure is one of the main challenges/barriers for the smooth running of the programme. In addition, they face difficulty in convincing people who ask for subsidy without fulfilling the criteria. Besides, they also shared that lack of authority within DHO/DPHO to verify the status of the service seekers, sometimes leads to recommendation for those who are not the actual bipanna. The hospital staffs also expressed, the hospital cannot deny the free service to the patient with recommendation even if their accessories and their possessions clearly show them to be from the elite group. Personnel from DHO/DPHO also added that even though the fund is said for bipanna there is no clear definition of bipanna and the service is being provided to all who have the recommendation from the local authority.

“As there is no clear definition for bipanna, certification by the local authority is the only means to identify any person as bipanna.” Representative of District Level Management Committee, Eastern Development Region

“We sometimes are pressurized politically to recommend free service to those who do not fulfil the criteria for the service.” Representative of District Level Management Committee, Eastern Development Region

Most of the hospital managers and staffs shared the limited number of machines compared to the flow of patients which leads to overuse and frequent break down of the machines. Besides, they also opined that the lack of dialysis service centres in the districts has led to overburden of the patients in the central hospitals. This has in turn also increased the expenses of the patients in transportation and lodging. Furthermore, they foresee the increasing trend in NCDs and number of patient requiring dialysis service incurring huge financial expenses as an emerging challenge based on the fact that the country has limited resources.

“The increasing number of CKD patients is one of the major challenges. It is beyond our capacity to give service to all the service seekers. We have started giving service in two shifts but still we are not able to serve all the service seekers.” Representative of Hospital Management Committee, Eastern Development Region

“We have to give service to a large number of patients with only two machines. So, our machines often break down of overuse and in such case we cannot offer regular service. The service should be available in the peripheral health centres so as to decrease the burden in the central hospitals.” Representative of Hospital Management Committee, Central Development Region
3.11 Sustainability of the program

Some of the participants from the management level shared that compared to other countries that are providing health service to their people, this support is nominal. They expressed that it is the responsibility of state to provide health services to its citizens. However, they had views that it would be very difficult for government to carry this program in the long run following the increasing trend in NCDs. In addition, the policy maker also does not foresee the long term sustainability of the program. They shared that alternative approaches should be adopted for long term sustainability of the program.

“Government does not have the capacity to sustain this program in the long run.” Representative of Department of Health Services, Central Development Region

“This program should ultimately be merged with the insurance program for long term sustainability.” Representative of District Level Management Committee, Central Development Region

3.12 Suggestions for improvement

3.12.1 Suggestions relating to policy changes

Defining poor

Participants from DHO/DPHO recommended that there should be clear criteria to identify of poor people by the government. According to participants, this is essential to control the misuse of fund and ensure that the real needy people get the services.

“The bipanna should be identified based on the real assessment and they should be provided with the identity cards. This would help to prevent misuse of the fund and ensure that the needy ones are getting the service.” Representative of District Level Management Committee, Eastern Development Region

Additional subsidies and free service

Research participants, especially patients opined that the tests should be made free and there should be additional subsidies for needy people. Patients undergoing dialysis emphasized on the need of amendment in policy to make the transplant free to the bipanna as patients are unable to pay for the procedure even if they have the donors. Some participants also shared that the there should be subsidy in accommodation and fooding for the patients as they have to arrange transportation from distance places and stay near hospitals in the process of seeking service.

“Providing free dialysis only is not sufficient. There should be subsidy for lodging and fooding for the patients.” Representative of Hospital Management Committee, Mid-Western Development Region

“I have the donor for kidney transplant but I cannot afford for the process. If I get free transplant from the government then only I will get the opportunity to live.” CKD Patient, Central Development Region

“CKD patients need to do different tests regularly which are expensive. So either it should be made free or the subsidy should be increases. Further, transplant should be promoted instead of providing lifelong dialysis and the policy should be changed to allow people other than blood relation to donate kidney.” Representative of Hospital Management Committee, Central Development Region

Covering non poor
In addition, some participants recommended that a person suffering from chronic disease would ultimately be impoverished so the program should cover all those with chronic disease irrespective of their economic status. As other possible alternative, some participants also suggested bringing the disease under benefit package of social health insurance scheme to being every citizen under the coverage of the program.

“A rich person will ultimately become poor when he suffers from disease like cancer, so the bipanna nagarik ausadhi upachar kosh should be changed to chronic disease ausadhi upachar kosh.” Representative of District Level Management Committee, Central Development Region

**Flexibility on kidney donation**

Some participants opined that policy changes are needed allowing other people than family members to donate the kidney. Participants shared that in some cases family members might not be eligible to donate or may not be willing to donate while there might be friends and distant relatives who are ready for donation on certain condition.

“There is the rule that only family member can donate, but people in family are illiterate and they don’t accept to donate. They think that they will die if they donate kidney. Despite having eligible family members (to donate) they don’t do so. So, where would they get (kidney) from? That’s why some facilities should be given in this regard.” Patient with CKD, Central Development Region

**Decentralization of service**

Participants emphasized on making dialysis service available in the district level so that they would not have to spend on transportation and accommodation. Furthermore, they shared that lodging facility should be arranged for those who come from distance places and who have their dialysis shifts in the evening.

“Cost for transportation is a big problem for us. If pass or discount cards could be provided, that would be a great relief.” Patient with CKD, Mid-Western Development Region

“Even though the service is free, we have to spend a huge sum on transportation and accommodation. So, the services should be available in the district level.” Patient with CKD, Central Development Region

**Covering through Insurance**

According to participants, one other way to address the cost of transportation would be to make provision of discount in public vehicles through privileged cards for the bipanna.

**Arranging employment opportunities for patients**

Research participants could help patients cover the cost of medicine, transportation, accommodation etc through arrangement of employment opportunities for the patients. According to participants, it is essential as the patients suffering from kidney disease are often not able to do heavy works and employers are unwilling to provide employment opportunity.

“We cannot do heavy works. Besides, the employers would not want to take risks by giving employment to people like us whose life is very risky and it is very difficult to sustain without doing any job. So the government should arrange for our employment.” Patient with CKD, Central Development Region
3.12.2 Suggestions relating to program management

Improving management of the program

Further, monitoring and supervision of the program should be strengthened to ensure that the needy ones are getting the service and the fund is not misused. They further suggested for coordination and communication among the hospital, DHO/DPHO and DOHS to identify the loop holes and hence improve the program implementation.

“There should be mechanism for the monitoring, supervision by the DHO/DPHO and reporting of the service provided by the hospital. Besides, the information on each of the program activities should be shared among the hospital, DHO/DPHO and the hospital.” Representative of District Level Management Committee, Mid-Western Development Region

“Sometimes, the dialysis finishes at 10-11 pm and in that case we face difficulty in accommodation. The hospital has no provision of accommodation and cannot afford to stay in hotels. So there should be provision for waiting rooms.” Patient with CKD, Central Development Region

To cater the need of increasing number of patients, service providers demanded that the hospitals should be provided with dialysis machines free of cost by the government.

Focus on preventive activities

Emphasize should be given on preventive measures and community awareness program rather than concentrating on curative services only. Screening programs such as creatinine test, blood urea test to identify disease in early stage were among other initiatives that should be considered as suggested by research participants that could reduce the burden of disease in the community thereby reducing the financial expenses that the country has to incur.

“This is a very expensive program and the number of service seekers is increasing day by day. So, there should be focus on prevention of the chronic disease along with this program. Awareness activities at the community level should be conducted addressing the risk factors for the chronic diseases.” Representative of District Level Management Committee, Mid-Western Development Region

“The screening programs like blood urea test, creatinine test should be conducted in the community level at least once a year to find out the potential cases in the initial stage.” Representative of Hospital Management Committee, Central Development Region

“The changes should be brought in the lifestyle of the people. Programs should be implemented to promote healthy life style. Besides, changes should be brought in the agriculture system as the fertilizers and pesticide use have led to increase in CKD.” Representative Hospital Management Committee, Eastern Development Region

3.12.3 Suggestions relating to research

Participants from hospital management recommended that studies/research should be done to find out the specific causes of NCDs and prevention programs should be designed and implemented based on the results. Further, they emphasized on control of haphazard use of medicines.
Chapter 4

Conclusion

The study shows that there is no clear definition of bipanna and it is hard to ensure that the service is being utilized by the real needy ones. Despite the program has supported many people, the numbers of patients beyond the capacity of the health facilities has been a factor for delayed service delivery to the patients. It was observed that the hospitals involved in the services delivery are overwhelmed with a large number of patients that are beyond their capacity. Whereas, as a consequence, patients are having less number and shorter session of dialysis than prescribed and they have longer waiting time.

Furthermore, the centralization of health facilities has increased the non-medical costs such as travel cost, lodging and fooding costs to the patient. Sustainability of services and maintenance of the quality of services deserve attention due to multiple factors. To name a few, the estimates for kidney patient needing renal replacement therapy is still lacking in Nepal, the health facility involved in Bipanna Nagarik Sahayata Kosh are treating a large number of patient beyond their capacity ultimately leading to poor quality services (long waiting time, reduced session of dialysis per week than actually required) provided to the kidney patients.

Thus, the study shows that the guideline for the program needs revision in order to clarify the eligibility criteria for the patients to receive the support. It also highlights the need for development of a mechanism that could be implemented nationwide to ensure that the real needy ones are getting the service and the fund is not misused. Furthermore, the challenges faced by the patients and hospitals should be addressed through decentralized service provision. The capacity of the hospitals designated for these services should be strengthen in order to provide quality service for the people. Concerns for the preventive aspect and early identification of the disease should be taken into consideration and alternative approaches like insurance system need to be focused on cost reduction to make the program sustainable.
REFERENCES


ANNEXURE

ANNEX I: Information Sheet

सुचना फार्म (Qualitative interview)

आदरणीय सहभागी .............

पृष्ठमुखी र उद्देश्य

नेपाल स्वास्थ्य अनुसन्धान परिषदबाट राष्ट्रिय दिर्योग सर्वेक्षण हुन गईरहेको छ ।

नेपालमा केही दिर्योगहरू: Diabetes (मधुमेघ), Coronary artery disease (मुद्र रोग),

Chronic obstructive pulmonary disease (दम), Chronic kidney disease (दिर्यकालिन

मृगीला रोग) र Cancer (स्वास्थ्य) को अवस्था पता लागाउनुका साथै स्वास्थ्य मन्त्रालयको विषयन नागरिक अधिकार उपचार कोषुदारा आर्थिक अवस्था कमजोर भई अविष्कृत अवस्थामा रहेका नेपाली नागरिकलाई लोकिका रोग उपचारमा राहत प्रदान गर्न आएको कार्य सम्बन्धी अनुसन्धान गर्नु सँग यस अनुसन्धानको उद्देश्य हो ।

तपाई पनि यस कार्यक्रमको व्यवस्थापनमा सलग नुहुनुको यस अन्तर्वार्ता को

लागि उद्योग सहभागीको रूपमा लिएका छ। त्यसैले तपाईलाई यस अन्तर्वार्ता मा

सहभागी हुनुका लागि अनुरोध छ। यस अनुसन्धानले नेपाल स्वास्थ्य अनुसन्धान परिष

द, नेपालको आचार सहिता सम्मिलित स्वीकृत प्राप्त गरेको छ। यो सर्वेक्षण नेपाल

स्वास्थ्य अनुसन्धान परिषद (स्वास्थ्यमन्त्रालय) बाट तलामाग्राम स्वास्थ्यकर्मी / तथापि

संकलनकहुदैरा संचालन गरिएको छ।

गोपनीयता

यो अन्तर्वार्ता अविष्कृत भर तपाईको आचार रेकर्ड गरिएको छ। तपाईले दिइएको तथापि

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प्रयोग गरिएको छ।

सहभागीता

यस सर्वेक्षण तपाईको स्वेच्छिक सहभागीता हुनेछ। तपाई चाहिएको खान्दा वा कुनै पनि

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ANNEX II: Consent Form

लिखित मन्जरीनामा पत्र (Qualitative interview)

मलाई यस शोधकार्यको उद्देश्य र आधार, अन्तर्वित्त प्रक्रिया, आफ्नो भूमिकाको बारेमा पूर्ण जानकारी छ।
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हर्दिक र म अन्तर्वित्त दिनको लागि मन्जरी छु।

अन्तर्वित्त दिनको सहिष्णु

मिति

अन्तर्वित्त लिनेको नाम धर

अन्तर्वित्त लिनेको सहिष्णु

मिति

साक्षी बस्नेको नाम धर

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ANNEX III: Interview Guidelines

A. Key Informant Interview with MoH/DoH
1. Could you please provide general overview on Bipanna nagarik sahayata kosh? Probe: Origin of the concept
   Probe: What are the chronic diseases for which government provide support for treatment under this kosh?
   Probe: Do you have any plan to include any other disease in this program
2. How is the services provided to the patient?
   Probe: Do patient need to be treated for those disease from government hospitals to receive financial support?
   Probe: What are the hospitals that are providing treatment service for such disease?
3. Are there any eligibility criteria for receiving that financial support?
   Probe: age, economic status, target groups
   Probe: what are the documents needed?
4. What is the amount that individual patient receives for the treatment of these disease, specifically kidney disease?
   Probe: What is the average annual amount spent for such diseases at national level?
   Probe: Is disaggregated data available for different type of disease?
   Probe: If yes, what is the average amount spent annually to support treatment of patient with kidney disease?
   Probe: How is patient aided with financial assistance......by cash or by kind/service?
5. Could you please clarify how the fund is operate and regulated?
   Probe: Is that amount provided to patient through ministry of health/DOHS, other ministry or Hospital?
   Probe: How does the amount flow before it reaches to patient?
   Probe: What is the mechanism to make sure that the amount is received by those who need or what is the mechanism to prevent misuse of fund?
6. What are the strengths of this program?
   Probe: Do you see any long term benefits from of this program?
   Probe: What are the approaches made to increase the accessibility of the disadvantaged toward these services?
7. What do you think are the limitations of this program?
   Probe: what are the barriers that hinder performing the activities related to the program?
   Probe: Is there any risk perceived during the implementations of these programs?
   Probe: Will the government be able to bear the financial burden in future?
   Probe: Is there any alternative plan or strategy to deal with such problems in future? Or do you think it needs to be revised?
   Probe: What can be done to make this program long term/sustainable/services?
   Probe: Are there any other organizations also operating such funds?

B. Key Informant Interview with District level committee
1. Could you please provide general overview on Bipanna nagarik sahayata kosh
   Probe: What are the chronic diseases for which government provide support for treatment?
   Probe: What is your role in the execution of this program? How is it cooperated?
2. Are there any eligibility criteria for receiving that financial support?
   Probe: Age, economic status, target groups
   Probe: What are the documents needed?
   Probe: How would you assess if the patient to be recommended or not for the financial support?

3. Could you please share about how the fund is regulated?
   Probe: Is that amount provided to patient through ministry of health / DOHS or Hospital or other ministry?
   Probe: How does the amount flow before it reaches to patient?
   Probe: Is there any mechanism to make sure that the amount is received by those who need or what is the mechanism to prevent misuse of fund?

4. What are the strengths of this program?
   Probe: Do you see any long term benefits from of this program?
   Probe: What are the approaches made to increase the accessibility of the disadvantaged toward these services?

5. What were the challenges while administering program at district level
   • Determining eligibility
   • Regulating the program, controlling misuse of fund

6. What do you think are the limitations of this program?
   Probe: What are the barriers that hinder performing the activities related to the program?
   Probe: Is there any risk perceived during the implementations of these programs?
   Probe: Will the government be able to bear the financial burden in future?
   Probe: Is there any alternative plan or strategy to deal with such problems in future? or do you think it needs to be revised?
   Probe: What can be done to make this program long term/ sustainable?
   Probe: Are there any other organizations also operating such funds?

C. **Key Informant Interview with Hospital manager**

1. Could you please provide general overview on Bipanna nagarik sahayata kosh
   Probe: What are the chronic diseases for which government provide support for treatment?

2. Are there any eligibility criteria for receiving that financial support?
   Probe: age, economic status, target groups
   Probe: what are the documents needed?

3. What is the amount that individual patient receives for the treatment of these disease, specifically kidney disease?
   Probe: What is the average annual amount spent for such diseases?
   Probe: Is disaggregated data available for different type of disease?
   Probe: If yes, what is the average amount spent annually to support treatment of patient with kidney disease?
   Probe: How is patient aided with financial assistance….. by cash or by kind?
   Probe: Whether a patient can seek assistance twice?
   Probe: What is the limit of financial assistance for treatment?

4. Could you please clarify how the fund is regulated?
   Probe: Is that amount provided to patient through ministry/ DOHS or Hospital?
Probe: How does the amount flow before it reaches to patient?
Probe: What is the mechanism to make sure that the amount is received by those who need
or what is the mechanism to prevent misuse of fund?
Probe: Is there any incident that we have rejected the patient in spite of recommendation by
district level committee?
Probe: how is medical expenditure re-imbursed?

5. What are the strengths of this program?
   Probe: Do you see any long term benefits from of this program?
   Probe: What are the approaches made to increase the accessibility of the disadvantaged
toward these services?

6. What were the challenges implementation of the program?
   • Determining eligibility
   • Regulating the program, controlling misuse of fund

7. What do you think are the limitations of this program?
   Probe: what are the barriers that hinder performing the activities related to the program?
   Probe: Is there any risk perceived during the implementations of these programs?
   Probe: Will the government be able to bear the financial burden in future?
   Probe: Is there any alternative plan or strategy to deal with such problems in future? or do you
   think it needs to be revised?
   Probe: What can be done to make this program long term/ sustainable?
   services?
   Probe: Are there any other organizations also operating such funds?

D. In-depth interview guideline for the patient utilizing the Bipanna Nagarik Sahayata Kosh.
1. Could you share us about your health in relation to CKD?
   Probe: How you were diagnosed with chronic kidney disease?
   Probe: What is the duration of having diagnosed CKD?
   Probe: What type of treatment are you being provided for CKD?
   Probe: Could you please indicate number of dialysis per week/ month that has been
   recommended for you or you have been doing?

2. What is the cost of the treatment you are having?
   Probe: Could you please specify cost of different treatment you are having?
   Probe: Do you have any difficulties in affording/paying for the service? How do you manage
to pay for the services? Have you obtained loan from any agencies to pay for health services?

3. What kind of other difficulties you face while seeking treatment for the service?
   Probe:
   • Geographical
   • Absence of accompanying person
   • Lack of information about the service availability
   • Behaviour of health personnel
   • Non availability of service or medicines

4. What do you know about government subsidies on chronic diseases?
   Probe: What are the eligibility criteria for obtaining the service?
   Probe: From where did you get the information on government subsidies on chronic diseases?
   Probe: What are the formalities required?
Probe: How long did it take to complete the process?
Probe: How was it subsidized (cash or by kind)- what components of treatment was included (medicine, laboratory investigation, dialysis)?
Probe: What amount was subsidized?

5. Patient's satisfaction

Probe: How much helpful do you find the subsidy?
Probe: How were you treated during the whole process of getting subsidy?
Probe: Were you given full information?
Probe: How adequate was the subsidy?
Probe: Do you find any difficulties during the process= duration, waiting time, difficulty in making appointment?
Probe: What are the areas for improvement for these kinds of subsidy?
### ANNEX IV: List of Selected Organizations

<table>
<thead>
<tr>
<th>Region</th>
<th>Selected Organizations</th>
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</thead>
<tbody>
<tr>
<td>1. Eastern Development Region</td>
<td>1. BP Koirala Institute of Health Sciences, Sunsari</td>
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<tr>
<td></td>
<td>2. District Public Health Office, Sunsari</td>
</tr>
<tr>
<td>2. Central Development Region</td>
<td>1. National Kidney Centre, Kathmandu</td>
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<tr>
<td></td>
<td>2. Bir Hospital, Kathmandu</td>
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<tr>
<td></td>
<td>3. Narayani Sub-Regional Hospital, Parsa</td>
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<tr>
<td></td>
<td>4. Chitwan Medical College, Chitwan</td>
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<tr>
<td></td>
<td>5. District Public Health Office, Kathmandu</td>
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<tr>
<td></td>
<td>6. Department of Health Services, Kathmandu</td>
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<tr>
<td>3. Western Development Region</td>
<td>1. Western Regional Hospital, Kaski</td>
</tr>
<tr>
<td></td>
<td>2. Universal College of Medical Sciences, Rupandehi</td>
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<tr>
<td></td>
<td>3. District Public Health Office, Kaski</td>
</tr>
<tr>
<td>4. Mid-Western Development Region</td>
<td>1. Nepalgunj Medical College, Banke</td>
</tr>
<tr>
<td></td>
<td>2. District Public Health Office, Banke</td>
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</table>
### ANNEX V: List of hospitals providing free dialysis service

<table>
<thead>
<tr>
<th>Region</th>
<th>Name of Hospital</th>
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</thead>
<tbody>
<tr>
<td>1. Eastern Development Region</td>
<td>1. BP Koirala Institute of Health Sciences, Sunsari</td>
</tr>
<tr>
<td></td>
<td>2. Koshi Zonal Hospital, Morang</td>
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<td></td>
<td>3. Golden Hospital, Morang</td>
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<td>4. Birat Hospital, Morang</td>
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<td></td>
<td>2. Central Development Region</td>
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<td></td>
<td>1. Bir Hospital, Kathmandu</td>
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<td></td>
<td>2. Tribhuvan University Teaching Hospital, Kathmandu</td>
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<td></td>
<td>3. Patan Hospital, Lalitpur</td>
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<td></td>
<td>4. Gangalal National Heart Centre, Kathmandu</td>
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<tr>
<td></td>
<td>5. Paropkar Maternity and Women’s Hospital, Kathmandu</td>
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<tr>
<td></td>
<td>6. Kanti Child Hospital, Kathmandu</td>
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<tr>
<td></td>
<td>7. National Kidney Centre, Kathmandu</td>
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<tr>
<td></td>
<td>8. Human Organ Transplant Centre, Bhaktapur</td>
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<tr>
<td></td>
<td>9. Narayani Sub-Regional Hospital, Parsa</td>
</tr>
<tr>
<td></td>
<td>10. Janakpur Zonal Hospital, Dhanusha</td>
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<tr>
<td></td>
<td>11. National Medical College, Kathmandu</td>
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<td></td>
<td>12. Chitwan Medical College, Chitwan</td>
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<tr>
<td></td>
<td>13. College of Medical Sciences, Chitwan</td>
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<tr>
<td></td>
<td>14. Dhulikhel Hospital, Kavrepalanchowk</td>
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<tr>
<td></td>
<td>15. B&amp;B Hospital, Lalitpur</td>
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<tr>
<td></td>
<td>16. National Dialysis Centre, Lalitpur</td>
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<tr>
<td></td>
<td>17. <em>ArogyaPratisthan</em>, Lalitpur</td>
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<tr>
<td></td>
<td>3. Western Development Region</td>
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<tr>
<td></td>
<td>1. Western Regional Hospital, Kaski</td>
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<tr>
<td></td>
<td>2. Manipal Medical College, Kaski</td>
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<td>3. Gandaki Medical College, Kaski</td>
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<tr>
<td></td>
<td>4. Universal College of Medical Sciences, Rupandehi</td>
</tr>
<tr>
<td></td>
<td>5. Mid-Western Development Region</td>
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<tr>
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<td>1. Nepalgunj Medical College, Banke</td>
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