Review of activities undertaken by NFHP and its partners to strengthen the partnership between Community and Health Facilities

Nepal Family Health Program
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Executive Summary

Background and Purpose

Nepal Family Health Program (NHFP) provides support to Ministry of Health and Population at all levels - national, district and community level. Over the years (2002-7), different programs have been implemented by NFHP itself and through the implementing partners CARE - Nepal and Save the Children US. The objectives were strengthening the delivery of and use of high impact FP/MCH services delivered at household and community levels. Community and Health Facilities as Partners (CHFP) was conceived based on NHFP's five years of experiences and have been implemented in 8 districts since October 2006. The present report summarizes the activities and achievements in decentralization of health services in general and community health facility interface approaches of NFHP in particular.

Methodology

The following methods have been applied in this review exercise namely, document review, field visit to NFHP-CHFP project areas and interaction with field staff, HFOMC members, DDC and VDC, interaction with key officials of MoHP and MoLD and Partner Organizations.

Findings

a. Desk Review

MoHP needs to have clarity on entire aspects of decentralization strategy. Although the LSGA has given clear direction towards "devolution" as ultimate goal at the same time sectoral ministries have freedom to decide how and at what time-frame they would like to achieve this goal. There is no clear documented plan of action of MoHP with post devolution package.

Decentralization and hand-over is a process, which is taking place in an unstable condition with unpredictable outcome. The capacity building packages are not built in the process. The available guidelines are not clear and there was not adequate preparation for hand-over of health facilities.

b. Health Facility Hand-over

NHTC has completed series of activities in relation to HF hand-over:

- Policy guidelines for HF hand-over to the local bodies
- A two days package for orienting on the roles, functions and responsibilities of staff and HF management committee members
- Revised Guideline for Hand-over and Operation and Management of Local Health Institutions
- NHTC in partnership with EDPs and USAID/NFHP has developed a two-day interaction program "Our Health, Our Responsibility" - A Program for Partnership Development between Community and Health Facility. This package, endorsed by the Government will be used in all re-orientation programs for HFOMC members as continuing efforts of capacity development. Further training modules were also developed for skill development of HFOMC members.

The anticipation that once the health facility management committees resume full ownership of the local level management, the committees will plan and manage the health institutions well have not been materialized.

The decentralization in health service management has resulted in increased roles and responsibilities of the health workers. Clarity about the roles of the health facility and the staff is a basic and fundamental element for managing the health facilities in the changed context. Often the management committee members and health workers are found in a state of confusion.

c. Community Health Facility Interface

There are wide ranges of factors that affect quality of services and level of use of services by the population. One set of determinants that is potentially very important is the relationship between health facility staff and members of the communities they serve. NFHP addresses these issues primarily through working with HFOMC and supporting the following activities:

- Technical assistance for HFs hand-over process
- Two days' orientation for HFOMC members by NHTC in which NFHP also shared resources in the pool
- Three days' training on Capacity Assessment and Strengthening to HFOMC members to further empower the HFOMCs for operation and management of HFs in a sustainable way
- Introduction of Partnership Defined Quality with an aim to improve health service delivery and utilization of services by the poor and marginalized population
- Introduction of REFLECT- new right-based development approach with two components literacy and community empowerment. It has helped to sensitize, aware, encourage and empower the community to address their problems in general and health issues in particular. This process has been applied in selected sites by mobilizing Female Community Health Volunteers.

d. Community and Health Facility as Partners (CHFP)

Community and Health Facility as Partners (CHFP) program was developed with based on NFHP's five years' of experiences of working in the community to improve access and quality of health services. The aim of the CHFP was to establish a linkage/bond between health facilities and community for delivering quality health services at community level in a sustainable manner. NFHP in partnership with local bodies and D(P)HO, implemented CHFP in selected VDCs (health facilities) in 8 Core Program Districts. The observations were drawn during the short implementation period of the program:

- At the facility level, it was very difficult to organize HFOMC meetings on regular basis.
- The participation of *dalits, janajati* and women members in HFOMCs remained just a token. Agenda of their interest were rarely discussed; their voice almost unheard. In some cases, they were just asked to put their signatures on the meeting minutes. The *dalit* and female members were still hesitant to speak up in the meetings. However,

the efforts made to reach the un-reached and marginalized population through the women and *dalit* members were appreciable.

- Self-assessment of HFOMC was helpful to analyze the existing situation. It builds their capacity to appraise their strengths and weaknesses that promotes sustainability in operation and management of local health facilities. However it is time-consuming and may not be required in every meeting.
- It was found that the HFOMCs were engaged in making the list of households who should be provided free services. This exercise of developing criteria of exemption in the local context was commendable. They had their own definition of 'safety-net' for those who are unable to pay for services - the poor and the underprivileged.
- Health facilities were handed over with a short notice and without adequate planning and preparation.
- In the absence of local elected bodies at present and gloomy situation to have a committee of people's representatives, the efforts in the coming year should be in consolidating the experiences and strengthening the capacities of handed over HFOMCs.

Recommendations

- High level political commitment and integrated plan of MoHP and MoLD is necessary to accelerate the process of HF hand-over effective. The high-level inter-agency coordination system should be strengthened. The body should be responsible to monitor the process and to ensure consistency in the process and outcomes.

- Both MoHP and the MoLD should mobilize their mechanism and system to facilitate the process of decentralization. The process and outcomes should be owned by the wings of both ministries, that is D(P)HO and DDC should take responsibility and be accountable for any intended and unintended outcomes from the process. Decentralization should be carried out as process rather than an event-based.

- Central government and other sub-national divisions/units should provide backstop support until the local body is fully capable of handling its responsibilities. Regular monitoring and quality assurance should be continued until local bodies are capable and empowered.

- Hand-over is not only the changing the signboard or letterhead, it should be a process to make local bodies capable to take up decentralized functions (to plan, execute, monitor and evaluate activities to improve health of the people). This should be based on the empirical learning, which can be gained from the decentralization process in other areas such as education.

- MoHP should come out with a post-devolution package with defined time-frame, responsibilities and resources.

- An approach and package owned by all organizations should be endorsed by the MoHP and should be followed. The EDPs needs to collaborate with the government

and together they should agree and follow consistent approach of decentralization in health system.

- Social inclusion is one of the dimensions of decentralization. More efforts are necessary to increase meaningful participation of women, *dalit* and marginalized groups. Special emphasis should be given for promoting the voices and interests of these groups in HFOMC meetings. Regular coaching to *dalits* and women members was necessary for them to understand their roles and responsibilities. More frequent and intensive technical support visits would be necessary and continued.

- All health workers should be oriented on the decentralized functions of health facilities, not just the in-charges. The concerned persons at the local bodies should fully understand their roles and ensure that they are able to assume their responsibilities.

- Adequate preparation at the ground is the prerequisites of hand-over. The hand-over of health facilities should take place only after adequate preparation. There should be demand from local bodies for hand-over rather than centrally imposed upon them.

- With the change in political environment, there is possibility of revival of local government and restructuring of HFOMC. With new members in, it may be needed to orient/ reorient the members.

- In the absence of local bodies and unstable political situation, the efforts should be on consolidating the gains and scaling up in areas where the local bodies are capable and willing to take up their roles and responsibilities as given by LSGA.

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Acronyms

AHW	Auxiliary Health Worker
ANC	Antenatal Care
BCC	Behavior Change Communication
CBO	Community Based Organization
CDP	Community Drug Program
CHFP	Community and Health Facility as Partners
CPD	Core Program District
DDC	District Development Committee
DHO	District Health Office
DoHS (DHS)	Department of Health Services
DPHO	District Public Health Office
EDPs	External Development Partners
FCHV	Female Community Health Volunteer
FGD	Focus Group Discussion
FHD	Family Health Division
FO	Field Office
FP	Family Planning
FP/C	Family Planning and Counseling
FPAN	Family Planning Association of Nepal
GO	Governmental Organization
GoN	Government of Nepal
HF	Health Facility
HFMC	Health Facility Management Committee
HFOMC	Health Facility Operation and Management Committee
HP	Health Post
HW	Health Workers
IEC	Information, Education and Communication
INGO	International NGO
IP	Infection Prevention
LB	Local Body
LDO	Local Development Officer
LHFMC	Local Health Facility Management Committee
LNGO	Local NGO
LSGA	Local Self Governance Act
MC	Management Committee
MCH	Maternal and Child Health
MCHW	Maternal and Child Health Worker
MoHP (MOHP)	Ministry of Health and Population
MoLD (MLD)	Ministry of Local Development
NFHP	Nepal Family Health Program
NGO	Non Government Organization
NHTC	National Health Training Centre
NPC	National Planning Commission
OPD	Outpatient Department

ORC	Out Reach Clinic
PDQ	Partners (Partnership) Defined Quality
PHC	Primary Health Care
PHCC	Primary Health Care Centre
PLA	Participatory Learning and Actions
QIT	Quality Improvement Team
REFLECT	Regenerated Frerian Literacy through Empowering Community Techniques
SHP	Sub-Health Post
SO	Strategic Objectives
ToT	Training of Trainers
TSV	Technical Support Visits
USAID	United States Agency for International Development
VDC	Village Development Committee
VHW	Village Health Worker

1.0 Background

Nepal Family Health Program (NHFP) is a consortium of organizations led by the John Snow Research and Training Institute Inc. (JSI). Engender Health, John Hopkins University/Center for Communication Program (JHU/CCP) and Johns Hopkins University Program in International Education on Reproductive Health (JHPIEGO) worked as co-managing partners and the CARE - Nepal, Save the Children US (SC/US), Management Support Service Pvt. Ltd. (MASS), Adventist Development and Relief Agency (ADRA), Nepali Technical Assistance Group (NTAG), Nepal Fertility Care Center (NFCC) worked as the collaborating partners. NFHP operates as a bilateral program between the United States Agency for International Development (USAID) and the Government of Nepal (GoN). It aims to support the GoN's long-term goal of reducing fertility and under-five mortality within the context of the National Health Policy 1991, Second Long Term Health Plan (1997-2017) and Health Sector Reform Strategy 2004.

NFHP provides support to Ministry of Health and Population at all levels - national, district and community level. It is an integrated and holistic program involving partnership at all levels. District and community level support is focused in 27 districts, of which 17 are the core program districts and 10 districts were limited to Technical Assistance only.

The duration of the program was five years, which started in 2002 to end in 2006. However one-year extension has been awarded until September 2007. Over the years, different programs have been implemented by NFHP itself and through the implementing partners CARE - Nepal and Save the Children US. The objectives were strengthening the delivery of and use of high impact FP/MCH services delivered at household and community levels. In addition, Community and Health Facilities as Partners (CHFP) was conceived based on NHFP's five years of experiences and implemented in 8 districts from October 2006.

The present exercise is to document the activities, achievements and recommendations for implementing community and health facility interface over the years and to examine critically the on-going CHFP program.

2.0 Purpose and Objectives

The main purpose of this study is to document the NFHP activities carried out during its lifetime with the objective of strengthening the interaction between the community and local health facilities. The specific objectives are, to:

- Review and extract the major findings of policy documents and assess reports related to health sector's decentralization efforts and partnership between health facilities and community.
- Document the activities undertaken by the NFHP and its partners including the detail results and impact, the lessons learned and the best practices
- Review the current Community and Health Facility as Partners (CHFP) approach
- Review the current CHFP monitoring data
- Generate recommendation for formulation of improved future program strategies.

3.0 Methodology

The following methods have been applied in this review exercise:

- Document Review
  A review of relevant policy documents and assessment reports prepared by external and/or internal teams related to health sector decentralization was carried out. More focus was given on the decentralization efforts made to strengthen the partnership between health facilities and communities. The major findings, recommendations and lessons learned documented in these reports were extracted to include in this report.

- Orientation and briefing by NFHP
  The senior management team of NFHP briefed the consultant about the scope of the study and the expected output of this exercise. The project staff of CHFP both at the center and field level had oriented and briefed the consultant about the objectives, activities undertaken, achievements made and constraints faced.

- Field visit to NFHP-CHFP project areas
  Field visits were made in two of the project districts namely Banke and Bardiya. The key district level officials such as DPHO, LDO, DDC, planning officer and designated decentralization focal person at DDC were interviewed using the guidelines. The field sites were observed.

- Interaction with field staff, HFOMC members, DDC and VDC
  Interaction with field staff of CHFP was held in both Banke and Bardiya Five sites were visited where the consultant interacted with HFOMC members, health workers and VDC personnel using the structured guidelines prepared for this purpose.

- Interaction with key officials of MoHP and MoLD
  In-depth interviews were conducted with key officials of the Ministry of Health and Population and Ministry of Local Development who are mainly responsible in activities related to decentralization of health services.

- Interaction with key officials of Partner Organizations – CARE Nepal and SC (US)
  In depth discussions were held with CARE Nepal, SC (US) and NFHP staff including the field level staff of Banke and Bardiya. The discussions mainly focused on process, outcomes and strengths and weaknesses of the programs.

- Analysis and Synthesis of findings
  The information collected from various sources were analyzed and synthesized to draw logical conclusions and to make recommendations.

4.0 Limitations

This review exercise has been carried in a short span of time (3.5 weeks) including 4 days' of field visit. Only two districts, namely Banke and Bardiya were visited to get first

hand knowledge of implementing the program at grass root level and perceive the impression of the community and stakeholders involved in the program.

5.0 Findings

a. Results of Literature Review

i. Review of policy documents of Government of Nepal

The need for decentralization is well recognized in Government of Nepal's (GoN) health sector policies, as reflected in:

- National Health Policy, 1991
- Second Long Term Health Plan (SLTHP), 1997-2017 (August 1999)
- Local Self Governance Act, 1999
- Health Sector Strategy: An Agenda for Reform (October 2004)
- Nepal Health Sector Programme: Implementation Plan, 2004-9 (October 2004)

The National Health Policy of Nepal, 1991

The National Health Policy, 1991 (NHP) established a policy framework to guide health sector development. The principle objective of the NHP was to upgrade the health standards of the majority of the rural population by strengthening the primary health care. The goal is to make effective health care services readily available at the local level. The Policy has elaborated specific objectives to address the main areas of preventive and promotive health services by strengthening organization and management of health system. The policy has anticipated increased community participation in health services. There will be adequate number of competent and appropriate number of human resources at the facility level.

NHP has clearly spelled out that decentralization and regionalization processes will be in placed to make peripheral health units more autonomous. Local level planning (micro-planning procedures for primary health plans at the village level) and management of curative and preventive services shall be supported.

The Second Long Term Health Plan, 1997-2017 (August 1999)

The Second Long Term Health Plan (SLTHP) is a 20 years perspective plan of MoHP. The plan would guide health sector development resulting in the improved health status of the population.

The vision of health and development stated in the SLTHP is to have ‘a health system in which there is equitable access to coordinated quality health care services in rural and urban areas, characterized by self-reliance, full community participation, decentralization, gender sensitivity, effective and efficient management, and private and NGO sector participation (an appropriate public/NGO/ private mix in the provision and financing of health services) resulting in improved health status of the population.’

The health plan aims at improving the health status of the population particularly those whose health needs often are not met:

- the most vulnerable groups
- women and children

- the rural population
- the poor
- the underprivileged and the marginalized.

Full community participation is recognized as an essential characteristic of an effective, efficient and sustainable health system. Community participation is not viewed as simple compliance to program activities nor by the provision of resources. Rather, community participation is the participation of the community in decision-making at various levels through its representatives and organizations. Within the context of full community participation, central, regional and district level personnel are expected to fulfill a supportive role in assisting and enabling the community to carry out their responsibilities.

The principal polices prescribed in SLTHP were:

1. Developing a district level long-term plan for the decentralization of primary health services. The plan will provide a blue print for a sequenced devolution of services up to the VDC level.
2. The DPHO will provide necessary support to enable the Village Health Development Committee (Health development Board) to carryout their roles and responsibilities in the village based primary and preventive health care system.
3. District budget for decentralized health programs will be vested in the DDC. eg. District Health Fund.
4. District level program budgeting will be developed to manage the new village based health system.
5. The capacity of the DDC and VDC will be developed in order that they are able to evaluate the effectiveness of their programs and negotiate for their budgets accordingly.
6. The DDC and VDC will develop plans for local support and resource generation.

Local Self-Governance Act, 1999

Government of Nepal (GoN) has undertaken an ambitious program of decentralization of government with full and active participation by the citizens of Nepal. For this purpose, the Local Self-Governance act (LSGA, 1991) has been enacted. It has created the legal basis for decentralization of planning to locally elected authorities. The underlying spirit of LSGA is to make the local bodies politically powerful, legally responsible and technically capable of managing their efforts. Many activities were undertaken to put LSGA into practice.

GoN is committed to decentralization as a model for delivering health care. The formulation of comprehensive periodic plan at district level has provided a mechanism for enabling integrated service delivery. Conventionally, basic health services, nutrition, education, access to safe drinking water and environmental sanitation have been organized on a sectoral basis within central command structure. This has led to lack of efficiency, coherence and responsiveness to local needs. The LSGA envisages greater convergence of local service provision coordinated by and provided through local bodies. It devolves responsibility to local bodies for delivering health care in their communities.

The Act and the Regulations takes the process of decentralization forward by setting out a process of cross-sectoral devolution with taking on key planning and provider roles with respect to health status of their respective community and health care delivery system.

The duties and responsibilities of Local Bodies (District Development Committee, Municipality and Village Development Committee) mentioned in the LSGA are as follows:

Village Development Committee	Municipality	District Development Committee
1. Operate and manage: – Village level health center – Health center – Health post – Sub health post	1. Operate and manage or cause to be operated and managed: – Municipal level hospitals – Ayurvedic dispensary – Health Center	1. Manage and operate (or get managed or operated)district level: – Health posts – Hospitals – Ayurvedic Dispensary – Health center
2. Prepare programs on: Primary health education and sanitation and disposal of wastes and garbage in the VDC area Implement the same	2. Open, operate and manage (or cause to be operated and managed) in the municipal area: – Health post – Sub health post	2. Plan and implement: – Family Planning – Mother and Child Welfare – Extended vaccination – Nutrition and population education – Public health – Other similar programs
3. Provide assistance in the development and expansion of herbs.	2. Plan and implement (get implement (get implemented): – Family planning – Mother and child welfare – Extended vaccination – Nutrition – Population education – Public health	3. Give permission(in the jurisdiction) to open and inspect and monitor: – Sub Health Post
4. Launch programs related with family planning and maternity and child care.	3. Arrange or get arranged prevention of: – Epidemics – Infectious diseases	4. Make arrangements for the necessary supply and inspection monitor the quality of: – Necessary drugs and – tools and apparatus
	4. Ban public use of things in municipal area harmful to public health.	5. Ban or remove from public use the substance detrimental to the public

		health
	5. Ban the sale and purchase and use of consumer goods harmful to public health at large.	6. Ban the sale and purchase and use of consumer goods harmful to public health at large.

Health Sector Strategy: An Agenda for Reform (October 2004)
The health sector strategy is the outcome of extensive work carried out by the GoN and its NGO partners, private sectors and EDPs. The key issues addressed in the strategy were:

- How will government leverage better value for the out of pocket health expenditure?
- How will government ensure access of Essential Health Care Services (EHCS) by the poor and vulnerable population?
- How will government run public health service in most effective manner?

The strategy clearly states that the government will give priority to intervention that will help to achieve the Millenium Development Goals (MDG). The strategies have set forth three program output and five sector management output.

Of three program outputs, the output 2 is decentralization, which states. 'Local bodies will be responsible and capable of managing health facilities in a participatory, accountable and transparent ways with effective support from the MoHP and its sector partners.'

Likewise of five-sector management outputs, the output 1 is about coordinated and consistent sector management (planning, programming, budgeting, financing and performance management in place within the MoHP to support the decentralized service delivery with the involvement of NGOs and private sectors.

The sector management output 2 is regarding sustainable development of health financing and resource allocation across the whole sector including alternating health-financing schemes in place.

Dialogue on the relationship and co-ordination with all stakeholders will be essential for effective decentralization. Resources need to be increased. The role of the center will change particularly in planning, staffing, resource mobilization and allocation and performance management. These will affect at all levels – central, regional and district. The district and the community will have new role in implementing health service delivery as per the needs of the communities. The community themselves will plan, implement and monitor health services at their levels. The center will monitor quality for both public and private sector.

Nepal Health Sector Programme – Implementation Plan, 2004-9 (October 2004)
Nepal Health Sector Program – Implementation Plan (NHSP-IP) has been developed in order to meet the health sector strategy and agenda for reform. Decentralization will involve developing new roles, responsibilities and skills for MoHP and local bodies.

NHSP-IP is the operational guideline for implementing the output of the health sector reform strategies. Some of the outputs directly related to decentralization and their indicators are as follows:

Indicators of Output 2: Decentralized health modalities will be implemented in all districts in phased manner by 2006/7. Districts that are capable, responsible and accountable will be identified. These identified districts will have their own health sector units by 2006/7. At least five districts will have their own five years plan including health by July 2005 and 45 districts will have district plans by the end of Tenth Plan. At least 1800 health facilities will be managed by Local Health Management Committee (LHMC) by 2006/7. At least five hospitals will be functioning as autonomous unit by 2006/7 and 10 by 2009.

Indicators of Output 4: Partnership policy and document will be in place. A number of joint annual reviews will be held involving all government stakeholders, NGOs and EDPs. The definition of capacity and the approach to the capacity building will be clearly spelled out. By the year 2006/7 at the district level, the decentralized planning program and budgeting will be established.

Indicators of Output 5: At least five percent of health expenditure is borne by local communities in public health facilities by 2006/7.
At least ten percent of health expenditure is borne by local bodies (DDC, VDC, Municipalities) in public health facilities by 2006/7

Review of Study/ Assessment Reports
Following assessment study reports have been reviewed and their findings extracted:
- Assessment of Management Training Needs Supply, Kathmandu University, School of Management (2001)
- SHP Decentralization Process Review, National Health Training Centre (October 2003)

1. Developing Health Sector Decentralization in Nepal: Collaborative Policy Development, British Council (2003)

- Study on Health Sector Decentralization, National Health Training Centre (October 2004)
- Outcome Assessment of SHP Hand-over, National Health Training Centre (January 2005)
- Health Service Decentralization in Nepal Development Resource Mobilization Network DFID Nepal (May 2006)

Assessment of Management Training Needs Supply, Kathmandu University, School of Management (2001)

District health Strengthening Project (DHSP) of the department for international development (DFID), the Health Sector Support Programme (HSSP) of the German Technical Cooperation (GTZ) and the strengthening human resource capacity of the health sector project of the United Nation's Population Fund (UNFPA) are all supporting for the health sector improvement. In April 2000 DHSP on behalf of above organization contracted the Kathmandu School of Management (KUSOM) to undertake an assessment of management training needs, supply and capacity development plan.

The findings of the assessment study suggest that the quality of health service delivery by district health institutions is not satisfactory. Their institutional performance is constrained by six major unfavorable conditions that operate on their management system. They include: lack of community relatedness, participation and accountability; domination of public institution framework and a lack of management culture: insufficient resource availability; poor management policies, systems and practices; inadequate management and professional capability and lack of performance values, commitment motivation and initiatives.

The analysis of the result showed that there is a considerable gap in terms of coverage, quantity and quality of the available management training to meet the needs. Various strategies for performance improvement of the district health institution have been recommended.

SHP Decentralization Process Review, National Health Training Centre (October 2003)
The SHP hand-over is a step towards positive environment to involve local people. However, it was observed that people's participation were not as expected due to absence of locally elected body.

The SHPMC members were not duly aware of their roles and responsibilities. District authority felt the process of decentralization as a threat to their authority and use of resources. The monitoring system of implementation is weak. MoHP and MoLD were not adequately prepared especially at the local level. MoHP is moving without adequate preparation in the ground. All the stakeholders were not aware of their roles and responsibilities. There is no clarity in function – leadership role, service integration, services to be devolved etc. There is only a partial ownership due to lack of complete devolution.

Hand-over should not merely be the 'transfer of SHP', it has to be knowledge and experience sharing and functions-based devolution. There has to be knowledge and experience sharing in decentralization process among stakeholders. Based on such experiences decentralization has to be planned in a phased manner. The local body should focus on functions; money, personnel and accountability while the center should focus on capacity development, monitoring and standard setting. In the absence of elected local body there is no serious drive. In the changed context with former people's representatives being reinstated, MoHP and MoLD needs to adopt close monitoring adopting 'watch and go' policy in handing over of the health facilities in future.

Developing Health Sector Decentralization in Nepal: Collaborative Policy Development British Council (2003)

In 2001, the Department for International Development UK through its District Health Strengthening Program, the Nuffield Institute for Health undertook research into health sector decentralization in Nepal. This is a collaborative work made up of external and internal teams of professionals from Ministry of Local Development; Ministry of Health and External Development Partners. The principal output of the research was to put an agenda for developing health sector decentralization in Nepal. The research identified the key points and issues of a program for effective health sector decentralization. The research concluded that the program component should include: process of change, organizational structure, resource generation and allocation, planning, resource management, accountability, participation of local self-help groups, capacity development for decentralization, public-private relations and inter-sectoral linking.

The study concluded that decentralization in Nepal is a cross-sector process that is changing the overall structure of the public sector. For decentralization to be effective, the necessary conditions for its effectiveness need to be developed. The programme is just a set of guidelines designed to provide a comprehensive process of change. Decentralization is process taking place in an unstable process with unpredictable outcomes. Many problems can only be understood only in the process of implementation. Thus flexibility and understanding are required in the process of changes.

Study on Health Sector Decentralization, National Health Training Centre (October 2004)

An independent consultant for NHTC has carried out this study. The objectives were to analyze the decentralization status in the health sector and to suggest a suitable model of decentralization.

In the absence of many prerequisites of decentralization, the country is not in a position to devolve all the local health institution (LHI) to the local bodies (LB). The phase-in modality would be most appropriate along with the capacity development of the local bodies.

The report has also identified the following problems and constraints faced by the Ministry of Health. The constraints were lack of capacity of the LBs to manage health sector; lack of technical know-how, lack of experience in health and its related functions; lack of clear responsibilities and accountabilities; poor resource management, delayed budget flow mechanism and unclear and non-transparent procurement system.

Institutional problems are absence of locally elected representatives, contradictory laws and policies and lack of accountability of staff to local bodies. The human resource management problems were related to control of staff by the central and regional institutions, absenteeism of the health workers and LB officials and low morale of staff.

Unmatched budgets, programs and plans, lack of regular and reliable mechanism of local fund generation, traditionally allocated budget not based on local requirements are the major bottlenecks in fund flow.

Finally, the study concluded that their needs develop clarity among MoHP officials about its plan. The 5 districts where hand-over has already taken place and prerequisites fulfilled should be fully devolved. Twenty districts should follow integrated deconcentration model and the remaining 50 districts should follow the form of functional deconcentration model.

Outcome Assessment of SHP Hand-over, National Health Training Centre (January 2005)
MoHP began SHP hand-over to local bodies from the year 2002/3. After two years of hand-over, NHTC, the executing agency of the Ministry for hand-over of the health institution and conduction of orientation program contracted the independent consultant through WHO to undertake an assessment of outcome after the hand-over of SHPs.

The findings of the study revealed that the SHP hand-over was started without adequate preparation. MoHP had positive expectations that the pre-requisites would be fulfilled gradually. In reality, it did not work that way. In the absence of local elected body, the decision of MoLD to entrust VDC Secretaries has reversed the zeal and enthusiasm of HFOMC members to assume leadership role and ownership of the health facilities. The VDC Secretaries who were given temporary role of VDC Chairs are resigning in mass and those who have not resigned have difficulty to stay in their work place. This is a major set back for decentralization.

Orientation on roles and responsibilities of SHP Management and Operation is not provided to all committee members. A thorough orientation and internalization of the roles and responsibilities by the members is the *key* to success of SHP hand-over.

Based on need assessment, specific training on various areas of management is to be provided for enhancing capacity of the MC members and the health staff. The district level stakeholders have asked for management capacity building of local bodies including of DDC. MoHP needs to hand-over entire health facilities including hospital to district, which have capacity and willingness to go through this process. The hand-over of SHP has given MoHP a number of useful lessons that will be helpful to expand decentralization in future.

Health Service Decentralization in Nepal, Development Resource Mobilization Network DFID Nepal (May 2006)
This study was commissioned through DFID to investigate the implementation status of decentralization in the health sector. The objective of the study was to review, analyze and identify gaps and differentiate between LSGA 'envisioned intentions' and 'current practices'. This study has reviewed the current status of decentralization in general and health sector in particular. Specifically it examines the status of handing over of sub-health posts. The findings of the study have been classified into two sections - general

and health sector related. The study revealed that at the local level, hand-over of SHP and re-routing the fund through DDC has some effect on the service delivery and operation of health services at the village level. The other important observations were lack of bottom-up planning process and center deciding the resource allocation. The health staff in general lacks skill to perform certain responsibility particularly administrative and financial records keeping. The conceptual and operational confusion regarding the devolution and decentralization is another constraint.

b. Overview of HF Hand-over Process

Government of Nepal has decided to devolve all sectoral ministries. MoHP has come up with a plan of decentralizing health sector by handing over health facilities (sub health post) as first step. The National Health Training Centre (NHTC) of the Department of Health Services has been given the responsibility for organizing orientation to the members of the Health Facilities Operation and Management Committee (HFOMC). The orientation programs were to be conducted before handing over of the health facilities.

MoHP has adopted a phase-in modality for hand-over of LHFs and capacity building of the members of HFOMC through orientation. In this connection, all the major stakeholders involved in health including USAID and NHFP shared resources with partnership approach in this process. A series of meetings and workshop were organized with related stakeholders, necessary preparations of hand-over completed and orientation package developed and capacity building program organized.

NHTC has so far completed the following activities in relation to HF hand-over:

- Prepared policy guidelines for HF hand-over to the local bodies
- A two days package for orienting on the roles, functions and responsibilities of staff and HF management committee members has been developed.
- The package has been revised following the process review of handover conducted in 2003-4. A new revised Guideline for Hand-over and Operation and Management of Local Health Institutions was developed and published in 2004 by NHTC. Prior to hand-over of health facilities, orientation programs were conducted using this guideline.
- NHTC in partnership with EDPs and USAID/NFHP has developed a two-day interaction program "Our Health, Our Responsibility" - A Program for Partnership Development between Community and Health Facility. This package, endorsed by the Government will be used in all re-orientation programs for HFOMC members as continuing efforts of capacity development. Further training modules were also developed for skill development of HFOMC members.
- An operational committee is functioning with active participation from External Development Partners.

In the budget speech for the fiscal year 2001/2, all districts and regions were instructed to prepare the district for the hand-over. Hand-over guidelines were prepared and approved by the Cabinet. Based on these guidelines, a two days package to orient the sub health post management committee was developed and implemented.

The hand over process started immediately after orientation program for HFOMC members. In the fiscal year 2002/3, 468 sub health posts were handed over in 12 districts. Following this, 14 more districts were targeted with a total number of handed over HF reaching 1175. To date, there are 1433 health institutions, which have been handed over to the community.

It is anticipated that once the health facility management committees resume full ownership of the local level management, the committees will plan and manage the health institutions well. The performance of decentralized health facilities will be better in comparison to centrally managed health facilities. Under decentralization, DDC is the main responsible body to facilitate financial and administrative backstopping to handed over health facilities through respective VDC and Municipality. The technical backstopping to decentralized health facilities were provided through District (Public) Health Offices.

The decentralization in health service management has given greater roles and opportunities for the local health institution to come forward in planning and managing health services of their locality. This has resulted in increased roles and responsibilities of the health workers particularly the in-charge of the health institution who is the chief executive of the institution. S/he has the responsibility to manage the health facility. Being the member-secretary of the Management Committee, s/he will be responsible for putting forward the issues in the committee for obtaining direction and later executing them. The Guideline for Hand-over and Operation and Management of Local Health Institutions have emphasized the in-charge's role particularly on the following aspects:

- program planning, monitoring and evaluation
- work plan
- referral
- health education and awareness raising
- supervision of technical staff
- preventive management
- financial management
- maintenance of citizen's charter for the protection of client's rights

Clarity about the roles of the health facility and the staff is a basic and fundamental element for managing the health facilities in the changed context. The coordination between people and the MC deserves topmost priority beside other things.

c. Review of NFHP Strategy and Activities

Nepal Family Health Program (NFHP) is an integrated program involving partnership from the national, district and community level. The program anticipates that there will be more active coordinated and inter-linked supportive role of the community to the health facilities at the local level for keeping the services sustainable. The district and community level results indicated those service providers and managers are providing higher quality services with increased demand and utilization of FP/MCH services.

Over the years (2001-6), NFHP supported MoHP under three components namely,

Component 1 - Support to community based activities
Component 2 - Support to district facilities
Component 3 - Support to national program.

Under Component 1, the support is mainly for community level activities. This component comprises of following strategies:

1. Improve the quality and quantity of FP/MCH services provided by health facilities and community health workers through regular on-the-job training, supervision and monitoring.
2. Strengthen management and coordination of community-based services by ensuring regular meetings of local health facility management committee
3. Ensure sustainability of FP/MCH services improvements by increasing financial and in kind support provided to FCHVs by local management committees.
4. Strengthen the capacity of community level providers (VHWs, MCHWs, FCHVs) to deliver FP/MCH services.
5. Promote key FP/MCH behavior change through community-based communication, heath education and training
6. Pilot test innovative strategies to improve quality of selected FP/MCH services.

There are wide ranges of factors that affect quality of services and appropriate level of use of services by the population. NFHP's interventions address many of them. One set of determinants that is potentially very important is the relationship between health facility staff and members of the communities they serve. Where relations are weak, health facility staff is not held accountable by the community. They receive little support from the community and they tend to achieve lower population coverage for their key services. NFHP addresses these issues primarily through working with HFOMC and supporting its activities.

In line with Strategy 2, the following activities were undertaken. Some of these were implemented directly by NFHP and others through its Implementing Partners CARE-Nepal and Save the Children US.

1. Technical assistance for HFs hand-over process

The NFHP has provided technical assistance to GoN in HF hand-over process in selected districts. The support included:

- Community orientation using two days' NHTC guideline
- HFOMC formation and handing over
- Logistics and administrative support

The aim of the support is to empower the community to assume ownership for operation and management of HFs resulting in improved quality of service.

Two days' orientation for HFOMC members were provided by NHTC in partnership with EDPs in which NFHP also shared resources in the pool. The objectives of the orientation

were to familiarize the HFOMC members on the concept of decentralization and explain their roles and responsibilities in the changed context in the operation and management of HFOMC at local level.

The orientation package consisted of following topics:
- Health situation of Nepal
- Goal, strategy and objectives of NHP 1991
- Concept of decentralization and delegation of authority
- Local Self Governance Act 1999
- Composition of HFOMC and its scope of work
- Relation between other organizations and HOMFCs
- Job description of HFOMC members

2. Strengthening capacity of HFOMCs

When MoHP started decentralization, only SHPs were handed over and NFHP supported NHTC in this process in seven districts. Later, MoHP decided to include HPs and PHCCs as well for handing over. Accordingly, NFHP supported D(P)HOs in this process. After this hand-over process was completed, NFHP provided three days' training on Capacity Assessment and Strengthening to HFOMC members. The objective of further training was to empower the HFOMCs for operation and management of HFs in a sustainable way. The three days' package constituted:
- planning, implementation, monitoring and quality assurance
- resource mobilization and budgeting
- decision making and delegation of authority
- organizing effective meetings and communication
- leadership and conflict management
- recording and reporting
- supporting and cooperation

The process of strengthening HFOMC involved participatory capacity assessment of HFOMCs using a set of pre-defined indicators and plotting them in the Spider Web Diagram for visual display.

The Spider Web Diagram is a self-assessment and monitoring tool, which has four pillars, namely:
- organization
- structure and management of the committee
- resource mobilization
- planning, implementation, monitoring and evaluation

The committee members use the Spider Web model in a participatory way. They discussed about various components and gave scoring to various defined set of indicators. The total scoring on four components will then be plotted in the diagram. In this way, they will identify their areas, which need to be strengthened. Following this, the HFOMC members were trained in the areas that they identify as their weaknesses. They were supported to prepare a plan of action to improve the quality of services. In the subsequent meetings of the HFOMCs, they will implement the plan, monitor and evaluate. They will re-assess their capacity after six months and compare the scores obtained before.

The HFOMC meeting was found to be dominated and manipulated by the HF In-charges and issues such as improving service quality/delivery, resource generation, CDP and sustainability of the services were found to be given less importance.

3. Facilitating dialogue and discussion between HF and Community through Partnership Defined Quality process

Partnership Defined Quality (PDQ) was applied in selected health institutions to improve health service delivery and increase FP/MCH service utilization by the poor and marginalized population.

Partnership Defined Quality (PDQ) is a process to arrive at common understanding between the health providers and the community with an objective of improving the health service delivery system at the local level. PDQ aims to increase involvement of community, improve quality of services and increase service utilization. The process involved following steps:

- orientation and advocacy to HF staff
- focus group discussions with community (marginalized, mothers-in-law, daughters-in-law, adolescent groups)
- focus group discussion with health staff
- "bridging the gap" workshop – analysis and prioritization of health issues
- preparation of action plan
- formation of a Quality Improvement Team (QIT). The team comprised of HFOMC members including members from marginalized group (*dalit, janajati*, women)
- working in partnership for improving quality of services
- linking issues and agenda at the local bodies
- securing resources from the district Quality Assurance Working Group and other relevant institutions including private sector

It is a tool applied for facilitating dialogue and discussion between service providers and community regarding the quality of service delivery. This process helps to harmonize the relation among service providers and community and compromise their expectations. It also helps to increase the community participation.

After identifying the issues by the different groups, 'bridging the gap' workshop will be organized which will again be participated by various groups such as mothers-in-law, daughters-in-law and male groups. Most of the problems identified were related to service availability and equity, short supply of drugs, supplies and equipment and management related problems. With these interventions, frequent monitoring and follow up, there has been increase in the service utilization.

4. Regenerated Frerian Literacy through Empowering Community Techniques (REFLECT)

The REFLECT is a new right-based development approach that has two major components i.e. literacy (NFE) and community empowerment. In this process,

community realities (especially health service coverage and utilization pattern) are identified and reflected through maps, diagrams and calendars. This approach has been applied in the districts in order to make the community particularly women and marginalized population aware of their basic health rights. Female Community Health Volunteers were mobilized as REFLECT facilitators. It has helped to sensitize, aware, encourage and empower the community to address their problems in general and health issues in particular. This process has been applied in selected sites.

REFLECT is a useful tool for community empowerment and is not an expensive exercise. Therefore, it has more scope of continuity by the government with commitments. However, high dropout rate in the class (circle) has been a constant problem due to the interest of participants in other urgent issues such as drinking water, community forestry, and road, and so forth than health. Therefore, there is a need to coordinate with other line agencies such as education, agriculture, livestock and women development offices.

Activities directly through NFHP

NFHP worked with local community to support for better operation of health facilities. MoHP adopted a decentralization policy and accordingly the management of local health facility has been gradually handed over to HFOMCs. NFHP supported for both the hand-over process and further strengthening of the capacity of HFOMC members. This has been accomplished by conducting three days orientation training to HFOMC members in addition to two days orientation package delivered by NHTC in partnership with other EDPs including NFHP.

In this effort, NFHP provided support to D(P)HOs in Rautahat and Rasuwa during HF hand-over process and capacity strengthening of HFOMCs.

SN	Activities	Coverage	Districts
1.	Support in HF Hand-over	115 HFs	Rautahat and Rasuwa
2.	Capacity assessment and strengthening of HFOMCs	115 HFs	Rautahat and Rasuwa

Until 2005/6, NFHP has supported hand-over of 97 HFs (4 PHCs, 8 HPs and 85 SHPs) in Rautahat and 18 HFs (1 PHC, 8 HPs and 9 SHPs) in Rasuwa. A total of 1016 members (871 in Rautahat and 145 in Rasuwa) were trained.

Activities through CARE/Nepal for NFHP

With the support of NFHP, CARE-Nepal implemented activities in seven districts in the provision of basic package of Family Planning/Maternal and Child Health services at community and household level. The activities were carried out in two phases:

In Phase I (July 2002-December 2004 and follow on), program was focussed in Kanchanpur, Mahottari and Dhanusha districts and in Phase II (December 2004-September 2006) the focus was on Nawalparasi, Chitwan, Parsa and Bajura districts.

The goal of CARE-NHFP was to contribute in NHFP's overall goal of reducing fertility and under-five mortality by assisting D(P)HO in implementing activities to strengthen delivery and use of high impact FP/MCH services delivered at household and community level.

CARE-NHFP implemented activities where both the service providers and communities were equally focused and inter-linked to achieve better health of the beneficiaries. The program model applied an interface of community and health facility. It seeks to find a common point where the service utilizers and service providers meet to improve the health status of the population. The objective of the interface was to facilitate the interaction between the service providers and the communities by empowering the community members through recognizing their rights to improve accountability of service providers, to improve social inclusion and to access and utilize quality FP/MCH services.

The project has made considerable achievements over the implementation period (2002-6). The major activities accomplished were:

SN	Activities	Coverage	Remarks
1.	Support in HF Hand-over	172 HFs	Kancahnpur, Dhanusha, Nawalparasi
2.	Capacity assessment and strengthening of HFOMCs	266 HFs	Dhanusha, Mahottari, Kanchanpur, Parsa, Chitwan, Nawlaprasi, Bajura
3.	Partnership Defined Quality	59 HFs	Dhanusha, Mahottari, Kanchanpur, Parsa, Chitwan, Nawlaprasi, Bajura
4.	REFLECT Circles	36 sites (17 VDCs)	Parsa, Chitwan, Nawalprasi, Bajura

Activities through Save the Children, US for NFHP

With the support of NFHP, Save the Children US (SC/US) implemented activities in seven districts namely Jhapa, Sunsari, Morang, Siraha, Banke, Bardiya and Kailiali districts. The activities centered on Partners Defined Quality (PDQ). The PDQ is an approach that takes into account the clients as well as the provider's perspectives on the quality of services and their standards. It provides an opportunity for the people (community) and the service providers (health workers at the facility) together to define and discuss their perceptions on quality of care in health facility.

The overall objectives of the project were to increase the use of selected FP/MCH services at community levels. The three intermediate result indicators were:

Result I Improved availability and accessibility of selected FP/MCH services.
Result II Improved quality of selected FP/MCH services.
Result III Increased role of Health Facility Management Committee (HFMC) in supporting health care services at community level.

SN	Activities	Coverage	Districts

1.	Support in HF Hand-over	215 HFs	Jhapa, Morang, Siraha
2.	Capacity assessment and strengthening of HFOMCs	390 HFs	Jhapa, Morang, Sunsari, Siraha, Banke, Bardia, Kailali
3.	Partnership Defined Quality	400 HFs	Jhapa, Morang, Sunsari, Siraha, Banke, Bardia, Kailali

The overall impact of the project indicated that the service utilization has started to increase with exception to few districts. The reasons for such increase are due to awareness, strengthening of services, increased participation of community including marginalized and disadvantaged group and mobilization of local resources.

d. Community and Health Facility as Partners (CHFP)

During the last five years, NFHP worked intensively to increase community support for health services and community participation in public health facility. Hand-over of health facilities, strengthening of HFOMC after hand-over, self-assessment and training, PDQ, REFLECT are the set of activities, which were implemented to mobilize and empower the community for improving their health. The sense of ownership towards their health facility for effectively managing and improving quality services at local level were realized by the community (HFOMC, HWs and people). However, there are still some gaps such as:

- Inadequate mobilization of local resources.
- Less utilization of health services especially by *dalits* and *marginalized* community people.
- Lack of ownership of program by health facility staff and community people.
- Lack of trust between service providers and community people
- Service providers less focused on needs of community.

In order to address these problems and gaps, the Community and Health Facility as Partners (CHFP) program was developed with a new approach. This program has been built on NFHP's 5 years' of experience and recommendations made in various assessment reports, meetings with stakeholders and lessons learnt from the field as to what worked and what didn't. The emphasis of CHFP approach will be to provide continued support for follow up on work done by NFHP to support community for accessing health services and to increase community participation in governance of public health facilities.

The CHFP effort also aims to establish a linkage/bond between health facilities and community for delivering quality health services at community level in a sustainable manner. As NFHP's strategies vary at national, district and community level, CHFP is geared up at community level. The strategic approach of CHFP is to strengthen management of community level services by ensuring that local management committee meetings are held regularly and address relevant management issues particularly related to delivery of quality FP/MCH services.

The overall objective of the CHFP program was to improve health status of community people especially of marginalized and un-reached population by empowering and making them actively participate in managing their health facilities.

The specific objectives were:

- Increased utilization of health facilities
- Strengthened capacity of HFOMC and QIT members
- Developed system for improving quality health services
- Increased mobilization of local resources

In order to achieve above objectives, the following strategies were adopted:

- Informing HFOMC to recognize their rights and responsibilities
- Enabling HFOMC to be fully involved in operation and management of their local health facilities and to take a lead role
- Mobilizing local resources to manage health facilities and health programs
- Ensuring inclusion in health services by marginalized and un-reached population
- Strengthening capacity of HFOMC
- Developing a system for improving quality health services
- Supporting intensive technical visits at HFs and community level

NFHP in partnership with local bodies and D(P)HO, implemented CHFP in selected VDCs (health facilities) in 8 Core Program Districts (CPD). These districts were Siraha, Mahottari, Rautahat, Bara, Parsa, Banke, Bardiya and Kailali. The criteria of selecting these districts and VDCs were based on their performance status. The following activities were carried out in health facilities and VDCs:

Startup activities

Consensus building meeting. One day meeting with central level stakeholders. The objective of the meeting was for consensus building.

District and VDC selection. The districts were selected according to their performance status revealed from HMIS. The low performing districts were given high priority for inclusion in CHFP. The same criteria were used to select VDCs. From each district, 12-20 VDCs were selected for special interventions. The selection of VDCs were done in close coordination with D(P)HOs.

Preparation of guidelines and monitoring tools. Guidelines for conducting two days interaction program has been developed and approved by the Government of Nepal. This guideline is titled as "Our Health, Our Responsibility" (Developing a Partnership Program for Community and Health Facility). The two days guideline includes:

- importance of healthy life
- responsibility for managing local health institutions
- roles and responsibilities of HFOMC members
- self assessment of functions of HFOMC and measures for improvement
- conducting effective meetings

- information about available services at HFs and other health programs
- support from VDCs to HFs
- social inclusion in health
- work plan

In addition to the guidelines for conducting interaction program, the CHFP has also prepared nine flexible modular courses of 4-6 hours duration. As needed, the course could be given to the members of HFOMC and other interested persons. The developed courses were on:

- identification of health needs
- good governance
- participatory planning
- resource mobilization at local level
- financial management
- monitoring and evaluation
- management of health institutions (meetings/logistics)
- leadership development
- social inclusion

Formation of Technical Advisory Group. A national level TAG was formed to provide technical support in implementing CHFP activities.

Preparation of District Profile. Some information from this profile could be used as baseline estimates for CHFP.

District level Orientation. One day orientation program was organized for D(P)HO staff to share the goal, objective and strategies of the program. The objective of this meeting was to reach consensus on program modality and VDC selection.

Orientation to HF In-charge. One-day orientation and planning meetings were conducted at district or Ilka level for HF In-charges.

Program activities

To increase the utilization of health services, the following activities were undertaken:

Three days reflection/interaction meeting at VDC/HF level

- participatory assessment of HFOMC
- dis-aggregated analysis of service utilization data
- promoting citizen charter and information display board
- FGDs to find out reasons for low service utilization
- sharing of FGD findings and leanings with D(P)HO and other stakeholders
- preparation of action plan

Monthly meetings. NHFP staff provide technical assistance in organizing monthly meetings of HFOMCs. The action plan prepared by HFOMC was followed up in

successive monthly meetings. FCHVs and other community groups were also involved in these meetings which produced synergy.

In special intervention VDCs, health service utilization data of *dalit* and other groups were presented. HFOMC was encouraged to prepare citizen charter and other information board for display at health facilities. The health issues of dalit and marginalized were discussed in HFOMC meetings. Special programs were planned for marginalized and needy groups. Progress and issues were shared with D(P)HO and DDC every quarter.

HFOMC members were encouraged to prepare a list of poor and marganized people. In number of health facilities, HFOMC has prepared a list of poor and marginalized people and authorized them to get the health services, including the drugs free of cost, which in turn improved their access to the health services.

To increase the capacity of HFOMC members and QI Team members, the following activities were undertaken:

- Encourage to conduct effective meetings
- Observing monthly meetings by D(P)HO and NFHP staff
- Award and recognition of best performing HFOMCs

Regular follow-up visits were made in special intervention VDCs. At least once in two months NFHP staff together with D(P)HO staff visited the areas and performed a set of activities for participatory assessment using the tool and reviewing the service utilization data and action plan. Dalit and women were interviewed and coached at site for their meaningful participation in the HFOMC meetings.

To increase the quality of services, the following activities were undertaken:
Client exit interview was conducted for improving quality of health services. The interviews were conducted by D(P)HO and NFHP Staff and the findings shared in HFOMC meeting. Quality issues were identified jointly by community, HFOMC, and health workers. These issues were regularly discussed in HFOMC meetings and also with quality improvement team both at the HF and with district level quality assurance working group.

To increase mobilization and allocation of local resources, the following activities were undertaken:

Advocacy meeting at district level was organized involving DDC, VDC and D(P)HOs. The purpose of this meeting was to share the situation and to get commitment for sharing resources. It also helped in monitoring and supervising the use of allocated resources effectively. Reflection meeting were organized with formal and informal groups existing in community.

The salient features of this approach were:

- Conduction of regular monthly meetings and follow-up of the action plan
- Decentralized operational model with flexibility to incorporate and address the need of each HFOMC
- Community mobilization activities/initiatives for promoting social inclusion and good governance
- Intensive follow up and monitoring
- Introduction of Self-Assessment Scoring System with simple indicators
- Linkage with DDC/VDC and HFOMC to bridge resource gap at local level
- A common package and modules developed to strengthen capacities of HF and HFOMC.
- *Dalit* and women members were frequently followed up, interviewed and coached to empower them and build their capacity
- Establishing a system to create a database to follow on and tracking the activities held at districts and below so as to monitor progress and provide feedback

Achievements of CHFP program

At the facility level, it was very difficult to organize HFOMC meetings on regular basis. The qualities of the meetings were poor. With NFHP's intervention, the meeting has been regularized. The meeting place and time were notified well in advance with written agenda. The consultant had witnessed some of those meetings held in Banke and Bardiya districts. The meetings were well organized, members were encouraged to speak up, particularly the *dalit* and female members were given time to put up their agenda and views. The efforts made to reach the un-reached and marginalized population through the women and *dalit* members were appreciable.

Regular coaching to *dalits* and women members were necessary for them to understand their roles and responsibilities. However, this effort was not adequate. The frequency of such capacity building measure need to be increased

Self-assessment of HFOMC was helpful to analyze the existing situation. It builds their capacity to appraise their strengths and weaknesses that promotes sustainability in operation and management of local health facilities.

In the past, GoN had made several attempts to develop exemption criteria for providing free services or drugs at government health facilities. These attempts had limited successes. There had been numerous problems. In health facilities where there had been NFHP's intervention to introduce CHFP approach, this exercise of defining exemption criteria has been relatively successful. It was found that the HFOMCs were engaged in making the list of households who should be provided free services. This exercise of developing criteria of exemption in the local context was commendable. They had their own definition of 'safety-net' for those who are unable to pay for services - the poor and the underprivileged. Only recently, the National Planning Commission has operationalized the definition of "poor" but in these health facilities the HFOMCs has already prepared the list of poor and marginalized population who should be provided free services or drugs. The have accomplished this task by collecting information by the

HFOMC members. They have defined the criteria for being poor at local level and discussed these in the HFOMC meetings. They adhered to these criteria while making the list of households for exemption of paying fee for services or for drugs. They also have a plan to update the list periodically. This exercise has bearing on national context, where it was felt so difficult to define "poor" and many controversies still exist. .

Ownership of the facility is fundamental for improving the quality of services. Further efforts are needed to strengthen the growing sense of ownership in the community. To print HFOMC letter heads, to put sign boards of HFOMC, to have HFOMC member's signature in the financial activities, involvement of HFOMC in the planning process of HFs and presentation of progress report and financial audit were some of the proactive examples shown by members of HFOMC in CHFP areas. Some VDCs have come forward to add value to their sense of belongingness. Some of the HFOMC remarked that ownership feeling would emerge only after having the authority to handle the budget and personnel. During the field visit, the evaluation team observed that one of the HF has printed HFOMC letterhead. They are also in the process of making rubber stamp of the committee. This is a proactive step towards ownership and leadership, which should be institutionalized systematically in other areas. Some MC has come up very aggressively. They would like to exercise their powers as mandated by LSGA.

6.0 Findings and Discussions

a. On Decentralization

Decentralization and hand-over is a process, which is taking place in an unstable situation with unpredictable outcome. All those who had been studying the decentralization process agreed that the capacity building should be in-built in the process with clear guidelines and there should be adequate preparation. Adequate preparation in the ground is the key to success.

MoHP needs to have clarity on entire aspects of decentralization strategy. Although the LSGA has given clear direction towards "devolution" as ultimate goal at the same time sectoral ministries have freedom to decide how and at what time-frame they would like to achieve this goal.

A strategic plan of decentralization is lacking in MoHP and MoLD resulting confusion on the expected time-frame for decentralization in health system. Different approaches have been piloted, but documentation on the merits and demerits of those approaches are lacking. MoHP do not have a concrete plan after hand-over of health facilities. It is very important for MoHP to have clarity about the type of decentralization to be pursued at this point of time. Various options of phasing, time frame, capacity building measures, resource allocation and human resource management are to be considered. Based on these factors a clear documented plan of action, post devolution package needs to be developed and implemented so that there would be a common approach which will help to rectify confusion.

The analysis of findings revealed that the local bodies are not able to take up decentralized roles as expected. DDCs, VDCs and Municipalities were found unable to provide necessary support to HFs after they are handed over to local bodies. There is lack of adequate and competent human resource in the local body. There is lack of clarity in their roles to support regular monitoring.

Decentralization should be carried out as process rather than an event-based. The process demands multi-sectoral cooperation, coordination and support in every step. Inter-sector and cross learning among various ministries e.g. agriculture, education, and MoLD, will produce synergy for good results. Mutual support is *key* for developing ownership and making them accountable for the outcome of the process.

b. On Health Facility Hand-over

Orientation should be a continuous process. Re-orientation should be provided regularly through district offices. The existing orientation package developed by NHTC was designed just to orient on the roles and responsibilities of the committee members. This is not adequate. There is a need of introducing a capacity development package (appropriate mix of technical and managerial skills) to increase competency of the management committee members. Equally important is the capacity development of the local bodies who are the real managers of the local health institution after hand-over. They should be given orientation and relevant training for effective management of their health facilities.

Health facility hand-over processes were carried out in relatively rush manner, without adequate preparation at district and community level. Community (including HFOMC members and HF staff) were not fully informed and not prepared to take up the decentralized functions, as envisioned by the program. Lack of clarity on decentralized functions, roles and responsibilities of various actors (e.g. VDC, DDC and DPHO) resulted in some confusion. In some instances, the VDC people were called at the district headquarters for hand-over. The hand-over was done without verifying the cash and kind stock existed at the health facilities. In some places, the orientation and hand-over went side-by-side. A thorough orientation about the roles, responsibilities and skill transfer for effective management of health facilities should precede the hand-over of health facilities for better results.

After hand-over of HFs, there was positive change of attitude among the community people towards the health facility. However, there was confusion regarding the role of HF itself and its linkage with local bodies (DDC, VDC, Municipality) and line agencies (DHO, DPHO, MoLD, MoHP) after hand-over. There was an increased sense of ownership and feeling among the HFOMC members to know about the decentralized functions, types of services delivered and their quality.

The expectations of the community including HFOMC members have risen after hand-over particularly in areas like budget for HFs, provision of medical commodities, staff accountability and responsiveness, and community's demand.

c. On Community Health Facility Interface

The Partnership Defined Quality (PDQ) process was introduced in improving the quality of services and empowering communities to claim their rights to health care. This approach has created environment for dialogue and conversation between health workers (service providers) and community people (service utilizers). In contrast to CARE, SC had implemented this in all health facilities. The process was rather found complicated and the health workers and community had little understanding about the components and meaning of the entire PDQ process. Some termed this process as a research methodology and apprehended that it might be difficult for HFOMC members to understand the process fully. The process was even objected by some health workers in initial phase. Conduction of FGDs is time consuming and finding the right group of *marginalized* and *dalit* population was extremely difficult.

As PDQ aims to facilitate interactive discussion between providers and consumers to improve the quality of service, so it was not necessary in areas where the provider-consumer dialogue is already good. PDQ will be more effective if applied in HFs where there is need of such intervention rather than applying in blanket approach.

Another innovative approach used was REFLECT circles. This approach was found to be useful for raising awareness and sensitizing the communities to understand their own health needs and claim their rights to quality health services. These exercises have encouraged them to discuss social issues, analyze local context and take actions to ensure their rights to health. Engagement of FCHVs on facilitating discussions was found to be helpful especially in linking health with social issues. Talking only about health may not be that interesting to the clients and therefore providing space for them to discuss issues of their interest was necessary. The REFLECT approach has captured this element. However, regular support of D(P)HO is necessary to encourage the community to make their demand. In addition, long-term project support would be necessary for social transformation and addressing the right based issues.

d. Community Health Facility as Partners

The activities implemented by NFHP and its partners during 2002-2006 were diverse in content, approach and expected results. Most of those activities were implemented on event basis rather than a process. There was poor inter-linkage between different program interventions. Different initiatives came with different jargons creating some confusion among health workers and communities. Some of those interventions were cost and labor intensive, so were not feasible to apply to all health facilities. Considering all these limitations, NFHP in collaboration with MoHP piloted a more community friendly, feasible and effective program known as "Community and Health Facility as Partners (CHFP)" from October 2006 in selected districts. The objectives of the program were to improve the quality of service and increase access to services particularly of those whose health needs is not often met.

The health facilities are focusing mostly on the delivery of curative services. But equally important are the preventive and promotive services, which are often less emphasized. The analysis of the review revealed that most of the HFOMC meetings were focused on the issues of drug purchase, infrastructure development and human resource issues. Awareness of the community to realize the about the importance of preventive and

promotive health including quality of services at the health facilities were rarely discussed.

Regarding the current structure of HFOMC, the representation of female and marginalized members is relatively fair. (Out of 9 members 4 are mandatory from women – a FCHV, a women ward member, at least one woman from the *Dalit and Janajati* category, and a women representing social worker). However, the members from marginalized groups (*Dalit, Janajati* and women) were not fully aware of their roles and responsibilities as compared to other members. Their participation was found just token. Agenda of their interest were rarely discussed; their voice almost unheard. In some cases, they were just asked to put their signatures on the meeting minutes.

In most of the meetings, it was found that HF In-charge were dominating and discussions focused on mainly administrative and infrastructure development issues. The discussions on service quality, coverage, utilization and inclusion of marginalized groups in the service delivery remained in shadow. The meetings are usually dominated by few personalities who are more vocal.

The HFOMC composition is to be broadened by inviting other influential members of the committee from time to time. These invited members (ex political party members, teachers or social workers) will play catalytic role in their respective areas in bridging the gap among the community members and health facility. They will also be able provide constructive advice for regularizing the meeting or making meetings more effective.

The analysis of the review also revealed that conducting meeting on a regular basis was also difficult. The investigator witnessed the NFHP field staff working as a catalyst for holding meetings effectively. It is necessary for some time to provide support until this is institutionalized.

The self-assessment tool is a good monitoring tool, however its implementation in every meeting is not that important. The committee members have realized this and they were not using it in every meeting.

A performance appraisal system of the HFOMC was a positive step to give recognition to the good performers. This system is to be institutionalized through DDC and DPH.

In the absence of local elected bodies at present and gloomy situation to have a committee of people's representatives in the near future, the efforts in the coming year should be in consolidating the experiences and strengthening the capacities of HFOMCs which had already been handed over.

7.0 Recommendations

On Decentralization
High level political commitment and integrated plan of MoHP and MoLD is necessary to accelerate the process of decentralized health service management. The high-level

interagency coordination system should be strengthened. The body should be responsible to monitor the process and to ensure consistency in the process and outcomes.

Both MoHP and the MoLD should mobilize their mechanism and system to facilitate the process of decentralization. The process and outcomes should be owned by the wings of both ministries, that is D(P)HO and DDC should take responsibility and be accountable for any intended and unintended outcomes from the process.

Central government and other sub-national divisions/units should provide backstop support until the local body is fully capable of handling its responsibilities. Regular monitoring and quality assurance should be continued until local bodies are capable and empowered.

Hand-over is not only the changing the signboard or letterhead, it should be a process to make local bodies capable to take up decentralized functions (to plan, execute, monitor and evaluate activities to improve health of the people). This should be based on the empirical learning, which can be gained from the decentralization process in other areas e.g. education.

An approach and package owned by all organizations should be endorsed by the MoHP and should be followed. A defined unit in the ministry should be made responsible to monitor the decentralization functions and streamline them as per the policy of the GoN.

The process of decentralization should be revised and adopted based on the experiences, lessons learnt and best practices. The practice of "re-inventing the wheel" should be stopped and use of tested tools/modules/approaches should be promoted. A comprehensive package for handing over all levels of HFs, including district hospitals has to be developed and implemented systematically within a defined time frame. Government should seek necessary support from EDPs to facilitate the process as planned. The EDPs needs to collaborate with the government and together they should agree and follow consistent approach of decentralization in health system.

On Strengthening Capacity of HFOMC

Social inclusion is one of the dimensions of decentralization. Hence more efforts are necessary to increase meaningful participation of women, *dalit* and marginalized groups. There is a need to have programs for empowering the *dalit* and *janjati* members to make their participation meaningful.

Special emphasis should be given for promoting voice and interest of marginalized groups in HFOMC meetings to make their representation more meaningful. More frequent and intensive technical support visits would be necessary and continued.

All health workers should be oriented on the decentralized functions of health facilities, not just the in-charges. Likewise, the concerned persons at the local bodies should fully understand their roles and ensure that they were able to assume their responsibilities.

With the change in political environment, there is possibility of revival of local government and restructuring of HFOMC. With new members in, it may be needed to orient/ reorient the members.

The reorientation package 'Our Health Our Responsibility' and the set of modules have been prepared by NHTC in partnership with different organizations and EDPs. These have been tested and were found useful. Government has endorsed these documents and therefore every effort should be made to utilize these. NFHP should continue to provide technical and financial assistance in this endeavor.

In the absence of local bodies and unstable political situation, the efforts should be on consolidating the gains and scaling up in areas where the local bodies are capable and willing to take up their roles and responsibilities as given by LSGA.

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