



Nepal Family Health Program II Technical Brief # 17 (Revised June 2012) www.nfhp.org.np

Health Facility Management Strengthening Program



Participatory game for team building among members of the Health Facility Operation and Management Committee.

BACKGROUND

The vision of the Government of Nepal (GoN) for health and development focuses on self-reliance, community participation, and involvement of the private sector and non-governmental organizations (NGOs). In 1999, the government passed the Local Self-Governance Act, based on which the Ministry of Health and Population (MoHP) decided to decentralize health service management to local bodies. The intention of this initiative was to encourage local communities to take greater responsibility in managing local health facilities and health programs.

The MoHP began the formal hand-over process of health facilities in 2002/2003. In 2003, the Nepal Family Health Program (NFHP) helped the GON implement this initiative in NFHP's 17 core program districts (CPDs). By 2006, this process was completed in 28 districts and involved 1,433 HFs, with approximately half being supported by NFHP. Following this formal process, three-day capacity assessments and strengthening trainings were given by NFHP to 502 members of the new Health Facility Operation and Management Committees (HFOMCs).

In 2006, NFHP assessed its input in this process, which revealed the following: mere hand-over of HFs to the communities did not meet program objectives; there was confusion about roles and responsibilities of different stakeholders; the hand-over of HFs should be thought of as a process not as a series of events; too much emphasis placed

by HFOMCs on improving physical infrastructure and limited focus on quality issues; dalit and women members require more support than other HFOMC members.

Based on these experiences, NFHP in close cooperation with the National Health Training Centre (NHTC) and other stakeholders engaged in capacity building of local health facilities developed a modified approach called *Community and Health Facility as Partners* (CHFP) which was implemented in 8 CPDs (Siraha, Sarlahi, Mahottari, Bara, Rautahat, Banke, Kailali and Bardia) covering 100 village development committees (VDCs). After further refinement and modification of the CHFP approach, it was implemented by Nepal Family Health Program II in 4 CPDs (Banke, Kanchanpur, Surkhet and Dang) and covered 55 VDCs.

In 2009, NFHP II changed the name of the program to the *Health Facility Management Strengthening Program* (HFMSM) to more accurately reflect program goals. After two years of HFMSM implementation in 55 VDCs and the favorable results collected through Technical Support Visits (TSVs), the approach was scaled up in 2010 in 557 VDCs of 9 additional districts (Rautahat, Sarlahi, Sindhuli, Rolpa, Pyuthan, Dailekh, Jumla, Kalikot and Salyan), covering a total of 612 HFs in 13 districts.

STRATEGIC APPROACH

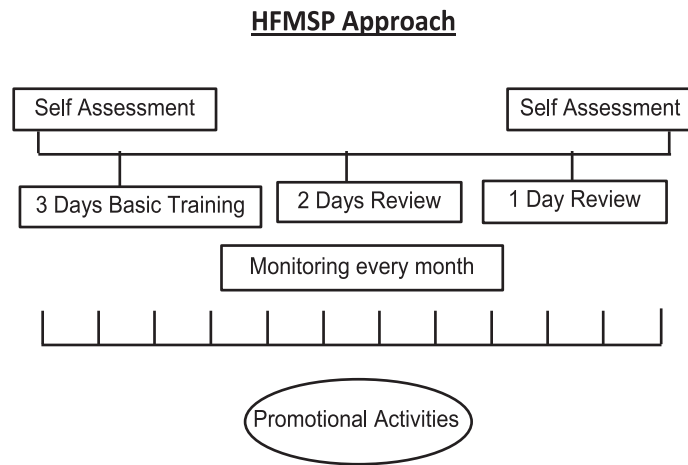
NFHP II's HFMSM approach seeks to improve the health of the community (with special focus on marginalized and underserved people) by empowering community members to manage their local HFs and other health programs. Key features of this approach include:

- Involving disadvantaged groups (e.g. dalits) in health facility management decision-making
- Delivering a complete package of interventions to develop knowledge and skills in managing health facilities, rather than one-time events like trainings
- Using simple, community friendly tools, guidelines, and training methods
- Focusing on building skills in organizational development, HF management, and health services provision using a phased-in model

- Considering ways to scale-up from the very beginning of the program
- Involving and developing leadership skills of District Development Committees (DDCs)/District Public Health Offices (DPHOs) in order to institutionalize the HFMSp approach
- Sharing results and advocating for HFOMCs at the central level (i.e., among concerned ministries and external development partners)

PROCESS

The HFMSp approach involves a two year period of support (one year intensive implementation and one year limited technical support) including a three-day interaction session, periodic review meetings, regular follow-up, and promotional activities.



Three-day Interaction Meeting with HFOMCs

After initial self assessment of HFOMC capacity, a participatory, three-day training is conducted for HFOMC members to orient them on their roles/responsibilities, the importance of community representation and ways to improve social inclusiveness in access to and use of health services. Members develop skills to conduct effective meetings and prepare action plans to respond to gaps/issues identified by the committee.

Technical Support Visits

NFHP field officers, and D(P)HO staff conduct monthly TSVs to observe, coach, and facilitate HFOMC meetings. Information regarding gaps in knowledge and skills of HFOMC members is collected, action plans are implemented, and supportive supervision and follow-up is provided.

Review Workshops

Review workshops every 4-6 months help address gaps identified during TSVs. Focus is placed on further knowledge and skills enhancement in the areas of: resource mobilization; program monitoring and supervision; good governance; VDC health-need assessment and plan; and conducting visioning activities.

Capacity of Dalit and Women HFOMC Members

Though the current composition of the HFOMC is intended to be inclusive, dalit and women members have tended not to actively participate. Therefore, strengthening the capacity of dalit and women members is given a high priority through assessment and coaching.



HFOMC members develop a social map to identify the dalits and poor in their community.

Promotional Activities

Promotional activities are carried out during the 1st year of intensive implementation, to create awareness among people about HF, HF services and HFOMCs, and to build trust between the community and HF.

Advocacy Meeting at District Level

Advocacy programs with DDC and VDC secretaries are organized periodically to update them on HFMSp progress, as well as to advocate for: resource mobilization; increased supervision, monitoring, and support to HFOMCs; and increased linkages between the VDC, DDC, D(P)HO, and HFOMC.

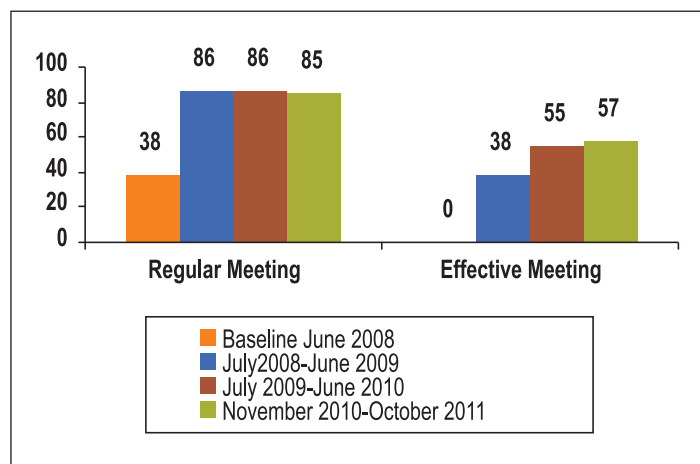
Progress monitoring

At the end of one-year intensive HFMSp implementation, self-assessment of HFOMC is undertaken again to assess the status of HFMSp-supported HFOMCs and to facilitate development of strategies for future technical support (but more limited).

RESULTS

Community participation through active engagement of HFOMCs in the management of HFs is one of the key successes under HFMSp. Data shows increases in regular and effective¹ HFOMC meetings (Figure 1), gathering of issues from the community, prioritization of issues, development of action plans based on local health needs, and sharing of decisions with the community.

Figure 1: Community participation-HFOMC meeting



The HFMSp was quite successful at mobilizing local resources for health through HFOMCs, from VDCs and local organizations (Table 1). The resources were used to hire local staff, infrastructure, conducting awareness activities, and staff motivation.

Table 1: Mobilization of local resources*

HFOMC mobilized resources	Baseline 2008	Nov 2010-March 2011	April-Sept 2011	Oct 2011-March 2012
From VDC	57%	86%	88%	86%
From other organizations	20%	50%	58%	59%

* Among percentage of sampled HFOMCs

HFOMC priorities have shifted from addressing basic infrastructure/commodity issues to more sophisticated service and program-related ones, including good governance. HFOMCs are increasingly involved in regular supervision and monitoring of HF; conducting social audits; and displaying citizen charter in HFs. As a result, the number of HFs running as per schedule and staff availability in HF has increased over the project period.

Participation in HFOMC meetings by at least one dalit member increased significantly from 30% in 2008 to 61% in 2011. Dalit proportion among all HF clients versus dalit proportion among catchment population has also increased over the monitoring period from 1.41 to 1.47.

LESSONS LEARNED

Capacity building

- Capacity building is a continuous process. It requires continuous engagement, and training needs to be backed by periodic follow-up, coaching and refreshers.
- Targeted support for marginalized populations is key. Regular coaching for dalits and female members on their roles and responsibilities has been very productive. Parallel interventions on livelihood and educational empowerment of the marginalized also need to be undertaken to ensure their meaningful and sustainable participation during meetings.
- The HFMSp is only a part of overall HFOMC capacity building. Other means of capacity building like policy and fund support are also necessary.
- Moving from comparatively simple activities to more complex ones is an effective approach to slowly build HFOMC capacity over time.
- HFOMC involvement in all aspects of HF management, programs and activities is necessary to develop their capacity. HFOMC members need continual exposure to health-related issues to empower them.

Representation

- The selection process for committee members should be done through the public gathering process to increase community accountability. The structure should be inclusive in nature and should ensure that the chosen individuals are motivated and competent (or have the potential to be competent), in order to maintain a spirit of active voluntarism and group empowerment. In many cases, locally nominated chairpersons have performed better than VDC secretaries.

Relationship of HFOMC with HF staff and wider community

- How effectively committees function is largely determined by the relationship between HF staff and HFOMC members; the relationship among HFOMC members from different political background; and between HFOMCs and the wider community.

¹ Effective meetings is defined as the % HFOMCs that: held a meeting in the last month with participation of 51% HFOMC members with at least a dalit and women member; prepared action plans; and shared responsibilities among HFOMC members.

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