Nepal Family Health Program II
Technical Brief # 28
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Local Health Governance Strengthening Program

HFOMC members carrying out bottom-up planning exercise for use of MOHP Block Grant

BACKGROUND

The enactment of the Local Self Governance Act 1999 was a milestone in the process of decentralization, ultimately aimed at devolving authorities to local bodies. In 2001, the Government of Nepal (GoN) announced a plan to hand-over local-level primary service institutions of four development sectors, including health, to local bodies. A plan was developed in this effect at the Ministry of Health and Population (MoHP) and a hand-over process of all the sub-health posts (SHPs) to VDCs was initiated. However, the capacity of local bodies emerged as an issue and this process in the health sector was halted.

In 2001/02, an orientation guideline for local health facility operation and management committees (HFOMCs) was developed, explaining the roles, responsibilities and functions of health personnel and institutions, respectively. A fresh hand-over process, in which the MoHP, in partnership with external development partners (EDPs) were involved, was launched in 2002/2003, which handed over 1,433 health facilities including SHPs, health posts (HPs) and primary health care centers (PHCCs) from 28 districts to local bodies. This process, however, was suspended due to leadership and other issues at the local level such as absence of elected local bodies.

A key concern was the management capacity of the handed-over health facilities - EDPs realized that mere orientation of the hand-over package prepared by the MoHP was not adequate to discharge the expected role by the HFOMCs. In addition, the inclusive composition of the HFOMCs turned out to be both its strength and weakness. On the one hand, the GoN attempted to make HFOMCs truly representative of the community and inclusive both by caste/ethnicity and gender. The limitation of this approach is that the awareness and educational background of HFOMC members limited their ability to understand their role and decision-making responsibility, even when their active involvement has been sought by the country. To address this, the Nepal Family Health Program (NFHP), in close coordination with the National Health Training Center, initiated a standard package to strengthen HFOMCs. NFHP II has been using a revised version of this package in thirteen districts to enhance the capacity of the decentralized health facilities under the name "Health Facility Management Support Program" (HFMSP) (see Technical Brief #17).

A number of assessments of the handed-over HFs found mixed results in terms of health care delivery, increased community participation, resource generation and ownership. Common concerns were also reported, including absence of elected people's representatives in the local bodies, inadequate preparation, lack of authority, limited management capacity of the committees, etc. Suggestions included enhancing the management capacity of HFOMC members, in which NFHP II has been actively engaged in thirteen districts. However, capacity alone could not suffice enriching the role of the HFOMCs while being unable to exercise authority over funds and personnel.

Considering this reality and to gain first-hand experience on devolving limited financial and human resource authorities to the local level, the MoHP designed and piloted the Local Health Governance Strengthening Program (LHGSP) in four districts with technical assistance from NFHP II (Surkhet and Dang) and GiZ (Kailali and Doti).

STRATEGIC APPROACH

NFHP II has been involved in the LHGSP pilot process since its conceptual development in 2007, in coordination with the Health Sector Reform Section, MoHP, the NHTC and the Health Sector Reform Support Program (HSRSP)/RTI. As one of the technical assistance agencies implementing LHGSP, NFHP II's roles and responsibilities include the following:

- Provide technical support to develop guidelines, manuals and conduct orientation to officials at different levels (center to village level);

- Establish a functional network and work in collaboration with partners at different levels;
- Support the LHGSP Steering Committee to design and conduct assessment of the LHGSP and document findings, prepare case studies, experiences and learning in collaboration with DDCs, VDCs, municipalities and health facilities at the local level and the MoHP and its departments at the central level;
- Provide need-based technical and other support;
- Provide support for periodic field and exposure visits to key officials involved in designing and implementing the pilot programme as per their rule and guidelines;
- Provide the following support to programme districts:
    - **Process facilitation** at the local level (support to develop systems and procedures as necessary)
    - **Technical support** i.e. capacity building, local planning, reporting, monitoring, review, etc
    - **Data collection, interpretation, analysis** and documentation of local innovations, experiences and best practices
- Facilitate learning at horizontal (between communities/ districts/regions) and vertical levels (between communities, districts, regions and central level).

ACTIVITIES

Development of the LHGSP concept and signing of MoU

The concept for the LHGSP was developed during the first phase of the NFHP in coordination with the Health Sector Reform Section of the MoHP, the NHTC and HSRSP/RTI. The concept of devolving limited authority over funds and human resources was agreed upon and LHGSP was formally approved by the MoHP on June 25, 2009. The MoU was signed on March 17, 2010 by the Ministry of Health and Population, Ministry of Local Development, Local Development Officers, District Public Health Offices from the four pilot districts and three technical assistance agencies: NFHP II, GiZ and HSRSP/RTI. The MoU outlines and defines structures, roles and responsibilities from the central to district level – at the center, there is a Steering Committee and a Technical Coordination Team (TCT) and at the district level, there is a District Technical Team (DTT).

Development of Documents

NHFP II helped the Steering Committee develop key LHGSP documents, including the Health Sector Devolution Framework, the LHGSP Implementation Guideline 2010 (LHGSP IG), the Advocacy Framework and the Facilitators' Manual. These materials provide stakeholders with comprehensive information about how authorities are devolved; how people are expected to benefit from this process; and guidelines on how to orient and build the capacity of HFOMC members and apply their devolved authorities to improve service provision at their health facilities and make them more inclusive.

District Technical Team formation and VDC selection

In coordination with the DPHOs, NFHP II helped establish the DTT in Dang and Surkhet, which is composed of 5 officials from the DPHO, District Development Committee (DDC) and other health-related agencies. The DTT subsequently selected fifteen VDCs each using prescribed criteria including: disadvantaged group mapping, population, remoteness, absence of NGOs, commitment of the VDCs, etc.

Orientation, planning and funding

NFHP II was heavily involved during the orientation and planning phase of the pilot. Each HFOMC in the 30 VDCs were oriented about the LHGSP, areas and extent of authorities devolved and their application. Having been exposed to the concept of health sector decentralization through the HFMSP helped HFOMC members better grasp concepts like planning, resource mobilization and social exclusion. During the orientation workshops, the HFOMCs developed prospective plans to improve services at their health facilities, with help from NFHP II. These plans were later shared with the DTT, who were responsible for assessing and approving them. Based on the merit of their plans, the HFOMCs received earmarked grants from the MoHP through the DDCs.

Preparation of VDC health profiles

The preparation of the VDC health profile was a key step in the pilot process as it depicts the health and health care situation and other socio-economic parameters of the VDCs, including information about the population structure, caste/ ethnicity/religious makeup of the community, education levels, wealth, access to safe drinking water sources, exclusion of service provision (if any), human resource situation at the health facilities, etc. NFHP II provided technical assistance to the VDCs and the out-sourced agency responsible for developing the profiles and was actively involved in the preparation of the documents. Information from the health profiles were used to develop the periodic health plans.

Preparation of periodic health plans

NFHP II provided technical and financial support to orient resource persons from the two districts about the appropriate method for preparing the periodic health plans.

To help the HFOMCs, the Technical Coordination Team at the MoHP approved of a format that is in line with the DDC periodic plan document.

RESULTS

In addition to the earmarked grant allocated by the MoHP. HFOMCs also received matching funds by DDC and VDC and other sources. Analysis of data from the two districts show significant differences in the matching funds (Figures 1 and 2). The majority of the total allocated budget in Surkhet came from the earmarked grant – the DDC and VDC's matching funds represented only 5% and 13%, respectively. In Dang however, the DDC was almost able to match the earmarked grant. This demonstrates more commitment and involvement from the district and village levels.

Figure 1: Dang

Total budget allocated: 3,887,400

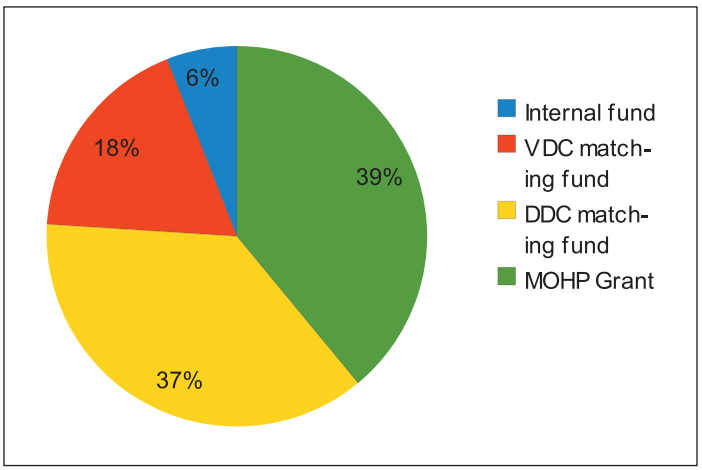
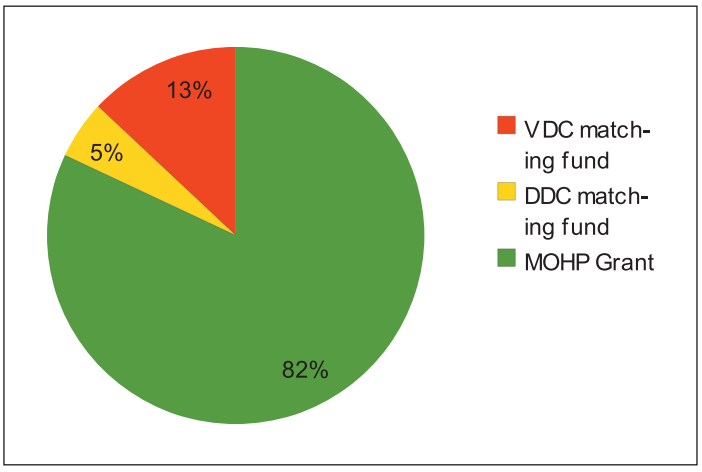


Figure 2: Surkhet

Total budget allocated: 3,345,385



Both districts have used the funds primarily for activities related to improving physical infrastructure and procurement of drugs (Figures 3 and 4). Surkhet allocated more money for capacity building than Dang, although in Dang too, it represented the area with the second-highest grant allocation.

Figure 3: Dang

Investment Areas

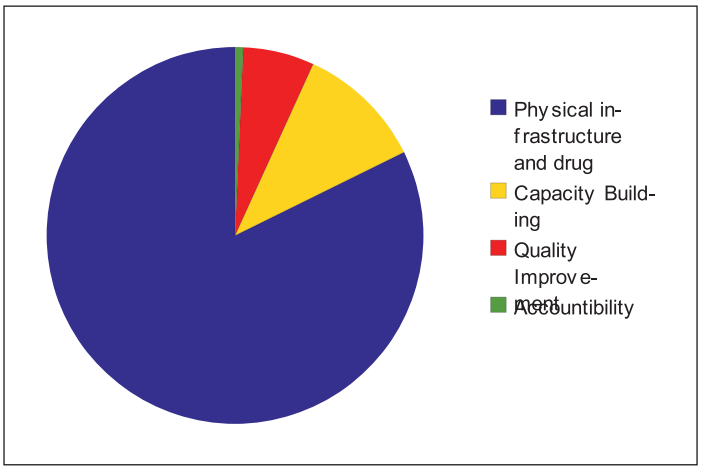
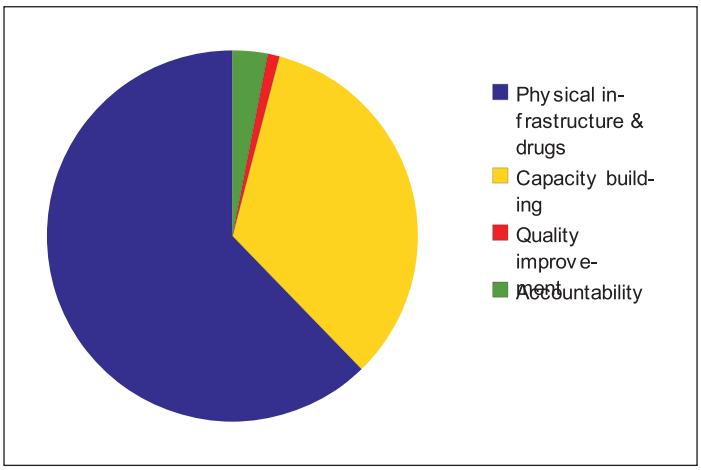


Figure 4: Surkhet

Investment Areas



LESSONS LEARNED

- **Encouragement in Communities:** Notable differences were seen in the attitude, action and contribution of HFOMC members and the community when they were asked about management of their health institutions. They fully realize that these institutions are their social assets and they need to make positive contributions towards their development.

- **Personal leadership:** It is clear that the leadership of the Local Development Officers (LDOs) made a difference in the pilot process. In Surkhet, the LDO made the decision to transfer the earmarked grant directly into the district development fund, while Dang lost theirs in the first round by not doing so. On the other hand, the new Dang LDO and his office were instrumental in allocating matching funds for the pilot VDCs. To build a workable system, individuals' personal assistance and support is essential, until the system has developed and matured.

- **Willingness and Capacity:** The willingness of the people, particularly the HFOMC as people's representatives, and the VDC Secretary need to be strong. Where these two elements are strong, the LHGSP process has been well explained and they have shown enthusiasm towards it. For example, despite the lack of a medical officer in Salkot VDC, Surkhet, a can-do attitude predominated, which was reflected in the approved plan and budget allocation. This attitude was also seen in the majority of Dang VDCs.

- **Fund flow:** At the time of fund disbursement, a small debate about fund flow surfaced during both DTT meetings concerning whether the fund should flow to the HFOMC account to shorten the process or should to be sent to the VDC account first. Dang decided on the latter while Surkhet chose the former option. However, the difference in fund flow made little difference to the process and end-result – rather it was the political mechanism[1] - that existed until recently – with long decision-making processes, that caused more delays. Simply put, the interests and attitude of the actors played a bigger role than did the fund flow mechanism. It was found that even though they followed a longer route, Dang VDCs accomplished more over the shorter route chosen by Surkhet.

- **Different needs:** Unless adequate support and mentoring is provided to VDCs, it is hard to build their confidence. Individual VDCs need to be treated differently in terms of support, based on their current management status and local dynamics. The willingness of the local leadership and their understanding of the issues have a profound impact on the success of this process. So a blanket time line and standard amount of support alone will not yield the desired results.

[1] In the absence of locally elected representatives, the GON introduced a mechanism whereby representatives from the seven prominent political parties were placed to manage the DDCs and VDCs. Because of their influence and authority, the decision-making space was significantly reduced.

The program/research described in this article was supported under the Nepal Family Health Program II which is made possible by the generous support of the American people through the United States Agency for International Development (USAID). The contents are the responsibility of NFHP II and do not necessarily reflect those of USAID or The United States Government.

NFHP II is implemented by JSI Research and Training Institute, Inc., in partnership with Engender Health, Jhpiego, Save the Children, World Education, Inc., Nepal Technical Assistance Group, Nepal Fertility Care Center, Management Support Services Private Ltd., Nepal Red Cross Society, United Mission to Nepal, BBC Media Action, Digital Broadcast Initiative Equal Access Nepal, Family Planning Association of Nepal and Center for Development and Population Activities.