ASSESSMENT OF NFHP ACTIVITIES TO STRENGTHEN THE INTERACTION BETWEEN COMMUNITY AND HEALTH SERVICE SYSTEM

Nepal Family Health Program
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Background

NFHP is involved with at community level, most important are those dealing with the *relationship between communities and the health professionals and facilities* providing them health services from its very beginning. Varying by district and VDC, these activities include various combinations of the following:

- Assistance in implementing HMG's decentralization of management authority (HFs handover),
- Complementary work (3 days training) aimed at strengthening health facility operation and management committees.
- PDQ work
- REFLECT

CARE/NFHP is also supporting DPHO to implement various programs at the district of *Dhanusha, Mahottari, Kanchanpur, Chitwan, Parsa, Nawalparasi* and *Bajura* districts and similarly SC/US-NFHP is engaged in the implementation of different community level interventions in *Jhapa, Morang, Sunsari, Siraha, Banke, Bardiya* and *Kailai* districts to bring the desired results.

Nepal Family Health Program has been doing studies , preparing reports for internal use as part of the continuing learning and knowing their program , in this contest NFHP has commissioned two consultant , Dr. BD Chataut and Mr. Ganesh Gurung to undertake an study on these communities level activities under the heading of "Assessment of NFHP activities to strengthen the interaction between Community and Health Service System". The main objective of the assessment is to assess the situation of *relationship between communities and the health professionals at the health facility level.* The study comprised a series of desk and field studies in three district , namely Chitawan, Sunsari and Dhanusha

We hope that this report will be informative and useful and will encourage the application of lessons learned and recommendations in local bodies strengthen programming in the future .

As NFHP is being engaged in analysis, study and communication on significant issues in health sector , NFHP endeavors to maintain the highest standards for accuracy and fairness. Opinions expressed by individual authors, however, do not necessarily reflect opinions or factual determinations of the NFHP So that his document does not represent the views of opinion of NFHP and USAID .

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LIST OF ABBREVIATIONS

ARI	Acquit Respiratory Infection
BCC	Behavioral Change Communication
CDP	Community Drug Program
DDC	District Development Committee
DHO	District Health Officer
DHO/DPHO	District Health Office/District Public Health Office
DHS	Department of Health Services
FCHVs	Female Community Health Volunteers
FP/MCH	Family Planning/Maternal Child Health
HFOMC	Health Facility Operation and Management Committee
HFs	Health Facilities
HFIs	Health Facility In-charges
HMG/N	His Majesty's Government of Nepal
HPs	Health Posts
IEC	Information Education and Communication
I/NGOs	International/Non Governmental Organizations
LDO	Local Development Officer
M+ E	Monitoring + Evaluation
MCHW	Maternal Child Health Worker
MOHP	Ministry of Health and Population
NFHP	Nepal Family Health Program
NFE	Non Formal Education
NHTC	National Health Training Center
NPC	National Planning Commission
PDQ	Partnership Defined Quality
PHCs	Primary Health Care Centers
PLA	Participatory Learning and Action
REFLECT	Regenerated Freirain Literacy through Empowering Community Techniques
RLG	Radio Listener Group
SC, US	Save the Children, USA
SHPs	Sub-health Posts
TOT	Training of Trainers
USAID	United State Agency for International Development
VDC	Village Development Committee
VHW	Village Health Worker

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A. INTRODUCTION

The Nepal Family Health Program (NFHP) is a five year (2001-2006) bilateral program of HMG/N and USAID/Nepal implemented in 27 districts of Nepal with an aim to support HMG/N for achieving its long term goal of reducing fertility and under five mortality in the context of the National Health Policy and the second long term Health Plan 1997-2017 of HMG/N. The key thrust of the program is to increase use of key quality Family Planning/Maternal and Child Health (FP/MCH) services at community and household level. NFHP assist the Ministry of Health and Population (MOHP) in implementing the delivery and use of quality FP/MCH services in close collaboration with the Department of Health Services (DHS) and other partner international/Non Governmental Organizations (I/NGOs).

NFHP is a fully integrated program in which community, district and national components of health are coordinated, inter-linked and mutually supportive. The community level expected results foreseen by the program includes community level service providers and public sector facilitators are providing higher quality and more sustainable services, increased demand and utilization of FP/MCH services, and more active and supportive role of community to the local health facilities and Female Community Health Volunteers (FCHVs).

Different program activities have been implemented in the districts in close collaboration with District Health Office/District Public Health Office (DHO/DPHO) and other development partners including Save the Children, USA (SC, US) and CARE Nepal to achieve the expected results of the program such as improved quality of FP/MCH service delivery, improved effectiveness/quality of health services, increased access to health services for poor, women and marginalized population, developed better understanding and relations between service recipients/providers and increased feeling of ownership regarding the local Health Facilities (HFs) among the local people.

The core program activities includes assistance in implementing HMG/N's decentralization of HFs management authority to local community, training for strengthening Health Facility Operation and Management Committees (HFOMCs), Partnership Defined Quality (PDQ) methodology, Regenerated Freirain Literacy through Empowering Community Techniques (REFLECT), Participatory Learning and Action (PLA), and others.

With an aim to assess to date experience of NFHP in terms of improving quality of services, improving access to health services particularly for marginalized/ excluded population, achieving greater public health impact, improving better relations between service providers and recipients of its program implementation this study was commissioned by NFHP. This report is an outcome of the study.

B. OBJECTIVES

The main objective of the study was to assess the NFHP activities to strengthen the interaction between community and health service system. The specific objectives of the study were to:

- Assess the effectiveness and impact of various community level activities
- Find out the relations between community and health facilities
- Know improvement in quality of health service delivery
- Assess improvement in access of socially marginalized people to public health services

C. METHODOLOGY

Descriptive analysis was the main method used to achieve the set objectives of the study. This study is mainly based on qualitative assessment of field activities, review of relevant documents and reports, debriefing with CARE, SC, US and NFHP staff on their exchange visits, in-depth discussion with key stakeholders including community leaders, health workers, NFHP field staff, government officials, representatives of implementing I/NGOs partners, and field observation of Sunsari, Dhanusha and Chitwan districts. The focus areas of the assessment were process and achievements of various activities, coordination and collaboration, social inclusion and management, and strengths and weaknesses of the activities implemented. Followings specific steps were taken during the study:

- **Review of relevant documents/records**

  A review of relevant documents and records relating to the program was conducted to assess the impact of the program inline with the set objectives of the study.

- **In-depth discussions with key stakeholders**

  In-depth discussions were conducted with the key stakeholders including District Health Officer (DHO), Local Development Officer (LDO), HFOMC members, community leaders, health-post in-charge, QI team, VDC representatives, health workers, key persons of District Development Committee (DDC), FCHVs, representatives of SC, US, CARE Nepal, professionals of HMG/N and National Planning Commission (NPC), and NFHP professionals. The in-depth discussions were conducted with the help of an open-ended checklist.

- **Debriefing with CARE, SC, US and NFHP staff on exchange visits**

  Debriefing sessions were conducted with CARE Nepal, SC, US and NFHP staff regarding their learning from exchange visits to the selected HFs of Nawalparasi, Sunsari, Kanchanpur and Bardia districts. The key issues of the discussion were process, outcomes, and strengths and weaknesses of the program.

- **Field Observation**

  Altogether three districts namely Sunsari, Dhanusha and Chitwan were visited during the course of the study to assess the implementation status of NFHP program activities at district and community level as well as to visualize the real field situation.

D. FINDINGS

1. Assessment of Community Level Activities of NFHP

An attempt was made to assess community level activities of the NFHP at community level. The program has designed and implemented different types of activities at local level such as assistance for HFs handover, Strengthening the capacity of HFOMC members, PDQ application, PLA/RLG, REFLECT and others.

1.1 Assistance for HFs Handover

With the Local Self Governance Regulation of 1999, HMG/N decided to decentralize management responsibility of HFs to lower levels. Decentralization of Sub-health Posts (SHPs) to VDC was begun in 2002 and decision was taken to form a local HFOMC to run the SHPs as it was recognized that the ultimate responsibility for health development lies with the community themselves. It is expected that once the HFOMC assume full ownership of the local level management, the committees will design benefit packages, prioritize their essential health care services and financing mechanism with technical backstopping and information updates from the District Public Health Offices (DPHOs). The government has implemented this program in 27 districts at the end of financial year 2061/62. As a result altogether 1578 health facilities including 1251 SHPs, 237 HPs and 90 PHCs of 27 districts of Nepal have been handed over to the local community up to the fiscal year 2061/62.

The NFHP has provided assistance to HMG/N in its endeavor of HFs handover to local community in its program focused districts. The support of NFHP in collaboration with the government and its partner I/NGOs includes technical support, community orientation, formation of HFMOC, logistic and administrative support, capacity building, infrastructure development and mass awareness raising for community ownership of the HFs. The main aim of this assistance is to support HMG/N in the handover process of HFs to local community as well as empower the community for operation and management of HFs with improved quality of service delivery in a sustainable way.

The team found that handover process in all the three districts has been in surprise and haste without any preparations. In Sunsari, DDC office frankly opined that both side handing over and taking over were not prepared for it. Even after many months of handing over, HFOMCs were not able to take their full responsibilities. This has been attributed to a large extent by the absence of elected body in VDC and current country's political scenario.

Certain indicators of the HFs have been improved such as regularity of staff, salary payment, number of patients and so forth. However, there are activities not being operated by the HFOMC such as resource generation and mobilization, developing plans to tackle local problems, and monitor accordingly. Similarly, there is lack of monitoring from DDC and VDC. Decentralized procedure have not been deeply rooted in visited DDCs and VDCs, because the authorities of the local bodies are more concentrated on to the implementation of projects/programs rather than being engaged in policy formulation, and supervision and monitoring of the project/programs. Therefore, present supervision and monitoring system is not adequate and result-oriented. Geographical setup of the country, patient load, incidence/burden of diseases, availability of manpower, level of health awareness among the people, supply of drugs, budget release and other related factors have directed bearing upon the types of health services. Irrespective of these factors, the government has uniform health policy application to all places. This has made it difficult to provide desired level of health services to the people in the districts (CSSP, Pro Public, Dec. 2005).

A three days training to HFOMC members was provided by NFHP in its program focused districts to assess and strengthen management capabilities of HFOMC as a complement to National Health Training Center (NHTC) designed two days handover orientation training. The contents of NFHP's training package includes resource mobilization and budgeting; decision- making, delegation of authority, communication and organizing effective meetings; leadership, conflict management and planning/implementation; monitoring and quality assurance; support and coordination; and recording and reporting. The main aim of this training is to assess capacity of HFOMC and strengthening their capabilities with special focus on operation and management of HFs, improvement in service delivery system, community participation, sensitization on the issues of inclusion and good governance.

It was noted that a few trainings in Dhanusha and Sunsari were conducted for the HFOMC after several months of handover of HFs.

NFHP through it partners has conducted strengthening program, which included orientation to the HFOMC members on their roles and capacity assessment and training.

Capacity assessment and training should be immediately commenced after orientation on HFOMC's roles and responsibilities for better understanding. For the continuity of the efforts to raise awareness and concerns of HFOMC on their roles and responsibilities and to monitor the increase in capacity, fallow ups were found not adequate. Routine follow ups can identify the problems and find out solutions. Monitoring was lacking from DDC and VDC side too.

1.2 PDQ Application

Partnership Defined Quality (PDQ) is a partnership approach applied to different key stakeholders including the community leaders and the service providers for quality improvement in service delivery.

This approach has been applied in the NFHP program focused districts with lead role of SC, US. This is an important tool applied for defining, implementing and monitoring the accessibility of services related to public health. This process gives insights to clients and non-clients regarding the limitations of quality health service delivery as well as helps to create an environment of mutual understanding to improve the health service delivery system at local level. It also helps to do away of misunderstandings in the management of existing health facilities between service providers and service recipients as well as helps to develop a harmonized relation among them and compromise their expectations. It also helps to increase community participation (including participation of women and marginalized people for operation and management of local HFs in a sustainable basis). SC, US and CARE Nepal have applied this approach in their respective program districts with an aim of improvement in the health service quality and health service delivery at community level.

PDQ is one of the most popular and liked approach of NFHP. PDQ poster has made more clear-cut understanding and popular among members of HFOMC. Spider web (a tool to assess strengths, management, resources mobilization and implementation with M and E) has made members to know their achievement in a very simple manner. However, there are certain constraints in PDQ in implementations.

First of all, Nepali name of PDQ (SAJHEDARI GUNASTARIYA SEWA) was long and complex which has made people confused. It was found that it would have been better if local name was coined than its literal translation.

SC, US has implemented PDQ in it's all the project areas whereas CARE Nepal has implemented it in its some of the selected project areas only. Keeping in mind the required cost for a PDQ, it was reported that PDQ is not feasible in all the project areas of a district.

In Dhanusha, it was found that there was no enough follow up. Similarly, in most PDQ, mostly infrastructure development/improvement issues were discussed where there was less discussion on improvement of quality of services and utilization of services. It was also found that PDQ meeting was heavily dominated and manipulated by the HFIs. In many cases, members have raised the issue of quality of services, timing of services, utilization of the health services, however the HFIs have not addressed the raised issues and have easily directed the issues towards infrastructure development/improvement issues such as drinking water in HFs, compound wall, furniture and medical equipments.

1.3 Regenerated Freirain Literacy through Empowering Community Techniques (REFLECT)

REFLECT is a new right-based development approach applied by various development organizations. It has two major components i.e. literacy (NFE) and community empowerment. In this process community realities are identified and reflected through maps, diagrams and calendars.

This approach has been applied in the NFHP focused districts with lead role of CARE Nepal in order to make the community particularly women and marginalized population aware of their basic health rights. It helps to sensitize, make aware, encourage and empower the community to address their problems in general and particularly health issues. This approach has been applied by CARE Nepal in Parsa, Chitwan, Nawalparasi and Bajura districts in the PDQ applied VDCs to compliment the PDQ process in coordination with its local NGO partners.

This approach is regarded as an important tool to aware community regarding their health rights, responsibilities and improves quality of public health service delivery system at local level as well as ensures sustainability of local HFs with active community participation. The REFLECT method is a nine months cycle with different steps including area selection, formation of REFLECT centers, selection of facilitators, TOT to facilitators and operation of REFLECT classes (1 or 2 classes/week).

REFLECT implementation, not only it has escalated the awareness of target population including socially excluded, but also has empowered the target population. Furthermore, in addition in creation of awareness and empowerment, it has also helped to search for solution of the health problems identified. Due to REFLECT, participants have raised the questions in health facilities about their health rights. In some of the areas, it was reported that due to REFLECT, participants have questioned to HFIs for the services for being late or not available in HFs.

In terms of cost REFLECT exercise is not an expensive exercise. It has cost requirements only for TOT and Facilitator. Thus, it has more sustainability potentials than other programs. It can be run by DPHO also if it is kept in its annual plan of action as a regular program and formalize it.

During the field visit, participants of the REFLECT expressed that if REFLECT exercise was not there; they would not have known their health rights and always would have begged for the treatment with the HFIs. Thus REFLECT tool was found very powerful tool for raising awareness about the health rights of the people. On the other hand, HFs of the areas are being handed over and local people are operating and managing the HFs which coincides with demand of health services through the REFLECT methodology.
However, it would have been much better if REFLECT would have taken first, and then only hand over process begun. REFLECT would have made people more prepared to take over the HFs than without REFLECT. However, the time has to be considered as it takes 9 months to complete

the REFLECT cycle. In four districts where REFLECT has been implemented, altogether 36 centers have been conducted since July, 2004 and about 1080 members have been trained.

It was found that due to feudal characteristics of Nepali rural society, in the beginning of REFLECT, it creates conflicts between health service providers and health service seekers which is a natural process of development. It was reported that implementing partners found them in difficult position in some areas due to this situation.

The weak part of REFLECT is time consuming and difficult to convince people in the beginning. Furthermore, dropout rate in the class (circle) has been a constant problem of REFLECT. On the other hand, another CARE Nepal program, which is being conducted in neighboring VDC, has been paying Rs. 15 per participant/day as snack expense that has further accelerated to dropout of the participants.

In one site, it was observed that a few local elite people have been enrolled in the REFLECT circle who always give low priority to health issues. They had tried to stop demand of services from the HFs.

It was reported that participants are much more interested in other urgent issues such as drinking water, community forestry, road, and so forth than health. If REFLECT centers can be integrated with other program which supports other services would have been ideal situation.

On the other hand, only a few centers have been established in selected VDCs. Without establishing several REFLECT centers in a district, it can not achieve changes that it has aimed in the field of health.

1.4 Others

To strengthen HFs for sustainable health services, improve quality of health service delivery system, increase access of poor and marginalized people to local HFs NFHP has supported to implement different other activities such as CDP, BCC, support to FCHVs, IEC interventions, rewarding HFOMCs and HFs, technical support to HFs, monitoring and evaluation support, follow-ups, interactive meetings, baseline study, and Flexible Fund. Similarly, different training/refresher training programs have been also conducted in the districts to strengthen the capabilities of health workers and health volunteers (FCHVs).

The training includes TOT on HFOMC, FP/C training to VHW/MCHW, RLG mobilization in the HFs etc.

2. ACHIEVEMENTS AND RESULTS

2.1 Technical inputs, Outputs and Capacity Building

The NFHP activities to strengthen the interaction between community and health service system are very relevant and supplement and compliment HMG/N's and other donor perspectives. The technical inputs and outputs can be sub grouped as follows:

- The three days training given to HFOMC members is one of the most important activities in enabling and strengthening the operation and management of the health facility by the community. It has helped in generating feeling of ownership of HFs among the HFOMC members, helped to understand regarding their authority and responsibility for the management of the HFs and service delivery. It has also sensitized them to organize meeting of HFOMC on regular basis. HFOMC members reported that the committee has been able to make the health workers punctual and stay full time unlike in the previous days.

- Most of the HFOMC were aware about the capacity of the HMG/N in supplying the drugs annually, which lasts only for 4-5 months. Thus, they have started to show their concern for making the drugs available round the year in the HFs and supportive in introducing Community Drug Program (CDP).

- In some HFs, the 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.

- The technical inputs given to HF staff, especially to HFI, have made them understand about decentralization, role of HFOMC, their own responsibility and accountability. Technical inputs such as involvement in PDQ process, IP training etc. have helped in improving the quality of services and developed their skill and competency in service delivery, planning, monitoring and evaluation.

2.2 Sustainability of Services

Apart from the service provision made available by HMG, some of the HFOMCs have taken initiatives such as setting up the laboratory in sub-health posts and recruit technical persons, pay some allowances to FCHV, operate cycle-ambulances etc. But in general there are very meager efforts made towards resource mobilization at the community level to make the services sustainable. The HFOMC members usually talk and look forward for additional financial resources either from VDC, DDC or MOHP or from donor agencies or some donation by somebody in kind or cash. In such a situation sustainability remains questionable.

The HFOMCs have been successful in some places in improving the physical facilities of HFs such as construction of the building, construction of

compound wall, electric wiring in the building, dug-well construction for drinking water, purchasing some medical equipments etc. through above means and resources but there does not appear to be any thinking towards developing mechanism at the community level for resource generation in a regular basis and to make the services and activities sustainable or keep the efforts upheld for improvement of the quality of the services delivered and also increase accessibility and utilization of these services.

2.3 Service Quality

The technical inputs provided by NFHP have helped in the improvement of the service quality. Though there is some improvement seen in utilization and coverage data, there does not appear to be real increase in demand. The HFOMC members who are representatives of the community mainly talk about more money for HF, more equipments, even such as x-ray machines, lab equipments etc. (as suggested/guided by HPIs) but hardly talk about the services that have been made available by HMG/N free of cost, such as FP services, immunization, vitamin A supplementation and treatment of TB, Malaria, Kala-azar, Diarrhoeal diseases, ARI, snake bite, etc. Health workers appear satisfied with the performance if the service coverage indicator is above 60% or so, say for immunization, rather than aiming for not to have a single child missed without getting immunized properly.

2.4 Management

Handed over health facilities have to be managed as per decentralization policy of HMG/N. It requires clear-cut directives from the central level regarding the authority delegated at various levels and the scope of work assigned to various bodies such as MOHP, DHS, DDC, VDC and HF, or HFOMC itself. It also requires clear directives about the flow of the fund to be made available to HFs. Though the process of handing over of the HFs started in 2000, these are not yet clear. The NPC is yet to finalize the policy directives. Within the MOHP the exact role of Monitoring and Evaluation division of MOHP, Management division of DHS, and the NHTC is not clear, although all of these have been assigned some tasks. Similarly, there is no regular and active linkage between DPHO and HFOMC. DPHO assumes that DDC is more responsible for the management of handed over facilities. The authorities in DDC including the DDC Chairman and LDO are so busy that they have hardly any time to think about the management of the HFs. One LDO frankly expressed that DDC does not have time, knowledge, skill and capacity to monitor health activities. He even demanded that he should have some knowledgeable health person, preferably a doctor, to assist him and then only he can do something, though he should have been taking such help from DPHO.

At the community level the creation of HFOMC is a good start and training provided to them by NFHP has been quite useful in generating the feeling of ownership and enhance their interest in the management of HFs. However the absence of elected body at the VDC level has been a major stumble block for proper functioning of the HFOMC as a real as well as psychological

factor. The VDC Secretaries who have been assigned as Chairmen of the HFOMCs usually stay at the headquarters of the district and have no time to really look after the management issues of the health facilities. The health workers also were unhappy with the confusing type of environment in regard to personnel administration.

2.5 Community Support

After handover of HFs there is positive change of attitude towards the health facility among the community people. Their growing sense of ownership and feeling to know about the function, type of services delivered and their quality. In the HFOMC meetings, the minutes show that the discussion and issues raised are on inadequate budget for HF, provision of medical commodities such as AD syringes, Anti-rabies vaccine, Anti snake bite serum, which are not available at present. It was also seen that they were concerned about the availability of the equipments such as BP instrument, foetuscope, weighing machine, gloves etc. and were able to get them procured. The community also has been supportive in physical development of HFs by helping to construct building, erect compound wall, procure furniture, making arrangements for water supply, electrification, help to run outreach clinic etc. At places, there are evidences that the HFOMCs have decided to build capacity of the staff (AHW, MCHW) by sending them for training.

Many HFOMCs have supported to help FCHVs by proving incentives in terms of allowance (usually Hundred rupees per month), uniform, bicycle, torch, umbrella etc. The news of providing allowance by some VDCs is spreading fast but needs to be considered seriously so that the spirit and proudness of voluntarism, which the FCHVs have and the respect they have been commanding from the community does not get lost. During the interview, one of the FCHV in fact shared her experience by telling that one of the household member told her “you must have come here to “digest your allowance”, when she was there to ask to take his child for vaccination. In reality, when the FCHV program started by HMGN in 1988, they were paid Rs. 100 per month. But within two years of time they started demanding more money by saying that the peon, who is just a cleaner and messenger gets so much of money, while they get only Rs. 100 only though they work as health promoter.

They also started demanding promotion as their career development. Against this backdrop HMG/N had to decide to stop their allowance being paid on monthly basis, even as a financial assistance to FCHVs, to pay them as training allowance whatever is the possible amount to pay, once or twice a year by organizing some training programs. This will prevent FCHVs to retain their voluntarism rather then develop a feeling of civil servants by being put under monthly pay role.

2.6 Social Inclusion

Present policy of HMG/N has created nine member HFOMC for Sub-health Post level. VDC Chairperson is the Chairperson of the HFOMC and HFI is the Member Secretary. There is provision of FCHV, Women of ward, school Headmaster/Teacher, a women Social Worker as member in HFOMC.

Thus, in present structure, there is provision of at least four women in the HFOMC. There is provision of two members on HFOMC from Dalit and Janajati. Out of two, at least one should be a woman (Annex –I).

REFLECT and PDQ have played vital role in voicing the local problem and health services that are not being provided in the remote areas as well as to the marginalized communities. In Chitwan, REFLECT has made the people to understand for their health rights in a broader perspective and due to REFLECT, HFs are forced to provide services to the socially and geographically excluded groups/areas.

In all the three districts that visited by the team found that the nominated members were Dalits and women. Janajatis (such as Tharu and others in the area) were mostly not nominated. Janajatis were left out due to high priority to Dalits. In all the three districts, Dalits were nominated due to their caste rather than not due to their representation of remote or inaccessible area.

It was interesting to note that all the visited HFOMCs, the nominated members especially Dalits, and women had little to say in the meeting unless they were asked any questions. It was also reported that they have little role in management of HFs in practical term. When interviewed individually with Dalit and women members, it was found that they were not aware of their duty, role and responsibilities. They have been attending the meeting as per the request of the HFI. It was surprising that they were not aware of their role for the service utilization of the HFs. In this situation, it can be imagined that their role is limited basically due to lack of their understanding and awareness.

When it was asked to other members about the reason, many members revealed that it was due to selection process. At present, HFI and VDC representative (presently Secretary) nominate the person as per their choice rather than any wider consultation or public consultation. Due to this, many villagers do not know who are the members of HFOMC and in most villages of Dhanusha and Morang, when asked who operates the HFs, it was answered that government runs it and they do not know that there is a HFOMC, which is an evidence of villagers do not know the HFOMC. They also opined to select through public gathering with criteria and role to be played.

It was also reported that orientation sessions conducted were mostly dominated by male and without refresher course; many of the nominated members had forgotten sessions of the orientation classes.

In present structure, there is enough women representation. At least four women will be there in HFOMC but it does not ensure from those areas where health services have not reached. Having Dalit and women in HFOMC does not mean the services to rural and un-reached areas.

In some cases, it was found that most of the members of HFOMC were non-user of HFs where they were members. When health services were needed, they use the services of district or private health services while they are members of the HFs. So, it was found that members of HFOMC do not have real motivation to improve the services of health facility where they are members. Being a member of HF is a social status or due to request of HFI or VDC Secretary.

In Dhanusha, there were villages where health services were less utilized by the Dalit groups, from where neither there was representation from the area in the HFOMC nor any effort had been made by the HFOMC members to utilize the services.

At present structure, even though there is at least four women representation in HFOMC, it was opined in Chitwan that there was no formal representation from Mothers Groups of the village which plays a vital role in the health delivery of mothers and children in the villages. It was opined that even though there are four women and among them four women in any case are from mothers groups, due to lack of formal representation from the mothers group, mothers groups were left out in the process.

At present in Spider Web tool is being used as monitoring tool and there are four pillars namely Organization, Structure and Management, Resource Mobilization and Planning, Implementation and M+ E. It does not include Social Inclusion. If Social inclusion was there as one of the pillar, the HFOMC would have reviewed the indicators of Social inclusion. It would not only review the indicators but also make aware and empower the HFOMC on social inclusion, which could have been a regular phenomenon of the HFOMC.

E. CONCLUSIONS AND RECOMMENDATIONS

1. Conclusions

Based on the descriptive analysis of the in-depth discussions with key stakeholders, review of relevant documents and field observations conclusions and recommendations of the assessment have been drawn as follows:

NFHP has provided assistance to HFs by providing three day long training to HFOMC with an aim to empower the HFOMCs for operation and management of HFs in a sustainable way. As expected the handover process has not met the expectations since it has been done without proper planning and preparation. As a result some of the HFOMC members were not aware regarding their roles and responsibilities as well as able to undertake their responsibilities and motivate the community. For the continuity of the efforts to raise awareness of HFOMCs follow ups and monitoring were found not adequate.

PDQ is a partnership approach applied in the for quality improvement in health service delivery as well as to increase community participation (including participation of women and marginalized people for operation and management of local HFs in a sustainable basis). PDQ poster has made more clear-cut understanding and popular among members of HFOMC. Spider web has also made members to know their achievement in a very simple manner. However, this process is time consuming, costly and complicated in the local context. PDQ is not feasible in all the project areas. The PDQ meeting was heavily dominated and manipulated by the HFIs and issues such as improving service quality /delivery, resource generation, CDP and sustainability of the services minimized.

NFHP has implemented basic Participatory Learning and Action (PLA)/non-formal education sessions (NFE) together with FP/MCH related radio program in its some of the selected districts with an aim to create mass awareness regarding FP/MCH and community participation targeting poor and marginalized people. However, in most cases Dalits and poor whose priority is subsistence they could not spare time or prioritize. Similarly, most Dalits households are scattered. There are no Dalit pocket areas as such to focus the program, therefore there less participation of the group to run the program. Therefore, due to nature of the program, target group and local context it was found less effective as well as costly.

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 are identified and reflected through maps, diagrams and calendars with in a cycle of nine months. 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. It has helped to sensitize, make aware, encourage and empower the community to address their problems in general and particularly health issues. In terms of cost REFLECT is not an expensive exercise and has more scope of continuity by the government with commitments. However, high dropouts rate in the class (circle) has been a constant problem with due to the interest of participants in other urgent issues such as drinking water, community forestry, road, and so forth than health.

NFHP has supported to implement other different activities such as CDP, BCC, support to FCHVs, IEC interventions, rewarding HFOMCs and HFs, technical support to HFs, monitoring and evaluation, follow-ups, interactive meetings, baseline study, and Flexible Fund, different training/refresher training to strengthen the capabilities of health workers/volunteers, strengthen HFs for sustainable and quality health services, increase access of poor and marginalized people to local HFs.

NFHP activities particularly the training, CDP, technical inputs to HFs and health workers/volunteers for planning, monitoring, service delivery were regarded important and relevant to strengthen the interaction between community and health service system to supplement/compliment HMG/N and other donors program activities.

Apart from the service provision made available by HMG, some of the HFOMCs have taken initiatives for infrastructure development, equipment acquirement in the HFs, recruitment of technical persons, providing some incentives to FCHV,

operate cycle-ambulances etc. But in general there are very little efforts had been made for resource generation at community level for sustainability of the services.

The technical inputs provided by NFHP have helped in the improvement of the service quality. Though there is some improvement seen in utilization and coverage data, there does not appear to be real increase in demand.

The handed over HFs have to be managed as per decentralization policy of HMG/ N. It requires clear-cut directives from the central level regarding the authority delegated at various levels and the scope of work assigned to various bodies such as MOHP, DHS, DDC, VDC and HF, or HFOMC itself. It also requires clear directives about the flow of the fund to be made available to HFs.

After handover of HFs there is positive change of attitude towards the health facility among the community people. Their growing sense of ownership and feeling to know about the function, type of services delivered and their quality. Their expectations have also raised regarding inadequate budget for HFs, provision of medical commodities. The community also has been supportive in physical development of HFs. However, the local people were less aware regarding quality improvement, sustainability of services and resource generation.

Regarding social inclusion the current structure of HFOMC (9 members) has provision of four women including FCHV, women Ward Member, Social Worker and at least one women from two Dalit and Janajati members. In all the three visited districts the nominated members were Dalits and Women who were unaware regarding their roles and responsibilities. Janajatis (such as Tharu and others in the area) were mostly excluded. In all the three districts, Dalits were nominated due to their caste and not due to their representation from inaccessible areas.

At present in Spider Web tool is being used as monitoring tool and there are four pillars namely Organization, Structure and Management, Resource Mobilization and Planning, Implementation and M+ E. It does not include Social Inclusion as pillar. But it has missing social inclusion as one of the important pillars that could help HFOMC make aware and empower on social inclusion.

2. Recommendations

ACTIONS TO BE TAKEN BY THE GOVERNMENT (MoH, NPC MLD)

2.1. Handover Process: At present, HFs is handed over with short notice and without any planning and preparation. In some cases in Sunsari, it was informed from centre that HFs should be handed over to community within fifteen days. When DDC invited Community people for handover, even HFI were also not aware of the hand over. So, it would better if orientation sessions are organized as preparatory to sensitize the community for the hand over.

2.2 Clear-cut Policy: Perhaps the above situation is the result of lack of clear cut policy directives from the centre. The key players of handover and implementation such as Divisions of MOPH, DOHS, MOLD, DDC, D(PHO), HFs, VCDs and

supporting partners , all are in a state of confusion about their authority and role to be played. Correction of this situation should be done as early as possible.

2.3 HFOMC Composition: The present arrangements made about the composition of HFOMC, is unable to have representation of all sectors of the society. Therefore, there should be flexibility about the composition, so that composition and the authority on it should be delegated to DDC.

2.4 HFOMC "Leadership Crisis" : As per present strategy, the chairman of the VDC is to be the chairman of the HFOMC. In the absence of locally elected body since long, the VDC secretaries have been assigned to chair. They are currently staying at district headquarters, rather than at village. This situation has in a way created leadership vacuum and made the HFOMC members apathetic as the present political situation indicates, it is going to take some more time to elect the local bodies. Therefore HMG should think seriously to do away with this situation immediately. Selection/ election of a local public figure could be one option.

2.5 Bridging the Gap : To manage the handover HFs properly, there is dire need of bridging the gap between the Ministries (MOPH & LMD), Intraministerial (Divisions at MOPH, DOHS), Centre and District, DDC and D(P)HO, DDC and VDCs, D(P)HO and HFs, HFOMC and HF, HFOMC and community etc, as early as possible.

2.6 Activity Consolidation: Activities implemented under the name of PDO, REFLECT, PLA, FF, PARHI (UNFPA), DACAW (of UNICEF), RHIYA (UNFPA/EU), HSSP (GTZ), SSMP (DFID) etc and programmes of many NGOs and INGOs are working, in a way, in isolation. There should be a forum at the district level to consolidate the activities and avoid duplication of activities and resources with a mechanism established for supervision and monitoring at the district level.

2.7 Social Inclusion: Community mobilization activities for promoting social inclusion and promoting good governance practical should be emphasized in addition to technical inputs through training. Community friendly tools for monitoring good governance and social inclusion status (social audit) should be designed to applied for/with/through health facility operation and management communities. Involvement of Dalit/marginalized population is not adequate, but definitely a step towards (meaningful) participation.

ACTIONS TO BE TAKEN BY THE NFHP

2.8 Implement Community Empowerment Measures: Some simple yet effective and practical measures could be and should be applied to further strengthen the growing sense of ownership in the community, such as inclusion of HFOMC in the letter heads and sign boards of HFs, one of the HFOMC;s signature in the financial activities, involvement of HFOMC in the planning process of HFs and presentation of progress report and financial audit report in HFOMC meeting etc.

2.9 Performance Appraisal of HFOMC: A performance appraisal system among all HFOMC of the districts should be developed with simple indicators and on the basis of scoring system, HFOMCs performing best should be rewarded and

socially recognized. For those lower scoring HFs, inputs can be provided through I/NGOs and NGOs and other projects within the district.

2.10 Partnership Coherence and Teamwork: There are many organizations working in health area at the community level but there is no coherence among them. There is duplication of many activities too. Perhaps, a strong leadership at the local level can streamline this situation.

2.11 Effective Social and Community Mobilization: Means and mechanisms which are effective to mobilize the community should be designed and implemented, conducting the monthly meetings of HFOMC in the VDC wards in a rotational basis could generate create interest of the community in health matters, educate them, create awareness and provoke for more participation with the feeling of growing ownership and mobilize.

2.12 Need Based Additional Complementary Activities: Complementary activities at high demand sites (e.g. PLA class at Muslim community/Dalit Community) would add value of the program and help to minimize the gap between different geographical sub-sectors. Thus some interventions should be applied on blanket approach (e.g. HFOMC) in all areas and others should be applied as per the need/demand basis (e.g. PLA class) on specific sites only.

2.13 Programme Vs Event: Some programs are taking place as events rather than as process. Initiatives taken by projects should be linked to and inbuilt within the public health to ensure ownership and continuity of program impact.

2.14 Optimize/Maximize Public Health Service and Resource Utilization: A great deal of public health services have been made available at the health facilities by HMG and other Organization but there was concern found among the stakeholders towards promoting their utilization. Steps should be taken to encourage the utilization of these services as much as possible.

APPENDICES

Appendix - I

Composition of Sub-health Post Level HFOMC

1.	VDC Chairperson	Chairperson - 1
2.	Elected Women Representation of the HF located ward	Member - 1
3.	Health Worker of the VDC	Member - 1
4.	Head master of the local school	Member - 1
5.	FCHV nominated by the VDC in consultation of DPHO	Member - 1
6.	One representative from Dalit and one from, Janjatis	Member - 2
7.	A Women Social Worker representative	Member - 1
8.	HF In-charge	Member Secretary - 1

An workshop (half day) was conducted on 5 June 2006 involving various participants (see the participants list). Following is the preceding of the workshop.

SESSION 1: Presentations on the field work findings

a. Save the Children

Based on the visits conducted in Nawalparasi and Dhanusha and the identified gaps and the strengths of various community level interventions, SC shared the following bulleted points of recommendations:

Recommendations:

- working approach - collaborative effort of different INGO in one project to avoid duplication
- community mobilization approach e.g. HFOMC training, PDQ
- skill transfer to district health office staffs and community people
- involvement of dalit and marginalized
- continuity in some core activities e.g. Training/interaction with QI/HFOMC members
- since government has handed over all health facility to DDC, working through and with DDC in the next phase
- Involvement of RTC and RHTC
- Monitoring and evaluation through users or community itself
- Local resource mobilization
- some flexibility in program

b. Consultants

Based on the field visits conducted in Sunsari, Dhanusha and Chitwan, Consultants have also presented their recommendations.

Recommendations from Consultants:

Consultants have recommended 7 actions to be taken by the government and 7 actions to be taken by the NFHP. (See Recommendations section for detail)

SESSION II: Discussion

A. ***The Pieces*** **:** conditions required for success, effectiveness, efficiency, keep/drop (relative importance), how to improve

HF handover (Decentralization)
HFOMC strengthening
PDQ
REFLECT

Discussion on the aspects of HF handover, HFOMC strengthening, PDQ and REFLECT was done in terms of "Overall approach", "Conditions for success", "Effectiveness", "Efficiency" and "How to improve. Points such as "Management effectiveness", "service quality", "accountability" and "sustainability" were taken into account as a cross cutting issues.

Appendix –II

Factors for Improvements (as discussed in the workshop)

	Condition for success	Effectiveness	Efficiency	How to improve
HF handover	1. Clear Roles and Responsibilities. Communication/coordination among government bodies at central, district and VDC level 2. Staff and Communities should be ready (should have a mechanism) 3. Enough time	Representatives with Knowledge in management Chairs. (Committee members)	Reduce confusion of HWs	1. Demand Driven. 2. D (P) HO and DDC should be well coordinated.
HFOMC Strengthening	1. Selective and should be need based. 2. Uniformity among NFHP Partners			Restructure of HFOMC board on community participation Involvement of HF in all social mobilization techniques and inbuilt it into system
PDQ	Integrate – innovative approach – all activities – HFOMC strengthening, PDQ and REFLECT	Simple language, Process- Possible		
REFLECT		For accountability need a forum where community voice will be effectively heard.		

The bulleted points for the **overall approach** were as follows:

- Program Flexibility, tailoring need based and learning by doing
- Minimize transfer of Health Workers
- Review and Reflection of Performance /Progress periodically
- Concept of inclusion (Social, geographically) very important to address the gaps in service provisions and utilization and main streaming the excluded ones.
- Scoring monitoring system with reward and more input to poor performance of HFs.
- Strong monitoring system needed
- Integrated , not piece-meal e.g. Stronger links with routine technical, supports visits – and on going coaching
- Process oriented
- Local level capacity building steering committee
- Privatization sharing progress with community
- Increase Community Participation/HFs (with possible resources contribution/ control) - Design, Plan and implement.
- Identify and address the gaps in achievements
- With the possible resources contribution and control
- Capacity building of local level

B. Pulling the Pieces Together (an integrated package)

i. Future works (KEY WORDS)

- Service (Supply side)
- Service utilization and access (demand side)
- No “Canned “ set .
- Do not implement everything everywhere. (Community needs).
- Focus on “Tasks” not “Tools”
- Effective partnership between communities and service providers.
- Ownership
- Purpose – reaching the un-reached and hard to reach
- Accountability – reduce staff absenteeism
- Quality of service utilization/coverage
- use of district personnel for maintenance
- Sustainability
- Client satisfaction
- Events VS Process
- Trust between providers and receivers.
- Promoting /building on existing best practices
- Focusing on relationship and quality of relationship
- Inclusiveness, empowerment and competence/quality
- Linkages with regional level.
- Prioritization (WHO DECIDES?)
- “aacharan” (Behavior, attitudes, ethics and ownership)
- Common understanding and vision. (WHO DECIDES?)
- Intersect oral approaches (Coordination)
- Programs
    - Core set of activities (for example , some elements of HFOMC and PDQ should be included as a core elements, flexibility on REFLECT implementation in various district)
    - Need based set of activities
    - Stronger monitoring system (Focusing on changes of people’s lives)
    - Immediate and intensive follow up.

What should be the name of the future program (activities) (Proposed name)

- *Samudai swashthya sewa.*
- *Sarva sulav swastha sewa*
- *Santulit swasthwa sewa.*
- *Byabasthit swasthwa sewa.*
- *Hamro shajha swasthwa*
- *Hamro swashthya*
- *Sabai milera swasthwa ko sudhar.*
- *Hamro swasthya, hamro daieotya*

iii. Challenges (Assumptions/recommendations)

- Design
- Government ownership
- Activating government staff
- Resources requirements
- Political instability
- Staff transfer
- Implementation of policy-Policies not accepted.

Participants: (20 participants)

CARE - Nirmala Sharma, Deepak Poudel and Chahana Singh
SC/US - Bharat Shrestha
USAID - Dharmpal P Raman, Sita Ram Devkota, Anita Gibson, John Quinley
NFHP - Steve, Ashoke, Janardan, Dirgha, Madan, Buddhi, Bishwa, Hira, Sabita,
Consultants - Dr. B.D. Chautaut, Ganesh Gurung
NTAG - Ram K. Shrestha

Appendix III - CARE FIELD REPORT

NEPAL FAMILY HEALTH PROGRAM (NFHP)
CARE-Nepal

As a collaborating partner of NFHP, CARE Nepal is supporting in: decentralization/hand over of health facilities to local bodies; strengthening Health Facility Operation and Management Committees (HFOMCs); application of Partnership Defined Quality (PDQ) process; capacity building of community health workers (VHWs/MCHWs) on delivering FP and counselling services; strengthening PHC/ORC program and empowering communities to sensitize on their rights to health care through REFLECT approach. These program activities are expected to contribute in improving health status of Mother and Child in program districts through: (a) empowering community members through recognizing their rights (b) improving accountability of service providers (c) improving social inclusion status (d) improving access to and quality of FP/MCH services and (e) improving sustainability and cost effectiveness.

A qualitative assessment of the NFHP activities to strengthen the interaction between Community and Health Service System in 7 HFs (3 in Morang and 4 in Sunsari) of SC/US's Sunsari and Morang, was undertaken from Jan 16 – 18, 2006 and 15 – 18 Feb 2006 respectively. The assessment aims were to assess the extent to which a community level program is effective in establishing a relationship between the community and the health facility staff and on the basis of this information to make recommendations on which aspect of the program is more relatively important and better sense of how we need to be moving further.

Health facilities were selected purposively by SC/US district team considering concerns on accessibility, security and variation in program inputs/outcomes. The assessment team was split into two sub-groups and visited two sites by each sub-group member.

Qualitative research techniques of semi-structured interview, HFs observation and discussion were used to explore a number of themes : the knowledge of decentralization, Improving quality of services, Improving access (including by the socially marginalized), assistance in implementing HMG's decentralization of management authority (HFs handover), complementary work (3 days training) aimed at strengthening health facility operation and management committees., PDQ work , Participatory Learning and Action (PLA) and others.

STUDY AREA:

Sunsari district

- Baklauri Health Post , Haripur SHP, Bakraha SHP and Basantpur SHP

Morang district

- Baijanathpur SHP, Dadarbaeriya HP and Dulari SHP

SOURCES AND METHODS OF INFORMATION COLLECTION:

- Interview with District Public Health Officer/ Administrative
- Interview with health facilities in charge.
- Interview with selected health facilities staff and record review of selected health facilities.
- Interview with HFOMC member
- Interview and interaction with FCHVs
- Interview with Planning Officer DDC
- Interview/interaction with Participatory Learning and Action (PLA) Groups
- Interaction with NFHP and SC/US project staff

OBSERVATIONS AND LESSONS LEARNT

1. Health Facility handover process was carried out and accomplished in relatively rush manner, without adequate preparation at district and community level. Community (including HFOMC and HF staff) were not fully informed and 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 the some state of confusion. Thus, DDC, VDC and other local influential should be more engaged on the process of decentralization of health facilities.

2. Only HF In-charge participated the HFOMC training and other HFOMC related activities. This limits other health workers' understanding and critical engagement in HFOMC functions.

3. HFOMC meetings are becoming regular after HF handover and HFOMC training and follow-up, but those meetings are found to be mainly dominated by HF In-charge and their interest. The HFOMC meetings agenda were revolved around the issues of drug availability, HF infrastructure and health commodities. Discussion on issues related to service quality, service access for poor and vulnerable people, the analysis of trends of health problems at health facility were rarely discussed on the HFOMC meetings. Thus, proper guidance for identification of issues for discussion, analysis of the local context and taking appropriate actions is necessary.

4. Participation of *dalit*, *janjati* and woman members in HFOMCs is just a token. Agenda of their interest are rarely discussed, their voice were almost unheard. In some cases, they were just asked to put their signatures on the meeting minutes.

5. The PDQ process was found quite instrumental in improving the quality of the services and empowering communities to claim their rights to health services. This approach also has created environment for dialogue and conversation between health workers (service providers) and community people (service utilisers). Though, the process was objected by health workers in initial days, it was found useful in building harmony between providers and consumers as the process moved on. This approach has been found most useful to make health workers accountable towards communities.

6. Some of the community based empowerment exercises such as (Regenerated Frerian Literacy through Empowering Community Technique) REFLECT and (Participatory Learning and Actions) PLA activities are found useful for awareness raising and sensitizing them 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 on rights issues are found to be helpful especially in linking them to health between the communities and health facilities/services.

RECOMMENDATIONS

1. District Development Committee should be more engaged in the process of decentralization (handover) of health facilities to local bodies (VDCs/Municipalities). The central level decisions should not just be sent out to the districts and expect the district officials to understand and apply the policy decisions on decentralization. Program should also focus on creating a common understanding, among the districts based authorities, building capacity of DDC and activate their systems to monitor the functions of peripheral health facilities after decentralization.

2. All health workers should be oriented on the decentralized functions of health facilities during HFOMC training and follow-up. Though, other health workers are not the members of HFOMCs, there should be a mechanism to include the other HWs as well (e.g. allowing them to participate as observers), whenever possible or informed by HF in-charge after HFOMC training.

3. HFOMC should be guided to discuss on broad range of issues related to equity in health services, social and geographic exclusions to access health services, making the service delivery reports inclusive at the health facility levels, quality of services delivered by health facilities etc.

4. Special/focused activities are necessary to empower dalit, janajati and women members for their active and meaningful participation at HFOMC meetings. This can be achieved jointly if the HFOMC members and HWs are oriented on importance of the active participation of dalit, janajati and women members.

5. The empowerment techniques such as PDQ and REFLECT can be helpful in harmonizing the relationship between health workers and communities. Such exercises should be expanded to other areas as well. Immediate and intensive follow-up is necessary to make it a process, not just an event so that it can be continued for longer period

6. FCHV's capacity should be enhanced in the areas of leadership, networking, social mobilization and analyzing local context, issues and advocacy efforts. FCHV's should be mobilized as local activists for community empowerment and advocacy efforts.

7. More harmonized relationship and coordination between (NFHP) partners and counterpart should be established. Central and regional health mangers of MoHP should be oriented on new approaches being implemented through NFHP and engaged on program planning, monitoring and evaluation. Planned and evidence

based advocacy efforts are required to mainstream and integrate/replicate successful strategies/ techniques (like PDQ and REFLECT) within the MoHP public health system.

8. Program monitoring and evaluation system should be enhanced. Program monitoring should not be limited to assessing the technical indicators. Monitoring system should be able to capture '*changes in people's life'* not only the '*change in physical structure*' of health system and '*improved capacity of health workers*'. Therefore monitoring technique should focus on quality aspects and going away from the quantitative indicators

9. Program should focus on strengthening system than on building individual capacity. Activities of current NFHP were designed primarily to enhance capacity and competence of health workers and volunteers. Efforts should be made to make health workers and managers responsible, accountable and responsive to community needs as health institutions.

10. Specific and focused strategies and interventions to uplift the situation and positions of dalit, jananjati and women are necessary to improve their health status. The usual blanket approach to uplift the social status of both 'marginalized' and 'other' population group has proven to be in effective therefore target groups specific strategy and interventions should be applied to bring significant change in the life of poor, vulnerable and socially excluded people.

11. Efforts should be put on harmonizing different program interventions and linked each other to develop synergistic effects. For this, core set of activities should be implemented throughout the program districts (and VDCs) but specific activities to be implemented as per the local need and context. The set of activities should be tailored-made to meet the specific target groups' needs and local context.

12. "Fill in the Gap" support at district and community level is necessary. Program should be flexible enough to accommodate district level needs and requirements, than planning new sets of activities which is time consuming and also costlier.

Appendix IV- SAVE FIELD REPORT

Assessment of NFHP Activities
To strengthen the interaction between
Community and Health Service System

INTRODUCTION:

A qualitative assessment of the NFHP activities to strengthen the interaction between Community and Health Service System in 8 HFs of CARE's Nawalparasi and Dhanusha, 4 in each district was undertaken from Jan 10–12, 2006 and 02–04 March, 2006 respectively. The assessment aims were to assess the extent to which a community level program is effective in establishing a relationship between the community and the health facility staff and on the basis of this information to make recommendations on which aspect of the program is more relatively important and better sense of how we need to be moving further.

Health facilities were selected purposively by Care district team considering concerns on accessibility, security and variation in program inputs/outcomes. The assessment team was split into two sub-groups and visited two sites by each sub-group member.

Qualitative research techniques of semi-structured interview, HFs observation and discussion were used to explore a number of themes : the knowledge of decentralization, Improving quality of services, Improving access (including by the socially marginalized), assistance in implementing HMG's decentralization of management authority (HFs handover), complementary work (3 days training) aimed at strengthening health facility operation and management committees, PDQ work, REFLECT, Participatory Learning and Action (PLA) and others.

STUDY AREA:

Nawalparashi district

- Shivapurmandir SHP, Harpur SHP, Tilakpur SHP and Pithoulia SHP

Dhanusha district

- Kurtha SHP Lovtoli SHP Yagyabhumi SHP Dalkebhar HP

SOURCES AND METHODS OF INFORMATION COLLECTION:

- Interview with District Public Health Office, Nawalparasi district
- Interview with health facilities in charge.
- Interview with selected health facilities staff and record review of selected health facilities.
- Interview with HFOMC member
- Interview and interaction with FCHVs –
- Interview with REFLECT member.
- Interview/Discussion with HFOMC /QI member
- Discussion with MGs member

RECOMMENDATIONS AND AREA OF IMPROVEMENT:

- Though marginalized and dalits are included, they just participate in the meetings, they do not participate in the discussion. **Regular coaching should be given to them** to make them capable.

- Staffs recommend that PDQ and HFOMC should be implemented as comprehensive package (this saves time and resources)

- Regarding the management aspect, it is suggested that the activities of Care NFHP and NFHP be merged.

- HFs handover seems as politically driven, no mechanism has been observed to transfer the responsibility and accountability to the HFOMC member. There was no proper planning in the handover process, still the member are confused about their roles and responsibilities. DDC member and DPHO staff were not oriented properly.

- A meeting between DPHO and DDC should be done frequently to discuss about the beneficial results of decentralization.

- DPHO feels that decentralization has been a management burden for them.

- Continuity in some core activities e.g. training /interaction with QI/HFoMC members

- Involvement of regional health training center and Regional health directorate.

- Some flexibility in program

- Working approach: collaborative effort of different INGO in one project.

- Skill transfer to district health office staff and community people.

EXPERIENCE FROM SAVE (USA) THE CHILDREN

Program	Strength	Weakness	Recommendations
PDQ Process Implementation	• Good community Mobilization and participation approach • partnering between health staff/committee and community people • Social inclusion • Problem identification/solving • Exploration and utilization of local resources • Regular meeting • Role and responsibilities clarification and feeling by both HF staffs and HFOMC members- Ownership feeling • Information to community people about available services from the HFs. • Social audit and pressure group for quality improvement. • Promotion of CDP and other new initiatives • Responsible behavior by health staffs • Follow of MoHP policy and rules/regulation by HF staffs • Capacity building of HF staffs and community • mutual understanding on health issues	• High coverage low monitoring and follow up • Some of HFOMC/ QIT members have not clear concept of community mobilization and PDQ. • Policy level issues of additional members • HFOMC /QIT members give priority to infrastructure and financial issues. • Not clear cut guidelines, guidebook and M&E tools. • inadequate follow up	• The additional representation of PDQ member at the HFOMC is very good but however we recommend that the added values of additional members should be assessed. • Not Specific indicators to measure outcome/impact of PDQ- Need to be reviewed. • PDQ should be continuous process and not one shot event so HFOMC/QIT should know the concept of Community Mobilization. • PDQ and HFOMC need to be merged and there should be integrated package. • Need of refresher training • Need of advocacy/ orientation program at regional and national level.
HFOMC capacity assessment and strengthening	• Capacity assessment/self assessment • Capacity building • Realization and reinforcement to HFoMC to shoulder the responsibilities. • Promotion of coordination and linkage.	• Situational problem (absence of chairperson, illiterate/ inactive HFOMC member), • Level of understanding problem by HFOMC member – especially Management terminology and concept.	• It should be a part of community mobilization process and not one shot event/training. • Address the issues of social inclusion. • Need of refresher training

Appendix –V

People Met by Dr. B.D Chataut and Ganesh Gurung during field visit.

Name	Post	Organization
Shree Hari Sharma	Field officer	NFHP/Chitwan
Ram Nath Yogi	Training officer	CARE/NFHP
Khim B.Khadka	District Health Coordinator	"/Chitwan
Sabitri Pandey	Research, Monitoring & Documentation officer	CARE/NFHP
Shanti Dhami	Health Supervisor	"/Chitwan
Birendra Mahat	Health Supervisor	"
Debendra Adhikari	Project Officer	CARE/NFHP/Dhanusah
Parash Phuyal	Field Officer	&Mahottari
Rajendra Chaudhari	Field officer	NFHP/Dhanusha
Devendra Karki	Field officer	NFHP/Dhanusha
Hira Tiwari	Field Team Leader	NFHP
Binod Singh	LDO	DDC
Bishnu B. Thapa	Chairman	"
Shanker Prasad Dahal	Chairman	"
Durga Chapagain		DPHO /Chitwan
Karya Yadav		Laxmipur High School
Dibas Chandra Mishra	Secretary	VDC
Mr. Krishna Guragain	"	"
Bal Bod Ray	Incharge Ghodegham HP	SAP
Chandra Bhusan Thakur	Incharge Phulgama SHP	AHW
Rajendra Yadav	Supervisor	CFWA
Urmila Lama	Facilitator	"
Rita Shah	"	"
Siribati Das	Participant	PLA
Hari Devi Mandal	"	PLA
Navaraj Lama	Coordinator	Infreni
Dr. Varaj Kishor Thakur		DHO
Mr. Rakesh Thakur		PHA
Tara Nath Acharya	BCCO	Save the Children
Mr. Dulal	Chair/DDC	SC
Mr. Lila Mani Sharma		"
Mr. Laxman Khat	Member	HC/SHC
Mr. Damber Pokhrel	"	"
Ms. Bindi Khat	"	"
Mr. Kedar Nepal		"
Ms. Laxmi Bhujel	"	"
Mr. Subhadra Adhikari	"	"
Mr. Santosh Dev	SAHW	SHP Babiya
Ms.Nilam Yadav		FCHV
Ms.Kalpana Khadka		"
Ms. Sita Bhujel		"
Ms. Siya Chaudhari		"
Ms. Sharada Sigdel		MCHW
Mr. Mithas Mehta		AHW

Appendix - VI

Scope of Work for assessment of NFHP Activities at the Meeting Point between Communities and Service Providers

Problem Statement:

Peripheral public-sector health services in Nepal are constrained by manpower and infrastructure limitations. However, within these limitations there is still scope for:

- improving quality of services,
- improving access (including by the socially marginalized),
- achieving greater public health impact, and
- developing relations between community and service provider that render continued provision of services more robust in the face of political and security turbulence.

Among the various activities that NFHP is involved with at community level, perhaps most important are those dealing with the *relationship between communities and the health professionals and facilities* providing them health services. Varying by district and VDC, these activities include various combinations of the following:

- assistance in implementing HMG's decentralization of management authority (sub-health-post handover),
- complementary work aimed at strengthening health facility management committees (based on ADRAs experience in Rasuwa),
- PDQ work (based on a PI/PLA model developed by SAVE and INTRAH),
- CARE's work using REFLECT and others.

Rationale for an Assessment:

Our diversity of experience under NFHP provides us a good opportunity to review

- what *resource inputs* are required,
- what particular *benefits* and *costs* derive from each activity,
- what their optimal role is,
- what kinds of synergies we see between these interventions,
- efficiency,
- scaleability, etc.

NFHP is nearing the beginning of its final year of implementation; for us, for USAID, and for other partners, *now* is an appropriate time to review experience to date and to formulate strategy for the future.

Furthermore, the government itself is dealing with issues of how to optimally decentralize, how to more constructively address social exclusion and how to continue to effectively deliver health services in the face of the conflict. We are well placed to contribute to national-level strategic discussion on such issues but, to do so, we need to clarify what lessons can be drawn from our experience to date.

Proposed Process:

- Preparation of assessment plan including:
  - scope of work for independent evaluator(s),
  - detailed interview guides/ templates for CARE/ SC cross-visits.

- Collection/ aggregation of relevant data already available (HMIS, LQAS, etc).
- Cross-visits by CARE/ SC, visiting a random selection of intervention VDCs (including FF areas), assessing *performance, consequences of inputs, costs*, etc (using standardized templates) and discussing approaches and impact with host implementers.
- Similar (but independent) process by independent evaluator (including key-informant and FG interviews, document review, etc.)
- Review workshop/ roundtable discussion (possibly with some role by independent assessor?).
- Write up process, results, conclusions, recommendations (role for independent assessor?).

Participants:

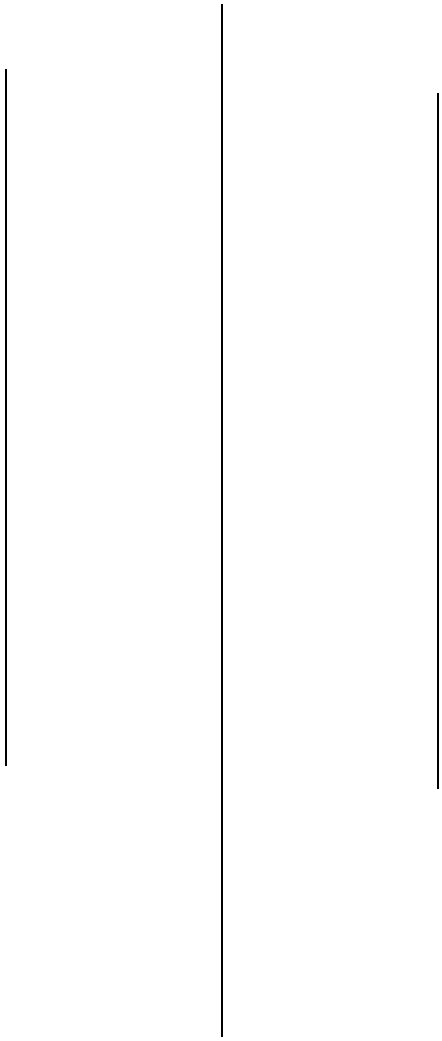
- NFHP/ CARE & SC staff who've been involved in implementing these activities
- Selected NFHP/JSI, EH, JHU staff (central and field)
- NTAG?
- Outside consultant (1 or 2), content expert(s) in community development/ mobilization, conscientization, peace-conflict, decentralization
- USAID?
- NHTC, Arjun B Singh (at least for certain parts)?

Expected Outputs:

A report including process, results, and consensus recommendations (for a *unified strategic approach, replicable at scale and linking with HMG decentralization effort*) for USAID, HMG, and other partners involved in similar work.

ANNEX : I

Assessment of NFHP Activities To strengthen the interaction between Community and Health Service System



Field Trip Report
DHANUSHA
Phase 1 district
02 – 04 March 2006

Assessment of NFHP Activities to strengthen the interaction between Community and Health Service System

GENERAL

District	:	Dhanusha
Field period	:	02 - 04 March 2006
Implementing Agency	:	CARE Nepal
Program Phase	:	Phase I district

[Dhanusha is one of the Terai district of Eastern Nepal with 715,458 populations (2001-2002 DHS Annual Report): 101 Village Development Committees, and 102 health facilities that include 5 PHC, 9 HP and 88 SHP. CARE Nepal implemented 1st phase of Nepal Family Health Program (NFHP) in 2002- 2004 and reentered in Dec 2005 for 2nd phase activities, mainly focusing on follow up of the activities. As other NFHP districts major activities of the Dhanusha are Partner Defined Quality (PDQ) application, PDQ follow up workshop, support DPHO for HF handover (Decentralization), Capacity assessment and strengthening of HFOMC member, support in Ilaka level meeting and FP refresher training for VHWs and MCHWs.]

Executive Summary

The qualitative assessment process used participatory approach, as guided by the core assessment team. The objective, purpose, methodology and coverage of the assessment were briefed among the assessment team and key respondents. The assessment team spent three days (02- 04 March, 2006) at Janakpur (for information gathering from DPHO) and four selected field sites (Kurtha SHP, Lavtoli SHP, Yagyabhumu SHP and Dalkebhar HP). Health facilities were selected by Care district team considering concerns on accessibility, security and variation in program inputs/outcomes. The assessment team was split into two sub-groups and visited two sites by each sub-group member. Discussion was held between the members of the team after returning from the field on the same day. Pre-designed interview guidelines were used for information collection from DPHO, HF In-charge, HFOMC Members and FCHVs). Observation and discussion were used to explore a number of themes: the knowledge of decentralization, Improving quality of services, Improving access (including by the socially marginalized), assistance in implementing HMG's decentralization of management authority (HFs handover), complementary work (3 days training) aimed at capacity assessment and strengthening health facility operation and management committees, PDQ work, Participatory Learning and Action (PLA) and others.

One event of interactive group discussion was also conducted with Care and NFHP staff working for Dhanusha district. Mr. Ram Kumar shrestha was also involved as an observer during this assessment period.

Persons involved:

- Madan R. Thapa, Team Leader, FCT Nepal Family Health Program , Kathmandu
- Chandra Rai , Senior Program Officer , SC/US Kathmandu
- Gagan Gurung , Project Officer, SC/US, Morang
- Paras Phuyal , Field Officer, NFHP Dhanusha
- Devendra Adhikari , Care, Dhanusha

Observer:

- Ram Kumar Shrestha, Executive Director, NTAG

Sources and methods of information collection:

- Interview with Mr. Indra Prasad Yadav District Public Health Officer , Dhanusha District Public Health Office, Dhanusha
- Interview and Record Review of selected Health Facilities (Dhalkebar Health Post, Kurtha Sub Health Post, Lavtoli Sub Health Post, Yagya bhumi SHP)
- Interview with Health Facility Operation and Management Committee (HFOMC) members -- including *dalit* members from QI team
- Interview and interaction with Female Community Health Volunteers (FCHV)
- Interaction with Care -NFHP staff

Field work

The assessment team visited 4 HFs (Kurtha SHP, Dhalkebar HP, Lovtolli SHP and Yagyabhumi SHP), and DPHO as given in the matrix

Date visited	Name of HF	QI/HFOMC member/ HFI	FCHVs	DPHO	VHW/ MCHW/ ANM/ Mukhiya
2 Mar 2006	Kurtha SHP	5	2		2
3 Mar 2006	DPHO			1	
3 Mar 2006	Lovtoli SHP	4	2		1
3 Mar 2006	Yagyabhumi SHP	5	1		2
3 Mar 2006	Dalkebhar	3			4
04 Mar 2006	Interaction with Care staff				

SUMMARY OF FINDINGS

Strengths

Kurtha SHP

Kurtha SHP – is 15 minutes drive from Janakpur city. Its total population is 7415 including 1421 the 15-49 years of MWRA. And 1030 under five years of children.

This SHP is a PDQ implemented health facilities in phase one and has done follow up workshop in phase two, The other activities includes : QI team support, support in HF handover (advocacy and orientation training), capacity assessment and strengthen training to HFOMC members, exposure visit, FP refresher training, ilaka review meeting and FCHV support.

PDQ and HFOMC implemented about 2 years ago (exact date not known). The HFOMC members feel more empowered and some changes brought in the SHP:

- Regularity (the 5th day of every month) of the QI/HFOMC meeting since the PDQ and HFOMC training had conducted. Meeting minutes checked. The last meeting

conducted on 2062- 11- 5. Out of 11 members 7 attended the meeting. Main agenda of the last meeting was 2nd round SNID program.

- Reactivated mother's group meeting and regularity of the meeting. Based on their version the mothers' group members and FCHV are being mobilized well.
- HF opens timely and full clinic hour. Since Poush 14 2062 the clinic started to run from 10 – 5 pm. One of the QI team member said "it used to open for short time and health workers come once in 4-5 day and sign for whole in the attendance register. Now I can tell if the health workers do not follow the rules".
- Service utilization for ANC and PNC has been increased. Date for ANC/PNC services and place fixed in coordination with FPAN. Since the SHP has only one room the FPAN clinic is being used by the SHP all day except Monday.
- Dhanusha district including Kurtha SHP has been using local media to disseminate message. E.g. digdigi through peon of VDC.
- Capacity of QI/HFOMC members (some members) has been increased. E.g. awareness on one's role and responsibilities, service availability from the SHP.

Labhtoli SHP

- Members are aware of role and responsibilities of HFoMC they know about the health services provided by health facilities. In their view, it was due to the advocacy workshop complimented by 3 days HFoMC strengthening workshop organized on Mangshir 2061.
- Improved environment cleanliness in health facilities- Before, there was not proper disposal system of medical and non medical waste, rampant dumping of waste. This issue was raised on HFoMC meeting on Aswin 2062 and decision was made to construct incinerator. Local resources like sand, brick and labor from community were tapped and other support like rods and technical support is asked with NFHP field office. Now it was observed that improved sanitation in health facilities and sharp needles and other waste are also collected from the out reach (PHC ORC and Immunization) and disposed at health facilities (incinerator and pits).
- Regularity of the meeting – meeting is regular with regular review of past progress, income and expenditure (BUDGET status), re- assessment of HFoMC capacity. There is practice of sharing the decision of HFoMC committee to concerns – FCHV who is representative in HFoMC has practice of sharing the information to rest of the FCHVs in monthly FCHV meeting. Similarly issues of the FCHVs and other community are channalised to HFoMC meeting thro their representative (FCHV who is HFOMC member).
- Initiated division of role and responsibilities among members making written decision.
- Prepared annual work plan and members have awarded of their work plan and its progress. So far, 5 out of 8 activities listed in work plan are finished and others are on the progress.
- Initiated a mass mobilization, an example of simple community mobilization during condom day celebration. HFoMC meeting took decision and celebrated the day in coordination with CMC group (income generation group thro' DDC/LGP) organizing street drama and rally.
- Give continuation of Growth monitoring program initiated by ASMAN Nepal. Those children who are malnourished are detected at PHC/ORC and health facilities and a demonstrative nutritious meal (named Khichadi pradasan) are prepared at community (with all resources like green veg, rice, and other locally

available foods) to facilitate a positive behavior. This is some what like a facilitation of positive deviance strategies used in nutrition.

Dhalkebar HP (COPE and non PDQ and Non HFOMC strengthening program)

- Both health facility committee and staff are active and confidence in their potential, role and responsibilities.
- A sense of ownership towards health facilities seen in both staff and committee members
- Utilized maximum local and VDC resources
    - Constructed clean drinking water facilities (dig well). Community contributed 10,000 and remaining 110000 were tapped from VDC for this work.
    - Initiated construction of delivery unit (prashuti kakchYa). For this work they managed to collect 50000 from VDC, local community commitment for brick, sand and labor. HP it self will use its OPD budget of 140000. Care Nepal and NFHP field office support a technical help.
    - They have partitioned the room for ANC and observation room with support from local plywood factory.
    - In short, they have a confidence, and commitment for utilizing the local resources for the health improvement.
- COPE facilitates the quality aspect in health facility. After the orientation, meeting are regular, raise the quality issues regularly, analyze the findings come from the client who utilize the service and response accordingly. Some tangible results are
    - Good IP practices
    - Clear job description and division of work
    - Built mutual trust
    - They internalized that quality is not expensive but can be maintained in existing system and condition.
- Extension of other services like- lab services, delivery services, 24 hour emergency services, separate prashuti kakchya.
- Generated extra resources through – training hall rent, delivery charge (of which certain amount goes to attendants/ health worker and remaining 25% collect in committee accounts.

Yagya bhumi SHP

- HFOMC has been active to conduct the regular meeting. (From the minute books it looks that there are altogether 38 meeting have been taken place.).
- Majority of the members said they knew the types of services provided by health facilities. They think the great achievement of the HFOMC is
    - Construction of boundary wall
    - Construction of Incinerator with the support form NFHP/Care
    - Electricity wiring in the SHP building
    - Establishment of FCHVs endowment fund
    - Regularity in the various health services.

Weaknesses

Kurtha SHP

- As per spider web and meeting minutes the members felt their planning is good but weak in the implementation.
- Lack of internal resource mobilization to address the quality issues. One of the main reasons for this is due to no coordination between VDC chair and HFOMC members. As per HFOMC members the FPAN is interested to handover the building to SHP matching with HF/VDC fund. This is not happening. The members think this is due to the Chairperson absence in the meeting and not supportive.
- The meeting agenda are usually the sharing national activities to be implemented at SHP level but agenda related quality issues and financial status were not seen.
- Marginalized/dalit representatives from Focused Group Discussion were not involved in the QI/HFOMC team. Out of 4 QI/team, 3 were from Pro-public, mother's group and Sathi Sikchak.

Lavtoli SHP

- Gap in local resource mobilization especially VDC resources. Even though, VDC chairperson positive in supporting health sector, there is very minimal support thro' VDC except monthly 100 rupees support for each FCHV. And there is no good reason for scarcity in VDC resource to support for health sector. This finding contradicts with the increasing trend of resource mobilization shown in capacity assessment of HFoMC (2nd time). The spider web analysis showed a sharp increase trend in resource mobilization from 7 to 13.

Dhalkebar HP

- No balanced committee- it was obvious because there is no new committee formed as per MOH guideline (not a single woman or Dalit).
- Concerns of committee mostly focus on extension of infrastructure and services but less focus on mobilizing community, and community participation.
- In charge and other committee member what they felt necessary are initiated rather than taking any feedbacks from community creating such system

Opportunity

- Utilization of VDC resources. (Labtoli and Kurtha SHP)

Dhalkebar HP

- Interaction of committee members and COPE initiatives which now confined with in the horizon of staffs.
- Restructure the committee with the efforts of DPHO/DDC/NFHP/Care- but incorporate the present member who is influential and active. Acknowledge the contribution of members by any means.
- What really works or not should be analyzed looking the process in broad framework. Because, even in the existing political turmoil, with the same support system (DPHO and other EDP), in some health facilities, the process is well

functioning and in some not functioning at all. It might be difficult to find such minor thread/ fine line /strand but it is high time to be critical as far as possible. Overtly it seems that, where in-chare is active, community is mixed, the group dynamic of HFoMC seems very satisfactory where as in case of inactive (so called) in-chares, and community dominated by terai caste/ethnicity only, opposite is true.

Threat

- Might develop dependency creation. The SHP has been receiving support through CARE and NFHP to address the quality issues identified by the HFOMC.
- In case of Dhalkebahar HP, it seems a bit ambitious favoring one-man enterprises. There should be a gradual process of improving leadership among the other committee members and rest of the community people (there might be the other hidden potentialities)

Recommendation (from the HFOMC members, in charges and CARE staff)

- Focus should be given to preventive work and awareness creation activities.
- Build linkage in district level leadership (DDC/ DPHO) by coordination meeting and also facilitate this process in RHCC forum.

Conclusion:

THE EFFORTS MADE BY CARE NFHP AND NFHP FIELD OFFICE IN COLLABORATION WITH DPHO AND OTHER STAKEHOLDERS IS REALLY A RESULT WORTHY, THEIR SENSE OF IMPORTANCE OF DECENTRALIZATION, USEFULNESS AND CONFIDENCE TO WORK IS BEING INCREASED UNDOUBTED, THERE IS SIGNIFICANT CHANGES IN THE COMMUNITY CAPACITY INCLUDING HF STAFF IN DECENTRALIZATION EFFORTS, COMMUNITY PARTICIPATION AND MOBILIZATION. AT LEAST THEY ARE AWARE OF THEIR ROLE AND RESPONSIBILITIES WITH PARTIALLY BUILD THEIR CONFIDENCE/CAPACITY IN HEALTH FACILITY MANAGEMENT. FURTHER EFFORT IS DEEMED IMPORTANT IN BUILDING THEIR ORGANIZATIONAL/INSTITUTIONAL CAPACITY IN DIFFERENT AREAS LIKE LEADERSHIP, EXTERNAL RESOURCE MOBILIZATION, FINANCIAL MANAGEMENT, AND ADVOCACY (SO THAT THEY CAN DIALOGUE/CREATE PRESSURE).

- **Name list of QI/HFOMC members of Kurtha SHP**

1. Nabin Kumar Jha – Chairperson
2. Kameshwor Prasad Singh – member (head teacher)
3. Geeta Mandal – member (w. no 9)
4. Sabita Mandal – member (w. no 5)
5. Bhogendra Raya – member (w. no 7)
6. Ram Ekal Mandal – member (dalit w. no 4)
7. Meena Mahaseth – member (w no. 2)
8. Laxman Shaha – Secretary (SHPI)
9. Pinki Shaha – QI team member from mother's group (w no. 7)
10. Sunil Kumar Jha – QI team member (w. no 8)
11. Gaya Das – QI team member (w. No 9)
12. Chandra Kala Jha – FCHV
13. Mahalaxmi Jhap – FCHV
14. Anita Shaha – ANM
15. Prabha Dahal – VHW

- **Participants during interview in Kurtha SHP**

1. Ram Ekal Mandal – member (dalit w. no 4)
2. Meena Mahaseth – member (w no. 2)
3. Laxman Shaha – Secretary (SHPI)
4. Pinki Shaha – QI team member from mother's group (w no. 7)
5. Sunil Kumar Jha – QI team member (w. no 8)
6. Chandra Kala Jha – FCHV
7. Mahalaxmi Jhap – FCHV
8. Anita Shaha – ANM
9. Prabha Dahal – VHW

- **Name list of QI/HFOMC members of Lavtoli SHP**

Birju Paswan member
Durga Devi Ghimire (member
Manoj K, Mahato
Urmila Tamang FCHV
Kalpana Thapa , FCHV

Tools used for interview

1. Interview Guide Questionnaire for DHO/DPHO/Health Facility in-charges (Tool #1)
2. Information Collection Guide for Health facility Management Committee (Tool # 2)
3. Discussion Guide for Dalit /QI team Health facility Management Committee (Tool # 3)
4. Discussion Guide for Female Community Volunteers (Tool # 4)
5. Interview Guide Questionnaire for DDC member and LDO (Tool # 5)

- **Interview and discussion with HFOMC member in Yagya bhumi SHP**

The HFOMC is comprised of 11 members. Interview was taken with following HFOMC members and social workers. Some of the HFOMC members were not present at the time of interview:

1. Ishwor Pd. Ghimire (Chairman, SHOMC) – Absent
2. Baliram Yadav (SHPI, member secretary)
3. Mrs. Bidhya Devi Bhujel (members, FCHV representative)
4. Mr. Shyam Bahadur Bhujel (members, Social worker)
5. Mr. Laxmi Narayan Mandal (members)
6. Mr. Chakra Bahadur Bishwokarma (Member, Dalit representative)
7. Ram Yash Yadav(Member) – Absent.

- The HFOMC members said that the health facility was handed over 2 yrs back. (BS 2060) They received 2 day NHTC developed orientation/training and 3 day NFHP developed HFOMC strengthening training.

- The last meeting conducted by the HFOMC was regular. (From the minute books it looks that there are altogether 38 meeting have been taken place.).

- Majority of the members said they knew the types of services provided by health facilities. They think the great achievement of the HFOMC is

    - Construction of boundary wall
    - Eraction of Incinerator with the support form NFHP/Care
    - Electricity wiring in the SHP building
    - Establishment of FCHVs endownment fund
    - Regularity in the various health services.

- The HFOMC strengthening training helps us to assess (spider web) where we were taught us to unite. Previously the meeting was irregular but now it has become a more frequently.

- Regarding the service availability in the health facility- since the SHPI is busy in the work and other official work, one more local AHW has been hired through private fund (individual donor) to work for TB follow up. Previously the SHP use to open 12 – 2 but started to open from 10 – 4 nowadays.

- When we asked about their suggestion or recommendation to improve the health service, they mentioned existing drug supply through district is not practical. Due to the mismatch in demand and supply of drugs chances of expiry of the supplied drugs are high. It would be nice if the local body could buy the drugs according to their need at the community level.

Interview and discussion with FCHVs of Yagya Bhumi SHP

Respondent: **Ms Bidhya Devi Bhujel ,** ward # 4,
(Bidhya Devi Bhujel 4, She has been working since BS 2045 (17 years of experience working as FCHVs)

- After the hand over, all FCHVs are meeting every month and discuss about the various health issues.

- She has been involved in the different health activities such as Vit A supplementation program, immunization clinic, polio mop up and health education to pregnant women and children. She gives a letter written by SHPI to immunized children and follow up them.

- They have raised FCHV fund by their own collecting Rs 50/ by each FCHVs since 4 yrs. SHPI helps to keep record of the fund. This fund has been used by the FCHV when needed.

- **Name list of QI/HFOMC members of Dhalkebhar**

1. Kul Bahadur shantang – Advisor
2. Ram Dular Mahato - Vice Chairman
3. Girendra K. Jha – HP In charge.

Discussion with NFHP Field staff (Care and NFHP)

04 March, 2006
Participants:

- Devendra Adhikari, PO , Care-NFHP
- Harimaya Luintel , HS , Care /NFHP
- Raj Kumar Mahato , Care
- Dhundhi Ra. Gyawali, HS, Care/NFHP
- Shushila Jha, Asst M&E Officer
- Paras Phuyal , FO, NFHP

We shared the objective of discussion with the district team. Our sharing issues were

1. Sharing on technical areas (programs, quantitative and qualitative achievement, their impact on accountability, responsibility, governance, social inclusion and community development)

2. Sharing on management areas –staffing, working modality, organizational identity.

- PDQ has been implemented in only 5 HFs
- The HFOMC members are aware about their roles and responsibilities but they are not very active, even today the Health post in charge takes the lead in making decision.
- Regarding social inclusion, dalits/Jajati and marginalized are included in the QI team but it seems that it does not look proper representation.

Areas for improvement and Recommendations for future

- Though marginalized and dalits are included, they just participate in the meetings, they do not participate in the discussion. **Regular coaching should be given to them** to make them capable.

- Staffs recommend that PDQ and HFOMC should be implemented as comprehensive package (this saves time and resources)

- Regarding the management aspect, it is suggested that the activities of Care NFHP and NFHP be merged.

- HFs handover seems as politically driven, no mechanism has been observed to transfer the responsibility and accountability to the HFOMC member. There was no proper planning in the handover process, still the member are confused about their roles and responsibilities. DDC member and DPHO staff were not oriented properly.

- A meeting between DPHO and DDC should be done frequently to discuss about the beneficial results of decentralization.

- DPHO feels that decentralization has been a management burden for them.

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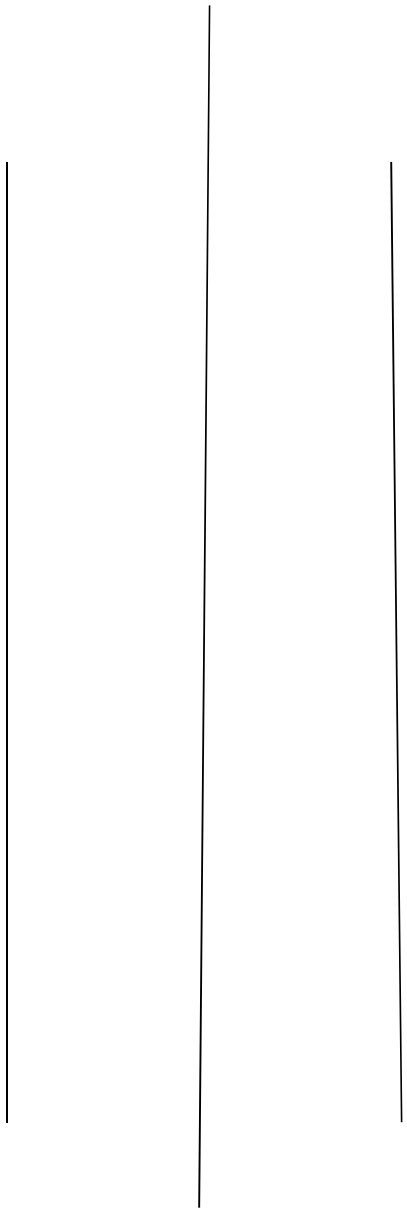
ANNEX II

Assessment of NFHP Activities to strengthen the interaction between Community and Health Service System



Field Trip Report
MORANG
Phase 11 district
15 – 18, February
2006

Assessment of NFHP Activities to strengthen the interaction between Community and Health Service System

GENERAL

District : Morang
Field period : 15-18 February 2006
Implementing Agency : Save the Children US
Program Phase : Phase II district

[Morang is one of the Terai district of Eastern Nepal; with 625,633 population (2001 CBS); 50 Village Development Committees, three municipalities; having one district hospital, 5 Primary Health Care Centers, 7 Health Posts, 41 Sub Health Post and 1064 Female Community Health Volunteers. Save the Children US is currently implementing key NFHP interventions to strengthen the delivery and use of high impact FP/MCH services at household and community level during July 2004 - Dec 2006. Plan Nepal, BNMT, Marie Stopes Clinic, NLR, ADRA Nepal, CBR, RedCross, Rotery, World Vision Nepal, UNICEF, WHO and UNFPA are other key external development partners supporting for health programs in Morang]

METHODOLOGY

The assessment process used participatory approach, as guided by the core assessment team. The objective, purpose, methodology and coverage of the assessment were briefed with persons involved in the process and key respondents (see list below). The assessment team spent three days (15-17 Feb 2006) at Biratnagar (for information collection from DPHO and DDC) and three selected field sites (Baijanathpur SHP, Dadarbaeriya HP and Dulari SHP). Health facilities were selected by SC-US district team considering concerns on accessibility, security and variation in program outcomes. Discussion was held between the members of the team after returning from the field on the same day. Pre-designed interview guidelines were used for information collection from DPHO, DDC, HF In-charge, HFOMC/QI team Members, and FCHVs). One event of interactive group discussion was also conducted with SC US staff working at Morang district.

Persons involved:

- Madan R Thapa, Team Leader, FCT, Nepal Family Health Program, Kathmandu
- Sabitri Pandey, Research Monitroing and Documentation Officer, CARE Nepal-NFHP, Program Support Office, Bharatpur
- Deepak Paudel, Community Health Specialist, CARE Nepal, Kathmandu
- Indra Prasad Bhattarai, Field Officer, Nepal Family Health Program, Morang, Biratnagar
- Hari Rana, Program Officer, Save the Children US, Eastern Regional Office, Biratnagar
- Gagan Gurung, Project Officer, Save the Children US-NFHP, Morang
- Pashupati Tuladhar, Monitoring & Documentation Officer, Save the Children US-NFHP,
- Ram Prasad BK, Training Officer, Save the Children US-NFHP, Morang
- Sabitri Rai, Health Supervisor, Save the Children US-NFHP, Morang

Sources and methods of information collection:

- Interview with Mr Nawaraj Subba, Public Health Administrator, Morang District Public Health Office, Biratnagar
- Interview and Record Review of selected Health Facilities (Dadarbairiya Health Post, Baijanathpur Sub Health Post, Dulari Sub Health Post)
- Interview with Health Facility Operation and Management Committee (HFOMC) members -- including *dalit* members from QI team
- Interview and interaction with Female Community Health Volunteers (FCHV)
- Interview with Mr Madhusudhan Pokherel, Planning Officer, DDC Morang
- Interaction with SC US-NFHP staff

SUMMARY OF FINDINGS

- Project team is doing well to implement project activities in close coordination with DPHO and health facilities.
- All health facilities have been handed over to local bodies.
- Health Facility Operation and Management Committee Strengthening (three days standard package) and Partnership Defined Quality process (five days standard process) completed
- Active implementation during phase II period (July 2004 – to date)

Major achievements/outcomes:

- HFOMC Capacity assessment and strengthening training were very fruitful to clarify their role and to carryout expected activities.
- Application of PDQ process helped to bridge the gap between communities and health facilities. The process helped to empower community members and sensitized health workers.
- HFOMC meeting are being held regularly, and in presence of majority of members. Meeting agenda are focused on drug issues, infrastructure development and income-expenditure of health facilities.
- HFOMC members were aware about the system to protect poor from accessing and utilizing health services. They lack clear ideas to disseminate it to communities and to help them to utilize services.

Areas of improvement/missed opportunities:

- More integration of project activities is necessary. District, regional and central level mangers were not oriented on the project activities in advance.
- Involvement of all health staffs on HFOMC and PDQ process is necessary. Programs are more focused on HF incharge. Other health staff felt that they were left behind.
- Agendas of HFOMC members limited mostly on drugs, equipment and infrastructure related issues. Committees were not guided/instructed to discuss on other aspects (e.g. service delivery, access and quality of services, concerns related to social inclusion and governance issues etc).

RECOMMENDATIONS:

- Activities that promote interaction between communities and health workers should be continued, to empower and enable communities to take-up new role of local health facility management.

- Intensive and immediate follow-up and monitoring within initial stage of program implementation is utmost necessary to gain expected program outcome. Follow-up support is necessary for NFHP Phase II district.

- More health workers have to be oriented and involved in the process of HFOMC and PDQ process to build-on ownership and responsibility among health workers.

Acknowledgements:

We would like to thank all respondents who spared their valuable time, opinions and ideas with the assessment team. Special thank goes to Mr Nawaraj Subba, DPHO Morang; all staff, FCHVs and HFOMC/QI team members from Dadarbariya Health Post, Baijanathpur Sub Health Post, and Dulari Sub Health Post for their open and critical comments and clear recommendations for the program. Save the Children US (HFO Health Team, ERO Team and Morang Team) and NFHP Field Office, Biratnagar deserves special thanks for their credible help, support, cooperation and participation in this process.

INTERVIEW WITH PUBLIC HEALTH ADMINISTRATOR- DPHO MORANG

Respondent:
Mr. Nawaraj Subba, Public Health Administrator

Health Facility Handover

- Morang is a full devolution district. The process of decentralization initiated three years ago (2060, Jestha) with HF handover from WHO/HMG/MOH fund.
- 40 SHPs were handed over to local bodies during first year. Last year it was planned for the hand over of the remaining HFs but the budget was released at Ashad (end of the Fiscal Year) and the political situation was unfavorable so the process could not be conducted. Fifteen (15) Health Facilities will be handed over in this year i.e 2062 B.S. SAVE/NFHP will support in the handover of the remaining HFs in Morang.
- DPHO perceived that health facility handover was carried out in rush, without necessary planning, community preparedness and at the time of absence of local elected personnel. The people of different wards were gathered and selection of the members (7 members) was done according to the Local Self Governance Act, 2056. Two days orientation was given to the HFOMC members after handover.
- Transparency and accountability should be the priority of organizations working in the district.
- DPHO, Nawaraj Subba of Morang said "Decentralization is itself good, looked at any angle. We have to incorporate our plan in the 5 year periodic plan of DDC and the I/NGOs working here should work incorporating their goal with overall district 5 year plan."

Health Facility Operation and Management Committees

- The training (HFOMC Capacity Assessment and Strengthening Training) is very helpful, to clarify the role of HFOMC members and to activate them to operate effectively
- Expectations are not fully achieved, as the committee is lacking elected representatives
- Emphasis is being provided to make active participation of dalit and women members in the committee.
- Support is provided to HFOMCs through orientation during handover, 3 days HFOMC Capacity assessment & strengthening.
- Community people are feeling ownership towards their HF. HFOMCs have started to take new initiatives like hiring of staffs at local level, purchasing equipments at the local level, spraying for malaria, searching land for the HFs.The program have synergistic effect on EPI clinic, PHC/ORC, support to FCHVs and regular health programs.

Partnership Defined Quality

PDQ has been and innovative new approach, good approach. It has focused/addressed both health services and community aspects and has aimed for quality of service.

- PDQ has helped to improve awareness level of community, on different aspects of health.
- Display of citizen charter has helped to improve community's awareness, a tool to convince them on the type and quality of services to be delivered from health facilities and roles of health workers
- DPHO expressed that -PDQ has improved the quality of services and the behavior of HF staffs towards their client and the community. The service delivery has improved (in terms of coverage and quality) and the staffs have been more respectful towards clients.

Social Inclusion/Participation of marginalized section

PDQ is a more democratic approach. It has helped in positive behavior change of the Health Workers, accountability and transparency. It has also sensitized people about their roles and responsibilities towards the HF.

- PDQ involves the participation of marginalized, Dalits and female during FGD, bridging the gap workshop. Beside HFOMC members the other OI team members are from Dalit/marginalized.
- System has been developed to bring the voices of community to the district level.

Changes observed:

There has been improvement in health indicators like EPI coverage, ANC visits, the staffs of HF and the HFOMC members are more conscious/accountable about the health activities of their HFs.

Areas for improvement/Missed opportunities (As expressed by DPHO..)

There are no elected bodies in the VDC so difficult in decision making (as secretaries are not present in meetings) .
Till now PDQ has been a top down approach; the program was planned at the center. Such type of planning should be done at the district level. Need assessment and the overall planning (where, when, how to do and evaluation of the program) should be done at the district level.

- Coordination should be strengthened at the regional and central level too. The central/regional level should also be oriented and informed about program that are implemented at their respective districts so that questions may not rise to the district about program implementation that are not incorporated in the red book.
- Till now the district has been implementing the programs. There is no system of integrated evaluation system of implemented programs. The district should be developed as the responsible and authorized unit for the evaluation of implemented programs.

Suggestions for days ahead:

- Program should be continued based on the need and status/performance of HF in a phase wise manner for effectiveness and the sustainable impact.
- Need to follow-up support for HFOMCs – to help them to act effectively.
- Program should be implemented on more decentralized operational model (through having some flexible fund to fulfill some immediate and necessary need of districts, example, the district has CDP program and it is not functioning well, the district needs assistance to strengthen CDP program but the organizations working here don't have programs to support CDP)

INTERVIEW WITH PLANNING OFFICER, DISTRICT DEVELOPMENT COMMITTEE, MORANG.

17 Feb, 2006
Respondent:
Mr. Madhusudhan Pokherel, Planning officer, Morang

[Mr. Pokherel has served for District Health Officer in Morang as an administrative officer sometimes seven years back. He has clear understanding and knowledge of the overall Government policy of decentralization but he was not involved in the Morang's HFs hand over process)

Concerns/Opinions

- Since majority of VDCs secretary are not in their respective VDCs so the significant problems and achievements have never been discussed with/among VDC secretary DDC as well.

- Current policy of decentralization is clear but DDC has not yet been able to work out /on to specify various issues (e.g. what if HFs intends to add a new position? what if current staff is retired? How to refill/transfer-in for such positions?, How/Who to decide regarding promotion and upgrading issues of current staffs?).

The issues of whom the HFs accountable (Monitoring/reporting) to - DHO or DDC should be clear.

- Need to formulate a guiding principle to spend a definitive proportion of VDC (and DDC) fund for health program.

- The handover process needs to be adopted with proper ground work.

- EDPs are supporting health facilities and hand over process, which has been good but they should maintain proper coordination with DDC. How EDP's program and budget expenditure fits into the DDC's five year plan and budget is not being clear.

- DDC need to have a focal person (point-person) for health programs. Current organizational structure and available human resource is not adequate (and appropriate) to take-up decentralized roles/functions.

- Decentralization and handover has been a single transfer of files but there has been no transfer of authority and responsibility. Even the health facilities does not have records(files)

Recommendations

- Development partners in coordination with DDC need to ensure organizational preparedness (at all levels) before deciding to support for decentralization
- Clarity on concerned issues (as listed above) is utmost necessary
- DDC is (and will be) able to play active role, as desired by program but required organizational (structural and other) changes have to be made and flexibility in allocation of fund is required.
- Need further orientation/training /coaching for HFOMC member. DDC can also help and participate to initiate this orientation process.

INTERVIEW WITH HEALTH FACILTY INCHARGE, FEMALE COMMUNITY HEALTH VOLUNTEER AND HEALTH FACILITY OPERTAION AND MANAGEMENT COMMITTEE MEMBERS

Participants :

- Baijanathpur SHP(Sanjeev Sapkota, Auxially Health Worker)
- Baijanathpur VDC, Secratory (Mala Sapkota)
- Sanjadevi Chaudhari (FCHV)
- Bajanathpur SHP Operation and Management Committee members (Durgilal Sardar from Dalit/Janajati,Deepak Sardar from QA team,Badri Lal Rajbansi from social worker and Gita Devi Rajbhar from QI team ,*Sashu Samuha*)
- Dulari SHP (Baburam Acharya, Auxially Health Worker)
- Dulari VDC,Secratory (Chandra Mani Bhattarai)
- Sarada Pokhrel (HFOMC member from FCHV, Ward-1)
- Dhankumari Regmi (FCHV)
- Sabitri Tiwari (FCHV)
- Chandika Chaudhari(FCHV)

Baijanathpur VDC is 25 minutes bus travel from Biratnagar, Sub Metropolitian city.

Information was taken from FCHV group and HFOMC/QI team members of Baijanathpur SHP. At the beginning of the discussion, introduction was done and we shared about the objective of our meeting and discussion. There were 9 participants in th e meeting, 6 from the HFOMC/QI team, 1 from CARE, 1from NFHP and 1 from SC/US. The HF was handed over to VDC according to the Local Self Governance Act, 2056. There are 7 HFOMC members and 4 members from Quality Improvement (QI). The HFOMC was formed according to the policy -from women, dalit/Janjati, FCHV, intellectuals, elected bodies, HF and VDC representative. Two days orientation was given to the HFOMC members followed by 5 days PDQ training package and 3 days HFOMC CapacityAssessment/Strengthening training package developed by NFHP, SC/US, CARE. The HF was destroyed by Maoist in 2060 BS & VDC had reestablished it again.
Dulari SHP is 90 minutes bus travel from Biratnagar Sub Metropolitian city.There are 7 HFOMC members and 2 members from QI team. We had discussion with FCHV, HFOMC members and QI team members of Dulari SHP. Firstly we had discussion with FCHV group and later with HFOMC/QI team members. During the discussion we introduced our self and shared the objective of the discussion. Four FCHVs, 4 HFOMC members and 2 QI team members participated in the discussion. The HF was handed over to VDC and HFOMC was formed according to the policy -from women, dalit/Janjati, FCHV, intellectuals, elected bodies, HF and VDC representative. Similarly,the HFOMC members had taken two days orientation on handover, followed by 5 days PDQ training package and 3 days HFOMC Capacity Assessment/Strengthening training package developed by NFHP,SC/US,CARE.

Major achievements and changes observed during last three years:

HFOMC

- Health facilities were handed over to the VDC about two years ago, on 2060 BS,Jestha
- Handover of HF has developed feelings of ownership in the people.
- The members are aware about Health services delivered from health facilities.
- Resources and support has been generated from local level and optimally utilized by health facilities (a building been established for PHC/ORC in the initiation of HFOMC members, MCHW has been appointed from VDC, spraying in 4 wards in Dulari VDC).
- In both HFs ,Citizen Charter and monthly work plan were displayed.
- Monthly meeting are being held (and almost on regular basis), though the agenda of meetings mostly focused on drugs, infrastructure, and equipments. Limited agenda on service quality, social inclusion issues, community access on health services & FCHV support etc.
- VDC has provided different support to HFs– construction/renovation of HF building, toilet construction, compound wall, dress and snacks/allowance for FCHVs, spraying at VDC, recruiting MCHW from VDC fund.
- HFOMCs have initiated initiatives – e.g. searching of land to build own HF building, establishing birth centers at HF to increase the number of delivery by trained health personnel.
- HF in charge feels that HFOMC Capacity Assessment and strengthening training has helped him analyze the problems, make action plan and mobilize resources.
- HFOMC & VDC have been supporting FCHV. Yearly 30,000 is collected in Endorsement Fund at Baijanathpur SHP.One FCHV gets Rs.1300 each year.

Provide allowance for working in Vit A day/Immunization Clinic *Nawajath Sishu* program has been supporting snacks during the monthly FCHV meeting VDC has provided support to FCHVs; FCHVs are receiving monthly meeting allowance, Sari and Cholo as dress. Similarly in Dulari SHP too, the VDC has been supporting in dress.
Similarly, the schools at the VDC have also provided bed for ANC check up and necessary support in plantation at HFs.

PDQ:

- In the FGD and bridging the gap workshop it was identified that there was no land for HF. Every member became aware of the issue and the people from there themselves offered land. Till now there have been four sites and HFOMC is going to decide where to select in the next meeting.
- In Baijanathpur VDC, community has offered land at four places and the committee has planned to select one of those sites from the meeting. Similarly in Dulari SHP, during the FGD and bridging the gap workshop, the people identified that delivery by trained health personal was low in their VDC. The data also showed low coverage (Delivery by trained Health personnel 2060/61-19%, 2061/62- 26 %). It was concluded that lack of delivery facility at HF was the main reason beyond the low coverage. So it was decided that HF be developed as the birth Center. At present the VDC has appointed one MCHW to assist in ANC, delivery and PNC. The VDC has committed to appoint ANM after the establishment of birth Center.

General Impression

Members of dalit and marginalized are also members of HFOMC according to the Act Free service for FCHVs,poor ,disabled and students(50% in some HFs).Members of QI team expressed that the poor and marginalized who are referred from local HF should get treatment at subsidy at District /Zonal /Central hospitals.

Strength areas:

- Establishment of BCC center.
- Improved availability of drugs at affordable cost
- Improved community awareness on health and social matters
- Improved availability of additional services (e.g. lab services from HPs)
- Regular (relatively) meeting of health facility operation and management committees
- Good trust and support to female community health volunteers (from health facility and community)
- Improved community trust on health facilities
- Continued support from village development committees
- “Bridging the Gap” Workshop helped greatly for developing better understanding among communities and health workers, thus to be continued (better communication and interaction among stakeholders)
- Same problem have different ideas/opinion/concerns among different stakeholders, thus events for having interaction between communities and health facilities is important

Areas for improvement

- Some QI team members do not attend HFOMC/ QI team meeting and don't know the names of HFOMC members.
- The PDQ members could not explain the spider web model of that HF. Also, they do not know about the work plan made in the HFOMC Capacity Assessment and strengthening training.

Finally,

HFOMC, QI team members themselves felt that they were confused about their roles and responsibility and that their meetings were irregular.
The HFOMC members demand technical support from DPHO & the line agencies.

The HFOMC members have participated in trainings and meetings, however there is no change in behavior. How can the behaviour be changed? a query was put in front of us.

We have to be informed about the activities been conducted at our VDC,

शिविर संचालन भयो, तर हामीलाई थाहा भएन,
कुनै कार्यक्रम गर्दा, हामीलाई र गा.वि.स. संग समन्वय गर्नुपर्छ ।

Free service for FCHVs,poor ,disabled and students(50% in some HFs)

- Members ofdalit and marginalized are also members of HFOMC according to the Act

Coverage of services,

- Balanced coverage of/for services for all ethnic/social groups
- Fair utilization pattern of health services (proportion of dalit at community and proportion of clients among total clients is balanced), for all type of program like EPI, Safe motherhood, treatment etc

Access to health services

- Access to health services improved, through year round availability of medicines at subsided rates through community drug program
- Free service for FCHVs,poor ,disabled and students(50% in some HFs)
- Service utilization from higher and middle class family is poor. They go to Biratnagar.The lower class family use service from private clinics. Very few utilize the service from SHP.

Areas for improvement/missed opportunities:

- The HF inchage and the VDC Secratory both were appointed 1 years back so they could not get the orientation package. The documents regarding hand over were in the VDC. No such documents in the HF. The in charge & VDC secretary were appointed 1 year back. Before the incharge had worked in Acham where he did not get the orientation package. Incharge and Sectary have no conceptual clearity on decentralization.There were no documents related to handover in the HF.
- Some HFOMC/QI team members don't know who are in their committee. Also some of he FCHVs don't know the HFOMC/QI team members.
- The meetings are held but the participation of members is low so they have to cancel meeting due to lack of adequate forum.

- Coordination on some areas – to be improved – especially those through partner NGOs (e.g. HF staff not aware/informed about the activities of PLA activities)

FCHV

- Nine FCHVs have been working in VDC, Sanjadevi Chaudhari ,FCHV of Ward –7 of Baijanathpur and Sarada Pokhrel of Dulari SHP are also HFOMC members.
- The FCHVs meet regularly each month .Most of the FCHVs have been working since 2047 BS and some are recently appointed,shifting roles from Mother in law Sashus to Daughter in law.These FCHVs have not taken basic training .
- FCHV have been distributing iron tablet to pregnant mothers,Vit A to lactating mothers,ORS,Cotrim , FP devices(Condom,Pills) , organizing mothers group meeting,supporting in PHC/ORC(giving information about days, weighing child).They also refer the cases to HF.
- The FCHVs have been supporting PHC/ORC by providing rooms. Most of the PHC/ORC run at the houses of FCHV in Baijanathpur and Dulari.
- FCHVs feel that the VDC and the community have been supporting them in their work.
- The FCHVs of Baijanathpur know the name, roles & responsibilities of HFOMC members,However the FCHVs of Dulari do not know about HFOMC ,its role and responsibility members. FCHV of Ward –5, had worked for PHC/ORC in her ward so she was awarded for best performance in the district.
- Representative from FCHV participate in HFOMC Meeting; however there is no system of disseminating decisions made in the meeting to the other FCHVs. Agendas discussed over in HFOMC meetings are-
    - Dress to FCHV
    - ORS and drug supply to FCHV
    - Endorsement Fund of FCHV
- FCHV demand
    - utensils to make *Jeevan Jal* at community
    - umbrella to walk in the rain
    - box to store their reports and drugs
    - light to walk in the dark.

- FCHVs are encouraged to work as HF incharge also visit the PHC/ORC regularly.
- FCHVs feel that they should also be informed about the issues/decisions made in the HFOMC meeting.
- "हामीलाई पनि बेला बेलामा मिटिङमा बोलाएर सामेल गर्नु पर्छ ।" FCHV demand for participation.
- FCHVs demand for transparency of money in the endorsement fund.

Problems

- FCHVs say that it is difficult to organize mothers group meeting in Wards as all women are busy in household work. FCHVs feel that if someone came from district, HF mothers would be encouraged and participate in the meetings. Some FCHVs organize mothers group meeting in the PHC/ORC for the convenience.

DISCUSSION WITH NFHP FIELD STAFF (from SC /US and NFHP)

16 th Feb,2006

Participants: Indra Prasad Bhattari,Field Officer ,NFHP
Gagan Gurung ,PO,SC-NFHP
Pashupati Tuladhar, M &DO,SC-NFHP
Sabitri Rai, HS,SC/NFHP

We shared the objective of discussion with the district team.Our sharing issues were

1. Sharing on technical areas (our programs, quantitative and qualitative achievement, their impact on accountability, responsibility, governance, social inclusion and community development)
2. Sharing on management areas –staffing, working modality, organizational identity\

Strength:

- PDQ and HFOMC training implemented in the district in blanket approach.
- HFOMC, as one sort event has been successful, participants have good response, the HFOMC members are aware about their roles and responsibilities.
- Regarding social inclusion, dalits/Jajati and marginalized are included in the QI team and they participate in HFOMC meetings.
- There have been some changes from PDQ in community empowerment.
- HMIS show improving trend of health service utilization pattern.

Indicators have raised (show improvement) however, the capacity development of community is weak.

Areas for improvement and Recommendations for future

Though marginalized and dalits are included, they just participate in the meetings, they have no say in the meetings, empowerment and capacity building is necessary but there are no programs to address their capacity building.

Staffs recommend that PDQ and HFOMC should be implemented as comprehensive package (this saves time and resources)

PDQ and other programs must be applied from community perspective rather than donar perspective.

PDQ should also fulfill demand in addition to creating demand. This encourages the community to move ahead.

Staffs feel that the programs like PDQ ought to be incorporated in D(P)HO regular program. Also they say, PDQ should not only create demand but should also fulfill some of the community demand so that people are encouraged to work .

- Some changes are necessary in PDQ guideline so that issues that can be approached from HFOMC/VDC level are discussed. At present community bring issues that are not possible to solve from HFOMc/VDC or District level .

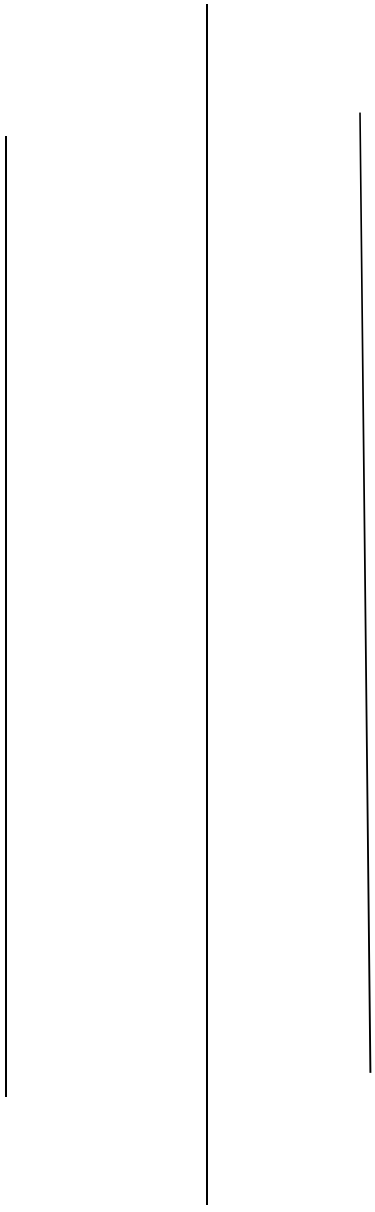
- Some of the indicators of Capacity Assessment are difficult for HFOMC members to understand.

- Level of understanding of the community regarding Health and Rights, Political instability (VDC secretary not in VDC) and economic condition (hand to mouth problem so very few from Dalit/marginalized come to meetings) are hindrances to effective PDQ implementation.."Volunteerism is one of the obstacle and it takes time to see tangible result. The people are doing well in agriculture, saving, participation is good in these activities so we hope PDQ & HFOMC will be successful. The people must be sensitized that Helath *is a matter.* We should work for community sensitization" was the expression of the staffs of SC-NFHP.

- Regarding the management aspect, it is suggested that the activities of SC-NFHP and NFHP be merged and roles/responsibility be defined according to the volume of activities. Separating districts for SC-NFHP and NFHP would be the best approach for accountability and responsibility. Staffs feel that organizational identity is essential as it contributes to motivation of staffs.

ANNEX - III

Assessment of NFHP Activities to strengthen the interaction between Community and Health Service System



Field Trip Report
Nawalparasi
10 – 12, January
2006

Community and Health Service System

Background

District : Nawalparasi
Date: Jan 10 – 12, 2006
Implementing agency : Care/NFHP
Program phase : 2nd phase

Profile of Nawalparasi

- District /Location : Terai /Hill
- Regional location : Western
- Population (062/63, DHO): 633,633
- No of VDCs: 73
- Municipality : 1
- No of Hospital: 1
- No of Private Hospital: 2
- Ayurbed Aushadhalaya: 6
- No of PHCs: 5
- No of HPs: 8
- No of SHP: 63
- No of FCHVs(Ward wise): 712
- TBAs: 257

Executive Summary

A qualitative assessment of the NFHP activities to strengthen the interaction between Community and Health Service System in four HFs of CARE's Nawalparasi was undertaken from Jan 10 – 12, 2006. The assessment aims were to assess the extent to which a community level program is effective in establishing a relationship between the community and the health facility staff and on the basis of this information to make recommendations on which aspect of the program is more relatively important and better sense of how we need to be moving further.

Qualitative research techniques of semi-structured interview, HFs observation and discussion were used to explore a number of themes : the knowledge of decentralization, Improving quality of services, Improving access (including by the socially marginalized), assistance in implementing HMG's decentralization of management authority (HFs handover), complementary work (3 days training) aimed at strengthening health facility operation and management committees, PDQ work, REFLECT, Participatory Learning and Action (PLA) and others.

Field Work:

Upon arrival on Nawalparasi to undertake an assessment the team met with the DPHO and supervisors, NFHP FOs and CARE staff and informed about the purpose of visit. After a short briefing with DPHO, all team assembled in the office of the CARE to work on detail field visit.

The assessment team spent two days (10- 11 Jan 2006) in Parasi and four selected field sites (Tilakpur SHP, Shivpurmandir SHP, Pithauli SHP, and Harpur SHP). The Care district team identified four HFs based on observation of relatively high performing (two HFs) and non-high performing health facilities (two HFs) and location. The security situation was also taken into account.

The assessment team was split into three groups. One group visited to a) Shivapurmandir SHP and b) Harpur SHP and another two group visited to c) Tilakpur SHP and d) Pithoulia SHP each.

Predesigned discussion guidelines were used for the information collection from DPHO, HF –In charge, HFOMC member and FCHVs.Discussion was also held with the Care staff working at the Nawalparasi.

Sources and methods of information Collection:

- Interview with District Public Health Office , Nawalparasi district
- Interview with health facilities in charge.
- Interview with selected health facilities staff and record review of selected health facilities.
- Interview with HFOMC member
- Interview and interaction with FCHVs –
- Interview with REFLECT member.
- Interview /Discussion with HFOMC /QI member
- Discussion with MGs member

Persons involved:

- Madan R. Thapa, Team Leader, FCT Nepal Family Health Program , Kathmandu
- Chandra Rai , Senior Program Officer , SC/US Kathmandu
- Min Raj Gyawali, HSC, Care , Nawalparasi
- Buddhi Pd. Rai, FTL, NFHP, Hetuda
- Gagan Gurung , Project Officer, SC/US, Morang
- Kanchan Raut , Asst M&E, Care, Nawalparasi
- Toya R. Giri. Sr. Field Officer, NFHP Nawalparasi
- Puja Dhawadi Health Supervisor, Care, Nawalparasi
- Ran Bdr. Thapa, HS, Nawalparasi
- Hasta Bdr. Hitan, HS, Care, Nawalparasi

Findings:

- Care staffs have very good communication and fruitful relationship with DHO, DDC and NFHP staff.
- The community level activities, such as Decentralization of HFs, HFOMC strengthening, Partnership Defined Quality, and REFLECT were smoothly implemented as follows: .....

  1. The handover has been done only in 63 (83%) Sub Health Post.
  2. The handover process has not yet started in PHC (5) and HP (8).
  3. Of the total 76 HFs (PHC, HP, SHP) 12 HFs (16%) (1 HP and 11 SHP) have received PDQ interventions.
  4. 6 (8%) SHP are marked as "REFLECT" health facilities.
  5. 57 HFs (75%) have received three days HFOMC capacity assessment and strengthening training.
  6. FCHVs usually meet at HFs in every month. In Nawalparasi, 50% of HFs is able to organize monthly meeting for FCHVs.

- The sequence of activities in Nawalparasi district is as follows:
  - a) Decentralization (April /May 2004)
  - b) HFOMC strengthening training for the HFOMC member (April 2005)
  - d) REFLECT (July 2005)
  - c) PDQ (NOV 2005)

- A total of 459 (Male 243 and Female 216 including 126 Janajati and 79 Dalit) HFOMC member were trained; (three days package of HFOMC capacity assessment and strengthening).A total number of 164 HFOMC/QI member in 12 PDQ implemented VDC were trained.

Major Achievements/observation:

- Observed "Citizen Charter" displayed in every health facilities. Initiations have been taken by the HFOMC to display in the proper place and HFOMC member advocates about the content of the charter. This has been very useful in disseminating the health service information to the communities.
- Demand creation from the HFs – to implement the PDQ process.
- HFs are proactive in assessing the capacity of the HFOMC member and to strengthen them by using "Spider web" model. One HFs has already applied this model without having any technical support from Care.
- The DHO is well aware about the process of decentralization but the HFOMC members do not feel the ownership of the HFs.
- Further exploration of a mechanism (democratic process) to select representation of Dalit from community is required in order to enhance continued active participation by the Dalit in the HFOMC/QI team.
- The service date shows the increment in the service utilization by the community particularly in the Immunization and ANC.
- The FCHV who represents HFOMC do not have practice to share the information and decision to her FCHV colleagues neither she brings any agenda from her colleagues for the HFOMC meeting.

- HFOMC/QI team is working their best to define priorities based on available resources but there are no such practices to define priorities based on health data and to generate/gather available resources.
- They have been able to built the fences around the HFs, erection of water tap inside the compound but less have been involved in providing quality health services to the communities.
- FCHVs in the villages are easily traceable than member of HFOMCs. The FCHVs regularly attend more group meetings than men. It seems that FCHVs are more reliable and are more disciplined than men.
- HFOMC have been able to manage conflict within the HFs.
- There is high variance of "Level of understanding" among the HFOMC member.
- HFOMC and health staff sees the activities as an one time events or "Project" not the "Program". (Spider web : should be a "means" to achieve certain "ends")
- Each subset (4 member of the HFOMC/QI) of the set (13 member of HFOMC) has been able to reactivate the HFOMC set.
- The relation between health staff and HFOMC member seems strong but however the "sense of coherence" within the HFOMC group is not so much strong but increasing very slowly. The "Dalit" representatives, since they are illiterate and not exposed compared to other member still feel some "Constraints" to participate in the decision making process ,
- HFOMC are playing crucial role in sparking the various HFs activities.

Recommendations:

A. Increase the "Sense of Coherence":

- HFOMC member should be oriented/exposed to "Team building exercise" and planning exercise. This should be done jointly with HF staff and HFOMC member.
- The HFOMC and HF staff should be trained on how to use various health related information and to analyze them to take the decision to prioritize the program.

B. Linkages

- Should develop linkages between various interventions (eg. Linkages between HFOMC /QI team and Quality Assurance Working Group, QAWG at district level, and linkages between HFOMC and REFLECT).
- Requirement of regular follow up after the handover and involve DDC member in the follow up activities.
- Define/design an approach to optimize the relation between community level program and on going health programs.

C. Strengthened Social inclusion

- Support to those activities which helps to reduce the health and non health risk factor in order to decrease powerlessness of the communities (especially the Dalit).
- HFOMC need to encourage to standardized a procedure to set priorities for the poor and powerless communities.

D. Program not the Project.

- Should encourage activities with the perspective of "Program" and not from the "Project" point of view.

PART 2

Interview and discussion with DPHO

Respondent: Mr. Ramesh Bdr. Adhikari

Interviewed with the DPHO and he seems very ambitious in improving quality of services, improving access and achieving greater public health impact and also will be helpful in developing relations between community and service provider .

- DPHO has taken initiation on the handover process. Feeling that all VDCs are not in the same status and the HFOMC members are not competent well enough in all HFs. - it varies.
- Not feeling of ownership. They were not prepared to take the responsibility so they need to be strengthened
- Need continuous follow up not only from the DPHO but also from EDPs.
- The problem is that there is no VDCs Secretary and VDC Chairman. The secretary quite often does not stay in the VDCs.
- Those who are active, they are meeting regularly in every months and those HFOMCs who are not active they met occasionally.
- Although the HFs have been handed over to local bodies, DDC are also not clear about their roles, all the responsibilities lies within the DPHO.
- The community has been taking initiation on health – all HFs have been handed over to the "local bodies".
- They have been providing support in increasing the set of activities and have observed the service improvements.
- Supporting in the conduction of PHC/ORCs and immunization camp and Vit A. supplementations. Observed change in the performance of various activities.
- HFOMC member have now being realized that there are various set of health activities being conducted by the HFs.
- PDQ and REFLECT have been effective in bringing people from various sector and talk about the health issues. But the community has now started demanding x-ray machine, Lab facilities; they are now recognizing the importance of these areas.
- The feelings about the importance of quality have been increasing. Feeling that the HFOMC member can also contribute is also increasing.
- Feelings of integration have now been developed. Help to sensitized the community
- REFLECT is playing a crucial role in the inclusion for disadvantaged sub – populations.
- There have been observed the impact of service coverage especially in immunization and ANC after the PDQ.
- Some unidentified persons forcedly closed the CDP activities; it was the initiation of HFOMC who have been able to reopen the CDP program at HFs.
- HFOMC usually prepare the yearly action plan
- HFs staff has now come to the office in the right time and stays up to 5 PM.

Interview and discussion with HFOMC member in Pithoulia SHP

Interview date: 10 Jan 2006 (26 Poush 2062)
Health Facility: Pithoulia, Nawalparasi
Program implemented: SHP handed over 2yrs back, PDQ, HFOMC
Interview to: The HFOMC is comprised of 11 members. Interview was taken with following HFOMC members and social workers. Some of the HFOMC members were not present at the time of interview:

1. Sukra Prasad Regmi (Chairperson, VDC secretary)
2. Om Bahadur Kunwar (members)
3. Mrs. Maya Devi Rijal (FCHV members)
4. Mrs. Rita Thanet (members)
5. Dinanath Bhusal (SHPI secretary)
6. Lekh Nath Kafle (QI team member)
7. Mrs. Gyanu Maya Sharma (members, Mother Group)
8. Mr. Dadhiram Pariyar (members)
9. Mr. Krishna Gurung (social worker)
10. Mr. Dhanbir Gurung (social worker)
11. Mr. Krisna Lal Mahato

- The HFOMC members said that the health facility is handed over to them 2 yrs back. They received 2 day NHTC developed orientation/training and 3 day NFHP developed HFOMC strengthening training. They could not remember exact year.

- The last meeting conducted by the HFOMC was in 2 months (6 Kartik 2062) back and agenda were; 1) school immunization, 2) regular immunization and 3) medical insurance. All decision were carried out and solved. The TT immunization has been completed; SHPI prepares immunization reminder slips for those children who did not come for immunization and gives FCHV so that FCHV will follow up with the family of this particular child. Total 158 families have become insurance members.

- Majority of the members said they knew the types of services provided by health facilities. They think the great achievement of the HFOMC is to add one immunization clinic in ward # 8 which immunization coverage is very low.

Pithouliya VDC ward # 8 has low immunization coverage compared to others. Majority of the community are Bote (fisherman), mushar and dalit who's day to day earning is from fishing. Mr. Dadhiram Pariyar a teacher is member of HFOMC from same community. He said the community believes that if immunization is given to children an evil's eye will catch them. So no mother brings their children in the immunization clinic which is in other wards. In one HFOMC meeting the committee decided to add one immunization clinic in this particular ward to bring the service closer to them. Orientation on importance of immunization was organized to the parents but only 13-15 mothers attended the program. Yet he has not discouraged. He thinks it is just a starting we still need to continue the awareness activities to improve the immunization status of this community.

- The HFOMC strengthening training helps us to assess (spider web) where we were taught us to unite. Previously the meeting was irregular but now it has become a more frequently.

- Regarding the service availability in the health facility- since the SHPI is busy in the work and other official work, one more local AHW has been hired through private fund (individual donor). Previously the SHP use to open 12 – 2 but started to open from 10 – 4 nowadays.

- HFOMC chair as a VDC secretary said that the health facility has been received the larger amount of developmental budget of VDC than other sector. It will be around 5- 6 thousand yearly. 2 years ago the VDC had given Sari, blouse to FCHVs which was wearing by the FCHV today as well. They have been supporting FCHVs in national campaign day such as Vit A distribution and Polio mop up.

- When we asked about their suggestion or recommendation to improve the health service, they mentioned existing drug supply through district is not practical. Due to the mismatch in demand and supply of drugs chances of expiry of the supplied drugs are high. It would be nice if the local body could buy the drugs according to their need at the community level.

Interview and discussion with FCHVs of Pithoulia SHP

Respondent: Maya Devi Rijal ward # 6,
(Maya Devi Rijal 6, Pithouliya. She is a treatment FCHV. There are 9 FCHV in this VDC. Studied upto grade 7 and she is a farmer.)

- Before this HFOMC becoming an active, she used to make a round in the community and did what was told. After the hand over and different HFOMC training she knew what different services provided by the HF.

- She has been involved in the different health activities such as vit A, immunization clinic, polio mop up and health education to pregnant women and children. She gives a letter written by SHPI to immunized children and follow up them.

- They have raised FCHV fund by their own collecting Rs 50/ by each FCHVs since 4 yrs. SHPI helps to keep record of the fund. This fund has been used by the FCHV when needed.

Interview and discussion with Mother's group in Pithoulia SHP

Respondent: Gyani Maya Sharma,
(Gyani Maya Sharma is an active member of the mother's group).

- They have registered their group as Nepal Ama Samuha in DDC and SWC. They have 11 members in ward and 11 VDC as well. Recently they have donated Rs. 20 – 30000 to charity (Yagya) to build the higher secondary school.

Interview and discussion with DDC member (HFOMC member) in Pithoulia SHP

Respondent: Om Bahadur Kunwar, DDC member
(Om Bahadur Kunwar is a member of HFOMC Pithouliya and member of DDC as well.)

- In his opinion great achievement of the HFOMC is to add one ORC and immunization clinic to reach left out people. Yet he thinks some lacks in the publicity of committee. Hardly few people beyond the committee know what the HFOMC does.

- He thinks if only the members come on time for the meeting would be improved.

Interview and discussion with QI team member in Pithoulia SHP

Respondent: Lekhnath Kafle

(Lekhnath Kafle 21yrs (12 grade student) unmarried is a QI team member. He lives in 1 KM near by the HF. He said that he was selected as QI team because other people (FGD participants) live far away).

- He said he has no voting rights and can't remember the prioritized issues discussed during the last HFOMC meeting...
- He said that he will disseminate the information got from this meeting to the community through choukidar.

Interview and discussion with HFOMC member in Tilakpur SHP

Tilakpur SHP is one of the well functioning health facilities of the Nawalparasi district. This health facility stood first position in FY 2061/2062. Care Nepal in collaboration with DHO has conducted the HFOMC strengthening program in the SHP. This HF is chosen for the assessment in reference to the HF has been well performing, but non REFLECT and non PDQ.

Findings of the discussion with HFOMC member.

General

- The HFOMC members are aware of the NFHP inputs/activities.
- Respondents knew about the handover of the SHP and it process, but do not know the exact date of the handover.
- Have received three days orientation training (DHO was fully involved in this process)
- Knew about the total number of members and could give details of them

Best practices:

- Supervision and monitoring plan prepared and implemented.
- (HFOMC member started to give intensive supervision and monitoring in more plan way after receiving strengthening training, Exposure visits to Kanchanpur reinforce them to adopt the best practices. i.e. clear supervision and monitoring plan for SHP, immunization clinic, PHC/ORC),
- Regular monthly meeting (review of all progress based on the authentic information, future plan prepared) this is the most strong point respondent focused because all the other activities are guided by the meeting. Good team work, supervision and monitoring plan are all meeting outcome.)
- Good team sprit/dynamic among SHP staff, VDCs FCHVs and committee member (this is the result of regular meeting, some members (3 in numbers) are having dual role of HFOMC member as well as VDC member.)

- Disseminated health related information through different networks such as MGs, DACAW, individual contacts (information: availabilities of health services by HFs, affordable price but quality drug through CPD program.)
- Once devolved CPD program revived. Service utilization improved and trust build in the community.
- Client flow improved regularity of PHC/ORCs and immunization clinics.
- Regularity of clinics, PHC/ORC
- Monitoring and supervision team formed.

FCHVs motivational fund:

- VDCs support to this fund – 9000(HFOMC raised this issues on regular meeting and VDC took the decision)
- Rs 50 supported every month to each FCHVs for
- Current status of fund- 55000 collected. FCHVs utilize this fund for loan repayment with in the FCHV group, make availability fund to fewer than five children for treatment /other health condition.
- Free health check up service from HFs to FCHVs.
- Cycles, dress and umbrella provided to each FCHVs.
- Supervision support to immunization and PHC/ORC.
- Emergency fund in each ward – through the initiation of DACAW and HFOMC. This fund is especially for safer motherhood.
- Rs 800/year for Vitamin A support.

Findings of the interview with FCHVs.

- FCHVs knew about number of FCHVs in VDCs. They knew about their roles in community. Treatment of diarrhoeal diseases, FP distribution and counseling, awareness program in MGs respondent knew about the member of HFOMC who selected among FCHVs but unaware of the sharing of information about HFOMC activities.

Interview and discussion with SHP staff in Shivamandir SHP

Respondents: Menuka Rizal . AHW In charge
Kiran Pandey VHWs
Mira Parajuli MCHW

Handover process :

- The exact date of the handover of SHP was 2061/Chaitra 09.
- VDCs secretaries and HF In charge have participated in the handover process organized in the district headquarters. HFs staffs do not know about the handover process.

What has been handed over?

- All logistics and supplies including furniture, instruments and medicines. But the health facilities do not have the records of items which have been handed over to the committee.

How the HFOMC have been working after the handover process:

- Participate in every monthly meeting. (10th day of every month)
- The meeting has been regular.
- Representation from every strata of the community.
- Feeling comfortable in working with the HFOMC member
- More organized team sprit among the member of the committee.

Community drug program

- CDP is being implemented. They add 5% more price value on it and sell it to the consumer.

Support to the marginalized and poor people

- A task force had been constituted from among the members of the HFOMC to identify the marginalized and poor people from their respective ward and to recommend for the "free consultation and drug". Then finally the HFOMC will decide in the meeting "who should be given free consultation and drug".
- HFOMC has decided to purchase appropriate medicine worth of Rs 10,000/

Partnership Defined Quality

- Aware about the purpose of PDQ as to focus and to increase the quality of services as well.
- The additional 4 PDQ member, being active member, from various group in the HFOMC have been very effective to mobilize the overall HFOMC functions.

How could we mobilize HFOMC/QI team?

- By encouraging competent person to join the HFOMC team.
- Follow up and regular orientation.
- Informing communities about the existence of HFOMC.
- Bringing many innovative ideas to activate the HFOMC member.

Weak points:

- Ownership has not been developing.
- Chairman is not active (he is paid worker)
- Not effective representation from various sectors.

Interview and discussion with REFLECT /Advocacy center, Lokaha (Shivamandir SHP)

Respondent: Tika Devi BK.
Parbati BK
Fulmaya BK
Namkala Bhusal, center's facilitator

- The participants are quite clear about the purpose of advocacy center, they motioned that it is the center where they can raised the topics with regard to the "Rights" and discuss on it.

- The benefits of the center has been the " to create awareness". They have been able to build about 25 "pit latrine" at the community level. They are educated and informed about the causes of diarrhea Pneumonia and were told about the skin diseases.

- There are 20 participants in one REFLECT center and have already been met (40 – 50 times).

- The participants from the center raise the topics of discussion and members put their thoughts in various perspectives and center facilitator facilitates the point of discussion.

- Most challenging issues rose so far includes the "widow's problem, social discrimination based on caste, etc.

- After the discussion, they contact various agency and source to the possible extent to address the issues.

- All participants wanted to have the continuation of this type of forum where they can communicate their ideas each other.

- Among the participants, they distribute their work activities and are supporting various health activities .eg immunization clinic, in promoting and advocating CDP activities Installation and fixing of water pipe stand.

Interview and discussion with FCHVs in Shivamandir SHP

Respondents: Ms. Ambika dawadi Khadka
Ms. Laxmi Khnal

- All FCHV meets at every end of the month. Where they submit their monthly activity record. They receive logistics eg iron cotrim FP contraceptives and ORS package. .
- They also shared about the lessons they have learned and various issues shared by the communities and discuss about the important upcoming activities.
- VDC is supporting Rs 100/ per months to FCHVs
- FCHVs have opened their "Dikuri" and deposit Rs 30 / every months by each FCHVs, this amount will be given to FCHVs by rotation basis.

Interview and discussion with HFOMC/QI team in Shivamandir SHP

Respondents:

Mr. Narayan Panta
Laxmi Pd. Poudel,
Ms Laxmi Khanal
Bhakta Bdr Thapa
Menuka Roizal

- Not so very much clear about the concept, purpose of the PDQ.
- They are somehow familiar with their roles as to create awareness of the community
- They express that they need on going coaching.

Interview and discussion with SHP staff in harpur SHP (No PDQ and No REFLECT)

Respondents: Jeevan Sapkota

(Jeevan Sapkota was not involve in the handover process of this SHP)

- The HFOMC are not feeling ownership - the general feeling is that - it could be because of the inactive member selected and simply because of the "Quota" system for the HFOMC member where capable persons are excluded.
- HFOMC meet every month.
- No agenda from HFOMC in the meeting.
- HFOMC have not doing any significant work to gain acceptance and support from the community. Communities also do not know who the HFOMC members are.

Thanks,

ANNEX : IV

ASSESSMENT OF COMMUNITY LEVEL NFHP INTERVENTIONS TO PROMOTE INTERACTION BETWEEN COMMUNITIES AND HEALTH FACILITIES

GENERAL

District	:	Sunsari
Field period	:	16-18 January 2006
Implementing Agency	:	Save the Children US
Program Phase	:	Phase I district

[Sunsari is one of the Terai district of Eastern Nepal; with 625,633 population (2001 CBS); 50 Village Development Committees, three municipalities; having one district hospital, 5 Primary Health Care Centers, 7 Health Posts, 41 Sub Health Post and 1064 Female Community Health Volunteers. Save the Children US implemented key NFHP interventions to strengthen the delivery and use of high impact FP/MCH services at household and community level during Phase I period (July 2002 - June 2004) and monitoring and following-up activities is ongoing during Phase II period (July 2004 - Dec 2006). Plan Nepal and World Vision Nepal are other key INGO partners supporting for health programs in Sunsari]

METHODOLOGY

The assessment process used participatory approach, as guided by the core assessment team[1]. The objective, purpose, methodology and coverage of the assessment were briefed with persons involved in the process and key respondents (see list below). The assessment team spent two days (17-18 Jan 2006) at Inaruwa (for information collection from DHO and DDC) and four selected field sites (Harpur, Baklauri, Bhokraha and Basantapur). Health facilities were selected by SC-US district team considering concerns on accessibility, security and variation in program inputs/outcomes. The assessment team was split into two sub-groups and visited two sites by each sub-group members. Discussion was held between the members of the team after returning from the field on the same day. Pre-designed interview guidelines were used for information collection from DHO, DDC, HF In-charge, HFOMC Members and FCHVs). One event of interactive group discussion was also conducted with SC US and NFHP staff working for Sunsari district.

Persons involved:

- Madan R Thapa, Team Leader, FCT, Nepal Family Health Program, Kathmandu
- Mahendra Narayan Mahato, Project Manager, CARE Nepal-NFHP, Program Support Office, Bharatpur
- Deepak Paudel, Community Health Specialist, CARE Nepal, Kathmandu
- Hira Tiwari, Field Team Leader, Nepal Family Health Program, Biratnagar Field Office, Biratnagar
- Hari Rana, Program Officer, Save the Children US, Eastern Regional Office, Biratnagar
- Devendra Karki, Field Officer, Nepal Family Health Program, Sunsari
- Purushottam Singh, Social Mobilization Officer, Save the Children US-NFHP, Sunsari
- Tara Nath Acharya, FP Officer, Save the Children US-FF Program, Sunsari

[1] Assessment team comprised members from CARE, NFHP and Save the Children US

Sources and methods of information collection:

- Interview with Dr Bajra Kishore Thakur, District Health Officer; and Mr Rakesh Thakur, Public Health Administrator, Sunsari District Health Office, Inaruwa
- Interview and Record Review of selected Health Facilities (Baklauri Health Post, Haripur Sub Health Post, Bakraha Sub Health Post, Basantapur Sub Health Post)
- Interview with Health Facility Operation and Management Committee (HFOMC) members -- including *dalit* members from QI team
- Interview and interaction with Female Community Health Volunteers (FCHV)
- Observation/Interaction with Participatory Learning and Action (PLA) Groups
- Interview with Mr Bishnu Bahadur Thapa, Local Development Officer
- Interaction with NFHP Project Staff (in group setting with SC US and NFHP staff at Sunsari)

SUMMARY OF FINDINGS

- Extra-ordinary and praise-worthy efforts have been made by project team. High commitment, dedication and good coordination of project team with concerned stakeholders helped to achieve good results within limited time-frame.
- Fifty two health facilities have been trained on Health Facility Operation and Management Committee Strengthening (three days standard package) and implemented Partnership Defined Quality process (five days standard process). A total of 624 HFOMC/QI team members were trained; among whom 308 (49%) are female participants and 106 (17%) are dalit/janajati/marginalized participants.
- Forty eight Basic Participatory Learning and Action (PLA) and 40 Post PLA sessions running in 16 selected VDCs (having high proportion of muslim and marginalized section of population)
- Active implementation during phase I period (July 2002 – June 2004) and monitoring and follow-up during phase II period (July 2004 – to date)

Major achievements/outcomes:

- All HFOMCs are aware about their role, and taking up their roles proactively as compared to two years back in all areas (except two highly conflict hit areas and three areas where training was conducted recently)
- Application of PDQ process provided forum and opportunities for health workers and communities to interact about their expectations and concerns on "access to", "quality of" services and other concerned matters. This process has been very effective and fruitful for developing better understanding among communities and health workers on those matters and to sensitize them for better participation for days ahead.
- Communities and management committees are proactively taking up new roles and initiatives to improve access and quality of FP/MCH services (e.g. establishment of laboratory centers in a Health Post). Regularity of HFOMC meetings is improving significantly. Communities and health workers are sensitized on social inclusion and good governance issues and motivated to work better.
- Quality of services delivered from health facilities has been improved (by providing regular services, ensuring technical quality of services, respectful/dignified behaviors towards clients irrespective of their ethnicity and economic status)
- Access to health services delivered from health facilities, especially for marginalized population section improved: through subsidized drug program, free treatment (consultation+drugs) for poor as selected/recommended by FCHV/VDC/

health workers, regularity in health services delivered from PHC/ORC; additional services through community initiatives etc
- Improved utilization of health services and better health outcomes realized by communities. Communities trust towards health facilities improved.

Areas of improvement/missed opportunities:
- Inadequate emphasis and efforts on program and outcome monitoring.
- Poor inter-linkage between different interventions and lacking synergy effects (e.g. inter-linkage between HFOMC and PDQ was not clearly observed)
- Efforts were limited/focused to selected group(s) of health workers, efforts focused to individual capacity building rather than institutional/organizational capacity building.
- Agendas of HFOMC members limited mostly on drugs, equipment and infrastructure related issues. Committees were not guided/instructed to discuss on other aspects (e.g. service delivery, access and quality of services, concerns related to social inclusion and governance issues etc). HFOMC meetings were guided/lead by HF in-charge with negligible influence of other members
- Majorities of interventions are happening as "event" rather than "process". Initiatives taken by projects should be linked to and inbuilt within the public health system to ensure ownership and to continue program impact.

RECOMMENDATIONS:
- Inter-linkage between different interventions is necessary to build synergy. Merging HFOMC and PDQ package (covering special feathers of each) and developing a combined package of about seven days would be better than implementing two interventions independently.
- Intensive and immediate follow-up and monitoring within initial stage of program implementation is necessary to gain designed and sustained program impact.
- "Fill in the gap" support from the project on the initiatives taken by HFOMC/community is necessary. Such support could be provided as per the need of specific area/district following the mandate and guideline for the program.
- Complementary activities at high-demand sites (e.g. PLA class at *muslim* community/*dalit* community) would add value of the program and help to minimize the gap between different geographical sub-sectors. Thus, some interventions should be applied on blanket approach (e.g. HFOMC) in all areas and others should be applied as per need/demand basis (e.g. PLA class) on specific sites only.
- Program management and operation structure (parallel staff from JSI and sub-grantee) at district and regional level should be reviewed and revisited.
- Community mobilization activities/initiatives for promoting social inclusion and promoting good governance practice should be emphasized, in addition to technical inputs through training/workshop/technical support visits. Community friendly tools for monitoring good governance and social inclusion status (e.g. social audit) should be designed to applied for/with/through health facility operation and management committees. Involvement of dalit/marginalized population is not adequate, but defiantly a step towards (meaningful) participation.

Acknowledgements:

We would like to thank all respondents who spared their valuable time, opinions and ideas with the assessment team. Special thank goes to Dr Bajra Kishore Thakur, DHO Sunsari; Bishnu Bahadur Thapa, LDO Sunsari; all staff, FCHVs and HFOMC/QI team members from Baklauri Health Post, Haripur Sub Health Post, Bakraha Sub Health Post and Basantapur Sub Health Post for their open and critical comments and clear recommendations for the program. Save the Children US (HFO Health Team, ERO Team and Sunsari Team) and NFHP Field Office, Biratnagar deserves special thanks for their credible help, support, cooperation and participation in this process.

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INTERVIEW WITH DISTRICT HEALTH OFFICER AND PUBLIC HEALTH ADMINISTRATOR- SUNSARI

Respondents:
Dr Bajra Kishore Thakur, District Health Officer
Mr Rakesh Thakur, Public Health Administrator

Health Facility Handover

- Process initiated three years ago, with WHO/HMG/MOH fund (?)
- 40 SHPs handed over to local bodies during first year, handed over 2 HPs and one PHC in second year, 4 HPs and 4 PHCs handed over on the third year (only one HP i.e. Inaruwa HP is remaining for handover)
- DHO and PHA perceived that health facility handover was carried out in rush, without necessary planning and community preparedness and at the time of absence of local elected personnel
- Orientation is needed after election, for newly elected members
- HF In-charges were not in favor of HF handover, especially during the first year; need and importance is gradually being realized among them
- Till now, most (HFOMCs and members) are focused on the issues related to: physical infrastructure related issues, local staff hiring and recruitment and drugs related issues
- Need to divert their emphasis to other (especially social issues)

Health Facility Operation and Management Committees

- The training (HFOMC Capacity Assessment and Strengthening Training) is very helpful, to clarify the role of HFOMC members and to activate them to operate effectively
- Expectations are not fully achieved, as the committee is lacking elected representatives
- Emphasis is being provided to make active participation of dalit and women members, but it will take time …
- Support is being provided to HFOMCs through orientation, supervision/monitoring and follow-up visits

- HFOMCs started to take new initiatives: Baklauri HPs started laboratory services After VDC/HF purchased equipments, the salary of lab assistance and other operational cost being covered from lab fee and DHO provided necessary training
- Program has been effective and recognized, thus visited by different other districts for cross-learning (e.g. Kanchanpur, Sunsari)
- Sitagunj HP assigned duty/role for different health activities at community level for effective health program and to maintain program impact

Partnership Defined Quality

- Good approach, as focus/address both health service and community aspects
- Helped to improve awareness level of community, on different aspects of health
- Display of citizen charter helped to improve community's awareness, a tool to convince them on the type and quality of services to be delivered from health facilities and roles of health workers
- Regularity in service delivery improved, quality of services improved (e.g. use of AD syringe), more respectful behaviors towards clients-without discrimination
- Patients flow increased, even after CDP implemenation
- PDQ process only at health facility is not adequate, it should go beyond VDC level (i.e. up-to ward/village level) and including PRA activities/process inbuilt in the process
- Not only one-shot PDQ is not enough, we need to have follow-up to sensitize them and encourage them

Social Inclusion/Participation of marginalized section

- Through CDP program, health facilities are selling medicines @ 50% of MRP (for general clients) and @ free for poor and marginalized section, as pre-selected by FCHVs and community jointly
- Instructed by DHO to provide (mandatory) 10-15% free consultation (registration fee) and drugs for each health facility; used to followup by DHO if the guideline is not enacted.
- Free service for FCHVs (once a month) and disabled
- Encouraged and motivated dalit and muslim communities for use of FP commodities, through flexible fund (FF) program

<u>Changes observed:</u>

- Improvement in health indicators observed (improved EPI coverage, improved health service utilization for safe motherhood and antenatal care, Contraceptive Prevalance Rate improved, practice of having VSC even when the couple have two daughters, improvement in literacy status among PLA group members, more positive and conscious attitude towards health)

<u>Areas for improvement/Missed opportunities:</u>

- Adequate and proper support from DDC is lacking, difficult unless elected representatives are in place
- Support from VDC secretary is satisfactory (based on current context!). Some understand well, others have hard time to understand. Variation has been observed among VDC secretary based on their awareness on health matters, attitudes and interests.
- No specified instruction to allocate fund/budget for health program. Thus, policy change (for explicitly stated instruction) for fund allocation for health

Suggestions for days ahead:

- Program to be continued – though on reduced intensity – for sustained program impact
- Need to follow-up support for HFOMCs – to help them to act effectively
- Program should be implemented on more decentralized opearational model (through having some flexible fund to fulfill some immediate and necessary need of districts (example, we have good training hall but not a functioning OHP. BNMT supported for chairs for the training hall. Such support would be very helpful for DHO and its program and also to development partners to implement their programs)
- Management support to ensure timely and quality submission of HMIS and LMIS is necessary
- Need to keep up good team, as in current days

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ANNEX - V

FIELD TRIP REPORT ON ASSESSMENT OF NFHP INVOLVEMENT IN STRENGTHENING HEALTH FACILITY AND OPERATIONS COMMITTEES IN CHITWAN DISTRICT

Submitted to:
NFHP
KATHMANDU

SUBMITTED BY:
RAM KUMAR SHRESTHA
Kathmandu

Field Trip Report on Assessment of NFHP Involvement in Strengthening Health Facility and Operations Committees in Chitwan District

(March 22nd — 24th, 2006)

1. Background:

Health services should reach people and should be accessible by everyone. According to decentralization principle, health facilities should be managed at the local level by local government and the community people. In order to follow this decentralization principle, His Majesty's Government started handing over health facilities to the community management committee. The objective of handing over the operation and management of the health facilities to the local management committee is to make community people utilize health services effectively and efficiently by managing services at local level. After handover of the health facilities to the local bodies, local management committees are expected to manage health facilities with more responsibility and accountability.

Furthermore, after the Decentralization Act the government has handed over health facilities in twenty five district to the local bodies in order to decentralize the health services, address social exclusion and to deliver health services to poor people. Out of the 25 districts CARE/NFHP has been providing technical support in five districts. .

The process of handing over health facilities to the local bodies is as follows:

a) Formation of Local Health Facility Operation and Management Committee

b) Profile collection of Health Facility employees and property

c) Handover/ Advocacy orientations to members of local bodies

d) Orientation to local facilitators

e) Orientation to local health facility operation and management committee

2. Objectives of The Field Trip:

- To participate in the ongoing assessment of NFHP involvement in strengthening Health Facility and Operations Committees, particularly through review of field-level implementation.

- To review Mothers-Group-related activities: 1) implemented by NFHP and 2) implemented by other agencies active in NFHP Core Program Districts, particularly through review of field-level implementation and also to assess potential for expanded community role as health promoters.

3. Field Trip Activities and Observations:

i. Orientation at CARE/NFHP Program support office:

I visited CARE district office in Chitwan, where we were briefed by CARE staff about the CARE /NFHP Phase I and Phase II activities. The program focused on Quality Service, Capacity building and Advocacy. Phase II mainly focused on the follow up activities of the Phase I. All HFs were handed over to local government except one HP and one PHC where the concerned people found difficult to dissolve the previous Health Committee as they had contributed everything for the health post and are afraid that the new committee may not be that much dedicated.

We were briefed that most places conducting regular meetings were not possible, as the secretaries did not live in the VDC. Representation from different sectors is well maintained in management committee. I was also briefed that some of the members did not give enough time for the improvement of the functioning of health facility. Most of the time they discussed about the curative issues rather than preventive care. Women and Dalit did not raise many issues about the group they represent. Furthermore, public health issues were not emphasized. Most of the time teachers were absent in the meeting as they did not have time.

VDC secretary plays a crucial role in facilitating the meeting and in decision making. Secretary position is lower in rank (Kharidar) than SHPI so health facility in-charges feel uncomfortable in dealing with them. It has been discussed that it would be helpful if ex VDC chairman or socially respected person could be given the responsibility of chairman until a new VDC chairman comes after election. The group also discussed that it would be better if HFOMC formed a committee that is similar to school committee where the members are selected from the stakeholders (parents or guardians).

Partner Defined Quality (PDQ) methodology was used to sensitize community people for support and mobilization, to develop partnership between community and health workers and to make HFOMC understand their roles and responsibilities.

ii. District Development Committee: Interaction with DDC members and LDO:

The meeting was conducted at the LDO office where DDC chairman was also present. During the discussion, DDC chairman remarked that there should be zero politics in the health services and in its management. He mentioned that local people should run the health facilities but there should be representation from all political parties. Unlike the present system of bringing members from different sectors, he suggested that the members should be selected from among the stakeholders as in the School Management Committee. The other people present in the room raised their concerns that the diversity of stakeholders will make the selection process complicated. Most of the comments were related to drugs supplies, transfer of staff and doctors spending more time in their private clinics.

LDO commented that the devolution started in 2055/56 by handing over health facilities, which happened as a ceremonial event. The concept of handing over health facilities to local people representing different groups is very good but this requires a detail understanding of the process, responsibilities and accountability to the operation and management of the health facilities He remarked that the

members should be well aware of the kinds of health services provided by health facilities as well as develop knowledge and skills in management and mobilizing local resources.

The members remarked that the health staff as well as local bodies was not clear about their roles and responsibilities. The main problems were lack of understanding of the magnitude of the responsibility, inadequate capacity and skills to implement and to generate the resources for the management. In addition, the VDC chairman, who plays important role in making decision and managing financial part of the process, has not been elected.

Progress has been made in some of the health facilities to improve the quality of health services. He commented that he is concerned that if resources and capacity of local management committee would not improve, the committee members might loose interest and resign from the committee. Furthermore, he mentioned that NGOs role is important in providing technical support but they should be transparent in their activities and should work closely.

iii. ***Padampur Sub-health post: Interaction with SHPI, QI team/HFOMC and FCHVs:***

SHI briefed that HFOMC was meeting regularly every month where they mainly discussed about how to create awareness among community people of the health services, about the use and management of user's fee and buying new equipments. The members of HFOMC have been very active in increasing the attendance of pregnant women for ANC checkup, and coverage of poor people seeking for health services, and availability of medicine.

The members remarked that SHPI is very active and motivated. He was able to solve many locally manageable problems by working closely with HFOMC e.g. collecting resources such as curtains from SHPI and CARE, water filter from VHW, etc. SHP has also conducted health camps, started school health program and utilized students to clean waste products. There was no particular "Mothers Group" as such but once a month the FCHV called mothers from the community where she provided health information. There was a saving credit mothers group and where FCHVs are also the members of that group. There was also outreach clinic, which they run during EPI clinics. There is an endowment fund of Rs.15000 established by VDC and has plan of adding Rs. 5000 this year. FCHVs were receiving Rs.50.

HFOMC has commented that PDQ was very helpful in developing work plan and Plan of Action. However, as the SHP was handed over without proper process and detail information about their roles and responsibilities, they would like to get more information and skills about management. The members mentioned that the technical and financial support from CARE/NFHP should be continued. This is partially helping them to fulfill their plan and decision.

HFOMC members have been promoting FCHVs in the community by highlighting her contribution in providing health services to women and children. This has increased the credibility of FCHVs in the community that has made them provide service smoothly.

iv. District Public Health Office in Chitwan: Interaction with PHA and district supervisor:

The district health staff commented that the health facility handing over process was not discussed with them before the actual handing over ceremony. Nobody consulted them so they did not have any idea as to what will happen to the operation and management of the health facilities. The HFs were handed over without making local body capable and ready for it. Health management committee members did not have complete understanding of their roles and responsibilities. They further mentioned about a need to develop skills needed to contribute in improving the quality of health services.

There were no regular HFOMC meetings as VDC secretary was not available in the village. It was felt that two days TOT was not enough to conduct the training. Also, regular follow-up of the HFOMC was required to improve the capacity of the HFOMC members. Most of the HFOMC were concerned about the administration and finance of the health facilities but very little discussion was made on the improvement of the quality of preventive health services. Necessity of a formal channel of dissemination and feedback mechanism of the decision or discussion occurred during the meetings was recommended. Furthermore, it was recommended that SHPI should play a lead role in facilitating the HFOMC meeting and in creating awareness among the people. They also felt that external support from CARE/NFHP is crucial for strengthening and functioning of the capacity of HFOMC.

v. Panchakanya Clinic (Municipality): Interaction with SHPI, HFOMC and FCHVs:

The HFOMC members commented that SHPI is very active and has good relation with the community people and the management committee members. The management committee meetings were held regularly on bi-weekly basis. As they had decided to construct their own building, management committee members were working hard to collect donation for the construction work. The HFOMC members requested for observation tour, refresher training, and external technical and administrative support.

Mothers Group meeting was held every month. They focused on saving and credit group but talked about health also. They all received Rs. 100 per month from VDC. As the clinic is situated in a municipality, ANC coverage is high; therefore it was recommended that they have privacy for ANC check-up and a separate delivery room.

vi. Gunjanagar VDC: Interaction with REFLECT Circle:

The CARE/NFHP staff briefed that the program had established a REFLECT circle in Gobreni Tharu Tole of Gunjanagar VDC. The circle had 32 participants who met every week on Thursday for two to three hours to discuss about the health and other social issues. Ms. Prabha Giri, a facilitator, had received training of 10 days. She facilitates the meeting every week. She uses different assessment tools (e.g. social mapping) to visualize problem and to find solutions to solve those problems with local resources. The center where the meeting occurs is called "Bahas Center". The objectives of this process are to sensitize community people to identify their health issues and to form a pressure group to advocate community people's health right issue.

CARE/NFHP supported to facilitate the meeting of the circle for nine months. The group members commented that the meeting has given them broad knowledge of

the health services provided by health facilities and also about their health rights. The group has been able to control alcohol drinking and gambling, which had brought many problems in the society. They also mentioned that the support from CARE/NFHP for nine months was not enough to conduct social campaign.

vii. Rural Self reliance Campaign:(Meeting with NGO):

Rural Self Reliance Campaign, a local NGO, is a REFLECT implementing partner in Chitwan. This NGO has been running 10 REFLECT centers in 5 VDC of Chitwan district. The field staff of RSRC briefed that RFLECT has been able to create social movement and pressure group in the field of health and other social aspects in the community. The process has been able to create awareness of health service available in the health facilities. It had helped to run outreach clinic smoothly. The problems faced by this process were irregularity of members participating in the meeting, marginalized groups such as poor and dalits were very busy and their dropout rate was high as they did not receive any compensation.

4. Conclusion:

This report includes the information collected from the members of two SHP management committees, DDC members, DPHO staff, one NGO staff and CARE/NFHP staff of Chitwan district. It has been able to capture the impression of different stakeholders on HF handover process, operation and management of health facilities under the HFOMC and the present situation of FCHV mothers group in the district.

a) ***Hand over process:*** One major comment that was common to all interviewees was that the hand over was done in a quick manner without enough preparation. Both parties (handing over and taking over) were not fully prepared for it and were not clear about their roles and responsibilities. Furthermore, parties' questions, comments and concerns were not discussed in a common forum.

b) ***Health facility operation and management committee:*** As the different groups of the community have represented as the members of the HFOMC, their background and previous experience are diverse. Due to this, the two-day orientation given by NHTC was felt to be inadequate. In order to make them fully aware of their managerial capacity, inputs must be focused on skills on HF management, developing plans to solve health service problems, monitoring and also in generating and mobilizing local resources. To achieve this, there is a need of continuous capacity building efforts with regular follow-up and assessments.

c) ***Reflect process:*** It has been able to sensitize women's group in Gunjanagar about their health service rights, which has led to the increase in utilization of health services. In addition to this, the process has built the capacity of women to put pressure on existing inappropriate social practices in their society. However, more clarity is needed on the long-term use of this process.

5. Proposed Future Plans:

Although the conclusion is based on the observations and interactions conducted only on a few SHPs and HFOMCs, I got some basic understanding about the stakeholders' feelings of handing over process and the present situation of the functioning of HFOMC. However, in order to understand the process in depth, it is necessary to interact with both service providers as well as receivers regarding their perception of handing over SHP to the management committee and the functioning of HFOMC. It is also essential to understand how much the quality of health services has been improved in terms of operation, management and administration. Based on this, I propose to conduct the following activities:

i. With service providers:

a) Interact with individual members of HFOMC to collect information about the problems they are facing during the handing over process

b) Interview VDC secretary about their experience of handing over process and functioning of HFOMC

c) Interviews with DPHO

d) Interview with MCHW and VHW

e) Interview with FCHVs mothers group activities

f) Interview with Mothers Group Members

g) Interview with school teachers

ii. With service receivers:

a. Exit interviews with the client about the quality of health services and compare it with the one before handing over process

b. Interact with mothers who have participated in PDQ process

c. Observe some REFLECT process and interact with its few members

INTERVIEW WITH HEALTH FACILTY INCHARGE, FEMALE COMMUNITY HEALTH VOLUNTEER AND HEALTH FACILITY OPERTAION AND MANAGEMENT COMMITTEE MEMBERS

- Haripur Sub Health Post (Md Yuinesh Khan, Village Health Worker)
- Baklauri Health Post (Deverndra Narayan Sharma, Sr AHW sixth level)
- Bhokraka Sub Health Post (Govind Prasad Ghimire, Village Health Worker)
- Basantapur Sub Health Post (Sunil Kumar Bhagat, Auxially Health Worker)

Major achievements and changes observed during last three years:

- Health facilities handed over about one and half years ago
- Initiated Community Drug Program, about two years ago, clarified importance of CDP for community and its outcome
- Helped to regularize health services delivered from health facilities
- Resources and supports has been optimally utilized by health facilities
- HFOMCs looking after (monitoring) available and required physical infrastructure for health facilities
- Monthly meeting are being held (and almost on regular basis), though the agenda of meetings mostly focused on drugs, infrastructure, and equipments. Very limited agenda on service quality, social inclusion issues, community access on health services, FCHV support etc
- The HFs which were visited by the assessment team have already addressed all identified issues. So, HFMCs are focusing the CDP & infrastructures issues now. We need to help HFOMC to develop mechanism/system to assess the issues and address them in continuous manner). By nature, people have more attention to physical things. Community mobilizer should play catalytic role.
- VDCs used to provide different support – construction/renovation of HF building, toilet construction, compound wall, dress and allowance for FCHVs
- HFOMCs initiated initiatives – e.g. establishment of lab services through management committees, being run through the lab fee
- Encouraged/proposed to provide support to FCHVs, thus FCHVs are receiving monthly meeting allowance, received Sari and Cholo this year
- Instructions/policies of DoHS/MoH discussed on HFOMC meetings, community more aware about policies, programs and procedures
- Less community complain against health facilities and health workers

Coverage of services,

- Balanced coverage of/for services for all ethnic/social groups
- Fair utilization pattern of health services (proportion of dalit at community and proportion of clients among total clients is balanced), for all type of program like EPI, Safe motherhood, treatment etc
- HFOMC reviewed service fee- reduced for few services (e.g. reduced to Rs 20 from Rs 50 for tooth extraction, to Rs 10 from Rs 20 for general dressing)

Access to health services

- Access to health services improved, through year round availability of medicines at subsided rates through community drug program
- Provision for free treatment (consulation+drugs) for poor people is fairly effective (?)
- Service utilization from *muslim* community is also relatively fair, as compared to days in past, more empowered clients/patients even from *muslim* communities

Strength areas:

- Improved availability of drugs at affordable cost
- Improved community awareness on health and social matters
- Improved availability of additional services (e.g. lab services from HPs)
- Regular (relatively) meeting of health facility operation and management committees
- Good trust and support to female community health volunteers (from health facility and community)
- Improved community trust on health facilities
- Continued support from village development committees
- "Bridging the Gap" Workshop helped greatly for developing better understanding among communities and health workers, thus to be continued (better communication and interaction among stakeholders)
- Same problem have different ideas/opinion/concerns among different stakeholders, thus events for having interaction between communities and health facilities is important

Areas for improvement/missed opportunities:

- Coordination on some areas – to be improved – especially those through partner NGOs (e.g. HF staff not aware/informed about the activities of PLA activities)
- Program activities should be implemented on logical order
    - Community Mobilization → PDQ → HFOMC → Follow-up

INTERVIEW WITH LOCAL DEVELOPMENT OFFICER (LDO)

Respondent:
Mr. Bishnu Bahadur Thapa, Local Development Officer, Sunsari

[Mr Thapa is a newly transferred in LDO for Sunsari district, thus lacks knowledge on the process adopted and progress happened to date especially for Sunsari district. He provided his opinion and common concerns related to handover of health facilities to local bodies, based on his understanding and knowledge on the overall government policy and process being adopted on different sectors]

Concerns/Opinions

- The issues raised during and after HF handover is never discussed with/among VDC secretary, during last four months
- If there was any significant problem or achievement, that would have defiantly be an agenda. As there is not any discussion, we can assume that this is happening on average-mode trend
- Current policy is not clear on some of the aspects of and after HF handover (e.g. what if HFs intends to add a new position?, what if current staff is retaired?, How to refill/transfer-in for such positions?, How/Who to decide regarding promotion and upgrading issues of current staffs? Monitoring/reporting and accountability issues is not yet clearly clear!!!)
- Need to formulate a policy (from higher level) explicitly specifying/guiding to spent a definitive proportion of VDC (and DDC) fund for health program
- Principally and theoretically, the concept of decentralization is very good, but the process and practice is not so good. Process has been adopted without proper ground work.
- DDC need to have a focal person (point-person) for health programs. Current organizational structure and available human resource is not adequate (and appropriate) to take-up decentralized roles/functions.
- Decentralization and handover happened only in papers (documents) not in practice. Everything is almost happing as usual, except diverting flow of funds.
- Central level coordination (between concerned ministries) is not satisfactory and adequate. Need more focus at central level, before moving to field level
- Flexible fund (or flexibility in funds mobilization is necessary), for effective and efficient decentralized management functions
- Limited resources and binding regulations is not helpful for moving ahead

Recommendations

- Development partners need to ensure organizational preparedness (at all levels) before deciding to support for decentralization
- Clarity on concerned issues (as listed above) is utmost necessary
- DDC is (and will be) able to play active role, as desired by program but required organizational (structural and other) changes have to be made and flexibility in allocation of fund is required

DISCUSSION WITH NFHP FIELD STAFF (from SC US and NFHP)

Presence: Purushattam Singh, Tara Acharya, MN Mahato, Hari Rana, Deepak Paudel, Devendra Karki, Hira Tiwari, Eakraj Dahal

Strength areas:

- Tools/interventions (like HFOMCs, PDQs) itself are not enough, wise application of them is utmost important
- Frequent monitoring and follow-up support, immediately after major intervention especially until first five-six months is necessary to bring and sustain program impact, as desired
- Programs/activities mostly focused to health facility in-charges, other staffs of health facilities should also be involved/engaged as much as possible (e.g. VHWs/MCHWs in SHPs; AHWs, ANMs in HPs). Should aim to build/develop organization capacity than individual capacity building. Should focus on Whole Site Intervention, than selected member focused
- Adding additional members (in QI team) have different implication, have some value-add but may have various implications (e.g. one QI member in one HF frustrated after he was not allowed to participate on an event organized for HFOMCs by DHO, due to budget constrains.) This should be further explored from other districts and find out appropriate solution
- HFOMC Capacity Strengthening is a phase-wise process/approach. Strategies and interventions for HFs crossing the phase I should be developed and applied
- HFOMC and PDQ both have their unique and important feathers. Both of them should be captured, but not separately. Need to workout the ways to keep them ahead together as different steps of an initiative to build capacity of local committees though participatory planning approach.
- Approach for annual review of key activities (e.g. HFOMC and PDQ) is necessary. Use of spider-web chart has been very useful, to make them understand their situation, stage to achieve and strategies to achieve desired stage and to motivate them to move ahead. Balanced representation (geographically vs other aspects) is important (even remaining within the current guideline framework). Mechanisms to ensure balanced and appropriate representative should be in place (as proper selection of members is very important for effective HFOMC operation)
- Interventions should be intervened on logical order, to the extent possible. Recommended order is as follow: Community Mobilization → PDQ → HFOMC → Follow-up (intensively for first five months) → Follow-up (in lowered intensity)

Areas for improvement and Recommendations for future;

- Monitoring and follow-up is relatively weak. Better role clarification between different NFHP partners is necessary. The same agency involved in program implementation should be involved on program follow-up and monitoring.
- High workload, need to be more focused on program implementation , no time for follow-up and monitoring on systematic manner as desired.

- Delayed in finalization and publication of some key documents (e.g. HFOMC package, FP/C Refresher Training Package, PDQ package).
- Though PDQ has been described and explained as a process, it has been applied as a event.
- Extending HFOMCs to QI team by adding some members from marginalized population may have some un-intended implications. Advocacy at national level for allowing flexibility to add more members from marginalized population as needed might be helpful. Efforts are lacking to make their participation meaningful from the stage of representation. Empowering female/dalit/jananati members to help them play effective role at HFOMC is necessary.
- Need to identify interventions to be applied on blanket approach and to be applied on selected sites (as required basis).
- Monitoring tools and indicators should be liked and inbuilt with HMIS and existing system, rather than developing additional system (e.g. HMIS indicators vs NFHP indicators).
- Need to review current program operation model (two parallel team – of JSI and sub grantee on same district). A merged team for NFHP or allocating specified districts for specific organization would be better (also recommended for further discussion at different level).
- Program should be focused on broad health agenda, not only on selected medical issues (e.g. drugs, equipment and infrastructure issues) – should be public based rather than patient based (health vs medical; public vs patient).

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