__Final Report__

EVALUATION STUDY OF DECENTRALISED HEALTH FACILITIES IN NEPAL

Prepared for:

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LIST OF ACRONYMS

ARI	:	Acute Respiratory Infection
CBMC	:	Community Based Maternal Care
CBNMC	:	Community Based Neonatal and Maternal Care
CBS	:	Central Bureau of Statistics
CDP	:	Community Drug Programme
CDO	:	Chief District Officer
CI	:	Contract In
CO	:	Contract Out
CSO	:	Civil Society Organisations
DDC	:	District Development Committee
DIMC	:	Decentralisation Implementation Monitoring Committee
DoHS	:	Department of Health Services
DPHO	:	District Public Health Office
ECs	:	Exit Clients
FCHW	:	Female Child Health Worker
FGD	:	Focused Group Discussion
GoN	:	Government of Nepal
HF	:	Health Facilities
HMC	:	Health Management Committee
HMCCP	:	Health Management Committee Chairperson
HP	:	Health Post
IMCI	:	Integrated Management of Childhood Illness
IOM	:	Institute of Medicine
JAR	:	Joint Annual Review
KAP	:	Knowledge, Attitude and Practice
KI	:	Key Informant
LB	:	Local Body
LDO	:	Local Development Officer
LHIOMC	:	Local Health Institution Operation Management Committee
LHI	:	Local Health Institution
LSGA	:	Local Self-Governance Act
LSGR	:	Local Self-Governance Regulation
MCHW	:	Maternal and Child Health Worker
MLD	:	Ministry of Local Development
MoAC	:	Ministry of Agriculture and Cooperatives
MoE	:	Ministry of Education
MoF	:	Ministry of Finance
MoLJ	:	Ministry of Law and Justice
MoH	:	Ministry of Health
MoHP	:	Ministry of Health and Population
MTSP	:	Medium Term Strategic Plan
NGO	:	Non Governmental Organisations

NHP	:	National Health Plan
NHSRP	:	Nepal Health Sector Reform Programme
NHTC	:	National Health Training Council
NLSS	:	Nepal Living Standard Survey
NPC	:	National Planning Commission
PDQ	:	Partner Define Quality
PHC	:	Primary Health Centre
PHCC	:	Primary Health Care Centre
PS	:	Private Sector
SHP	:	Sub-Health Post
SHPI	:	Sub-Health Post Incharge
SLTHP	:	Second Long Term Health Plan
VDC	:	Village Development Committee
VHW	:	Village Health Volunteer
VPs	:	Village Panchayats

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I believe that the findings of this report will be of great value to planners, policymakers, researchers, managers and service providers involved in these areas for the effective programme planning, monitoring and evaluation of plans and programmes in Nepal.

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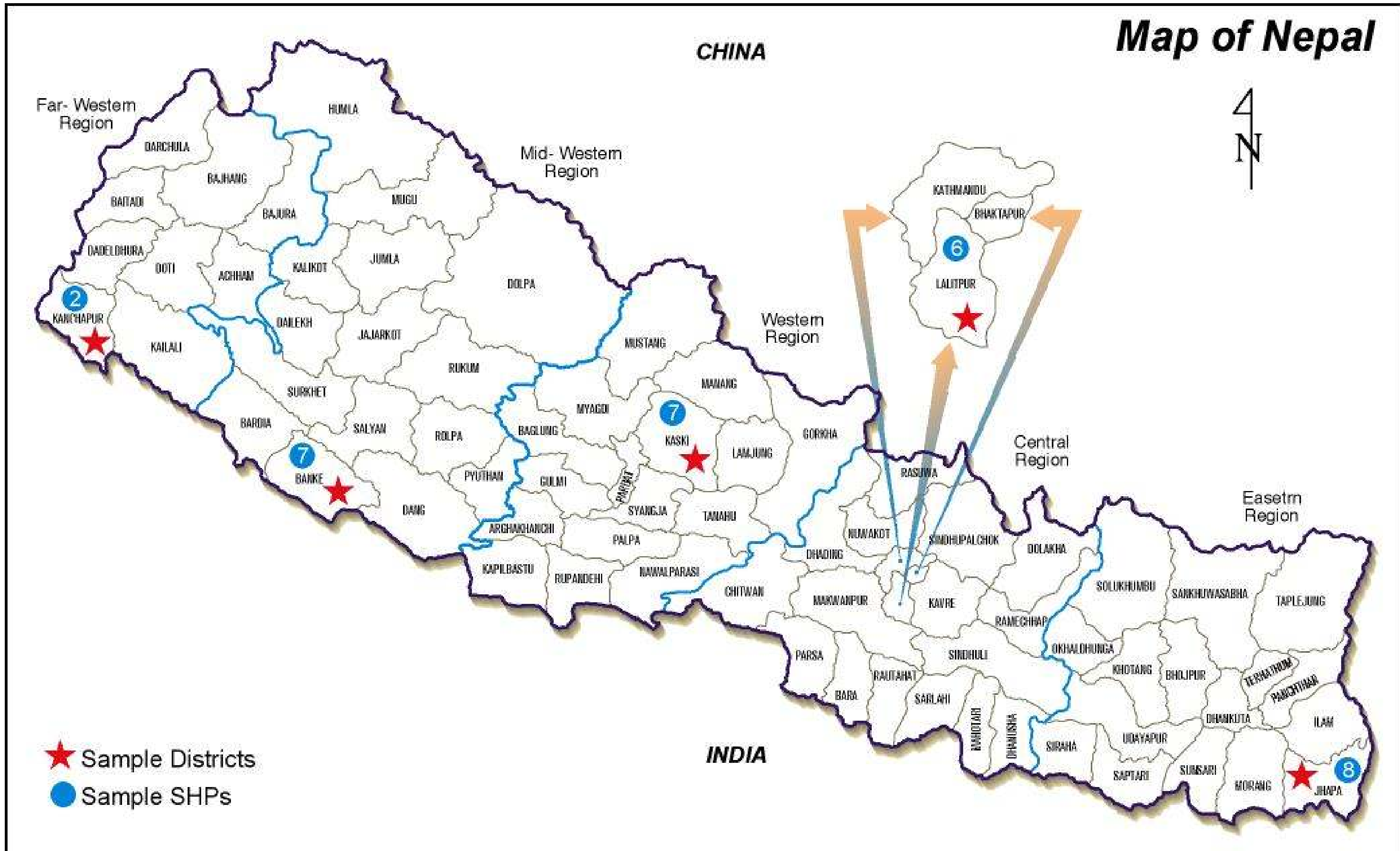
MAP OF NEPAL SHOWING SAMPLE DISTRICTS AND SAMPLE SHPs



EXECUTIVE SUMMARY

In a more explicit way, after the enactment of Local Self Governance Act (LSGA) and its regulation 1999, Government of Nepal (GoN) decided to decentralise management responsibility to its lower authorities. Decentralisation of Sub Health Posts (SHPs) to Village Development Committees (VDCs) begun in 2002 with a decision to form a local health facility operation and management committee, therefore giving ultimate responsibility for health development to communities themselves.

Over the years several documents dealing with decentralisation of health services were produced. Although the government and its stakeholders who are involved in health sector decentralisation have produced different studies, the comprehensive study covering the wider community coupled with literature review, self-observation and along side the international experience was yet to be carried out. However, it was realised that a review of all related documents on decentralisation of health facilities and handover status with the verification of SHPs with empirical data need to be carried out. This report is the one that has been carried out to realise those needs, which provides first hand information to the wider communities of those who are involved.

The objectives of the study were to review the existing documents and studies related to decentralisation of health facilities in Nepal, analyse the current status of handover of health facilities to the community and recommend the appropriate strategy for the effective operation of the community managed health facilities.

Retrospective review coupled with cross sectional descriptive study was conducted. Information was basically collected from primary sources while literature review served the secondary source of information. Purposive sampling technique was applied putting the geographic regions into strata. In this connection five districts, each representing each development region, were selected. They were Jhapa, Lalitpur, Kaski, Banke and Kanchanpur. In-depth interviews and focused group discussions were carried out covering 30 SHPs (20% of the total handed over SHPs). Besides, on-site observation of few SHPs per district was also carried out. The data received were triangulated with other respondents. For in-depth interviews, key informants of central, district and village level were contacted. This research also reached out to the health management committee, SHP In-charges and exit clients level.

Literature review revealed that 1251 SHPs, 237 HPs and 90 PHCs of 27 districts were already handed over to the local communities. In the fiscal year 2059/60, the government handed over 146 SHPs in the selected sample districts only. It was found that majority of HMC Chairperson; SHP In-charges and district level authorities had sufficient background information about the handover who mentioned, this being a good one. The communities, on the other hand were found to have very limited knowledge and even uninformed in many cases.

The stakeholders who are part of the handover process took capacity building as major concern. None of the respondents found satisfied with the one or two time of orientation, hence needing 'a package' training in a modular basis. It was suggested that the package should have good mix of technical and managerial contents.

Majority of the respondents claimed that there have been remarkable changes in the condition of SHPs after handover. Community awareness is increasing than before, and communities started to take ownership of towards SHPs. The utilisation aspect of the health service was also found to be increased. However, some of the respondents perceived that after handover to communities there was no change observed as of before, and very few responded only a minor change.

Generally speaking respondents were satisfied with the inclusiveness of the HMCs. This committee was trying to be take initiatives however, is just limited within the paper. Because, firstly there were no elected local bodies and secondly the VDC secretaries were unable to be on the site to chair and run the SHPs. Second this associated with this was the authority delegated to the committee and the status conflict between VDC secretaries and SHP In-charges. In general the behavior and punctuality of SHP staff was found to be improved.

Mixed results came out in terms of SHPs preparing plans and implementing them. Generally speaking dominant number of SHPs had annual or long-term plans however failed to implement due to financial constraints. Communities were unable to mobilise local resources. Apart from regular drug supply from the government, very few SHPs have community drug programme. SHPs were also found to be charging certain extra fees, which has served them as a source of income, however communities were not found satisfied with those rates. It is important that resource mobilization is important for the sustainability of the services provided by SHPs and they must be able to generate income for the running of the SHP activities, but at the same time effective policy protecting the access of the poor to the services must be implemented. To maintain the willingness of the population to pay for the services and the quality of the services must be improved simultaneously with the implementation of user fees. The drug supply system was criticised being delay one and not providing quality medicines or medicines that are about to be expired. The budget transfer system was also found to be lengthy and time consuming hence requiring DDC to transfer budget directly to VDCs from where SHPs can get funds.

Majority of SHPs also lack required infrastructure. This ranges from not having toilets to the pregnancy check up in the storeroom. Many respondents have urged to have at least one separate room for the maternity related check up.

Conflict has also adversely affected the proper decentralisation process. In comparison to other sectors, the effect in health sector was found to be minimal, however demands from rebels in terms of donation, looting of medicines and in some cases the destroying of SHP, has affected the proper implementation of the process. Besides, the conflict has its major impact denying VDC Secretaries to reside in their own VDC sites, and for the timely elections at local and district level.

Needless to emphasize, regardless of many bottlenecks there has been remarkable changes occurred at the local level. These changes were communities taking initiatives towards SHPs' activities, increased service utilization, changes in staff behavior and punctuality, building of SHP infrastructures etc. Saying these it does not mean that all changes happened in a positive way. Whatever mentioned, there is still a room to question about staff attitude towards their support in the decentralization process wholeheartedly. Because the recent strike of over 26,000 paramedical staff demanding to end the SHP handover does not support their field level opinion. This is one of the serious areas that tarnish the overall credibility.

At the 'policy making communities' level, there is also a concern that whether government really takes forward the decentralisation movement or not. If we say they do, current forms of authority and responsibility handed over to local levels does not support their positive intention. If we say no, there are some forms of deconcentration rather a complete devolution where very limited authorities have been given up. Current forms of deconcentration has put the both SHP staff and VDC Secretaries in a dilemma that what should they do or not. It is not yet clear what are their working lines and accountability mechanisms. Because the LSGA, which has been taken as a major basis of health services decentralisation, does not explicitly draws a clear picture for health services decentralisation and responsibility and accountability mechanisms. Further, some laws still contradict with LSGA. Therefore, a need for a new act to for health services decentralisation has been realised. Needless to emphasize, policies does not work out itself rather it needs to be worked by the people who are in positions and power. As other things remain constant, we still need a higher degree of resources, not in terms of millions of rupees, but in terms of greater commitment to institutionalise a functional system of health service decentralisation at local level.

CHAPTER ONE: INTRODUCTION

1.1 Background

During the past decades, Nepal has undergone through a series of rapid changes. Fast-pace and drastic changes in economics, politics, culture and information technology have all impacted the health systems. These changes have ultimate impact our existing health systems to be unable to adjust to the emerging circumstances of the current world.

Sound economic health of the nation greatly relies upon the sound health of its people that should be ensured through equitable and high quality health services to all. The formulation of the Health Sector Strategy in Nepal: an Agenda for Reform, Nepal Health Sector Programme Implementation Plan (NHSP-IP) 2004-09 was necessitated having clearly identified eight outputs to health sector. The key consideration in achieving these outputs can be summarised as:

- Providing essential health care services in an inclusive approach
- Decentralisation of health services for improving the access to and coverage of health care delivery
- Recognition of the role of private sector in assuming some functions of health care delivery and forming public private partnerships for efficient and effective health care delivery, and
- Sector wide approach for the sector management

This showed that Government of Nepal (GoN) has taken necessary steps towards the process of health sector decentralisation since many decades. More explicitly the enactment of Local Self Governance Act (LSGA) and its regulations 1999 were the milestones to prove government's political commitment into action through legal provision. At operational level, the budget speech of 2002 was the first one that gave permission to Ministry of Health and Population (MoHP) to handover the Health Facilities (HFs) to Local Bodies (LBs).

1.2 Problem Identified

In spite some progress, numerous problems in various aspects of health delivery services have made the overall health sector probably a mess. The planning process was centralized model and policy decisions regarding planning including settings of targets were taken at central level based on central level budget, capacity and priorities. Plans were not need based in the absence of mechanisms to guarantee community representation in the planning process and receiving feedback from service user regarding quality, quantity, and appropriateness of service provided. Logistic supplies including drugs were not timely delivered to the districts due to the lack of transportation resources and budget. The supply of drugs at the district health facilities was inadequate with the annual provision of essential drugs sufficient for only 3-5 months.

Moreover, there was shortage of qualified manpower, which was aggravated by the excessive political pressure, for placement, on the one hand ministry of health and population (MoHP) placement in the remote areas, but on the other hand they created unnecessary lobby system staying at Kathmandu. Opportunities for staffs were very much guided by the concept of nepotism and favoritism at the district based health facilities such as sub-health posts (SHPs), health posts (HPs), primary health care centers (PHCs) and district hospitals. Moreover, release of program budgets from the centre was often late and the budgets from one heading to other were not generally allowed to be transferred even if there was surplus budget in one heading and deficit on the other. In these circumstances, the current practice of decentralization seems to be very difficult. The dissolution of

the elected local bodies, conflict and security are considered other key hindering factors for successful management of the decentralized Health Facilities.

1.3 Rationale of the Study

Evaluation is the application of social science research procedure to judge and improve the ways in which social policies and programmes are conducted, from the earliest stage of defining and designing programmes through their development and implementation (Rossi and freeman, 1993). Evaluation results should inform programmes management, strategic planning, the design of new projects or initiatives, and resource allocation.

Evaluation results are also important inputs into strategic planning and programme design. Measures the programme performance, output, and population outcomes describe the current state of demand for services and the programme environment. Results linking inputs and activities to programme outputs and changes at the population level serve to demonstrate what has worked in the past and to suggest potential directions for the future. Successful intervention can be scaled up or replicated in new programme or project phase, where as activities that do not produce result can be phased out. Moreover, evaluation can be used to explore why certain interventions did not work.

In short, those responsible for implementing programmes and those who fund programmes should require that evaluation be an integral part of any intervention. For maximum benefit, evaluation should be built into the programme design from the start and provide data to managers over the life of the activities. Evaluation result will help administrators and managers to learn what they are doing right, identify shortcomings to be corrected, and make informed decisions about the future directions of their programmes. In the current climate of budgetary constraints, evaluation results point to the most rational use of scarce resources-human and material-to achieve results.

Since several documents including internal and external surveys, current evaluation and process review and special studies related to decentralization of Health Facilities in Nepal are widely available, but the major part of such documents/reports seems less likely to be looked at while designing the strategy for effective operation of the community managed health care facilities. Although different stakeholders in the health sector have conducted various research/studies regarding handover of Health care Facilities, the duplicity of their programs and impact on the basis of comprehensive review is yet to be carried out. Moreover, strengths and weaknesses in managing health facilities in terms of planning and management; monitoring and supervision; infrastructure and resources; quality of care, future planning and sustainability issues; exercise of role and responsibilities; ownership feeling and understanding of the meaning/process of decentralization; consistency, uniformity and coverage of service provision, training/orientation and other support required for better management, including differences in management of health facilities and in providing health care services before and after decentralization/handover the health facilities, etc are also not clearly understood.

The Tenth-Fiver Year Plan has also clearly stated that, the handover of remaining Health Facilities will be continued based on the findings of additional studies and researches regarding present experiences.

Therefore, it has been realized the need of conducting the present evaluation study with the following specific objectives:

1.4 Objectives

The overall aim of the study work was to strengthen of the process of decentralization of Health Facilities in Nepal. The specific objectives were as follows:

- To review and analyze the existing literature and documents including National Policies, Structure and Strategies in relation to decentralization of Health Care Facilities in Nepal,
- To review and analyze the decentralization plan and programme, process and assess current status of decentralized Health Care Facilities in Nepal in terms of effectiveness, efficiency, participation and sustainability,
- To assess and compare the provision of quality services before and after decentralization of Health Care Facilities to the local bodies, and
- To recommend the appropriate strategy about the future directions and/or effective operation of the community managed Health Care Facilities.

CHAPTER TWO: METHODOLOGY

2.1 Overall Approach

This research heavily depended on primary source of information. However, information was also collected through secondary sources mainly through desk study/literature reviews. The primary source of information was entirely based on field survey. The survey consist of 8 instruments, which have been carefully designed to obtain fairly detailed quantitative and qualitative information with emphasis on semi-structured focus groups and participatory research methods.

For the collection of secondary information, the review was retrospective that made an attempt to assess all the available documents and studies related to decentralization of health service facilities in Nepal. The review followed different methods of information collection and analysis. A networking sampling technique was adopted. An information collection format was developed and used as a tool for gathering the relevant information.

For the collection of primary information, cross-sectional descriptive study was conducted in order to collect the primary information from the field setting. Stratified random sampling technique was applied for the selection of health facilities using urban and rural as a main strata from each selected five districts of five development regions.

2.2 Distribution of respondents

The data for this survey came out of a total of 211 respondents (Table 2.1), 187 FGDs Participants (Appendix 1) and self observation by researchers in 30 different SHPs from the sampled districts. This constituted 20% of a total of 146 handed over SHPs in the fiscal year 2059/60 BS representing each districts and each Development Regions.

Districts	SHP In-Charge	HMC CP	KI	DPH Os	LDOs	MCHWs/ FCHVs	ECs	Total
Kaski	7	7	14	1	1	7	13	50
Banke	7	7	12	1	1	5	13	46
Kanchanpur	2	1	4	1	1	2	4	15
Jhapa	8	7	15	1	1	8	16	56
Lalitpur	6	6	12	1	1	6	12	44
Total	**30**	**28**	**57**	**5**	**5**	**28**	**58**	**211**
Eco.Regions								
Hill	13	13	26	2	2	13	25	94
Terai	17	15	31	3	3	15	33	117
Total	**30**	**28**	**57**	**5**	**5**	**28**	**58**	**211**
Areas								
Urban	14	12	27	5	5	12	26	101
Rural	16	16	30	-	-	16	32	110
Total	**30**	**28**	**57**	**5**	**5**	**28**	**58**	**211**

Table 2.1: Frequency Distribution of Respondents by districts, regions & areas

Within SHPs, a total of 30 SHP In-charges, 28 Health Management Committees (HMC) Chairpersons, 28 Maternal Child Health Workers (MCHWs)/Female Child Health Volunteers (FCHVs), 58 Exit Clients were met[1] (Table 2.1), and 54 Key Informants (KIs) were interviewed (Appendix 4).

In addition, 13 KIs were interviewed at district level (Appendix 4) as well as data/information was gathered form each of sampled District Public Health Offices (DPHOs) and Local Development

[1] Originally out plan was to meet 30 KIs but could meet 1 VDC secretary in our repeated visits while one of the Sampled SHPs HMC CP was not provisioned due to its location within Municipality which is overseen by DDC. Therefore we met DDC Programme Officer of Jhapa to get information for that SHP. In the same way we should have met 60 ECs but we could not met any ECs in Chisapani SHPs coming to treatment where we stayed for the whole day

Officers (LDOs). Ecologically, 43 per cent of the SHPs were from Hill areas while Terai being the 57. In relation to urban and rural areas, there were 47 and 53 per cent respectively. (Table 2.1 and Appendix 2).

2.3 Survey tools

Information was gathered using different survey tools. Besides, a number of integrated approaches were adopted for field observation and recording of service statistics/information regarding the client flow before and after decentralization. In this connection, in-depth interviews, KI interviews, semi structured Focus Group Discussions (FGDs) were carried out. (Table 2.2) The relevant surveys, statistical data/information and other document's documentations were reviewed to obtain fairly detailed quantitative and qualitative information on each of the sample Health facilities. The findings of FGDs and in-depth interviews were triangulated. (See Appendix 1 for the characteristics of FGD respondents)

Instrument	No.	Remarks
In-depth interviews	144	Field level
Focus group Discussions	20	Field level
Key informant interviews	67	Field & district level
Observations of SHPs	30	Field level
Key informant interviews	8	Central level

Table 2.2: Tools and coverage of the respondents

When applying survey tools, in-depth interviews were carried out to 144 respondents while the numbers of SSFGDs were 20 (10 female 10 male/ 4 in each sampled district each of female and male), both at field level. Similarly KI interviews were conducted, 67 at field and district level, where as 8 at central level. On the site observation was accomplished in 30 places (SHPs).

2.4 Preparation of instruments/checklists

Based on the information gathered from the desk study/literature review and interviews with persons in central level, required survey instruments/check lists and participant screening guideline were carefully designed, reproduced and administered in the field, after doing pre-test and required amendment. All the survey tools are annexed in appendix 17-21.

2.5 Sampling procedure and sample size

The health facilities survey should have completed between the periods of Falgun 15, 2062 to Ashad 15, 2063. However, duo the people's movement demanding for the restoration of democracy, it was only possible to carry out after mid Baishakh 2063 when the movement came to an end. It was the time of the restoration of democracy and initiation of dialogue for peace between GoN and Maoists. In the formulation and implementation of the methodology, it was necessary to take into account several factors such as coverage for national representation, by ecological and development regions, securities situation as well as maturity of handed over health facilities for evaluation purpose. Moreover, an important aspect of the present study was to develop the methodology for evaluating the decentralized health facilities. The methodology for the evaluation of any programme has suggested by Miller and Frerichs “it would be evaluated approximately three years or more after the program implementation, if the objective would be to evaluate changes that may have occurred as a result of program improvements. The impact of these changes would be measured in terms of improved health facilities potential to provide quality of care, and in the actual receipt of quality of care by clients. (Miller and Frerichs, 1992-1993).

Therefore, without any alternatives, SHP was considered for this evaluation as no other Health Facilities (HFs) were found enough matured to evaluate. Therefore, Jhapa, Lalitpur, Kaski, Banke and Kanchanpur districts were randomly selected to capture Ecological and Development Regions (See Appendix 2 for sampling overview). In this connection, a representative samples (20%) of SHP from each sample district were considered. Further, equal proportion of SHPs from each district from rural and urban areas was also taken into account. When selecting sample SHPs a close coordination with DPHOs was also maintained as the detail information of these institutions were not readily available at MoH level. (See following Table 2.3 for SHP sampling and Appendix 3 for detail data sheet of handed over HFs).

Development Region	District	HFs Handed Over in 2059/2060			Sample distribution of SHP by habitants		Total Sample of SHP
		SHP	PHC	PHC	Rural	Urban	
Eastern	Jhapa	38	-	-	4	4	8
Central	Lalitpur	29	-	-	3	3	6
Western	Kaski	34	-	-	4	3	7
Mid-Western	Banke	35	-	-	4	3	7
Far-Western	Kanchanpur	10	-	-	1	1	2
	Total	**146**			**16**	**14**	**30**

Table 2.3: Overview of SHP sample size.

The following criteria were used when selecting SHPs for survey:

- Representation of Rural and Urban settings (at least 60-40% by rural and urban respectively)
- Coverage of districts by location, and representation of ethnicity
- Not many far from one day to cover the SHP survey
- SHP performance (good, bad , moderate in management)
- Already handed over to the community during the year 2059/60 B.S.

2.6 Report structure

This report is organised in six chapters. In the chapter one we have presented the introduction and in the running chapter methodological aspects of this survey. In chapter three we also present a brief overview of Nepal's overall socio-economic situation with a focus on health sector in order to set the scene for the subsequent analysis. This is followed by a literature review on history and impact of decentralisation in general and health sector in particular in Chapter four. Based on the primary data obtained from the five sampled districts, the main findings are brought together in Chapter Five. In Chapter six we have presented the main conclusions and discusses some of the key issues as recommendations.

CHAPTER THREE: COUNTRY BACKGROUND

3.1 General

Situated in the lap of Himalaya, Nepal is located in between the latitude 26O 22’ N to 30O 27’ North and longitude 80O4’ E to 88O 112’ East and elevation ranges from 90 to 8848 meters. The average length being 885 km. east to west and average breadth is about 193 km. north to south.

The country borders with the world's two most populous countries, India in the east, south, west and China in the north. The total area of this country is 147 thousand square kilometers that is distributed in three regions, the Mountains, the Hills and the Terai occupying 25, 42 and 23 per cent area respectively (CBS 2001). According to the population census of 2001, the total population of the country stands at 22.3 million that is distributed by 7.3, 44.3 and 48.4 per cent in above geographic regions respectively.

Recently Nepal has become a secular state. However, it consists of diverse array of ethnic, caste, linguistic and religious communities (Gellner 1997). According to the statistics published by Central Bureau of Statistics, Nepal has 106 castes and Hinduism is the dominant religion (80 per cent of the total population) followed by Buddhism (CBS 2004).

For the purpose of social and economic development the country is divided into five development regions; Eastern, Central, Western, Mid-Western and Far-Western consisting of 23.1, 34.7, 19.7 13.0, and 9.5 percent of population respectively in 2001. There are 75 administrative districts. Districts are further divided into smaller units, called Village Development Committees (VDCs) and municipality. Currently, there are 3,915 VDCs and 58 Municipalities in the country. Each VDC is composed of 9 wards, while the number of wards ranges from 9 to 35 depending upon the size of municipality and population. Kathmandu is the capital city of Nepal.

In Nepal, the process of planned economic development has commenced since 1956 with the inception of the first Five Year Plan (1956-1961). So far, nine periodic plans were implemented and the tenth plan (2002-2007) is being implemented. Over the periods, some progress has been made, however the overall socio-economic problems of one-third Nepalese people particularly living in rural setting is still remains to be achieved (NPC 2002). Even though, the later three periodic plans made poverty mitigation as their sole objective, still 31 per cent of the national population lives below poverty line (WB 2005).

On the other hand the high population growth rate of 2.2 has overshadowed the country's economic growth since our development plans could not actually address this population increase rate. Little over half (58.2%) of the population of working age reported usually economically active in 2001. Population Census 2001 reports that 53.1 percent population of age 10 years & over are employed and 5.1 percent are unemployed. Contribution of non-agricultural activities is gradually increasing in the GDP. The preliminary estimates of per capita GDP and Per capita GNP in terms of US dollar are 237 and 300 respectively for the year 2003 (UNDP 2005).

3.2 Overall socio-economic indicators

South Asia is home to 43.5 per cent of the world's poor who earn less than $1 a day. Of the total population 31 per cent live on less than $1 a day while 82.5 per cent live less than $2 a day (World Bank 2006). Spatially, most of the poor, over 90 per cent, live in rural areas with their poverty rate of 44 per cent compared to 23 per cent in urban setting and only 4 per cent in Kathmandu (NPC 2004). The UNDP report noted that western mountains have almost 1.7 times more poverty compared to

eastern ones (UNDP 2004). Therefore, Nepal is not only the one of the poorest countries of the world but also ranks low in terms of its Human Development Index (HDI)[2], 136th of 177 countries with a HDI 0.525 (UNDP 2005). Similarly, among the SAARC[3] countries it ranks sixth followed by Bangladesh. The following statistics were recorded in UNDP Human Development Report for 2005: an infant mortality rate of 130[4]; maternal mortality rate of 740[5]; life expectancy at birth of 61 and adult literacy rate of 48.6.

3.3 Situation of health sector

Provision of health service contributes to the improvement of health, which is linked with the economic growth of the individual and country. Therefore, this sector is critical for human development, improving living standards in rural areas and for mainstreaming marginalized groups and communities. In developing countries the problems of access are concerned with the ability to visit a doctor, or to receive health care during sickness. However, in developed countries, access is concerned with the degree of comprehensiveness offered by health care systems (Gulliford *et al.* 2003). So, the concept of health service provision; **'access'** incorporates both *'availability'* and *'utilisation'* of health services.

Despite significant efforts and progresses in past decades, both availability and utilisation of health services still remained weak. Although an extensive network of primary healthcare centers has been constructed nation-wide, it has not been functioning well in many rural areas due to lack of comprehensive and coordinated response particularly of clear policies, proper decentralisation, capacity building of both health personnel and management people, supply of drugs and medicines etc. The sector's overall performance has suffered due to inadequate funding for essential recurrent expenditure, misallocation of resources and limited capacity for supervision and, co-ordination of the activities of other agencies providing health care services.

The Universal Declaration of Human Rights 1948 considers access to health care a basic human right.[6] Similarly, the OHCHR of 1996[7] declares that respective home governments are required to recognise the right of everyone to enjoy their highest standard of health, and required to assure all medical service to all of its citizens. Access to health service in particular is of great importance because the issue of health is linked with other livelihood building activities, therefore becoming crucial to the overall economic prosperity of a country (Nelson 1999). Therefore, the developed countries have been offering a comprehensive health care service to their citizen.

[2] The HDI in UNDP report (2004:137) is expressed interms of: life expectancy at birth, adult literacy rate, combined gross ratio for primary, secondary and tertiary schooling and per capita Gross Domestic Product (GDP).

[3] SAARC: South Asian Association for Regional Cooperation

[4] Infant mortality rate is measured per 1,000 live births

[5] Maternal mortality rate is measured per 100,000 live births

[6] Article 25:(1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control. (Source: www.un.org/Overview/rights.html)

[7] Article 12 (1) The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. 2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for: (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases; (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness. **(Source: http://www.ohchr.org/english/law/cescr.htm)**

In Nepal, up to 2005, health services were provided by 89 hospitals, 186 Primary Health Care Centres (PHCCs), 698 Health Posts (HPs) and 3129 Sub Health Posts (SHPs). In addition, 14,710 Primary Health Care Outreach Clinics also provided health care.

However, in developing countries access to the health care services has been much problematic and they have a long way to go to meet these declarations. The same applies for Nepal where regardless of various efforts; the access to health care services has become a major bottleneck in mitigating deeply rooted poverty (NPC 2004). Until 2001, only 41 percent of the total population had access to basic health care within a walking distance of 30 minutes or less, and the situation of women and children is much more vulnerable (NLSS 2002).

While the world progresses towards provisioning adequate health care for its citizen, the situation in Nepal is still becoming a challenging one. Although Nepal has already ratified international conventions, the assessment of the overall health situation of Nepali people verifies that there is a lot to do in order to realise these ratifications. In Rural Nepal the key role of women is to serve as household labour and bear children, particularly sons. Early and excessive child bearing has weakened women's health. Some of such women die while many of them are chronically disabled from complications of pregnancy. Pregnancy is taken as natural process and God's gift, for which medical care is regarded as unnecessary.[8]

The life expectancy of women is 59.4 years that is one of the lowest in south Asia (NLSS 2002). The infant mortality rate is 130 and rural babies are exposed to 1.6 times more to the risk of death than their urban counterparts UNDP (2004b). Similarly, maternal mortality rate is 740. This means one of every 185 pregnant women aged 15-49 years dies because of pregnancy complications. This figure is among the highest in the world (Options 1999; UNDP 2004a).

Moreover, about 89 percent of births take place at home and without professional health attendance (MOH 2004). In addition, 53.4 and 18.8 percent women receive ante-natal and post natal care respectively. The total fertility and contraceptive prevalence rate are 3.7 and 39 percent respectively ((UNDP 2005).

The immunisation against tuberculosis and measles on one year old babies is 91 and 75 per cent (ibid). The DOHS 2005 report showed that the incidence of Acute Respiratory Infection (ARI) is 360 per 1,000 under five children.

[8] Women Rehabilitation Centre (WOREC), Nepal. http://www.worecnepal.org/women_health.html

CHAPTER FOUR: FRAMEWORK AND EXPERIENCE OF DECENTRALISATION

In this chapter we will first discuss theoretical concept about decentralisation with its linkage with health services. This will be followed by some lessons learned from the international experiences about the decentralised health system. Thereafter we will put together the Nepal's history on decentralisation followed by in-country lessons learned based on the previous reports and studies.

4.1 Theoretical framework

Decentralisation is in the process of implementation within the public sector in Nepal. It involves the transfer of functions, resources and authority from higher levels of government through legal provisions. This also involves changes in the form of accountability and participation in the system (Collins *et al.* 2003).

Researchers argue that the impact of decentralisation towards quality health services is very difficult aspect to express. However, it is the notion of the concept that this process leads towards the quality service delivery of communities. For this the the quality of services can be understood at three levels, the managers, the health workers and the clients. For the quality health services, the manager always needs to see the results or outcomes providing high quality services. The service delivery is fully functional if it has trained staff, supplies, equipments and other facilities. If all these are present, the service delivery is likely to be functional. But this further needs motivation and refresher training for the health workers. Similarly, having all these set up does not guarantee that it will be easily utilized by the clients. Therefore, this needs clients' interaction to visit the doctor or health facility; in return they expect them to be treated with respect and consideration (Steven Solter 1999).

According to Jukka *et al* 2003, decentralisation, involving a variety of mechanisms to transfer fiscal, administrative, managerial, ownership and/or political authority for health service delivery from the central ministry of health to alternate institutions, has been promoted as a key means of improving health sector performance. The following benefits of decentralisation have been proposed: improved allocative efficiency, improved technical efficiency, service delivery innovation, improved quality, transparency, accountability and legitimacy and greater equity. The data regarding the achievements of these benefits is limited.

There are four models of decentralisation, namely:

- **Devolution** implies the transfer of power to locally elected bodies (DDC/VDC) that are substantially independent of the national level with respect to a defined set of functions. They are rarely "completely autonomous" but are bodies largely independent of the national government in their areas of responsibilities, e.g. raising revenues and staff appointment. The policy is usually the only function retained centrally.
- **Deconcentration** implies the handing over of some authorities to local officers of the Ministry of health by administrative means. It also implies establishing local management with a degree of discretion that would enable local officials to manage without going through the process of constant approval from the ministry of health.
- **Delegation** implies the transfer of managerial responsibilities for defined functions to the organizations that are outside the central government structure and only indirectly controlled by the Ministry of Health. Ultimate responsibility remains with the MOH, but its agent has broad discretion to carry out its specified functions and duties. The exact managerial and funding relationships vary, but all day-to-day executive decisions are given to the delegated bodies.
- **Privatization**- Transfer of authorities to private companies/sectors

On top of this classification decision space approach has been promoted. Decision space is the range of choice in making decisions. The areas where decision space is looked at are: finance (for example sources of revenue), service organization (health facilities/hospital autonomy, required programmes, human resources (salaries, training, and contracts), access rules (targeting) and governance rules (local government, community participation).

The decision space can be narrow even if the power has been delegated to semi-autonomous agencies if the user fees and other ways of income are limited and/or salaries are centrally agreed. On the other hand in cases where the finances are given as a lump sum to district governments they might use it to other purposes than health according to local priorities or political reasons.

In centrally managed systems health facilities/hospital autonomy can be granted by the central management authority delegating the authority to the health facilities/hospital managers or boards or by contracting out/in the hospital management on individual hospital level, as group of hospitals or as part of health facilities/health services in a district or region. The management of all health facilities/hospitals has been delegated to semi-autonomous paragovernmental organization in some countries.

In decentralised system the local governments can govern the health facilities/hospitals or they can delegate authority to the board or manager of the health facilities/hospital.

Health facilities/hospital autonomy can include financial management, personnel management and product or service development. They can be included to various degrees.

In systems with autonomous or decentralised health facilities/hospitals there must be enough control from the Ministry of Health to ensure that the government's health policies are followed, but there should be enough decision space to give benefits from the decentralisation.

Health sector personnel management is highly politicized issue and may have dramatic effects on the viability of decentralisation reform. Health care workers might experience significant loses as a result of decentralisation, which makes it difficult to secure their support and cooperation (Jukka *et al* 2003).

4.2 Experiences/lessons on decentralisation from different countries

Here in this chapter we highlight the experiences gained from other countries mainly from Cambodia, Zambia, Indonesia, Philippines, Colombia and Pakistan with regard to decentralisation of health services are worth to mention here. Various experiences with individual models in different countries describe mainly the problems encountered however the successes are less well documented.

In Cambodia, a pilot-testing project was carried out of contracting with non-governmental organizations (NGOs) for the delivery of primary health care on a large scale. Three approaches were compared: Contracting out (CO) in which contractors have complete authority for hiring, firing, and paying staff as well as procuring drugs and supplies; Contracting in (CI) where contractors provide management services within the existing district health structure; and comparison/control (CC) where the existing district health management teams receive a budget supplement (as do CI districts). All the contracts were given to INGOs.[9]

[9] Benjamin Loevinsohn, Contracting for the delivery of primary health care in Cambodia: Design and initial experience of a large pilot-test. The World Bank

Significant improvements were achieved in all contracted districts in health care coverage and utilization. The progress has been slower in the contracted–in districts. Human resources management is probably a very significant factor. This includes training, with supervision and support, clear understanding of the tasks and expected outputs reinforced by monitoring and feedback. Also salary level should be acceptable.

Relationship to communities was improved through outreach and different committees. Disbursement of budget, equipment and drugs from central and provincial level was a common problem as was the mal-distribution and shortages of staff.[10]

Introduction of official hospital fees did not result in reduction in attendance, instead it rose. This was due to improved quality and discontinuation of unofficial fees by health care workers, which was achieved mainly by staff training, supervision and performance based staff incentive structure.

In Zambia, the health sector reform introduced user fees, which reduced the patients flow rate drastically. This also happened in other countries such as Ghana, Eritrea, Tanzania too. The decline was partly because patients who were supposed to be exempted were charged. It was found out that hospital fees caused many not to seek care at all due to inability to pay. The adverse effects happened in a short time while the gains appear to happen over a much longer timeframe.[11]

In Indonesia some of the public hospitals were given partial autonomy. They could decide about the hospital fees, except for the lowest category; and they could retain the earned income. The hospitals however did not have the power to hire and fire staff. In the hospitals the fees increased to the lower levels of fees in private hospitals and the numbers of beds reserved for the poor dropped. With incentives the staff attendance improved, otherwise the evidence of improvements is missing[12,i].

In Indonesia policy allowed public hospitals to have cost recovery beds after 1993. The objective was to produce income also to cover some costs of the other beds. The recurring costs and salaries however were more than the income from the beds. This was mainly because of higher staff costs than planned. If commercial beds are put to public hospitals, there should be the capacity to control the costs and adjust the fees.[13]

The purpose of decentralization was to delegate power to local level and increase the participation of the local community. After health services decentralization only mayors and municipal health officers felt empowered. Community members were not aware of devolution and their potential roles in decision-making. The historical background of centralized governance is not easily changed to a participatory decision-making.[14]

In Philippines after devolution of health services management the national guidelines for TB were not followed as well as before. The training and supervision reduced as the local government units reduced these activities, as they were not prioritized locally. One reason being the health care becoming politicized; leading to hiring of political supporters and building and renovation of

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[10] Cambodia Health Sector Boosting Programme, Feasibility and Design Study, Revised Draft-November 2001.
[11] Blas E, Limbambala M.User-payment, decentralization and health service utilization in Zambia. *Health Policy and Planning* 16(suppl 2): 19-28.
[12] Bossert T, et al, Hospital autonomy in Indonesia. http://www.hsph.harvard.edu/ihsg/publications/pdf/No-39.PDF
[13] Suwandono A. Cost recovery beds in public hospitals in Indonesia. *Health Policy and Planning* 16 (Suppl 2): 10-18.
[14] Ramiro LS et al. Community Participation in local health boards. *Health Policy and Planning* 16(suppl 2): 61-69

facilities, which were seen as means of acquiring political support, instead of using money for the services.[15]

To sum of the international experiences the contracting out or in (CO and CI) model of decentralisation functioned relatively well in Cambodia. The success could depend on the experience and strength of the contractors. The performance of the public health services was improved with more patients treated by public health services regardless of the introduction of fees. But were this only attracting people from the private sector or was a wide section of population using the services is unanswered.

Insurance-based system with managed competition could increase the coverage of insured persons rapidly, but sometimes the insurance coverage did not mean availability of services. Also this system requires strong management capacity at all levels to function well.

User fees may reduce the attendance to health services, and targeting the exemptions and implementing the exemptions is not easy. The fee structure can be used to redirect the use to primary care and to some key services. The negative effects are manifested quickly, but the positive effects are slow to materialize.

Personnel management is central issue in success of autonomy. Models where there was more space for personnel management seemed to function better. Performance based incentives improved the services in Cambodia and additional incentives improved the personnel attendance in Indonesia. Training and supervision were also important for success in Cambodia.

Central level must have power and capacity to monitor the adherence to national health policies and equity of services as these might be overrun by local priorities. At the same time to achieve the benefits of autonomy and decentralization the decision power must be delegated to a great extent for the autonomous body.

Community participation is difficult to attain. It is not done by laws and guidelines. It requires also changes in attitudes and values. In places with history of central decision-making it is not easy to get the communities involved

Decentralization and autonomy are highly political issues. It is essential to secure wide continuous support for the process. It is important to gain the support of politicians and the health care personnel as their resistance can slow or stop the process.

Finally, Collins *et al.* (2003) argue that every country that embarks on the process of health sector decentralisation is unique. They operate in their own environment, which, to a large extent, moulds the experience of decentralisation. As we found from the experiences of other countries, no single model worked out well in all the countries. However the commonality in all areas is that for the success of decentralisation, community participation is most, which is very difficult to achieve. The other issue associated with this is local resource generation and increased service charge, which should be managed in a way, and in return of this people need to be well satisfied with the services they receive. Political will also strongly impacts the process of decentralisation.

[15] Health Sector Reform. TDR-Final Report Series. http://www.who.int/tdr/research/finalreps/no9.htm

4.3 Decentralisation in Nepalese context:

The history of organized health system in Nepal goes back to many centuries. It has developed from a stage of traditional medical practice like faith healing, naturopathy, Yoga, Ayurved and Homeopathy to modern and allopathic practices. Pokharel *et al.* argue that Nepal has experienced different types of decentralisation since its emergence as a unified state in 1769 AD where late king Prithvi Narayan Shah completed the formation of single government in the country (Pokharel *et al.* 2005). He and his successors structured the administration and directly ruled the country initially dividing the country into 12 areas and later into smaller units. Therefore, they argue that:

"The key point of the historical context is that health sector decentralisation will need to take into account is that despite the current centralisation of government, there is strong tradition of decentralisation."

Broadly, it can be organised in following periods:
1. Rana Regime
2. Shah dynasty and Rana rule
3. The down fall of Rana rule and Panchayat system
4. The restoration of democracy and the LSGA, 1999.
5. Periodic Plans and decentralisation

4.3.1 Before Rana Regime

According to Dhakal (1986) the genesis behind the spirit of decentralisation in Nepal started from the Quirt period and lasted until the first century. At that time the Kingdom was divided into a number of local administrative body known as *"Thums"* each consisting of five elders, known as *"Panchas"*. These Thums used to rule their respective units being responsible for construction of irrigation canals, agriculture and taxes collection. Later, Lichhivis also ruled the country dividing the kingdom into two-tier administration, the central ruled by heredatiry king and the provincial administration ruled by centrally appointed governor called *"Samata"*. During this period there were also village administration that was administred by locally elected people called *"Panchali"*. Dhakal again argues that these Panchalis are similar to present Village Development Comittees (VDCs). Similar characteristics of decentralisation existed during the Malla period.

4.3.2 Shaha Dynasty and Rana Rule

According to Dhakal (1986) following to unification of Nepal by late King Prithvi Narayan Shaha in 1769 until the time of hereditary premiership of Rana in 1846, Nepal adopted expasionist policy and developed a centralised system of administration. During this period there was no recognised form of decentralisation however some institutions known as Panchayats were formed in parts of country with a mandate of solving the local disputes. At the later stage, the Rana family took power following a coup against the Shah Kings and ruled the country through hereditary Prim Ministerial system for 104 years (Pokharel *et al.* 2005). They divided the country into four regions by its revenue potential i.e. Eastern, Western, North and South. In this connection they also appointed one of their brothers to rule the particular region.

It is mentioned that the first step in decentralisation of governance to the local level was introducing Municipal and Village Panchayat Act in 1949. This act authorised village councils to collect land tax and solve local disputes hence people not needing to go to the court. Over the Rana period 170 VPs were established through out the country but people were not addressed as "citizen" rather called "*raiti (subject"* (ibid).

4.3.3 The downfall of Rana Regime and Panchayat period

In 1956, when the Rana rulers were overthrown, civillian government was formed. At this time two important steps took place. Firstly, the administrative reorganisation and planning Commission was set up in 1956. This made provision of dividing country into 7 divisions, 76 sub divisions and 175 blocks. Secondly, an Administration Commission giving power for decentralisation was formed which was headed by Bishow Bandhu Thapa (Collin *et al.* 2003).

In addition, Pokharel *et al.* (2005) documented that during this time people's representative drafted a new act and an Interim Administration law was enacted stating *"the state shall establish village panchayats and develop into self governing institutions with necessary authorities"*. It was the first time in history of Nepal, the term *'local self-governance'* used with its objective to strengthen the foundation of local governance in rural areas.

In 1952 a Municipal Act and in 1956 another Panchayat Act was enacted giving wide development authorities to local bodies. This Municipal Act declared Kathmandu Valley as a Metropolis (Mahanagar). After the first general elections in 1958, the elected government recognised the local Panchayats as the foundations of the democracy and made some institutional changes for their strengthening.

In 1959 when the multi-party government was dissolved by King Mahendra and partyless system was introduced several exercises were undertaken in relation to decentralisation. This mainly includes dividing the country into five development regions, 14 zones and 75 districts. In 1963, a decentralisation plan was formulated.

In 1982, a Decentralisation Act was introduced with the purpose of getting effective participation of local people to take ownership and accountability of overall development in their respective areas. All the line agencies were kept under District Panchayat. In addition government prepared a decentralisation scheme and piloted in 14 model districts. Despite many weaknesses, this act had provided an institutional and legal set up and can be considered as a milestone in the decentralisation process (CSSP 2005). Whatever is mentioned, this effort was the means for existing 'Panchas' to expand their central implementing hands to the local level for their political benefit and resources were still highly under the controlled by centre. But researchers argue that, this can be taken as an positive step in the sense that it brought awareness among local people about the concept of decentralisation (Collins *et al.* 2003).

This partyless system which lasted almost for 30 years (1959-1990), also introduced Panchayat system at district and national levels. However, this system suffered from the central control of "Panchas" and the system of decentralisation was entirely built around the supremacy of central authority and sovereignty of the King. (Pokharel *et al.* 2005). This system was collapsed with the increased pressure for liberal economy and multiparty democracy.

3.3.4 Restoration of Democracy and LSGA, 1999

In 1990, the partyless Panchayat system was overthrown through popular movement and multiparty system was introduced. New constitution 1990 was enacted envisioning decentralisation as one of the fundamental elements of democracy and one of the directive principles[16]. At the operational level, for

[16] See Constitution of Kingdom of Nepal, 1990, Part four; directives, article 24 where it is mentioned "decentralised means

the initial few years the structure of decentralised governance remained the same. However, in the development of decentralisation, three separate acts were passed i.e. District Development Committee Act, Village Development Committee Act and Municipality Act in 1992 and local bodies were formed following these acts.

In a precise way, the decentralisation movement only took place when the government formed a high level Decentralisation Coordination Committee under the Chairpersonship of Prim Minister in 1996. Based on the recommendation of this committee, the Local Self Governance Act (LSGA) 1999 was enacted in 1999 that serves as a legal foundation for the development of devolution in Nepal. In the same year, government approved the Local Self Governance Regulation (LSGR) making all the provisions of act effective at operational level.

The underlying principles of LSGA and LSGR are to make the local bodies politically powerful, legally responsible and technically capable of managing their own development affairs. With this provision, District Development Committees (DDCs), Village Development Committees (VDCs) and Municipalities are the autonomous public bodies governed by elected representatives under political party banner. The respective councils are the apex bodies these institutions, as the parliament is for the nation. Other feature of LSGA and LSGR are that they give equal weight to the State, Civil Society Organisations (CSOs), Private Sectors (PS) and Non Government Organisations (NGOs). With this provision, non state entities are considered as development partners of the state. The act has realised the concept of decentralisation, sovereign people, governance process, benefits of democracy, capacity building, resource mobilisation, and equitable distribution of resources, leadership, decision making and authority as a part of state mechanism and local self-governing system (LSGA 1999).

4.3.5 Periodic plans and health sector decentralisation

HMG/Nepal introduced systematic “Periodic Development Plans” with sets of programmes including health in 1956. In addition to the legislation, decentralisation has also been a theme and topical issues in all periodic plans which is illustrated in table 1 below:

Periodic plans	Aspects of decentralization
First five year plan (1956-61)	➢ No specific activities planned
Second and third five year plan (1962-70)	➢ Introduced a new chapter “Population and Manpower” to cope with different health problems. ➢ Following specific programmes launched with the additional international support to achieve optimum health goals. • Malaria Eradication Programme (1958) • Leprosy and Tuberculosis Control Programmes (1964-1965) • Smallpox Eradication Programmes (1967) • Family Planning and Maternal and Child Health Projects (1968)
Fourth five year plan (1971-1975)	➢ There was a shift from vertical projects toward an integrated approach in the form of Integrated Basic Health Services (IBHS) providing basic health services ➢ Middle level health worker training programs were also initiated. ➢ Institute of Medicine (IOM) was established in 1972. ➢ Sixty-three Hospitals with 2,174 beds, 33 Health Centers, 351 Health Posts, and 82 Ayurvedic dispensaries came under operation ➢ A Long-Term Health Plan (1975-1990) was formulated with a calendar of operation in the Fifth, Sixth and Seventh-Five Year Plans

to provide opportunity to the citizen in the governance and reap the benefit of democracy". Part 8; Provision for Parliament, article 46 (ga) where it mentions mandatory provision for one fourth of the National Assembly members to be elected from local bodies.

Fifth five year plan (1976-1981)	➢ Expansion of the basic health care services to the rural areas for the provision family planning, maternal and child health and welfare services by producing health manpower. ➢ Establishment of effective centers in some of the remote areas to provide adequate medical attention for the rural population. ➢ Popularized family planning programme to check the population growth.
Sixth five year plan (1981 – 1986)	➢ Provide basic health services in rural areas through Health Post. Also train and mobilize village health workers/volunteers at ward level. ➢ Attract private sectors to establish hospitals
Seventh five year plan (1986 -1991)	➢ Private sectors to be promoted if the there is no favorable environment to deliver health services by the government self.
Eighth five year plan ((1882 – 1997)	➢ National Health Policy 1991 prepared[17] ➢ The government in 1993 endorsed the present structure of Ministry of health and the Department of Health Services was established with the responsibility to plan, implement, and monitor and supervise the preventive, curative and rehabilitative health services. ➢ The number of PHCCs and SHPs reached to 100 and 3,199 ➢ The number of CHVs and birth attendants were 46,427 and 1,559 respectively. ➢ Second Long Term Health Plan (SLTHP) was prepared period covering 1997-2017[18]
Ninth five year plan (1997-2002)	➢ The plan emphasised right-based approach of health services delivery with the aim of integrating and extending basic health services to the VDC level and developing DDC as a focal point of strengthening the health system. ➢ With the enactment of LSGA, 1999 and LSGR, 1999, HMG/Nepal was taken series of steps in decentralizing health facilities. ➢ National Health Training Center (NHTC), DoHS has been given all the responsibilities for preparing health facilities handover guideline, managing the process of orientation of Health Management Committee (HMCs), handing over, monitoring and supervision. ➢ Medium Term Strategic Plan (MTSP) 2001 prepared[19] ➢ Health Sector Strategy was produced in 2002[20]

[17] After the restoration of democracy, the first elected government with its considerable commitment through National Health Policy (NHP) to accorded highest priority to upgrading the health standard of country's rural population (93% of the total population) . It came up with a 14 point health plan that included (i) Family Planning and Maternal and Child Health Care programs and programs for prevention and control of communicable and non-communicable diseases. (ii) Health promotion by increasing awareness of health matters among the general public, promotion, promotion of breast feeding and supplementing essential nutrients such as iron, iodine and vitamin A for instance, and (iii) Expansion of curative services through establishing S/HPs and PHCCs at the peripheral levels and through district, regional and central level referral hospitals. Its intended goals were to bring about positive, yet realistic change in community health indicators.

[18] It advocated continued liberalization with open and competitive financial planning in health. It pledged development of infrastructure by the sate and also pledged to create conducive environment for strengthening the private sector. Through the implementation of 'Basic Health Care Package' it aimed to achieve universal accessibility to resources and services. It also emphasized decentralization and community financing schemes. Private sector strengthening in health was further elaborated in the ninth plan. The concept of fee for specialized services was put forward. It has also presented health insurance as a promising alternative system for health financing.

[19] This paper focused on (i) Strengthening health service delivery, (ii) Decentralization, (iii) Improving the public-private-NGO mix, and (iv) Strengthening sector management. To address the health sector needs, the government has also formulated a Health Sector Strategy in august 2002, which clearly outlined essential health care services, decentralization, privatization, health care financing and management of the health sector as key issues. The second outputs of the programme of same strategy document envisaged that “Local bodies will be responsible and capable of managing health facilities in a participative, accountable and transparent way with effective support from the Ministry of Health and its sector partners”.

Tenth five year plan (2002 – 2007)/PRSP	➢ Health Sector Strategy Development: an agenda for reform, 2002 prepared ➢ Nepal Health Sector Programmes Implementation Plan (NHSP-IP) prepared ➢ Directives for Transfer and Operation of Local Health Institutions 2003 came under implementation ➢ Formation of Health Post Decentralisation Core Group at MoH

The Tenth Plan has adopted a number of strategies to achieve the health sector objectives : (i) Expansion of primary health centers and district hospitals, and strengthen out-patient services in hospitals; (ii) Development and retain of trained health personal in rural areas; (iii) Increased supply of essential drugs and vaccines; (iv) Improve delivery of health services, publicity, through decentralized management/delivery, through increased participation of the private sector, NGOs and INGOs, or through public private partnerships; (v) Improved regulatory mechanism to ensure the quality and accessibility of health services; and (vi) Improving human resource development and management and health care financing.

This plan has further emphasise in decentralization/handover of basic service delivery functions considering that the decentralization is an important means of bringing development closer to the rural poor – by involving local communities in developing appropriate programs which are best suited to their needs and in implementing them. It also ensures greater accountability for use of public resources, and mainstreaming the poor and deprived groups.

The main objectives of the Tenth-Five Year Development Plan regarding decentralization/handover of the essential health care services are to ensure greater participation of people in the governance process to accelerate the development process by implementing fiscal devolution in a phase-wise manner within the frame work of The LSGA and LSGR, 1999. A decentralization Implementation and Monitoring Committee (DIMC) was also set up to oversee effective implementation. But progress so far has been hindered by many reasons such as institutional capacity and fiscal constraints, by the dissolution of local elected bodies, conflicts and security.

However, Nepal: Health Sector Program, Joint Annual Review (JAR) paper stated "studies varying quality have shown that health sector decentralization has advanced better compared with that in other sector and that there is improved service provision in the decentralized service facilities. The same paper further suggests continuing the decentralization process with the in-depth analysis of the LHMCs capacity, their infrastructure and resources, and clearly defined roles and responsibilities of LHMCs.

[20] This strategy clearly outlined essential health care services, decentralization, privatization, health care financing and management of the health sector as key issues. The second outputs of the programme of same strategy document envisaged that *"Local bodies will be responsible and capable of managing health facilities in a participative, accountable and transparent way with effective support from the Ministry of Health and its sector partners".*

CHAPTER FIVE: RESULTS AND DISCUSSIONS

5.1 Decentralisation in action: findings from literature review

The achievements and issues towards the health sector decentralisation can be described in following sub headings:

5.1.1 Achievements to date

With the declared commitment of MoHP/GoN, to decentralise health services, it is encouraging to note that until 2005, a total of 1578 Health Facilities (SHPs, HPs and PHCs) of 27 districts have been handed over to Local Health Management Committees (LHMCs).[21] The number of Health Facilities (HFs) handed over to the Local Bodies (LBs) as fiscal year wise is presented in Table 5.1 (For detail please see Appendix 3). The GoN in the Budget and Programme for the Fiscal Year 2005/06 have stated that the operation and maintenance of 18 Districts Hospitals, all the SHPs, and PHCs of 10 additional districts will be handed over to the DDCs and LHMCs respectively during the year. As a result of these initiatives, Tenth-Five Year Development Plan envisaged that over the plan period, all SHPs will have been transferred to local bodies.

Fiscal Year (BS)	No. of SHPs	No. of HPs	No. of PHCs	Total no. of HFs
2059/60	468	-	-	468
2060/61	689	18	9	716
2061/62	94	219	81	394
2059-60	**1,251**	**237**	**90**	**1,578**

Table 5.1: HFs handed over to LBs

According to MoHP (2004) 'readyness to decentralise' health services among its stakeholders is other achievement. In principle there is no confusion among other ministries i.e. MLD, Ministry of Agriculture and Cooperation (MoAC) and Ministry of Education (MoE), DDCs, VDCs and other local associations for the devolution.

There is also an exciting development in the number of health personnel. Over the past fifteen years the number of medical doctors trebled, the number of nurses quadrupled and the number of paramedics increased by several folds (Upadhyaya 2006).

In line with the other health related strategy and LSGA, 'Directive for the Transfer and Operation of Local Health Institutions, 2003' was in place giving overall guideline for the devolution. This is an important policy document to devolve local health institutions.[22]

5.1.2 Issues and Challenges

a) Policy perspectives

It is important to note that the LSGA 1999 and LSGR 2000 have laid a rather broader framework to work in health sector decentralisation. According to Pokharel *et al.* (2005) the MOH is probably the most 'prepared sector' to take this process forward and has been proactively considered decentralisation of its functions. They further argued that MoH already took the process of handing over SHPs before the LSGA came in existence as guided by NHP 1991 and SLTHP. These documents explicitly stated the need to devolve MoH's functions at local level. Formation of Health

[21] This includes 1,251 SHPs, 237 HPs and 90 PHCs

[22] This directive has following provisions; (i) Formation of Committees for the operation and management of LHIs including human resource, financial and information management, (ii) Roles and responsibilities of LBOs and LHIs, (iii) Composition of LHIMCs,, (iv) format for record keeping and (v) short description of planning, monitoring and supervision process in LHIs.

Sector Reform Group (HSRG) and S/HPs Decentralisation Core Group (S/HPDCG) is the key and encouraging steps showing government's commitment to take this process forward (Shrestha 2003). Moreover NHTC, the MoH's executing authority on SHPs handover process, has prepared SHP handover process to VDCs which is now being implemented. Similarly preparation of SHP management committee training package is another practical development.

However, Shrestha (2003) argues that since the LSGA has been in place, there was not adequate preparation for its implementation. The policy guideline is also rigid in terms of composition of HMC and the terms of elected members in the committee are not clear. MoH should be responsible to develop a broad based policy guideline and the detail work out should be done at local level.

In addition, Collins *et al.* (2003) argue that there was not in-depth policy analysis of the context of health sector decentralisation in respect to international experience and therefore the policy maker needs to be aware of this and adopt in the light of specific conditions in Nepal. There was very little mention of the Maoist insurgency and the policy lacks proper consultation with stakeholders. An important thing that Collin *et al.* mention is about the lack of international evidence base for the health sector decentralisation. Monitoring system was also lacking.

The other issue associated at policy level is the government priority. According to Upadhyaya (2006), health has never been a priority in the national development agenda other than in seminars and workshops. This is always limited in politician's speech which is evidenced by low budgetary allocation which is less than five per cent of national budget. He criticises that the existing health bureaucracy is weak and run by a set of cadre bureaucrats with very little knowledge and insights of health system, and a set of technocrats who are not well equipped in leadership and managerial skills. What is needed is a combination of both in order to produce a synergistic effect.

Inter ministerial coordination is another important issue. According to Shrestha (2003) in the process of handing over SHPs there was only vertical linkage for which horizontal linkage must be emphasised. There is no institutional inter-ministerial coordination rather it was a monotonous planning exercise. For effective decentralisation the concerned parties must internalise the concept and must take ownership of the process. Since, Ministry of Local Development (MLD) should take the lead role, their involvement and ownership is very much crucial. There was documentary evidence that district authorities felt decentralisation as a threat to their authority and use of resources.

b) On hand over process:

Pokharel *et al.* (2005) mention that the 'hand over' has gone far ahead of the 'take over' in many cases. They doubt whether the timing for hand over was right and urgency of handover overlooked the capacity to take over. Shrestha (2003) adds, the hand over process lacked adequate planning meeting with stakeholders and the committee was not aware of their roles and responsibilities. The other issue associated with this is whether this handover was 'total handover' or partial handover. In other words whether it is deconcentration, devolution or delegation.

c) Question of accountability

Researchers have documented that the question of accountability within the context of health sector decentralisation was always remained an issue and hot topic of discussion. One serious finding was that the Local Development Officer (LDO) is not responsible to DDC where DDC are elected by local people. Because the decentralisation of health services, LDOs has a crucial role to play (Collins *et al.* 2003). Going to further local level, i.e. at VDC, there arose a hierarchical issue between the staff of S/HPs and VDCs (MoH 200?). Because S/HPs In-charge relate to non gazette first or second class

while VDC In-charge, which is at present are the VDC secretaries, are lower in their hierarchy as compared to S/HPs staff.

d) Institutional problem

The political instability and civil strife has also delayed the decentralisation process and hve made LHIs and LBs in effective. Because the LBs lacking elected representatives, the government at the centre looked some what hesitant to handover the LHIs. There is another difficult in recipient side as well. The condition of already handed over LHIs was worse that the time of handover, and new initiatives for take over of LHIs was lacking (MoHP 2004).

e) Capacity of LBs and LHIMCs

Capacity refers to the individuals and organisation's knowledge, skills and ability to manage things. MoH (2061) mentions that generally speaking the newly formed LHIOMC and LBs officials lack required managerial know how, and therefore it is very much difficult to run LHIs without competent and visionary leadership. Pokharel *et al.* (2005) questions, was it just 'hand over' of 'take over' as well. Because in their opinion the variations in local context, level of security and community preparedness, capacity and motivations greatly affect the outcome of hand over process. MoH (2003) also has same opinion and mentions the handover process was more the 'push factor' from the centre rather than the 'pull factor' from the local bodies. In this regard, the MoH, NPC and donor agencies are persuading the decentralisation work and there is little voice in this regard. For the effective handover, promoting the awareness of existing LBs, political paties and local people is important so that it produces a synergistic and empowered initiation from the bottom level.

Though there was some orientation given using 'clustering' approach, it was found to be insufficient and 'onsite' orientation to all Management Committee (MC) members as well as re-orientation is crucial (Shrestha 2003). In addition, the existing orientation package focuses on the roles and responsibilities, however there needs to be a good mix of technical and managerial skills to increase the competency of MCs.

f) Financial and administration issues

There is also confusion related to technical supervision and management audit after handover. The S/HPMC does not have autonomy and the policy is unclear regarding leave, transfer and deputation. There exists a political bias in assessing the performance of staff. A very simple but a big issue, who hires and fires staff? Is that centre, or District Public Health Office (DPHO) or local communities? Does the local SHMCs have enough capacity to do that? Who sets the standards for quality? Is that community or DPHO or VDC or DDC or Centre?

The other issue is related to budgetary issues and resource mobilisation. Are there sufficient evidences of local resource mobilisation? Perhaps not. Are VDCs being accountable to transfer and management of funds? Who supplies the drug? Is hand over is just like a 'washing hands'? One of the findings of CSSP (2005) documents that SHP staffs were facing difficulty in getting their monthly salary. This was because of procedural delay of getting funds from DDC through DPHO. Moreover, majorities of HMC members were not aware of their financial transparency matters. If it is who and how the quality of drugs are ensured? Perhaps, there must be message that the drug supply will be continued even after the handover until they are trained and arrange necessary mechanism in an effective way.

5.1.3 Summing up

As discussed in the earlier chapters, a few relevant conclusions can be easily derived from the history of health services development in the country.

Firstly, the stakeholders from political to top level government officials and LBs have clearly emphasised the need for decentralisation in health sector. The enactment of LSGA can be taken as a high level political commitment while the other relevant strategy, directive and policy guidelines can be seen as a part of their commitment. However, there seems some what confusion whether these top level 'policy making communities' have really internalised the issue or not. The other issue associated with this is the forms of decentralisation. Whatever mentioned in the documents and policies, the documented evidences confirm that the current handing over activities seem like a deconcentration rather than the complete devolution. If this is so, are we willing to control the handed over LHIs centrally?

Secondly, it is important to note that when decentralising health services, 'preparing and building self' and 'preparing and building others' are important aspects. Under building self-mechanism, structural alignments of MoH structures and institutionalisation of inter-ministerial coordination is important. Under the part of preparing and building others, LBs and LHIMCs preparedness and capacity greatly affected the entire process. Therefore, this should not be taken lightly since local capacity to take over and sustain the 'handed over package' determines the effectiveness of our decentralisation process.

Thirdly, community participation and feeling of ownership in health activities is perhaps, the most important aspect. Documented evidences showed that community participation was found to be encouraging than of previous years and they have begun to feel ownership of their SHPs. This needs to be further ensured.

Finally, policy itself does not decentralise the power, authority and responsibility. It is the people who somehow linked with the entire chain do the things. The overall planning process at VDC and DDC, integration of health service activities into their plans, staff portfolios and accountability mechanism and the 'common goal and ethos' of serving poor people plays determining factor to materialise 'theory in action, than into practice'. There is a pertinent question, which could be probably the hot topic of debate that is all government staff really committed for handover process. Of course not. The recent indefinite strike launched by over 26,000 paramedical personnel strongly demanding to end to the process of handing over the health institutions to the communities questions the overall credibility of the government's effort in decentralisation. (The Kathmandu Post, August 18th 19th, 2006). What does this indicate? Are all the ministries and its structure really ready for decentralisation? Over the years, there has been significant achievement in terms of quantity handover, however it needs further effort to transform these achievements into quality standards and to 'completely brain wash' the mentalities of its front line staff.

5.2 Findings from field survey

The field studies carried out in above mentioned sampled districts and with the mentioned respondents also found more or less similar findings with little differences in some of the aspects. The findings from field study has been mentioned below:

5.2.1 Policy Planning

The enactment of LSGA and its regulation has served as a major basis of health services decentralisation in Nepal. Some of the Key Informants said that though the basis for health sector decentralisation is LSGA 1999, concerns were raised to have separate policy for health sector decentralisation since this act is not sufficient enough to decentralise health sector in a more complete sense. Because the LSGA mentions about providing all health services but does not clarify about budget, service delivery, financial accountability and responsibility, the role of central management and, vaccine and medicine purchase and supply matters. They also mentioned that LBs and HMCs cannot effectively handle the medicine and vaccine issues right after the handover for which technical and managerial capacity building is crucial. Though the SHPs were handed over, services are still under MoHP and DoHS which should be under the control of LBs. LBs must be made responsible to deal with staff issues to make them accountable to LBs but the current pattern shows that there is decentralisation of functions rather than the authority. In this connection one of the reacted saying:

> *Government is sending the medicines worth only about Rs .21,500 per SHP per year. But in Kathmandu we are spending minimum of 20-21,000 per year per person for medical treatment. In such case delegating the full authority to the HMCs with strong poliy planning support could provide a greater room to bridge such gap of disparities for the provision of quality health services at the local level.*
>
> *One of the Key Informants from INGO*

> *"the plans made in Singa Durbar could not meet the local need and requirements, so that full authority should be given to local level to make and implement the health plan to improve the health service provided by the SHPs"* *--LDO, Banke*

Inter ministerial coordination is also other issue for which arrangement are needed to clear the concepts of decentralisation and their roles.

At the district level, respondents pointed out that LSGA was not implemented properly, since the overall aim of decentralisation is increase peoples' access to health. This was mainly due to lack of elected LBs and VDC secretaries not staying in their duty station. They also mentioned that the budget transfer system is also rather cumbersome. In addition, LSGA is silent about staff administration issues. Very simple and practical question, where should SHPs send their attendance sheet?

Some of the central level KIs mentioned that current policy does not guarantee lower and oppressed peoples' access to health, and it needs certain provision for such people. It is not just making a policy, but the central bodies should refine, monitor and evaluate the policies and also need to manage resources. Under the current policy the issue of social inclusion has been overlooked. Doing these things needs creative personalities in order to make policy, plan and implement the decentralisation movement.

However, in terms of policy planning the respondents differed in their views. The policy is good but it is not properly implemented. The policy should be clear and applicable according to the geographical, economical, political and social situation of the country. Contradictory laws and policies need to be eliminated. As mentioned by one of the VDC Secretaries quoting the saying of Jawahar Lal Neharu

"We are the best planners but worst implementers" we make good policies but failed to outwork them. Therefore, the only thing now we need is commitment at our work and towards our profession.

5.2.2 Knowledge about handover and hand over process

a) Knowledge about handover

Generally speaking, majority of KI at central and district level expressed that the overall basis for health care facilities decentralisation was based on the LSGA 1999. All the respondents at local and central level were found to be clear about the objectives of health service decentralisation except the exit clients (ECs). The local level respondents mentioned the overall grasps of decentralisation, which is about empowering local communities through their participation and ownership. The central and district level representatives put their opinion in a more explicit ways. (See Annex 4 for KIs).

According to them the objectives behind the health service decentralisation were:

- To develop ownership feeling in local communities towards SHPs.
- To make the SHPs sustainable through community and the local resources mobilisation.
- To maintain transparency in medicine distribution and financial aspects.
- To improve the quality of health services increasing communities' participation and making them access to all people.
- To ensure planning, monitoring and evaluation by LBs and local communities, thereby reducing budgetary and managerial burden to central level. For example one of the respondents of MoHP said:
- To develop the local authority as a local well functioning government and go towards full devolution.

> "*In some districts, it takes 6-7 days to reach to the SHPs. Monitoring also cannot be done frequently as planned. Additionally supervisors are taking TA/DA for 20-22 days for the work. If monitoring and evaluations are ensured at local level to the LBs, it will reduce budgetary and managerial burden to central structures, and the money saved can be diverted in other areas such as strengthening quality care services".*
> *One of the Key Informants from MoHP.*

At SHP level, most of the In-charges and MCHWs were found having good knowledge about health facility handover giving more emphasis to community participation. As per MCHWs saying it is delegating the power/authority to the local level provides opportunities to the couumnities to work together in order to get the 'fruit' of their own effort and is also a process of self-help. In village level KIs' saying the it is like *"Afno Gaun Aafai Banaun*[23] "Health is wealth" and According to SHP Incharges, SHP's plan should be based on the requirements of locals and based on the local resource mobilisation. However, the significant percentage of ECs; 58.62 had any knowledge regarding handover.

Some community level respondents were found with different views regarding the objective of handover. In their opinion, government wants to pull its hand from the health facility, and therefore the decentralisation is so rush.

[23] This means "make your village self"

b) Knowledge about handover process

Towards the process of SHPs hand over, all categories of respondents except ECs and village level KIs, were found to be familiar with the process of handover. With some exceptions to newly appointed and recently transferred VDC secretaries, all respondents mentioned that the SHPs were handed over to community in the presence of VDC Secretary, and HMC Chairperson, DDC, CDO and DPHO authorities in DDC hall which was the process adopted for handover. During hand over process, for example in Lalitpur and Kanchanpur, the Regional Health Directors were also present. In all the districts except in Kanchanpur, two-day orientation training[24] was delivered to key HMC members, SHP In-charge and VDC Secretaries. However, in Kanchanpur, a form was distributed and asked them to fill up that form and come up in the district HQs having formed HMC. The orientation training was only given after handing over the SHP. Further more the duration of training was also different from 2-3 days. For example in Banke district it was for three days while in other districts it was of 2 days.

At the district and local level, respondents said that the two days orientation training was not sufficient enough, and the main stakeholder, the communities are overlooked in entire process.

On the part of Exit Clients (ECs), on an average 41.2 percent of them heard about the handover. (Appendix 5). Only the nominal percentage of them, 8.7 percent got information of ongoing activities of handover. Similarly, only the 18.4 percentage of ECs got information about provision and formation of HMC. Going through the district, the ECs knowing the information of handover process is generally nil in Lalitpur, Kanchanpur and to some extent in Banke and Kaski. These data revealed that a significant number of ECs, were overlooked into the entire process of HFs handover. Generally speaking, of the total ECs the percentage of female knowing the information was relatively and in some case significantly well off than that of male ones If the huge masses of communities, to whom the whole purpose of decentralisation is meant for, how can the communities come and participate in SHP activities and take ownership of the HFs

On the part of village level KIs, majority of them were found to be known about the hand over process while others had just heard about it. In addition, KIs of Kaski mentioned that the NHTC trainers were not clear in the policy matters.

A contrasting view regarding the requirements for handover came up from the district level respondents. The respondents of Jhapa and Kaski said that SHPs needed certain infrastructure as a precondition for example enough equipment, qualified manpower and willingness of local community to take over SHPs while this was not heard in other districts where they simply said that there were no prerequisites set rather following ministry's decentralisation policy.

The outcomes of FGD were also more contrasting. Most of the male and female participants were highly unknown about the handover process. They criticised saying that it was a "*kothe nirnaya (a Decision made in the room)* of higher authorities without involving the people to whom the health facility is handed over. They were also unknown about HMC formation what they only knew about the existence of committee in the health facility only when they saw their names. One women of Kanchanpur reacted as: *"it is just now that I came to know that there is HMC in our SHP, other wise I would have uninformed".*

[24] According to DPHO, Kaski, the key focus of the training was to assess local health problems, inform local authorities about the importance of health facilities decentralisation, assess the existing health infrastructures, to make health plans based on local needs and local resource mobilisation and to increase ownership of the local people.

The above analysis revealed that a great majority of ECs and communities were not aware about handover process and they were not included. If we overlook these great masses of people whom the programme is designed and targeted, how SHPs could work effectively? This is a big question mark for all concerned.

c) Perception about timing of handover

Some mixed reactions came out of the district and village level respondents with the dominant number of people claiming the handover time appropriate.

It was found that 57.14 per cent of MCHWs were positive towards handover process. In terms of timing of handover, 28.57 per cent of them reported that the timing for handover was not appropriate due to their inability to operate SHPs and formulate plans while 14.28 had no idea about the process. (Table 5.2)

No.	Opinion	%
16	Yes (appropriate)	57.14
8	No (inappropriate)	28.57
4	Don't know	14.28
28		**100**

Table 5.2: Showing MCHWs response on timing of SHPs handover

Districts	**KIs (N=57)**	**LDOs (N=5)**	**DPHOs (N=5)**
	Yes (appropriate) n (%)	**Yes (appropriate) n (%)**	**Yes (appropriate) n (%)**
Kaski	7(50)	1(100)	0
Banke	8(66.7)	1(100)	1(100)
Kanchanpur	4(100)	1(100)	0
Jhapa	13(86.7)	0	1(100)
Lalitur	8(66.7)	1(100)	1(100)
Total	**40(70.1)**	**4(80)**	**3(60)**
Ecological Regions			
Hill	15(57.7)	2(100)	1(50)
Terai	25(80.6)	2(6.7)	2(66.7)
Total	**40(70.1)**	**4(80)**	**3(60)**
Areas			
Urban	20(74)	-	-
Rural	20(66.7)	-	-
Total	**40(70.1)**	**-**	**-**

Table 5.3: Appropriateness of Timing of handover

At the district level, except the LDO of Kaski and Kanchanpur and DPHO of Jhapa (Table 5.3) all mentioned that the handover time was on right time saying that right time could not be waited anymore. Slowly, community will build on their experience. They added that when the elected LBs back into the power after the restoration of peace, it will take the effective momentum. The other side of the coin who responded the time being inappropriate questioned that if there are nobody to look after the handed over SHPs and community are also not aware enough, who will take care of SHPs? Still the opinions were different among the district level KIs with an average of 70 percent perceiving the handover positively and others not doing so. This is highest in Kanchanpur with all saying the time being appropriate followed by Jhapa where 86.7 percent KIs said. A least percentage was found in Jhapa, 50 percent saying the time being appropriate followed by Lalitpur and Banke, which is 66.6 percent.

In addition, the same table 4.2 showed that the district level KIs had also mixed reactions saying the time appropriate (70.17%) and inappropriate (28.07%). Those who claimed to be appropriate mentioned that the issue of handover is more about concern and interest towards SHP and its improvement for which work could be done without being in the chair. It is a good learning opportunity by doing things and communities slowly learn things by their mistakes. Where the communities were active, take interest and had enthusiasm SHPs were operating properly and able to raise funds from different sources. However, opponents argued that the work of handover is worthless if there are no elected LBs.

However, HMCCPs' put serious question mark behind the time of handover. They argued that the hand over must be *'demand base rather than decision based. It should also be bottom up against the current practice of top down"*. Before handing over the such institutions government should take consideration of build certain infrastructures such as building, lab and equipments etc, increase community awareness, make SHPs somewhat sustainable both financially and technically and impart managerial skills to the key persons. Some Chairpersons of Banke argued saying that ***"handing over SHPs without building certain infrastructures is just like giving empty plate to the hungry people rather it should have filled in with rice and vegetables to eat. If the plate is empty, what to eat by communities".*** Unless the communities are sensitized and become aware, the whole rational of decentralisation always fails.

5.2.3 Authorities, Financial Management and Capacity Building

a) Authorities

The findings show that except purchasing of medicine, the handed over SHPs had no administrative and financial authorities. The SHPs cannot approve leave of their staff, and the transfer of staff is never possible under the current arrangement. It is also provisioned that the HMCs can also recruit staff if they have funds but this was never practised. Almost all the respondents claimed that all the financial and administrative control was under DPHOs and other higher authorities, thereby making SHPs dependent. They argued that there has been no change as of earlier.

The KIs also identified other issue related to the authority and *"superiority complex"* which was observed in some places because under the current situation, HMC Chairperson is *Kharidar level* while the In-charge belongs to *Subba level.* In addition, SHP In-charge is technical person, and the question was who is higher than whom.

b) Financial management

It was found that regular budget from the government, registration fee and 5 percent of the budgets from VDCs were serving as the main sources of income in SHPs. Besides, as a part of income SHPs were found to be charging certain extra fee for their services[25]. As reported by SHPIs more than 73 SHPs charged certain fee for their services while others not. By district all SHPs in Jhapa and Kanchanpur charged fee followed by Kaski where the percentage was 71.4. The highest percentage of SHPs not charging fee was found in Lalitpur where the ratio of charging and not charging fee was 1:1. By areas, almost all SHPs charged fee for their services, which is 93.8 percentages (Appendix 6).

Districts	SHPI (N=30)	HMCCP (N=28)
	Yes n (%)	**Yes n (%)**
Kaski	1 (14.3)	0
Banke	0	0
Kanchanpur	0	0
Jhapa	0	1 (14.3)
Lalit pur	1 (16.7)	1 (16.7)
Total	**2 (6.7)**	**2 (7.1)**
Ecological Regions		
Hill	2 (15.3)	1 (7.7)
Terai	0	1 (6.7)
Total	**2 (6.7)**	**2 (7.1)**
Areas		
Urban	0	1 (8.3)
Rural	2 (12.5)	1 (6.3)
Total	**2 (6.7)**	**2 (7.1)**

Table 5.4: Adequacy of budget in SHPs

Generally speaking, SHPs were having financial problems hindering them to perform well. 93.33 percent SHPIs and 92.9 percent HMCCPs mentioned that they did not get sufficient budget according to their plan. They also did not have any special budget to operate SHPs except OPD

[25] SHPs were found to be charging 10 for each of TT Vaccine and Depo-Provera, 20-30 for each of Dental check up and extraction and Stool and Urine test, 10-20 for Dressing, 20 for wound operation, 50 for Insulin test (sugar) and 100 for each case of Filling the Police report and Blood test. (Note: currency is all in NRs).

registration fee and some funds from VDC and different I/NGOs and in some case from industries. Only the 6.7 percent SHPIs said that they had adequate budget to operate their facility. Where as this figure in the case of HMCCP was slightly higher by 0.4 percent. Ecologically, the Hill and Rural based SHPs seemed slightly well off than that of the Terai and Urban ones. (Table 5.4)

Since four years government has been providing NRs 30,000 to each SHP to purchase medicines. SHPs are asked to purchase medicines from district level, and only the medicines, which were not available at that level (e.g. spacing methods, vaccines etc.), are being sent from centre. At the district level, the DPHO purchase required medicines and sends to each SHP and charges the amount. It was also found that the medicine supply system was also slow being one of the hurdles of quality health service delivery.

As expressed by the respondents, not being financially well off had multiple implications. Some SHPs could not prepare their short and long term plans. Others could not train their staff in new approaches while HMC members also could not receive capacity building training. They indicated that there is a clear need for staff, however could not hire because of financial problems.

Budget flow system also seemed more complex. After handover, the budget was transferred from DDC to DPHO, DPHO than sends money to VDC and finally it goes to SHP. Questions were raised about this budget flow system being lengthy; time consuming and needing a lot of administrative work. This indicates that SHPs need financial assistance from the government and non government entities to make them financially sustainable.

c) Capacity building

All respondents mentioned that capacity building is very much important but mostly overlooked aspect of current decentralisation process. It was found that the SHPIs and HMC members received a form of 2-3 days orientation training that was followed by immediate handover of SHPs to them. There was no back stopping for this. The HMCCPs criticised that the handover was just like "exchange of file". Technically, MCHWs also received some training in their own areas[26]. A huge amount of budget have been spent in the name of building capacity of SHPs. similarly one of the HPIs mentioned that "millions of dollars that came in the name of decentralisation has helped senior officials to built ensuit buildings in and outside of country, but the situation of SHPs never changed. Capacity building is not just like that of giving one time off or two times off training rather it needs a definite package and also is a continuous process".

In broad sense, the term capacity building also includes communities as well. If we expect communities participation and taking them the ownership of SHPs they also need certain capacity building activities. This also affects them to increase their health service utilisation by developing health seeking behavior.

5.2.4 Development of short and long term plans

More than 50% SHPs have developed annual or long-term plans (Table 5.5). Of the total SHPCP, 60 per cent said that they have developed annual or long-term plans which are similar to SHP Incharges' response but the village level KIs response was less by 6 per cent. In contrast, the DPHO's response was that all the SHPs have long term plan whereas except the LDO of Jhapa, all mentioned that they have either plans to improve the health service of SHPs.

[26] MCHWs received safe motherhood and family planning, safe abortion and delivery, ARI, CBMNC/IMCI, DOTS, HIV/AIDS, Leprosy, Immunisation, Vitamin A and record keeping training provided by the government.

According to HMC's response, 85 per cent of SHP's have developed long term plan in Jhapa district followed by Banke where 71 percent of SHPs have such plan. In contrast, SHPs in Kaski has the lowest percentage of plans developed which is only 14.

Ecologically, the SHPs located in Terai areas seemed to have developed long term plans as compared to the Hill ones. By geographic locations the Rural areas seemed to be better in developing long-term plans which is, on an average, more by 12 per cent to that of later ones.

Districts	HMCCP (N=28)	SHPIs (N=30)	KIs (N=57)	DPHOs (N=5)	LDOs (N=5)
	Yes n (%)	Yes n (%)	Yes n (%)	Yes n (%)	Yes n (%)
Kaski	1 (14.3)	5 (71.4)	8 (57.2)	1 (100)	1 (100)
Banke	5 (71.4)	4 (57.1)	4 (33.3)	1 (100)	1 (100)
Kanchanpur	1 (100)	2 (100)	2 (50)	1 (100)	1 (100)
Jhapa	6 (85.7)	4 (50)	10 (66)	1 (100)	0
Lalit pur	4 (66.7)	3 (50)	7 (58.3)	1 (100)	1 (100)
Total	**17(60.7)**	**18 (60)**	**31 (54)**	**5 (100)**	**4 (80)**
Ecological Regions					
Hill	5 (38.5)	8 (61.5)	15 (58)	2 (100)	2 100)
Terai	12 (80)	10 (58.8)	16 (52)	3 (100)	2 (6.7)
Total	**17(60.7)**	**18 (60)**	**31 (54)**	**5 (100)**	**4 (80)**
Areas					
Urban	5 (41.7)	8 (57.1)	15 (56)	-	-
Rural	12(75)	10 (62.5)	16 (53)	-	-
Total	**17(60.7)**	**18 (60)**	**31 (54)**	**-**	**-**

Table 5.5: Formulation of annual or long term plan in the SHPs

Majority of such plans are related to improvement of physical facility, management of manpower and improve and extend health service delivery to the communities. The plans also focused on creating public awareness about some of the endemic diseases such as malaria and HIV/AIDS etc, increase health seeking behaviour and service utilisation aspects and to make school health education programme effective. Some of the SHPs have established some extra facilities such as lab, weekly clinics on ENT, Dental camps, DOTS, Safe Motherhood Tablet, IMCI, CBMNC, CBMC, Malaria Service and PDQ service. OF the SHPs who could not prepare plans mentioned that due to lack of budget and absence of elected LBs, some SHPs could not prepare plans to improve health service delivery of SHPs.

However, SHPIs also claimed that most of the plans and policies were made at district level for which SHPs have no alternatives except to follow them. As they said this is part of the authority what they were not delegated.

5.2.5 Composition and functioning of HMC

a) Composition of HMC

In respect to the composition of HMC, MoHP has made provision to form a mixed and inclusive committee lead by VDC Chairperson[27]. In general it was found that satisfaction towards the composition of HMC was over 50 per cent across all respondents except ECs. It was the highest in case of MCHWs (85.7 %) followed by HMCCP which is 75 per cent. 53 percent of SHPIs found to be satisfied towards the HMC composition because of the representation of caste and class of the community and helpfulness of the committee members. Whereas 47 percent of them expressed their dissatisfactions due to the mandatory provision for them to be as HMC Chairperson, hence prohibiting community to select the appropriate members (Table 5.6). They argued this as ***"putting***

[27] The other members of the committee includes Chairperson of Population and Development Committee, Headmaster of local School, Female ward member of VDC, FCHV representative, Marginalised people (Dalit), female social worker and Sub Health Post Incharge as Member Secretary.

two legs in two boats". For the committee to be more effective, they suggested that it should be the person who is respectful by all political party, has some technical know-how, possess influencing personality and also literate. It is the community who should have authority to choose and appoint the HMC. Some of them opposed very strongly to their mandatory Chairpersonship in HMC since they were unable to stay at their work place due to ongoing conflict, and therefore could not effectively perform their mandatory duties. They said, it is like a Nepali proverb *"Budho Gorule Gai Ogate Jasto"* [28]

In the case of ECs their satisfaction level is 41 percent. Those who are not satisfied mentioned that the committee was formed in the district, community had no interest on them and in fact they don't exactly represent the community. They added that the result was defunct committee. Interesting thing here to note is that respondents of each category of ecological region had almost similar level of satisfaction towards the composition. In contrast, by areas the opinion in each category respondents except MCHWs and SHP Incharges greatly varied. This difference is highest in the case of HMCCP which is 66 and 81 per cent by Urban and Rural respectively.

	SHP Incharge (N=30)	**HMC CP (N= 28)**	**MCHWs /FCHVs (N= 28)**	**Exit Clients (N= 58)**
Districts	**Yes n (%)**	**Yes n (%)**	**Yes n (%)**	**Yes n (%)**
Kaski	5 (71.4)	5 (71.4)	6 (85.7)	8 (61.5)
Banke	3 (42.9)	3 (42.9)	5 (100)	10 (76.9)
Kanchanpur	1 (50)	1 (100)	1 (50)	1 (25)
Jhapa	5 (62.5)	7 (100.0)	7 (87.5)	4 (25)
Lalit pur	2 (33.3)	5 (83.3)	5 (83.3)	1 (8.3)
Total	**16 (53.3)**	**21 (75)**	**24 (85.7)**	**24 (41)**
Ecological Regions				
Hill	7 (53.8)	10 (76.9)	11 (84.6)	9 (36)
Terai	9 (52.9)	11 (73.3)	13 (86.7)	15 (45.5)
Total	**16 (53.3)**	**21 (75)**	**24 (85.7)**	**24 (41)**
Areas				
Urban	7 (50.0)	8 (66.7)	10 (83.3)	9 (34.6)
Rural	9 (56.30	13 (81.3)	14 (87.5)	15 (46.8)
Total	**16 (53.3)**	**21 (75)**	**24 (85.7)**	**24 (41)**

Table 5.6: Satisfaction with the Composition of HMC

Those who have greater satisfaction mentioned that the current composition of HMC saying this as inclusive of all class, caste and gender. In turn, the dissatisfied MCHWs said that the current composition is conducive for political egoism towards non-supporters of HMC members.

> *"I am supporter of .... party so that the HMC members of other parties don't give credit for my work"   -- One of the MCHWs of Kanchanpur district*

Almost all categories of local respondents stressed to include local NGO, Youth Clubs and religious and ethnic group in the committee. For example VDC secretaries suggested to include religious leaders i.e. '***Muslim Leader'*** in Banke district and '***Tharu Leader'*** in Kanchanpur district in the HMC.

All these figure indicated that the community should make aware about the composition of HMC and give emphasis to select members by themselves.

[28] It is like a holding the position rather performing the job.

b) HMC meetings

It was found that 71.4 percent meetings were held regularly as scheduled by HMC's Chairperson while 28.4 percent did not held. This was due to the their busyness and not having time of Chairpersons to participate in the meetings. The holding of meetings as scheduled by Chairperson was also differed by district, region and areas. By district, in Jhapa and Kanchanpur this figure is hundred percent followed by Kaski which is equal to average of meetings held. The meetings were poorly held as per schedule in Lalitpur which is 50 percent followed by Banke (43). By regions, the meetings were as per schedule in Terai based SHPs where 80 percent meetings were held against the Hill SHPs of 61.5. Similarly, the holding of scheduled meetings was better in Urban areas (75%) as compared to Rural ones which is 68.8 percent. (Table 5.7)

Districts	Yes n (%)	No n (%)
Kaski	5 (71.4)	2 (28.6)
Banke	4(57)	3(43)
Kanchanpur	1(100)	0
Jhapa	7(100)	0
Lalitpur	3(50)	3(50)
Total	**20(71.4)**	**8 (28.6)**
Ecological Regions		
Hill	8(61.5)	5(38.4)
Terai	12(80)	3(20)
Total	**20(71.4)**	**8(28.6)**
Areas		
Urban	9(75)	3(25)
Rural	11(68.8)	5(31.2)
Total	**20(71.4)**	**8(28.6)**

Table 5.7: Holding meeting scheduled by Chairpersons

4.5.2 Attendance of HMC members

The data also revealed that the average attendance in the HMC meeting was also encouraging. As shown by the data, the average attendance by the HMC members in the meeting is 78.8 percent, which is quite exciting. However, the average attendance varies by district, region and areas. This is the highest in Jhapa, where average members attending more than 80 percent meeting was 70.8 percent followed by Kanchanpur which is 66.7 percent. This figure was the least in Kasti having 47.6 percent members attending more than 80 percent meeting. (Appendix 7)

In addition the average meeting attending by more than 80 percent members was found better in the Terai SHPs which is almost higher by 7 percent than that of the Hill ones which is 53.8 percent. Similarly, In Urban based SHPs average members attending over 80 percent meeting were found to be 54.8, almost less by 7.7 percent.

The regions behind not attending meeting were due to negligence and business. Some of the HMC members felt the meeting as waste of time saying *"I won't be able to participate in the meeting and will put my signature when I will have leisure time"*. In addition, the attendance of *Dalits* (down-trodden) and females was also discouraging mostly their business and thinking that the meeting would not benefit them. Moreover, some of the FGD participants were not found to be satisfied with the passiveness of HMC and not fulfilling their responsibilities as expected by the communities. This has questioned the commitment of MC members towards the improvement of SHP.

> *"One NGO named SAVE provided a freeze and a bed to SHP but HMC even did not know from where that has came"*
> ***Male FGD participant, Banke*

5.2.6 Coordination, Monitoring and Supervision and Reporting

a) Coordination and Linkage

According the response given by SHPIs', an average of 73.3 percent (Table 5.8) SHPs have ability and authority to coordinate their programmes and activities with I/NGOs through regular meetings, personal contact and correspondence. Mainly this type of linkage was established with NGOs for

training, to manage equipments, to construct and repair buildings and to purchase medicines. This response is almost similar to that of HMCs response which is 71.4. By districts, both the SHPIs' and HMCCP of Banke and kanchanpur said that they have full ability and authority to coordinate their activities with other I/NGOs followed by Jhapa where 75 percent Banke and kanchanpur said that they have full ability and authority to coordinate their activities with other I/NGOs followed by Jhapa where 75 percent Incharges and 71.5 percent Chairpersons said of having those ability and authority.

In contrast, the Incharges and Chairpersons of Kaski said they have very limited ability and authority for coordination which is 42.8 and 28.5 percent. By regions, the Terai based SHPs seems better able and better authorised (SHPI and CPs saying 88.2 and 86.7 percent) compared to the Hill ones where 53.8 percent of both group of respondents have ability and authority to coordinte. By areas the two groups of respondents have different views. According to SHP Incharges response, Rural based SHPs had slightly better ability than that of Urban ones; the figures being 75 and 71.4 percent respectively. While 75 percent Chairpersons of Urban based SHPs said, they have that ability compared to 68.8 percent of Rural ones.

Districts	SHPIs (N=30)	HMCCP (N=30)
	Yes n (%)	Yes n (%)
Kaski	3 (42.8)	2 (28.5)
Banke	7 (100)	7 (100)
Kanchanpur	2 (100)	1 (100)
Jhapa	6 (75)	5 (71.5)
Lalit pur	4 (66.7)	5 83.3)
Total	**22 (73.3)**	**20 (71.4)**
Ecological Regions		
Hill	7 (53.8)	7 (53.8)
Terai	15 (88.2)	13 (86.7)
Total	**22 (73.3)**	**20 (71.4)**
Areas		
Urban	10 (71.4)	9 (75)
Rural	12 (75)	11 (68.8)
Total	**22 (73.3)**	**20 (71.4)**

Table 5.8: Coordination with Different NGOs/INGOs

b) Reporting

Encouraging results came out in reporting. The data showed that all the SHPIs and MCHWs/FCHVs were regularly sending their reports to DPHO. No differences was noted by district, region and areas (Appendix 8). There might be some implications of this result. For example, though we talk a lot about decentralisation, however they see that DPHO is still a major vertical governing and administrative body for them. Perhaps DPHO might have played its role in that way as well. It hits strongly towards overall norms of decentralisation process.

c) Monitoring and Supervision

Districts	SHP In-charge (N=30)	HMCCP (N=28)	MCHWs/ FCHVs (N=28)
	Yes n (%)	Yes n (%)	Yes n (%)
Kaski	7 (100)	7 (100)	5 (71.4)
Banke	7 (100)	2 (28.5)	4 (80)
Kanchanpur	2 (100)	1 (100)	2 (100)
Jhapa	7(87.5)	4(57.1)	8 (100)
Lalit pur	6 (100)	3(50)	5 (83.3)
Total	**29 (96.6)**	**17 (60.7)**	**24 (85.7)**
Ecological Regions			
Hill	13 (100)	10 (76.9)	10 (76.9)
Terai	16 (94.1)	7 (46.7)	14 (93.3)
Total	**29 (96.6)**	**17 (60.7)**	**24 (85.7)**
Areas			
Urban	13 (92.8)	7 (58.3)	11 (91.7)
Rural	16 (100)	10 (62.5)	13 (81.3)
Total	**29 (96.6)**	**17 (60.7)**	**24 (85.7)**

Table 5.9: Practice of Record Keeping

Generally speaking it is the DHPO that is carrying out the monitoring and supervision of SHPs.. In addition Health Posts, Regional Health Directorate were also involved. In some instances, Pro-Public was also found to be involved.

Field level data revealed that almost SHPs, in general were having records of supervision system, which is over 60% with the respondents view (HMCCP, MCHWs and SHPI's) ranging from 60.7 - to 85.7 and to 96.6 percent of respectively. Average practice of having records of supervision was found to be good in the Hill based SHPs, which is over 76 to 100 percent while in Terai, the practice ranges from 46.7 to 94 percent. (Table 5.9). All the MCHWs claimed that the suggestions and comments given by the

supervisors were being taken to HMC at the time of meeting.

However, the other forms of response claimed that the monitoring and evaluation system aspect was the weakest one in SHPs. It was found that most of the SHPs, who are nearby roads and easily accessible were supervised frequently than the others. The SHPIs responded that, to some extent, the ongoing conflict also had some negative impact to have timely and effective evaluation. In some places the supervisors just signed in the register without their comments.

Some valuable suggesstions came out of the respondents. HMCCP suggested that *"government should monitor the improvement of SHPs as MCHWs monitor the growth of the baby"*. They suggested forming an evaluation committee under DDC and delegate necessary authorities for monitoring and evaluation.

5.2.7 Human Resources Management (HRM)

a) Staff Vacant positions

In general SHPs have staffing of four persons[29]. Contrasting views came in terms of vacant staff positions in SHPs. Except in Banke, 33.3 percent SHPIs reported that they have staff vacant positions in their SHPs.

Districts	Reported by SHPI (N=30)	Reported by HMCCP (N=28)
	Yes n (%)	**Yes n (%)**
Kaski	2 (28)	1(14.3)
Banke	0	0
Kanchanpur	2 (100)	0
Jhapa	3 37.5)	2(28.6)
Lalit pur	3 (50)	0
Total	**10 (33.3)**	**3(10.7)**
Ecological Regions		
Hill	5 (38.4)	1(7.7)
Terai	5 (29.4)	2(13.3)
Total	**10 (33.3)**	**3(10.7)**
Areas		
Urban	7 (50)	2(16.7)
Rural	3 (19)	1(6.3)
Total	**10 (33.3)**	**3(10.7)**

Table 5.10: Vacant Staff Positions in SHPs

In contrast, only 10.7 percent of HMCCPs reported so. The positions not fulfilled were MCHWs and peons. In Kaski, 28 percent SHPIs reported that they have vacancy but in the same district the percentage of HMCCPs reporting the same matter was only 14.3 percent. In other district Kanchanpur, all SHPIs reported they have staff vacancy; however HMCCP did not report that. Therefore, except in Banke, the differing views came from these two groups of respondents (Table 5.10).

b) Appointment of staff using local resources

On an average 24.5 SHPIs reported that they appointed staff such as peons, Lab Assistant and ANMs using local resources whereas less percent of HMCCPs (21.4) reported the activity. The data were also differed by districts, regions and areas. By districts, except in Kaski, Banke, Lalitpur and Kanchanpur. In Jhapa 62 percent of SHPIs said they appointed staff using local resources while 57 percent HMCCPs saying the same case. Kaski and Banke districts did not appoint staff using local resources while others did. Following to the both groups of respondents view, staff appointment using local resources was found to be encouraging in the Terai and Urban areas compared to the Hills and Rural ones respectively. (Appendix 9)

Discussing about the HRM, contrasting views came out of SHPIs and HMCs. The issue of staff vacant position and appointment of staff is related to facts and figures and actual one, and hence does not relate to giving their perception. This clearly indicates that there is no proper coordination and

[29] The positions held in SHP are AHW, MCHWs, VHWs and Peon.

cooperation between HPIs and HMCCPs. Adding more, this also indicates that there is also information gap between these two personalities.

b) Staff professional development support

Almost all the DPHOs except the Kaski were found to be concerned to develop the professional competency of SHP health personnel. They were providing regular training such as infection control, family planning (MCHWs), Partner Define Quality (PDQ) and Community Based Maternal and Neonatal Care (CBNMC), Oral Health, CBIMCI and account management. However, in the case of Kaski no training were organised except the two days orientation training provided at the time of handover.

Almost all the field level respondents (HMCCPs, SHPIs and MCHWs) mentioned the business of health staff both in technical and administrative work. According to them, this has hindered them to provide timely and quality health services to their clients. Therefore, they suggest to have one more staff to look after all the administrative work.

5.2.8 SHPs effectiveness before and after handover

a) Patients flow rate

The data showed that there is mixed results in the patients flow rate[30] before and after handover; however the general trend was that there has been increased rate of patients after handover which ranges from 11.6 for Measles in Jahapa to 200 percent for attending trained Sudeni (trained birth attendants) in Lalitpur district. Looking at the decreased flow rate, it was noted that the rate ranges from -57 for attending trained Sudeni in Kaski to -1.7 for OPD services in Banke district. (Appendix 10)

By districts, in Lalitpur and Jhapa, the patients flow rate in all cases was found to be increased. In consrast the flow rate in Kanchanpur decreased in all cases except in getting family planning services, which showed 22 percent increases. The highest increased flow rate was observed in Lalitpur in attending trained Sudeni, which was 200 percent followed by the 146 percent increase in getting delivery services in the same district.

b) Health infrastructures and facilities

Though the data to compare availability of health infrastructures and facilities were not found, however, the present situation of SHPs showed that SHPs are trying to equip with required infrastructures and other health related facilities.

As shown by the data, (Appendix 11) the SHPs in Kanchanpur posesses required basic infrastructures and health facilities except electricity which was found to be available in 50 percent SHPs.

In general the SHPs having electricity facility ranges from 40 percent to 100. The lowest percentage was noted in Kanchanpur followed by Kaski and Banke (57.1%). The highest percentage was found in Jhapa with all SHPs having electricity followed by Lalitpur where an average of 66.7 percent SHPs have that facility. Similarly, the data on the availability of drinking water also ranged from 42.9 (Jhapa) to 00 percent (Kanchanpur. Generally speaking the SHPs did not have telephone facilities

[30] Patients flow rate was measured in different 10 cases. They were OPD, ANC/ PNC, DPT3, Measles, Delivery services, Family planning, Trained Sudeni, Diarrhoea, DOTs and STI/UTI.

except some SHPs of Jhapa and Lalitpur. The availability of toilet facility seems relative better one where over 83.3 percent were having toilets.

In addition, all the SHPs of Jhapa and Kanchanpur have put citizen charter. The names of the HMC members have been displayed in Kaski and Kanchanpur. Moreover, the SHPs having reference materials and graphic charts ranged from 83.3 to 100 and 85.7-100 percent. All SHPs had ICE/BCC materials except the SHPs of Kaski where an average of 85.7 percent SHPs had those materials. Majorities of SHPs also had waiting rooms for patients and if not some furniture were also managed for patients. Generally clients were found to be satisfied with that arrangement.

Communities have raised concern about the management and regular supply of drinking water. In general drinking water was readily available in SHPs especially in the Terai regions except in some SHPs of Banke (Puraini and Bhawanipur VDCs) where water pumps were stolen frequently. Most of the clients of the Hilly area were found to be facing water scarcity and some patients were bound to carry water to take medicine from their homes. Similarly, concerned were also raised about using the toilet facilities. Though most of the SHPs have toilet facilities, are locked at all the times and only used by staff. In some cases toilets were open but lack water.

c) Drug Supply and purchasing

Since four years, SHPs are getting NRs. 30,000 for medicine purchase. Only the medicines which were not available at district were being sent from central level. In the district, DPHO is supplying medicines. The amount of medicines being sent by central and district was 50:50.

In the fiscal year 2005/06, the average percentage of SHPs who purchased drug and other necessary equipments[31] stood at 83.3 percent while others not. In Kaski and Kanchanpur all SHPIs reported that they purchased drug in that year.

Districts	Yes n(%)	No n(%)
Kaski	7(100)	0
Banke	5(71.4)	2(28.6)
Kanchanpur	2(100)	0
Jhapa	6(75)	2(25)
Lalit pur	5(83.3)	1(16.7)
Total	25(83.3)	5(16.7)
Ecological region		
Hill	12(92.3)	1(7.7)
Terai	13(76.4)	4(23.6)
Total	25(83.3)	5(16.7)
Geographical area		
Urban	13(92.8)	1(7.2)
Rural	12(75)	4(25)
Total	25(83.3)	5(16.7)

Table 5.11: Drug purchase in this fiscal year

This was followed by Lalitpur where 85.3 percent SHPs reported the activity. The lowest percentage of SHPs purchasing drug was found in Banke where 71.4 percent SHPs did that activity. By region, drug purchase in the Hill based and Urban based SHPs was more than the Terai and the Rural ones (92.3 vs. 76.4 percent and 92.8 vs. 75 respectively). (Table 5.11)

c) Community Drug Programme

Regarding Community Drug Programme (CDP), this programme was introduced in 50 percent SHPs. By districts, all SHPs of Kaski and Kanchanpur had CDP in place followed by Banke where the figure was 85.7 percent. In Jhapa and Lalitpur, CDP was not found to be introduced till the survey date. By region and areas the data seemed different. For example the percentage of SHPs having CDP in the Hills is higher by 7.6 than that of the Terai, which are 46.2. Similarly, the ratio of SHPs having and not having CDP was 50:50. (Appendix 12)

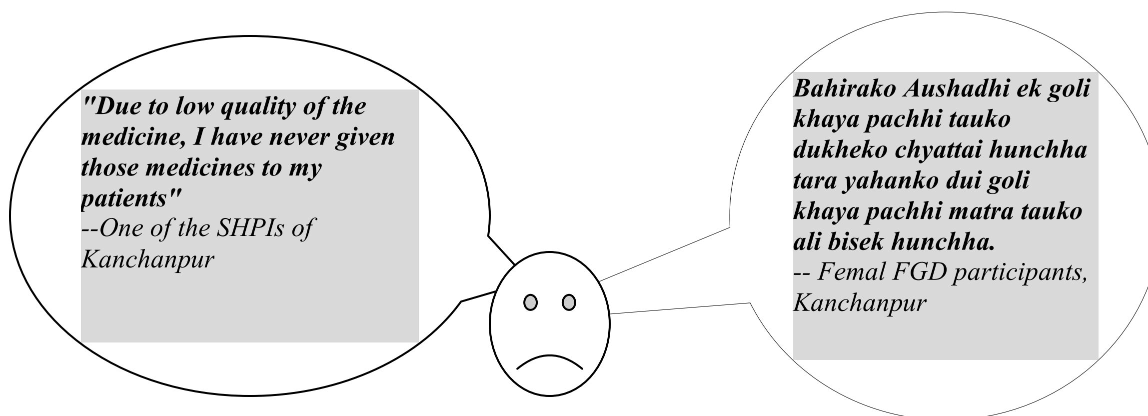
[31] The equipments and medicines purchased by SHPs were Citamol, Tetracycline, Albendazole, Metro, Amoxicillinn, Cortimoxazole, Antilargin, Brucet, Beta dine Solution, Vitamin B Complex, Fuel (Kerosene), Stationary, BP Set, Stethoscope, Gauze, Disposable Syringe, Weighting Machine etc.

d) Drug availability and client satisfaction

Majority of clients were found to be satisfied with the medicine distributed by SHPs. In general an average of 90 percent ECs reported that they were getting sufficient medicines in their each visits. 92.9 percent male respondent said that the drugs were available in their each visits while this in case of female ECs was less by 2.9 percent. By districts, all the male and female respondent of Jhapa mentioned the availability of drugs in their each visits while only the male respondent of Banke and Lalitpur said the same. The percentage of female respondent in later two districts saying availability of drug was 85.7 and 83.3 respectively. Under the drug availability Kanchanpur showed poor performance where the percentage of male and female saying drug availability was 50:50. In contrast, all the female of this district said the availability of drug. By region and areas, the availability of drug does not differ significantly in case of male respondent. However, according to the female respondent drug availability in Terai based SHPs were higher by 9.5 percent than that of the Hill ones which is 84.6. In the rural based SHPs, drug availability was higher by 11.4 percent than that of the urban ones, which were 78.6. (Appendix 13)

Majority of the MCHWs (75 percent) also mentioned that they were getting the medicines from DPHO to distribute the community in time. If they could not get medicines from DPHO, they also managed it from SHPs.

Questions were raised about the drug supply system by all categories of district and village level respondents. They complained about the drug supply system being late and of low quality. They strongly urged central authorities to stop sending such low quality drugs. The ECs also commented that not all the drugs were available in SHPs while some of them did not work. In such cases they purchased medicines from private clinics.



e) Service charge

SHPs were charging certain amount as registration and service charge. Registration fee in the SHPs was not same. They were charging minimum NRs 2 to maximum 5 per patient. For example Godawari SHP (urban Lalitpur) and Sarangkot SHP (Rural Kaski) were charging NRs 2 while Pitamber SHP (rural Kanchanpur) and Bhalam SHP (Urban Kaski) were found to be charging NRs 3. The remaining SHPs were charging NRs 5. Towards service charge, some of the SHPs (73 percent) reported that they were charging extra fee, for some services[32]. By district all SHPs in Jhapa and

[32] SHPs were found to be charging 10 for each of TT Vaccine and Depo-Provera, 20-30 for each of Dental check up and extraction and Stool and Urine test, 10-20 for Dressing, 20 for wound operation, 50 for Insulin test (sugar) and 100 for each case of Filling the Police report and Blood test. (Note: currency is all in NRs).

Kanchanpur charged fee followed by Kaski where the percentage was 71.4. The highest percentage of SHPs not charging fee was found in Lalitpur where the ratio of charging and not charging fee was 1:1. By areas, almost all SHPs charged fee for their services, which is 93.8 percentages. (Appendix 6). In most of the SHPs there was a provision of providing medicine in free of cost to poor and helpless people. This is exciting.

f) Staff support and behavior

Majority of ECs were satisfied with the behavior and good suggestions of health personnel. According to them health personnel were providing them sufficient instruction about spacing method and use of medicine. It was also found that MCHWs and VHWs regularly carried out home visits and provided medicines for pneumonia, diarrohoea and spacing method. At the same time they also imparted health education about nutrition, sanitation, family planning etc. FGD participants were most excited and praised the work done by FCHVs and they demanded FCHVs to get allowances for their allowances for their remarkable contribution in improving the health condition of the community. Some of the clients reported that they did not see staff visiting their homes. Majority of clients particularly female were not found to be satisfied regarding not maintaining privacy during the check up and demanded to have separate room for medical check up.

g) Office hours and staff availability

Majority of ECs and SMCMCCPs were not found to be satisfied towards the SHP's opening hours of 10AM to 4PM. However, some of them reported that presence of health personnel during this time was not regular. For example in SHPs there is provision of only one AHW. If he/she goes for training or leave, people had to return without medication. It is based on their experience.

i) Community Participation and local resource mobilisation

Following to the response of ECs, the data revealed that community participation in SHP improvement activities was very discouraging. Of the total female respondents, 76.6 percent (Table 5.12) reported that they did not have either form of participation in SHP improvement activities. Similarly, among the male respondents, 67.9 said that they also had no involvement in SHP improvement activities. The situation was found to be the worst in Kanchanpur district, where the participation of communities in the said activity was nil. The data seemed somewhat well off in Kaski and Banke where an average of 50 percent male said that they have involved in SHP improvement activities. Looking at the data by regions, it seems almost no difference than the average data of district, however by areas, male and female involvement was even worse by 23.8 and 7.8 percent than that of average of districts. Those who did not participate in SHP activities replied that nobody informed them to participate.

District	Male		Female	
	Yes n(%)	No n(%)	Yes n(%)	No n(%)
Kaski	3(50)	3(50)	2(28.6)	5(71.4)
Banke	3(50)	3(50)	2(16.7)	5(83.3)
Kanchanpur	0	2(100)	0	2(100)
Jhapa	2(25)	6(75)	2(25)	6(75)
Lalitur	1(16.7)	5(83.3)	1(16.7)	5(83.3)
Total	**9(32.1)**	**19(67.9)**	**7(23.3)**	**23(76.6)**
Ecological region(n)				
Hill	4(33.3)	8(66.7)	3(23)	10(77)
Terai	5(31.3)	11(68.7)	4(23.5)	13(76.5)
Total	**9(32.1)**	**19(67.9)**	**7(23.3)**	**23(76.6)**
Geographical area				
Urban	1(8.3)	11(91.7)	2(15.4)	11(84.6)
Rural	8(50)	8(50)	4(25)	12(75)
Total	**9(32.1)**	**19(67.9)**	**7(23.3)**	**23(76.6)**

Table 5.12: Community participation in SHP's improvement

> *"Paisa navayara gharko chhano ta ferna sakiyako chhaina, swanthya chhauki lai ke le sahayog garne?*
> *** FGD participant, Kanchanpur*

Resource mobilisation is very important aspect in order to make SHPs effective and also to extend and advance their services. However, the data that came out of SHPIs response revealed that an average of 60 percent SHPs did not see any possibility of local resource mobilisation to increase the income of SHPs. In Banke, SHPIs mentioned that they see no possibility to mobilise resources followed by Kaski where average of 71.5 SHPs said they had no possibility. In contrast some encouraging response came from SHPIs of Jhapa with 87.5 SHPIs saying possibilities to do this activity. (Appendix 14). By areas, urban based SHPs see less possibility (71.5) compared to Rural ones (50) for local resource generation. In line with the central level KIs response, SHPs capacities need to be built to mobilise local resources more effectively and efficiently before going to full devolution process. For the effective implementation of decentralisation, the SHPIs suggested to empower VDCs and make communities clear about their roles and responsibilities.

The other issue associated with the community participation is effective functioning of HMC. We found that HMCs were not able to mobilise the community properly. The main cause behind this we found was the displacement of influential people who could actually provide leadership to the community. Inactiveness of the committee and lack of concern and commitment for the improvement the health facility was other cause behind this. The other cause of this could be I/NGOs have made people money oriented by providing the incentives against their participation without which people do not want to come and attend the meetings. For example one of the MCHW of Banke district mentioned that , when she asked a mother to participate in the mothers group meetings, the mother asked with her ***"Kuchh Milega ki nahi?"***[33]

The KIs also identified other issue related to the VDC development grant. As provisioned by the Act, each year each VDC gets 5 lakhs development grant, of which 5 percent can be allocated to health sector. Firstly, VDCs were not able to spend all the money allocated to them, and the issue of allocating 5 percent grants was not observed. Under the current governments policy arrangement its has provisioned the MoHP to provide medicines and health equipments, MoLD to build required infrastructures, DDC to allocate 10 percent of total budget to SHPs, VDCs to allocate 5% of total budget and community to collect 5% amount through in kind or cash support. Overall it looks good, if happened, probably SHPs overcome almost all the problems they are facing.

5.2.9 Overall changes after handover

In general there has been some changes in the functioning of SHPs after handover. Though data to compare all parameters were not available, where possible the changes have been compared with the available ones. A comparative table below presents with the perceived responses of the respondents in terms of changes in SHPs.

> *"If people don't know about SHPs being handed over to the communities to own it, what comments they give about handover and subsequent changes?"*
> *** DPHO Kaski*

In general the KIs put three different views. Few of them said community participation in SHPs' activities was increased as of before since they are more concerned to improve and utilize health services, taking ownership. In contrast few KIs said there has been no change as of earlier due to low level of educational status and awareness. The

[33] This means "shall I get some incentive or not?"

other response was in between of these diverse ones saying that participation and ownership is developing slowly and takes some more time. In particular the responses can be summarised as follows:

<table>
<tr><th colspan="2">Respondents' view</th></tr>
<tr><th>Before Handover</th><th>After handover</th></tr>
<tr><td>SHP staff were like spoiled child

SHP staff did not behave properly to the clients because they were not able to mingle with the people due to their superiority feeling being a 'government employee'.

SHPs were providing limited health services

'SHPs' and 'Communities' were operating in an environment of isolation</td><td>➢ Positive attitude of staff
➢ Staff punctuality and their regularly
➢ Staff creativity, capability and activeness improved
➢ Frequency of health staff visiting field increased
➢ Communities were positive towards the services provided by SHPs.
➢ Extension of health services such as lab facility, dental services and family planning
➢ People who used to go to private clinics now come to SHPs
➢ Increased assistance of NGOs to construct buildings
➢ Effective cooperation between SHPs and local organisation to improve health services
➢ Harmonious relationship between SHP staff and the community
➢ Financial transparency and to some extent local resource mobilisation improved</td></tr>
<tr><td rowspan="2">People did not care about SHP activities</td><td>➢ Communities' ownership towards SHPs increased.
➢ Community was acting as 'watch dog' in SHP affairs
➢ Positive attitude of communities towards SHPs
➢ The physical facility especially the building were constructed
➢ Increased participation in SHPs' activities
➢ Awareness on health issues and service utilisation increased
➢ Drug availability improved
➢ No difference has been observed except the usual business of SHPs.
➢ The level of community participation seems to be very low due to inactiveness of committee members.
➢ No changes in financial, human resource management, in local resource mobilisation part
➢ There is no change as of earlier</td></tr>
<tr><td>➢ Lack of faith towards SHPs health services
➢ Almost defunct HMC
➢ Nepotism of committee when appointing FCHVs
➢ Political misunderstanding between committee members
➢ High registration fee and lack of medicines
➢ Unavailability of extra rooms, furnitures and necessary equipments
➢ No proper implementation of decentralisation as per the intended goals and objectives
➢ Long and delayed process of budget allocation and transfer</td></tr>
</table>

(For respondent wise opinion please see Appendix 15)

5.2.10 Suggestions for the SHPs improvements

Towards macro policy:

- Many respondents outlined that policy on paper does not work rather it needs to be outworked. It should not be limited within few seminars or workshops. For the proper policy implementation we must be accountable in our word, proving worthy of it by work. It requires readyness to develop policies and uphold the power and authorities preserved by senior government officials.

- The study showed that the SHPs and its MC members now are in big dilemmas that what should they do and what should not. If they follow the act, they are not fully authorised and DPHO and Central health body may not cooperate. If don't follow, they have given something to do, which is almost meaningless. Therefore, for the long-term sustainability of SHPs, they need to be fully devoluted giving all the responsibility and authority of HRM and financing system. The centre should remain as policy making and monitoring body, and administering the important drug and vaccines.

- The other thing is structural adjustment and arrangement of central level mechanism. Apart from MoHP, concerned line ministries role did not seem much effective. In the district, it is the DDC that should be make most powerful in terms of dealing with decentralisation issues, hence bringing all the government wings under it. It is the DDC, the representative of people, need to administer and deal the health service decentralisation matters.

Staffing and office time:

- Staff must be regular and on duty during office hours.

Micros policise and management related:

- The role of DDC, DPHO and VDC need to be clarified in a precised manner.
- Before handing over SHPs to the communities, they need to be fully equipped both physically and financially. Even after handover, government should not pull its hands in the name of handover. Handover should be driven on voluntary and demand basis rather being mandatory and supply basis.
- The provision of sending budget and medicines is not scientific one. It should consider the SHP coverage, ecology, population and nature of endemic diseases. Current form of blanket policy and quota system does not address the real problem.
- To the date, SHPs were staffed of four persons. The village level KIs saw these posts insufficient needing more and senior staff i.e. Health Assistants and staff for CDP. In addition, SHPs were facing difficulties to provide effective health services due to lack of administrative manpower. They suggested having one extra person to do all the administrative work in the SHPs.
- It would have been greater impact if government could arrange visits of a specialist specially Gynecologist once in the month which would benefit most of the rural women. In addition, government needs to consider implementing Safer Motherhood, Pediatric and ENT services at SHP level.
- Timely supply of medicines and of good qualities having enough time to expire.
- Now the government is providing some information through television ***"Sewa Gare Mewa Painchha".*** Better to include some HMC information through that programme.
- Package training to HMCs rather one or two event off orientation.
- If possible the office hours need to be extended from current six hours (10AM-4PM) to more hours (as possible) since health is very sensitive and urgent issue. AHWs should have residential facility within the compound of SHP so that even after office time and under emergency cases, people could get health services.
- Provision of some allowances for FCHVs and TBAs would encourage them to perform better.

- Transportation facility for staff when they carry out field visits.

SHP service related:

- Physical facility in SHPs. For example having a separate for safe delivery in a confidential way. This room could be used for ANC/PNC check up and insertion of spacing methods.
- SHPs need to consider free of treatment to poor, disable and helpless people. Registration fee need to be waved off. In addition, communities cannot pay the cost of lab test that also need to be minimised.

Others:

- Health education and community mobilisation need to be considered as two essential pillars of current decentralisation policy.
- Training need to be provided to communities to make them capable to operate the handed over health facilities.

5.2.11 Effect of conflict

The ongoing conflict had very negatively affected the proper decentralisation process and effective functioning of SHPs. Majority of HMCCPs (60.71 percent) mentioned that the ongoing conflict negatively affected the service delivery and operation of SHPs. SHPIs, to some extent also agree with the Chairpersons' perception where 50 percent of them said the same. In contrast, a majority of MCHWs (67.85 percent) mentioned that there is no such direct effect of conflict in the service delivery of SHPs, but others said there are certainly some effects. Generally it was the village level respondents view that conflict did not affect much in health sector as that negatively affected the other ones. Broadly the impact of conflict can be summarised as follows:

Negative impacts:

- The effect of conflict did not merely impact the proper functioning of SHPs rather it impacted in multiple ways. The first and foremost important aspect was that there could not be local elections of VDCs, where, it is as provisioned by the Act, VDC Chairpersons are the key person for the overall functioning of SHPs. The elected VDC representatives being representing their people, of course take ownership of the work and are very much concerned for the overall health improvement of their people. Expecting the same outcome from VDC Secretaries as a chairperson of HMC, who are not only the civil servants but also outside persons, is mammoth ill-understanding.
- The other impact was that the VDC Secretaries, who are the mandatory In-charge of HMC, could not stay in their working VDCs. As expressed by them, they stayed mostly in general and all the times in particular in district HQs.
- Conflict also had its impact on psychological aspects of both staff and patients. It ranged from minor mental tension to explosion of SHP building (Kakadvitta, Jhapa). Besides, there was decreased patient flow.
- In some SHPs Maoist took medicines. This resulted patients not getting medicines immediately after check up. Besides, Maoists also asked for financial contribution.
- Frequent imposition of *"Bandas and Curfews"* denied free movement of staff for SHPs business. However, the effect was lesser in rural areas compared to urban ones.
- Except in Kaski, there were no reported cases of physical torture to the health staff during home visits and running health clinics. However, the staff always traveled with a fear that anything could happen at any time to them. In Kaski, some health personnel were found to be taken into custody by the security forces while implementing programmes during *banda* and *corfew*.

Positive impacts:

- Conflict has also some positive impacts too. As mentioned by one of the central level KIs, the conflict had positively impacted the functioning of SHPs. For example Maoist came and looked at the records of transactions of medicines and money which helped to keep up to date records, maintain transparency and improve service utilisation.

5.2.12 Onsite observation of SHPs

Besides having in-depth interviews, FGD and other means of data collection, we also visited particular 30 SHP sites and had observation on the spot. The findings of the observation have been presented in the box below:

A. Infrastructures and facilities

Generally speaking all SHPs in all the districts had their own buildings except Godawari SHP in Lalitpur and Belbhar and Chisapani SHPs of Banke. It was found that one SHP, Satasidham, Jhapa was renting its building to VDC getting NRs 2,200 per month while it had rented others house for office use paying NRs 2,700. Among the SHPs, the Damak was found to be richest in terms of having more number of buildings. It had six buildings of which one was rented by an NGO, AMDA-Nepal paying NRs 8,500 per month.

Almost all the SHPs of Kanchanpur had drinking water, toilet and sitting facilities. Most of the SHPs of Jhapa and Banke had drinking water facility while least had toilet facilities. In Bhawaniyapur SHP the toilet was found to be locked and it was provisioned only for the use of staff. Water scarcity and toilet being dirty was observed in Lalitpur. The SHPs of Kaski lacked needed furniture. Damak and Dangibari SHPs of Jhapa and Jhalari SHP of Kanchanpur had lab facility where as we could not see lab facility in case of other SHPs in other districts

B. Citizen charter and display of materials

Of the SHPs, we found citizen charter displayed well mentioning available facilities, rate and time in detail only in Jhalari SHP of Kanchanpur. Majority of SHPs had displayed boards on Staff, HMC members and FCHVs name. IEC/BCC materials were also found to be properly displayed on the wall in Jhapa and Jhalari SHP of Kanchanpur. In the other SHPs, they were displayed improperly.

C. Patients flow rate

In Kanchanpur, particularly in Jhalhari SHP, we recorded a very good patients flow rate. We observed 35 patients; 15 women coming for treatment on 7th Jestha, 2063. In contrast, the number of patients were nil for three consequtive days in Belbhar SHP in Banke. People explained that it was due the presence of teaching and other hospitals in Kohalpur and Nepalgunj. The other reason was being a mission hospital in neighbouring country India where patients get treatment in cheaper rates and with free medicine. In Lalitpur, we noticed a less number of patients coming in the SHPs on the day of our visit.

D. Staff and their behavior

Staff were found to be busy in most of the SHPs where as in some SHPs, they were idle because of the no clients coming in. They were dealing with the staff more politely giving suggestions and medication.

In one of the SHPs (Lamachaur) of Kaski MCHWs were not regular on their work while they were in leave in other two SHPs (Sarangkot and Hemja)

E. Coordination and linkages

In Jhapa district, most of the SHPs were having good linkage with different organisations. In general they had established linkage with UNHCR for building construction, with Save the Children for safer motherhood and child health, Women Development Association and NFHP for family planning and SAHARA-Nepal for FCHVs training. In Banke, Plan International was supporting NRs 500,000 to construct building for Belbhar SHP. In Kanchanpur CARE-Nepal was providing half of the salary of lab assistant of Jhalari SHP.

F. HMC meetings

In general SMC meeting were not held as schedules and regularly. Generally HMC had following agenda: to organise community awareness programme for vaccination, DOTs and vitamin A programme, purchase of medicine, fulfilling staff positions, increasing the registration fee, to form DOTs awareness committee and raise awareness, to form mothers group, building construction etc.

G. Effect of conflict
Physically, we did not notice any negative impact of ongoing conflict towards SHPs. However, in one SHP, Kakadvitta, Jhapa, the building was found to destroyed. According to SHP staff and local people, it was destroyed by Maoist by planting a bomb inside the building.

5.2.13 Issues, challenges and prospects

a) Issues

- It was mentioned that the hand over process was not satisfactory in many ways. Firstly it was an uninformed one doing things at district level. Therefore, most of the lay people did not know about the process and content. In fact it was not handed over to communities but to the some local elites. One of the SHP Incharges in Banke ridiculed that *"Jasko biha, usailai thaha nadiya."*[34] Under this situation, how can we expect communities to come and participate in the SHP improvement activities and take ownership of the work?

- OF the SHPs who could not prepare plans mentioned that due to lack of budget and absence of elected LBs, some SHPs could not prepare plans to improve health service delivery of SHPs.

- The data revealed that 50-60 per cent SHPs have formulated annual or long term plans to extend and improve the health services. However, they are unable to carry out those plans due to budgetary constraints.

- From the above analysis it can be easily revealed that a great majority of ECs, say communities, were not aware about the handover process and they were not included. If we overlook this great masses of people to who the programme is designed and target, how SHPs could work effectively? This is a big question mark for us.

- Confusion about functional clarity of NHTC and Management division was clearly expressed by KIs. Respondents at central level pointed out that there exists power exercise and red tapism in terms of who should take the responsibility of SHP hand over, thereby to consume resources that came in the name of health services decentralisation.

b) Challenges:

- Under the ongoing conflict situation one can never expect desired changes as expected by policy makers in the functioning of SHPs. As expressed by the respondents the conflict affected decentralisation in many ways. For example the local elections could not be held on time, administrative and policy confusion at central level due to lack of people's government and the security situation not favoring VDC secretaries to stay in their working locations.

c) Prospects

In the context of current decentralised system, the accomplishments to the date, responses from the audiences and overall country's political scenario, following prospects have been visualised:

- It seems that SHPs are now concentrating their effort to provide curative services but they should also carry out preventive activities to make the people aware about health. For example peoples'

[34] This means "Bride or Groom him/her self not informed about the marriage"

suffering from malnutrition may be due to lack of food, perhaps it could be lack of knowledge about food selection and preparation.

- All categories of respondents realised that the information flow was not in an appropriate manner. Also they expressed that it must happen as far as possible. Communities were also found eager to take over the responsibilities. What they need is information and awareness. If this could be done in a precised manner, there is high possibility that whole rational of decentralisation will get a momentum to fulfill its intended goals.
- The election of LBs and resuming their roles. Since they are people's representatives and therefore are very much concerned with the overall health status of their people.
- The health service utilisation patter has been found ever increasing. This indicates that communities are becoming aware in health issues and therefore taking interest in SHP activities.
- Punctuality and commitment of SHP staff has found to be improved. This indicates their greater motivation to serve the rural and poor communities.
- In many instances, non-government entities were found to be supporting the decentralisation intervention. This can be institutionalise through the public-private partnership with some policy mechanisms.
- Documenting and disseminating the best practices, lessons learned and experiences to the wider community through a organised and institutionalised information dissemination process.

As such, decentralisation of health services would be an effective way to functionalise the system. If the local people are themselves made responsible and accountable to plan, implement and supervision of health services with the financial and technical backstopping from the government, it can be expected that a functional system will be developed and institutionalised in a sustainable way.

Finally there exists a great potentiality of improving health sector if we could establish a functional system. Whatever problems exist now are some how related with the conflict. The conflict, in many, has become, an excuse for people not doing the activity or not delegating the power. It has been said that and we also observed that not only the micro level but also the state machinery as a whole has become ill functioning. When the country will get a way out to the current political instability, hopefully there will be peace that will open many windows and of course it will have greater positive impact in health sector supporting decentralisation in a complete devolution.

CHAPTER SIX: CONCLUSIONS AND RECOMMENDATIONS

6.1 Conclusions

All categories of respondents and SHP stakeholders found positive towards the current effort of government in decentralising its health services to local communities and emphasized the need of decentralized management of health services. The finding of in-depth interviews, FGD and KIs coupled with literature review of the various documents and on site observation proved the same information. However, this has also many weaknesses. Such weaknesses were found to be related with policy, process and most importantly with the mentality shift. Because policy and process shift does not have greater impact in action rather the mentality shift has.

Most importantly, the effort of government to decentralise its health services to local communities is most exciting and encouraging thing. However, it is useless unless there are local elected bodies, and 'core stakeholder'; the community, is not well informed and does not take ownership of the entire work. In order to exploit the potentials of the decentralisation in a full manner, the government, in particular the MoHP, should document the impacts to date, learn from its experience and must demonstrate commitment to decentralisation endeavors.

Finally, looking at the decentralization theory, where we pointed out three levels of actors for the quality service delivery, it is our overall conclusion that the role at managerial level were found to be somewhat functioning. Generally speaking there was a renewed commitment to make some policies, however at the other levels, it was generally found weak. The health workers were not committed and motivated, HFs lack required necessities, and there was no proper mechanism for staff professional development. Supply systems have always suffered from weak management. At the client level, very less amount of work was done to improve their service utilization part.

6.2 Recommendations

In light of the findings confirmed by both field level data and literature reviews, the following recommendations have been visualised:

1. The LSGA 1999 has been taken as a major basis for health service decentralisation in Nepal. It is true that it gives an overall framework and implicit background for the decentralisation of health services, however does not more explicitly mentions for health sector. On the other hand the findings of both literature and field confirmed that current form of decentralisation looks like a deconcentration rather being a complete devolution. Therefore, MoHP in collaboration with other ministries such as MLD, and Ministry of Finance (MOF), and Ministry of Law and Justice (MoLJ) should take initiation to enact a separate act or regulation for the complete devolution of health care facilities in Nepal. Appropriate organizational and management structure are required in order to ensure that the revised policy framework is effectively implemented.

2. The SHPs hand over policy should not be implemented in a '*blanket*' form in terms to fulfilling annual or periodic targets. In order to make hand over more result oriented MoHP should develop only a broad guideline and the detail working out authority could be handed over to local authorities. The DDC, DPHO, VDC and other stakeholders can sit together and prepare a localised guideline by reflecting their specific situation.

3. The presence of elected LBs is crucial for the effective implementation of hand over and operation process. However, it was also observed that there was no seriousness in driving the process by internalising the norms of decentralisation. MoHP must take this factor into account. According to the policy, HFs are to be handed over to LBs. If there are no LBs to whom to hand over?

4. A two-day orientation to VDCs and HMC was found to be ineffective and very short in order to build the capacity of concerned stakeholders. In addition, the main stakeholders, the community, were overlooked in the entire process. Therefore, it needs a 'package' rather than one or two time off training/orientation. The package must have the good mix of both managerial and technical competencies needed for the overall management of SHPs. Parallely, there must be provision for sensitizing communities.

5. Current composition of HMC is some what in inclusive across sectors, class and caste. In order to make it as inclusive as possible, there must be room to include local NGOs, since government's tenth plan and LSGA has recognised them as one of the development partners in the overall development process. In addition other social development entities and religious and influencing leaders need to be included.

6. The data confirmed that the *"hand over"* process overtook the *"take over"* process. LBs and HMCs were not ready to take all the functions both conceptually and practically. Security situation was not sufficient enough to take this process forward in many areas. However, in some areas the situation was favorable, and the hand over process took momentum without considering these factors. Therefore, a handover process should go ahead by analysing the specific conditions of the particular location/health facility.

7. It was found that SHPs were having huge financial problems. Local resources were not identified and mobilised. It is said that decentralisation heavily rests on mobilisation of local resources but never outlined what are the resources to be mobilised and how locals can do this. Therefore, SHPs, until they become self-sustaining, they should be trained on how to generate resources at local level.

8. There was limited authority handed over to HMCs. It has raised a lot of issues about who governs the SHP. Is that DPHO or Centre or HMC? If it is HMC, than why can't they approve leave and handle budget or deal with staff transfer issues? Under a current arrangement, can the SHP staff be responsible to HMC since they are civil servants who have secured permanent job. Even the court can't do anything for them, expecting them to be accountable to HMC or VDC is just like an illusion. This can be a small issue but has huge impact. Therefore, there should be a clear-cut policy for leave management and performance appraisal with a clear job description mentioning the supervisory roles.

9. Each and every sanctioned position of the SHPs should have to be fulfilled with an appropriate plans and policies. When having provision of staff it should not be equal rather need to be based on the size of the population, occurrence of diseases, geo-structure etc. In addition, in the SHPs where there was no or less patient flow or in the areas where there are teaching/government/private hospitals, the possibility of closing down the SHPs or downsizing the staff and resources need to be actively sought. In turn, the resources could be diverted into needy and the rural, areas.

10. The HMC does not have autonomy and the roles of centre and district were confusing. Under this circumstance, DPHO can do technical supervision, management related things can be dealt by VDCs and centre can administer the quality standards.

11. Current practice of budget flow system is that it flows from DDC-DPHO-VDC and finally to SHP. Questions have been raised about this system being lengthy and needing a lots of administrative work. Therefore, budget should directly go from DDC to VDCs. DPHO can get required information from DDC, there will be inline with the LSGA as it aims that all the development agencies should function under the umbrella of DDC.

12. Talking about the human resource management, contrasting views came out of SHPIs and HMCs. The issue of staff vacant position and appointment of staff is related to facts and figures and actual one and hence does not relate to giving their perception. This clearly indicates that there is no proper coordination, cooperation between these two positions. Adding more, there was also information gap between these positions. This may be due to their 'difference in protocols' SHPIs being higher in portfolios than the VDC secretaries. A different option for managing such SHPs, for example appointing a Area Manager or Coordinator, thereby putting 3-5 SHPs under his/her supervision, and s/he being supervised by Ilaka member of DDC may work better.

13. Local resource mobilisation is very important aspect in order to make SHPs effective and also to extend and advance their services. However, the data that came out of SHPIs response revealed that an average of 60 percent SHPs did not see possibility of resource mobilisation. One of the outlined assumption of the decentralisation is to identify and mobilise local resources, however the attitude of SHPIs have not changed yet. This might be because of two reasons. Firstly, their capacities are not sufficiently built on how to identify and mobilise resources. The other thing is how the policy level people have thought of this issue. Because this is not merely ordering local level staff to identify and mobilise resources but also giving them a package as well. Secondly this issue is associated with the attitude of both staff and management. If they own the SHP in real sense, there must possess mentality shift committing for decentralisation.

14. It was mentioned by KIs that at policy level, there has been arrangement for SHP resourcing. The MoHP to provide medicines and health equipments, MoLD to build required infrastructures, DDC to allocate 10 percent of total budget to SHPs, VDCs to allocate 5% of total budget and community to collect 5% amount through in kind or cash support. Overall it looks good, however it is not happening. Therefore, there must be strong mechanism to look at whether the policies really came out of paper or not.

15. Service fee was in practice in the name of CDP. On the one hand it is good that the services are available at local level. On the other hand it shadows the affordability of health services. In many instances locals expressed that the fee rate is bit higher one. Therefore, the charge should be set according to the ability of local people, perhaps would be good if the communities themselves decide on this. When deciding rates, SHPs should give proper attention to women, marginalised and disable people so that they will not be excluded from the service provision.

16. Respondents raised the issue of maintaining privacy in SHPs. Health check up of pregnancy cases can not be possible in common room or in store room. SHPs need to allocate or should make provision for separate room to deal with pregnancy cases. In this case MOHP should have a revised policy with regards to the standard of SHP/health facilities.

17. Visiting health professionals. Majority of respondents have requested to arrange visiting specialists such as Gynecologists at different intervals of time. MoHP and other district level key people should seek the possibility of arranging such visits.

18. There was a strong opinion that the SHPs should remain open generally for more hours. Therefore, this time should be fixed in participation with communities analysing the pros and cons, therefore communities reach into a consensus decision.

19. Almost all field level respondents questioned the delaying drug supply system and quality of drugs. The mater of drug is very central and key to the patients from which they are supposed to be cured. One in either circumstance cannot take this issue lightly since it carries the overall weightage of medical science. Therefore, MoHP should assess the current drug supply system, the suppliers and distributors and track the supply routine so that the good quality medicine reaches to the SHPs on time.

20. In general, regarding the decentralized management of health facilities, it is recommended therefore that a high-powered decentralisation Technical Committee is established in MoHP, which has overall responsibility for decentralisation of HFs management programme throughout the country. The secretary of MoHP should chair the Committee and its member should be drawn from senior management in all the key divisions in the ministry (in particular DoHS). Representatives from I/NGOs involved in health services and support activities, and other key ministries such as Ministry of Local Development, Finance, General Administration, etc. should also be involved to sit on this Committee.

21. The success of the decentralisation of health facilities strategy depends critically on a coordinated multicultural approach to both handover and takeover process. It is essential therefore that all the decentralisation activities in the MoHP are carefully coordinated with the activities of other key organizations at both the national, district and village level. In particular, MoHP staff should actively participate in HFs dcecentralisation activities. It is essential therefore that a full time Coordinator for HFs decentralisation is appointed. He/She should report directly to the Secretary of MoHP and the Technical Committee.

22. Much will also depend on the commitment of DHOs, LDOs and LBs. As a first step, it is very important that they are briefed about the main findings and recommendations of this evaluation study. It is recommended therefore that a three-day workshop for all the DHOs and LDOs is organized to meet the KAP Gap. In the mean time, an action plan for the further planning should be developed.

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CHAPTER ONE
INTRODUCTION

1.1 Background

During the past decades, Nepal has undergone through a series of rapid changes. Fast-pace and drastic changes in economics, politics, culture and information technology have all impacted the health systems. These changes have ultimate impact our existing health systems to be unable to adjust to the emerging circumstances of the current world.

Sound economic health of the nation greatly relies upon the sound health of its people that should be ensured through equitable and high quality health services to all. The formulation of the Health Sector Strategy in Nepal: an Agenda for Reform, Nepal Health Sector Programme Implementation Plan (NHSP-IP) 2004-09 was necessitated having clearly identified eight outputs to health sector. The key consideration in achieving these outputs can be summarised as:

- Providing essential health care services in an inclusive approach
- Decentralisation of health services for improving the access to and coverage of health care delivery
- Recognition of the role of private sector in assuming some functions of health care delivery and forming public private partnerships for efficient and effective health care delivery, and
- Sector wide approach for the sector management

This showed that Government of Nepal (GoN) has taken necessary steps towards the process of health sector decentralisation since many decades. More explicitly the enactment of Local Self Governance Act (LSGA) and its regulations 1999 were the milestones to prove government's political commitment into action through legal provision. At operational level, the budget speech of 2002 was the first one that gave permission to Ministry of Health and Population (MoHP) to handover the Health Facilities (HFs) to Local Bodies (LBs).

1.2 Problem Identified

In spite some progress, numerous problems in various aspects of health delivery services have made the overall health sector probably a mess. The planning process was centralized model and policy decisions regarding planning including settings of targets were taken at central level based on central level budget, capacity and priorities. Plans were not need based in the absence of mechanisms to guarantee community representation in the planning process and receiving feedback from service user regarding quality, quantity, and appropriateness of service provided. Logistic supplies including drugs were not timely delivered to the districts due to the lack of transportation resources and budget. The supply of drugs at the district health facilities was inadequate with the annual provision of essential drugs sufficient for only 3-5 months.

Moreover, there was shortage of qualified manpower, which was aggravated by the excessive political pressure, for placement, on the one hand ministry of health and population (MoHP) placement in the remote areas, but on the other hand they created unnecessary lobby system staying at Kathmandu. Opportunities for staffs were very much guided by the concept of nepotism and favoritism at the district based health facilities such as sub-health posts (SHPs), health posts (HPs), primary health care centers (PHCs) and district hospitals. Moreover, release of program budgets from the centre was often late and the budgets from one heading to other were not generally allowed to be transferred even if there was surplus budget in one heading and deficit on the other. In these

circumstances, the current practice of decentralization seems to be very difficult. The dissolution of the elected local bodies, conflict and security are considered other key hindering factors for successful management of the decentralized Health Facilities.

1.3 Rationale of the Study

Evaluation is the application of social science research procedure to judge and improve the ways in which social policies and programmes are conducted, from the earliest stage of defining and designing programmes through their development and implementation (Rossi and freeman, 1993). Evaluation results should inform programmes management, strategic planning, the design of new projects or initiatives, and resource allocation.

Evaluation results are also important inputs into strategic planning and programme design. Measures the programme performance, output, and population outcomes describe the current state of demand for services and the programme environment. Results linking inputs and activities to programme outputs and changes at the population level serve to demonstrate what has worked in the past and to suggest potential directions for the future. Successful intervention can be scaled up or replicated in new programme or project phase, where as activities that do not produce result can be phased out. Moreover, evaluation can be used to explore why certain interventions did not work.

In short, those responsible for implementing programmes and those who fund programmes should require that evaluation be an integral part of any intervention. For maximum benefit, evaluation should be built into the programme design from the start and provide data to managers over the life of the activities. Evaluation result will help administrators and managers to learn what they are doing right, identify shortcomings to be corrected, and make informed decisions about the future directions of their programmes. In the current climate of budgetary constraints, evaluation results point to the most rational use of scarce resources-human and material-to achieve results.

Since several documents including internal and external surveys, current evaluation and process review and special studies related to decentralization of Health Facilities in Nepal are widely available, but the major part of such documents/reports seems less likely to be looked at while designing the strategy for effective operation of the community managed health care facilities. Although different stakeholders in the health sector have conducted various research/studies regarding handover of Health care Facilities, the duplicity of their programs and impact on the basis of comprehensive review is yet to be carried out. Moreover, strengths and weaknesses in managing health facilities in terms of planning and management; monitoring and supervision; infrastructure and resources; quality of care, future planning and sustainability issues; exercise of role and responsibilities; ownership feeling and understanding of the meaning/process of decentralization; consistency, uniformity and coverage of service provision, training/orientation and other support required for better management, including differences in management of health facilities and in providing health care services before and after decentralization/handover the health facilities, etc are also not clearly understood.

The Tenth-Fiver Year Plan has also clearly stated that, the handover of remaining Health Facilities will be continued based on the findings of additional studies and researches regarding present experiences.

Therefore, it has been realized the need of conducting the present evaluation study with the following specific objectives:

1.4 Objectives

The overall aim of the study work was to strengthen of the process of decentralization of Health Facilities in Nepal. The specific objectives were as follows:

- To review and analyze the existing literature and documents including National Policies, Structure and Strategies in relation to decentralization of Health Care Facilities in Nepal,
- To review and analyze the decentralization plan and programme, process and assess current status of decentralized Health Care Facilities in Nepal in terms of effectiveness, efficiency, participation and sustainability,
- To assess and compare the provision of quality services before and after decentralization of Health Care Facilities to the local bodies, and
- To recommend the appropriate strategy about the future directions and/or effective operation of the community managed Health Care Facilities.

CHAPTER TWO
METHODOLOGY

2.1 Overall Approach

This research heavily depended on primary source of information. However, information was also collected through secondary sources mainly through desk study/literature reviews. The primary source of information was entirely based on field survey. The survey consist of 8 instruments, which have been carefully designed to obtain fairly detailed quantitative and qualitative information with emphasis on semi-structured focus groups and participatory research methods.

For the collection of secondary information, the review was retrospective that made an attempt to assess all the available documents and studies related to decentralization of health service facilities in Nepal. The review followed different methods of information collection and analysis. A networking sampling technique was adopted. An information collection format was developed and used as a tool for gathering the relevant information.

For the collection of primary information, cross-sectional descriptive study was conducted in order to collect the primary information from the field setting. Stratified random sampling technique was applied for the selection of health facilities using urban and rural as a main strata from each selected five districts of five development regions.

2.2 Distribution of respondents

The data for this survey came out of a total of 211 respondents (Table 2.1), 187 FGDs Participants (Appendix 1) and self observation by researchers in 30 different SHPs from the sampled districts. This constituted 20% of a total of 146 handed over SHPs in the fiscal year 2059/60 BS representing each districts and each Development Regions.

Districts	SHP In-Charge	HMC CP	KI	DPH Os	LDOs	MCHWs/ FCHVs	ECs	Total
Kaski	7	7	14	1	1	7	13	50
Banke	7	7	12	1	1	5	13	46
Kanchanpur	2	1	4	1	1	2	4	15
Jhapa	8	7	15	1	1	8	16	56
Lalitpur	6	6	12	1	1	6	12	44
Total	**30**	**28**	**57**	**5**	**5**	**28**	**58**	**211**
Eco.Regions								
Hill	13	13	26	2	2	13	25	94
Terai	17	15	31	3	3	15	33	117
Total	**30**	**28**	**57**	**5**	**5**	**28**	**58**	**211**
Areas								
Urban	14	12	27	5	5	12	26	101
Rural	16	16	30	-	-	16	32	110
Total	**30**	**28**	**57**	**5**	**5**	**28**	**58**	**211**

Table 2.1: Frequency Distribution of Respondents by districts, regions & areas

Within SHPs, a total of 30 SHP In-charges, 28 Health Management Committees (HMC) Chairpersons, 28 Maternal Child Health Workers (MCHWs)/Female Child Health Volunteers (FCHVs), 58 Exit Clients were met[1] (Table 2.1), and 54 Key Informants (KIs) were interviewed (Appendix 4).

In addition, 13 KIs were interviewed at district level (Appendix 4) as well as data/information was gathered form each of sampled District Public Health Offices (DPHOs) and Local Development

[1] Originally out plan was to meet 30 KIs but could meet 1 VDC secretary in our repeated visits while one of the Sampled SHPs HMC CP was not provisioned due to its location within Municipality which is overseen by DDC. Therefore we met DDC Programme Officer of Jhapa to get information for that SHP. In the same way we should have met 60 ECs but we could not met any ECs in Chisapani SHPs coming to treatment where we stayed for the whole day

Officers (LDOs). Ecologically, 43 per cent of the SHPs were from Hill areas while Terai being the 57. In relation to urban and rural areas, there were 47 and 53 per cent respectively. (Table 2.1 and Appendix 2).

2.3 Survey tools

Information was gathered using different survey tools. Besides, a number of integrated approaches were adopted for field observation and recording of service statistics/information regarding the client flow before and after decentralization. In this connection, in-depth interviews, KI interviews, semi structured Focus Group Discussions (FGDs) were carried out. (Table 2.2) The relevant surveys, statistical data/information and other document's documentations were reviewed to obtain fairly detailed quantitative and qualitative information on each of the sample Health facilities. The findings of FGDs and in-depth interviews were triangulated. (See Appendix 1 for the characteristics of FGD respondents)

Instrument	No.	Remarks
In-depth interviews	144	Field level
Focus group Discussions	20	Field level
Key informant interviews	67	Field & district level
Observations of SHPs	30	Field level
Key informant interviews	8	Central level

Table 2.2: Tools and coverage of the respondents

When applying survey tools, in-depth interviews were carried out to 144 respondents while the numbers of SSFGDs were 20 (10 female 10 male/ 4 in each sampled district each of female and male), both at field level. Similarly KI interviews were conducted, 67 at field and district level, where as 8 at central level. On the site observation was accomplished in 30 places (SHPs).

2.4 Preparation of instruments/checklists

Based on the information gathered from the desk study/literature review and interviews with persons in central level, required survey instruments/check lists and participant screening guideline were carefully designed, reproduced and administered in the field, after doing pre-test and required amendment. All the survey tools are annexed in appendix 17-21.

2.5 Sampling procedure and sample size

The health facilities survey should have completed between the periods of Falgun 15, 2062 to Ashad 15, 2063. However, duo the people's movement demanding for the restoration of democracy, it was only possible to carry out after mid Baishakh 2063 when the movement came to an end. It was the time of the restoration of democracy and initiation of dialogue for peace between GoN and Maoists. In the formulation and implementation of the methodology, it was necessary to take into account several factors such as coverage for national representation, by ecological and development regions, securities situation as well as maturity of handed over health facilities for evaluation purpose. Moreover, an important aspect of the present study was to develop the methodology for evaluating the decentralized health facilities. The methodology for the evaluation of any programme has suggested by Miller and Frerichs “it would be evaluated approximately three years or more after the program implementation, if the objective would be to evaluate changes that may have occurred as a result of program improvements. The impact of these changes would be measured in terms of improved health facilities potential to provide quality of care, and in the actual receipt of quality of care by clients. (Miller and Frerichs, 1992-1993).

Therefore, without any alternatives, SHP was considered for this evaluation as no other Health Facilities (HFs) were found enough matured to evaluate. Therefore, Jhapa, Lalitpur, Kaski, Banke and Kanchanpur districts were randomly selected to capture Ecological and Development Regions (See Appendix 2 for sampling overview). In this connection, a representative samples (20%) of SHP from each sample district were considered. Further, equal proportion of SHPs from each district from rural and urban areas was also taken into account. When selecting sample SHPs a close coordination with DPHOs was also maintained as the detail information of these institutions were not readily available at MoH level. (See following Table 2.3 for SHP sampling and Appendix 3 for detail data sheet of handed over HFs).

Development Region	District	HFs Handed Over in 2059/2060			Sample distribution of SHP by habitants		Total Sample of SHP
		SHP	**PHC**	**PHC**	**Rural**	**Urban**	
Eastern	Jhapa	38	-	-	4	4	8
Central	Lalitpur	29	-	-	3	3	6
Western	Kaski	34	-	-	4	3	7
Mid-Western	Banke	35	-	-	4	3	7
Far-Western	Kanchanpur	10	-	-	1	1	2
	Total	**146**			**16**	**14**	**30**

Table 2.3: Overview of SHP sample size.

The following criteria were used when selecting SHPs for survey:

- Representation of Rural and Urban settings (at least 60-40% by rural and urban respectively)
- Coverage of districts by location, and representation of ethnicity
- Not many far from one day to cover the SHP survey
- SHP performance (good, bad , moderate in management)
- Already handed over to the community during the year 2059/60 B.S.

2.6 Report structure

This report is organised in six chapters. In the chapter one we have presented the introduction and in the running chapter methodological aspects of this survey. In chapter three we also present a brief overview of Nepal's overall socio-economic situation with a focus on health sector in order to set the scene for the subsequent analysis. This is followed by a literature review on history and impact of decentralisation in general and health sector in particular in Chapter four. Based on the primary data obtained from the five sampled districts, the main findings are brought together in Chapter Five. In Chapter six we have presented the main conclusions and discusses some of the key issues as recommendations.

CHAPTER THREE
COUNTRY BACKGROUND

3.1 General

Situated in the lap of Himalaya, Nepal is located in between the latitude 26O 22’ N to 30O 27’ North and longitude 80O4’ E to 88O 112’ East and elevation ranges from 90 to 8848 meters. The average length being 885 km. east to west and average breadth is about 193 km. north to south.

The country borders with the world's two most populous countries, India in the east, south, west and China in the north. The total area of this country is 147 thousand square kilometers that is distributed in three regions, the Mountains, the Hills and the Terai occupying 25, 42 and 23 per cent area respectively (CBS 2001). According to the population census of 2001, the total population of the country stands at 22.3 million that is distributed by 7.3, 44.3 and 48.4 per cent in above geographic regions respectively.

Recently Nepal has become a secular state. However, it consists of diverse array of ethnic, caste, linguistic and religious communities (Gellner 1997). According to the statistics published by Central Bureau of Statistics, Nepal has 106 castes and Hinduism is the dominant religion (80 per cent of the total population) followed by Buddhism (CBS 2004).

For the purpose of social and economic development the country is divided into five development regions; Eastern, Central, Western, Mid-Western and Far-Western consisting of 23.1, 34.7, 19.7 13.0, and 9.5 percent of population respectively in 2001. There are 75 administrative districts. Districts are further divided into smaller units, called Village Development Committees (VDCs) and municipality. Currently, there are 3,915 VDCs and 58 Municipalities in the country. Each VDC is composed of 9 wards, while the number of wards ranges from 9 to 35 depending upon the size of municipality and population. Kathmandu is the capital city of Nepal.

In Nepal, the process of planned economic development has commenced since 1956 with the inception of the first Five Year Plan (1956-1961). So far, nine periodic plans were implemented and the tenth plan (2002-2007) is being implemented. Over the periods, some progress has been made, however the overall socio-economic problems of one-third Nepalese people particularly living in rural setting is still remains to be achieved (NPC 2002). Even though, the later three periodic plans made poverty mitigation as their sole objective, still 31 per cent of the national population lives below poverty line (WB 2005).

On the other hand the high population growth rate of 2.2 has overshadowed the country's economic growth since our development plans could not actually address this population increase rate. Little over half (58.2%) of the population of working age reported usually economically active in 2001. Population Census 2001 reports that 53.1 percent population of age 10 years & over are employed and 5.1 percent are unemployed. Contribution of non-agricultural activities is gradually increasing in the GDP. The preliminary estimates of per capita GDP and Per capita GNP in terms of US dollar are 237 and 300 respectively for the year 2003 (UNDP 2005).

3.2 Overall socio-economic indicators

South Asia is home to 43.5 per cent of the world's poor who earn less than $1 a day. Of the total population 31 per cent live on less than $1 a day while 82.5 per cent live less than $2 a day (World Bank 2006). Spatially, most of the poor, over 90 per cent, live in rural areas with their poverty rate of

44 per cent compared to 23 per cent in urban setting and only 4 per cent in Kathmandu (NPC 2004). The UNDP report noted that western mountains have almost 1.7 times more poverty compared to eastern ones (UNDP 2004). Therefore, Nepal is not only the one of the poorest countries of the world but also ranks low in terms of its Human Development Index (HDI)[2], 136th of 177 countries with a HDI 0.525 (UNDP 2005). Similarly, among the SAARC[3] countries it ranks sixth followed by Bangladesh. The following statistics were recorded in UNDP Human Development Report for 2005: an infant mortality rate of 130[4]; maternal mortality rate of 740[5]; life expectancy at birth of 61 and adult literacy rate of 48.6.

3.3 Situation of health sector

Provision of health service contributes to the improvement of health, which is linked with the economic growth of the individual and country. Therefore, this sector is critical for human development, improving living standards in rural areas and for mainstreaming marginalized groups and communities. In developing countries the problems of access are concerned with the ability to visit a doctor, or to receive health care during sickness. However, in developed countries, access is concerned with the degree of comprehensiveness offered by health care systems (Gulliford *et al.* 2003). So, the concept of health service provision; **'access'** incorporates both *'availability'* and *'utilisation'* of health services.

Despite significant efforts and progresses in past decades, both availability and utilisation of health services still remained weak. Although an extensive network of primary healthcare centers has been constructed nation-wide, it has not been functioning well in many rural areas due to lack of comprehensive and coordinated response particularly of clear policies, proper decentralisation, capacity building of both health personnel and management people, supply of drugs and medicines etc. The sector's overall performance has suffered due to inadequate funding for essential recurrent expenditure, misallocation of resources and limited capacity for supervision and, co-ordination of the activities of other agencies providing health care services.

The Universal Declaration of Human Rights 1948 considers access to health care a basic human right.[6] Similarly, the OHCHR of 1996[7] declares that respective home governments are required to recognise the right of everyone to enjoy their highest standard of health, and required to assure all medical service to all of its citizens. Access to health service in particular is of great importance because the issue of health is linked with other livelihood building activities, therefore becoming crucial to the overall economic prosperity of a country (Nelson 1999). Therefore, the developed countries have been offering a comprehensive health care service to their citizen.

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[2] The HDI in UNDP report (2004:137) is expressed interms of: life expectancy at birth, adult literacy rate, combined gross ratio for primary, secondary and tertiary schooling and per capita Gross Domestic Product (GDP).

[3] SAARC: South Asian Association for Regional Cooperation

[4] Infant mortality rate is measured per 1,000 live births

[5] Maternal mortality rate is measured per 100,000 live births

[6] Article 25:(1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control. (Source: www.un.org/Overview/rights.html)

[7] Article 12 (1) The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. 2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for: (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases; (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness. **(Source: http://www.ohchr.org/english/law/cescr.htm)**

In Nepal, up to 2005, health services were provided by 89 hospitals, 186 Primary Health Care Centres (PHCCs), 698 Health Posts (HPs) and 3129 Sub Health Posts (SHPs). In addition, 14,710 Primary Health Care Outreach Clinics also provided health care.

However, in developing countries access to the health care services has been much problematic and they have a long way to go to meet these declarations. The same applies for Nepal where regardless of various efforts; the access to health care services has become a major bottleneck in mitigating deeply rooted poverty (NPC 2004). Until 2001, only 41 percent of the total population had access to basic health care within a walking distance of 30 minutes or less, and the situation of women and children is much more vulnerable (NLSS 2002).

While the world progresses towards provisioning adequate health care for its citizen, the situation in Nepal is still becoming a challenging one. Although Nepal has already ratified international conventions, the assessment of the overall health situation of Nepali people verifies that there is a lot to do in order to realise these ratifications. In Rural Nepal the key role of women is to serve as household labour and bear children, particularly sons. Early and excessive child bearing has weakened women's health. Some of such women die while many of them are chronically disabled from complications of pregnancy. Pregnancy is taken as natural process and God's gift, for which medical care is regarded as unnecessary.[8]

The life expectancy of women is 59.4 years that is one of the lowest in south Asia (NLSS 2002). The infant mortality rate is 130 and rural babies are exposed to 1.6 times more to the risk of death than their urban counterparts UNDP (2004b). Similarly, maternal mortality rate is 740. This means one of every 185 pregnant women aged 15-49 years dies because of pregnancy complications. This figure is among the highest in the world (Options 1999; UNDP 2004a).

Moreover, about 89 percent of births take place at home and without professional health attendance (MOH 2004). In addition, 53.4 and 18.8 percent women receive ante-natal and post natal care respectively. The total fertility and contraceptive prevalence rate are 3.7 and 39 percent respectively ((UNDP 2005).

The immunisation against tuberculosis and measles on one year old babies is 91 and 75 per cent (ibid). The DOHS 2005 report showed that the incidence of Acute Respiratory Infection (ARI) is 360 per 1,000 under five children.

[8] Women Rehabilitation Centre (WOREC), Nepal. http://www.worecnepal.org/women_health.html

CHAPTER FOUR
FRAMEWORK AND EXPERIENCE OF DECENTRALISATION

In this chapter we will first discuss theoretical concept about decentralisation with its linkage with health services. This will be followed by some lessons learned from the international experiences about the decentralised health system. Thereafter we will put together the Nepal's history on decentralisation followed by in-country lessons learned based on the previous reports and studies.

4.1 Theoretical framework

Decentralisation is in the process of implementation within the public sector in Nepal. It involves the transfer of functions, resources and authority from higher levels of government through legal provisions. This also involves changes in the form of accountability and participation in the system (Collins *et al.* 2003).

Researchers argue that the impact of decentralisation towards quality health services is very difficult aspect to express. However, it is the notion of the concept that this process leads towards the quality service delivery of communities. For this the the quality of services can be understood at three levels, the managers, the health workers and the clients. For the quality health services, the manager always needs to see the results or outcomes providing high quality services. The service delivery is fully functional if it has trained staff, supplies, equipments and other facilities. If all these are present, the service delivery is likely to be functional. But this further needs motivation and refresher training for the health workers. Similarly, having all these set up does not guarantee that it will be easily utilized by the clients. Therefore, this needs clients' interaction to visit the doctor or health facility; in return they expect them to be treated with respect and consideration (Steven Solter 1999).

According to Jukka *et al* 2003, decentralisation, involving a variety of mechanisms to transfer fiscal, administrative, managerial, ownership and/or political authority for health service delivery from the central ministry of health to alternate institutions, has been promoted as a key means of improving health sector performance. The following benefits of decentralisation have been proposed: improved allocative efficiency, improved technical efficiency, service delivery innovation, improved quality, transparency, accountability and legitimacy and greater equity. The data regarding the achievements of these benefits is limited.

There are four models of decentralisation, namely:

- **Devolution** implies the transfer of power to locally elected bodies (DDC/VDC) that are substantially independent of the national level with respect to a defined set of functions. They are rarely "completely autonomous" but are bodies largely independent of the national government in their areas of responsibilities, e.g. raising revenues and staff appointment. The policy is usually the only function retained centrally.
- **Deconcentration** implies the handing over of some authorities to local officers of the Ministry of health by administrative means. It also implies establishing local management with a degree of discretion that would enable local officials to manage without going through the process of constant approval from the ministry of health.
- **Delegation** implies the transfer of managerial responsibilities for defined functions to the organizations that are outside the central government structure and only indirectly controlled by the Ministry of Health. Ultimate responsibility remains with the MOH, but its agent has broad discretion to carry out its specified functions and duties. The exact managerial and

funding relationships vary, but all day-to-day executive decisions are given to the delegated bodies.

- **Privatization-** Transfer of authorities to private companies/sectors

On top of this classification decision space approach has been promoted. Decision space is the range of choice in making decisions. The areas where decision space is looked at are: finance (for example sources of revenue), service organization (health facilities/hospital autonomy, required programmes, human resources (salaries, training, and contracts), access rules (targeting) and governance rules (local government, community participation).

The decision space can be narrow even if the power has been delegated to semi-autonomous agencies if the user fees and other ways of income are limited and/or salaries are centrally agreed. On the other hand in cases where the finances are given as a lump sum to district governments they might use it to other purposes than health according to local priorities or political reasons.

In centrally managed systems health facilities/hospital autonomy can be granted by the central management authority delegating the authority to the health facilities/hospital managers or boards or by contracting out/in the hospital management on individual hospital level, as group of hospitals or as part of health facilities/health services in a district or region. The management of all health facilities/hospitals has been delegated to semi-autonomous paragovernmental organization in some countries.

In decentralised system the local governments can govern the health facilities/hospitals or they can delegate authority to the board or manager of the health facilities/hospital.

Health facilities/hospital autonomy can include financial management, personnel management and product or service development. They can be included to various degrees.

In systems with autonomous or decentralised health facilities/hospitals there must be enough control from the Ministry of Health to ensure that the government's health policies are followed, but there should be enough decision space to give benefits from the decentralisation.

Health sector personnel management is highly politicized issue and may have dramatic effects on the viability of decentralisation reform. Health care workers might experience significant loses as a result of decentralisation, which makes it difficult to secure their support and cooperation (Jukka *et al* 2003).

4.2 Experiences/lessons on decentralisation from different countries

Here in this chapter we highlight the experiences gained from other countries mainly from Cambodia, Zambia, Indonesia, Philippines, Colombia and Pakistan with regard to decentralisation of health services are worth to mention here. Various experiences with individual models in different countries describe mainly the problems encountered however the successes are less well documented.

In Cambodia, a pilot-testing project was carried out of contracting with non-governmental organizations (NGOs) for the delivery of primary health care on a large scale. Three approaches were compared: Contracting out (CO) in which contractors have complete authority for hiring, firing, and paying staff as well as procuring drugs and supplies; Contracting in (CI) where contractors provide management services within the existing district health structure; and comparison/control (CC) where

the existing district health management teams receive a budget supplement (as do CI districts). All the contracts were given to INGOs.[9]

Significant improvements were achieved in all contracted districts in health care coverage and utilization. The progress has been slower in the contracted–in districts. Human resources management is probably a very significant factor. This includes training, with supervision and support, clear understanding of the tasks and expected outputs reinforced by monitoring and feedback. Also salary level should be acceptable.

Relationship to communities was improved through outreach and different committees. Disbursement of budget, equipment and drugs from central and provincial level was a common problem as was the mal-distribution and shortages of staff.[10]

Introduction of official hospital fees did not result in reduction in attendance, instead it rose. This was due to improved quality and discontinuation of unofficial fees by health care workers, which was achieved mainly by staff training, supervision and performance based staff incentive structure.

In Zambia, the health sector reform introduced user fees, which reduced the patients flow rate drastically. This also happened in other countries such as Ghana, Eritrea, Tanzania too. The decline was partly because patients who were supposed to be exempted were charged. It was found out that hospital fees caused many not to seek care at all due to inability to pay. The adverse effects happened in a short time while the gains appear to happen over a much longer timeframe.[11]

In Indonesia some of the public hospitals were given partial autonomy. They could decide about the hospital fees, except for the lowest category; and they could retain the earned income. The hospitals however did not have the power to hire and fire staff. In the hospitals the fees increased to the lower levels of fees in private hospitals and the numbers of beds reserved for the poor dropped. With incentives the staff attendance improved, otherwise the evidence of improvements is missing[12].[i]

In Indonesia policy allowed public hospitals to have cost recovery beds after 1993. The objective was to produce income also to cover some costs of the other beds. The recurring costs and salaries however were more than the income from the beds. This was mainly because of higher staff costs than planned. If commercial beds are put to public hospitals, there should be the capacity to control the costs and adjust the fees.[13]

The purpose of decentralization was to delegate power to local level and increase the participation of the local community. After health services decentralization only mayors and municipal health officers felt empowered. Community members were not aware of devolution and their potential roles in decision-making. The historical background of centralized governance is not easily changed to a participatory decision-making.[14]

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[9] Benjamin Loevinsohn, Contracting for the delivery of primary health care in Cambodia: Design and initial experience of a large pilot-test. The World Bank
[10] Cambodia Health Sector Boosting Programme, Feasibility and Design Study, Revised Draft-November 2001.
[11] Blas E, Limbambala M.User-payment, decentralization and health service utilization in Zambia. *Health Policy and Planning* 16(suppl 2): 19-28.
[12] Bossert T, et al, Hospital autonomy in Indonesia. http://www.hsph.harvard.edu/ihsg/publications/pdf/No-39.PDF
[13] Suwandono A. Cost recovery beds in public hospitals in Indonesia. *Health Policy and Planning* 16 (Suppl 2): 10-18.
[14] Ramiro LS et al. Community Participation in local health boards. *Health Policy and Planning* 16(suppl 2): 61-69

In Philippines after devolution of health services management the national guidelines for TB were not followed as well as before. The training and supervision reduced as the local government units reduced these activities, as they were not prioritized locally. One reason being the health care becoming politicized; leading to hiring of political supporters and building and renovation of facilities, which were seen as means of acquiring political support, instead of using money for the services.[15]

To sum of the international experiences the contracting out or in (CO and CI) model of decentralisation functioned relatively well in Cambodia. The success could depend on the experience and strength of the contractors. The performance of the public health services was improved with more patients treated by public health services regardless of the introduction of fees. But were this only attracting people from the private sector or was a wide section of population using the services is unanswered.

Insurance-based system with managed competition could increase the coverage of insured persons rapidly, but sometimes the insurance coverage did not mean availability of services. Also this system requires strong management capacity at all levels to function well.

User fees may reduce the attendance to health services, and targeting the exemptions and implementing the exemptions is not easy. The fee structure can be used to redirect the use to primary care and to some key services. The negative effects are manifested quickly, but the positive effects are slow to materialize.

Personnel management is central issue in success of autonomy. Models where there was more space for personnel management seemed to function better. Performance based incentives improved the services in Cambodia and additional incentives improved the personnel attendance in Indonesia. Training and supervision were also important for success in Cambodia.

Central level must have power and capacity to monitor the adherence to national health policies and equity of services as these might be overrun by local priorities. At the same time to achieve the benefits of autonomy and decentralization the decision power must be delegated to a great extent for the autonomous body.

Community participation is difficult to attain. It is not done by laws and guidelines. It requires also changes in attitudes and values. In places with history of central decision-making it is not easy to get the communities involved

Decentralization and autonomy are highly political issues. It is essential to secure wide continuous support for the process. It is important to gain the support of politicians and the health care personnel as their resistance can slow or stop the process.

Finally, Collins *et al.* (2003) argue that every country that embarks on the process of health sector decentralisation is unique. They operate in their own environment, which, to a large extent, moulds the experience of decentralisation. As we found from the experiences of other countries, no single model worked out well in all the countries. However the commonality in all areas is that for the success of decentralisation, community participation is most, which is very difficult to achieve. The other issue associated with this is local resource generation and increased service charge, which

[15] Health Sector Reform. TDR-Final Report Series. http://www.who.int/tdr/research/finalreps/no9.htm

should be managed in a way, and in return of this people need to be well satisfied with the services they receive. Political will also strongly impacts the process of decentralisation.

4.3 Decentralisation in Nepalese context:

The history of organized health system in Nepal goes back to many centuries. It has developed from a stage of traditional medical practice like faith healing, naturopathy, Yoga, Ayurved and Homeopathy to modern and allopathic practices. Pokharel *et al.* argue that Nepal has experienced different types of decentralisation since its emergence as a unified state in 1769 AD where late king Prithvi Narayan Shah completed the formation of single government in the country (Pokharel *et al.* 2005). He and his successors structured the administration and directly ruled the country initially dividing the country into 12 areas and later into smaller units. Therefore, they argue that:

"The key point of the historical context is that health sector decentralisation will need to take into account is that despite the current centralisation of government, there is strong tradition of decentralisation."

Broadly, it can be organised in following periods:
1. Rana Regime
2. Shah dynasty and Rana rule
3. The down fall of Rana rule and Panchayat system
4. The restoration of democracy and the LSGA, 1999.
5. Periodic Plans and decentralisation

4.3.1 Before Rana Regime

According to Dhakal (1986) the genesis behind the spirit of decentralisation in Nepal started from the Quirt period and lasted until the first century. At that time the Kingdom was divided into a number of local administrative body known as *"Thums"* each consisting of five elders, known as *"Panchas"*. These Thums used to rule their respective units being responsible for construction of irrigation canals, agriculture and taxes collection. Later, Lichhivis also ruled the country dividing the kingdom into two-tier administration, the central ruled by heredatiry king and the provincial administration ruled by centrally appointed governor called *"Samata"*. During this period there were also village administration that was administred by locally elected people called *"Panchali"*. Dhakal again argues that these Panchalis are similar to present Village Development Comittees (VDCs). Similar characteristics of decentralisation existed during the Malla period.

4.3.2 Shaha Dynasty and Rana Rule

According to Dhakal (1986) following to unification of Nepal by late King Prithvi Narayan Shaha in 1769 until the time of hereditary premiership of Rana in 1846, Nepal adopted expasionist policy and developed a centralised system of administration. During this period there was no recognised form of decentralisation however some institutions known as Panchayats were formed in parts of country with a mandate of solving the local disputes. At the later stage, the Rana family took power following a coup against the Shah Kings and ruled the country through hereditary Prim Ministerial system for 104 years (Pokharel *et al.* 2005). They divided the country into four regions by its revenue potential i.e. Eastern, Western, North and South. In this connection they also appointed one of their brothers to rule the particular region.

It is mentioned that the first step in decentralisation of governance to the local level was introducing Municipal and Village Panchayat Act in 1949. This act authorised village councils to collect land tax

and solve local disputes hence people not needing to go to the court. Over the Rana period 170 VPs were established through out the country but people were not addressed as "citizen" rather called "*raiti (subject"* (ibid).

4.3.3 The downfall of Rana Regime and Panchayat period

In 1956, when the Rana rulers were overthrown, civillian government was formed. At this time two important steps took place. Firstly, the administrative reorganisation and planning Commission was set up in 1956. This made provision of dividing country into 7 divisions, 76 sub divisions and 175 blocks. Secondly, an Administration Commission giving power for decentralisation was formed which was headed by Bishow Bandhu Thapa (Collin *et al.* 2003).

In addition, Pokharel *et al.* (2005) documented that during this time people's representative drafted a new act and an Interim Administration law was enacted stating *"the state shall establish village panchayats and develop into self governing institutions with necessary authorities"*. It was the first time in history of Nepal, the term *'local self-governance'* used with its objective to strengthen the foundation of local governance in rural areas.

In 1952 a Municipal Act and in 1956 another Panchayat Act was enacted giving wide development authorities to local bodies. This Municipal Act declared Kathmandu Valley as a Metropolis (Mahanagar). After the first general elections in 1958, the elected government recognised the local Panchayats as the foundations of the democracy and made some institutional changes for their strengthening.

In 1959 when the multi-party government was dissolved by King Mahendra and partyless system was introduced several exercises were undertaken in relation to decentralisation. This mainly includes dividing the country into five development regions, 14 zones and 75 districts. In 1963, a decentralisation plan was formulated.

In 1982, a Decentralisation Act was introduced with the purpose of getting effective participation of local people to take ownership and accountability of overall development in their respective areas. All the line agencies were kept under District Panchayat. In addition government prepared a decentralisation scheme and piloted in 14 model districts. Despite many weaknesses, this act had provided an institutional and legal set up and can be considered as a milestone in the decentralisation process (CSSP 2005). Whatever is mentioned, this effort was the means for existing 'Panchas' to expand their central implementing hands to the local level for their political benefit and resources were still highly under the controlled by centre. But researchers argue that, this can be taken as an positive step in the sense that it brought awareness among local people about the concept of decentralisation (Collins *et al.* 2003).

This partyless system which lasted almost for 30 years (1959-1990), also introduced Panchayat system at district and national levels. However, this system suffered from the central control of "Panchas" and the system of decentralisation was entirely built around the supremacy of central authority and sovereignty of the King. (Pokharel *et al.* 2005). This system was collapsed with the increased pressure for liberal economy and multiparty democracy.

3.3.4 Restoration of Democracy and LSGA, 1999

In 1990, the partyless Panchayat system was overthrown through popular movement and multiparty system was introduced. New constitution 1990 was enacted envisioning decentralisation as one of the

fundamental elements of democracy and one of the directive principles[16]. At the operational level, for the initial few years the structure of decentralised governance remained the same. However, in the development of decentralisation, three separate acts were passed i.e. District Development Committee Act, Village Development Committee Act and Municipality Act in 1992 and local bodies were formed following these acts.

In a precise way, the decentralisation movement only took place when the government formed a high level Decentralisation Coordination Committee under the Chairpersonship of Prim Minister in 1996. Based on the recommendation of this committee, the Local Self Governance Act (LSGA) 1999 was enacted in 1999 that serves as a legal foundation for the development of devolution in Nepal. In the same year, government approved the Local Self Governance Regulation (LSGR) making all the provisions of act effective at operational level.

The underlying principles of LSGA and LSGR are to make the local bodies politically powerful, legally responsible and technically capable of managing their own development affairs. With this provision, District Development Committees (DDCs), Village Development Committees (VDCs) and Municipalities are the autonomous public bodies governed by elected representatives under political party banner. The respective councils are the apex bodies these institutions, as the parliament is for the nation. Other feature of LSGA and LSGR are that they give equal weight to the State, Civil Society Organisations (CSOs), Private Sectors (PS) and Non Government Organisations (NGOs). With this provision, non state entities are considered as development partners of the state. The act has realised the concept of decentralisation, sovereign people, governance process, benefits of democracy, capacity building, resource mobilisation, and equitable distribution of resources, leadership, decision making and authority as a part of state mechanism and local self-governing system (LSGA 1999).

4.3.5 Periodic plans and health sector decentralisation

HMG/Nepal introduced systematic "Periodic Development Plans" with sets of programmes including health in 1956. In addition to the legislation, decentralisation has also been a theme and topical issues in all periodic plans which is illustrated in table 1 below:

Periodic plans	Aspects of decentralization
First five year plan (1956-61)	➢ No specific activities planned
Second and third five year plan (1962-70)	➢ Introduced a new chapter "Population and Manpower" to cope with different health problems. ➢ Following specific programmes launched with the additional international support to achieve optimum health goals. • Malaria Eradication Programme (1958) • Leprosy and Tuberculosis Control Programmes (1964-1965) • Smallpox Eradication Programmes (1967) • Family Planning and Maternal and Child Health Projects (1968)
Fourth five year plan (1971-1975)	➢ There was a shift from vertical projects toward an integrated approach in the form of Integrated Basic Health Services (IBHS) providing basic health services ➢ Middle level health worker training programs were also initiated. ➢ Institute of Medicine (IOM) was established in 1972. ➢ Sixty-three Hospitals with 2,174 beds, 33 Health Centers, 351 Health Posts, and 82 Ayurvedic dispensaries came under operation

[16] See Constitution of Kingdom of Nepal, 1990, Part four; directives, article 24 where it is mentioned "decentralised means to provide opportunity to the citizen in the governance and reap the benefit of democracy". Part 8; Provision for Parliament, article 46 (ga) where it mentions mandatory provision for one fourth of the National Assembly members to be elected from local bodies.

	➢ A Long-Term Health Plan (1975-1990) was formulated with a calendar of operation in the Fifth, Sixth and Seventh-Five Year Plans
Fifth five year plan (1976-1981)	➢ Expansion of the basic health care services to the rural areas for the provision family planning, maternal and child health and welfare services by producing health manpower. ➢ Establishment of effective centers in some of the remote areas to provide adequate medical attention for the rural population. ➢ Popularized family planning programme to check the population growth.
Sixth five year plan (1981 – 1986)	➢ Provide basic health services in rural areas through Health Post. Also train and mobilize village health workers/volunteers at ward level. ➢ Attract private sectors to establish hospitals
Seventh five year plan (1986 -1991)	➢ Private sectors to be promoted if the there is no favorable environment to deliver health services by the government self.
Eighth five year plan ((1882 – 1997)	➢ National Health Policy 1991 prepared[17] ➢ The government in 1993 endorsed the present structure of Ministry of health and the Department of Health Services was established with the responsibility to plan, implement, and monitor and supervise the preventive, curative and rehabilitative health services. ➢ The number of PHCCs and SHPs reached to 100 and 3,199 ➢ The number of CHVs and birth attendants were 46,427 and 1,559 respectively. ➢ Second Long Term Health Plan (SLTHP) was prepared period covering 1997-2017[18]
Ninth five year plan (1997-2002)	➢ The plan emphasised right-based approach of health services delivery with the aim of integrating and extending basic health services to the VDC level and developing DDC as a focal point of strengthening the health system. ➢ With the enactment of LSGA, 1999 and LSGR, 1999, HMG/Nepal was taken series of steps in decentralizing health facilities. ➢ National Health Training Center (NHTC), DoHS has been given all the responsibilities for preparing health facilities handover guideline, managing the process of orientation of Health Management Committee (HMCs), handing over, monitoring and supervision. ➢ Medium Term Strategic Plan (MTSP) 2001 prepared[19]

[17] After the restoration of democracy, the first elected government with its considerable commitment through National Health Policy (NHP) to accorded highest priority to upgrading the health standard of country's rural population (93% of the total population) . It came up with a 14 point health plan that included (i) Family Planning and Maternal and Child Health Care programs and programs for prevention and control of communicable and non-communicable diseases. (ii) Health promotion by increasing awareness of health matters among the general public, promotion, promotion of breast feeding and supplementing essential nutrients such as iron, iodine and vitamin A for instance, and (iii) Expansion of curative services through establishing S/HPs and PHCCs at the peripheral levels and through district, regional and central level referral hospitals. Its intended goals were to bring about positive, yet realistic change in community health indicators.

[18] It advocated continued liberalization with open and competitive financial planning in health. It pledged development of infrastructure by the sate and also pledged to create conducive environment for strengthening the private sector. Through the implementation of 'Basic Health Care Package' it aimed to achieve universal accessibility to resources and services. It also emphasized decentralization and community financing schemes. Private sector strengthening in health was further elaborated in the ninth plan. The concept of fee for specialized services was put forward. It has also presented health insurance as a promising alternative system for health financing.

[19] This paper focused on (i) Strengthening health service delivery, (ii) Decentralization, (iii) Improving the public-private-NGO mix, and (iv) Strengthening sector management. To address the health sector needs, the government has also formulated a Health Sector Strategy in august 2002, which clearly outlined essential health care services, decentralization, privatization, health care financing and management of the health sector as key issues. The second outputs of the programme of same strategy document envisaged that “Local bodies will be responsible and capable of managing health facilities in a participative, accountable and transparent way with

	➢ Health Sector Strategy was produced in 2002[20]
Tenth five year plan (2002 – 2007)/PRSP	➢ Health Sector Strategy Development: an agenda for reform, 2002 prepared ➢ Nepal Health Sector Programmes Implementation Plan (NHSP-IP) prepared ➢ Directives for Transfer and Operation of Local Health Institutions 2003 came under implementation ➢ Formation of Health Post Decentralisation Core Group at MoH

The Tenth Plan has adopted a number of strategies to achieve the health sector objectives : (i) Expansion of primary health centers and district hospitals, and strengthen out-patient services in hospitals; (ii) Development and retain of trained health personal in rural areas; (iii) Increased supply of essential drugs and vaccines; (iv) Improve delivery of health services, publicity, through decentralized management/delivery, through increased participation of the private sector, NGOs and INGOs, or through public private partnerships; (v) Improved regulatory mechanism to ensure the quality and accessibility of health services; and (vi) Improving human resource development and management and health care financing.

This plan has further emphasise in decentralization/handover of basic service delivery functions considering that the decentralization is an important means of bringing development closer to the rural poor – by involving local communities in developing appropriate programs which are best suited to their needs and in implementing them. It also ensures greater accountability for use of public resources, and mainstreaming the poor and deprived groups.

The main objectives of the Tenth-Five Year Development Plan regarding decentralization/handover of the essential health care services are to ensure greater participation of people in the governance process to accelerate the development process by implementing fiscal devolution in a phase-wise manner within the frame work of The LSGA and LSGR, 1999. A decentralization Implementation and Monitoring Committee (DIMC) was also set up to oversee effective implementation. But progress so far has been hindered by many reasons such as institutional capacity and fiscal constraints, by the dissolution of local elected bodies, conflicts and security.

However, Nepal: Health Sector Program, Joint Annual Review (JAR) paper stated "studies varying quality have shown that health sector decentralization has advanced better compared with that in other sector and that there is improved service provision in the decentralized service facilities. The same paper further suggests continuing the decentralization process with the in-depth analysis of the LHMCs capacity, their infrastructure and resources, and clearly defined roles and responsibilities of LHMCs.

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effective support from the Ministry of Health and its sector partners".

[20] This strategy clearly outlined essential health care services, decentralization, privatization, health care financing and management of the health sector as key issues. The second outputs of the programme of same strategy document envisaged that *"Local bodies will be responsible and capable of managing health facilities in a participative, accountable and transparent way with effective support from the Ministry of Health and its sector partners".*

CHAPTER FIVE
RESULTS AND DISCUSSIONS

5.1 Decentralisation in action: findings from literature review

The achievements and issues towards the health sector decentralisation can be described in following sub headings:

5.1.1 Achievements to date

With the declared commitment of MoHP/GoN, to decentralise health services, it is encouraging to note that until 2005, a total of 1578 Health Facilities (SHPs, HPs and PHCs) of 27 districts have been handed over to Local Health Management Committees (LHMCs).[21] The number of Health Facilities (HFs) handed over to the Local Bodies (LBs) as fiscal year wise is presented in Table 5.1 (For detail please see Appendix 3). The GoN in the Budget and Programme for the Fiscal Year 2005/06 have stated that the operation and maintenance of 18 Districts Hospitals, all the SHPs, and PHCs of 10 additional districts will be handed over to the DDCs and LHMCs respectively during the year. As a result of these initiatives, Tenth-Five Year Development Plan envisaged that over the plan period, all SHPs will have been transferred to local bodies.

Fiscal Year (BS)	No. of SHPs	No. of HPs	No. of PHCs	Total no. of HFs
2059/60	468	-	-	468
2060/61	689	18	9	716
2061/62	94	219	81	394
2059-60	**1,251**	**237**	**90**	**1,578**

Table 5.1: HFs handed over to LBs

According to MoHP (2004) 'readyness to decentralise' health services among its stakeholders is other achievement. In principle there is no confusion among other ministries i.e. MLD, Ministry of Agriculture and Cooperation (MoAC) and Ministry of Education (MoE), DDCs, VDCs and other local associations for the devolution.

There is also an exciting development in the number of health personnel. Over the past fifteen years the number of medical doctors trebled, the number of nurses quadrupled and the number of paramedics increased by several folds (Upadhyaya 2006).

In line with the other health related strategy and LSGA, 'Directive for the Transfer and Operation of Local Health Institutions, 2003' was in place giving overall guideline for the devolution. This is an important policy document to devolve local health institutions.[22]

5.1.2 Issues and Challenges

a) Policy perspectives

It is important to note that the LSGA 1999 and LSGR 2000 have laid a rather broader framework to work in health sector decentralisation. According to Pokharel *et al.* (2005) the MOH is probably the most 'prepared sector' to take this process forward and has been proactively considered

[21] This includes 1,251 SHPs, 237 HPs and 90 PHCs

[22] This directive has following provisions; (i) Formation of Committees for the operation and management of LHIs including human resource, financial and information management, (ii) Roles and responsibilities of LBOs and LHIs, (iii) Composition of LHIMCs,, (iv) format for record keeping and (v) short description of planning, monitoring and supervision process in LHIs.

decentralisation of its functions. They further argued that MoH already took the process of handing over SHPs before the LSGA came in existence as guided by NHP 1991 and SLTHP. These documents explicitly stated the need to devolve MoH's functions at local level. Formation of Health Sector Reform Group (HSRG) and S/HPs Decentralisation Core Group (S/HPDCG) is the key and encouraging steps showing government's commitment to take this process forward (Shrestha 2003). Moreover NHTC, the MoH's executing authority on SHPs handover process, has prepared SHP handover process to VDCs which is now being implemented. Similarly preparation of SHP management committee training package is another practical development.

However, Shrestha (2003) argues that since the LSGA has been in place, there was not adequate preparation for its implementation. The policy guideline is also rigid in terms of composition of HMC and the terms of elected members in the committee are not clear. MoH should be responsible to develop a broad based policy guideline and the detail work out should be done at local level.

In addition, Collins *et al.* (2003) argue that there was not in-depth policy analysis of the context of health sector decentralisation in respect to international experience and therefore the policy maker needs to be aware of this and adopt in the light of specific conditions in Nepal. There was very little mention of the Maoist insurgency and the policy lacks proper consultation with stakeholders. An important thing that Collin *et al.* mention is about the lack of international evidence base for the health sector decentralisation. Monitoring system was also lacking.

The other issue associated at policy level is the government priority. According to Upadhyaya (2006), health has never been a priority in the national development agenda other than in seminars and workshops. This is always limited in politician’s speech which is evidenced by low budgetary allocation which is less than five per cent of national budget. He criticises that the existing health bureaucracy is weak and run by a set of cadre bureaucrats with very little knowledge and insights of health system, and a set of technocrats who are not well equipped in leadership and managerial skills. What is needed is a combination of both in order to produce a synergistic effect.

Inter ministerial coordination is another important issue. According to Shrestha (2003) in the process of handing over SHPs there was only vertical linkage for which horizontal linkage must be emphasised. There is no institutional inter-ministerial coordination rather it was a monotonous planning exercise. For effective decentralisation the concerned parties must internalise the concept and must take ownership of the process. Since, Ministry of Local Development (MLD) should take the lead role, their involvement and ownership is very much crucial. There was documentary evidence that district authorities felt decentralisation as a threat to their authority and use of resources.

b) On hand over process:

Pokharel *et al.* (2005) mention that the 'hand over' has gone far ahead of the 'take over' in many cases. They doubt whether the timing for hand over was right and urgency of handover overlooked the capacity to take over. Shrestha (2003) adds, the hand over process lacked adequate planning meeting with stakeholders and the committee was not aware of their roles and responsibilities. The other issue associated with this is whether this handover was 'total handover' or partial handover. In other words whether it is deconcentration, devolution or delegation.

c) Question of accountability

Researchers have documented that the question of accountability within the context of health sector decentralisation was always remained an issue and hot topic of discussion. One serious finding was that the Local Development Officer (LDO) is not responsible to DDC where DDC are elected by

local people. Because the decentralisation of health services, LDOs has a crucial role to play (Collins *et al.* 2003). Going to further local level, i.e. at VDC, there arose a hierarchical issue between the staff of S/HPs and VDCs (MoH 200?). Because S/HPs In-charge relate to non gazette first or second class while VDC In-charge, which is at present are the VDC secretaries, are lower in their hierarchy as compared to S/HPs staff.

d) Institutional problem

The political instability and civil strife has also delayed the decentralisation process and hve made LHIs and LBs in effective. Because the LBs lacking elected representatives, the government at the centre looked some what hesitant to handover the LHIs. There is another difficult in recipient side as well. The condition of already handed over LHIs was worse that the time of handover, and new initiatives for take over of LHIs was lacking (MoHP 2004).

e) Capacity of LBs and LHIMCs

Capacity refers to the individuals and organisation's knowledge, skills and ability to manage things. MoH (2061) mentions that generally speaking the newly formed LHIOMC and LBs officials lack required managerial know how, and therefore it is very much difficult to run LHIs without competent and visionary leadership. Pokharel *et al.* (2005) questions, was it just 'hand over' of 'take over' as well. Because in their opinion the variations in local context, level of security and community preparedness, capacity and motivations greatly affect the outcome of hand over process. MoH (2003) also has same opinion and mentions the handover process was more the 'push factor' from the centre rather than the 'pull factor' from the local bodies. In this regard, the MoH, NPC and donor agencies are persuading the decentralisation work and there is little voice in this regard. For the effective handover, promoting the awareness of existing LBs, political paties and local people is important so that it produces a synergistic and empowered initiation from the bottom level.

Though there was some orientation given using 'clustering' approach, it was found to be insufficient and 'onsite' orientation to all Management Committee (MC) members as well as re-orientation is crucial (Shrestha 2003). In addition, the existing orientation package focuses on the roles and responsibilities, however there needs to be a good mix of technical and managerial skills to increase the competency of MCs.

f) Financial and administration issues

There is also confusion related to technical supervision and management audit after handover. The S/HPMC does not have autonomy and the policy is unclear regarding leave, transfer and deputation. There exists a political bias in assessing the performance of staff. A very simple but a big issue, who hires and fires staff? Is that centre, or District Public Health Office (DPHO) or local communities? Does the local SHMCs have enough capacity to do that? Who sets the standards for quality? Is that community or DPHO or VDC or DDC or Centre?

The other issue is related to budgetary issues and resource mobilisation. Are there sufficient evidences of local resource mobilisation? Perhaps not. Are VDCs being accountable to transfer and management of funds? Who supplies the drug? Is hand over is just like a 'washing hands'? One of the findings of CSSP (2005) documents that SHP staffs were facing difficulty in getting their monthly salary. This was because of procedural delay of getting funds from DDC through DPHO. Moreover, majorities of HMC members were not aware of their financial transparency matters. If it is who and how the quality of drugs are ensured? Perhaps, there must be message that the drug supply will be

continued even after the handover until they are trained and arrange necessary mechanism in an effective way.

5.1.3 Summing up

As discussed in the earlier chapters, a few relevant conclusions can be easily derived from the history of health services development in the country.

Firstly, the stakeholders from political to top level government officials and LBs have clearly emphasised the need for decentralisation in health sector. The enactment of LSGA can be taken as a high level political commitment while the other relevant strategy, directive and policy guidelines can be seen as a part of their commitment. However, there seems some what confusion whether these top level 'policy making communities' have really internalised the issue or not. The other issue associated with this is the forms of decentralisation. Whatever mentioned in the documents and policies, the documented evidences confirm that the current handing over activities seem like a deconcentration rather than the complete devolution. If this is so, are we willing to control the handed over LHIs centrally?

Secondly, it is important to note that when decentralising health services, 'preparing and building self' and 'preparing and building others' are important aspects. Under building self-mechanism, structural alignments of MoH structures and institutionalisation of inter-ministerial coordination is important. Under the part of preparing and building others, LBs and LHIMCs preparedness and capacity greatly affected the entire process. Therefore, this should not be taken lightly since local capacity to take over and sustain the 'handed over package' determines the effectiveness of our decentralisation process.

Thirdly, community participation and feeling of ownership in health activities is perhaps, the most important aspect. Documented evidences showed that community participation was found to be encouraging than of previous years and they have begun to feel ownership of their SHPs. This needs to be further ensured.

Finally, policy itself does not decentralise the power, authority and responsibility. It is the people who somehow linked with the entire chain do the things. The overall planning process at VDC and DDC, integration of health service activities into their plans, staff portfolios and accountability mechanism and the 'common goal and ethos' of serving poor people plays determining factor to materialise 'theory in action, than into practice'. There is a pertinent question, which could be probably the hot topic of debate that is all government staff really committed for handover process. Of course not. The recent indefinite strike launched by over 26,000 paramedical personnel strongly demanding to end to the process of handing over the health institutions to the communities questions the overall credibility of the government's effort in decentralisation. (The Kathmandu Post, August 18th 19th, 2006). What does this indicate? Are all the ministries and its structure really ready for decentralisation? Over the years, there has been significant achievement in terms of quantity handover, however it needs further effort to transform these achievements into quality standards and to 'completely brain wash' the mentalities of its front line staff.

5.2 Findings from field survey

The field studies carried out in above mentioned sampled districts and with the mentioned respondents also found more or less similar findings with little differences in some of the aspects. The findings from field study has been mentioned below:

5.2.1 Policy Planning

The enactment of LSGA and its regulation has served as a major basis of health services decentralisation in Nepal. Some of the Key Informants said that though the basis for health sector decentralisation is LSGA 1999, concerns were raised to have separate policy for health sector decentralisation since this act is not sufficient enough to decentralise health sector in a more complete sense. Because the LSGA mentions about providing all health services but does not clarify about budget, service delivery, financial accountability and responsibility, the role of central management and, vaccine and medicine purchase and supply matters. They also mentioned that LBs and HMCs cannot effectively handle the medicine and vaccine issues right after the handover for which technical and managerial capacity building is crucial. Though the SHPs were handed over, services are still under MoHP and DoHS which should be under the control of LBs. LBs must be made responsible to deal with staff issues to make them accountable to LBs but the current pattern shows that there is decentralisation of functions rather than the authority. In this connection one of the reacted saying:

> *Government is sending the medicines worth only about Rs .21,500 per SHP per year. But in Kathmandu we are spending minimum of 20-21,000 per year per person for medical treatment. In such case delegating the full authority to the HMCs with strong poliy planning support could provide a greater room to bridge such gap of disparities for the provision of quality health services at the local level.*
>
> *One of the Key Informants from INGO*

> *"the plans made in Singa Durbar could not meet the local need and requirements, so that full authority should be given to local level to make and implement the health plan to improve the health service provided by the SHPs"*
>
> *--LDO, Banke*

Inter ministerial coordination is also other issue for which arrangement are needed to clear the concepts of decentralisation and their roles.

At the district level, respondents pointed out that LSGA was not implemented properly, since the overall aim of decentralisation is increase peoples' access to health. This was mainly due to lack of elected LBs and VDC secretaries not staying in their duty station. They also mentioned that the budget transfer system is also rather cumbersome. In addition, LSGA is silent about staff administration issues. Very simple and practical question, where should SHPs send their attendance sheet?

Some of the central level KIs mentioned that current policy does not guarantee lower and oppressed peoples' access to health, and it needs certain provision for such people. It is not just making a policy, but the central bodies should refine, monitor and evaluate the policies and also need to manage resources. Under the current policy the issue of social inclusion has been overlooked. Doing these things needs creative personalities in order to make policy, plan and implement the decentralisation movement.

However, in terms of policy planning the respondents differed in their views. The policy is good but it is not properly implemented. The policy should be clear and applicable according to the geographical, economical, political and social situation of the country. Contradictory laws and policies need to be eliminated. As mentioned by one of the VDC Secretaries quoting the saying of Jawahar Lal Neharu

"We are the best planners but worst implementers" we make good policies but failed to outwork them. Therefore, the only thing now we need is commitment at our work and towards our profession.

5.2.2 Knowledge about handover and hand over process

a) Knowledge about handover

Generally speaking, majority of KI at central and district level expressed that the overall basis for health care facilities decentralisation was based on the LSGA 1999. All the respondents at local and central level were found to be clear about the objectives of health service decentralisation except the exit clients (ECs). The local level respondents mentioned the overall grasps of decentralisation, which is about empowering local communities through their participation and ownership. The central and district level representatives put their opinion in a more explicit ways. (See Annex 4 for KIs).

According to them the objectives behind the health service decentralisation were:

- To develop ownership feeling in local communities towards SHPs.
- To make the SHPs sustainable through community and the local resources mobilisation.
- To maintain transparency in medicine distribution and financial aspects.
- To improve the quality of health services increasing communities' participation and making them access to all people.
- To ensure planning, monitoring and evaluation by LBs and local communities, thereby reducing budgetary and managerial burden to central level. For example one of the respondents of MoHP said:
- To develop the local authority as a local well functioning government and go towards full devolution.

> *"In some districts, it takes 6-7 days to reach to the SHPs. Monitoring also cannot be done frequently as planned. Additionally supervisors are taking TA/DA for 20-22 days for the work. If monitoring and evaluations are ensured at local level to the LBs, it will reduce budgetary and managerial burden to central structures, and the money saved can be diverted in other areas such as strengthening quality care services".*
> *One of the Key Informants from MoHP.*

At SHP level, most of the In-charges and MCHWs were found having good knowledge about health facility handover giving more emphasis to community participation. As per MCHWs saying it is delegating the power/authority to the local level provides opportunities to the couumnities to work together in order to get the 'fruit' of their own effort and is also a process of self-help. In village level KIs' saying the it is like *"Afno Gaun Aafai Banaun*[23] "Health is wealth" and According to SHP Incharges, SHP's plan should be based on the requirements of locals and based on the local resource mobilisation. However, the significant percentage of ECs; 58.62 had any knowledge regarding handover.

Some community level respondents were found with different views regarding the objective of handover. In their opinion, government wants to pull its hand from the health facility, and therefore the decentralisation is so rush.

[23] This means "make your village self"

b) Knowledge about handover process

Towards the process of SHPs hand over, all categories of respondents except ECs and village level KIs, were found to be familiar with the process of handover. With some exceptions to newly appointed and recently transferred VDC secretaries, all respondents mentioned that the SHPs were handed over to community in the presence of VDC Secretary, and HMC Chairperson, DDC, CDO and DPHO authorities in DDC hall which was the process adopted for handover. During hand over process, for example in Lalitpur and Kanchanpur, the Regional Health Directors were also present. In all the districts except in Kanchanpur, two-day orientation training[24] was delivered to key HMC members, SHP In-charge and VDC Secretaries. However, in Kanchanpur, a form was distributed and asked them to fill up that form and come up in the district HQs having formed HMC. The orientation training was only given after handing over the SHP. Further more the duration of training was also different from 2-3 days. For example in Banke district it was for three days while in other districts it was of 2 days.

At the district and local level, respondents said that the two days orientation training was not sufficient enough, and the main stakeholder, the communities are overlooked in entire process.

On the part of Exit Clients (ECs), on an average 41.2 percent of them heard about the handover. (Appendix 5). Only the nominal percentage of them, 8.7 percent got information of ongoing activities of handover. Similarly, only the 18.4 percentage of ECs got information about provision and formation of HMC. Going through the district, the ECs knowing the information of handover process is generally nil in Lalitpur, Kanchanpur and to some extent in Banke and Kaski. These data revealed that a significant number of ECs, were overlooked into the entire process of HFs handover. Generally speaking, of the total ECs the percentage of female knowing the information was relatively and in some case significantly well off than that of male ones If the huge masses of communities, to whom the whole purpose of decentralisation is meant for, how can the communities come and participate in SHP activities and take ownership of the HFs

On the part of village level KIs, majority of them were found to be known about the hand over process while others had just heard about it. In addition, KIs of Kaski mentioned that the NHTC trainers were not clear in the policy matters.

A contrasting view regarding the requirements for handover came up from the district level respondents. The respondents of Jhapa and Kaski said that SHPs needed certain infrastructure as a precondition for example enough equipment, qualified manpower and willingness of local community to take over SHPs while this was not heard in other districts where they simply said that there were no prerequisites set rather following ministry's decentralisation policy.

The outcomes of FGD were also more contrasting. Most of the male and female participants were highly unknown about the handover process. They criticised saying that it was a "*kothe nirnaya (a Decision made in the room)* of higher authorities without involving the people to whom the health facility is handed over. They were also unknown about HMC formation what they only knew about the existence of committee in the health facility only when they saw their names. One women of Kanchanpur reacted as: *"it is just now that I came to know that there is HMC in our SHP, other wise I would have uninformed"*.

[24] According to DPHO, Kaski, the key focus of the training was to assess local health problems, inform local authorities about the importance of health facilities decentralisation, assess the existing health infrastructures, to make health plans based on local needs and local resource mobilisation and to increase ownership of the local people.

The above analysis revealed that a great majority of ECs and communities were not aware about handover process and they were not included. If we overlook these great masses of people whom the programme is designed and targeted, how SHPs could work effectively? This is a big question mark for all concerned.

c) Perception about timing of handover

Some mixed reactions came out of the district and village level respondents with the dominant number of people claiming the handover time appropriate.

It was found that 57.14 per cent of MCHWs were positive towards handover process. In terms of timing of handover, 28.57 per cent of them reported that the timing for handover was not appropriate due to their inability to operate SHPs and formulate plans while 14.28 had no idea about the process. (Table 5.2)

No.	Opinion	%
16	Yes (appropriate)	57.14
8	No (inappropriate)	28.57
4	Don't know	14.28
28		**100**

Table 5.2: Showing MCHWs response on timing of SHPs handover

Districts	KIs (N=57)	LDOs (N=5)	DPHOs (N=5)
	Yes (appropriate) n (%)	Yes (appropriate) n (%)	Yes (appropriate) n (%)
Kaski	7(50)	1(100)	0
Banke	8(66.7)	1(100)	1(100)
Kanchanpur	4(100)	1(100)	0
Jhapa	13(86.7)	0	1(100)
Lalitur	8(66.7)	1(100)	1(100)
Total	**40(70.1)**	**4(80)**	**3(60)**
Ecological Regions			
Hill	15(57.7)	2(100)	1(50)
Terai	25(80.6)	2(6.7)	2(66.7)
Total	**40(70.1)**	**4(80)**	**3(60)**
Areas			
Urban	20(74)	-	-
Rural	20(66.7)	-	-
Total	**40(70.1)**	**-**	**-**

Table 5.3: Appropriateness of Timing of handover

At the district level, except the LDO of Kaski and Kanchanpur and DPHO of Jhapa (Table 5.3) all mentioned that the handover time was on right time saying that right time could not be waited anymore. Slowly, community will build on their experience. They added that when the elected LBs back into the power after the restoration of peace, it will take the effective momentum. The other side of the coin who responded the time being inappropriate questioned that if there are nobody to look after the handed over SHPs and community are also not aware enough, who will take care of SHPs? Still the opinions were different among the district level KIs with an average of 70 percent perceiving the handover positively and others not doing so. This is highest in Kanchanpur with all saying the time being appropriate followed by Jhapa where 86.7 percent KIs said. A least percentage was found in Jhapa, 50 percent saying the time being appropriate followed by Lalitpur and Banke, which is 66.6 percent.

In addition, the same table 4.2 showed that the district level KIs had also mixed reactions saying the time appropriate (70.17%) and inappropriate (28.07%). Those who claimed to be appropriate mentioned that the issue of handover is more about concern and interest towards SHP and its improvement for which work could be done without being in the chair. It is a good learning opportunity by doing things and communities slowly learn things by their mistakes. Where the communities were active, take interest and had enthusiasm SHPs were operating properly and able to raise funds from different sources. However, opponents argued that the work of handover is worthless if there are no elected LBs.

However, HMCCPs' put serious question mark behind the time of handover. They argued that the hand over must be *'demand base rather than decision based. It should also be bottom up against the current practice of top down"*. Before handing over the such institutions government should take consideration of build certain infrastructures such as building, lab and equipments etc, increase community awareness, make SHPs somewhat sustainable both financially and technically and impart managerial skills to the key persons. Some Chairpersons of Banke argued saying that ***"handing over SHPs without building certain infrastructures is just like giving empty plate to the hungry people rather it should have filled in with rice and vegetables to eat. If the plate is empty, what to eat by communities".*** Unless the communities are sensitized and become aware, the whole rational of decentralisation always fails.

5.2.3 Authorities, Financial Management and Capacity Building

a) Authorities

The findings show that except purchasing of medicine, the handed over SHPs had no administrative and financial authorities. The SHPs cannot approve leave of their staff, and the transfer of staff is never possible under the current arrangement. It is also provisioned that the HMCs can also recruit staff if they have funds but this was never practised. Almost all the respondents claimed that all the financial and administrative control was under DPHOs and other higher authorities, thereby making SHPs dependent. They argued that there has been no change as of earlier.

The KIs also identified other issue related to the authority and *"superiority complex"* which was observed in some places because under the current situation, HMC Chairperson is *Kharidar level* while the In-charge belongs to *Subba level.* In addition, SHP In-charge is technical person, and the question was who is higher than whom.

b) Financial management

It was found that regular budget from the government, registration fee and 5 percent of the budgets from VDCs were serving as the main sources of income in SHPs. Besides, as a part of income SHPs were found to be charging certain extra fee for their services[25]. As reported by SHPIs more than 73 SHPs charged certain fee for their services while others not. By district all SHPs in Jhapa and Kanchanpur charged fee followed by Kaski where the percentage was 71.4. The highest percentage of SHPs not charging fee was found in Lalitpur where the ratio of charging and not charging fee was 1:1. By areas, almost all SHPs charged fee for their services, which is 93.8 percentages (Appendix 6).

Districts	SHPI (N=30)	HMCCP (N=28)
	Yes n (%)	**Yes n (%)**
Kaski	1 (14.3)	0
Banke	0	0
Kanchanpur	0	0
Jhapa	0	1 (14.3)
Lalit pur	1 (16.7)	1 (16.7)
Total	**2 (6.7)**	**2 (7.1)**
Ecological Regions		
Hill	2 (15.3)	1 (7.7)
Terai	0	1 (6.7)
Total	**2 (6.7)**	**2 (7.1)**
Areas		
Urban	0	1 (8.3)
Rural	2 (12.5)	1 (6.3)
Total	**2 (6.7)**	**2 (7.1)**

Table 5.4: Adequacy of budget in SHPs

Generally speaking, SHPs were having financial problems hindering them to perform well. 93.33 percent SHPIs and 92.9 percent HMCCPs mentioned that they did not get sufficient budget according to their plan. They also did not have any special budget to operate SHPs except OPD

[25] SHPs were found to be charging 10 for each of TT Vaccine and Depo-Provera, 20-30 for each of Dental check up and extraction and Stool and Urine test, 10-20 for Dressing, 20 for wound operation, 50 for Insulin test (sugar) and 100 for each case of Filling the Police report and Blood test. (Note: currency is all in NRs).

registration fee and some funds from VDC and different I/NGOs and in some case from industries. Only the 6.7 percent SHPIs said that they had adequate budget to operate their facility. Where as this figure in the case of HMCCP was slightly higher by 0.4 percent. Ecologically, the Hill and Rural based SHPs seemed slightly well off than that of the Terai and Urban ones. (Table 5.4)

Since four years government has been providing NRs 30,000 to each SHP to purchase medicines. SHPs are asked to purchase medicines from district level, and only the medicines, which were not available at that level (e.g. spacing methods, vaccines etc.), are being sent from centre. At the district level, the DPHO purchase required medicines and sends to each SHP and charges the amount. It was also found that the medicine supply system was also slow being one of the hurdles of quality health service delivery.

As expressed by the respondents, not being financially well off had multiple implications. Some SHPs could not prepare their short and long term plans. Others could not train their staff in new approaches while HMC members also could not receive capacity building training. They indicated that there is a clear need for staff, however could not hire because of financial problems.

Budget flow system also seemed more complex. After handover, the budget was transferred from DDC to DPHO, DPHO than sends money to VDC and finally it goes to SHP. Questions were raised about this budget flow system being lengthy; time consuming and needing a lot of administrative work. This indicates that SHPs need financial assistance from the government and non government entities to make them financially sustainable.

c) Capacity building

All respondents mentioned that capacity building is very much important but mostly overlooked aspect of current decentralisation process. It was found that the SHPIs and HMC members received a form of 2-3 days orientation training that was followed by immediate handover of SHPs to them. There was no back stopping for this. The HMCCPs criticised that the handover was just like "exchange of file". Technically, MCHWs also received some training in their own areas[26]. A huge amount of budget have been spent in the name of building capacity of SHPs. similarly one of the HPIs mentioned that "millions of dollars that came in the name of decentralisation has helped senior officials to built ensuit buildings in and outside of country, but the situation of SHPs never changed. Capacity building is not just like that of giving one time off or two times off training rather it needs a definite package and also is a continuous process".

In broad sense, the term capacity building also includes communities as well. If we expect communities participation and taking them the ownership of SHPs they also need certain capacity building activities. This also affects them to increase their health service utilisation by developing health seeking behavior.

5.2.4 Development of short and long term plans

More than 50% SHPs have developed annual or long-term plans (Table 5.5). Of the total SHPCP, 60 per cent said that they have developed annual or long-term plans which are similar to SHP Incharges' response but the village level KIs response was less by 6 per cent. In contrast, the DPHO's response was that all the SHPs have long term plan whereas except the LDO of Jhapa, all mentioned that they have either plans to improve the health service of SHPs.

[26] MCHWs received safe motherhood and family planning, safe abortion and delivery, ARI, CBMNC/IMCI, DOTS, HIV/AIDS, Leprosy, Immunisation, Vitamin A and record keeping training provided by the government.

According to HMC's response, 85 per cent of SHP's have developed long term plan in Jhapa district followed by Banke where 71 percent of SHPs have such plan. In contrast, SHPs in Kaski has the lowest percentage of plans developed which is only 14.

Ecologically, the SHPs located in Terai areas seemed to have developed long term plans as compared to the Hill ones. By geographic locations the Rural areas seemed to be better in developing long-term plans which is, on an average, more by 12 per cent to that of later ones.

Districts	HMCCP (N=28)	SHPIs (N=30)	KIs (N=57)	DPHOs (N=5)	LDOs (N=5)
	Yes n (%)	Yes n (%)	Yes n (%)	Yes n (%)	Yes n (%)
Kaski	1 (14.3)	5 (71.4)	8 (57.2)	1 (100)	1 (100)
Banke	5 (71.4)	4 (57.1)	4 (33.3)	1 (100)	1 (100)
Kanchanpur	1 (100)	2 (100)	2 (50)	1 (100)	1 (100)
Jhapa	6 (85.7)	4 (50)	10 (66)	1 (100)	0
Lalit pur	4 (66.7)	3 (50)	7 (58.3)	1 (100)	1 (100)
Total	**17(60.7)**	**18 (60)**	**31 (54)**	**5 (100)**	**4 (80)**
Ecological Regions					
Hill	5 (38.5)	8 (61.5)	15 (58)	2 (100)	2 100)
Terai	12 (80)	10 (58.8)	16 (52)	3 (100)	2 (6.7)
Total	**17(60.7)**	**18 (60)**	**31 (54)**	**5 (100)**	**4 (80)**
Areas					
Urban	5 (41.7)	8 (57.1)	15 (56)	-	-
Rural	12(75)	10 (62.5)	16 (53)	-	-
Total	**17(60.7)**	**18 (60)**	**31 (54)**	**-**	**-**

Table 5.5: Formulation of annual or long term plan in the SHPs

Majority of such plans are related to improvement of physical facility, management of manpower and improve and extend health service delivery to the communities. The plans also focused on creating public awareness about some of the endemic diseases such as malaria and HIV/AIDS etc, increase health seeking behaviour and service utilisation aspects and to make school health education programme effective. Some of the SHPs have established some extra facilities such as lab, weekly clinics on ENT, Dental camps, DOTS, Safe Motherhood Tablet, IMCI, CBMNC, CBMC, Malaria Service and PDQ service. OF the SHPs who could not prepare plans mentioned that due to lack of budget and absence of elected LBs, some SHPs could not prepare plans to improve health service delivery of SHPs.

However, SHPIs also claimed that most of the plans and policies were made at district level for which SHPs have no alternatives except to follow them. As they said this is part of the authority what they were not delegated.

5.2.5 Composition and functioning of HMC

a) Composition of HMC

In respect to the composition of HMC, MoHP has made provision to form a mixed and inclusive committee lead by VDC Chairperson[27]. In general it was found that satisfaction towards the composition of HMC was over 50 per cent across all respondents except ECs. It was the highest in case of MCHWs (85.7 %) followed by HMCCP which is 75 per cent. 53 percent of SHPIs found to be satisfied towards the HMC composition because of the representation of caste and class of the community and helpfulness of the committee members. Whereas 47 percent of them expressed their dissatisfactions due to the mandatory provision for them to be as HMC Chairperson, hence prohibiting community to select the appropriate members (Table 5.6). They argued this as ***"putting***

[27] The other members of the committee includes Chairperson of Population and Development Committee, Headmaster of local School, Female ward member of VDC, FCHV representative, Marginalised people (Dalit), female social worker and Sub Health Post Incharge as Member Secretary.

two legs in two boats". For the committee to be more effective, they suggested that it should be the person who is respectful by all political party, has some technical know-how, possess influencing personality and also literate. It is the community who should have authority to choose and appoint the HMC. Some of them opposed very strongly to their mandatory Chairpersonship in HMC since they were unable to stay at their work place due to ongoing conflict, and therefore could not effectively perform their mandatory duties. They said, it is like a Nepali proverb *"Budho Gorule Gai Ogate Jasto"* [28]

In the case of ECs their satisfaction level is 41 percent. Those who are not satisfied mentioned that the committee was formed in the district, community had no interest on them and in fact they don't exactly represent the community. They added that the result was defunct committee. Interesting thing here to note is that respondents of each category of ecological region had almost similar level of satisfaction towards the composition. In contrast, by areas the opinion in each category respondents except MCHWs and SHP Incharges greatly varied. This difference is highest in the case of HMCCP which is 66 and 81 per cent by Urban and Rural respectively.

	SHP Incharge (N=30)	**HMC CP (N= 28)**	**MCHWs /FCHVs (N= 28)**	**Exit Clients (N= 58)**
Districts	**Yes n (%)**	**Yes n (%)**	**Yes n (%)**	**Yes n (%)**
Kaski	5 (71.4)	5 (71.4)	6 (85.7)	8 (61.5)
Banke	3 (42.9)	3 (42.9)	5 (100)	10 (76.9)
Kanchanpur	1 (50)	1 (100)	1 (50)	1 (25)
Jhapa	5 (62.5)	7 (100.0)	7 (87.5)	4 (25)
Lalit pur	2 (33.3)	5 (83.3)	5 (83.3)	1 (8.3)
Total	**16 (53.3)**	**21 (75)**	**24 (85.7)**	**24 (41)**
Ecological Regions				
Hill	7 (53.8)	10 (76.9)	11 (84.6)	9 (36)
Terai	9 (52.9)	11 (73.3)	13 (86.7)	15 (45.5)
Total	**16 (53.3)**	**21 (75)**	**24 (85.7)**	**24 (41)**
Areas				
Urban	7 (50.0)	8 (66.7)	10 (83.3)	9 (34.6)
Rural	9 (56.30	13 (81.3)	14 (87.5)	15 (46.8)
Total	**16 (53.3)**	**21 (75)**	**24 (85.7)**	**24 (41)**

Table 5.6: Satisfaction with the Composition of HMC

Those who have greater satisfaction mentioned that the current composition of HMC saying this as inclusive of all class, caste and gender. In turn, the dissatisfied MCHWs said that the current composition is conducive for political egoism towards non-supporters of HMC members.

"I am supporter of .... party so that the HMC members of other parties don't give credit for my work" *-- One of the MCHWs of Kanchanpur district*

Almost all categories of local respondents stressed to include local NGO, Youth Clubs and religious and ethnic group in the committee. For example VDC secretaries suggested to include religious leaders i.e. '***Muslim Leader'*** in Banke district and '***Tharu Leader'*** in Kanchanpur district in the HMC.

All these figure indicated that the community should make aware about the composition of HMC and give emphasis to select members by themselves.

[28] It is like a holding the position rather performing the job.

b) HMC meetings

It was found that 71.4 percent meetings were held regularly as scheduled by HMC's Chairperson while 28.4 percent did not held. This was due to the their busyness and not having time of Chairpersons to participate in the meetings. The holding of meetings as scheduled by Chairperson was also differed by district, region and areas. By district, in Jhapa and Kanchanpur this figure is hundred percent followed by Kaski which is equal to average of meetings held. The meetings were poorly held as per schedule in Lalitpur which is 50 percent followed by Banke (43). By regions, the meetings were as per schedule in Terai based SHPs where 80 percent meetings were held against the Hill SHPs of 61.5. Similarly, the holding of scheduled meetings was better in Urban areas (75%) as compared to Rural ones which is 68.8 percent. (Table 5.7)

Districts	Yes n (%)	No n (%)
Kaski	5 (71.4)	2 (28.6)
Banke	4(57)	3(43)
Kanchanpur	1(100)	0
Jhapa	7(100)	0
Lalitpur	3(50)	3(50)
Total	**20(71.4)**	**8 (28.6)**
Ecological Regions		
Hill	8(61.5)	5(38.4)
Terai	12(80)	3(20)
Total	**20(71.4)**	**8(28.6)**
Areas		
Urban	9(75)	3(25)
Rural	11(68.8)	5(31.2)
Total	**20(71.4)**	**8(28.6)**

Table 5.7: Holding meeting scheduled by Chairpersons

4.5.2 Attendance of HMC members

The data also revealed that the average attendance in the HMC meeting was also encouraging. As shown by the data, the average attendance by the HMC members in the meeting is 78.8 percent, which is quite exciting. However, the average attendance varies by district, region and areas. This is the highest in Jhapa, where average members attending more than 80 percent meeting was 70.8 percent followed by Kanchanpur which is 66.7 percent. This figure was the least in Kasti having 47.6 percent members attending more than 80 percent meeting. (Appendix 7)

In addition the average meeting attending by more than 80 percent members was found better in the Terai SHPs which is almost higher by 7 percent than that of the Hill ones which is 53.8 percent. Similarly, In Urban based SHPs average members attending over 80 percent meeting were found to be 54.8, almost less by 7.7 percent.

The regions behind not attending meeting were due to negligence and business. Some of the HMC members felt the meeting as waste of time saying *"I won't be able to participate in the meeting and will put my signature when I will have leisure time"*. In addition, the attendance of *Dalits* (down-trodden) and females was also discouraging mostly their business and thinking that the meeting would not benefit them. Moreover, some of the FGD participants were not found to be satisfied with the passiveness of HMC and not fulfilling their responsibilities as expected by the communities. This has questioned the commitment of MC members towards the improvement of SHP.

> *"One NGO named SAVE provided a freeze and a bed to SHP but HMC even did not know from where that has came"*
> ***Male FGD participant, Banke*

5.2.6 Coordination, Monitoring and Supervision and Reporting

a) Coordination and Linkage

According the response given by SHPIs', an average of 73.3 percent (Table 5.8) SHPs have ability and authority to coordinate their programmes and activities with I/NGOs through regular meetings, personal contact and correspondence. Mainly this type of linkage was established with NGOs for

training, to manage equipments, to construct and repair buildings and to purchase medicines. This response is almost similar to that of HMCs response which is 71.4. By districts, both the SHPIs' and HMCCP of Banke and kanchanpur said that they have full ability and authority to coordinate their activities with other I/NGOs followed by Jhapa where 75 percent Banke and kanchanpur said that they have full ability and authority to coordinate their activities with other I/NGOs followed by Jhapa where 75 percent Incharges and 71.5 percent Chairpersons said of having those ability and authority.

In contrast, the Incharges and Chairpersons of Kaski said they have very limited ability and authority for coordination which is 42.8 and 28.5 percent. By regions, the Terai based SHPs seems better able and better authorised (SHPI and CPs saying 88.2 and 86.7 percent) compared to the Hill ones where 53.8 percent of both group of respondents have ability and authority to coordinte. By areas the two groups of respondents have different views. According to SHP Incharges response, Rural based SHPs had slightly better ability than that of Urban ones; the figures being 75 and 71.4 percent respectively. While 75 percent Chairpersons of Urban based SHPs said, they have that ability compared to 68.8 percent of Rural ones.

Districts	SHPIs (N=30)	HMCCP (N=30)
	Yes n (%)	Yes n (%)
Kaski	3 (42.8)	2 (28.5)
Banke	7 (100)	7 (100)
Kanchanpur	2 (100)	1 (100)
Jhapa	6 (75)	5 (71.5)
Lalit pur	4 (66.7)	5 83.3)
Total	**22 (73.3)**	**20 (71.4)**
Ecological Regions		
Hill	7 (53.8)	7 (53.8)
Terai	15 (88.2)	13 (86.7)
Total	**22 (73.3)**	**20 (71.4)**
Areas		
Urban	10 (71.4)	9 (75)
Rural	12 (75)	11 (68.8)
Total	**22 (73.3)**	**20 (71.4)**

Table 5.8: Coordination with Different NGOs/INGOs

b) Reporting

Encouraging results came out in reporting. The data showed that all the SHPIs and MCHWs/FCHVs were regularly sending their reports to DPHO. No differences was noted by district, region and areas (Appendix 8). There might be some implications of this result. For example, though we talk a lot about decentralisation, however they see that DPHO is still a major vertical governing and administrative body for them. Perhaps DPHO might have played its role in that way as well. It hits strongly towards overall norms of decentralisation process.

c) Monitoring and Supervision

Generally speaking it is the DHPO that is carrying out the monitoring and supervision of SHPs.. In addition Health Posts, Regional Health Directorate were also involved. In some instances, Pro-Public was also found to be involved.

Districts	SHP In-charge (N=30)	HMCCP (N=28)	MCHWs/ FCHVs (N=28)
	Yes n (%)	Yes n (%)	Yes n (%)
Kaski	7 (100)	7 (100)	5 (71.4)
Banke	7 (100)	2 (28.5)	4 (80)
Kanchanpur	2 (100)	1 (100)	2 (100)
Jhapa	7(87.5)	4(57.1)	8 (100)
Lalit pur	6 (100)	3(50)	5 (83.3)
Total	**29 (96.6)**	**17 (60.7)**	**24 (85.7)**
Ecological Regions			
Hill	13 (100)	10 (76.9)	10 (76.9)
Terai	16 (94.1)	7 (46.7)	14 (93.3)
Total	**29 (96.6)**	**17 (60.7)**	**24 (85.7)**
Areas			
Urban	13 (92.8)	7 (58.3)	11 (91.7)
Rural	16 (100)	10 (62.5)	13 (81.3)
Total	**29 (96.6)**	**17 (60.7)**	**24 (85.7)**

Table 5.9: Practice of Record Keeping

Field level data revealed that almost SHPs, in general were having records of supervision system, which is over 60% with the respondents view (HMCCP, MCHWs and SHPI's) ranging from 60.7 - to 85.7 and to 96.6 percent of respectively. Average practice of having records of supervision was found to be good in the Hill based SHPs, which is over 76 to 100 percent while in Terai, the practice ranges from 46.7 to 94 percent. (Table 5.9). All the MCHWs claimed that the suggestions and comments given by the

supervisors were being taken to HMC at the time of meeting.

However, the other forms of response claimed that the monitoring and evaluation system aspect was the weakest one in SHPs. It was found that most of the SHPs, who are nearby roads and easily accessible were supervised frequently than the others. The SHPIs responded that, to some extent, the ongoing conflict also had some negative impact to have timely and effective evaluation. In some places the supervisors just signed in the register without their comments.

Some valuable suggesstions came out of the respondents. HMCCP suggested that *"government should monitor the improvement of SHPs as MCHWs monitor the growth of the baby"*. They suggested forming an evaluation committee under DDC and delegate necessary authorities for monitoring and evaluation.

5.2.7 Human Resources Management (HRM)

a) Staff Vacant positions

In general SHPs have staffing of four persons[29]. Contrasting views came in terms of vacant staff positions in SHPs. Except in Banke, 33.3 percent SHPIs reported that they have staff vacant positions in their SHPs.

Districts	Reported by SHPI (N=30)	Reported by HMCCP (N=28)
	Yes n (%)	**Yes n (%)**
Kaski	2 (28)	1(14.3)
Banke	0	0
Kanchanpur	2 (100)	0
Jhapa	3 37.5)	2(28.6)
Lalit pur	3 (50)	0
Total	**10 (33.3)**	**3(10.7)**
Ecological Regions		
Hill	5 (38.4)	1(7.7)
Terai	5 (29.4)	2(13.3)
Total	**10 (33.3)**	**3(10.7)**
Areas		
Urban	7 (50)	2(16.7)
Rural	3 (19)	1(6.3)
Total	**10 (33.3)**	**3(10.7)**

Table 5.10: Vacant Staff Positions in SHPs

In contrast, only 10.7 percent of HMCCPs reported so. The positions not fulfilled were MCHWs and peons. In Kaski, 28 percent SHPIs reported that they have vacancy but in the same district the percentage of HMCCPs reporting the same matter was only 14.3 percent. In other district Kanchanpur, all SHPIs reported they have staff vacancy; however HMCCP did not report that. Therefore, except in Banke, the differing views came from these two groups of respondents (Table 5.10).

b) Appointment of staff using local resources

On an average 24.5 SHPIs reported that they appointed staff such as peons, Lab Assistant and ANMs using local resources whereas less percent of HMCCPs (21.4) reported the activity. The data were also differed by districts, regions and areas. By districts, except in Kaski, Banke, Lalitpur and Kanchanpur. In Jhapa 62 percent of SHPIs said they appointed staff using local resources while 57 percent HMCCPs saying the same case. Kaski and Banke districts did not appoint staff using local resources while others did. Following to the both groups of respondents view, staff appointment using local resources was found to be encouraging in the Terai and Urban areas compared to the Hills and Rural ones respectively. (Appendix 9)

Discussing about the HRM, contrasting views came out of SHPIs and HMCs. The issue of staff vacant position and appointment of staff is related to facts and figures and actual one, and hence does not relate to giving their perception. This clearly indicates that there is no proper coordination and

[29] The positions held in SHP are AHW, MCHWs, VHWs and Peon.

cooperation between HPIs and HMCCPs. Adding more, this also indicates that there is also information gap between these two personalities.

b) Staff professional development support

Almost all the DPHOs except the Kaski were found to be concerned to develop the professional competency of SHP health personnel. They were providing regular training such as infection control, family planning (MCHWs), Partner Define Quality (PDQ) and Community Based Maternal and Neonatal Care (CBNMC), Oral Health, CBIMCI and account management. However, in the case of Kaski no training were organised except the two days orientation training provided at the time of handover.

Almost all the field level respondents (HMCCPs, SHPIs and MCHWs) mentioned the business of health staff both in technical and administrative work. According to them, this has hindered them to provide timely and quality health services to their clients. Therefore, they suggest to have one more staff to look after all the administrative work.

5.2.8 SHPs effectiveness before and after handover

a) Patients flow rate

The data showed that there is mixed results in the patients flow rate[30] before and after handover; however the general trend was that there has been increased rate of patients after handover which ranges from 11.6 for Measles in Jahapa to 200 percent for attending trained Sudeni (trained birth attendants) in Lalitpur district. Looking at the decreased flow rate, it was noted that the rate ranges from -57 for attending trained Sudeni in Kaski to -1.7 for OPD services in Banke district. (Appendix 10)

By districts, in Lalitpur and Jhapa, the patients flow rate in all cases was found to be increased. In consrast the flow rate in Kanchanpur decreased in all cases except in getting family planning services, which showed 22 percent increases. The highest increased flow rate was observed in Lalitpur in attending trained Sudeni, which was 200 percent followed by the 146 percent increase in getting delivery services in the same district.

b) Health infrastructures and facilities

Though the data to compare availability of health infrastructures and facilities were not found, however, the present situation of SHPs showed that SHPs are trying to equip with required infrastructures and other health related facilities.

As shown by the data, (Appendix 11) the SHPs in Kanchanpur posesses required basic infrastructures and health facilities except electricity which was found to be available in 50 percent SHPs.

In general the SHPs having electricity facility ranges from 40 percent to 100. The lowest percentage was noted in Kanchanpur followed by Kaski and Banke (57.1%). The highest percentage was found in Jhapa with all SHPs having electricity followed by Lalitpur where an average of 66.7 percent SHPs have that facility. Similarly, the data on the availability of drinking water also ranged from 42.9 (Jhapa) to 00 percent (Kanchanpur. Generally speaking the SHPs did not have telephone facilities

[30] Patients flow rate was measured in different 10 cases. They were OPD, ANC/ PNC, DPT3, Measles, Delivery services, Family planning, Trained Sudeni, Diarrhoea, DOTs and STI/UTI.

except some SHPs of Jhapa and Lalitpur. The availability of toilet facility seems relative better one where over 83.3 percent were having toilets.

In addition, all the SHPs of Jhapa and Kanchanpur have put citizen charter. The names of the HMC members have been displayed in Kaski and Kanchanpur. Moreover, the SHPs having reference materials and graphic charts ranged from 83.3 to 100 and 85.7-100 percent. All SHPs had ICE/BCC materials except the SHPs of Kaski where an average of 85.7 percent SHPs had those materials. Majorities of SHPs also had waiting rooms for patients and if not some furniture were also managed for patients. Generally clients were found to be satisfied with that arrangement.

Communities have raised concern about the management and regular supply of drinking water. In general drinking water was readily available in SHPs especially in the Terai regions except in some SHPs of Banke (Puraini and Bhawanipur VDCs) where water pumps were stolen frequently. Most of the clients of the Hilly area were found to be facing water scarcity and some patients were bound to carry water to take medicine from their homes. Similarly, concerned were also raised about using the toilet facilities. Though most of the SHPs have toilet facilities, are locked at all the times and only used by staff. In some cases toilets were open but lack water.

c) Drug Supply and purchasing

Since four years, SHPs are getting NRs. 30,000 for medicine purchase. Only the medicines which were not available at district were being sent from central level. In the district, DPHO is supplying medicines. The amount of medicines being sent by central and district was 50:50.

In the fiscal year 2005/06, the average percentage of SHPs who purchased drug and other necessary equipments[31] stood at 83.3 percent while others not. In Kaski and Kanchanpur all SHPIs reported that they purchased drug in that year.

Districts	Yes n(%)	No n(%)
Kaski	7(100)	0
Banke	5(71.4)	2(28.6)
Kanchanpur	2(100)	0
Jhapa	6(75)	2(25)
Lalit pur	5(83.3)	1(16.7)
Total	25(83.3)	5(16.7)
Ecological region		
Hill	12(92.3)	1(7.7)
Terai	13(76.4)	4(23.6)
Total	25(83.3)	5(16.7)
Geographical area		
Urban	13(92.8)	1(7.2)
Rural	12(75)	4(25)
Total	25(83.3)	5(16.7)

Table 5.11: Drug purchase in this fiscal year

This was followed by Lalitpur where 85.3 percent SHPs reported the activity. The lowest percentage of SHPs purchasing drug was found in Banke where 71.4 percent SHPs did that activity. By region, drug purchase in the Hill based and Urban based SHPs was more than the Terai and the Rural ones (92.3 vs. 76.4 percent and 92.8 vs. 75 respectively). (Table 5.11)

c) Community Drug Programme

Regarding Community Drug Programme (CDP), this programme was introduced in 50 percent SHPs. By districts, all SHPs of Kaski and Kanchanpur had CDP in place followed by Banke where the figure was 85.7 percent. In Jhapa and Lalitpur, CDP was not found to be introduced till the survey date. By region and areas the data seemed different. For example the percentage of SHPs having CDP in the Hills is higher by 7.6 than that of the Terai, which are 46.2. Similarly, the ratio of SHPs having and not having CDP was 50:50. (Appendix 12)

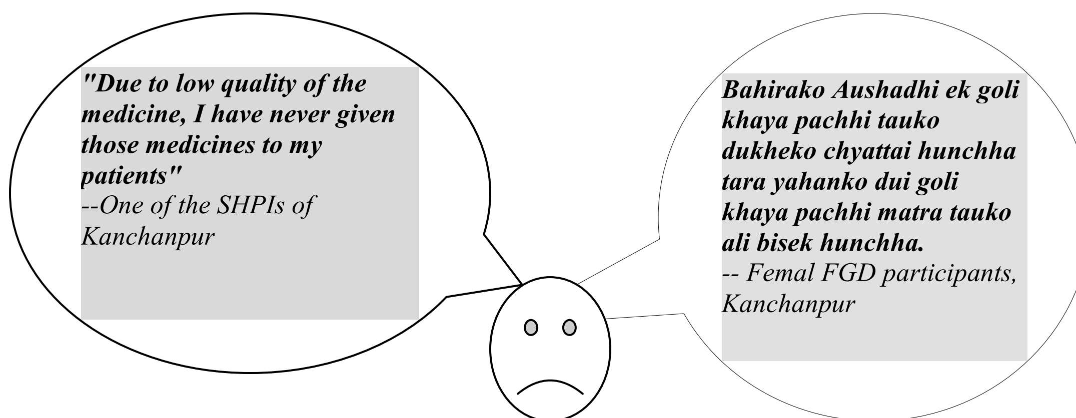
[31] The equipments and medicines purchased by SHPs were Citamol, Tetracycline, Albendazole, Metro, Amoxicillinn, Cortimoxazole, Antilargin, Brucet, Beta dine Solution, Vitamin B Complex, Fuel (Kerosene), Stationary, BP Set, Stethoscope, Gauze, Disposable Syringe, Weighting Machine etc.

d) Drug availability and client satisfaction

Majority of clients were found to be satisfied with the medicine distributed by SHPs. In general an average of 90 percent ECs reported that they were getting sufficient medicines in their each visits. 92.9 percent male respondent said that the drugs were available in their each visits while this in case of female ECs was less by 2.9 percent. By districts, all the male and female respondent of Jhapa mentioned the availability of drugs in their each visits while only the male respondent of Banke and Lalitpur said the same. The percentage of female respondent in later two districts saying availability of drug was 85.7 and 83.3 respectively. Under the drug availability Kanchanpur showed poor performance where the percentage of male and female saying drug availability was 50:50. In contrast, all the female of this district said the availability of drug. By region and areas, the availability of drug does not differ significantly in case of male respondent. However, according to the female respondent drug availability in Terai based SHPs were higher by 9.5 percent than that of the Hill ones which is 84.6. In the rural based SHPs, drug availability was higher by 11.4 percent than that of the urban ones, which were 78.6. (Appendix 13)

Majority of the MCHWs (75 percent) also mentioned that they were getting the medicines from DPHO to distribute the community in time. If they could not get medicines from DPHO, they also managed it from SHPs.

Questions were raised about the drug supply system by all categories of district and village level respondents. They complained about the drug supply system being late and of low quality. They strongly urged central authorities to stop sending such low quality drugs. The ECs also commented that not all the drugs were available in SHPs while some of them did not work. In such cases they purchased medicines from private clinics.



e) Service charge

SHPs were charging certain amount as registration and service charge. Registration fee in the SHPs was not same. They were charging minimum NRs 2 to maximum 5 per patient. For example Godawari SHP (urban Lalitpur) and Sarangkot SHP (Rural Kaski) were charging NRs 2 while Pitamber SHP (rural Kanchanpur) and Bhalam SHP (Urban Kaski) were found to be charging NRs 3. The remaining SHPs were charging NRs 5. Towards service charge, some of the SHPs (73 percent) reported that they were charging extra fee, for some services[32]. By district all SHPs in Jhapa and Kanchanpur charged fee followed by Kaski where the percentage was 71.4. The highest percentage of

[32] SHPs were found to be charging 10 for each of TT Vaccine and Depo-Provera, 20-30 for each of Dental check up and extraction and Stool and Urine test, 10-20 for Dressing, 20 for wound operation, 50 for Insulin test (sugar) and 100 for each case of Filling the Police report and Blood test. (Note: currency is all in NRs).

SHPs not charging fee was found in Lalitpur where the ratio of charging and not charging fee was 1:1. By areas, almost all SHPs charged fee for their services, which is 93.8 percentages. (Appendix 6). In most of the SHPs there was a provision of providing medicine in free of cost to poor and helpless people. This is exciting.

f) Staff support and behavior

Majority of ECs were satisfied with the behavior and good suggestions of health personnel. According to them health personnel were providing them sufficient instruction about spacing method and use of medicine. It was also found that MCHWs and VHWs regularly carried out home visits and provided medicines for pneumonia, diarrohoea and spacing method. At the same time they also imparted health education about nutrition, sanitation, family planning etc. FGD participants were most excited and praised the work done by FCHVs and they demanded FCHVs to get allowances for their allowances for their remarkable contribution in improving the health condition of the community. Some of the clients reported that they did not see staff visiting their homes. Majority of clients particularly female were not found to be satisfied regarding not maintaining privacy during the check up and demanded to have separate room for medical check up.

g) Office hours and staff availability

Majority of ECs and SMCMCCPs were not found to be satisfied towards the SHP's opening hours of 10AM to 4PM. However, some of them reported that presence of health personnel during this time was not regular. For example in SHPs there is provision of only one AHW. If he/she goes for training or leave, people had to return without medication. It is based on their experience.

i) Community Participation and local resource mobilisation

Following to the response of ECs, the data revealed that community participation in SHP improvement activities was very discouraging. Of the total female respondents, 76.6 percent (Table 5.12) reported that they did not have either form of participation in SHP improvement activities. Similarly, among the male respondents, 67.9 said that they also had no involvement in SHP improvement activities. The situation was found to be the worst in Kanchanpur district, where the participation of communities in the said activity was nil. The data seemed somewhat well off in Kaski and Banke where an average of 50 percent male said that they have involved in SHP improvement activities. Looking at the data by regions, it seems almost no difference than the average data of district, however by areas, male and female involvement was even worse by 23.8 and 7.8 percent than that of average of districts. Those who did not participate in SHP activities replied that nobody informed them to participate.

District	Male		Female	
	Yes n(%)	No n(%)	Yes n(%)	No n(%)
Kaski	3(50)	3(50)	2(28.6)	5(71.4)
Banke	3(50)	3(50)	2(16.7)	5(83.3)
Kanchanpur	0	2(100)	0	2(100)
Jhapa	2(25)	6(75)	2(25)	6(75)
Lalitur	1(16.7)	5(83.3)	1(16.7)	5(83.3)
Total	**9(32.1)**	**19(67.9)**	**7(23.3)**	**23(76.6)**
Ecological region(n)				
Hill	4(33.3)	8(66.7)	3(23)	10(77)
Terai	5(31.3)	11(68.7)	4(23.5)	13(76.5)
Total	**9(32.1)**	**19(67.9)**	**7(23.3)**	**23(76.6)**
Geographical area				
Urban	1(8.3)	11(91.7)	2(15.4)	11(84.6)
Rural	8(50)	8(50)	4(25)	12(75)
Total	**9(32.1)**	**19(67.9)**	**7(23.3)**	**23(76.6)**

Table 5.12: Community participation in SHP's improvement

> "*Paisa navayara gharko chhano ta ferna sakiyako chhaina, swanthya chhauki lai ke le sahayog garne?*
> *** FGD participant, Kanchanpur*

Resource mobilisation is very important aspect in order to make SHPs effective and also to extend and advance their services. However, the data that came out of SHPIs response revealed that an average of 60 percent SHPs did not see any possibility of local resource mobilisation to increase the income of SHPs. In Banke, SHPIs mentioned that they see no possibility to mobilise resources followed by Kaski where average of 71.5 SHPs said they had no possibility. In contrast some encouraging response came from SHPIs of Jhapa with 87.5 SHPIs saying possibilities to do this activity. (Appendix 14). By areas, urban based SHPs see less possibility (71.5) compared to Rural ones (50) for local resource generation. In line with the central level KIs response, SHPs capacities need to be built to mobilise local resources more effectively and efficiently before going to full devolution process. For the effective implementation of decentralisation, the SHPIs suggested to empower VDCs and make communities clear about their roles and responsibilities.

The other issue associated with the community participation is effective functioning of HMC. We found that HMCs were not able to mobilise the community properly. The main cause behind this we found was the displacement of influential people who could actually provide leadership to the community. Inactiveness of the committee and lack of concern and commitment for the improvement the health facility was other cause behind this. The other cause of this could be I/NGOs have made people money oriented by providing the incentives against their participation without which people do not want to come and attend the meetings. For example one of the MCHW of Banke district mentioned that , when she asked a mother to participate in the mothers group meetings, the mother asked with her ***"Kuchh Milega ki nahi?"***[33]

The KIs also identified other issue related to the VDC development grant. As provisioned by the Act, each year each VDC gets 5 lakhs development grant, of which 5 percent can be allocated to health sector. Firstly, VDCs were not able to spend all the money allocated to them, and the issue of allocating 5 percent grants was not observed. Under the current governments policy arrangement its has provisioned the MoHP to provide medicines and health equipments, MoLD to build required infrastructures, DDC to allocate 10 percent of total budget to SHPs, VDCs to allocate 5% of total budget and community to collect 5% amount through in kind or cash support. Overall it looks good, if happened, probably SHPs overcome almost all the problems they are facing.

5.2.9 Overall changes after handover

In general there has been some changes in the functioning of SHPs after handover. Though data to compare all parameters were not available, where possible the changes have been compared with the available ones. A comparative table below presents with the perceived responses of the respondents in terms of changes in SHPs.

> *"If people don't know about SHPs being handed over to the communities to own it, what comments they give about handover and subsequent changes?"*
> *** DPHO Kaski*

In general the KIs put three different views. Few of them said community participation in SHPs' activities was increased as of before since they are more concerned to improve and utilize health services, taking ownership. In contrast few KIs said there has been no change as of earlier due to low level of educational status and awareness.
The other response was in between of these diverse ones saying that participation and ownership is developing slowly and takes some more time. In particular the responses can be summarised as follows:

[33] This means "shall I get some incentive or not?"

<table>
<tr><th colspan="2">Respondents' view</th></tr>
<tr><th>Before Handover</th><th>After handover</th></tr>
<tr><td>SHP staff were like spoiled child

SHP staff did not behave properly to the clients because they were not able to mingle with the people due to their superiority feeling being a 'government employee'.

SHPs were providing limited health services

'SHPs' and 'Communities' were operating in an environment of isolation</td><td>➢ Positive attitude of staff
➢ Staff punctuality and their regularly
➢ Staff creativity, capability and activeness improved
➢ Frequency of health staff visiting field increased
➢ Communities were positive towards the services provided by SHPs.
➢ Extension of health services such as lab facility, dental services and family planning
➢ People who used to go to private clinics now come to SHPs
➢ Increased assistance of NGOs to construct buildings
➢ Effective cooperation between SHPs and local organisation to improve health services
➢ Harmonious relationship between SHP staff and the community
➢ Financial transparency and to some extent local resource mobilisation improved</td></tr>
<tr><td rowspan="2">People did not care about SHP activities</td><td>➢ Communities' ownership towards SHPs increased.
➢ Community was acting as 'watch dog' in SHP affairs
➢ Positive attitude of communities towards SHPs
➢ The physical facility especially the building were constructed
➢ Increased participation in SHPs' activities
➢ Awareness on health issues and service utilisation increased
➢ Drug availability improved
➢ No difference has been observed except the usual business of SHPs.
➢ The level of community participation seems to be very low due to inactiveness of committee members.
➢ No changes in financial, human resource management, in local resource mobilisation part
➢ There is no change as of earlier</td></tr>
<tr><td>➢ Lack of faith towards SHPs health services
➢ Almost defunct HMC
➢ Nepotism of committee when appointing FCHVs
➢ Political misunderstanding between committee members
➢ High registration fee and lack of medicines
➢ Unavailability of extra rooms, furnitures and necessary equipments
➢ No proper implementation of decentralisation as per the intended goals and objectives
➢ Long and delayed process of budget allocation and transfer</td></tr>
</table>

(For respondent wise opinion please see Appendix 15)

5.2.10 Suggestions for the SHPs improvements

Towards macro policy:

- Many respondents outlined that policy on paper does not work rather it needs to be outworked. It should not be limited within few seminars or workshops. For the proper policy implementation we must be accountable in our word, proving worthy of it by work. It requires readyness to develop policies and uphold the power and authorities preserved by senior government officials.

- The study showed that the SHPs and its MC members now are in big dilemmas that what should they do and what should not. If they follow the act, they are not fully authorised and DPHO and Central health body may not cooperate. If don't follow, they have given something to do, which is almost meaningless. Therefore, for the long-term sustainability of SHPs, they need to be fully devoluted giving all the responsibility and authority of HRM and financing system. The centre should remain as policy making and monitoring body, and administering the important drug and vaccines.

- The other thing is structural adjustment and arrangement of central level mechanism. Apart from MoHP, concerned line ministries role did not seem much effective. In the district, it is the DDC that should be make most powerful in terms of dealing with decentralisation issues, hence bringing all the government wings under it. It is the DDC, the representative of people, need to administer and deal the health service decentralisation matters.

Staffing and office time:
- Staff must be regular and on duty during office hours.

Micros policise and management related:
- The role of DDC, DPHO and VDC need to be clarified in a precised manner.
- Before handing over SHPs to the communities, they need to be fully equipped both physically and financially. Even after handover, government should not pull its hands in the name of handover. Handover should be driven on voluntary and demand basis rather being mandatory and supply basis.
- The provision of sending budget and medicines is not scientific one. It should consider the SHP coverage, ecology, population and nature of endemic diseases. Current form of blanket policy and quota system does not address the real problem.
- To the date, SHPs were staffed of four persons. The village level KIs saw these posts insufficient needing more and senior staff i.e. Health Assistants and staff for CDP. In addition, SHPs were facing difficulties to provide effective health services due to lack of administrative manpower. They suggested having one extra person to do all the administrative work in the SHPs.
- It would have been greater impact if government could arrange visits of a specialist specially Gynecologist once in the month which would benefit most of the rural women. In addition, government needs to consider implementing Safer Motherhood, Pediatric and ENT services at SHP level.
- Timely supply of medicines and of good qualities having enough time to expire.
- Now the government is providing some information through television ***"Sewa Gare Mewa Painchha".*** Better to include some HMC information through that programme.
- Package training to HMCs rather one or two event off orientation.
- If possible the office hours need to be extended from current six hours (10AM-4PM) to more hours (as possible) since health is very sensitive and urgent issue. AHWs should have residential facility within the compound of SHP so that even after office time and under emergency cases, people could get health services.
- Provision of some allowances for FCHVs and TBAs would encourage them to perform better.
- Transportation facility for staff when they carry out field visits.

SHP service related:

- Physical facility in SHPs. For example having a separate for safe delivery in a confidential way. This room could be used for ANC/PNC check up and insertion of spacing methods.
- SHPs need to consider free of treatment to poor, disable and helpless people. Registration fee need to be waved off. In addition, communities cannot pay the cost of lab test that also need to be minimised.

Others:

- Health education and community mobilisation need to be considered as two essential pillars of current decentralisation policy.
- Training need to be provided to communities to make them capable to operate the handed over health facilities.

5.2.11 Effect of conflict

The ongoing conflict had very negatively affected the proper decentralisation process and effective functioning of SHPs. Majority of HMCCPs (60.71 percent) mentioned that the ongoing conflict negatively affected the service delivery and operation of SHPs. SHPIs, to some extent also agree with the Chairpersons' perception where 50 percent of them said the same. In contrast, a majority of MCHWs (67.85 percent) mentioned that there is no such direct effect of conflict in the service delivery of SHPs, but others said there are certainly some effects. Generally it was the village level respondents view that conflict did not affect much in health sector as that negatively affected the other ones. Broadly the impact of conflict can be summarised as follows:

Negative impacts:

- The effect of conflict did not merely impact the proper functioning of SHPs rather it impacted in multiple ways. The first and foremost important aspect was that there could not be local elections of VDCs, where, it is as provisioned by the Act, VDC Chairpersons are the key person for the overall functioning of SHPs. The elected VDC representatives being representing their people, of course take ownership of the work and are very much concerned for the overall health improvement of their people. Expecting the same outcome from VDC Secretaries as a chairperson of HMC, who are not only the civil servants but also outside persons, is mammoth ill-understanding.
- The other impact was that the VDC Secretaries, who are the mandatory In-charge of HMC, could not stay in their working VDCs. As expressed by them, they stayed mostly in general and all the times in particular in district HQs.
- Conflict also had its impact on psychological aspects of both staff and patients. It ranged from minor mental tension to explosion of SHP building (Kakadvitta, Jhapa). Besides, there was decreased patient flow.
- In some SHPs Maoist took medicines. This resulted patients not getting medicines immediately after check up. Besides, Maoists also asked for financial contribution.
- Frequent imposition of *"Bandas and Curfews"* denied free movement of staff for SHPs business. However, the effect was lesser in rural areas compared to urban ones.
- Except in Kaski, there were no reported cases of physical torture to the health staff during home visits and running health clinics. However, the staff always traveled with a fear that anything could happen at any time to them. In Kaski, some health personnel were found to be taken into custody by the security forces while implementing programmes during *banda* and *corfew*.

Positive impacts:

- Conflict has also some positive impacts too. As mentioned by one of the central level KIs, the conflict had positively impacted the functioning of SHPs. For example Maoist came and looked

at the records of transactions of medicines and money which helped to keep up to date records, maintain transparency and improve service utilisation.

5.2.12 Onsite observation of SHPs

Besides having in-depth interviews, FGD and other means of data collection, we also visited particular 30 SHP sites and had observation on the spot. The findings of the observation have been presented in the box below:

A. Infrastructures and facilities

Generally speaking all SHPs in all the districts had their own buildings except Godawari SHP in Lalitpur and Belbhar and Chisapani SHPs of Banke. It was found that one SHP, Satasidham, Jhapa was renting its building to VDC getting NRs 2,200 per month while it had rented others house for office use paying NRs 2,700. Among the SHPs, the Damak was found to be richest in terms of having more number of buildings. It had six buildings of which one was rented by an NGO, AMDA-Nepal paying NRs 8,500 per month.

Almost all the SHPs of Kanchanpur had drinking water, toilet and sitting facilities. Most of the SHPs of Jhapa and Banke had drinking water facility while least had toilet facilities. In Bhawaniyapur SHP the toilet was found to be locked and it was provisioned only for the use of staff. Water scarcity and toilet being dirty was observed in Lalitpur. The SHPs of Kaski lacked needed furniture. Damak and Dangibari SHPs of Jhapa and Jhalari SHP of Kanchanpur had lab facility where as we could not see lab facility in case of other SHPs in other districts

B. Citizen charter and display of materials

Of the SHPs, we found citizen charter displayed well mentioning available facilities, rate and time in detail only in Jhalari SHP of Kanchanpur. Majority of SHPs had displayed boards on Staff, HMC members and FCHVs name. IEC/BCC materials were also found to be properly displayed on the wall in Jhapa and Jhalari SHP of Kanchanpur. In the other SHPs, they were displayed improperly.

C. Patients flow rate

In Kanchanpur, particularly in Jhalhari SHP, we recorded a very good patients flow rate. We observed 35 patients; 15 women coming for treatment on 7th Jestha, 2063. In contrast, the number of patients were nil for three consequtive days in Belbhar SHP in Banke. People explained that it was due the presence of teaching and other hospitals in Kohalpur and Nepalgunj. The other reason was being a mission hospital in neighbouring country India where patients get treatment in cheaper rates and with free medicine. In Lalitpur, we noticed a less number of patients coming in the SHPs on the day of our visit.

D. Staff and their behavior

Staff were found to be busy in most of the SHPs where as in some SHPs, they were idle because of the no clients coming in. They were dealing with the staff more politely giving suggestions and medication.

In one of the SHPs (Lamachaur) of Kaski MCHWs were not regular on their work while they were in leave in other two SHPs (Sarangkot and Hemja)

E. Coordination and linkages

In Jhapa district, most of the SHPs were having good linkage with different organisations. In general they had established linkage with UNHCR for building construction, with Save the Children for safer motherhood and child health, Women Development Association and NFHP for family planning and SAHARA-Nepal for FCHVs training. In Banke, Plan International was supporting NRs 500,000 to construct building for Belbhar SHP. In Kanchanpur CARE-Nepal was providing half of the salary of lab assistant of Jhalari SHP.

F. HMC meetings

In general SMC meeting were not held as schedules and regularly. Generally HMC had following agenda: to organise community awareness programme for vaccination, DOTs and vitamin A programme, purchase of medicine, fulfilling staff positions, increasing the registration fee, to form DOTs awareness committee and raise awareness, to form mothers group, building construction etc.

G. Effect of conflict

Physically, we did not notice any negative impact of ongoing conflict towards SHPs. However, in one SHP, Kakadvitta, Jhapa, the building was found to destroyed. According to SHP staff and local people, it was

destroyed by Maoist by planting a bomb inside the building.

5.2.13 Issues, challenges and prospects

a) Issues

- It was mentioned that the hand over process was not satisfactory in many ways. Firstly it was an uninformed one doing things at district level. Therefore, most of the lay people did not know about the process and content. In fact it was not handed over to communities but to the some local elites. One of the SHP Incharges in Banke ridiculed that *"Jasko biha, usailai thaha nadiya."*[34] Under this situation, how can we expect communities to come and participate in the SHP improvement activities and take ownership of the work?

- OF the SHPs who could not prepare plans mentioned that due to lack of budget and absence of elected LBs, some SHPs could not prepare plans to improve health service delivery of SHPs.

- The data revealed that 50-60 per cent SHPs have formulated annual or long term plans to extend and improve the health services. However, they are unable to carry out those plans due to budgetary constraints.

- From the above analysis it can be easily revealed that a great majority of ECs, say communities, were not aware about the handover process and they were not included. If we overlook this great masses of people to who the programme is designed and target, how SHPs could work effectively? This is a big question mark for us.

- Confusion about functional clarity of NHTC and Management division was clearly expressed by KIs. Respondents at central level pointed out that there exists power exercise and red tapism in terms of who should take the responsibility of SHP hand over, thereby to consume resources that came in the name of health services decentralisation.

b) Challenges:

- Under the ongoing conflict situation one can never expect desired changes as expected by policy makers in the functioning of SHPs. As expressed by the respondents the conflict affected decentralisation in many ways. For example the local elections could not be held on time, administrative and policy confusion at central level due to lack of people's government and the security situation not favoring VDC secretaries to stay in their working locations.

c) Prospects

In the context of current decentralised system, the accomplishments to the date, responses from the audiences and overall country's political scenario, following prospects have been visualised:

- It seems that SHPs are now concentrating their effort to provide curative services but they should also carry out preventive activities to make the people aware about health. For example peoples' suffering from malnutrition may be due to lack of food, perhaps it could be lack of knowledge about food selection and preparation.
- All categories of respondents realised that the information flow was not in an appropriate manner. Also they expressed that it must happen as far as possible. Communities were also found eager to

[34] This means "Bride or Groom him/her self not informed about the marriage"

take over the responsibilities. What they need is information and awareness. If this could be done in a precised manner, there is high possibility that whole rational of decentralisation will get a momentum to fulfill its intended goals.

- The election of LBs and resuming their roles. Since they are people's representatives and therefore are very much concerned with the overall health status of their people.
- The health service utilisation patter has been found ever increasing. This indicates that communities are becoming aware in health issues and therefore taking interest in SHP activities.
- Punctuality and commitment of SHP staff has found to be improved. This indicates their greater motivation to serve the rural and poor communities.
- In many instances, non-government entities were found to be supporting the decentralisation intervention. This can be institutionalise through the public-private partnership with some policy mechanisms.
- Documenting and disseminating the best practices, lessons learned and experiences to the wider community through a organised and institutionalised information dissemination process.

As such, decentralisation of health services would be an effective way to functionalise the system. If the local people are themselves made responsible and accountable to plan, implement and supervision of health services with the financial and technical backstopping from the government, it can be expected that a functional system will be developed and institutionalised in a sustainable way.

Finally there exists a great potentiality of improving health sector if we could establish a functional system. Whatever problems exist now are some how related with the conflict. The conflict, in many, has become, an excuse for people not doing the activity or not delegating the power. It has been said that and we also observed that not only the micro level but also the state machinery as a whole has become ill functioning. When the country will get a way out to the current political instability, hopefully there will be peace that will open many windows and of course it will have greater positive impact in health sector supporting decentralisation in a complete devolution.

CHAPTER SIX

CONCLUSIONS AND RECOMMENDATIONS

6.1 Conclusions

All categories of respondents and SHP stakeholders found positive towards the current effort of government in decentralising its health services to local communities and emphasized the need of decentralized management of health services. The finding of in-depth interviews, FGD and KIs coupled with literature review of the various documents and on site observation proved the same information. However, this has also many weaknesses. Such weaknesses were found to be related with policy, process and most importantly with the mentality shift. Because policy and process shift does not have greater impact in action rather the mentality shift has.

Most importantly, the effort of government to decentralise its health services to local communities is most exciting and encouraging thing. However, it is useless unless there are local elected bodies, and 'core stakeholder'; the community, is not well informed and does not take ownership of the entire work. In order to exploit the potentials of the decentralisation in a full manner, the government, in particular the MoHP, should document the impacts to date, learn from its experience and must demonstrate commitment to decentralisation endeavors.

Finally, looking at the decentralization theory, where we pointed out three levels of actors for the quality service delivery, it is our overall conclusion that the role at managerial level were found to be somewhat functioning. Generally speaking there was a renewed commitment to make some policies, however at the other levels, it was generally found weak. The health workers were not committed and motivated, HFs lack required necessities, and there was no proper mechanism for staff professional development. Supply systems have always suffered from weak management. At the client level, very less amount of work was done to improve their service utilization part.

6.2 Recommendations

In light of the findings confirmed by both field level data and literature reviews, the following recommendations have been visualised:

1. The LSGA 1999 has been taken as a major basis for health service decentralisation in Nepal. It is true that it gives an overall framework and implicit background for the decentralisation of health services, however does not more explicitly mentions for health sector. On the other hand the findings of both literature and field confirmed that current form of decentralisation looks like a deconcentration rather being a complete devolution. Therefore, MoHP in collaboration with other ministries such as MLD, and Ministry of Finance (MOF), and Ministry of Law and Justice (MoLJ) should take initiation to enact a separate act or regulation for the complete devolution of health care facilities in Nepal. Appropriate organizational and management structure are required in order to ensure that the revised policy framework is effectively implemented.

2. The SHPs hand over policy should not be implemented in a '*blanket*' form in terms to fulfilling annual or periodic targets. In order to make hand over more result oriented MoHP should develop only a broad guideline and the detail working out authority could be handed over to local authorities. The DDC, DPHO, VDC and other stakeholders can sit together and prepare a localised guideline by reflecting their specific situation.

3. The presence of elected LBs is crucial for the effective implementation of hand over and operation process. However, it was also observed that there was no seriousness in driving the process by internalising the norms of decentralisation. MoHP must take this factor into account.

According to the policy, HFs are to be handed over to LBs. If there are no LBs to whom to hand over?

4. A two-day orientation to VDCs and HMC was found to be ineffective and very short in order to build the capacity of concerned stakeholders. In addition, the main stakeholders, the community, were overlooked in the entire process. Therefore, it needs a 'package' rather than one or two time off training/orientation. The package must have the good mix of both managerial and technical competencies needed for the overall management of SHPs. Parallely, there must be provision for sensitizing communities.

5. Current composition of HMC is some what in inclusive across sectors, class and caste. In order to make it as inclusive as possible, there must be room to include local NGOs, since government's tenth plan and LSGA has recognised them as one of the development partners in the overall development process. In addition other social development entities and religious and influencing leaders need to be included.

6. The data confirmed that the *"hand over"* process overtook the *"take over"* process. LBs and HMCs were not ready to take all the functions both conceptually and practically. Security situation was not sufficient enough to take this process forward in many areas. However, in some areas the situation was favorable, and the hand over process took momentum without considering these factors. Therefore, a handover process should go ahead by analysing the specific conditions of the particular location/health facility.

7. It was found that SHPs were having huge financial problems. Local resources were not identified and mobilised. It is said that decentralisation heavily rests on mobilisation of local resources but never outlined what are the resources to be mobilised and how locals can do this. Therefore, SHPs, until they become self-sustaining, they should be trained on how to generate resources at local level.

8. There was limited authority handed over to HMCs. It has raised a lot of issues about who governs the SHP. Is that DPHO or Centre or HMC? If it is HMC, than why can't they approve leave and handle budget or deal with staff transfer issues? Under a current arrangement, can the SHP staff be responsible to HMC since they are civil servants who have secured permanent job. Even the court can't do anything for them, expecting them to be accountable to HMC or VDC is just like an illusion. This can be a small issue but has huge impact. Therefore, there should be a clear-cut policy for leave management and performance appraisal with a clear job description mentioning the supervisory roles.

9. Each and every sanctioned position of the SHPs should have to be fulfilled with an appropriate plans and policies. When having provision of staff it should not be equal rather need to be based on the size of the population, occurrence of diseases, geo-structure etc. In addition, in the SHPs where there was no or less patient flow or in the areas where there are teaching/government/private hospitals, the possibility of closing down the SHPs or downsizing the staff and resources need to be actively sought. In turn, the resources could be diverted into needy and the rural, areas.

10. The HMC does not have autonomy and the roles of centre and district were confusing. Under this circumstance, DPHO can do technical supervision, management related things can be dealt by VDCs and centre can administer the quality standards.

11. Current practice of budget flow system is that it flows from DDC-DPHO-VDC and finally to SHP. Questions have been raised about this system being lengthy and needing a lots of administrative work. Therefore, budget should directly go from DDC to VDCs. DPHO can get required information from DDC, there will be inline with the LSGA as it aims that all the development agencies should function under the umbrella of DDC.

12. Talking about the human resource management, contrasting views came out of SHPIs and HMCs. The issue of staff vacant position and appointment of staff is related to facts and figures and actual one and hence does not relate to giving their perception. This clearly indicates that there is no proper coordination, cooperation between these two positions. Adding more, there was also information gap between these positions. This may be due to their 'difference in protocols' SHPIs being higher in portfolios than the VDC secretaries. A different option for managing such SHPs, for example appointing a Area Manager or Coordinator, thereby putting 3-5 SHPs under his/her supervision, and s/he being supervised by Ilaka member of DDC may work better.

13. Local resource mobilisation is very important aspect in order to make SHPs effective and also to extend and advance their services. However, the data that came out of SHPIs response revealed that an average of 60 percent SHPs did not see possibility of resource mobilisation. One of the outlined assumption of the decentralisation is to identify and mobilise local resources, however the attitude of SHPIs have not changed yet. This might be because of two reasons. Firstly, their capacities are not sufficiently built on how to identify and mobilise resources. The other thing is how the policy level people have thought of this issue. Because this is not merely ordering local level staff to identify and mobilise resources but also giving them a package as well. Secondly this issue is associated with the attitude of both staff and management. If they own the SHP in real sense, there must possess mentality shift committing for decentralisation.

14. It was mentioned by KIs that at policy level, there has been arrangement for SHP resourcing. The MoHP to provide medicines and health equipments, MoLD to build required infrastructures, DDC to allocate 10 percent of total budget to SHPs, VDCs to allocate 5% of total budget and community to collect 5% amount through in kind or cash support. Overall it looks good, however it is not happening. Therefore, there must be strong mechanism to look at whether the policies really came out of paper or not.

15. Service fee was in practice in the name of CDP. On the one hand it is good that the services are available at local level. On the other hand it shadows the affordability of health services. In many instances locals expressed that the fee rate is bit higher one. Therefore, the charge should be set according to the ability of local people, perhaps would be good if the communities themselves decide on this. When deciding rates, SHPs should give proper attention to women, marginalised and disable people so that they will not be excluded from the service provision.

16. Respondents raised the issue of maintaining privacy in SHPs. Health check up of pregnancy cases can not be possible in common room or in store room. SHPs need to allocate or should make provision for separate room to deal with pregnancy cases. In this case MOHP should have a revised policy with regards to the standard of SHP/health facilities.

17. Visiting health professionals. Majority of respondents have requested to arrange visiting specialists such as Gynecologists at different intervals of time. MoHP and other district level key people should seek the possibility of arranging such visits.

18. There was a strong opinion that the SHPs should remain open generally for more hours. Therefore, this time should be fixed in participation with communities analysing the pros and cons, therefore communities reach into a consensus decision.

19. Almost all field level respondents questioned the delaying drug supply system and quality of drugs. The mater of drug is very central and key to the patients from which they are supposed to be cured. One in either circumstance cannot take this issue lightly since it carries the overall weightage of medical science. Therefore, MoHP should assess the current drug supply system, the suppliers and distributors and track the supply routine so that the good quality medicine reaches to the SHPs on time.

20. In general, regarding the decentralized management of health facilities, it is recommended therefore that a high-powered decentralisation Technical Committee is established in MoHP, which has overall responsibility for decentralisation of HFs management programme throughout the country. The secretary of MoHP should chair the Committee and its member should be drawn from senior management in all the key divisions in the ministry (in particular DoHS). Representatives from I/NGOs involved in health services and support activities, and other key ministries such as Ministry of Local Development, Finance, General Administration, etc. should also be involved to sit on this Committee.

21. The success of the decentralisation of health facilities strategy depends critically on a coordinated multicultural approach to both handover and takeover process. It is essential therefore that all the decentralisation activities in the MoHP are carefully coordinated with the activities of other key organizations at both the national, district and village level. In particular, MoHP staff should actively participate in HFs dcecentralisation activities. It is essential therefore that a full time Coordinator for HFs decentralisation is appointed. He/She should report directly to the Secretary of MoHP and the Technical Committee.

22. Much will also depend on the commitment of DHOs, LDOs and LBs. As a first step, it is very important that they are briefed about the main findings and recommendations of this evaluation study. It is recommended therefore that a three-day workshop for all the DHOs and LDOs is organized to meet the KAP Gap. In the mean time, an action plan for the further planning should be developed.

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APPENDICES

Appendix 1: Age/ Gender, Education, Occupation and Ethnicity of FGD Participants

Characteristics of FGD Participants		Male		Female		Total	
		No.	%	No	%	No.	%
Age group:	Below 20	11	11.6	12	12.6	23	12.2
	20-30	25	27.2	39	41.1	64	34.2
	30-40	17	18.5	21	22.1	38	20.3
	40-50	14	15.2	10	10.5	24	12.8
	50-60	14	15.2	8	8.3	22	11.8
	60-70	9	9.8	2	21	11	5.8
	70-80	2	2.2	1	1.1	3	1.6
	Above 80	0	0	2	2.1	2	1.7
	Total	**92**	**100**	**95**	**100**	**187**	**100**
Education:	Illiterate	0	0	6	6.3	6	3.2
	Just literate	44	47.8	69	72.6	113	60.4
	SLC	19	20.7	11	11.6	30	16
	Intermediate	16	17.4	8	8.4	24	12.9
	Bachelor	12	13	1	1.1	13	7
	Degree	1	1.1	0	0	1	0.5
	Total	**92**	**100**	**95**	**100**	**187**	
Occupation:	Agri	42	45.6	44	46.3	86	45.9
	Teacher	11	11.6	3	3.1	14	7.5
	Student	17	18.5	13	13.6	30	16
	Office employee	8	8.6	3	3.6	11	5.88
	Business man	9	10.8	7	7.4	16	8.55
	Labour	2	2.17	0	0	2	1.06
	Housewife	0	0	22	23	22	11.76
	Volunteer	3	3.2	3	3.1	6	3.2
	Total	**92**	**100**	**95**	**100**	**187**	**100**
Ethnic Group	Kshetri	43	46.7	21	22.1	58	34.2
	Brahman	31	33.7	30	31.6	61	32.6
	Newar	3	3.3	13	13.7	16	8.5
	Dalit	7	7.6	20	21	27	14.4
	Janajati	3	3.2	4	5.2	7	3.7
	Tharu	3	3.3	6	6.3	9	4.81
	Thakuri	4	4.3	2	2.1	6	3.2
	Others	2	2.1	1	1.1	3	1.6
	Total	**92**	**100**	**95**	**100**	**187**	**100**

Appendix 2: Samples by Districts, Ecological Regions, RU Settings, SHP and Respondents

District	SHP	Rural& Urban Settings	Hill & Terai	Respondents						
				Incharge	HMC chairman	MCHW/ FCHV	Exit clients	KIs	LDOs	DPHOs
Jhapa	Kakarvitta	U	T	1	1	1	2	2	**1**	**1**
,,	Garamani	U	T	1	1	1	2	2		
,,	Dhauladubba	R	T	1	1	1	2	2		
,,	Dhaijan	R	T	1	1	1	2	2		
,,	Dangibari	R	T	1	1	1	2	2		
,,	Charpane	R	T	1	1	1	2	2		
,,	Satasidham	U	T	1	1	1	2	2		
,,	Damak	U	T	1	-	1	2	1		
Lalitpur	Bishankhunarayan	R	H	1	1	1	2	2	**1**	**1**
,,	Jharuwarasi	R	H	1	1	1	2	2		
,,	Chapagaun	U	H	1	1	1	2	2		
,,	Khokana	U	H	1	1	1	2	2		
,,	Champi	R	H	1	1	1	2	2		
,,	Godawari	U	H	1	1	1	2	2		
Kaski	Lumle	R	H	1	1	1	2	2	**1**	**1**
,,	Nirmal Pokhari	R	H	1	1	1	2	2		
,,	Sarangkot	R	H	1	1	1	2	2		
,,	Lama Chour	U	H	1	1	1	1	2		
,,	Hemja	U	H	1	1	1	2	2		
,,	Rakhi	U	H	1	1	1	2	2		
,,	Bhalam	R	H	1	1	1	2	2		
Banke	Mahadevpuri	R	T	1	1	1	2	2	**1**	**1**
,,	Rajhena	U	T	1	1	-	2	2		
,,	Chisapani	R	T	1	1	1	2	2		
,,	Puraini	R	T	1	1	1	2	1		
,,	Belbhar	U	T	1	1	1	2	2		
,,	Bhawaniyapur	R	T	1	1	1	2	1		
,,	Khajura Khurda	U	T	1	1	-	1	2		
Kanchanpur	Jhalari	U	T	1	1	1	2	2	**1**	**1**
,,	Pitambar	R	T	1	-	1	2	2		
			Total	30	28	28	58	57	**5**	**5**

Appendix 3: Status of existing and decentralized health facilities in Nepal (2059/60–2081/62 BS)

Development Region	S. N.	District	Existing No. of HFs In Nepal			HFs Handed Over in 2059/2060			HFs Handed Over in 2060/2061			HFs Handed Over in 2061/2062		
			SHP	HP	PHC	SHP	HP	PHC	SHP	HP	PHC	SHP	HP	PHC
EASTERN	1	Ilam	38	7	3	-	-	-	38	2	-	-	5	3
	2	**Jhapa**	**38**	**7**	**5**	**38**	**-**	**-**	**-**	**2**	**1**	**-**	**5**	**4**
	3	Morang	49	11	6	49	-	-	-	-	1	-	11	5
	4	Sunsari	40	7	5	40	-	-	-	2	1	-	5	4
	5	Saptari	103	9	4	-	-	-	103	-	-	-	9	4
	6	Siraha	93	12	3	-	-	-	93	-	-	-	12	3
CENTRAL	7	Dhanusha	88	9	5	-	-	-	88	-	-	-	9	5
	8	Bhaktapur	12	7	2	9	-	-	3	2	1	-	5	1
	9	Chitwan	32	6	3	31	-	-	1	-	1	-	6	2
	10	Sarlahi	84	10	5	-	-	-	84	-	-	-	10	4
	11	**Lalitpur**	**29**	**9**	**3**	**29**	**-**	**-**	**-**	**2**	**1**	**-**	**7**	**3**
	12	Mahottari	67	6	3	67	-	-	-	2	-	-	4	3
	13	Rautahat	85	8	4	-	-	-	-	-	-	85	8	4
	14	RASUWA	9	8	1	-	-	-	-	-	-	9	8	1
WESTERN	15	Tanahu	31	13	2	-	-	-	31	-	-	-	13	2
	16	Nawalparasi	63	8	5	-	-	-	63	-	-	-	8	5
	17	Palpa	53	9	3	-	-	-	53	-	-	-	9	3
	18	Rupandehi	58	7	4	58	-	-	-	-	-	-	7	4
	19	Kapilvastu	68	7	2	68	-	-	-	2	1	-	5	1
	20	**Kaski**	**34**	**12**	**2**	**34**	**-**	**-**	**-**	**-**	**-**	**-**	**12**	**2**
MID WESTERN	21	Surkhet	39	9	3	-	-	-	39	-	-	-	9	3
	22	Dang	26	11	3	-	-	-	26	-	-	-	11	3
	23	Bardia	22	8	3	-	-	-	22	-	-	-	8	3
	24	**Banke**	**35**	**10**	**2**	**35**	**-**	**-**	**-**	**2**	**1**	**-**	**8**	**1**
FAR WESTERN	25	Kailali	30	8	5	-	-	-	30	-	-	-	8	5
	26	Dadeldhura	15	11	1	-	-	-	15	-	-	-	11	1
	27	**Kanchanp-ur**	**10**	**8**	**3**	**10**	**-**	**-**	**-**	**2**	**1**	**-**	**6**	**2**
		Total	**1251**	**237**	**90**	**468**	**-**	**-**	**689**	**18**	**9**	**94**	**219**	**81**
		All Total	**1578**											

Source: Ministry of Health and Population, 2061/062

Appendix 4: Name List of Key Informants (KIs)

Name list of the Key Informants at Centre level

S. No.	Name	Designation	Related Office
1	Mr. Kedar Neupane	Under Secretary	Ministry of Local Development, Pulchowk
2	Mr. Gyanendra Kumar Shrestha	Program Director	National Planning Commission, Singhadurbars
3	Mr. Rishi Ram Khadka	Section Officer	NHTC, Dohs, MoHP, Teku
4	Mr. Bhim Prasad Dhungana	General Secretary	National Association of VDCs
5	Mr. Ramji Dhakal	Deputy Prog. Manager	Health Sector Support Programm, GTZ,Teku
6	Dr. Babu Ram Marasini	Section Officer	Management Division,Teku
7	Mr. Krishna Prasad Sapkota	Chairman	National Association of DDCs
8	Mr. Bishnu Man Maleku	Section Officer	Management Department, DoHS, Teku

Name List of Key Respondents at District Level

S. No.	Name	Designation	District
1	Mr. Jayanti khanel	Municipality Secretary	**Jhapa**
2	Mr. Uttam Prasad Nagila	LDO	Jhapa
3	Mr. Dambar Baral	Planning Officer	Jhapa
4	Mr Jhalak Sharma Poudel	DPHO	**Lalitpur**
5	Mr. Narahari Baral	LDO	Lalit pur
6	Ms. Maiya Ranjitkar	Senior Public Health Administrator	**Kaski**
7	Mr. Ganesh Prasad Gyawali	LDO	Kaski
8	Mr. Krishna Chandra Ghimire	LDO	**Banke**
9	Mr. Ram Prasad Kumal	Act. DPHO	Banke
10	Mr. Buddhi Bhusal	UNSCO Representative	Banke'
11	Mr. Bhan Dev Bhatta	Programme Officer	**Kanchanpur**
12	Mr. Dal Bashadur Mahat	LDO	Kanchanpur
13	Mr. Hawaldar Chaudhary	Programme Officer (BASE)	Kanchanpur

Name list of Key Informants at SHPs Level

S. No.	Name	District	Designation/Organisation	Location
1	Mr. Reet Prasad Bhetwal	**Jhapa**	Ward Mukhiya	**Kakarvitta**
2	Mr. Chandra Kumar Basnet	Jhapa,	Co-operative Manager	Kakarvitta
3	Mr. Jalpa Chimaria	Jhapa	Post Office Mukhiya	**Garamani**
4	Mr. Rudra Prasad Dahal	Jhapa	Social Mobiliser	Garamani
5	Mr. Sushil Kumar Shrestha	Jhapa	Teacher	**Ghailaduba**
6	Mr. Raghu Nath Pathak	Jhapa	Teacher	**Dhaijan**
7	Mr. Shiva Updhaya	Jhapa	Social Worker	Dhaijan,
8	Mr. Bhumi Nath Mishra	Jhapa	Teacher	**Dangabari**
9	Mr. Tika Sibakoti	Jhapa	Social Worker	Dangabari
10	Mr. Devi Prasad Kafle	Jhapa	Member-Asal Shasan youth Club	**Charpane**
11	Mr. Shankar Rijal	Jhapa	Member - School Mgt. Committee	Charpane
12	Ms. Devi Maya Sapkota	Jhapa	Social Worker	**Satasidham**
13	Mr. Deepak Kumar Neupane	Jhapa	Teacher	Satasidham
14	Mr. Tek Prasad Pathak	Jhapa	Teacher	**Damak**
15	Mr. Ram Nath Mehta	Jhapa	Health Administrator	Damak
16	Mr. Jagannath Silwal	**Lalitpur**	Head Teacher	**Bisankhunarayan**
17	Mr. Surendra KC	Lalitpur	Chairman - Youth Club	**Jharuwarasi**
18	Mr. Hari Kumar KC	Lalitpur	Teacher	Jharuwarasi
19	Mr. Kishor KC	Lalitpur	Social Worker	**Chapagaun**
20	Mr. Lab Ram KC	Lalitpur	Teacher	Chapagaun
21	Mr. Baburam Thapa	Lalitpur	Head Teacher	**Khokana**
22	Mr. Krishna Govinda Maharjan	Lalitpur	NGO Secretary	Khokana
23	Ms. Pushpa KC	Lalitpur	Teacher	**Chhampi**

24	Mr. Shailendra Bistha	Lalitpur	Enumerator - Vitamin A	Chhampi
25	Mr. Thir Kumari Silwal	Lalitpur	Secretary - Mothers Group	**Godawari**
26	Mr. Rabindra Silwal	Lalitpur	Head Teacher	Godawari
27	Mr. Tara Prasad Gurung	**Kaski**	Teacher	**Lumle**
28	Mr. Bishnu Prasad Sapkota	Kaski	Social worker	Lumle
29	Mr. Jagannath Paudel	Kaski	Teacher	**Nirmal Pokhari**
30	Mr. Padam Lal Bhandari	Kaski	Ward Chairperson	Nirmalpokhari
31	Ms. Devi BK	Kaski	President-Self Depend Group	**Sarangkot**
32	Mr. Min Bahadur Thapa	Kaski	Teacher	Sarangkot
33	Mr. Bashu Dev Paudel	Kaski	Head Teacher	**Lamachour**
34	Mr. Hut Raj Paudel	Kaski	Former DDC Member	Lamachour
35	Mr. Hem Lal Timila	Kaski	Ward President	**Hemja**
36	Mr. Babu Shanker Paudel	Kaski	Head Teacher	Hemja
37	Mr. Hem Bahadur Banjara	Kaski	Social Worker	**Rakhi**
38	Mr. Damador Shapkota	Kaski	Head Teacher	Rakhi
39	Mr. Lila Nath Subedi	Kaski	Community Leader	**Bhalam**
40	Mr. Min Bahadur GC	Kaski	Head Teacher	Bhalam
41	Mr. Guru Prasad Acharya	**Banke**	Teacher	**Mahadevpuri**
42	Mr. Wasid Ahmad	Banke	Head Teacher	Mahadevpuri
43	Ms. Subhadra Regmi	Banke	Teacher	**Rajhena**
44	Mr. Chudamani Pokhrel	Banke	Teacher	Rajena
45	Ms. Ekata Shah	Banke	RH Volunteer	**Chisapani**
46	Mr. Thir Prasad Adhikari	Banke	NGO Secretary	Chisapani
47	Mr. Shuman Shah	Banke	Teacher	**Puraini**
48	Mr. Mohmad Alamin Rai	Banke	Head Teacher	**Belbhar**
49	Mr. Netra Narayan Regmi	Banke	NGO Member	Belbhar
50	Mr. Makhan Lal Barma	Banke	Teacher	**Bhawaniyapur**
51	Ms. Gita KC	Banke	Social Worker	**Khajurakhurd**
52	Mr. Ganesh Bdr.Chand	**Kanchanpur**	Head Teacher	**Pitamber**
53	Mr. Arjun Singh Mahara	Kanchanpur	Social Worker	Pitamber
54	Mr. Dal Bahadur Air	Kanchanpur,	Teacher	**Jhalari**

Appendix 5: Information on hand over, its process and formation of HMC among Exit Clients

Districts	Heard about Handover (N=58)		Information about Activities of Handover (N=58)		Informed about Formation of HMC (N=58)	
	Male	Female	Male	Female	Male	Female
	Yes, n(%)	Yes, n(%)	Yes, n(%)	Yes, n(%)	Yes, n(%)	Yes, n(%)
Kaski	4(66.7)	3(42.9)	0	2(28.6)	0	2(28.6)
Banke	2(33.3)	5(71.4)	0	0	0	4(57.1)
Kanchanpur	0	1(50)	0	0	0	1(50)
Jhapa	3(37.5)	3(37.5)	2(25)	0	1(12.5)	3(37.5)
Lalitur	1(16.7)	2(33.3)	0	0	0	0
Total	**10(35.7)**	**14(46.7)**	**3(10.7)**	**2(6.7)**	**1(3.5)**	**10(33.3)**
Ecological Regions						
Hill	5(41.7)	5(38.5)	0	2(15.4)	0	2(15.4)
Terai	5(31.3)	9(52.9)	3(18.8)	0	1(6.2)	8(47.1)
Total	**10(35.7)**	**14(46.7)**	**3(10.7)**	**2(6.7)**	**1(3.5)**	**10(33.3)**
Areas						
Urban	3(25)	4(28.6)	1(8.3)	1(7.1)	0	2(14.3)
Rural	7(43.8)	10(62.5)	2(12.5)	1(6.3)	1(6.3)	8(50)
Total	**10(35.7)**	**14(46.7)**	**3(10.7)**	**2(6.7)**	**1(3.5)**	**10(33.3)**

Appendix 6: Charging of fee for the services provided by SHP (Self reported by SHP in-charge)

Districts	Yes n (%)	No n (%)
Kaski	5 (71.4)	2 (28.6)
Banke	4 (57.1)	3 (42.9)
kanchanpur	2 (100)	0
Jhapa	8 (100)	0
Lalitpur	3 (50)	3 (50)
Total	22 (73)	8 (27)
Ecological regions		
Hill	8 (61.5)	5 (38.5)
Teraii	14 (82.3)	3 (17.7)
Total	22 (73)	8 (27)
Areas		
Urban	7 (50)	7 (50)
Rural	15 (93.8)	1(6.2)
Total	**22 (73)**	**8 (27)**

Appendix 7: Attendance of All members of HMC in Last Three Meetings

Attendance Percentage by Districts	Kaski (N=21)	Banke (N=21)	Kanchanpur (N=6)	Jhapa (N=24)	Lalitpur (N=18)	Total (N=90)
<50%	0	0	0	3(12.5)	1(5.6)	**4(4.5)**
50-80%	11(52.4)	9(42.9)	2(33.3)	4(16.7)	6(33.3)	**32(35.5)**
>80%	10(47.6)	12(57.1)	4(66.7)	17(70.8)	11(61.1)	**54(60)**
Attendance Percentage by Ecological Regions	**Hill (N=39)**			**Terai (N=51)**		
<50%	1(2.5)			3(5.9)		
50-80%	17(43.6)			17(33.33)		
>80%	21(53.84)			31(60.7)		
Attendance Percentage by Areas	**Urban (N=42)**			**Rural (N=48)**		
<50%	2(4.8)			2(4.2)		
50-80%	17(40.5)			16(33.3)		
>80%	23(54.8)			30(62.5)		
Overall Attendance Percentage	**78.8**					

Appendix 8: Regular Sending of Report to DPHO

Districts	SHP In-Charge	MCHWs/FCHVs
	Yes, n (%)	**Yes, n (%)**
Kaski	7 (100)	7(100)
Banke	7(100)	5(100)
Kanchanpur	2(100)	2(100)
Jhapa	8(100)	8(100)
Lalit pur	6(100)	6(100)
Total	**30(100)**	**28(100)**
Ecological Regions		
Hill	13(100)	13(100)
Terai	17(100)	15(100)
Total	**30(100)**	**28(100)**
Areas		
Urban	14(100)	12(100)
Rural	16(100)	16(100)
Total	**30(100)**	**28(100)**

Appendix 9: Appointment of Staff by Local Resources

Districts	SHP In-charge (N=30)	HMC Chairman (N=28)
	Yes n (%)	Yes n (%)
Kaski	0	0
Banke	0	0
Kanchanpur	2 (100)	1 (100)
Jhapa	5 (62.5)	4 (57.1)
Lalit pur	1 (16.7)	1 (16.7)
Total	**8 (24.5)**	**6 (21.4)**
Ecological Regions		
Hill	1(7.7)	1 (7.7)
Terai	7(41)	5 (33.3)
Total	**8 (24.5)**	**6 (21.4)**
Areas		
Urban	4 (28.5)	2 (16.7)
Rural	4 (25)	4 (25.0)
Total	**8 (24.5)**	**6 (21.4)**

Appendix 10: Patients Flow Rate in Different Health services before and after handover

INDICATORS	DISTRICTS					Regions		Areas	
	Kaski %	Banke %	Kanchanpur %	Jhapa %	Lalitpur %	HIll %	Terai %	Urban %	Rural %
OPD	+ 18.13	- 1.07	- 16.4	+ 71.8	+ 82.3	+ 51.8	+ 31.3	+ 46.5	+ 32.9
ANC/PNC	+ 30	+ 111.5	- 54.4	+ 82	+ 43.8	+ 39	+ 52	+ 76.8	+ 26.3
DPT3	- 21.6	- 5.3	- 12.3	+ 42.1	+ 81	+ 17.2	+ 32	- 24	+ 0.4
Measles	- 24.7	+ 20.5	- 44	+ 11.6	+ 42.1	- 1.7	+ 8.5	+ 6.2	+ 6.1
Delivery Service	+ 280	+ 86	- 18.7	+ 19.3	+ 146.1	+ 67.7	+ 30.4	+ 9.8	+ 241.4
Family planning	+ 23	+ 69	+ 22	+ 11.9	+ 44.4	+ 36	+ 92	+ 59	+ 80
Trained Sudeni	- 57.8	- 51	- 5	+ 62	+ 200	+ 31	- 13	- 0.9	- 13.8
Diarrhoea	+ 75.9	- 33.9	- 17	+ 18	+ 130	+ 107	+ 5.4	+ 71.7	- 0.05
DOTS	-	- 33	-	+ 52.9	-	-	+ 30.4	+ 52	- 33
STI/UTI	-	+ 30.7	-	-	-	-	+ 30.7	- 33.3	+ 85

+ = Increased
- = Decreased

Appendix 11: Different Health Facilities in different SHPs

	DISTRICTS					REGION		AREAS	
Facilities	Kaski (n=7)	Banke (n=7)	Kanchanpur (n=2)	Jhapa (n=8)	Lalitpur (n=6)	Hill (n=13)	Terai (n=17)	Urban (n=14)	Rural (n=16)
Drinking water	3(42.9)	4(57.1)	2(100.0)	7(87.5)	4(66.7)	7(53.8)	13(76.4)	13(92.8)	7(37.5)
electricity facility	4(57.1)	4(57.1)	1(50.0)	8(100)	4(66.7)	8(61.5)	13(76.4)	11(78.5)	10(62.5)
telephone facility	0	0	0	2(25)	1(16.7)	1(7.6)	2(11.6)	1(7.14)	2(12.5)
toilet facility	6(85.7)	6(85.7)	2(100)	7(87.5)	5(83.3)	11(84.6)	15(88.2)	13(50)	13(50)
waiting room	5(71.4)	6(85.7)	1(100)	4(50)	4(66.7)	9(69.2)	11(64.7)	11(78.5)	9(56.25)
HMCmembername	7(100)	4(57.1)	2(100)	6(75)	4(66.7)	11(84.6)	12(70.5)	11(78.5)	12(75)
services and rate	4(57.1)	3(42.9)	2(100)	8(100)	5(83.3)	9(62.9)	13(76.4)	11(78.5)	11(68.75)
openingdaysandtime	0	2(28.6)	2(100)	8(100)	4(66.7)	4(30.7)	12(70.5)	8(57.14)	8(50)
Organogram	7(100)	6(85.7)	2(100)	7(87.5)	3(50)	10(76.9)	15(88.2)	12(87.5)	13(81.25)
graphic charts	6(85.7)	6(85.7)	2(100)	8(100)	6(100)	12(92.3)	16(94.1)	13(92.8)	13(81.25)
IEC/BCC materials	6(85.7)	7(100)	2(100)	8(100)	6(100)	12(92.3)	17(100)	14(100)	15(93.75)
references	7(100)	6(85.7)	2(100)	8(100)	5(83.3)	12(92.3)	16(94.1)	14(50)	14(50)

Appendix 12: Availability of CDP in selected SHPs

District	Yes n(%)	No n(%)
Kaski	7(100)	0
Banke	6(85.7)	1(14.3)
Kanchanpur	2(100)	0
Jhapa	0	8(100)
Lalit pur	0	6(100)
Total	15(50)	15(50)
Ecological region		
Hill	7(53.8)	6(46.2)
Terai	8(47)	9(53)
Total	15(50)	15(50)
Geographical area		
Urban (14)	7(50)	7(50)
Rural (16)	8(50)	8(50)
Total (30)	15(50)	15(50)

Appendix 13: Availability of Drugs in Every Visit of the Clients

Districts (n)	Male		Female	
	Yes n(%)	No n(%)	Yes n(%)	No n(%)
Kaski	5(83.3)	1(16.7)	6(85.7)	1(14.3)
Banke	6(100)	0	6(85.7)	1(14.3)
Kanchanpur	1(50)	1(50)	2(100)	0
Jhapa	8(100)	0	8(100)	0
Lalitur	6(100)	0	5(83.3)	1(16.7)
Total	26(92.9)	2(7.1)	27(90)	3(10)
Ecological region				
Hill	11(91.7)	1(8.3)	11(84.6)	2(15.4)
Terai	15(93.8)	1(6.3)	16(94.1)	1(5.9)
Total	26(92.9)	2(7.1)	27(90)	3(10)
Geographical area(n)				
Urban	11(91.7)	1(8.3)	11(78.6)	3(21.4)
Rural	15(93.8)	1(6.3)	27(90)	3(10)
Total	26(92.9)	2(7.1)	27(90)	3(10)

Appendix 14: Possibility of resource mobilization for the income of SHPs

District	Yes n(%)	No n(%)
Kaski	2(28.5)	5(71.5)
Banke	0	7(100)
Kanchanpur	1(50)	1(50)
Jhapa	7(87.5)	1(12.5)
Lalit pur	2(33.3)	4(66.7)
Total	12(40)	18(60)
Ecological region		
Hill	4(30.7)	9(69.3)
Terai	8(47)	9(53)
Total	12(40)	18(60)
Geographical area		
Urban	4(28.5)	10(71.50
Rural	8(50)	8(50)
Total	12(40)	18(60)

Appendix 15: Respondent wise Opinions on Changes in SHPs before and after handover

Response	Respondents
➢ Communities' ownership towards SHPs increased. ➢ Increased participation in SHPs' activities ➢ Positive attitude of staff and increased punctuality ➢ Community was acting as 'watch dig' in SHP affairs ➢ Awareness on health issues and service utilisation increased ➢ Communities built SHPs infrastructure such as community buildings ➢ No difference has been observed except the regular business of SHPs.	Key Informants (Central level)
➢ The level of community participation seems to be very low due to inactiveness of committee members. ➢ The physical facility especially the building is improving ➢ Extension of health service and availability of drug improved ➢ Communities are positive towards SHPs health services and starting to take ownership	HMCCP
➢ Level of community participation and resource mobilisation was low. ➢ Physical facilities have been improved. ➢ No changes observed in terms of financial and human resource management, however health staff stay regularly	SHPIs
➢ Level of community participation and resource mobilisation was low. ➢ No changes observed except physical facility, medicine supply and community awareness ➢ People are positive about the services provided by MCHWs.	MCHWs
➢ Availability of health staff and their regularity ➢ Additional health facilities included such as lab, dental treatment etc. ➢ Increase in community awareness about health in general and family planning in particular ➢ People who used to go to private clinics now come to SHPs ➢ There is no change as of earlier	ECs
➢ SHP plans being prepared having identified local health needs and requirement ➢ Improved availability of health personnel and drug supply ➢ Increased community participation and ownership ➢ Extension of health service facilities such as lab and dental camps ➢ Staff creativity and capability improved ➢ Increased assistance of NGOs to construct buildings ➢ Lack of faith towards SHPs health services ➢ Almost defunct HMC ➢ Nepotism of committee when appointing FCHVs ➢ Political misunderstanding between committee members ➢ High registration fee and lack of medicines ➢ Unavailability of extra rooms, furnitures and necessary equipments	Key Informants (Village Level)
➢ Increased community participation and feeling of ownership ➢ Regular and active health personnel ➢ Effective cooperation between SHPs and local organisation to improve health services ➢ Harmonious relationship between SHP staff and the community ➢ Increased level of awareness regarding health service utilistion ➢ No proper implementation of decentralisation as per the intended goals and objectives ➢ Long and delayed process of budget allocation and transfer ➢ Financial transparency and resource mobilisation was increased	DPHO, LDO and KIs

Appendix 16: Survey Instruments/tools

Instrument/Tool No. 1
Time: 30-45 mins.

Check-list for Secondary Data Collection and Key Informants Interview at Central Level

NEPAL HEALTH RESEARCH COUNCIL
Ramshahpath,Kathmandu,Nepal

EVALUATION STUDY OF DECENTRALIZAED HEALTH FACILIYIES IN NEPAL

1. **Secondary Data Collection/Literature Review Checklist**

a) Review of historical perspective of health services development:
- In the periodic plans of Nepal.
- Health facilities decentralization initiatives.

b) Assessment of key documents and studies related to decentralization of health facilities in Nepal:
- Policy paper /statements, objectives and need of decentralization.
- Policy making process, planning, strategy and implementation process.
- Capacity building of local health facility by the centre for decentralization, and Present status.

2. **Review of national and international literature**
- In the contest of health sector decentralization.
- Problems and challenges of health sector decentralization, and
- Developing a programme for effective health sector decentralization in Nepal.

3. **Interviews with key informants in policy/planning level and other stakeholders considering the following key issues**
- Objectives, policy planning, programming and process of HFs decentralization.
- Administrative, financial management and capacity building activities offered.
- Perception on present status, effectiveness and efficiency of SHP
- Perception on participation and feeling of ownership by the local community
- Problems encountered and prospects of decentralization of HFs
- Experience/Perception on differences in service provision/management of HFs before and after decentralization
- Knowledge about any long term plans formulated by the HMCs for the sustainability of HFs in long-run

Instrument/Tool No 2
Time: 45-60 minus.

Check-list for In-depth Interviewing with SHP In-charge

NEPAL HEALTH RESEARCH COUNCIL
Ramshahpath, Kathmandu, Nepal

EVALUATION STUDY OF DECENTRALIZED HAELTH FACILITIES IN NEPAL

Date	Time	Location	Position and Name of Respondent	Study Team
	start: End:	VDC:___________ Name of SHP :___________ District:___________ Date of SHP handover:___________	Position: ___________ Name: ___________	Interviewer: ___________ Note taker: ___________

Introduction and warm-up

Namaste, my name is ________________. I am here on behalf of the Nepal Health Research Council (NHRC) of the HMG/Nepal to collect information on the EVALUATION STUDY OF DECENTRALIZED HAELTH FACILITIES OF NEPAL The information provided by you will be instrumental to strengthen and /or to overcome barriers of health facilities decentralized initiation in Nepal to improve the health of this community in the days to come. With your kind consent, I would like to ask you some questions. Your names will remain confidential with me. Please feel free to express your opinions openly, and ask me if you have any questions.

A. Knowledge regarding Health facility Hand over to the community.

1. When did you enter in the health services?
2. How long have you been in this SHP?
3. At the time of handover of this SHP where were you working?
4. What are the main objectives of health facility decentralization?

Key areas to be discussed (Do not read but probe by asking):

- To allocate appropriate resources and involve people's participation for the equal distribution of the fruits of development for the promotion of social welfare envisaged by the constitution..
- To established an effective system of planning and implementation at the local level.
- To ensure institutional development of the local VDC so that they are capable to exercise.
- To decentralize authority for enabling people to manage their affairs and maters related to daily necessities.

5. What are your policies and strategies to expand and improve the quality of health service provided by SHP?
   ………
   ………………………………………………………………………......
6. What are the main achievements of this health facility since hand over?
   a) ………………………………………………………………………………
   b) ……………………………………………………………………………………
   c) …………………………………………………………………………………
7. What are the health services are being provided by this health facility?
   a) ……………………………………………………………………………………
   b) ……………………………………………………………………………………..
   c) ……………………………………………………………………………………..
8. What are the additional health facilities included by this SHP after hand over?
   a) ………………………………………………………………………………………………………
   b) ……………………………………………………………………………………………………….
   c) ………………………………………………………………………………………………………..

9. Do you/HMC have any annual, long-term plan for further development of health services?
   a) Yes b) No
   If yes, which facility has given main priority? Please specify.
   a) ……
   b) ……………………………………………………………………………………………………….
   c) ……

B. Process of health facility handover.

1. Could you please explain how this SHP handed over to the community?
   a) ……...
   b) ……..
   c) ……...
2. What was the process of HMC formation?
3. Who are the representatives in the HMC?
4. Are you satisfied with the composition of HMC?
   a) Yes b) No
   If No, why?
5. In your opinion, who should include in the HMC to make it more effective?

C. CapacityBuilding, Linkage and functioning Health Management Committee (HMC).

1. What type of back-up support,capacity building program did you get during the hand over this SHP?
   - Physical facilities
   - Training /Orientation
   - Health manpower
   - Drugs
   - equipments
   - Others (Specify)
2. Are you able and authorized to establish the linkages with NGOs/INGOs and other local organizations and/or district to central level authority in the context of strengthening of services?
   a) Yes b) No
   With whom and how?
   ……
   ……
3. In the last one year, how many management committee meetings were conducted and what were the main decisions made?
   ……
   ……
4. Did all the members presented whenever the meeting was conducted?
   a) Yes b) No
   If no, who were they and why?
   ……
5. Are there any obstacles, while implementing the decisions made by the Management Committee?
6. How the financial transaction is carried out in order to operate the SHP?

D. Financial management

1. What are the major sources of budget / income of this SHP?

S. No.	Source	Amount
1	HMG	
2	I/NGOs	
3	V.D.C. contribution	
4	Own resource	
5	Prizes	
6	Others (Please Specify)	

2. Do you charge any fee for the services provided by this health facility?
   a) Yes b) No

If yes, for what service and how much?

S. No.	Facility	Amount
1.		
2.		
3.		
4.		

E. Human resource provision.

1. Is there any post vacant in the SHP?
   a) Yes b) No
   If yes, why? For how long?
   ………
2. Are there any people appointed by HMC in own source after hand over this SHP?
   a) Yes b) No

F. Health service Delivery.

1. Have you found any changes in the health facility after hand over? If yes, in what aspect?

S. No.	Particular	Changed	Not changed	If Charged specify
1	Physical facilities			
2	Service delivery			
3	Human resource			
4	Financial management			
5	Health facility management			
6	Drug supply management			
7	Others			

2. How the plans are made for improvement of the health services provided by the SHP? Is sufficient budget allocated according to the plan?
1. What are the problems and difficulties that you are facing regarding overall management and quality service provision after handover?
   a)…….
   b) ……………………………………………………………………………………………………..
   c) ………………………………………………………………………………………………………

G. Community participation and ownership

1. Whether there is any provision of
   a) Emergency fund
   b) Community health volunteer
   c) Village health clinic
   d) Manage the record of local resources.
   e) Ambulance
2. Did the HMC tried to mobilized the community in terms of :
   - Development of the SHP
   - Proper functioning of SHP
   - Awareness on availability of health services
   - Resource mobilization
   - Health seeking behaviour
   - Infrastructure development
   - Management and fund rising programs
   - Others…………………………………………………………………………………………………….
3. Do you see any other possibilities of local resource generation to increase the income of this health facility?
   a) Yes b) No
4. What are the areas that need to strengthen for the efficiency of decentralized health facilities/ SHP?
   ……
   ………

5. What type of support do you expect from?

S.No.	Sponsor	Area of support	How often
1	Village Development Committee		
2	District Development Committee		
3	DPHO		
4	Regional Health Service Directorate		
5	Department of Health Services		
6	Ministry of health and Population		
7	Regional Health Training Centre		
8	Health management Committee		

H. Drugs and logistic management

1. Has Community Drugs Program been introduced in this health facility?
   a) Yes b) No
   If yes, When started?
   ……………………………………………………………………………………………………
2. Did the SHP purchase any medicines and other necessary materials in the last year?
   a) Yes b) No
   If yes, what they are?
   a)……………………………………………………………………………………………………
   b)…………………………………………………………………………………………………….
   c)……………………………………………………………………………………………………

I. Impact of conflict

1. What is the impact of conflict on the service delivery and operation?
   ……………………………………………………………………………………………………
   ……………………………………………………………………………………………………
2. What is the impact of conflict in implementing outreach clinics and visit wards?
   ……………………………………………………………………………………………………
   ……………………………………………………………………………………………………
3. What is the impact of conflict on the movement of people to the health facilities? *Especially during bandh /curfew.*
   ……………………………………………………………………………………………………
   ……………………………………………………………………………………………………
4. What are the people using indigenously in terms of transportation and treatments?
   ……………………………………………………………………………………………………
   ……………………………………………………………………………………………………
5. What types of transportation assistance to community members need?
   ……………………………………………………………………………………………………
   ……………………………………………………………………………………………………

J. monitoring and supervision

1. Who supervises his health facility?
   ……………………………………………………………………………………………………
   ……………………………………………………………………………………………………..
2. How many times this health facility has been supervised since hand over?
   ……………………………………………………………………………………………………
   ……………………………………………………………………………………………………
3. Do you have any records of supervision?
   a) Yes b) No
4. Are those suggestions and comments have been taken up to the Health Management Committee?
   ……………………………………………………………………………………………………
   ……………………………………………………………………………………………………
5. Are the necessary actions taken up on those suggestions and comments?
   ……………………………………………………………………………………………………
   ……………………………………………………………………………………………………

6. Are you preparing and sending the progress report of the SHP to DPHO regularly?
   a) Yes b) No

K. What is your opinion in the following issues?

- Handover process
- Policy
- Strategies
- Financial accountability
- Capacity building
- Health services.
- Others

………
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Instrument /Tool No. 3
Time: 30-45 mins.

Checklist for in-depth Interviewing with health workers / Service providers(FCHVs /MCHWs)

NEPAL HEALTH RESEARCH COUNCIL
Ramshahpath, Kathmandu, Nepal

EVALUATION STUDY OF DECENTRALIZED HAELTH FACILITIES IN NEPAL

Date	Time	Location	Position and Name of Respondent	Study Team
	Start: End:	VDC:__________________ Name of SHP :__________________ District:________________ Date of SHP handover:_________	Position: __________________ Name: __________________	Interviewer: __________________ Note taker: __________________

Introduction and warm-up

Namaste, my name is _________________________. I am here on behalf of the Nepal Health Research Council (NHRC) of the HMG/Nepal to collect information on the EVALUATION STUDY OF DECENTRALIZED HAELTH FACILITIES OF NEPAL The information provided by you will be instrumental to strengthen and /or to overcome barriers of health facilities decentralized initiation in Nepal to improve the health of this community in the days to come. With your kind consent, I would like to ask you some questions. Your names will remain confidential with me. Please feel free to express your opinions openly, and ask me if you have any questions.

A. Knowledge regarding Health Facility handover

1. When did you enter in health service? ……………………………………………………………..…….....
2. How long have you been in this SHP? ....
3. At the time of hand over where you have been working? ....
4. What do you mean by health facility handover to the community? Is it the right time for handover?
   ……………………..
   ……………………………………………………………………………………………………...

B. Process of Health Facility Handover.

1. Could you please explain how this SHP handed over to the community?
   ……………………………………………………………………………………………………
   ……………………………………………………………………………………………………
2. What was the process of HMC formation?
   ……………………………………………………………………………………………………
   ……………………………………………………………………………………………………
3. In your opinion who should included in HMC?
   ……………………………………………………………………………………………………
   ……………………………………………………………………………………………………
4. Are you satisfied with this HMC?
   a) Yes b) No
   If no, Why? ……………………………………………………………………………...………………
5. Are you satisfied with overall management of HMC? What do you think about the functioning of HMC in terms of over all management, service provision and activities?
   ……………………………………………………………………………………………………
   ……………………………………………………………………………………………………

C. Health Service

1. What are the health facilities you are providing to the community?
   a) Safe motherhood b) Family planning
   c) Immunization d) Nutrition
   e) ANC/PNC care f) Respiratory infection control
   g) Environmental Sanitation h) Reproductive health
   i) DOTs j) Leprosy treatment
2. From where you are getting necessary medicines to distribute in the community?
   ……
   ……
3. Are you getting medicines and other necessary materials/equipment within the time?
   ……
   ……
4. What are the trainings/facilities did you received before and after hand over, to improve your skill and health service delivery?
   ……
   ……

D. Community participation and ownership

1. Did the HMC tried to mobilized the community in terms of
   - Create awareness on availability of health service
   - Resource Management /mobilization
   - Health seeking behavior
   - Infrastructure development
   - Emergency fund rising program
   - Village health clinic
   - Mobilization of Community health volunteers (mothers group, youth group, TBAs etc.)
   - Others………………………………………………………………………………………….…….
2. What are the areas that need to strengthen for the effectiveness in decentralized SHPs?
3. What are .the difficulties you are facing to work after and before hand over this SHP?
   After…………………………………………………………………………………………………
   ……
   Before……………………………………………………………………………………..……………..
   ………………………………………………………………………………………………….……
4. What are the difficulties you are facing in health service delivery before and after hand over of this SHP?

S. No.	Health facilities	Difficulties before hand over	After hand over	Remarks
1	Physical Facilities			
2	Service delivery			
3	Human resources			
4	Financial Management			
5	Community Mobilization			
6	Health facility management			
7	Drug supply management			
8	Others			

5. Have you received any positive and negative reactions from the people regarding the service delivery after handover? If yes, what were those reactions?
   Positive:…………………………………………………………………………………………..................
   ....
   Negative:………………………………………………………………………………………..............
   ....

E. Impact of conflict

1. What is the impact of conflict on the service delivery and operation of this SHP?
   ……………………………………………………………………………………………..……………
   ………
2. What is the impact of conflict in implementing outreach clinics and visit wards?
   ………
   ………
3. What is the impact of conflict on the movement of people to the health facilities? *Especially during bandh/curfew.*
   ………
   ………
4. What are the people using indigenously in terms of transportation and treatments?
   ………
   ……..
5. What types of transportation assistance to community members need?
   ………
   ………

F. Monitoring and supervision

1. Who supervises his health facility?
   ……………………………………………………..……………………………………………………
   ……………………………………………………………………………………………………….
2. How many times this health facility has been supervised since handover?
   ………
   …..……
3. Do you have any records of supervision?
   a) Yes b) No
4. Are those suggestions and comments been taken up to the HMC?
   ………
   ……
5. Are those suggestions/comments recommended by the supervisors have been implemented?
   ....
   ....
6. Are you preparing and sending the progress report of SHP to DPHO regularly?
   a) Yes b) No

Do you have any suggestions/comments regarding the health services provided by SHP?

....
....
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Instrument/Tool No. 4
Time: 45-60 mins.

Checklist for in-depth Interviewing with HMC chairman /VDC secretary

NEPAL HEALTH RESEARCH COUNCIL
Ramshahpath, Kathmandu, Nepal

EVALUATION STUDY OF DECENTRALIZED HEALTH FACILITIES IN NEPAL

Date	Time	Location	Position and Name of Respondent	Study Team
	Start: End:	VDC:____________ Name of SHP :____________ District:____________ Date of SHP handover:_______	Position: ____________ Name: ____________	Interviewer: ____________ Note taker: ____________

Introduction and warm-up

Namaste, my name is ________________________. I am here on behalf of the Nepal Health Research Council (NHRC) of the HMG/Nepal to collect information on the EVALUATION STUDY OF DECENTRALIZED HAELTH FACILITIES OF NEPAL The information provided by you will be instrumental to strengthen and /or to overcome barriers of health facilities decentralized initiation in Nepal to improve the health of this community in the days to come. With your kind consent, I would like to ask you some questions. Your names will remain confidential with me. Please feel free to express your opinions openly, and ask me if you have any questions.

A. Knowledge Regarding Health Facility handover by the Government.

1. How long you have been working in this VDC/HMC?
   ....
   ....
2. When was this health facility handed over to the community?
   ………
   ………
3. What are the major objectives for handing over this Health Facility to the local Community?
   ………
   ....

Key areas to be discussed (do not read but probe by asking)

- To appropriate allocation of resources and involve people's participation for the equal distribution of the fruits of development for the promotion of social welfare envisaged by the constitution.
- To established an effective system of planning and implementation at the local level.
- To ensure institutional development of the local VDC so that they are able to exercise.
- To decentralize authority to enable people to manage their affairs and maters related to daily necessities.

4. Whether any annual plan has been made by this HMC last year?
   a) Yes b) No
5. What are the main achievements of this health facility since hand over? In terms of:

- Physical Facilities.
- Capacity building of the staffs.
- Quality of service.
- Community mobilization
- Drug supply management
- Others (specify)……………………………………………………………………………………

B. Process of Health facility hand over.

1. Do you remember how the handover process was carried out?
   a)……
   b)…….
   c)…….
2. What was the process of HMC formation?
   ……
   ……
3. Are you satisfied with the composition of HMC?
   a) Yes b) No
4. In your opinion, who should be included in the HMC?
   a)……………………………………………………………………………………………………….
   b)……………………………………………………………………………………………………..
   c)……………………………………………………………………………………………………...

C. Capacity, linkage and functioning Health Management Committee.

1. What type of back-up support/capacity building program did you get during the hand over process of this SHP?
   - Physical facilities
   - Training /Orientation
   - Health manpower
   - Drugs
   - Equipments
   - Others (Specify)

   ……
   ……
2. Have you been able to establish the linkage with NGO/INGO and local organizations for expansion of services?
   a) Yes b) No
   With whom? How? ....
   ……
3. What are the major functions of HMC?
   a) Improve and manage the essential health facilities.
   b) Manage the staffs in local health facility.
   c) Financial management
   d) Supply management
   e) Management of Community Health Volunteer
   f) Manage and mobilize the local resource
   g) IEC management
   h) Co-operation and co-ordination
4. Are you calling HMC meeting as pre schedule?
   a) Yes b) No
5. Did all the committee members are present whenever the meeting was conducted?
   a) Yes b) No
   If no, who are they and why? ……………………………………………………………………………
   ……
6. In last meeting what are the main decisions taken by HMC?
   a)…….
   b)…….
   c)…….
7. Are there any obstacles while implementing the decisions made by the Health Management Committee?
   a)…….
   b)…….
   c)…….

D. Financial Management

1. How much annual budget has been allocated for functioning of the SHP?
   ……
   ……..
2. Whether the health facility financially sustainable?
   a) Yes b) No
3. What are the major sources of budget besides of the GoN?
   a)………………………………………………………………………………………………….
   b)………………………………………………………………………………………………….
   c)………………………………………………………………………………………………….
4. Is there any sources raised by HMC besides the budget of GoN?

S. No.	Resources	Amount
1	Agriculture production	
2	Wood and grass	
3	Rent	
4	Ticketing	
5	Private company	
6	Others	

E. Human resource provision.

1. Is there any post vacant in the SHP?
   a) Yes b) No
   If yes, for how long and which position?
   ……
   ……
2. Is any staff appointed by HMC in own source after hand over this SHP?
   a) Yes b) No

F. Health Facility service

1. Have you found any changes in the health facility after hand over? If yes, in what aspect.
   Such as:

S. No.	Facilities	Changed	Not changed	Remark
1	Physical facilities			
2	Service delivery			
3	Human resource			
4	Financial management			
5	Health facility management			
6	Drug supply management			
7	Others			

2. What are the problems and difficulties that you are facing regarding overall management and quality service provision after handover?
   a)………………………………………………………………………………………………….
   b)………………………………………………………………………………………………….
   c)………………………………………………………………………………………………….
3. Are you getting any positive and negative reactions from the people about the services after hand over? If yes, what are those reactions?

G. Community participation and ownership

1. Did the HMC tried to mobilize the community in terms of:
   - Awareness on availability of health service
   - Resource mobilization
   - Health seeking behavior
   - Infrastructure development
   - Management and fund rising program.

……
……
…………………………………………………

2. What are the areas need to strengthen for the effectiveness of decentralized Health Facility?
3. If you have any other suggestions or comments or views regarding hand over process capacity building and future plans.

• Hand over process. • Physical facility. • HMC management. • Monitoring and Evaluation. • Others(specify)

4. What problems you are facing for overall management and service provision of this SHP? What do you expect from the government to overcome from these problems?

H. Logistics Management

1. What are the HMC is doing under the logistic management?

• Purchase essential medicines and necessary materials. • Manage the essential medicines for epidemic disease. • Conduct the community drug program. • Distribute the essential medicines to the poor and helpless patients in free of cost. • Logistic supervision and dispose the date expired medicine.

I. Impact of conflict

1. What is the impact of conflict on the service delivery and operation?
   ……
   ……
2. What is the impact of conflict in implementing outreach clinics and visit wards?
   ……
   ……
3. What is the impact of conflict on the movement of people to the health facilities? e*specially during bandh/curfew.*
   ……
   ……
4. What are the people using indigenously in terms of transportation and treatments?
   ……
   ……
5. What types of transportation assistance to community members need?
   ……
   ……

J. Supervision and monitoring

1. Who supervises his health facility?
   ……
   ……
2. How many times this health facility has been supervised since handover.
   ……
   ……
3. Do you have any records of supervision?
   a) Yes b) No
4. Are those suggestions taken up to the HMC?
   ……
   ………………………………………………………………………………………………………
5. Are those suggestions/comments recommended by the supervisors have been implemented?
   a) Yes b) No

What type of support do you expect from?

S. No.	Organizations	Area of support	Duration
1	Village Development Committee		
2	District Development Committee		
3	DPHO/DHO		
4	Regional Health Service Directorate		
5	Department of Health Services		
6	Ministry of health and Population		
7	Health management Committee		

K. What is your opinion on the terms of

1. Handover process
2. Policy
3. Strategies
4. Financial accountability
5. Capacity building
6. Health services.
7. Others

………
………
………
………
………
………
………
………
………
………
………
……………………………………………………………………………….

Instrument /Tool No. 5
Time: 30-45 mins.

Checklist for in-depth Interviewing with Exist clients.

NEPAL HEALTH RESEARCH COUNCIL
Ramshahpath, Kathmandu, Nepal

EVALUATION STUDY OF DECENTRALIZED HAELTH FACILITIES IN NEPAL

Date	Time	Location	Position and Name of Respondent	Study Team
	Start: End:	VDC:__________________ Name of SHP :__________________ District:________________ Date of SHP handover:________	Position: __________________ Name: __________________	Interviewer: __________________ Note taker: __________________

Introduction and warm-up

Namaste, my name is ________________________. I am here on behalf of the Nepal Health Research Council (NHRC) of the HMG/Nepal to collect information on the EVALUATION STUDY OF DECENTRALIZED HAELTH FACILITIES OF NEPAL The information provided by you will be instrumental to strengthen and /or to overcome barriers of health facilities decentralized initiation in Nepal to improve the health of this community in the days to come. With your kind consent, I would like to ask you some questions. Your names will remain confidential with me. Please feel free to express your opinions openly, and ask me if you have any questions.

A. Knowledge Regarding Health Facility handover

1. Do you know this health facility handed over to the community?
   a) Yes b) No
2. Do you know about the formation of HMC?
   a) Yes b) No
3. What should be the main reasons of handing over this health facility to the community?
   a)…………………………………………………………………………………………………….….
   b)……………………………………………………………………………………………………..
   c)…………………………………………………………………………………………….………….
4. What is the difference in the health facilities provided by the SHP before and after hand over?

………
………

B. Process of Health Facility Hand Over.

1. Do you know how the SHP was handed over to the community?
   a) Yes b) No
   If yes, How?
   a) By mass meeting
   b) Orientation to the community before hand over
   c) By providing grants
   d) Others…………………………………………………………………………………………………
2. Are you fully satisfied with the process of HMC formation and its composition?
   a) Yes b) No
   If not, why?
   …………………………………………………………………..…………………………………………
   ……………………………………………………………………………………………

C. Opinion

1. Are you fully satisfied with the function of present HMC? In terms of:
   - Physical Facilities
   - Service provided by this SHP
   - Human resource management
   - Financial management
   - Community mobilization
   - Health facility management
   - Drug supply management
   - Others………………………………………………………………………….…………………
     ……………………………………………………………………………………………………

D. Health service

1. When did you come here before for the treatment? …………………………………………………………
2. Did you come here before 3 years?
   a) Yes b) No
3. Whether the ticket was free or you paid for it?
   a) Yes b) No
   If you have paid, how much? Rs...
4. Did you pay any extra charges for other services?
   a. Yes b. No
   If yes, how much for which service? Rs……………………………………………………..…………..
5. How was the behavior of service providers?
   ………
   ………...
6. Are you getting required medicines from this SHP when you come for the treatment?
   a. Yes b. No

7. What is your view towards below mentioned facilities?

S. No.	Facilities	Opinion			
		Very Good	Good	Satisfactory	Remarks
1.	Opening Hour				
2.	Availability of Drugs				
3.	Quality Counseling				
4.	Home visit of MCHWs/VHWs/ANMs				
5.	Availability of the health personnel (10-2)				
6.	Informed Choice				
7.	Privacy				
8.	Water Supply				
9.	Toilet				
10.	Waiting room				
11.	Behavior of the service providers				
12.	Management of the health facility				

D. Community participation and ownership

1. Is there any provision of providing the essential medicines to the poor and helpless people?
   a) Yes b) No
2. Did you ever receive that facility?
   a) Yes b) No
3. Have you ever been participated in the improvement of the health facility of this SHP?
   a) Yes b) No
4. What are the problems you are facing to get health services from this SHP?

E. If you have any suggestion /comments about strengthening the health Facilities of this SHP?
………
………
……...

Instrument /Tool No. 6
Time: 30-45 minutes

Check list of key interview with LDO/Focal person/DPHO /Medical superintend/ Community leaders/Social activist/Teachers/I/NGOs personnel.

NEPAL HEALTH RESEARCH COUNCIL
Ramshahpath, Kathmandu, Nepal

EVALUATION STUDY OF DECENTRALIZED HEALTH FACILITIES IN NEPAL

Date	Time	Location	Position and Name of Respondent	Study Team
	Start: End:	VDC:__________________ Name of SHP :_________________ District:_______________ Date of SHP handover:________	Position: __________________ Name: __________________	Interviewer: __________________ Note taker: __________________

Introduction and warm-up

Namaste, my name is ________________________. I am here on behalf of the Nepal Health Research Council (NHRC) of the HMG/Nepal to collect information on the EVALUATION STUDY OF DECENTRALIZED HEALTH FACILITIES OF NEPAL. The information provided by you will be instrumental to strengthen and /or to overcome barriers of the health facilities decentralized initiation in Nepal to improve the health of this community in the days to come. With your kind consent, I would like to ask you some questions. Your names will remain confidential with me. Please feel free to express your opinions openly, and ask me if you have any questions.

1. In your district, how many SHPs are handed over to the community?
   ……
   ……
2. What are the main objectives of handing over the health facilities to the community?
   ……
   ……
3. What was the process of handing over health facility to the community in your district?
   a)……………………………………………………………………………………………………
   b)……………………………………………………………………………………………………
   c)……………………………………………………………………………………………………
4. What are the basic requirements/policies of handing over health facility to the community?
   a)……………………………………………………………………………………………………
   b)……………………………………………………………………………………………………
   c)……………………………………………………………………………………………………
5. What kinds of authorities are delegated to the HMCs, of the handed over SHP?
   a)……………………………………………………………………………………………………
   b)……………………………………………………………………………………………………
   c)……………………………………………………………………………………………………
6. Do you have any periodic plan for the further development of health services?
   a) Yes b) No
7. How the Local Self-Governance Act is implemented in health sector? What are the constraints?
   ……
   ……
8. What do you think about health facility hand over to the community?
   Is it right time for handover?
   a) Yes b) No

9. What are the positive and negative aspects of health facility after handing over to the Community?
……………………………..
10. What is the provision of budget to run the decentralized SHPs? What is your opinion about the quality health service?
………
………
11. What is the condition of health services provided by SHPs before and after hand over?
………
………………………………………………………………………
12. What are the programs/trainings have been conducted to improve professional efficiency of the health personnel?
………
………
13. What are the reactions of service receiver you have received after handover?
………
…….
14. What is the impact of conflict on service delivery and operation?
………
…….
15. What is the impact of conflict in implementing outreach clinics and visiting wards?
………
………
16. Do you have any suggestion/comments about strengthening the health facility of handed over health facilities.
………
………
………
………
………
………
………………………………………………………………………………………….

Instrument /Tool No.7
Time: 45-60 mins.

Beneficiaries/Local Groups FGD Guideline

NEPAL HEALTH RESEARCH COUNCIL
Ramshahpath,Kathmandu,Nepal

EVALUATION STUDY OF DECENTRALIZED HEALTH FACILITIES IN NEPAL

Introduction and warm-up

Namaste, my name is ________________________. I am here on behalf of the Nepal Health Research Council (NHRC) of the HMG/Nepal to collect information on the EVALUATION STUDY OF DECENTRALIZED HEALTH FACILITIES OF NEPAL. The information provided by you will be instrumental to strengthen and /or to overcome the barriers of health facilities decentralized initiation in Nepal to improve the health of this community in the days to come. With your kind consent, I would like to ask you some questions. Your names will remain confidential with me. Please feel free to express your opinions openly, and ask me if you have any questions.

(Ensure their consent for their participation, note taking and recording of the discussions, put them at their ease. Encourage them to ask questions, if any. Ask the participants to introduce them including their name, age, ethnicity, education occupation, and marital status, and fill in the participant's profile form).

A. Knowledge Regarding Health Facility handover by the Government.

1. Do you know this health facility handed over to the community?
   a) Yes b) No
2. Do you know about the formation of HMC?
   a) Yes b) No
3. What should be the main reasons of handing over this health facility to the community?
   a)…………………………………………………………………………………..………………………….
   b)………..
   c)……….
4. What is the difference in the health facilities provided by the SHPs before and after handover?
   ………
   ………

B. Process of Health Facility Hand Over.

1. Do you know how the SHP was handed over to the community?
   a) Yes b) No
2. Are you fully satisfied with the process of HMC formation and its composition?
   a) Yes b) No
   If yes/no, why?
   ………
   ………
3. Are you fully satisfied with the function of present HMC? In terms of:
   1. Physical Facilities
   2. Service provided by this SHP
   3. Human resource management
   4. Financial management
   5. Community mobilization
   6. Health facility management
   7. Drug supply management
   8. Others…………………………………………………………………………………………………
   ………………………………………………………………………………..……………………………

C. Health service

1. When did you came here before for the treatment? Year/month ……………………………………………
2. Did you come here before 3 years?
   a) Yes b) No
3. Whether the ticket was free or you paid for it?
   a) Yes b) No
   If yes, how much? NRs..
4. Did you pay any extra charges for other services?
   a) Yes b) No
   If yes how much for which service? NRs……………………………………………….
5. How was the behavior of the doctors (health personnel)?
………
………
6. Are you getting required medicines from this SHP when you come for the treatment?
   a) Yes b) No
7. What is your view towards below mentioned facilities?

S. No.	Facilities	Opinion			
		Very Good	Good	Satisfactory	Remarks
1.	Opening Hour				
2.	Availability of Drugs				
3.	Quality Counseling				
4.	Home visit of MCHWs/VHWs/ANMs				
5.	Availability of the health personnel (10-2)				
6.	Informed Choice				
7.	Privacy				
8.	Water Supply				
9.	Toilet				
10.	Sufficient sitting arrangement				
11.	Behavior of the service providers				
12.	Management of the health facility				

D. Community participation and ownership

1. Is there any provision of providing the essential medicines in free of cost to the poor and helpless people?
   a) Yes b) No
2. Did you ever receive that facility?
   ………
   ………
3. Have you ever been participated in the improvement of the health facility of this SHP?
   ………
   ………
4. What are the problems you are facing to get health services from this SHP?
   ………
   ………
5. How are you thinking that this SHP is yours?
   ………
   ………
6. What are the areas to be strengthen to get effective health service from the SHP?
………
………
7. What do you think about hand over the SHP to the community? Is it good decision taken by the government? Why?
   ………
   ………
8. Do you have any suggestion /comments about strengthening the health facility of this SHP?
   ………
   ………

Instrument/Tool No. 8
Time: 30-45 mins.

Health Facility Observation Check-List

NEPAL HEALTH RESEARCH COUNCIL
Ramshahpath, Kathmandu, Nepal

EVALUATION STUDY OF DECENTRALIZED HEALTH FACILITIES IN NEPAL

Date	Time	Location	Study Team
	Start: End:	VDC:_________________ Name of SHP_________________ District:________________ Date of handover_________________	Name: _________________ _________________

.

Formal Introduction:

Request this with SHP in-charge, ensure their consent for their cooperation, note for recording all the required data/information, and note accordingly in the following data/information sheet along together your perception after you have thoroughly observed the facilities and ongoing activities of SH.

1. Service Utilization Record Sheet After and Before Hand over of SHP

S. No.	Health service	Clients receiving the services during immediate past three month of SHP hand over					Clients receiving the services immediate past three months				
		M	F	Total	Target	Achievements	M	F	Total	Target	Achievements
1.	OPD Visit										
2.	4 Times ANC/PNC Services										
3.	DP3 Coverage										
4.	Measles Coverage										
5.	Female seeking Maternal Care Services										
6.	Depo + Pills+ Condom Distributed										
7.	Delivery Conducted by Trained Personnel (TBAs)										
8.	Diarrhoeal Disease Treatment										
9.	STDs,HIV/AIDS										
10.	Referral Services										
11.	DOTs clinic										

Note: SHPs handed over in 2059 Shrawan /Bhadra

2. Availability of service utilities

S. No.	Specification	Yes	No	Remarks
1	Piped running water/tube well water facility			
2	Electricity			
3	Telephone			
4	Working toilet/latrines			
5	Sufficient sitting arrangements for the clients.			
6.	Others:			
a				
b				
c				

3. Availability of Display Boards

S. No.	Specification	Yes	No	Remarks
1	Names and Position of HMC Committee			
2	Types of services available and cost			
3	Opening days and times			
4	Name, Position and Qualification of Service Providers			
5	Graphic charts			
6	IEC/BCC materials			
7	Reference materials			
8	Others			
9				
10				

4. HMC Meeting and Minute Keeping (Last three HMC meetings)

S. No.	Month/date	Attendance (%)	Agenda and Decisions	Action taken
1				
2				
3				

5. Record of supervision

S. No.	Related Office	Date	Suggestions/Recommendation
1			
2			
3			
4			

6. Available Physical facilities

S. No.	Particulars	Total No.
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

7. Budget/ income source of this SHP

S. No.	Income Source	Budget
1	Government of Nepal	
2	I/NGO	
3	VDC	
4	Own resource	
5	Prizes	
6	Others	
7		
8		
9		

8. Distribution of Budget

S. No,	Particulars	Total Amount	Percentage
1	Total Budget		
2	Health Service		
3	Salary/Allowance		
4	Construction/Reconstruction		
5	Drug Purchase		
	Total		

9. Researcher's/Observer's Special Remarks on his/her Observation

Appendix 17: Photographs of Field Activities

Photographs of Field Activities

Some Glimpses of Tools Developments, Training and Debriefing Activities.

Photographs of Field Activities

Some Glimpses of Research Tools Pre- Testing in Bhaktapur District.

Photographs of Field Activities

Some Glimpses of Field Activities in Jhapa District.

Photographs of Field Activities

Some Glimpses of Field Activities in Lalitpur District.

Photographs of Field Activities

Some Glimpses of Field Activities in Kaski District.

Photographs of Field Activities

Some Glimpses of Field Activities in Banke District.

Photographs of Field Activities

Some Glimpses of Field Activities in Kanchanpur District.