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HEALTH GOVERNANCE AT THE LOCAL LEVEL IN NEPAL: RETENTION OF HEALTH WORKERS AS A CRITICAL FACTOR

Narendra Raj Paudel*
Public Administration Campus, Tribhuvan University, Nepal

ABSTRACT

This article examines the health governance situation in Nepal in order to explore crucial factors responsible for effective health service delivery at the country's local level, particularly its far-western region. To this end, qualitative information from two well performing and to bad performing Health Facilities (HFs) of Doti and Kailali districts out of the nine districts of Far Western Development Region was used. These sources included field observations and interviews, health profiles, public hearing records, and social audit reports pertaining to the aforementioned HFs. The study showed that HFs have to tackle issues of resource restrictions, availability of other facilities (such as human resources and training), internal reliability measures, and intra-HF coordination when delivering their services to the public. In this regard, increasing government reliance on contract-based employees rather than permanent ones has exacerbated the issue of decreasing employees in remote HFs, while resources seem to be increasingly allocated to well performing HFs, reinforcing the marginality of bad performing ones which are structurally disadvantaged as well. Resource scarcity has led to lack of incentives to increase the reliability, efficiency, and effectiveness of bad performing HFs, while having a similar impact on their coordination strategies too. The study argues, therefore, that while individual fields of action such as coordination and resource allocation should be given serious attention to, it is equally – if not more – important to make sure that the structural marginalities which perpetuate the ineffectiveness of bad performing HFs are addressed with public input, not only to make local health service delivery more effective, but also give true meaning to local self-government in Nepal.

Key words: Nepal, Health Governance, Health Facilities, Health Service Delivery

* Corresponding author e-mail:
narendra.radharam@gmail.com

INTRODUCTION

Although there are a number of definitions of governance, it is difficult to come across one that is universally acceptable. The roots of the concept of governance can be traced to classical Latin and ancient Greek words referring to steering boats. Conceptually, the meaning of governance has been clarified by the Oxford English Dictionary as 'an action or manner of governing'. In an encompassing definition by the Human Development Center of Pakistan (1999), governance "is a continuing process through which conflicting diverse interests may be accommodated and cooperative action may be taken. It includes formal institutions and regimes empowered to enforce compliance as well as informal arrangements that people and institutions either have agreed to or perceive to be in their interest" (p. 29).

Despite efforts to improve the situation of governance in developing countries like Nepal, the status of governance in these countries does not paint a bright picture (UNDP 1997). This is partly due to the fact that efforts towards improving governance do not sit well with local socio-cultural dynamics. Recently, the Nepali government jointly initiated a project with the German organization Gesellschaft für Internationale Zusammenarbeit (GIZ) in financial year 2013, called the Local Health Governance Service Programme (LHGSP) which was implemented in the districts of Kailali and Doti in the Far Western Region of Nepal. The main objective of the programme was to strengthen local health governance. This article explores the factors which play a vital role in steering health service delivery in the rural areas of Nepal, focusing on the LHGSP project as its case study.

HEALTH GOVERNANCE SITUATION IN NEPAL

Several attempts have been made in Nepal to strengthen local governance since the last 50 years. These include adopting different models such as *gram panchayats, panchayats,* and *the democratic model*. In the country's developmental history of local governance, more than ten commissions were also constituted to identify the strengths and weaknesses of these endeavors, with a view to learn from past experience and introduce more informed models. To this end, institutional and legal frameworks were developed and tested to make local governance more effective. However, results have shown to be far below expectation.

The Local Self Governance Act of 1999 is the latest legal instrument that governs local government, its development practices, and delivery of public services in Nepal. At present, there are 75 District Development Committees (DDCs), more than 100 Municipalities, and 3000 Village Development Committees (VDCs) as local bodies in Nepal. These legal instruments and structures are considered as a focal point to deliver services to the people (LGSA 1999, p. 26). For health service delivery, there is at least one HF in each VDC.

Health policies developed in Nepal have been by guided by trends in global health policies/ strategies. Following the declaration of Health for All Strategy in 1978, the Government of Nepal (GoN) undertook policy measures and programmes for promoting health at the national and district levels. The GoN is also fully committed to implement the Programme of Action of the International Conference of Population and Development (ICPD) of 1994, Beijing Plan for Action (BPFA), of 1995, and Millennium Development Goals (MDGs) of 2000. The ICPD emphasizes on integral linkages between population and development, and focuses on meeting the needs of individuals rather than on achieving demographic targets. The Beijing conferences emphasize on 'women and health' and 'child health' (Ministry of Local Development

2004). The Millennium Declaration set out eight MDGs and eighteen targets to create an environment – at the national and global levels – conducive to development and elimination of poverty. The health sector is particularly involved in five of these targets namely reduction of infant and child mortality rates, improving maternal health, achieving universal access to reproductive health services, combating HIV/ AIDS, and combating malaria and other diseases (MOH 2004).

The GoN is officially committed to devolve power in order to provide more effective health services for the people. However, in practice, as in most developing countries, there is a tendency to prefer delegating power to the public service rather than to locally elected authorities (Paudel 2013, p. 175), because although there has been much rhetoric about participation and local autonomy, but central governments have jealously guarded their power (Turner and Hulme 1997).

The focus of the GoN rather seems to be on gradually privatizing the health sector. There are approximately 100 private hospitals and nursing homes, along with thousands of private health clinics and laboratories offering access to pharmaceuticals (DOHS 2013). However, such facilities are mainly available in urban areas, and are offered by private hospitals which lie beyond the capacity of rural and poor people to afford (ESP 2001).

Despite these developments, the GoN has also introduced various means by which health services may be obtained by the rural majority. Starting with the National Health Policy (NHP) adopted in 1991 to bring about improvement in the country's health conditions as per national and international commitments (MOH 1991), the Eighth Plan (1992-1997), Ninth Plan (1997-2002), Second Long-Term Health Plan (SLTHP) of 1997-2017, the Tenth Plan (2002-2007), the Eleventh Interim Plan (2007-2010), the Twelfth Interim Plan (2010-2013), and the Thirteenth Interim Plan (2013-2016) all aim to realize this goal, in keeping with the recommendations of the National Planning Commission (NHP) made through the period of 1986-2010.

The public health sector in Nepal consists of 87 hospitals, 6 Health Centers, 697 Health Posts, 287 Ayurvedic Hospitals, 186 Primary Health Centers, and 3129 sub-Health Posts. Among them, 75% are distributed in the rural areas of the country. However, they are in an overwhelmingly poor condition, with no water, no electricity, and a serious lack of infrastructure (DOHS 2012).

25,000 health workers – including health experts – are engaged in providing health services to the people (DOHS 2012). However, when distributed nationally, this number is woefully inadequate to maintain even a minimum level of health care. Brain drain is also a prominent reason contributing towards intensifying the inadequacy of health workers in Nepal (Paudel 2004; Paudel 2012). In this background, the GoN launched the LHGSP with the assistance of donor countries to address these issues. The aim of this study is to assess the impact of the programme within a framework of identifying factors that are critical in the effective implementation of a sound health policy.

METHODOLOGY

For the purpose of this study, the districts of Doti and Kailali in the Far Western Development Region of Nepal were chosen. Out of the nine districts in the region, these two were chosen because they have the most disparity in terms of their respective population size, crude death rate, infant mortality rate, and maternal mortality rate. On the count of life expectancy, they were similar. The two districts also accommodated both good and bad performing HFs, which further encouraged the choice.

Doti district has a population of 200,000,

and is located in the hills of the Far Western region. It has a crude death rate of 8.12 for every 1000 births. The infant mortality rate of the district is 42.18 for every 1000 births, while the maternal mortality rate is at 107 for every 100,000 deliveries. Kailali district accommodates a population of 100,000, and is located in the Far Western Terai region. Its crude death rate is at 7.64 for every 1000 births. Kailali has an infant mortality rate of 49.2 for every 1000 births, along with a maternal mortality rate of 120 for every 100,000 deliveries. Both districts have similar life expectancy of 65 years (CBS 2014).

The performance of the HFs in these districts was ascertained on the basis of their process, output, and outcome indicators as outlined in the Monitoring and Evaluation framework of the LHGSP (2013). This data was triangulated by the observations of the field enumerators, as well as interviews with experts in the respective localities. Based on this input, one good and bad performer HF was selected from each district. Thus, four HFs from both districts were selected for conducting the case study. The case study explores the reasons behind the performance of the HFs, thereby attempting to identify factors that may improve health sector service delivery in rural Nepal.

To this end, Dododhara HF from Kailali and Durgamandu HF from Doti were selected as good performers because these HFs had achieved the set target of health indicators at the time of fieldwork. In contrast, Durgauli HF from Kailali and Barchhen HF from Doti had relatively low health indicator achievements, thus encouraging their choice as bad performers. Following field location selection, key informant interviews were undertaken with the District Public Health Officer (DPHO), GIZ local focal persons, respective Village Development Committee (VDC) secretaries, and HF in-charges to collect additional in-depth qualitative information. The qualitative information pertained to issues of resource mobilization, human resource hiring and training, social audit conduction, coordination with stakeholders, village health profile preparation, ensuring the quality of health services delivered, and maintaining stocks of drugs.

FINDINGS

Resource Mobilization

In total, Rs. 400,999 was mobilized in the financial year 2014/15 in the Durgamandu HF. The grant was for multiple initiatives including the Safe Mother Programme, the LHGSP, and the VDC. Funds were spent on institutional delivery, infrastructure building, transportation of drugs, furniture, salaries, and so on (see table 1). However, this HF displayed a lack of spending capability which, according to its health in-charge, owed to the scarcity of human resources, lack of guidance by the management committee, and issues with effective identification of problems. In addition, he reported that there was a delay in the release of the grant on the part of the government, resulting in a mirror delay in spending (Durgamandu HF health in-charge, personal communication, Durgamandu HF, April 15, 2016).

In comparison, the volume of resource mobilization in the Dododhara HF was found to be higher. In total, more than 1.2 million was generated as income from sources such as LHGSP grants, VDC activities, and the Safe Mother Programme. Of this, Rs. 1.1 million was spent on the Safe Mother Programme, procurement, infrastructure building, medicine, and salaries.

Consultation of this HFs records and field work revealed that the income and expenditure of the HF were always presented before the health management committee, and no funds were spent without the approval of the committee. This strict following of financial rules and regulations had resulted in greater

Table 1: Income and Expenditure of the Durgamandu HF During the Financial Year 2014/15

Source of income	Amount (Rs.)	Line item	Expenditure
Safe Mother program	160,000/	Delivery	23,196/
LHGSP	100,000/	Transportation	11,000/
Free Health Program	25,000/	Cleaning	32,500/
Grants from VDC	100,000/	Infrastructure	60,000/
Child club	15,000/	ENT & BP set	6,400/
Matching funds from VDC	999/	Citizens' charter	2,500/
Care Nepal	34,000/	Social audit	900/
DPHO	60,000	Sweeper salary	32,500/
-	-	TV showcase	15,000/
-	-	Furniture	20,000/
Total	494,999/	Total	203,996/

Source: Durgamandu Social Audit Report (2013)

Table 2: IIncome and Expenditure of the Dododhara HF in the Financial Year 2014/15

Source of income	Amount (Rs.)	Line item	Expenditure
Free health care	80,000/	Safe Mother Programme	599823/
LHGSP	55,000/	Procurement	47309/
Grants from VDC	31,000/	Infrastructure	77642/
Internal income ???	12640/	Medical equipment	235080/
Safe mother program	10,05,745/	Medicine	50000/
-	-	Salaries	36000/
-	-	Training and orientation	14950/
-	-	Other (paint)	20583/
-	-	Incentives	24930/
Total	12,98,145/	Total	11,06,317/

Source: Dododhara Social Audit Report (2013)

financial accountability in the Dododhara HF. Further, the level of activism in the HF (stemming possibly from the satisfaction with financial good practice) has encouraged greater mobilization of local financial resources for the facility. To illustrate, the health in-charge of the Dododhara HF revealed that workers of the HF had started constructing an immunization center despite the absence of funding to complete the project. The seed grant had been a loan from the LHGSP fund. Continuing the initial enthusiastic spirit, they are looking to tap into other sources to complete the building construction, some of which has started to come from locally based sources (Dododhara HF health in-charge, personal communication, Dododhara HF, April 17, 2016).

In the Durgauli HF (chosen as a bad performing HF in this study), a total of Rs. 303,000 was mobilized in the financial year 2014/15. This was the income from the first and second instalments of the LHGSP and the free health

programme. The Durgauli HF had also been able to mobilize local resources by way of timber, which was used for making doors and other furniture. In terms of expenses, it had spent Rs. 83,351 on different line items such as medicine, procurement, health equipment, infrastructure building, and maintenance. Despite its bad performance indicators, the HF had followed the guidelines of the quality improvement plan and VDC health periodical plan. Additionally, all expenditure was made with the approval of the Health Management Committee (Durgauli Village and Health Profile 2013).

Only Rs. 136,000 as resources was mobilized by the Barchhen HF, which also was chosen as a bad performing HF. Out of this fund, Rs. 36,000 was from the Free Health Programme, and Rs. 100,000 from the LHGSP. Due to the lack of a permanent health worker cadre, income sources and expenditure records were not maintained by this HF due to the perception that it was not necessary to document temporary health workers. The Secretary of the VDC informed that no local resource was mobilized, and its only source of income from the locality came from Out Patient Department charges (Secretary, Barchhen VDC, personal communication, Barchhen HF, April 20, 2016).

Shortage of Medicine

The Durgamandu HF has been suffering from a shortage of medicine for some time now. Out of 33 medicines that the government has committed itself to make available at each HF, 24 were not available at the time of the fieldwork. This was due to two factors: First, the cost of transportation is not covered by the District Public Health Office (DPHO), compromising the timely arrival of drugs in the HF. Second, the GIZ focal person opined that this was also partly due to the lethargic recording and reporting system of the HF in question, and that whenever the relevant GIZ officer attempts to raise the issue with the government officer in charge of health, s/he is transferred immediately or within the course of a few months (Secretary, personal communication, Durgamandu HF, April 15, 2016).

In the Dododhara HF too, at the time of field observation, almost two dozens of drugs out of 33 essentials were out of stock. In this case, a key informant reported that they faced the problem of a high flow of patients, which drained the HF of its medicine stock quickly. The respondent also mentioned that although the HF typically requests reinforcements from the DPHO in time, the DPHO also suffers from deficits and cannot always guarantee a timely supply to meet the demand. However, the crisis occurs only 2-3 times during the year, not more, according to the respondent (Pharmaceuticals Officer, personal communication, Dododhara HF, April 17, 2016).

In the case of bad performing HFs, drug deficit is largely due to high patient inflow and there not being a regular supply of drugs from the DPHO. A respondent explained that while the DPHO does not usually arrange a vehicle to transport only 2-3 drugs, the HF also does not have a surplus of health workers to be assigned to bring the medicine from the DPHO. Another problem relates to indicators of medicine stock-out: The bulk of these medicines is kept in the dispensary once acquired. In such situations, even though the registry indicates that the HF is out of a certain drug, it is not (Secretaries, personal communication, Barchhen HF, April 20, 2016; Durgauli HF, April 21, 2016). These coordination problems account for a significant proportion of the crises in HFs, and should be addressed before any accurate assessment of the capacities of such HFs can be made.

Health Manpower and Training

In the well performing HF of Durgamandu,

all the sanctioned positions had been filled, including the post of Auxiliary Nurse Midwife (ANM) which was filled on contract. As per the Health Services Act of 1996, health workers who meet the minimum required qualifications as set forth by the Public Services Commission can be hired locally on contract basis if there a deficit of permanent health workers. The number of permanent health workers in Nepal is not sufficient both nationally and locally (DOHS 2013), necessitating the recruitment of health workers on contract basis. An interview with the officer in charge of health of the Durgamandu HF revealed that all recruits, include those on contract, are provided opportunities to receive training on Community Based Integrated Management of Childhood Illness (CB-IMCI), Community Based Nursing Care Plan (CB-NCP), and the use of Intrauterine Contraceptive Devices (IUCDs) under the human resource development programme of the HF. The Durgamandu HF had been awarding outstanding Auxiliary Nurse Midwives (ANMs) with the support of the District Health Office since the past two/three years, in addition to winning the best performing Female Community Health Volunteers (FCHVs) together with the VDC. This HF also followed the Performance Based Incentive System (PBIS) to identify its best performing employees. As a result, this HF was evaluated by the District Health Office of Doti as one with a regular supply of trained health workers.

In the Dododhara HF, the sanctioned positions were in the main filled by permanent health workers, while positions such as Auxiliary Health Assistant, ANM, lab assistant, and office assistant were filled on contract. Similar to the Durgamandu HF, here too supplementary training was offered to increase the competencies of the workers, whether permanent or contract. While fieldwork revealed that there were no great challenges or obstacles to carrying out the HF's operations during the past year, there were incidents of management committee members attempting to pressurize the HF into recruiting health workers of their choice, but to no avail.

In the bad performing Durgauli HF, although all the sanctioned positioned were filled, this has been more due to the pressure of contingencies than due to any particular keenness of the HF to actually fill its vacancies. This fact is evidenced by events in the recent past where one AHW and one ANM were hired on the basis of the regional quota and district quota respectively from December 2014 to June 2015. But in June 2015, the contract had expired and the post had become vacant. In July 2015, there had been an increased flow of patients due to an epidemic because of which the management committee had decided to rehire them for an extra month at an additional cost of Rs. 5,000 per person. Rules, regulations, and guidelines prescribed by the LSGA had not been strictly followed in the process of re-recruitment, and those who were thus re-recruited had been transferred to the next HF immediately upon the expiration of their extended contracts. These employees had also not got any opportunity for training (GIZ focal person, personal communication, Doti District GIZ office, April 25, 2016).

In the case of the bad performing Barchhen HF, there were no permanent health workers available throughout the year. The ANM who was also serving on contract basis, worked as the acting officer in charge of health. The post of the officer in charge of health was filled in May 2015. An interview with him suggested that he was unaware of the Local Health Governance Programme that was being implemented in this HF. Field observations brought to light how administrative oversights leading to severe human resource problems have caused this state of oblivion on the part of the presiding officer. All the sanctioned posts of the HF were vacant, save for those of the ANM and MCHW, which were filled with

employees hired on contract. In an interview with the VDC secretary, GIZ focal person, and DPHO focal person, it was revealed that health workers did not stay in the HF in the long term due to its remoteness and the unavailability of basic logistical support. The Public Service Commission was also not too enthusiastic in filling these positions in a timely manner, according to the respondents. Thus, the health programme could not be implemented the way it was envisaged. Further, fieldwork revealed that no one working in this HF had received training.

The preceding account also raises important questions about the implications of expanding the contract-based labour pool in government services. Having a permanent cadre for these positions will obviously address the issues of lack of training and officers vacating their posts due to lack of facilities. A permanent employee of the government will have to serve in difficult areas as part of their training, and refusing the appointment without due justification will result in the termination of employment. This being the case, why is contract employment treated as the go-to option without, in most instances, considering drawing from the permanent pool? If the permanent workforce is indeed shrinking, what does this say, among other things, about the government's incentive to maintain such a workforce? As is well known, hiring on contract significantly reduces the responsibility of the employer especially in monetary terms (since no investment has to be made in social security including EPF, ETF, paid leave, etc.). It could very well be, then, that the government opts for contract employment as the first preference to lessen the monetary strain on itself. The impact of contract-based employment on the quality of health services in the chosen locations has already been illustrated. The government, therefore, needs to invest in either improving the facilities available in these areas to attract trained contract labour, or in expanding its permanent force that will serve in any area regardless of the facilities available.

Social Audit

In the good performing Durgamandu HF, a social audit was conducted in the financial years of 2014 and 2015 in accordance with the procedure prescribed by MHP and GIZ, following which a report was compiled in each year. People from every walk of life such as political party activists, health workers, and common citizens participated in the social audit organized by DHO and facilitated by the Development and Communication Group of Doti. The audit sought people's assessment of and opinion on various dimensions of their HF such as regular supply of drinking water, delivery room facilities, citizens' charter, laboratory facilities, availability of and access to health service information and health workers, etc. Field interviews revealed that Safe Motherhood, child health, nutrition, and family planning programmes were incorporated in the local plan as a result of the social audit (Durgamandu Social Audit Report 2013).

Similar to the Durgamandu HF, in 2014 and 2015 a social audit was conducted in the good performing Dododhara HF as well. FAYA Nepal conducted the social audit under the authorization of the DPHO, based on the guidelines prescribed by the MHP. As the first step of the process, the HF took measures to form a committee representing all sectors of the local society. Next, members from the *Dalit* (untouchable) community and economically marginalized communities were invited to join. The final composition of this body was 90 people, of which 52 were women and 38 were men. The social audit concentrated on issues of annual expenditure and services delivered by the HF. The report prepared following the social audit flagged such concerns as including a suggestion box in the HF, lack of training to the health workers conducting delivery and implanted family planning devices, lack of beds in the

birthing center, lack of ambulance services, the non-availability of drugs, and the need for an x-ray machine. As a result of the social audit, a Citizens' Charter was prepared and made public, and a waiting hall in the HF was constructed (Dododhara Social Audit Report 2013).

The bad performing HF in Durgauli conducted its social audit in the financial year of 2015 under the guidance of FAYA Nepal as per the directives of the MHP. There were a series of consultative meeting with health workers, members of the management committee, and public at large. In the first stage, 16 people participated in the social audit. In the second stage of the social audit, there were 111 people (49 males and 62 females) who participated. In addition, members from the *Dalit* community as well as minorities were also involved in the social audit separately. There was two-way interaction between the people and the concerned authority by way of the former asking questions on health service delivery and the latter answering them (Durgauli Social Audit Report 2013).

In the bad performing Barchhen HF, a social audit was conducted in FY 2014/ 2015. More than 60 people including those from political parties and local organizations, health workers, and common people participated in the social audit. It was organized by the DHO of Doti with the support of GIZ and facilitation of the Development and Communication Group of Doti. People voiced their need for the construction of a building with adequate rooms and fencing, making health workers available, an active management committee, as well as effective coordination internally and externally. In addition, issues were flagged like the lack of required drugs, irregular conduction of the village clinic, and the unavailability of delivery services. However, the ANM who was in charge of the HF at the time of the social audit had not been aware of the directives of the social audit. However, as a marginal gain, a toilet had been constructed in response to the social audit (Barchhen Social Audit Report 2013). At the time of the field research, the AHW was appointed as health in-charge, but he was also not aware of the LHGSP programme.

Quality Assurance

In the interest of health quality assurance, a Quality Assurance Committee (QAC) has been formed in the well performing HF of Durgamandu. It comprises the officer in charge of health, the nursing staff, and a member of the health management committee. Health workers along with other stakeholders are oriented about the quality assurance plan of the HF through this body. As a complementary structure, a Citizens' Forum is also formed in each ward. However, the QAC has not been able to function properly due to the lack of clear guidelines (Durgamandu Village and Health Profile 2013).

In the well performing Dododhara HF also a similar body – with similar composition and functions – has been formed on the directives prescribed by the MHP. However, the Committee has not been able to hold a meeting until now, and its mandate (of ensuring quality service delivery to the public) is currently performed by the health management committee. Due to the high quality of health services, a high flow of patients from nearby VDCs comes into the Dododhara HF (Dododhara Village and Health Profile 2013).

In the case of bad performing HFs of both districts, quality assurance directives are received directly from the ministry, under whose guidance a quality assurance task force has been formed in each HF. However, even with the necessary institutional and resource provisions in place, neither of these task forces function at present.

Coordination

In the financial year 2015, the Health Management Committee (HMC) of the Durgamandu HF was able to hold its monthly meetings regularly except for a few months. The committee was inclusive with the *Dalit* community, women, and minority ethnics groups adequately represented and involved in local health management. Respondents of this field location held that the success of the HF was due to the team work spirit in team members. "Without motivation and positive attitude coordination is impossible," (Officer in charge of health, personal communication, Durgamandu HF, April 15, 2016). However, the DPHO focal person argued that the performance of the HF would have been better if there had been good coordination between health workers and members of the HMC.

In the case of Dododhara HF, monthly meetings of the HMC were held only six months in the year. The meetings witnessed the participation of women, members of the *Dalit* community, and minority ethnic communities. However, the key informant mentioned experiencing functional issues because the members of the HMC were in the main old and lacked energy to take constructive measures for the betterment of the HF (Secretary, personal communication, Dododhara HF, April 17, 2016). Both the officer in charge of health and VDC secretary claimed that the HF became a good performer due to proper coordination among the stakeholders. Regular HMC meetings and staff meetings were key indicators of the smooth process of coordination behind the health facility. The officer in charge of health reported that HMC meetings were held mostly every two months, but ad hoc meetings were summoned if needed. He also added that daily staff meetings were conducted for quality assurance (Officer in charge of health and VDC Secretary, personal communication, Dododhara HF, April 17, 2016).

No calendar was prepared for HMC meetings as far as the Durgauli HF was concerned. While HMC members were familiar with the LHGSP programme and the planning process of the HF was linked with those of the VDC and DDC, there was no participatory mechanism for its stakeholders' involvement. In the financial year 2014, HMC meetings with all its members including women and ethnic members were held seven times, and clear decisions were made on the HF's activities. Regular meetings of the HMC were held from July to December, 2015 (Durgauli Social Audit Report 2013). The officer in charge of health in the Dugauli HF opined that members of the HMC were active and positive, and demonstrated a keen interest in implementing new health-related programmes. In addition, he opined that they discussed the problems faced by the HF and put forward suggestions to resolve them (Officer in charge of health, personal communication, Durgauli HF, April 21, 2016).

In the case of the Barchhen HF, the local HMC's meetings were not held regularly because of the post of the officer in charge of health being vacant for a long time, a problem exacerbated by the VDC secretary's inability to fill in due to the remoteness of the location and the access problems it posed. Consequently, no health programme was implemented in this HF until 2014. When an ANM was appointed in 2014, meetings of the HMC were held from April to July of that year (Minutes of Barchhen HF 2014). Field observations suggested that neither the members of the HMC nor health workers were particularly interested in coordinating their efforts to improve health service delivery of the area.

DISCUSSION AND CONCLUSION

In order to examine factors that are crucial for effective health service delivery in rural Nepal,

this article has conducted a case study in four Health Facilities (HFs) in the Far Western Region of Nepal, based on their performance in delivering health services. These HFs were Durgamandu and Dododhara (well performing HFs), and Durgauli and Bacchen (bad performing HFs). Performance was assessed based on the health profiles, public hearing records, and social audit reports of the jurisdictions of the respective HFs.

The findings suggest a clear division between well and bad performing HFs in terms of the resources available to them and their internal functions (such as the reliability measures they take and the extent to which they coordinate affairs within the HF), which could have mutually reinforcing effects on each other. For instance, the well performing HF of Dododhara also had an excellent record of team work and coordination as well as timely social audits, driving their health indicators higher. They also had more resources at their disposal, which could partially owe to their good performance attracting more government funds, and partially to their central location which attracted a lot of patients anyway. Increasing resources seemed to have encouraged further enhancement of internal functions. Dododhara's performance (in terms of the number of people who use the HF), however, was negatively affected by some patients opting for private medical care and the high incidence of male migration out of the region.

At the other end of the spectrum one finds HFs like Durgauli which have not performed quite so well. Again, similar explanations can be used to understand the situation whereby bad performance and resource availability seem to be interdependent. Durgauli is located in a remote area, leading patients of the area to seek help from the more accessible Tikapur hospital. Consistently low patient turnout has pushed this HF further into the background, drawing less and less government attention and funding, leading to increasingly less incentives for the staff to improve internal functions. The cycle is completed when the government makes its funding decisions based on such functions of HFs.

Any attempt at improving local self-government in the health sector of Nepal, therefore, should take into account these interplays in order to be effective. While measures to strengthen individual fields of action (such as coordination, resource allocation and mobilization, accessibility, etc.) are indeed extremely important, they should be undergirded by a larger attempt at identifying and addressing structural marginalities that perpetuate the ineffectiveness of bad performing HFs. These measures range from raising the awareness of the local population about the health facilities available to them, to improving the infrastructure in and around such HFs (like access roads and electricity), and to assigning a permanent cadre to such facilities and arming them with the technical capacity to enhance internal integrity and efficiency of the HF.

Consultations with the local community are an integral part of such a process because local specificities can hinder or help the realization of an effective HF in the area. For instance, people of Barchhen were reluctant to visit their HF because it was geographically located above the *Naga* temple of the village, and they were afraid of angering their goddess by seeking medical help from a facility that was located above her. This in turn impacted the HF's patient turnout figures, contributing in a significant way to its 'bad performer' status.

A culturally informed approach to improving local health service delivery can therefore go a long way. Participatory decision-making to this end would not only increase the legitimacy of the process and thereby secure success for the new strategy, but also give true meaning local self-government in Nepal.

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