Capacity building is not an event but a process: lesson from health sector decentralization of Nepal

G Gurung

Save the Children, Nepal Family Health Program, Kathmandu, Nepal

Corresponding author: Gagan Gurung, Team Leader-Nepal Family Health Program, Save the Children, Baghdarbar, Sundhara, Kathmandu, Nepal; e-mail: gtamu2000@hotmail.com; ggurung@nfhp.org.np

ABSTRACT

Health Facility Operation and Management Committee are supposed to govern all the affairs of local health facilities under decentralization policy. The capacity building of the committee was deemed necessary and thus different stakeholders involved in the capacity building process. All agreed up on the need of capacity building of the committee but there were different school of thoughts on the contents and process of capacity building. Major capacity building inputs included orientations and training to the committee. However the follow up part was not uniform; some organizations conducted periodic reflection meeting, where as many ended up with the training. There were some tangible changes observed by the capacity building inputs. Their priority however was on infrastructure and drug purchase. The changes observed were very short lived and not sustainable. The capacity building was equated with training and an event with low priority on follow up, monitoring and coaching. It was not thought as a process. A concept of complete package of capacity building should have been developed where training component would be only an element of overall capacity building.

Keywords: Capacity building, health facility operation and management committee, training.

MAIN TEXT:

Capacity building is a catchphrase in development field. It is an important issue in health sector decentralization also. Keeping in view the importance of community participation in governance of local health facilities and services, Ministry of Health and Population (MOHP), Nepal decided to handover the local health institutions to local bodies as per decentralization policy.[1] Under this provision, Health Facility Operation and Management Committee (HFOMC) are supposed to govern all the affairs of local health facilities. The HFOMC is a legitimate body formed locally at each health facility whose structure is inclusive in nature.[2] But mere handover of the health facilities to local body thus HFOMC was not sufficient. The capacity building of HFOMC was deemed necessary.

In past few years different organizations involved in the capacity building of the HFOMC.[3] All agreed up on the need of capacity building of HFOMC to make it capable in managing local health facilities and health services but there were different school of thoughts on the contents and process of capacity building.

Major capacity building inputs by these organizations included orientation and training to HFOMC.[3, 4] In the beginning, MOHP initiated its efforts by organizing an orientation through National Health Training Center (NHTC). This orientation was conducted just after the handover process was over. Other organizations conducted cascade trainings. The contents of the training included mainly HFOMC capacity assessment and management issues like planning, supervision and monitoring including others. The follow up part was not uniform; some organizations conducted periodic reflection meeting where as many ended up with the training.

There were some tangible changes observed by the capacity building inputs. HFOMC used to conduct regular monthly meeting. They tried to manage local resources. Their priority however was on bringing out the tangible outputs - infrastructure, drug purchase, hiring of local staff and extension of laboratory/x-ray services but underestimating the process – improving organizational capacity. Further, *dalits* and women HFOMC members had only token participation in health facility management with no say in decision making.[5] Most importantly, the changes observed were very short lived and not sustainable. The major drawback was capacity building equated with training and an event with low priority on follow up, monitoring, coaching, periodic review. The capacity building of HFOMC was not thought as a process. Besides, the training component also was not smoothly conducted. It was more knowledge based which should be skills mixed otherwise. These are the main reasons why even after long engagement of large number of organizations, strengthening of HFOMC did not take headway. Since, training was thought all in all, many contents were

delivered at a time. Since hand over and orientation process was not adequately done, their level of knowledge and skills on health facility management was so poor. Most of them even did not know their roles and responsibilities.

A concept of complete package of capacity building should have been developed where training component would be only an element of overall capacity building. The initial training should have covered only simple contents like internalization of their roles/ responsibilities, introduction of health facilities and its services, effective meeting conduction and decision making process. And necessary skills could have been delivered during regular monthly meeting of HFOMC and periodic review meeting. The capacity building process should have followed simple to complex technique while designing and delivering the contents. Furthermore, composition of the HFOMC was so heterogeneous that the content of the training should have been designed taking these things in to consideration. Instead, focus of the capacity building should be on imparting different management skills on HFOMC which would lead to performance improvement like increased resource mobilization, infrastructure, staff management and would possibly contribute to improve health outcomes like increase in service coverage.

The capacity building is a process that improves the ability of a system to improve performance and it does not necessarily directly influence health status but contributes to it through its link to performance.[6] The capacity building of HFOMC should be understood as a process of strengthening a peripheral community health system. In short, capacity building of HFOMC in future should focus on process and be implemented in a complete package.

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