Nepal health sector decentralization in Limbo: What are the bottlenecks?

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ABSTRACT

Nepal's efforts to decentralize its governance date back to over half a century. These efforts remained incomplete due to different reasons including administrative responses and political development affecting its implementation. The Local Self Governance Act (LSGA), 1999 envisaged, for the first time, to decentralize governance in the health sector through devolution of responsibilities, authority and resources to the local bodies. However, the pace of health sector decentralization in Nepal even after the LSGA was enacted has not progressed satisfactorily due to different reasons. The purpose of this paper is to discuss why health sector decentralization in Nepal has not advanced as expected. This paper identifies many issues—policy related, political, functional, and institutional— as stumbling blocks for health sector decentralization of Nepal. More specifically, the major bottlenecks for progress are lack of a clear cut policy, poor coordination among different sectors, improper handover process, lack of elected bodies, poor selection process of management committees, lack of coherence in the capacity building process of local bodies, ongoing debate about state restructuring including federalism and different political ideologies on decentralization.

Keywords: Local self governance, decentralization, health facility operation and management committee, state restructuring, federalism, local bodies, capacity building.

BACKGROUND

Nepal's efforts to decentralize its governance dates back to over half a century. These efforts have remained incomplete due to different reasons including administrative responses and political development affecting its implementation. The Local Self Governance Act (LSGA) 1999 envisaged to further decentralize governance, including of the health sector, through devolution of responsibilities, authority and resources to local bodies.[1,2] Health sector decentralization is also in important part of the overall health sector reform in Nepal and an important output of the Nepal Health Sector Program-Implementation Plan (NHSP-IP).[2,3] As per LSGA 1999, more than fourteen hundred peripheral government heath facilities (HFs)—sub-health post (SHP), health post (HP), primary health center (PHC)—were handed over to local bodies.[3-5] These health facilities provide a range of preventive and curative health care services, including immunization, family planning, antenatal and postnatal care, nutrition education and growth monitoring, health education and treatment of communicable diseases as well as home and healthcare facility deliveries. SHP from an institutional perspective is the first contact point for basic health services. Each level above the SHP is a referral point in a network from SHP to HP to PHC and to district, zonal and finally to specialty tertiary care centers at the central level.[6] As per the LSGA, local health committees named Health Facility Operation and Management Committees (HFOMCs) are supposed to govern the affairs of local health facilities, including their operation and management, in decentralized settings. HFOMCs work as a sub-committee and local health body of the Village Development Committee (VDC) to look after the health matters of the VDC. These Committees consist of a variety of community representatives—VDC elected members, school teacher, Female Community Health Volunteer (FCHV), *dalit (scheduled caste)* and women members, among others.[7-9] The decision to involve individuals from a variety of different backgrounds was made because it recognizes that the ultimate responsibility for health development lies with the communities themselves. And it also fosters social inclusion in health, ensuring voices of all, especially the marginalized in HF management, are heard. It was expected that once the HFOMCs assume full ownership of local level management, the committees would identify the local health problems, prioritize them, develop and implement action plans and mobilize local resources, with technical backstopping and information updates from the District Public Health Office (DPHO).

Current status of health sector decentralization

While there have been improvements in the decentralization of health governance, confusion on the conceptual and operational part of LSGA still prevails. The handover of HFs to HFOMC has had some positive effect on management of the HFs. Awareness about the HFs and concerns of local people over the HFs have increased after the handover. The VDCs and local people are willing to put resources together to improve their HF's physical facilities. In addition, the capacity of the HFOMCs, with regards to knowledge and skills in managing HFs is increasing and they are demanding authority be rightly devolved to them. In some districts, there is the practice of

funds, allocated for health, to flow through the District Development Fund (DDF) to VDCs and then to HFOMC and finally to HFs, which is envisaged by LSGA. Earlier, funds used to flow through the District Development Committees (DDCs) to DPHOs and then to HFs directly, which is not the ideal mechanism of fund flow in a decentralized setting. Bringing certain DPHO activities under the DDC has certainly brought these two institutions closer and subsequently improved their relationship and cooperation. This, however, has not led to any significant changes in the way the health institutions work and health services are provided. Despite the handover, human resource transfers, placements, leave and promotions are still controlled by the central and regional offices of the MoHP. Decision making about resource allocation to the local level HFs is also made by the central level offices. Furthermore, the planning process remains as it was before devolution. Bottom- up planning incorporating local level needs and demands is yet to be practiced.[2,10-15]

Thus, except for enhanced awareness among the communities and mobilization of local resources for health, the pace of health sector decentralization in Nepal has, in fact, stagnated, due to different reasons. The purpose of this paper is to discuss the reasons as to why health sector decentralization has not progressed as expected.

Bottlenecks in Nepal's Health Sector Decentralization

Lack of clear-cut policy: To effectively manage handed over HFs under decentralized setting, it requires clear-cut directives from the central level regarding the authority delegated at various levels, and the scope of work assigned to various concerned bodies such as MoHP, Department of Health Service (DoHS), DDCs, VDCs, HFs and HFOMCs themselves.[10]

Although the process of handing over HFs started in 2000, the roles and responsibilities are not yet clear. Within the MoHP, the exact roles of different divisions and centers are unclear. Other key partners and stakeholders such as the Ministry of Local Development (MoLD), DDCs, DPHOs, HFs, VDCs and supporting partners, are also in a state of confusion with regards to their respective roles and authority. For example, DPHO assume that the DDC is more responsible for the management of handed over facilities and vice versa. DDC authorities, including the DDC Chairman and Local Development Officer (LDO) are busy with other responsibilities and as such, the management of HFs is not a priority.[10-12]

Furthermore, it is important to mention here that health staff under the devolved districts has dual loyalties. For example LDO has supervisory authority over health staff on day to day issues like vacation, travel etc. but broader aspects of personal management like performance appraisals, promotions and deputations are still handled by health ministries[2].

The above situations are the result of a lack of clear cut policy directives from the centre. Therefore, amendment of such contradictory and ill defined policies is essential.

Lack of coordination among different sectors: To manage the HFs that have been handed-over properly, there is an urgent need for coordination between the Ministries and intra-ministerial divisions at MoHP, DoHS, the centre and districts, DDCs and DPHOs, DDCs and VDCs, DPHOs and HFs, HFOMCs and HFs, HFOMCs and communities, etc. Coordination among these stakeholders- at both vertical and horizontal levels- has remained weak. In many cases, disputes have occurred due to a lack of understanding and coordination among various stakeholders.[10,11]

Handover process not conducted properly: The handover process of the HFs to HFOMCs was carried out in haste and without any preparation. For example, in some cases, VDCs received a fifteen day notice that HFs would be handed over to the community. As such, when the DDCs invited the community for the handover ceremony, HF in-charges themselves were not aware it was happening.[10] Orientation sessions are needed to better prepare and sensitize not just the community, but all concerned actors, about the handover process.

Lack of coherence on capacity building of local bodies: Merely ensuring the handover process was properly carried out, however, was not sufficient. The capacity building of HFOMCs was deemed necessary, which many organizations in the past few years have been actively involved in, albeit with their own schools of thought on the process and content. Initially, capacity building of HFOMCs was not thought of as a process, rather, it was being equated to a one-time event or training and was given low priority with regards to follow-up, monitoring, coaching and periodic review. Moreover, the training component was not smoothly conducted, being more knowledge-based instead of a mix of knowledge and skills. In addition, since handover and orientation was not properly or adequately carried out, HFOMC member's level of knowledge and skills on health facility management was poor. Most members were not aware of their roles and responsibilities. These are the main reasons why despite long engagement of a large number of organizations, strengthening of HFOMCs did not make headway. A complete capacity building package is needed, where the training component is only one element among many.[14] Therefore until and unless there is capacity within local bodies to bear the devolved authorities and responsibilities, backed by consolidated and effective capacity building measures, health sector decentralization won't achieve its desired objectives.

Lack of elected local Bodies: Lack of elected bodies at the VDC level is another key reason why decentralization is not making expected progress. As per the present strategy, the chairman of the VDCs is to chair the HFOMCs. In reality however, in the absence of a locally elected body, the VDC secretaries are currently chairing them. VDC secretaries seldom go to the village, preferring instead to remain at the district headquarters. Lack of security is one of the reasons cited why they don't prefer to go the duty station. This situation has created a leadership vacuum and has made the HFOMC

members apathetic because, as the present political situation indicates, it is unlikely that local level elections will be held soon. Indeed, the weak handover process is attributed, to a large extent, to the absence of elected bodies in VDCs and the country's current political scenario. Political stability is therefore an essential prerequisite for successful decentralization and consequently, proper functioning of HFOMCs.[10,15]

Selection of the management committee: The absence of locally elected bodies has had a direct impact on the selection and work ethics of HFOMC members. Selected HFOMC members should have a high level of motivation and willingness to work for the sake of the community voluntarily. However, in most cases, the member selection process has been carried out hastily and without following correct procedures. In many cases, members are selected within the discretion of HF in-charges, instead of the community's. This results in questions on the legitimacy and accountability of the committee members. As per the guidelines and following the process of gender and social inclusion, a certain number of seats are to be allocated to *dalits* and women. In many cases however, this quota has been filled by others[8] affecting the inclusiveness of the committee envisioned by the policy. Therefore, for the health sector decentralization to progress smoothly, selection of local committees following proper protocol as per the standard guideline is necessary.

Federalism and state restructuring process in Nepal: As a result of recent political development, Nepal has become a Federal Democratic Republic and the country is in the process of political restructuring. Due to this development, there is confusion on how the decentralization process is to move ahead, including its relevance when such structural changes happen. In fact the difference between a unitary and a federal state is not that one is more decentralized than the other, but that the former can be decentralized through legislation whereas the latter is decentralized by constitution. Federally constituted states can be highly centralized and states constituted in a unitary fashion can be highly decentralized.[13,16] Since there is still political debate and dialogue regarding modality of state restructuring including federalism, it has major implications on the further progress of health sector decentralization at both policy and operational levels, directly and indirectly.

Ideological difference on the decentralization: Another way in which the political environment plays a part in or influences the process of decentralization is ideological differences on the issue. For instance, the Unified Communist Party of Nepal (Maoist), the major political party in Nepal, has challenged some of the decentralization policy on an ideological basis. They have stopped handing over primary schools to School Management Committees and health facilities to HFOMCs. They claim that it is the responsibility of the state to provide such services to the people and that the state cannot escape from its responsibility by handing it over to the communities.[10] Ideological debate on decentralization among major political parties has also slowed its development.

From the above points, it is clear that there are many issues — policy related, political, functional and institutional — which have acted as major barriers for the health sector decentralization of Nepal. The major bottlenecks in Nepal's health sector decentralization identified by this paper are lack of a clear cut policy, poor coordination among different sectors, improper handover process, lack of elected bodies, poor selection process of management committees, lack of coherence in the capacity building process of local bodies, ongoing debate on state restructuring including federalism and ideological differences on decentralization.

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