

Health Governance at Local Level from Human Resource for Health Perspectives: the Case of Nepal

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ABSTRACT

Background: Evidence about effects of good governance in Human Resources for Health (HRH) is scant in Nepal. The study aimed to explore the situation of health governance at the local level and suggest measures to address the HRH challenges.

Methods: Ninety health facilities from Siraha, Bardiya and Doti districts were included in the study. Focus group discussions (N=36) with different groups and key informants interviews (33 VDC Secretaries, 76 Health Facility Management Committees and 9 central level policy makers and managers) were conducted.

Results: Only 49 (54%) of the health facilities have properly displayed signboard, 42 (47%) citizen charter, 36 (40%) free health services and Information on Aama program in 25 (28%) health facilities. In total 52 (58%) health facilities have not displayed names of women receiving *Aama* benefits. Seventy two out of 90 health facilities have not displayed social audit reports and 80 (89%) of the health facilities have not maintained complaint box.

The initiative of decentralized human resource management, where implemented, has increased ownership at the local level. Staff retention has been reported well though it does not apply in case of the medical doctors. Rule of law in terms of human resource recruitment and transfer, promotion, and training were not fully implemented and were lenient in the upper level. Nepotism and power exercise was frequently reported as a hindrance in implementing the gender and social inclusion policy fully.

Conclusions: Transparency, gender and social inclusion is yet to be implemented fully at the district and health facility level.

Keywords: Health governance; human resources for health; Nepal.

INTRODUCTION

Good governance is one of the six building blocks of a health system as a catalyst for strengthening health services delivery.¹ The human resources for health (HRH) is central to attaining the health-related Millennium Development Goals (MDGs).² However, studies have shown that influence of governance is undervalued both globally and in country in addressing the health workforce crisis.³ A shortage health personnel and unequal distribution are one of the challenges in managing HRH.^{2,4}

Debates exist whether governance is an elephant in the room of HRH that could address the ongoing HRH crisis.³ To provide quality health services and to establish public accountability, a functional governance system and mechanisms should be in place. The issues of governance thus should be acknowledged as the centre of HRH planning and implementation.^{3,5}

Nepal has a two-tier system of local governance, the village development committees (VDC) and

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municipalities, and the district development committees. There is at least one health institution in each VDC or municipality. Nepal's health system, however, faces several challenges of good governance: understaffing and absenteeism; poor supervision and monitoring; poor community participation; lack of transparency, ownership and accountability; and a mismatch between plans and people's health needs.⁶

There are number of laws, plans and policies with provisions to strengthen the local health governance system and promote health services locally.⁷ Human resources management is one of the six components of Local Health Governance Strengthening Program. As per the spirit of local self governance act (LSGA),⁸ a total of 1,433 health facilities have been handed over to the local community with authority for their self-management and several others are under the process.⁹ However, the process has been installed because of lack of elected representatives at local level in particularities of the violent conflict.¹⁰

In 2009, MOHP developed a gender empowerment and social inclusion (GESI) strategy to enable the poor and excluded for accessing health services and ensuring health as their fundamental rights.¹¹ The governance infrastructure, its status and challenges at the grassroots level in relation to HRH is not known in Nepal. This study aimed to explore the situation of health governance at local level in relation to power structure and accountability mechanisms including GESI in the health system governance.

METHODS

Three districts namely Doti, Bardiya and Siraha, out of 75 districts of the country, were included in the study. The districts represented Mid west (Bardiya), Far-West (Doti) and Eastern region (Siraha). All together 90 health facilities were included in the study including district hospital, primary health care centre, health posts, sub-health posts, district Aurvedic health centre and Aurvedic dispensaries. Among these health facilities 73.8 (82%) of them were health posts and sub-health posts that serve as the first point of contact between the people and the public health services. In addition to the observation of the health facilities (N=90), focus group discussions (N=36) with different groups and key informants interviews (33 VDC Secretaries and 76 Health Facility Management Committees and 9 central level) were conducted.

Observation checklist was used to extract information on certain principles of governance such as transparency and accountability. Similarly, interview questions were used to interview district level and central level key

informants. Guiding questions were used for conducting focused group discussions with community male and female and health service providers separately.

Quantitative data derived through observation checklist was analyzed using SPSS 17 and qualitative data was analyzed manually under different themes.

RESULTS

Display of governance-related public messages:

The study attempted to gauge visibility of the key components of the health governance at local health facilities. Four out of ten health facilities observed had no signboard and about three out of ten health facilities had not posted Citizen Charter at the premises of the health facility. The list of free drugs was found published in about half of the health facilities only. The list of women who received Amma benefits (maternity incentive) provided by the state to the women was published by a quarter 25 (28%) of the health facilities only (Table 1).

Table 1. Visibility of governance-related information at the health facilities observed (N=90).

| Components displayed | Displayed at appropriate place | Displayed at inappropriate place | Not displayed |
|--|--------------------------------|----------------------------------|---------------|
| Health facility sign board | 49 (54) | 9 (10) | 32 (36) |
| Citizen Charter | 42 (47) | 18 (20) | 30 (33) |
| List of free drugs | 36 (40) | 13 (14) | 41 (46) |
| List of women received Amma benefits | 25 (28) | 13 (14) | 52 (58) |
| Names of women delivered at health facility | 27 (30) | 7 (8) | 56 (62) |
| Social audit report | 11 (12) | 14 (16) | 65 (72) |
| Organization chart | 29 (32) | 10 (11) | 51 (57) |
| Monitoring chart/plan | 25 (28) | 17 (19) | 48 (53) |
| IEC materials on rights of clients | 41 (46) | 22(24) | 27(30) |
| Staff name in front of door/wall | 12(13) | 16(18) | 62(69) |
| Kept complaint/ suggestion box for service users | 6 (7) | 4(4) | 80 (89) |

According to the Local Self Governance Act 1997 and the Accountability-related Mechanism Implementation Strategy 2010 developed by the Local Development Ministry, public service organizations are required of conducting social audit of their programs and publishing the report to the public. In this study, as against the provision of social audit, nine out of ten health facilities (88%) had not displayed their social audit report, meaning that they did not undertake social audit at their health facilities. Similarly, over two-thirds of the health facilities (68%) had not made organization chart and nearly three-quarters (72%) had not made public their monitoring plan. In four out of ten health facilities (39%) information, education and communication (IEC) materials on the rights of the service users were not displayed. Interestingly, only 12 (13%) health facilities had written names of the staff in front of their rooms-in appropriate place. Only 6 (7%) of the health facilities had placed complaint box/suggestion box in appropriate place while 4 (4%) of the health facilities had placed it but at inappropriate place.

Gender equality and social inclusion

Mixed response was reported in terms of rolling out of the GESI initiative. The focused group discussions and key informants claimed that the GESI had been implemented as 50% of female and dalits were reportedly working in the health sector. However, some level of suspicion existed on whether it was implemented at the lower level. As reported, GESI component is well reflected in health related training and training packages at the central level but more concerted efforts focusing women and excluded groups were lacking. However, there was genuine need to reduce the gap between promoting GESI initiative and the claim that health is a specialised sector requiring specific knowledge and skills among its staff. On the service providers' side, there was general feeling that everyone including dalits, women and persons with disability were getting free health services. However, some malpractices in supply and distribution of drugs were reported.

Decentralization of human resources management

Health facilities are handed over to local bodies in 28 districts and there are positive feedbacks about the decentralized human resources management.⁹ The initiative has promoted ownership at the local level and there are examples of resource sharing with VDCs and district development committees (DDCs) to equip health posts, recruit health workers, improved and additional services like lab for blood and urine test and to support some physical facilities. Staff retention has been reported well though it does not apply with the

doctors. However, there are respondents who also feel if the decentralization has not been fully implemented and health facilities staff are less disciplined than before. Nevertheless, long gap in getting elected bodies and weak monitoring have been seen as one of the key obstacles in promoting local leadership and the unstable political situation is counted as another reason for not being able to implement decentralization as planned.

Delegation of authority

The respondents took delegation of authority to health facility management committee (HFMC) in a positively note. The delegation of authority has allowed recruiting staff locally that are more regular at work. However, two of the focused groups did not agree with this. The delegation mechanism within health facilities and especially from higher level to subordinate level does not seem to be clear among the majority of service users. However, one FGD talked about health facility in-charges who delegated responsibilities to the support staff or peon. The service providers also felt that their higher authorities were reluctant and/or less interested in transferring their rights to the subordinates. Few service providers opined that rights transference was followed from higher to lower lines.

Transfer of skills and resources

The transfer of skill and resources to lower level got mixed response. Some service providers responded positively and shared maintenance of proper record as well. However, others could not agree that the skill and resources were transferred to the lower level staff.

Accountability

Many respondents revealed that the job description for their positions was not updated. No formal ways to receive complains and suggestions from the beneficiaries or other stakeholders had been established. This was largely contingent upon direct talk with the service providers which may not be convenient and sufficient to protect confidentiality of the individual who wants to make a complain. Most of the respondents had not seen complain/suggestions box inside the health facilities. While service providers said they responded to complains and/or suggestions but the beneficiaries have different experiences of not getting back responses. The poor economic status has been mentioned as one of the reasons of their voices not being heard. The absence of elected body had had weakened the accountability aspect as there was no follow up from the VDC representatives as in the past. The display of citizen charter was regarded as a contributing factor to increase accountability.

Rule of law

Most of the service providers believed that the law was not followed in staff transfer and this was more serious at the central level compared to the district. The political connection had greater influence in staff transfer, training opportunities and promotion. For most of the respondents its in-charge and or/ other senior staff who get more training opportunities. Nevertheless, the national and central level staff feel the set criteria and policies including reservation for few minority groups are applied whenever the nominations for training are done. However, lack of post-training follow up mechanism has been discussed as one of the areas for improvement. The local government can play a significant role in ensuring rule of law but it was not able to do so.

Responsibility and participation

The service providers argue that they are fulfilling their "duties" even they are not compensated well. However, the key informants consider that the service providers are not acting responsibly. The beneficiaries opine that they have got support from service providers for using free health services, vaccination, family planning services and delivery incentives. However, they were concerned about staff irregularities at health facilities, long absence especially In-charge from the work, not being on time to work, leave the health facilities earlier and pressure to buy medicines from staff operated pharmacy.

The management of health facilities has been handed over to local communities in 28 districts. Involvement of women, dalits, people with disability and other minor communities in HFMCs show an increasing trend in participation and inclusion. However, the influence of certain powerful elite has not been overruled.

DISCUSSION

Nepal Governments' policies and plans have consistently emphasized improving governance at local level through decentralization. MOHP has also adopted the policy of local governance with regards to the human resources for health, among other areas. It has introduced local health governance strengthening program (LHGSP) as a new initiative for decentralized local health governance by devolving authority to the local bodies. The Health Sector Devolution Framework (2010) considers HRH as one of the key areas. However how the government commitments have been translated into action was largely unknown.

The findings indicate that visibility of some of the governance-related information and practices were still poor in particular displaying citizen charter,

signboard of the health institution and communication materials as about one-third of them had not displayed these information for public use. In small proportions of the health institutions they were displayed but not in appropriate or visible places. Display of the names of free drugs, names of women who received delivery incentives and Amma benefits had not been done in more than half of the health institutions. Social auditing was not practiced by 88 percent of the health institutions and another 84 percent had not conducted social auditing. Of those who had conducted social audit, the reports were not displayed at visible places. In nearly six out of ten health institutions, names of the key staff were not shown at the entrance of their room. Moreover, despite the consistent priority of the government to have provision of user complaint boxes, nearly three quarters of the health institutions did not maintain the complaint boxes. The reason behind lack of these services were attributed to budget constraints, inadequate human resources, frequent transfer of staff, and staff perception that these services were not necessary in their service sites.

The GESI strategy was not fully implemented while recruiting human resources in the health sector. A case pending in the Supreme Court against Public Service Commission and the Government demanding more inclusive provisions for recruiting human resources in health sector was reported as a barrier in implementing the GESI strategy.¹² Favoritism and nepotism in selecting participants for training and other career development opportunities were frequently reported. Handing over the skills learned while participating in training and workshops was not taking place at the grass root level.

Though small number of health facilities has been handed over to the local communities as per the Local Self-Governance Act (1999), the process was discontinued in the absence of elected local government for over a decade. The study findings indicate that effectiveness of the decentralized health facilities was encouraging for some services and health facilities while it was not successful in many other services and health facilities.¹³

In health institutions delegation of authority to subordinate and junior staff was not taking place formally and fully. It was frequently reported that even the helpers or peons run the health institutions unofficially during absence of the senior staff. The problem of authority delegation was seen as a national problem in health sector. The district level managers are not informed about the transfer of their staff in most occasions.¹²

As reported, rule of law was frequently violated while at transfer of staff. Political influence was a dominating factor to decide whether the staff has to be transferred

or not. Accountability and the sense of responsibility on the part of the staff were reportedly weaker.

Finally, governance and its influence in addressing the HRH crisis has been an unaddressed issue in Nepal. The ongoing political instability has been the obstruction in implementing governance at the peripheral and below district level. The absences of local election in last ten years have left the local structures without legitimately elected people's representatives.

CONCLUSION

In a context of post-conflict transition characterized with low governance capacity, Nepal needs to focus on establishing rule of law, providing staff opportunities for their professional development, strengthening local governance including HFMCs to make effective use of its rights, maintaining and strengthening monitoring and supervision with practical ways of authority delegation and decentralization at the local level.

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