Social Accountability in the Health Sector Programme (SAHS)
Applied Political Economy Analysis (Baseline)

November 2017
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<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>APEA</td>
<td>Applied Political Economy Analysis</td>
</tr>
<tr>
<td>CAC</td>
<td>Citizen Awareness Centre</td>
</tr>
<tr>
<td>CSO</td>
<td>civil society organisation</td>
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<tr>
<td>DCC</td>
<td>District Coordination Committee</td>
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<tr>
<td>DDC</td>
<td>district development committee</td>
</tr>
<tr>
<td>DFID</td>
<td>U.K. Agency for International Development</td>
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<tr>
<td>DHO</td>
<td>District Health Office</td>
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<tr>
<td>DLI</td>
<td>Disbursement Linked Indicator</td>
</tr>
<tr>
<td>FCHV</td>
<td>Female Community Health Volunteer</td>
</tr>
<tr>
<td>FGD</td>
<td>focus group discussion</td>
</tr>
<tr>
<td>GON</td>
<td>Government of Nepal</td>
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<tr>
<td>HDC</td>
<td>Hospital Development Committee</td>
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<tr>
<td>HFOMC</td>
<td>Health Facilitation Operations and Management Committee</td>
</tr>
<tr>
<td>ICT</td>
<td>information and communications technology</td>
</tr>
<tr>
<td>IGFT</td>
<td>Inter-Governmental Fiscal Transfer</td>
</tr>
<tr>
<td>KII</td>
<td>key informant interview</td>
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<tr>
<td>MCPM</td>
<td>MOFALD Minimum Conditions and Performance Measures</td>
</tr>
<tr>
<td>MOF</td>
<td>Ministry of Finance</td>
</tr>
<tr>
<td>MOFALD</td>
<td>Ministry of Federal Affairs and Local Development</td>
</tr>
<tr>
<td>MOGA</td>
<td>Ministry of General Administration</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>NGO</td>
<td>non-governmental organisation</td>
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<tr>
<td>NHSS</td>
<td>National Health Sector Strategy</td>
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<tr>
<td>NHSSP</td>
<td>National Health Sector Support Programme</td>
</tr>
<tr>
<td>O&amp;M</td>
<td>organisation and management</td>
</tr>
<tr>
<td>PHCRD</td>
<td>Primary Health Care Revitalization Division</td>
</tr>
<tr>
<td>SA</td>
<td>social accountability</td>
</tr>
<tr>
<td>SAHS</td>
<td>Social Accountability in the Health Sector programme</td>
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<tr>
<td>VDC</td>
<td>village development committee</td>
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<tr>
<td>WCF</td>
<td>Ward Citizen Forum</td>
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<td>$</td>
<td>United States dollar(s)</td>
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1. Introduction

The Pact-led Social Accountability in the Health Sector (SAHS) programme aims to support the U.K. Agency for International Development (DFID) to more effectively promote social accountability (SA) within the health sector in Nepal. SAHS collaborates closely with the Ministry of Health (MOH) and a range of other health sector stakeholders to promote learning and good practices related to SA. SAHS also aims to provide a platform for practitioners, including the Government of Nepal (GON), donors, civil society, and other stakeholders, to critically examine SA practices, share lessons, and generate ideas on how accountability can be advanced within the health sector.

As part of a core set of analytical products to be developed for DFID and its implementers, Pact conducted an Applied Political Economy Analysis (APEA) to examine a cross-section of institutional factors and underlying incentives that affect prospects for promoting SA within the health sector. The APEA is the foundational activity of SAHS's implementation period and follows a baseline Situation Analysis conducted during the inception phase. The Situation Analysis provided a broad review of key initiatives, mechanisms, and stakeholders engaged in promoting SA within the health sector, as well as limited discussion of accountability initiatives in other sectors. While the Situation Analysis took stock of what is taking place within the SA space, the APEA builds on that analysis to understand the underlying reasons why SA initiatives and key actors engage as they do. This involves deliberately investigating the constraints and opportunities faced by those pushing for an accountable and responsive health sector.

The APEA focused broadly on examining the economic and political factors that affect implementation of SA mechanisms and processes, but specific emphasis was placed on understanding how the political federalisation and decentralisation processes affect prospects for SA within the health sector. After the promulgation of Nepal's constitution in September 2015, the country began reorganising its governance structure from a centralised, Kathmandu-led government toward a federal structure that includes three autonomous levels: Federal, Provincial, and Local (municipal and gaunpalika). The first local elections took place in May 2017 and provincial and federal elections are scheduled for November and December 2017, respectively. The establishment of local and provincial governments should empower a whole new set of political actors who are closer to individual citizens and their communities. However, it also means that existing SA processes and structures for ensuring citizen voice over service delivery must be retrofitted into an evolving system of governance.

The Pact team found widely shared optimism among key stakeholders over the potential for local governance to contribute to more responsive service delivery and accountable governance. Although key risks to the federalisation process exist, federalisation offers the potential to establish a link between citizens and State figures with significant authority over policies and resources, which has never existed in Nepal. At the same time, stakeholders must manage a range of tensions and potential flashpoints between the three levels of government, and the commitment to the spirit federalisation of some within the GON remains unclear. At this transition period, various blurred responsibilities and unclear guidelines between the federal, provincial, and local level authorities remain. This leaves many actors within the governance system, including the health sector, unable or unwilling to perform their basic mandates. It also leaves citizens and civil society uncertain about where ultimate accountability lies, at least in the near term.

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1 Local elections took place in three phases on May 14, June 28, and September 18.
2. Background

Health remains an area of stated national priority, central to the GON’s effort to pursue socio-economic development and graduate to middle-income status by 2022. The GON’s National Health Sector Strategy (NHSS) is organised around nine key outcomes that, combined, aim to ensure equity, quality, and accountability: ‘improved health status of all people through accountable and equitable health service delivery system’ (MOH 2017: 4).

Nepal has made marked progress in access to health services and in health outcomes in the past 15–20 years. This period saw large increases in the number of health facilities, with significant increases in antenatal care coverage and delivery in health facilities (MOH et al. 2016). Likewise, there have been corollary and significant improvements in neonatal, infant, and under-five mortality, with the latter dropping from 118 per 1,000 live births in 1996 to 39 in 2016 (MOH et al. 2016). Improvements have been seen well beyond maternal, newborn, and child health. For example, 69% of households have access to drinking water on their premises, compared to 9% in 1996, and 62% have access to improved toilet facilities, compared to 23% in 2016 (MOH et al. 1996; MOH et al. 2016).

Even with these important improvements, numerous challenges remain. As reported in the SAHS Situation Analysis, conditions within health facilities are frequently below standard, with only half of facilities having access to soap, running water, and regular electricity (MOH et al. 2016). Similarly, absenteeism remains a perennial challenge, particularly in remote communities and basic infrastructure remains inadequate. Furthermore, there are significant shortfalls in the availability of essential medicines (MOH et al. 2016), with lack of access to medicine being a frequent subject of reporting in local and national media. Inadequate access to services within government-run facilities is one factor that pushes Nepalese into the growing private health care system, and medical practitioners in the public system often simultaneously operate private practices.

The MOH has sought to address these persistent challenges in part through the use of a defined set of institutional structures and processes for facilitating SA and gathering feedback from citizen-users. Health Facility Operations and Management Committees (HFOMCs), formed in the early 2000s, aim to provide local-level oversight to health facilities, with Hospital Development Committees (HDCs) providing a similar function at hospitals. HFOMCs are directly linked to Female Community Health Volunteers (FCHVs) and mother’s groups, which aim to provide a feedback channel to local communities. Furthermore, over the last half decade, the MOH has scaled up the use of a holistic social audit process to more than 1,700 health facilities; these processes aim to facilitate robust input from citizen-users through a combination of direct observation, stakeholder consultation, and public meetings facilitated by a third-party contractor. Likewise, international and national NGOs have carried out their own processes for facilitating SA within the health sector, including community scorecards, public audits, and social audits. These and other structures and processes for promoting SA are discussed in more detail in Section 4.

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2 The DOHS Annual Report from 1995-96 showed that there were 74 hospitals, 97 primary health care centres, 765 health posts and 2588 sub-health posts. Twenty years later, the DOHS 2015-16 annual report shows that there are 105 public hospitals, 202 primary health care centres, and 3804 health posts.

Investments in community- and facility-level structures and processes that promote SA within the health sector are reflective of a broader infrastructure for promoting citizen participation and accountability around service delivery and local governance. The Local Self-Governance Act (1999) provided a legal basis for constituting local government bodies and deconcentrating key governance functions to the local level. However, elected local governments were disbanded in 2002 at the height of the Maoist insurgency and full implementation of the Act was never realised. In the absence of elected local government, donors, NGOs, and even the GON turned to user groups and related structures to engage citizens in civic processes and provide levels of oversight over solution-holders. During and following the conflict, user groups represented one of the 'only remaining forms of non-military social organisation', particularly in rural areas (Hobley & Shields 2015: 6).

The Ministry of Federal Affairs and Local Development (MOFALD) has had a primary role in promoting implementation of the Local Self-Governance Act and imbedding civic engagement and SA mechanisms within local government processes. In the absence of elected local governments, this approach involved leveraging user-groups and similar structures. The centrepiece of MOFALD’s approach to promoting participatory governance was a 14-step participatory planning process that began at the settlement (i.e., neighbourhood) and ward levels to inform village development committee (VDC) and district development committee (DDC) plans and budgets. MOFALD similarly supported citizen other feedback processes, such as public hearings, public audits, and social audits.

The impact of SA structures and processes in the health sector and beyond has been mixed. Processes such as the MOFALD-supported 14-step planning process and related oversight mechanisms provided opportunities for public participation. However, one study from Dialekh found that the stove-piped nature of planning and oversight processes contributed to ‘incoherence’ in key service delivery and governance processes (Hobley & Shields 2015). A GIZ study found that health facility social audits contributed to addressing issues such as staffing shortages, drug stock-outs, and infrastructure challenges (GIZ 2014). Similarly, a National Health Sector Support Programme (NHSSP) study similarly found contributions to health service improvements, but also noted that issues requiring significant resources to address typically elicited a ‘weak response’ (HURDEC 2015: 9-10). The NHSSP study similarly identified insufficient annual follow-up after initial social audits and weaknesses in the identification and cultivation of competent third-party contractors. Moreover, as is discussed in Section 4, many stakeholders complain that SA processes have been ‘ritualised’ such that they are completed in order to check a box, rather than to contribute constructively to policy and resource decisions.

After more than a decade of negotiation on the long-term structure of the Nepali governance system, as of 2017 the country is in the midst of a transition to a federal and decentralised state with elected governments at the local and soon provincial levels. Having deconcentrated service delivery in more than 1,400 health facilities in the 2000s, the health sector in many ways has a head start in shifting authorities and resources down to the local level compared to other sectors (Aryal 2015). However, there remains a long history of centralised health planning and many within the bureaucracy remain resistant to reform. The federalisation process has the potential to realise Nepal’s vision for democratic development. It also could provide opportunities for better linking service delivery to citizen needs and interests. However, as Section 4 of this report demonstrates, key questions remain around the roles and responsibilities across the three levels of government. It remains unclear as to when key issues such as the final transfer of civil service staff to local and provincial governments or the ultimate structure of provincial governments will be resolved.
3. Methodology

3.1. Analytical framework

Pact deployed the same definition of SA as was used in the Situation Analysis: SA is understood as activities other than voting that citizens carry out to hold governments accountable (Zinnbauer 2017). More specifically, SA represents ‘the broad range of actions and mechanisms beyond voting that citizens can use to hold the state to account, as well as actions on the part of government, civil society, media, and other societal actors that promote or facilitate these efforts’ (Malena and McNeil 2010: 1). This definition led the Pact team to centre on the range of institutional structures and processes that have developed to foster accountable relationships between state institutions and citizens. This included examining the roles played and constraints faced by community structures, such as HFOMCs, as well as established processes like social audits.

Prospects for achieving SA are directly linked to other aspects of accountability, namely political and administrative accountability. Local officials who are in effect alienated from their constituencies are unlikely to ensure that state institutions respond to citizen feedback flowing from SA mechanisms. Likewise, civil servants able to operate without sanction may be less inclined to take citizen input seriously. Therefore, the APEA also analysed broader elements of accountability that have direct or indirect bearing on the functionality of established SA practices. This stemmed from an understanding that social accountability is directly and indirectly influenced by political and administrative accountability and included examining how the evolving relationship between citizens and their local government could both promote and threaten SA.

Dimensions of accountability

Social accountability: Activities other than voting that citizens carry out to hold governments accountable

Political accountability: The ability of constituents to hold government office holders accountable, particularly through elections and related processes

Administrative accountability: The ability of a system or bureaucracy to promote desired behaviour, including through the combined use of rewards and sanctions

Pact’s approach to APEA focuses on developing a comprehensive understanding of the incentives that operate around a central issue, i.e., the factors that motivate the decisions or behaviour of individual and institutional actors. Incentives can be formal, such as established laws and policies that either constrain or enable action by key stakeholders. They also can be informal or largely invisible, such as cultural norms or even emotional sentiments that shape how relevant players engage on a particular issue. This APEA aimed to examine both of these to get a whole picture of the incentives that affect opportunities for driving SA within the health sector moving forward.

Drawing on DFID’s Drivers of Change methodology (DFID 2014), the APEA examined three distinct ‘drivers’, or determinants, of behaviour:

- **Structures** representing long-term contextual factors of which an individual programme has limited influence, including social structures, such as caste, for the Nepal case
- **Institutions**, sometimes referred to as ‘rules of the game’, that influence behaviour, including formal, written rules, such as a constitution or laws, and unwritten norms
- **Agents** of direct relevance to the issue of SA in the health sector, in this instance understanding the discernible interests of these key stakeholders

These drivers are not discussed as distinct elements, but integrated into the larger analysis.
3.2. Research scope

The scope of the APEA focused on understanding the underlying political and economic factors that explain the degree of SA within the health sector and help determine the potential for SA to be promoted moving forward. This scope was defined by a core set of research questions that defined a broad area of inquiry for the APEA:

- Why do designated formal and informal SA mechanisms and processes at the sub-national and local level function or not function as intended?
- What are the specific barriers and opportunities (particularly political factors) that impact the effectiveness and coherence of these processes?

To further guide the research, Pact developed a set of supporting research questions to provided clear (if still general) avenues of exploration:

- What are the gaps in the current legal and policy framework for SA within the health sector?
- To what extent do existing SA mechanisms and processes connect to actual decisions over key policy and resource decisions? What kinds of incentives exist, if any, for better linking SA processes to decision-making?
- To what extent do women, ethnic minorities, youth, low caste citizens, and other marginalised groups have equitable access to SA mechanisms and decision-making processes within the health sector? Who is responsible for ensuring GESI considerations are reflected in SA mechanisms and processes?
- **How will political federalism impact the effectiveness of existing or planned SA mechanisms and processes? What are the incentives for local governments to implement SA processes and be responsive to issues that arise from those processes?**

While each of these supporting questions were considered during analysis, the last set of questions related to political federalism received disproportionate focus. Conversations with DFID and other stakeholders made clear that the federalization/decentralization process represents the most significant factor affecting health service delivery and the overarching governance system in the present context. While some of the other questions have been examined at least in part through various studies, some of which are referenced in this report, champions of SA are in the process of thinking through how the new federal structure is likely to impact structures and processes that have been established for facilitating citizen input into the health system.

3.3. Methods

The APEA was rooted in a qualitative data collection approach that aimed to cultivate insight from a wide range of stakeholders across all levels of Nepal’s health sector and local governance structure. This analysis of political and economic factors benefitted from the secondary and primary research conducted during the Situation Analysis. Combined with preliminary discussions held in June 2017 with Kathmandu-based health and local governance experts from government and civil society, the Situation Analysis helped define the study’s focus and parameters. Pact developed a scope of work, which DFID approved.

While the emphasis for this study was on primary research, the research team also consulted various secondary sources. This included evaluations of existing SA processes and local governance structures in Nepal and broader academic literature on SA, accountability, and local governance. The study team also monitored political reform processes throughout the study via newspaper articles. All reports and articles referenced and consulted are included in the References.
The centrepiece of the study was direct consultations with a diverse set of stakeholders in the health and local governance sectors. Primary data collection took place July to November 2017. Discussions occurred in Kathmandu and four target districts selected to cover a range of geographies, including four of seven provinces and Terai, Hill, and Mountain districts: Banke, Dolakha, Lamjung, and Surkhet.

Pact consulted with more than 324 informants over from August – November 2017 which consisted of semi-structured key informant interviews (KIIs) and focus group discussions (FGDs). Key informants included:

- Members of community-based structures, such as HFOMCs, Ward Citizen Forums (WCFs), Citizen Awareness Centres (CACs), and mother’s groups
- Mayors, gaunpalika chiefs, ward chiefs, and other members of local governance
- District government, such as the District Health Office (DHO), Women’s and Children Office, and District Coordination Committee (DCC)
- Federal government officials, including various offices of the MOH and MOFALD
- Close observers of the health sector, some of whom have worked in the MOH
- A range of non-governmental partners, including multi-lateral donors; international, national, and district-based NGOs; and journalists

Table 1 provides an overview of key informants consulted as part of the APEA.

**Table 1: APEA key informants**

<table>
<thead>
<tr>
<th>Stakeholder group</th>
<th>District (number of informants per district)</th>
<th>Totals (324)</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Surkhet (114)</td>
<td>Ramechhap+ Dolakha (129)</td>
</tr>
<tr>
<td><strong>Breakdown by Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>68</td>
<td>52</td>
</tr>
<tr>
<td>Female</td>
<td>46</td>
<td>77</td>
</tr>
<tr>
<td><strong>Breakdown by Caste</strong></td>
<td></td>
<td></td>
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<tr>
<td>Dalit</td>
<td>22</td>
<td>33</td>
</tr>
<tr>
<td>Janajati</td>
<td>21</td>
<td>21</td>
</tr>
<tr>
<td>Other</td>
<td>71</td>
<td>75</td>
</tr>
<tr>
<td><strong>Breakdown by Entity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>District government office</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>DCC</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Municipality</td>
<td>22</td>
<td>35</td>
</tr>
<tr>
<td>Rural municipality</td>
<td>18</td>
<td>13</td>
</tr>
<tr>
<td>Health facility</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>HFOMC</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>FCHV</td>
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<td>8</td>
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<td>Mother’s group</td>
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<td>WCF</td>
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<td>15</td>
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<tr>
<td>CAC</td>
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<td>Development agency</td>
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<td>Local civil society organisation (CSO)</td>
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<td>0</td>
</tr>
<tr>
<td>NGO federation</td>
<td>4</td>
<td>13</td>
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</table>
Pact read informed-consent statements and received verbal consent before all KIIs and FGDs, and information from those consultations are reported in a way that preserves the anonymity of all informants. Detailed notes were taken during KIIs and FGDs and a minimum of two members of the research team took part in them to facilitate the triangulation of information. Where possible, note-takers worked to accurately capture direct quotations, many of which are presented in this report.

The semi-structured nature of the KIIs and FGDs meant that the consultations were built around interview guides that outlined focal areas of inquiry (see the Appendix). This provided a degree of consistency in the questions fielded by informants from specific stakeholder groups. However, interviewers were encouraged to tailor, follow up, or dive deeper on issues during individual consultations. Following consultations, KIIs and FGDs were reviewed and analysed. District-level consultations were coded using a qualitative analysis software program, MaxQDA, until reaching a saturation point in terms of identifying new themes.

<table>
<thead>
<tr>
<th>Stakeholder group</th>
<th>Surkhet (114)</th>
<th>Ramechhap+ Dolakha (129)</th>
<th>Lamjung (52)</th>
<th>Banke (29)</th>
<th>Kathmandu --</th>
<th>Totals (324)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federation of Nepali Journalists (FNJ)/media</td>
<td>5</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>--</td>
<td>7</td>
</tr>
</tbody>
</table>
4. Findings

4.1. The opportunity of the moment

The present social and political moment in Nepal—marked by the mutually reinforcing processes of implementation of the Nepali Constitution (federalism) and the devolution of power to local governments (decentralisation)—is defined by cross-currents of emotions, many of which are reviewed and unpacked in this report. These include feelings of confusion regarding new political mechanisms and processes that are simultaneously evolving and stalling and frustration with the pace of change, particularly among elected local government officials who hope to fully inhabit their constitutional authorities. However, many stakeholders exhibited a palpable sense of hope and optimism about the current political climate, rooted in expectations of more representative government and extending to a belief that service delivery will improve under local control. In answering the question Do you expect health service delivery to improve under elected local governments?, many stakeholders described key challenges that local government will face in pursuing its role, including lack of budget, human resources, and technical capacity. Nevertheless, a significant majority of informants in federal government, local government, and community structures expected to see significant improvements.

It is worth investigating what explains Nepalese’ optimism regarding a federal system of governance. On the one hand, the hopefulness reflects dissatisfaction with the centralised system of governance and health service delivery that has existed up till now. Community members, such as CACs and mother’s groups, decried stock-outs of essential medicines, the lack of emergency services, treatment by health facility staff, and the low quality of care. Even those within the system described key inefficiencies, including understaffing, lack of required medical equipment and medicine, and insufficient monitoring and supervision. Given the weakness of the status quo, the idea of transferring authority to local government from a centralised bureaucracy, which is perceived by many at the ground level as having underperformed, has clear appeal.

While yet-untested local government control may be judged in relative terms, its potential is also evaluated as representing progress in absolute terms. One CAC member from Baiteshwor Gaunplaika, Dolakha summarised this view of many particularly well: ‘We anticipate progress because the local elected representatives are people from within our community; we hope they will support and improve our lives through needed programmes in the entire sector’. Stakeholders at all levels, but particularly the local level, believe that moving the locus of decision-making closer to communities will result in more responsive and accountable government. This sentiment aligns well with common donor justifications of decentralisation, which tend to focus on the potential for empowering local levels of government to contribute to a range of governance and economic development outcomes.

It is possible to form a conceptual model of the system of accountability for which stakeholders are hoping or even expecting. Under the previous centralised structure of governance, the MOH had primary authority over policy and resource decisions, with
significant involvement of other institutions, such as the Ministry of Finance (MOF). This centralised model required citizen-user feedback to be communicated vertically across multiple tiers, i.e., the health facility, district, region, and up to the ministry level where critical decisions were made. By contrast, the new federal governance model shortens the distance between where service delivery information is derived and where significant public policy is formed. While the MOH will continue to play a policy-making and technical assistance role within this federal system, local governments will have enhanced discretion over policy and resources. In describing their optimism, stakeholders seemed to feel that their closer proximity to decision-makers at the municipal/gaunpalika level, as compared to the DHO and MOH, will contribute to more responsive service delivery.

Figure 1 represents simplified models of the old and new governance systems. The figure cuts out key elements of the health system, including regional health directorates, which existed under the centralised system, and a provincial health ministry or department, which will be a feature of the federal system, but highlights the most visible elements of both systems and, in many ways, represents the systems as they look to communities and local actors. Under the federal system, citizens expect to have opportunities to provide direct feedback to the health facility (and extensions of those facilities, such as FCHVs) and to local governments. By comparison, citizens experienced fewer direct opportunities for providing feedback to DHOs and higher authorities under the centralised system. As one donor-funded staff person explained, under the federal system ‘there is not the long channel [for decision-making]; now they will listen to feedback’.

**Figure 1: Alternative governance models**

**CENTRALISED GOVERNANCE MODEL**

- ministry of health
- district health office
- health facility
- citizens

- aggregated data from social accountability processes
- inform policy and resource allocation
- provide technical assistance resources based on social accountability data
- respond to information

**FEDERAL GOVERNANCE MODEL**

- ministry of health
- district coordination committee
- municipal/gaunpalika government
- health facility
- citizens

- direct support
- social accountability data
- resource and policy decisions
- technical assistance and monitoring

Note: conceptual model does not include provincial government, which are yet to be established.
4.2. Successes and limitations of existing social accountability mechanisms

This section examines the implementation of key institutions and processes designed to promote citizen-user feedback and SA in the health sector, as well as in the larger governance structure. In focusing on existing mechanisms, this review places disproportionate emphasis on factors affecting the implementation of MOH social audits, which serve as a key pillar of the Ministry’s broader SA strategy. An examination of key incentives surrounding the implementation of social audits highlights key social, political, and economic dynamics surrounding a flagship SA process and provides a sense of some of the issues that could persist into the future.

4.2.1. Institutionalisation of social accountability

As is discussed in detail in the SAHS Situation Analysis, Nepal has significantly invested in developing structures and processes that promote SA, including in the health sector. Of the multiple reasons for this development, the nearly two-decade absence of elected local government stands out. Lacking elected representatives, donors, NGOs, and government established complex networks of community-based user groups to aggregate citizen demands, oversee local projects, and generally serve as a bridge between citizens and the State. Through this, Nepali communities and government departments developed experience with a range of SA tools, including public hearings, public audits, and social audits, some of which were led by supply-side agencies and others by the NGO sector. Khadka & Bhattarai (2011) documented as many as 163 different tools in practice in Nepal.

Available statistics convey the degree of institutionalisation of SA within the overarching system of local governance and health service delivery. Although WCFs lost their formal role within key governance process (e.g., local planning) under the federal system, there were 31,304 WCFs covering 99.7% of municipalities and the now defunct VDCs. Additionally, 13,040 CACs provided a platform for marginalised women to provide input into core governance and accountability processes (LGCDP Annual Progress Report 2017). Within the health sector, 4,009 HFOMCs were charged with providing community oversight over health facilities, while more than 51,470 FCHVs and mother’s groups linked communities to the formal health system (DoHS Annual Report 2015/16). Similar statistics could be cited in other service delivery sectors, such as agriculture, forestry, and education. Consultations with a diverse set of key informants, including newly elected members of local government, support the notion that these community structures have served as information sources for decision-makers.
Beyond these structures, the GON instituted a set of processes for insuring citizen feedback and input over government action. With donor support, MOFALD rolled out district-level public hearing, public audit, and social audits processes. Within the health sector, social audits at the health-facility level have served as the centrepiece of the MOH’s approach to SA. Social audit of the health facilities which was initiated in 2012 has so far undergone social audit in 1758 HFIs. The target for next FY 2017/18 is 1958 HFIs (CE in Health Sector, MoH 2017).

There are a range of questions related to the effectiveness of government-led SA structures and processes. Some of these relate to the capacity of key structures, and others relate to the real incentives that drive the behaviour of supply-side institutions. Many of these questions are addressed directly in this report. However, the extent of the established SA infrastructure and practices convey at a basic level a bureaucratic commitment to at least the form of SA. As one officer at the Dolakha DHO explained, SA is ‘a must practice in the health sector’. Using similar words, a mayor in Lamjung explained that SA mechanisms are ‘a must in the new federal structure… as we are new, we need a mechanism to make us aware of our roles and responsibilities, receive feedback from the citizens, and plan future activities based on local needs’. At a minimum, past and ongoing investments in SA have contributed to a view that structures such as management committees and processes such as public hearings and social audits are part of the normal course of governance and service delivery. This successful norm-setting likely provides some momentum for the continuation of formal SA mechanisms.

4.2.2. Low levels of awareness of social accountability processes

A wide range of stakeholders operate with limited awareness of key SA mechanisms. A significant majority of newly elected local government officials reported no awareness of processes such as social audits, which is perhaps not surprising given that they are only a few months into their jobs. However, a range of community-level stakeholders, including those who are extensions of the health apparatus at the local level, have had limited-to-no engagement with or knowledge of key SA processes, particularly social audit. While a few social mobilisers noted that they had participated in social audits, almost none of the more than 40 CAC members consulted expressed familiarity with the practice. Given that CACs are the lead community structure designed to give voice to traditionally excluded groups, their nearly universal alienation from social audit processes in the visited municipalities and gaunpalikas raises questions about how effective the audits have been at including marginalised communities4.

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4 CACs do not have a formal role in the social audit process. However, CAC members represent some of the most mobilised and civically engaged marginalised citizens within a community. It would be expected that a deep, penetrating social audit process would come into contact with at least some CAC members.
While CACs sit somewhat outside of the health system, structures more directly imbedded in the sector seem similarly disconnected from the social audit process. For example, FCHVs and mother’s group members from Doudhpokhari Gaunpalika in Lamjung District were unaware of social audits. These are not isolated cases, as most FCHVs and mother’s group members in Baitheshwor, Dolakha were likewise unaware of the social audits that have occurred in their local facilities. More surprising, multiple HFOMCs, which are charged with overseeing the management of health facilities, expressed limited understanding of the process. HFOMCs from both Surkhet and Lamjung explained that they had not been involved in recent social audits.

HFOMC members, along with other stakeholders, commonly expressed uncertainty over the distinction between social audits, public audits, and public hearings. It is tempting to dismiss this confusion as pedantic, of interest only to accountability experts, but it speaks to the limitations of how social audits have been executed. The gap between how social audits are supposed to be implemented on paper versus how they often are implemented in practice is illustrated in Figure 2.

**Figure 2: Five-day social audit process**

**Formal process**

1. **Preparation, Information Collection and Analysis: 3 Days**
   - On-site observation, information collection and exit interviews with clients
   - Preparation for mass meeting (participants, venue, issues for discussion and roles of stakeholders)
   - Collection of information from community (group discussion, interview and meeting with program beneficiaries)
   - Analysis of information
   - Sharing of preliminary findings with HFOMC and health service providers and preparation of draft action plan

2. **Conduct Mass Meeting and Preparation of Action Plan: 1 Day**
   - Facilitation of mass meeting (organise, present findings, open discussion)
   - Present and revise action plan

3. **Prepare Report and Develop Future Road Map: 1 Day**
   - Submit action plan to the health facility and discuss with HFOMC and service providers to agree on future roadmap
   - Prepare a brief report

**Reality**

1. **Preparation and Development of Action Plan: Up to 1 Day**
   - Contractor requests Health Facility In-Charge to prepare key documents, including budgets and facility plans; prepares initial findings and action plan

2. **Conduct Mass Meeting: 1 Day**
   - Contractor asked Health Facility In-Charge to invite participants to mass meeting; Mass meeting held

3. **Prepare Report: 1 Day**
   - Action plan submitted to the health facility and final report prepared

Figure 2 demonstrates that the five-day baseline social audit process is commonly reduced to three days or fewer. Informants explained that it is not uncommon for the Preparation and Development of Action Plan and Conducting Mass Meeting steps to be collapsed into a single day. For example, one health post In-Charge in Surkhet explained that a recently conducted follow-up social audit that was supposed to take two days, took place over three to four hours and consisted of the contractor reviewing some budget and service-related documents prepared by the health facility, combined with a mass meeting to disseminate the results. Another explained that the audit took two hours and that the contractor ‘called ahead’ for the documents so that they were prepared when they showed up. Therefore, in many cases the entire public audit process is reduced to a public meeting in which fairly standard issues are discussed, such as the lack of medicines or deficiencies in facility infrastructure. Furthermore, the health facility In-Charge is often given the task of inviting...
community members to the public forum, enabling them to hand-pick those providing critical feedback on service quality.

It is important to emphasize that what is lost in truncated social audit processes are more intimate data collection processes, such as on-site observation and FGDs. This has significant impact on efforts to ensure inclusion within the audit process because it is through consultation within safer spaces that auditors are best able to capture the voices of marginalised groups. By comparison women and other excluded groups remain less inclined to engage in more public mass meetings.

4.2.3. Factors influencing the implementation of social audits

From a political economy perspective, the interesting question is why social audits are often implemented in a manner that is shallower than MOH guidelines envision. Low awareness among key stakeholders regarding the purpose and structure of social audits likely serves as both a cause and effect of their sometimes superficial implementation. However, other factors related to the selection and oversight of contractors and bureaucratic incentives are also instrumental.

It is important to note that the DHO is the sole party responsible for selecting third-party contractors, typically district-based NGOs. Thus, the DHO and contractor are exclusively accountable for properly implementing the process, while stakeholders more directly tied to the health facility have limited-to-no ability to influence the process. Because DHOs lack the resources—and in many cases the inclination—to closely oversee the social audits, contractors are able to act largely as independent agents, enabling what many stakeholders describe as a contractor-driven process. Furthermore, the monitoring and evaluation system is geared toward tracking the completion of social audits as opposed to monitoring the quality of those audits or the extent to which action plans are completed. The MOH has set and exceeded its own targets for rolling out social audits, but there is no discernible formal punishment or informal chastisement for audits that fail to achieve either the letter or spirit of policies. Many stakeholders suggest that the check-the-box mentality of DHOs and contractors has contributed to the ritualization of the social audits.
Consultations with a range of stakeholders and other evaluations of the social audit process point to other weaknesses in the selection of contractors, typically district-based NGOs. While hiring guidelines emphasise selecting qualified contractors, there is often a lack of qualified service providers that apply for contracts. The lack of qualified contractors is made more significant by the fact that the NGOs typically receive limited to no orientation or training on the audit process. Furthermore, cost criteria are typically given more weight in the selection process than factors such as institutional capacity and past performance. One evaluation noted that the selection of contractors is often shaped by ‘political pressure’ (HURDEC 2015: 7). A number of stakeholders consulted for this study made similar statements, suggesting that the DHO liked to work with its ‘preferred’ contractors. Multiple stakeholders made charges of outright corruption in the selection processes. For example, one unsuccessful applicant argued that the winning contractor had issued bribes to the DHO during the application processes; notably, the successful contractor admitted to occasionally writing applications to be submitted by other organisations to ensure that there would be enough applications for the procurement process.

Technical advisors to the MOH reported that PHCRD’s budget for supporting social audits is also insufficient. As one adviser explained, PHCRD’s proposed budget is routinely cut by the MOH, leaving them ‘compelled’ to hit the same targets for number of health facilities receiving audits. This overall budget for social audits translates into contractor budgets that are tight at best and sometimes unrealistic, creating significant incentive for cutting corners in effort to save on expenses.

The MOH stipulates that contractors budget $245 per facility for baseline audits and $125 per facility for follow-up audits. The limited remuneration is reported to cause many organisations that would be qualified to not seek the work and to incentivise contractors to trim costs on travel and level of effort, in particular. Most problematic, the provided budgets fail to differentiate between geographies, using instead the same budget formula for urban areas such as Kathmandu or Nepalgunj as for remote districts such as Jumla or Lamjung. One contractor from a hill district argued that a more realistic budget would include $398 per facility for baseline audits and $269 for follow-up audits (see Figure 3 for breakdown). Another contractor from a submetropolis in the Terai provided a higher cost estimate, suggesting that a five-day audit would cost $480. At least two contractors noted that their remuneration was further limited by having funds withheld as informal ‘commission’ by the DHO.

4.2.4. Limited connection to decision-making

To facilitate accountability, SA processes must do more than provide opportunities for citizen voice and citizen-state interaction; they must link citizen feedback into public policy and resource decisions. Some evidence exists showing that SA mechanisms, including social audits and established committees, such as HFOMCs and FCHVs, have had an appreciable

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5 Budget figures in this report are presented in U.S. dollars ($) based on an exchange rate of 100 Nepali rupees to 1 U.S. dollar.
effect on decisions that are under the health facility’s jurisdiction. Various stakeholders, including members of WCFs, CACs, FCHVs, HFOMCs, Health In-Charges, DHOs, and NGOs, cited examples of health facilities extending their hours of operation from, for example, 2 pm to 5 pm because of feedback gleaned through social audits or directly from HFOMCs. Stakeholders similarly pointed to improvements in small-scale infrastructure at the facility level that required little cost. These observations align with findings from past studies, such as the 2015 NHSSP Social Audit Process Evaluation Report, which identified certain outcomes, such as providing Aama entitlements and making HFOMCs more inclusive, as being comparatively easy to change, while others were more difficult. In particular, certain ‘structural issues’, such as the distribution of expired medicines, are not readily influenced by social audits (HURDEC 2015: 38). Figure 4 demonstrates links between these processes.

Figure 4: Social accountability influence on decision-making

There appears to be a generally weak link between the SA processes and decisions that sit at higher levels of the health bureaucracy. Consultations with stakeholders highlighted isolated cases of social audits informing DHO decisions. For example, the In-Charge of one health facility in Surkhet explained that the social audit helped him lobby the DHO to provide funding to repair a broken solar system⁶. However, across interviews with stakeholders at all levels, there was a lack of examples of feedback from SA processes informing MOH policy or resource decisions at the central level. Past reports have similarly found evidence of

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⁶ The In-Charge explained that while solar system was repaired the DHO had not yet paid the contractor for the work.
‘weak response’ from the centre to demands from processes such as social audits (HURDEC 2015: 10).

Within the centralised system that has existed until recently, the failure of SA data to penetrate the centre represents a significant limitation as health facilities operate with minimal unrestricted resources or discretion over policy. One staff member from a donor-funded project said that SA mechanisms are ‘good at fixing problems at the bottom level’, but not major problems at the top. Multiple informants explained that social audit reports are generally not read at higher levels. As the same project staffer explained, ‘they [MOH staff] get the social audit reports, but who cares?’ As a DHO staff member asked in a separate report, ‘if the PHCRD does not read the report sent from the district after social auditing and does not take necessary steps to support the implementation of the action plan, what is the use of PHCRD managing the social audit?’ (HURDEC 2015: 10).

Importantly, citizen feedback influence on higher-level decision-making remains weak despite some formal processes aimed at extracting information from below. To date, review processes at the facility, district, regional, and national levels have considered health management information system and other data. Information from social audits and other SA mechanisms have a limited role above the district level. However, many informants described the review processes as overly formal and effectively preordained. One implementer of a donor-funded programme described the review processes as ‘theatre’, noting that, higher up the chain, numerous ‘gatekeepers’ are impervious to influence by information emanating from lower levels. Instead, the greatest determinant of how funds are allocated is how they previously have been funded, with those overseeing specific programs or budgets incentivised to see them live on. This tendency to build from previous budgets seems to have played out with the conditional health grants provided to local governments for the current fiscal year, considering that they largely build off of allocations from last year’s budget.

The reality is that budget decisions are not only the MOH’s domain, but ultimately must be approved by the MOF’s Budget and Programme Division. One long-time adviser to the MOH explained that the MOF is similarly reluctant to deviate significantly from past budgets and makes key budgetary decisions with insufficient technical knowledge. Furthermore, resource decisions are frequently made based on the strength of personal relations between MOH and MOF staff, rather than data. For example, while division chiefs are supposed to submit proposed budgets to their department for aggregation and submission to MOH, they frequently go directly to the counterparts at the MOF to negotiate and win support for their budgets.

From where does local government get information?

The social audit—the centrepiece of the MOH’s approach to SA—represents a highly structured means of facilitating citizen-state engagement and capturing feedback from citizen-users of the health system. Various committees at the local level, such as HFOMCs, FCHVs, and mother’s groups similarly have their structured processes for taking in and feeding back information within and beyond the health sector. For example, HFOMCs conduct meetings and key members, including an FCHV representative, raise key issues they source from mother’s groups.

While champions of SA seek to create structured opportunities for facilitating community voice, conversations with a range of elected local officials suggest that their most trusted means of generating information are largely informal in nature. Mayors, gaunpalika chiefs, and ward chiefs explained that they remain highly imbedded in their communities and use their constituent networks to identify local-level needs and facilitate feedback. For example, one deputy mayor from Ramechhap explained that on a daily basis, local officials speak to 100–150 constituents. A gaunpalika chief from Surkhet district explained that ‘our office is located within the gaunpalika, which is easily accessible six days a week for our constituents to come and talk to us’. Nearly all local officials viewed their phone as their most valuable tool for gathering information. Mayors and
gaunpalika chiefs also report depending on ward chiefs and ward members to provide information on service delivery and other issues within their jurisdictions.

Local government described the media as an important source of information. Additionally, some elected officials view their political opposition as a critical information channel. Complementing these informal sources of information, many informants explained that formal meetings with local committees at the ward level provide venues for feedback. References to local committees suggest that structures such as HFOMCs, CACs, and FCHVs are positioned to potentially influence local government. However, it is clear that many elected officials place greater currency in their own networks and interactions with constituents.

The reliance on informal networks and citizen contact as primary sources of information raises profound questions about inclusion because excluded groups can be expected to sit at the margins of existing political networks. Although anecdotal and based on only a few months of elected local governance, this point is supported by the fact that consulted CAC members across districts report having little to no contact with their local representatives. As one CAC member from Gutu, Surkhet, said, ‘during the elections they all [those running for office] said ‘Namaste.’ Now when we say ‘namaste’ they turn their backs’.

4.3. The impact of the federalisation process

Under a federalised and decentralised system of governance, accountable service delivery depends on having in place federal governmental units in place that are confident and able to inhabit their mandated authority. Consultations with a range of stakeholders, particularly elected local government officials, made clear that there are many factors related to the rollout of the federalisation process that negatively impact gaunpalika and municipal governments’ ability to perform key functions, at least in the near term. Many local governments reported high levels of confusion, suggesting that they generally understand what their broad responsibilities are, but there is a significant lack of clarity on how they should fulfil those functions. Local governments also face severe shortfalls in human resources and misalignments in lines of authority for human resources that do exist, which negatively impact local gaunpalika and municipal government’s ability to perform key duties, even where they are clear. Furthermore, unresolved questions remain on the scale and function of key institutions in the emerging governance system, including the roles of the district and the province.

That fundamental questions on the new governance framework’s operations and structure remain is perhaps not surprising given that local governments have been in place for six months and provincial governments are not yet established. However, key actors must function with little clarity over when remaining questions will be resolved, a status quo that could contribute to local government remaining inactive in key domains.

4.3.1. Local government requests for guidance

Elected local officials repeatedly emphasised that the constitution is clear in its intent to shift authority to local governments. However, many complain that they have received incomplete guidance from the federal government, particularly MOFALD, regarding how to carry out key duties. A deputy mayor from Dolakha district captures the view of many when he explains, ‘we are very clear on our role and responsibility as stated in the constitution of the Nepal based on which we have started our work…but there is a need for policies and guidelines to implement our role and responsibilities more effectively’. Another deputy mayor describes the situation in similar terms: ‘my role and responsibility has been stated in the constitution, but it has not been further clarified into details’.

Local governments have received some guidance in the form of circulars from key federal government institutions, including MOFALD, MOF, Ministry of General Administration (MOGA), MOH, and the Office of the Prime Minister and Council of Ministers. Chief among these documents are the Local Level Administrative Structure and Staff Management
Directive (2074) and the Local Level Operation and Management Directive (2074), which has been superseded by the Local Government Operations Act (2074). Likewise, the federal government has provided discrete guidance on various topics, such as a circular from MOH on the formation of HFOMCs (the role of policy directives and state of legislative reform is discussed in more detail in Section 4.3.6).

A common complaint from elected local government was that guidance that did reach them was insufficiently clear on the mechanics of key functions of local-level government. While local governments frequently described a macro-level state of confusion, they were less specific on the precise areas where they needed guidance. However, when pushed, elected officials described uncertainty about how to draft local legislation. Specifically, local governments complained about the lack of ‘model laws’ that easily could be adjusted to the local context. Local officials also expressed uncertainty about the budgeting and planning process and felt insecure about the extent to which they did their recent budgets ‘correctly’.

A clear factor contributing to feeling confused has been insufficient training and orientation to local governments on their roles and operations. To date, only some of the mayors and deputy mayors elected in the first round have received orientation, meaning that no elected officials from the second and third round elections have received orientation. Additionally, key legislation, such as the Local Government Operations Act, have not been distributed to local governments, particularly in a format that is accessible to the many elected officials with low literacy skills; as one international NGO staff person explained, ‘I’m an expert on local governance and I need clarity on what [the act] means’. At the same time, it should be noted that the MOH and other line ministries are intending to roll out orientations in the coming months. Statements related to the confusion of local governments or lack of guidance are also intricately connected to shortfalls in human resources from sector line ministries, which is discussed in Section 4.3.2. In brief, when local elected officials complain of not knowing what to do, they are not only complaining about the lack of written guidance, but also the lack of qualified, accountable staff that can provide ongoing guidance in terms of activities and investments in different sectors.

Orienting local governments

Orientations by sector ministries to newly elected local officials have been limited to mayors and deputy mayors elected during the first round of elections. This means that no elected ward members and no officers elected during the second and third rounds of local elections have received formal orientations. The orientations held in June 2017 were fairly limited; the MOH had the longest session of 1.5 hours to cover basic information on health services and programmes.

The MOH is planning to roll out more detailed orientations to local governments in early 2018. However, multiple stakeholders suggested that the MOH’s approach to training and orientation, both with the initial session in June and those planned in the months ahead, focuses too heavily on technical information around disease burdens and programmatic approaches. These informants argued that the MOH should instead focus on communicating a simple, compelling case for why they should invest in the health sector. As an illustration of the issue, one health policy expert noted that following the June orientations, local elected officials from Province 3 came out with a statement of priorities in the form of the Dhulikhel Declaration. Conspicuously absent from a long list of key areas for investment was public health.

Perceived insufficient guidance for gaunpalika and municipal governments fuels tensions between local elected officials and the federal structures. Many in local government see the lack of orientation, gaps in written guidance, and absence of staff as a purposeful effort by federal authorities to undermine their ability to protect powers that have traditionally been held in Kathmandu and in district headquarters. This view is exemplified by a ward chief from

If the guidelines from the top came, then we’d be in a better position. Instead, they are blaming us for not being able to do things in the first two to three months.

- Ward Chief, Barahatal Rural Municipality
Birendranagar, who stated that ‘the central government knows that they have been lying to everyone and they don’t want to give up the power. The central government is in a predicament. Because they continue to have the idea that they should have the power in the centre. Because before the constitution they used to be the kings and they didn’t help the people’. Another explained that the lack of direct, enabling guidance to local governments made him ‘a bit worried that the federal government may be trying to take power from them’.

The desire for guidance from the federal government also speaks to the mind set of many in local government: Although many local elected officials spoke of jealously guarding their prerogatives, there remains a reluctance to move forward on key actions without the explicit sanction of central authorities. This points to a certain fear of risk-taking in this early period of federalisation, as local governments are growing into their roles. An interesting point of tension has arisen in the minds of individual actors because some of the same officials that fear federal government intrusion also seek guidance from above. However, some elected officers have resolved this tension, developing a clear view of the type of support they do and do not want. Rather than ‘guidelines’ from federal ministries, they want templates, model laws, and staff who can guide their independent action.

4.3.2. Deputation of civil service staff to local governments

Accountable and responsive health service delivery depends on gaunpalika and municipal governments having adequate staff and clear authority over those staff. The health sector has made more progress in deputing federally employed staff to local governments compared to other sectors7. The MOH’s relative progress compared to many other ministries can be explained by its longer history with deconcentrating, dating back to the early 2000s, when the MOH began deconcentrating some primary health services to local governments in line with the Local Governance Act (1999). As one of the largest service delivery sectors, significant staffs are already deployed to forward locations in the health and education sectors in the form of health facilities. Therefore, the primary challenge has been moving staff largely based in the DHO to gaunpalika and municipal government administrative offices.

The staff deputation process began under the MOGA Local Level Administrative Structure and Staff Management Guidelines (2074). Decisions on staff deputation have been made at the district level by the District Staff Management Committee, headed by the Chief District Officer. The Staff Equalisation Act (2074) made legal provision for staff ‘equalisation’ across government, provincial, and federal governments, mandating that staff distribution be based on an organisation and management (O&M) survey. Transferred, or equalised, staff will be made permanent staff at each of the three levels of government. In the interim, local governments are limited to hiring staff via service contracts for specialised expert services. Furthermore, staff sent by line ministries are considered ‘deputed’ until the O&M survey is complete.

The Equalisation Act sets in place multiple dynamics. The Organisational and Management Survey Committee will be formed at the national level, meaning that the federal government plans to drive the equalisation process. Civil service has strongly resisted deputation (see text box, below), contributing to a situation in which substantial vacancies remain in local governments because many within the bureaucracy delay arriving at post. Notably, this situation is even more dire in sectors other than health, such as education and agriculture. Informants reported resistance to permanent transfer, with interest groups, such as public sector unions, being positioned to play the role of spoiler. This suggests that the O&M

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7 Comparisons between the MOH and other ministries on staff deputation is based on the qualitative report of key informants, including from MOFALD, engaged in supporting inter-ministerial planning around federalisation. The research team was not able to gather concrete specifics on the numbers of staff that have been deputed.
survey could be a protracted process, possibly taking multiple years. This could lead to an extended period in which deputation becomes the norm.

### The controversy of staff transfer

It is helpful to understand exactly why the issue of staff transfer is so controversial and represents a fault line within the governance structure that may not soon be resolved. Perhaps obviously, many staff strongly object to a transfer process that could permanently send them to remote, undesirable locations. Under the centralised system, local government placements were temporary and civil servants could hope for progressively more desirable posts as they advanced in their careers. Furthermore, transfer to local governments is seen by many in the civil service as a loss of status and a threat their potential career trajectory. A particular source of grievance is that some transferred technical staff will report to administrative staff that are lower in rank, which offends the sensibilities of those shaped by a hierarchical civil service. Multiple observers stated in different ways the same fundamental idea: that under the centralised system, someone who began their career as a medical assistant could theoretically finish as secretary of the MOH. This sense of possibility is cut short by staff transfer.

Staff deputation creates a situation in which federal staff are effectively seconded to and receive salary from local governments, but remain employees of the MOH. Multiple informants explained that this gives rise to dual loyalties and causes elected government officials to question the extent to which transferred staff are accountable to them or the ministry. One mayor in Lamjung described deputed staff as being non-cooperative, noting ‘we feel that the bureaucrats are not happy with local elected representatives’. This dynamic is directly observable at the local level; the field team saw multiple deputed staff arrive at the municipal administrative offices at 4:30 pm to sign their timesheet, but otherwise did not attend to their jobs.

In the near to long term, the staff deputation/transfer process will complicate management of the civil service at the local level by creating multiple categories of employees with different rights and privileges. At least three categories are likely to exist based on current discussions, including staff previously hired by local governments, staff transferred from federal service, and staff newly hired by local governments. Unlike the other two categories, transferred staff are likely to retain some capacity to move between municipalities and levels of government service. In the meantime, a proliferation of short-term contract hires is likely before the O&M survey is complete. These distinctions have the potential to create feelings of inequity and hierarchy within the local government service.

### 4.3.3. The role of the district

The district’s long-term role has been a source of tension between elected local officials and district and federal government. At the same time, over a six-month period, views on the district’s potential place within the emerging health system have shifted and illustrate how establishing elected local governments have changed the centre of gravity in the overall governance system.

When preliminary discussions for the APEA began in June 2017, multiple MOH stakeholders spoke of the potential for maintaining a DHO structure at the district level. Arguments in favour fell into two categories. First, proponents argued that severe capacity constraints exist at the local level, requiring greater support from district extensions of the MOH. Second, some federal- and district-level officials argued that there are economies of scale to maintaining some functions and managing certain programs at the district level. For example, a senior MOH official argued that 50–60 years of experience in the health sector in Nepal indicates that functions such as vaccines, drug supply, and technical support for facilities are most efficiently provided through district structures. The impetus for these and other comments were to ensure that the federalisation process did not contribute to decline in service delivery and key programmatic outcomes, especially as local governments were
just being established. However, these arguments carried historical baggage, as similar arguments regarding local capacity and economies of scale were used to avoid full implementation of the 1999 Local Governance Act.

By August 2017, it seemed that many in the system recognised that the DHO and related district-based extensions of line ministries (e.g., District Education Offices, District Agriculture Offices) were vestigial structures of the old, centrally administered governance system that will be phased out. Even officers in DHOs, for example, described their continued existence as a separate office as time-bound, limited to the transition phase when authorities are being transferred to local governments. At the same time, a debate emerged over the scale and function of the DCC. At one extreme, some elected local officials saw no role for a district presence within the federal structure. For example, a ward chief from Gutu, Surkhet, described the district as ‘obsolete’. A gaunpalika chief from the same district asked, ‘where is the district in the constitution’? At the other extreme, some in federal and district government envisioned a more robust role for the DCC, including an ability to provide monitoring, technical assistance, capacity development, and other support to municipality/gaunpalika governments. One DCC official in Surkhet, for example, argued that his office should have a cabinet of sector staff equivalent to that of municipality/gaunpalika governments.

As of November 2017, the DCC’s role is likely to remain slight, limited to a yet-to-be-defined coordination function. Stakeholders increasingly talk of monitoring and quality assurance functions shifting to the province level. Furthermore, consultations at the local level demonstrated that district appendages, including the DCC and DHO, are being side-lined. However, it remains uncertain what role the districts will play over the long term.

### 4.3.4. The role of the province

The province’s role in the governance structure generally and the health sector specifically remains unknown at this juncture. Debates over the proper operational scope for the province to date have been conducted without provincial governments in place, meaning that there is effectively no champion for provincial interests within the overall governance structure and specific sectors, such as health. Multiple policy observers emphasised that it was no accident that local elections were held prior to provincial elections; according to them, federal authorities preferred to work directly with local government to set up the new governance structure and are interested in weaker provincial structures.

In the absence of elected provincial governments, the lines between the province on the one hand and federal and local government on the other hand have not been determined. However, with provincial elections scheduled for late November and early December 2017, it seems likely that there will be a vigorous debate over the province’s role. At present, its basic governance structure remains unclear and the number and mandate of provincial ministries are still undefined. Conversations with government stakeholders and a review of internal MOH documents suggested that there likely will be seven provincial-level ministries, including for education, health, and social welfare. But, the final structure will not be announced until a new federal parliament is set up, meaning that provincial governments will likely begin their term without basic institutional frameworks and structures in place.

It remains to be seen how provincial elections change the balance of power within the overall governance structure and how effectively provincial governments advocate for resources, claim policy authority, and inject themselves between federal and local governments. The extent to which elected local governments have shifted decision-making away from districts

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8 The constitution references a District Assembly and DCC. Functions at the district level include ‘coordination between the Village Bodies and Municipalities within the district’, the ‘monitoring of development and construction works’, and ‘coordination between the Federal and the State Government offices and Village Bodies and Municipalities in the district’.
suggests that provincial governments may have a similar effect. However, the experience of weak regional structures under the centralised system points to a history of intermediate structures being side-lined by both central and deconcentrated government units.

While much remains uncertain regarding the province’s role, some degree of continuity exists in how health policy experts envision or advocate for it, which, if enacted, would give provincial governments a critical role in promoting social and administrative accountability within the health systems. Multiple stakeholders believed that the provincial health department should take on key back-end functions that support basic health service delivery at the local level, including human resources, capacity development, technical assistance, monitoring, and quality assurance. One adviser to the MOH on social audits saw an opportunity to shift responsibility for social audit oversight to provincial departments, believing that there is an opportunity for closer monitoring of the process.

However, even if empowered, provincial governments likely will see significant lag time as they get set up. Some informants suggested that provinces can start monitoring and streamlining key activities, such as social audits, as soon as next fiscal year. This seems potentially over ambitious given that whole ministries will need to be built from scratch and are likely to operate with limited guidance.

4.3.5. Confusion within community structures

Confusion over the federalisation process and the evolving structure of governance is not limited to formal government institutions, but extends to the network of community structures that have been set up over the past decade as appendages of the governance and service delivery systems. These include WCFs, which played a central role in MOFALD’s 14-step local planning process, and CACs, which served as local structures for empowering and giving voice within governance processes to marginalised and vulnerable women. In the health sector, some HFOMCs were charged with managing health facilities and mother’s groups and FCHVs have made up the health sector’s volunteer army at the community level.

As a DFID-funded study in Dailekh revealed, these governance structures have been marked by a degree of incoherence as different sectors have established their own ‘pipelines’ of committee structures (Hobley & Shields 2015). However, these bodies also have served as primary conduits of information between citizens and state actors. Significant donor and government investment has gone into establishing these structures, and consultations with stakeholders, including local government, suggested that they serve as key sources of information for decision-makers. At the same time, the various committees’
current activities appear muted by their lack of understanding of where they fit in the federal government structure.

The Local Government Operations Act empowers municipal and gaunpalika governments to form committee structures at the local or community level, although it remains to be seen how most local governments use this power. When Pact completed most of its consultations between July and September 2017, structures such as CACs and WCFs were unclear about the role they would play, if any, in the evolving structure, with almost all reporting limited to no engagement with newly elected officials. Pact’s USAID-funded local governance programme, Sajhedari Bikaas, found that local governments are continuing to fund CACs as structures for organising and conducting outreach to historically marginalised groups. At the same time, it remains to be seen how CACs will link to governance processes at the ward and municipal levels.

By contrast, MOFALD circulars and the Local Governance Operations Act, 2017 made no reference to WFCs, and they have lost their role in governance processes, such as local planning and oversight. Many in local government contended that WCFs were created in the absence of elected local bodies and that they have outlived their purpose with the newly elected local governments in place. WCF members disagreed, viewing themselves as critical connectors of constituents and local government, which effectively facilitates social accountability. One WCF member from Barahatal, Surkhet, explained that ward chiefs are involved in broader political issues that strain their ability to closely monitor their constituents’ concerns; by comparison, he explained, WCFs are responsible for smaller geographic areas and can focus on raising local issues to elected government. Some local governments informally used WCFs (or their members) during the annual planning process that took place in June and July 2017. However, it seems unlikely that many local governments will sustain a formal role for WCFs, especially since the forums were viewed by many as political structures that represent alternative centres of power and are influenced by politics. It is possible that Tole Lane Associations, a structure that emerged in municipal governments under a United Nations Development Programme-supported programme in the early 2000s, will emerge as an alternative community structure of choice for many local governments.

Health sector committee structures similarly expressed uncertainty about their place within the governance system. This was particularly true for HFOMCs. Whereas they were previously situated under the DHO structure, they are now under the jurisdiction of the municipal or gaunpalika government, with the local ward chief serving as chair. As of September 2017, multiple HFOMCs reported having little to no contact with the ward chiefs, despite the fact that the chiefs were designated to take over management of the committees. The MOH released a circular dated October 7, 2017 announcing the dissolution of existing HFOMCs and the planned reformation of the structures under ward chiefs. This appeared to leave committee members generally confused about whether they still had a role and what the timeline would be for re-establishing HFOMCs.

Despite the near-term confusion stemming from the HFOMC reformation process, ward chiefs’ role in chairing the bodies represents a significant opportunity. Consultations with informants at the community and national levels suggested that HFOMC effectiveness has significantly varied. Where they have been supported by externally funded projects, HFOMCs have been effective in overseeing health facility operations. One assessment of HFOMC structures found that the bodies can be effective at mobilisation, but many are inactive without regular meetings and community awareness of HFOMCs is limited (Fehringer et al. 2015). HFOMCs also often have served as political bodies, with party cadres slotted into positions on the committee with limited preparation or training. For example, in a municipality in Lamjung, Pact spoke with an HFOMC chief who had been placed in the position by a former Minister of Health, but who had no real awareness of his function. In some cases, HFOMC chairs do not even reside consistently in the local
community. By contrast, ward chiefs should be more grounded in local communities, and their role in chairing HFOMCs would create a direct linkage between health facility management and local government that has never existed. The newly reformed HFOMCs will need to receive training early so they establish healthy, constructive habits early in their tenures.

4.4. Prioritisation of healthcare

Perhaps obviously, for political decentralisation to contribute to SA in the health sector, local governments must prioritise it as an area of investment. Formal SA processes and informal feedback channels in health facilities and local government will continue to absorb information about inadequate or inefficient health service delivery. An unanswered question is the extent to which local governments will use their resource and policy discretion and their bargaining capacity within the larger government structure to respond to citizen-user concerns. Part of MOH officials’ anxiety about political federalisation stems from a fear that healthcare will be crowded out by other priorities, most notably investment in road and infrastructure development. This is a concern shared by some in donor-funded projects that are closely engaged in health sector reform and technical assistance for health service delivery.

Consultations with local government revealed that they have numerous priorities. Commonly cited priorities included roads, water, electricity, other infrastructure development, tourism, waste management, natural resource management, agriculture, education, and health. Within this list, local government officials commonly identified health as one of three or four top priorities. However, when pushed, healthcare was typically secondary to infrastructure-related areas of investment, including roads, water, and electricity. Local government appears to be largely aligned with the priorities of its communities. Even members of community committees, such as CACs or FCHVs, who were more apt to emphasise investments in social sectors such as health likewise described road and infrastructure as top priorities. Notably, many saw infrastructure development as interlinked with investments in the health sector because poor road infrastructure remains a primary constraint to facilitating access to health facilities, just as inadequate water supply gives rise to waterborne disease.
It is difficult to evaluate the sincerity of statements of support for healthcare by elected local officials. Instead, the best means of intuiting the extent to which local government prioritises healthcare at this early date is by analysing the annual budgets recently approved by municipal and village councils. This endeavour was challenging because most local governments were unwilling to share their budgets, possibly driven by a concern that they may not have done their budgets ‘correctly’. However, Pact was able to obtain budgets for a handful of municipalities and gaunpalikas, including Besisahar Municipality and Doodh Pokhari Gaunpalika in Lamjung and Baiganath Gaunpalika in Banke. The research team also discussed budget allocations with informants from other local governments without seeing the budget details.

Local governments receive a combination of ‘conditional’ grants, which are earmarked for specific sectors including health, and ‘equalisation’ grants over which they have full authority. Pact decided to focus on analysing the equalisation grants to understand how local governments choose to allocate resources over which they have full discretion. Some informants based in Kathmandu shared that individual local governments make significant investments in the health sector, including to purchase local pharmaceuticals. However, these reports were not evidenced in the research team’s visits to 10 local governments, where local investment in the health sector from equalisation budgets ranged from less than 2% to about 8% (see Figure 5). By contrast, investments in infrastructure ranged 50–80%. Notably, where health sector investment was higher, most of the funds were reserved for supporting local infrastructure and supplies for mother’s groups and FCHVs, such as the construction of meeting venues.

**Restrictions on conditional budgets**

While the allocation of equalisation grant funds provides the best indication of the extent to which local governments prioritise health compared to other sectors, most of the funds for the health sector actually come in the form of conditional grants. For example, the Baiganath Gaunpalika government allocated $25,157 to the health sector from the equalisation grant, compared to $178,210 from the conditional grant.

Analysis of the conditional grants suggests that they are highly restrictive and reflect continuity with the central approach to planning that has existed up till now. For example, of the 98 line items that compose the conditional grant budget for Baiganath, 90 are for health compared to 1 for agriculture, 1 for livestock, and 6 for education. This is the case even though the education budget is nearly 5 times larger than the health budget ($875,370 versus $178,210). The proliferation of health-related line items is in part a reflection of the many unique programme and service lines that predominate within the health sector; 43 of the line items for Baiganath are for district programme activities. However, it also stems from a desire to place very specific guidance and conditions on the spending of health sector funds. For example, conditional grants include separate lines for items such as per diems, other staff incentives, electricity, rent, and even garden and guard expenses. At least in this first year of conditional grants, budget decisions were made following the traditional top-down approach to planning and budgeting.

The combined result of modest investments in the health sector from equalisation grants and highly restrictive conditional grants could be that local governments have limited latitude for making...
resource allocations that respond to emergent needs and citizen feedback. It will be important to track the extent to which both conditions and allocations from equalisation grants evolve over time.

4.5. Political incentives to continue social accountability mechanisms

The medium- to long-term status of SA mechanisms depends to a large extent on local government’s interest in investing in robust feedback and accountability processes. Although elected local officials demonstrate limited awareness over mechanisms such as social audits, they uniformly described themselves as committed to the principle of SA and to cultivating processes through which they generate citizen input. However, evaluating the sincerity of these statements is difficult. Many in local government expressed confidence in their ability to intuit local opinion over service delivery and other issues through their own informal networks, suggesting a potential under-valuation of more formal processes for capturing citizen perceptions and feedback.

One question that remains unanswered is the extent to which elected officials will view SA processes as a tool for holding themselves accountable or as a set of processes that help them hold service delivery providers accountable. In nearly all consultations with local government, Pact asked a version of the question: In the event of poor service delivery within the health system, such as at a health centre or hospital, who is responsible for that poor service delivery? Answers to these questions varied. Some were inclined to see other actors as primarily responsible. For example, a ward chief in Baiteshwor said that health facility staff were primarily responsible for delivery and the federal government was responsible for ensuring the facility had requisite resources. By contrast, others such as a deputy mayor in Dolakha described the local government as having ultimate responsibility for ensuring adequate service delivery. Still others described a hybrid set of responsibilities between facilities, local government, and central government, which likely best reflects the system as it presently exists.

These perceptions matter because they could shape the extent to which local government interprets feedback on health service delivery as a reflection on their performance versus the performance of other actors within the health governance system. Advocates of accountability have perhaps a delicate balance to strike in how they present and promote SA mechanisms. On the one hand, they will want to encourage local government to accept ultimate responsibility for basic health service delivery. On the other hand, elected local officials could feel threatened by SA mechanisms that are framed primarily as a means of holding themselves accountable. The extent to which local government views other actors as responsible (or partially responsible) for service delivery could represent an opportunity for accountability champions because they can describe SA mechanisms as targeted information-gathering devices that will help elected officials hold health facilities, HFOMCs, municipal health units, and other stakeholders accountable.

Confusion and lack of awareness of local government over existing SA mechanisms is on the one hand understandable, given that local officials are only a few months into their jobs and have not yet seen processes such as social audits in practice. On the other hand, this may speak to the limited capacity of local elected officials to absorb and interact with a range of accountability and processes across multiple stakeholders. This leads many in both the local governance and health sectors to predict that some version of an integrated, multi-sector SA process, such as the district-wide social audit previously supported by MOFALD, is likely to represent the centrepiece of SA approaches moving forward.

The primary logic of an integrated SA approach is that it could significantly reduce some of the transaction costs of multiple, sector-specific mechanisms and parallel SA processes would not compete with the attention of local decision-makers. It is also easy to envision
how, for example, a single multi-sector social audit could be linked to local planning and budgeting processes. However, an integrated process may not have the capacity to incorporate the very specific and textured challenges experienced across many health facilities and among related community structures, such as mother’s groups. Thus, some of the strongest SA advocates in the health sector argue for the continuation of processes such as health facility social audits alongside multi-sector mechanisms.

It remains unclear the extent to which local governments will have sole responsibility for determining how SA processes are implemented or the degree to which federal and provincial governments will be able to incentivise or compel the use of SA mechanisms. As described above, many local governments are wary of federal mandates even, while they seek guidance and clarification on how to carry out key elements of their mandates. Among consulted policy experts at the national level, the verdict seems to be mixed. Some argue that decisions on whether particular SA processes will be used will be at the discretion of local governments. Others hold that the MOH will be able to set conditions whereby local governments must carry out social audits or related SA tools. Still others suggest that the MOH must not mandate use of a single tool, but establish basic guidelines around ensuring accountability and citizen feedback within the health system. Under this system, local governments or possibly provincial governments would be able to select from a range of recommended accountability tools and methodologies.

One initiative that could have influence is the World Bank-supported ‘Disbursement Linked Indicator’ (DLI) 11, which aims to support citizen engagement approaches in the health sector. Under DLI 11, the MOH will pilot multiple citizen engagement methodologies that could become part of a menu of approaches adopted by local governments. It remains to be seen what level of uptake stems from this initiative.

4.6. Constraints on administrative accountability and its impact on social accountability

SA depends on a requisite level of administrative accountability within the bureaucracy to reward behaviours that respond to citizen-user needs and punish actions (or inaction) that hinder the system’s ability to deliver effective services. Therefore, an ideal governance system would create incentives for staff and administrative units, such as health facilities, to respond to information gathered from SA processes.

The health system largely fails to link SA processes to administrative rewards and punishments. As explained above, processes such as social audits are monitored for their completion rather than the extent to which action plans are implemented or citizen feedback is used for decision-making. MOFALD used its Minimum Conditions and Performance Measures (MCPM) to incentivise VDC performance in a number of domains, including the extent to which planning originated from local communities, but a similar system has never existed in the health sector.

Beyond the failure to link incentives to SA processes, stakeholders described weak systems for staff accountability. This weak system is perhaps best illustrated by the proliferation of private clinics that surround large hospitals, frequently with signboards advertising the proprietor’s status as a doctor in the public hospital as a credential. These private clinics highlight the extent to which health system employees can violate official rules and norms with impunity. Informants laughed at the question of whether health staff can be fired for poor performance or closing public health facilities early to operate private practices. For example, they noted that the operation of private practices is common not only for doctors and medical assistants in local health facilities, but senior MOH officials.
Informants offer a combination of explanations for the existing weak system of administrative accountability. Some blamed the regulatory framework, describing relevant laws and policies as antiquated. For example, the Civil Service Act was described as ineffectual, with key weaknesses including weak mechanisms for making individual officials responsible for lack of responsiveness to citizens and the lack of performance-based incentives. Similarly, a journalist who covers national health policy explained that that the codes of conduct from bodies such as the Nepal Medical Council rely largely on self-regulation and are not codified into the formal legal framework.

While key gaps in the regulatory framework may exist, the primary drivers of weak administrative accountability seem to be informal and rooted in basic power dynamics. Even where they exist, laws and policies are not enforced. For example, the National Health Policy (2014) called for a single professional trade union to represent the sector, yet a single hospital can have staff represented by upwards of 15 trade unions. The association of trade unions with political parties makes it highly unlikely that the government would force their consolidation. Many informants described both political parties and trade unions as barriers to administrative accountability. Health staff commonly align themselves with political parties, which effectively insulates them from sanctions and can be a source of advancement; as one former adviser to the MOH argued, health system staff increasingly have no choice but to align with a party if they hope to get ahead.

The forces that serve to de-incentivise robust administrative accountability are strong—perhaps overwhelming—and include other factors not discussed here, most notably low wages for health staff, as well as the short rotations civil servants typically complete, particularly in remote districts, which theoretically could be improved through a transition to a local civil service. Some stakeholders noted that there could be opportunities for reformist-minded local and provincial governments to strengthen accountability systems within their own jurisdictions. However, their ability to institute reforms and consolidate their authority over their staff will be limited until the transfer of civil servants is complete and they have the ability to hire long-term personnel.
5. Conclusion and Recommendations

In Banke district, the field team heard a story that, although originating from outside the health sector, in many ways represents the accountability challenge as it presently exists within the evolving federal governance structure in Nepal. A farmer had visited the District Agriculture Development Office seeking subsidised fertilizer and was redirected to the sub-metropolitan office in Nepalgunj, noting that the responsibility for the subsidisation program had shifted to the local government. But, upon reaching the sub-metropolitan office, the farmer learned that there were no technical staff or resources to run the program. Thus, the farmer faced a situation in which neither the district nor his local government was able to provide a core service.

This is one story, the study team has seen versions of it playing out across sectors in Nepal. Just enough responsibility has been devolved to the local level for federal and district authorities to argue that municipal and gaunpalika governments are responsible for key services and government programmes. At the same time, enough resources, technical knowledge, and guidance has been withheld from local government to credibly argue that their counterparts at the federal and district levels remain accountable for key functions. The risk is that a situation in which multiple levels of government are accountable for defined services and activities could contribute to an environment in which no entity is fully accountable.

The factors that give rise to incomplete or overlapping accountability are manifold. The constitutional framework established numerous areas of concurrent powers, which have been incompletely addressed by the GON’s analysis of the ‘unbundling’ of powers across the three levels of governance or subsequent sector-focused analysis. Thus, key uncertainties remain in terms of the near and long-term role of governance structures as fundamental as the district and province. Significant budget has been allocated for local governments in the form of both conditional and equalisation grants. However, in the health sector, the budgeting process has given the MOH outsized influence in defining financial allocations and most municipal and gaunpalika governments have yet to use equalisation funds to significantly augment health spending. Furthermore, the staff deputation process potentially creates dual lines of accountability over sector staff placed in local government offices, and when permanent staff transfer will be achieved remains unclear.

While the challenges associated with the transition to a system of political federalism are significant, the transition also presents key opportunities. The GON has been effective in building structures and processes that facilitate community feedback in the health sector and beyond. These mechanisms have too often functioned as rituals and failed to contribute to higher-level decision-making. However, they have helped establish the norm that citizen-user input should be part of service delivery and local governance processes. Furthermore, some evidence suggests that mechanisms such as health sector social audits can elicit positive outcomes at the health facility level, where requisite authority and resources exist. With the federal structure, there are new opportunities to better link citizen feedback to decision-making and inter-governmental advocacy by local governments. For example, the reformation of HFOMCs under ward chiefs could tighten the connection between health facility management and local government.

Much remains uncertain in how the governance system will evolve, where power will coalesce, and how these dynamics will affect the health sector, including SA processes. However, enough is known to provide a set of recommendations for SAHS and other DFID-funded projects and for other implementers of SA initiatives. These recommendations include specific areas for further research and analysis, convening stakeholders around defined topics, and exploring the efficacy of programme ideas that respond to the current political conditions.
5.1. Programming recommendations to DFID and implementers of health and local governance interventions

Develop strategies for leveraging local government’s interest in achieving quick wins for their constituents.

Conversations with a range of elected local officials make clear that they are interested in making immediate gains in development priorities. This desire to achieve development outcomes appears to come from local elected officials’ sincere interest in improving the lives of their constituents and a political imperative to provide communities with direct, visible evidence of results. In part, the focus in showing near-term progress stems from politicians needing to live up to their own rhetoric. For example, a Gaunpalika Chief from Surkhet explained that ‘if you come back in a year you will see a lot of changes’.

The quality and responsiveness of health service delivery ultimately will depend on the willingness of local other government levels to prioritise and invest in the sector. While road and infrastructure development seem to have attracted the most attention from local governments to date, multiple observers argued that a selling point for a focus on the health sector is that modest, targeted investments could realise quick outcomes in a way that is visible to constituents. SAHS may explore with other stakeholders the potential for generating newly elected local governments’ interest in the health sector.

Promoting local government interest in health sector investment may require health advocates, including those in the MOH, to adjust how they speak about the importance of health. MOH orientations for local government on the health sector largely have focused on technical matters, such as the discussion of specific disease burdens and the rationale behind discrete health programmes. Instead, greater emphasis should be placed on building the political case for investing in the health sector. In brief, health advocates should effectively explain to local politicians why programming and investment in the health sector can make for good politics. The Asia Foundation plans to pilot such an initiative funded by the Australian Government’s Department of Foreign Affairs and Trade. SAH and other DFID-funded implementers should follow up with The Asia Foundation as it generates lessons on its approach.

Focus on strengthening the capacity of newly reformed HFOMCs.

The restructuring of HFOMCs under the leadership of ward chiefs could directly link health facility management to local government. HFOMCs were already varied in their level of performance, and their reorganisation leaves many of the committees unclear on their roles and processes for fulfilling key functions. An important window of opportunity exists to properly orient and train HFOMCs to contribute to revitalised structures. Notably, training should include helping HFOMCs think through how they will connect hospital management issues to decision-making processes, including planning and budgeting, within local governments.

Test alternative strategies for framing SA to local government.

The degree to which the federal government and potentially provincial governments can incentivise or even mandate the implementation of specific SA processes remains to be seen. However, local governments will be the primary driver in determining whether SA mechanisms are effective and actually contribute to accountable service delivery and governance. One question that remains is whether local officials see SA processes as a threatening means of holding themselves accountable or as useful tools for generating useful information about constituent needs and interests.
SA remains an abstract concept to many in local government, and implementers should consider how they frame the term and associated processes. In particular, they should test whether deliberately emphasising the degree to which defined SA mechanisms can help local governments close information gaps that exist between them and citizens helps build support for the processes. Given that local governments are just being established and may have severe restrictions on their ability to function for some time, champions of SA should give careful consideration to the right time to emphasise the accountability aspects of SA processes. Driving forward with harder-hitting SA processes could be counterproductive in building local support and could undermine the position of local government at a critical moment.

5.2. Recommendations for the SAHS-supported social accountability forum

SAHS intends to convene an SA forum as a convening platform at the national and district levels for public sector and civil society engaged in supporting SA activities in the health sector. This APEA focused primarily on supply-side SA mechanisms, as compared to demand-side or CSO-led SA processes. However, the research team identified a dearth of platforms, particularly at the district level, for coordinating SA activities and learning. Thus, the SA forum seems poised to play a critical role in facilitating joint learning and information exchange across both supply-side and demand-side actors. Furthermore, a range of topical issues can be deliberately explored through the SA forum structure.

Convene dialogue on the proper role for provincial governments in supporting SA in the health sector and beyond.

The provincial structure remains the most undefined element of the federal structure. At the same time, the monitoring and oversight role envisioned by many suggests that provincial governments could play an important role in supporting and encouraging SA; some technical advisers to the MOH felt that provincial health departments could be positioned to coordinate processes such as social audits. SAHS should use the SA forum as a platform for discussing province’s ideal roles and responsibilities in coordinating and providing technical oversight and other support for SA processes. Where consensus views are evident, they should be communicated to key decision-makers in both the MOH and provincial governments.

Evaluate the efficacy of incentivising the use of SA process through the Inter-Governmental Fiscal Transfer (IGFT) formula.

SA champions have a delicate balance to strike in promoting local government ownership over SA processes that emerge under the federal structure and incentivising or even compelling the use of particular mechanisms. Significant risk exists that strict requirements could continue or even exacerbate the ritualization of processes, such as of social audit, which already exists.

Multiple informants suggested that the MCPM system established by MOFALD was effective at inducing positive practices among VDCs and DDCs and that a similar process could encourage SA within the emerging local governance system. One possibility would be to have the IGFT formula incentivise a combination of processes related to SA and citizen engagement. The SA forum should discuss the relative benefits of using the IGFT formula in this matter. Depending on the level of interest among members of the SA community, SAHS may directly explore the political feasibility of using the IGFT in this manner and convene discussions on the topic with key policy-makers.
Convene and contribute to discussion around the right balance of multi-sector versus health-specific SA mechanisms.

Critical questions remain on the capacity of local governments to absorb information and adequately finance a range of sector-specific SA processes, such as the health facility social audits. One or a set of core multi-sector citizen engagement and accountability tools likely will be deployed, likely building on processes such as public hearings and public audits previously supported by MOFALD. Integrated SA processes could address the lack of coherence that has existed within the governance system up till now, as identified in previous assessments such as the Dailekh District Mapping Study. However, whether multi-sector processes can adequately capture issues related to the range of health services provided in a given municipality or gaunpalika remains uncertain. SAHS should use the SA forum to explore the benefits and drawbacks of integrated versus health-specific SA mechanisms.

5.3. Recommendations for continued analysis under SAHS

Support ongoing analysis of political trends and their potential impact on accountability within the health sector.

The dynamic political environment, which defines Nepal and in which so much remains uncertain, means that the shelf life on any one analysis is limited. Key insights collected in July had to be rethought by the time the final report was written in November. As such, APEA must be treated as an ongoing analysis, carried out over the life of SAHS. This will require updating this baseline APEA on an annual basis and completing issue-focused APEA studies on an opportunistic basis, as is envisioned under the SAHS contract. SAHS and DFID may wish to explore ways of enabling ‘lighter touch’ analyses of key political trends on a defined basis (such as quarterly), either through building that analysis into planned deliverables or modifying or adding to the contract.

Track local government investments in the health sector over time.

The extent to which local governments will choose to prioritise the health sector relative to other sectors remains unclear. Budget allocations will remain the best indicator of municipal and gaunpalika government priorities. The few budgets the research team was able to analyse suggest that limited discretionary funds are being allocated to the health sector, with the exception of infrastructure-related investments for mother’s groups. SAHS or other DFID-supported projects may find track how spending decisions by local governments change over time useful. Additionally, there may be opportunities for assessing the extent to which SA mechanisms, such as social audits or HFOMCs, actually inform decisions on budget allocations.

Map and study the impact of informal information gathering by local governments.

As explained in this report, elected local officials take in and process information in ways that are highly informal and based on existing political and constituent networks. Citizen voice could inform investments in health and other sectors primarily through these informal communications channels, as compared to more formal SA processes. At the same time, who is effectively included in these networks is unclear and that the most marginalised groups fit into existing communications patterns is doubtful. Given that the greatest ‘action’ may sit within these informal processes, it could be worth explicitly mapping this informal flow of communication and studying both who has access to this communication and how they contribute to local government decision-making.
Assess accountability issues within the private health care system.

With more than 300 private hospitals in the country, a significant % of health care is provided through the private sector (Central Bureau of Statistics 2013: 8). However, private hospitals and clinics generally are not covered by existing MOH-established SA processes and mechanisms. SAHS could examine private sector practices for generating and responding to feedback from users, as well as possible approaches the GON could take for encouraging SA within the private system.

Investigate the role of information and communications technology (ICT) in promoting SA within the health system.

Past efforts to use ICT to facilitate citizen-user feedback into the health system, through the Smart Health portal at the MoH website which includes complain and grievance handling, healthy facility registry, results framework and E-attendance but these have not come to full fruition. At the same time, the stated local government preference for communicating via phone and SMS conveys the degree to which ICT, particularly mobile technology, could be a useful platform for facilitating feedback. This report has not explored key incentives around the introduction of ICT-based SA solutions. However, there may be opportunities for deliberately investigating the potential for uptake of such solutions through case studies that are planned over the implementation of the SAHS project.
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Appendix: Interview Guides

Focus Group Discussion Guide—CAC and WCF

A. General information

1. Please describe for me the role. What are your main activities?

- How often do you meet as a group?
- What challenges do you face in fulfilling your functions?

2. To what extent are you familiar with the term SA? How do you understand the term? Can you list for me 3-5 words that you associate with the term SA?

- Has the social audit processes been helpful? If so, how? If not, why not?
- How comfortable are you communicating your concerns in public meetings to authorities?
- What have been the major findings of recent social audits?
- Has there been follow up from the findings of the social audits?

3. Are you familiar with the social audit process? What has the role of the CAC/WCF been in the social audit process?

- Has there been follow up from the findings of the social audits?

i. What has been followed up on and what has not?
B. Understand communication between CAC/WCF and local government

4. Have you had any contact with your newly elected local government? If so, on what topics and how supportive have they been?

5. What is your future plan in contributing to the local governance system?

6. What issues would you like your local government to prioritize?

7. Do you think local government will have the same priorities as you? Where do you think healthcare will fit within their priorities?


We have come to the end of our interview. Thank you for your time.
Focus Group Discussion Guide – Media

A. General information

1. How is health covered in the media? What is covered and what is not? [-rf/df :jf:Yo lq s;/L ;d][6g] u/[sf] 5 < s;tf ;jfnx? ;d][6G5g\ / s;tf ;d][6b]gg\ < _

2. How frequently is health covered in media? - :jf:Yo ;DalGw ;dfrf/x? lqoldt ?kdf slQsf] ;d][6g] u/[sf 5g\ < _

3. What are the differences between national vs local news coverage on health? -s]Gb| / :yfgLo :t/sf ;dfrf/x?df ;d][6g] :jf:Yo ;DalGw ;jfnx?df s] s;tf] leGgtf x'g\ ub[5 <_

4. How do you get information on health issues from the district (including remote areas)? - tkfO[x? lhNnf tyf :yfgLo :t/-b'u[d lf]q_ af6 :jf:Yo;Fu ;DalGw hfgsf/L tyf ;'rgfx? s;/L k|fKt ug'{ x'G5 <_

B. Media understating on social accountability

5. To what extent are you familiar with the term social accountability (SA)? How do you understand the term? Can you list for me 3-5 words that you associate with the term SA? - tkfO[x? ;fdflhs hafkmb[xtsf] af]/df s] slt hfgsf/ x'g' x'G5 < olb x'g' x'G5 eg] s] s;/L a'em\g' ePsf] 5 < ;fdflhs hafkmb[xtsf] ;Gb[enfO{ hFf8]/ # b]lv % zAbdf atfO{ lbg'xf];_

6. Are you familiar with the social audit process? -s] tkfO[x? ;fdflhs k/Lf0sf] k|ls|ofs af]/df hfgsf/ x'g' x'G5 <_

C. Understand communication between media and local government

7. Have you had any contact with your newly elected local government? If so, on what topics and how supportive have they been? -s] tkfO[x?n] g] lqgf[lrt hgk|ltGlwx?;Fu e]63f6, 5nkfn u[g' ePs] 5 < olb u[g' ePs] 5 eg] s] ;jfn / ljjfodf e]63f6 u[g' ePs] 5 < tkfO[x?sf ;jfnfD pgLx? slQsf] ;xof]UL /x]sf 5g\ <_

8. What service/issues have the local government prioritize? How will media ensure that these services have been satisfactorily fulfilled? [If not - what can be the incentive to mobilize this 4th sector?]
   -s] s;tf ;jif / ;jfnx?df :yfgLo ;/sf/sf k|fyldstfx? /x]sf 5g\ <

Opportunity < cfufdL lbgdf ;jf:Yo lflqdf s] s:tf cj;/x? b]Vg' ePsf] 5 <


We have come to the end of our interview. Thank you for your time.
FGD/KII Guide – District I/NGOs

A. General information
1. Describe for me briefly how your organization engages within the health sector and/or local governance sector. -tkfO[sf] ;:+yf ;jf:Yo lqf / ;yfgLo zf;gsf] lqf qdf s;/L ;+:nfUg 5 ;+:lfKtdf atfO[ lbg'xf]; .

B. Understand INGO/NGO views on social accountability (SA) and specific SA mechanisms
2. To what extent does your organization work on the issue of SA? How do you understand the term SA? Can you list for me 3-5 words that you associate with the term? -tkfO[sf] ;:+yfn] ;fdflhs hafkmb][xtsf] ;jfnfO[ s lsf ub(5 < tkfO[n] ;fdflhs hafkmb][xtf] ;a'sm \g' ePs] 5 < ;fdflhs hafkmb][xtsf] ;Gb[enfO[ hf]/8] # b]lv % zAbdf atfO[ lbg ;Sg' x'G5 <

3. What do you see as the most important supply-side (or GON) mechanisms that facilitate SA within the health system? [If the informant only lists 1 or 2 mechanisms, directly ask if there are others, including informal feedback mechanisms] -jf:Yo ;]jfsf] lqf qdf ;fdflhs hafkmb][xtf] ;xlhs/0f ug[sf nflu ;a] eGbf dxTjk"0f{ Supply-side (or GON) mechanisms s] b]Vg' ePs] 5 < olb ; 'rgfbftfbn] !, @ j6f dfq eg][df c? klg s]lx 5g \ Is egL l:w] ;jWg]

a. How well do you feel that each of the mechanisms you have mentioned are functioning? -tkfO[n] eg] c'g';/sf ;+oGqx? slQsf] /fd]l]g;Fu sfof{Gjog ePs] 5g \ eGg] s'/f dxz'; ug'{ ePs] 5 <

i. What have been the outcomes of these SA processes? [Specifically ask for achievements at the facility, district, and central levels] -To:tf ;fdflhs hafkmb][xtsf] ;+oGqn] ;jf:Yo ;:+yf, lhNnf / s]Gb \ :t/df s] s:tf pknAw xfl;n ePs] 5g \ <

b. To what extent do these mechanisms ensure the quality participation of marginalized groups? To what extent do you believe they are structured to be GESI sensitive? -ltgL ;+oGqx?n] ljkGg \ d'xsf] cy[k"0f{ ;xeflutf slt ;Dd ;lglZrt ub(5g\ t < tkfO[ \ lgLx? n]lu+s ;dfgtf / ;fdflhs ;dfj]lz lx;fan] ++]bglzn 5g \ eGg] s'/fslf slt ;Dd ljZj:t x'g' x'G5 t <

4. For those of you that have worked as implementers of the social audit process -s] tkfO[x? klgs] ;fdflhs k/Lif0f k lS] osf] sfof{Gjogstf[x?sf] kdf sfd ug'{ ePs] 5 <

a. What were you able to achieve and what were you not able to achieve? -tkfO[x? s] s'/f k] fKt ug{ ;kmm x'g' eof] < / s] s'/f k] fKt ug{ ;kmm xg' ePg <

b. What have been the barriers in terms of fulfilling the social audit process? -;fdflhs k/Lif0fsf] k lS] ofnfO{ \ k'/f ug[sf nflu s] s:tf afwf c8\rgx? /x]sf 5g\ <

c. What type of orientation or training did you receive through DHO? -tkfO[x?n] lhNnf

40
5. What do you see as the most effective demand-side (NGO-led) SA processes in the health sector? Please describe the relative success and limitations of these processes. [Note to interviewer: probe into the extent to which specific NGO-led initiatives link to formal processes/mechanisms within the health system]

a. How do NGO-led SA initiatives ensure the quality participation of marginalized groups? How do they incorporate a GESI perspective?

C. Understand health planning processes and the role of SA mechanisms within those processes

6. Based on your understanding of the local government and MoH planning processes, to what extent do results and data from SA processes inform planning by local government and MoH? Please explain how data is used, or why it is not used.

D. Understand INGO/NGO views on local government and political federalism

7. How do you see the importance of SA in the new federal system? -casf] gFoF ;+3Lo k|0ffnLdf ;fdflhs hafkmb]lxtsf] dxtj slQsf] b|Vg' ePsf] 5 <

a. As a social organization how can you contribute? (lobby/incentive) -tkFO[x? ;fdflhs ;+yf ePsf] lx;fan] ;fdflhs hafkmb]lxtf k|a4|gsf nflu s/L of]ubfg ug'{ s'/f b}Vg' x'G5 <;fdflhs hafkmb]lxtf k|ab|gsf nflu s/L k]l] ug'{ x'G5 < k]/l] ug[sgf nflu tkFO|x|nfO{s:tf] vfnsf] ;xof]usf] cfjZostf b)Vg' ePsf] 5 <

8. What issues and types of investments do you expect local governments to prioritize? Where does healthcare fit within their priorities?

9. How well equipped do you believe local governments are to make policy and resource decisions related to health services? Please explain.

10. How does your organization anticipate working with local governments in the future? What do you see as your role in supporting accountability of local governments accountable?
11. Do you expect health service delivery to improve with political federalism? What do you see as the primary factors in determining whether federalism leads to improved health services? Opportunity/Risk?

- Opportunity
- Risk

We have come to the end of our interview. Thank you for your time.
Key Informant Interview Guide—Women and Children Office

A. General Information

1. Can you please briefly describe for me the role and focus of the Women and Children Office?

B. Understand Women and Children Office views on social accountability (SA) and specific SA mechanisms

2. Can you explain to me how you understand the term social accountability? Can you list for me 3-5 words that you associate with the term SA?

a. How can ensure your target groups have received the promised services? What are the mechanisms to discuss and ensure citizen satisfaction?

b. How can develop a collaborative environment between LG and citizen?

3. What do you see as the most important mechanisms that facilitate SA? [If the informant only lists 1 or 2 mechanisms, directly ask if there are others]

4. How well do you feel that each of the mechanisms you have mentioned are functioning? What are the successes and challenges of these mechanisms? What have been the results?

a. What is your office’s role within these SA processes?

b. How well are women and marginalized communities included in SA processes?

c. What is the role of local government within these mechanisms? How well do they understand and implement the mechanisms?
What is the role of external actors (such as donors, INGOs, and NGOs) in supporting these processes? How do their efforts impact the ministry?

Beyond the mechanisms listed, what are the other ways that you get information or feedback about health service quality and access at the facility, district, and central level?

5. Beyond the mechanisms listed, what are the other ways that you get information or feedback about health service quality and access at the facility, district, and central level? - o:\t f k\ls \osdf bft[ lgsfo / u];x?sf s ] s:t f e \l<dsf x'g] ub\{5 < pgLx?sf\} k\{of;n];sf/\nfO{s;L k\efj kfb[5_ 

C. Understand Women and Children planning processes and the role of SA mechanisms within those processes

6. Does the Women and Children Office have any input into the development of health sector budgets? - :jf:Yo If[qs] ah\]6 tof/ ug\]s;Gb[edf tkfO[sf sfof[nosf s]\lx of\ubfg x'g] u/]sf 5 < _ 
   a. Do you know whether data from Social Audit processes influence health sector budgets? If so, how? - ;fdflhs k/Lt0fsf] glthfn] :jf:Yo If[qs] ah\]6 lgdf0fs{df \lx st} k\efj kf/]sf b'Vg' ePsf] 5 < olx 5 eg] s;L k\efj kf/]sf 5 < _
   b. Are there processes for women to input into the development of health sector budgets? Please explain. - :jf:Yo If[qs] ah\]6 lgdf0fs{df \lxnxfsnfO{k lkg k]\ls \osdf ;xeflu u/fO(G5 < s[kof a0fg u'g'{xf];\_ _

D. Understand Women and Children Office views on local governments and political federalism

7. Please describe for me your relationship with the local governments. How do you communicate with them? How do you support them? -s[kof ;yfgLo ;/sf;Fu tkfO[x?sf s;DaGwsf] af/]df atfO{ lbg'xf];. pgLx?;Fu tkfO{x? s;L ;'rgf cfbf k\bfg u'{ x'G5 < pgLx?nfO{ tkfO{x? s;L ;xof\u u'{ x'G5 < _
   a. Do you believe that there should be Women and Children Office staff stationed at the district level? If so, what should be their role? If not, where should your staff be stationed? -tkfO{x?sf sfof[nosf sd{rf/Lx? lhnNf .:\t df x'g' kb[5 eGg] s'/f;f]Rg' ePsf] 5 < _
   b. Do you believe some roles have been transferred to local government that is better
fulfilled by your office? -ca ;yfgLo ;/sf/df w]/} e'lds k| bfg ul/Psf] 5 o:tf] cj:yfdf tkfO{sf] sfof{non] /fd| f|Fu sfo{ ;Dkfbg ub{ eGg] s'/fdf lj;j: t x'G' x'G5 t <

9. What issues and types of investments do you expect local governments to prioritize? Where do women fit within their priorities? Where does healthcare fit within their priorities? -:yfgLo ;/sf/n] s:tf ;jfn / ifqsf] nufgLsf nflu k|fyldstf b|cf]; eGg] cfzf ug'{ x'G5 < dlxnsf  Ifqsf k|fyldstfx? sxFF ;df]jz ug{ pk'o'Qm x'G5g\ < :jf:Yo ;]jfsf k|fyldstfx? sxFF ;df]jz ug{ pk'o'Qm x'G5g\ <

10. Do you expect women’s and children’s issues to be better addressed under the newly elected local governments? -gj lgtj[ljt k|ltglwx?n] dlxnf tyf afnaflnsfsf ;jfnx?nfO{ /fd|f];Fu ;Daf]wg u/L lbpg eGg] ck]ff ug'{ ePsf] 5 t <


• Opportunity< cfufdl lbgdf :jf:Yo Iffqdf s] s:tf cj; /x? b]Vg' ePsf] 5 <

• Risk< s] s:tf hfjldx? b]Vg' ePsf] 5 <

We have come to the end of our interview. Thank you for your time.
Key Informant Interview Guide – Health Facility In-charge

A. General information

1. Please describe for me your role as a Health Facility In-charge. What are your main activities?

   a. How do you oversee the operations of health facilities?
   b. What challenges do you face in fulfilling your function?

B. Understand the role of the HF In-charge on social accountability (SA) and specific SA mechanisms

2. To what extent are you familiar with the term SA? How do you understand the term? Can you list for me 3-5 words that you associate with the term SA?

3. What is your role in the social audit process?

   a. How well do you think the social audit process functions?
   b. What have been the major findings of recent social audits?
   c. Are findings from social audits shared with DHO, MoH, local government and other stakeholders? How interested are each of these stakeholders? What do they do with the information?

4. Beyond social audit, what are the other ways that you get information or feedback about health service quality and access at the facility level?

C. Understand health facility views on LGs
5. What issues and types of investments do you expect local governments to prioritize? Where does healthcare fit within their priorities?

12. Do you expect health service delivery to improve under elected local governments? 
   Opportunity/Risk
   - Risk< s] s:tf hf]lvdx? b)Vg' ePsf] 5 <

*We have come to the end of our interview. Thank you for your time.*
KII/FGD Guide– Local Government

A. General information

1. Describe for me your role within the [municipality/gaunpalika/ward chief/members]? -gu/kflnsf/uffpmkflnsf/j8f cWolf/b:o tyf kbflwsf/Lsf] ?kdf oxFx?sf] e’ldsO{ lbg’ xfj];\._

B. Understand the extent to which local governments priorities health issues relative to other issues

2. What are your priorities? How do you plan on pursuing these priorities? -tkfO{x?q:sf d’Vo k|fyldstfx? s} /x=sf 5g\ < ol k|fyldstfx?nfO{ k'/f ug[sf nflu s;/L of]hgf agfpg’ ePsf] 5 <_

3. What are your specific priorities within the health sector? How much equalization budget has been allocated for health? Please provide the planned budget of this FY. -tkfO{x?q:sf} ;jf:Yo l|qsf nflu [j|sf k|fyldstfx? s] s} x’g\ < tkfO{x?n} ;jf:Yo l|qsf nflu cgFt/s / afXo >f[tsf] cfDbfgLaf6 slt ah}=6 ljlgof|ug’{ ePsf] 5 < s[kof tkfO{sf] lgsfosf] o; cf=a= sf] ljlgof|lht ah}=6 pknAw u/fO{ lbg’ xfj];\._

4. Do you have all adequate staff and ToR for your various line units? (E.g. health, education, agriculture, livestock) If not how you are doing? -tkfO{sf] lgsfo cGtu{t ;a} l|qut zfvfx?sf] sfd cuf8L a9fpgsf nflu k|ofKt sd{rf/L / lhDd}jf/L 5 t < olb 5}g eg] s;/L sfo{ ;”rfng u/L /xg’ ePsf] 5 <_

C. Understand local government perspectives on social accountability (SA) and key SA mechanisms and processes

5. Are you familiar with the term SA? How would you describe the term? Please list for me 3-5 words that you associate with the idea of SA? -tkfO{x?} ;fdflhs hafkmb]lxtsf] ljlodf hfgsf/ x’g’ x’G5 < tkfO{ ;nfO{ s;/L jO{f|ug’{ x’G5 < ;fdflhs hafkmb]lxtsf} ;Gb[enfO{ hF8]/ # b]lv % zAbdf atfO{ lbg’xfj];\ _

6. How do you plan to get information or feedback from your constituents regarding their concerns and desires? How do you plan to communicate to your constituents? -tkfO{x?n} gful/sx?sf] ;f/sf/, pgLx?sf] O[R5f rfxgsf ;Gb[esf,’rgf tyf k[i7kfjif0fx? s;}L k|fKt ug’{ x’G5 < s;/L cfkm\gf gful/sx:?Fu ;dGjo u]g{ of]hgf agfpg’ ePsf] 5 .
   a. How do ensure that you receive “balanced” feedback from constitutes that is reflective of both marginalized groups and more privileged communities? -tkfO{x?n} ljkGg ;d’x tyf k5fl8 k|f/Psf;d’b’ofaf6 k|fKt u’gf; tyf k[i7kfjif0fx?nfO{ ;Gt’Int lx;fan] k’/f ug]s;/f s;}L ;’lglZrt ug’{ x’G5 <_

7. Do you have any ways of getting information about quality or access to services in health facilities? If so, please explain. -jf:Yo ;;+yfaf6 k|afx x’g] ;[jfsf] u’0f:Lotf, ;xhtf / ;”netfsf
8. In the event of poor service delivery within the health system, such as at a health center or hospital, who is responsible for that poor service delivery? -olb :jf:Yo \:+yfaf6 sdhf]/ tl/sfn ];jf k | afx eof] jf u'O:t/Lo :jf:Yo ;];jf k | afx gePsf] cj:yfdfs To;sf] lhDd]jf/L s;sf] x'G5 <


10. Are you familiar with the social audit in health? [IF YES ASK: Do you know what issues have been raised through health facility social audits in your area?] -s] tkfO[ jf:Yo \:+yfysf] ;fdfhhs k/Lgh0fsf] af/]df hfgsf/ x'g'x'G5 < olb x'g' x'G5 eg] tkfO[sf] lF]q cGtu[tsf] jf:Yo \:+yfx?sf] ;fdfhhs k/Lgh0fdfs t:t ;jf:nx? p7]sf] hfgsf/L kfpg' ePsf] 5 <


D. Review the relationship between local government and the Ministry of Health


We have come to the end of our interview. Thank you for your time.
Key Informant Interview Guide— DHO and DCC

A. Understand views on social accountability (SA) and specific SA mechanisms

1. How do you understand the term? Can you list for me 3-5 words that you associate with the term SA?

2. What do you see as the most important mechanisms that facilitate SA? [If the informant only lists 1 or 2 mechanisms, directly ask if there are others]

3. Describe for me your office’s role within these SA processes?

4. What is the role of local government within these mechanisms? How well do they understand and implement the mechanisms?

5. Beyond the mechanisms listed, what are the other ways that you get information or feedback?
6. Can you explain briefly the social audit process? 

- What were you able to achieve and what were you not? 

- Have been the barriers in terms of fulfilling the social audit process/findings? 

- How are NGOs selected? How are their capacity strengthened if needed? 

7. What specific feedback/accountability processes are built into different program areas within the health sector (i.e. HIV/AIDS, nutrition, TB, Family Planning etc.) 

8. Can you walk me through the steps of health sector plans and budgets in this transition period? 

a. How have you collaborated with LG in the planning process? 

b. IF NOT ALREADY ADDRESSED: To what extent were data from SA processes (including social audits) considered when drafting plans and budgets? Please explain. 

C. Understand MoH views on local governments and political federalism 

9. Please describe for me your relationship with the local governments. How do you communicate with them? How do you support them?
10. In the current context, what do you think should be the role of the local government versus your office?

a. Do you believe that there should be health staff (DHO/LG) stationed at the district level? If so, what should be their role? If not, where should health staff (DHO/LG) staff be stationed?

b. Do you believe some roles have been transferred to local government that is better fulfilled by your office?

11. What issues and types of investments do you expect local governments to prioritize? Where does healthcare fit within their priorities?

12. Do you expect health service delivery to improve under elected local governments?

We have come to the end of our interview. Thank you for your time.
Focus Group Discussion Guide–HFOMC

A. General information

1. Please describe for me the role of the HFOMC. What are your main activities?

a. How often do you meet as a group?

b. How do you oversee the operations of health facilities?

c. What challenges do you face in fulfilling your function?

B. Understand the role of the HFOMC on social accountability (SA) and specific SA mechanisms

15. To what extent are you familiar with the term SA? How do you understand the term? Can you list for me 3-5 words that you associate with the term SA?

16. What is the HFOMC’s role in the social audit process?

a. How well do you think the social audit process functions?

b. What have been the major findings of recent social audits?

c. Are findings from social audits shared with DHO, local government and other stakeholders? How interested are each of these stakeholders? What do they do with the information?

4. Beyond social audit, what are the other ways that you get information or feedback about health service quality and access at the facility level?
C. Understand health facility views on LGs

5. How do you foresee your role in the new local government system? How would you establish yourself at ward and municipal level?

- What can be your collaborative role between supply and demand?

What can be your collaborative role between supply and demand?

6. Please describe for me your relationship with local governments. How do you communicate with them? How do they support you?

7. What issues and types of investments do you expect local governments to prioritize? Where does healthcare fit within their priorities?


We have come to the end of our interview. Thank you for your time.
Focus Group Discussion Guide – Mother’s Group and FCHVs

A. General information
1. Please describe for me the role of the mother’s group/FCHV. What are your main activities?
   a. How often do you meet as a group?
   b. What challenges do you face in fulfilling your functions?

B. Understand the role of the mothers group and FCHV on social accountability (SA) and specific SA mechanisms
2. How do you get information about the quality and access to health services in your area?
   a. What do you do with the information you receive?
   b. If you’re sharing information on health service quality, what happens as a result of sharing that information?
   c. How do you make sure to get feedback from marginalized groups?
3. To what extent are you familiar with the term SA? How do you understand the term? Can you list for me 3-5 words that you associate with the term SA?
4. Are you familiar with the social audit process? What has the role of the mother’s group/FCHV been in the social audit process?
   a. Has the social audit processes been helpful? If so, how? If not, why not?
   b. How comfortable are you communicating your concerns in public meetings to authorities?
c. What have been the major findings of recent social audits? -kl5Nnf] ;do ;DkGg ePsf] ;fdflhs k/Lif0fdf s] s:tf d'Vo ;jfnx? /x]sf lyP <

d. Has there been follow up from the findings of the social audits? -s] ;fdflhs k/Lif0fdf d'Vo ;jfnx?sf] follow up ePsf] 5 t <

i. What has been followed up on and what has not? -s'g s'g ;jfnx?sf] followed up eof] < s'g s'g ;jfnx?sf] followed up ePg <

C. Understand mothers group and FCHV views on LGs and political federalism

5. Have you had any contact with your newly elected local government? If so, on what topics and how supportive have they been? -s] tkfO[x?n] gi lgjf[lrt hkg[ltfglw;Fu e]63f6, 5nkmm ug'{ ePsf] 5 < olb ug'{ ePsf] 5 eg] s] ;jfn /ljifodf e]]63f6 ug'{ ePsf] 5 < tkfO[x?sf ;jfnx?sf] slQsf] ;xof]uL /x]sf 5g <


7. Do you think local government will have the same priorities as you? Where do you think healthcare will fit within their priorities?


We have come to the end of our interview. Thank you for your time.