

Addressing the challenges to health sector decentralization in Nepal: an inquiry into the policy and implementation processes

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ABSTRACT

The objective of the study was to analyze the status and explore the challenges to decentralization policy implementation in Nepal. Thirty seven key informants rich in experience and knowledge, seven focus group discussions, observation of six health facilities and analysis of about 25 key policy documents provided the data for this study. The study identified the challenges to the implementation of decentralization reforms in the public health sector as: i) centralised and weak management and programming practices of the government; ii) weak legal and institutional framework; iii) conflicting policy objectives; iv) lack of implementation strategy; v) poor financial and human resource management system; vi) lack of adequate preparation for managing the reform; vii) weak capacity at all levels; viii) political instability. It was revealed that the implementation of the policy in Nepal was extremely poor as many of the important policy measures were either never initiated or they were only partially implemented. The challenges lie both at - policy design and implementation phase. Clear policy objectives, appropriate structure, sound planning, financing and human resources policy, adequate capacity, responsive information system, defined service packages, active participation of stakeholders and a conducive socio-political environment are considered imperative for successful implementation of the policy. Preparation for managing reform implementation at national and district levels is prerequisite for decentralization to work. Pushing for decentralization in a politically fragile environment may rather lead to further fragmentation, instead of strengthening government legitimacy.

Keywords: Decentralization, policy, health sector, challenges, Nepal.

INTRODUCTION

The rationale for decentralization encompasses the transfer of responsibility for planning, management, resource generation, and allocation away from the central government to the periphery, with the aim to improve governance and make service delivery more equitable and responsive to local needs.¹⁻³ It is anticipated that decentralization facilitates community participation, inter-sectoral collaboration, efficiency, effectiveness and equity.^{4,5} The international literature has highlighted a number of critical challenges to implementation of decentralization. It has been revealed that political, legal, financial, institutional, and administrative and human resources are the major challenges decentralization implementation. Evidence also shows that implementation of a policy can be highly influenced by the political environment, policy objectives and its characteristics. Decentralization could create additional challenges to the national health system, so there is need for developing strong organizational and institutional capacity, therefore, capacity development must continuously accompany the decentralization process as needs for new skills emerge during the course of implementation.^{6,7}

Health sector decentralization reforms in Nepal: Objectives and strategies

The public health system in Nepal caters services to 33.5% of the population.⁸ The health system is highly centralized with major policy decisions regarding planning and financing taken at central level. Inter and intra-sectoral coordination is weak between the private sector, academic institutions, NGOs, and local government authorities, as well as within different units of the Ministry of Health and Population (MOHP). Human resource development is not linked to the overall health-planning framework. There is a persistent mismatch between demand and supply across broad arrays of personnel categories.⁹

The Decentralization Act of 1982 and respective by-laws of 1984 were milestones in accelerating decentralization in Nepal. Later, the statutory framework for decentralization and local governments was defined by the LSGA, 1999 and the Local Self-Governance Regulation, 2000.¹⁰ In addition, a number of other policy initiatives also had a significant bearing on the overall reform framework for decentralization, inter alias: the High Level Decentralization Implementation Monitoring

Committee, Local Bodies Fiscal Commission (LBFC) and the Sector Devolution Guidelines. Key reform measures in the health service include: the Health Policy, 1991,¹¹ Second Long Term Health Plan (SLTHP,1997),¹² Nepal Health Sector Programme – Implementation Plan (NHSP-IP, 2004),¹³ successive annual work program and budget (AWPB). The review of the literature show important deficiencies in the existing decentralization policies: for instance, the failure to assign clear roles to national level institutions, e.g. MOHP and Ministry of Local Development (MLD). MOHP’s decentralization policy directives focused only on the handover of health facilities to Health Management Committees (HMCs) and assigned responsibilities to manage local health facilities and prepare and implement health programs.¹⁴

In 2002, the Ministry of Health realized the weaknesses in the previous policies and the need for a more radical reform measure to overcome systemic problems for improved service delivery. With this vision, the Health Sector Strategy (HSS): An Agenda for Reform¹⁵ and subsequently, the Nepal Health Sector Program Implementation Plan (NHSP-IP), 2004 were developed. The HSS and NHSP- IP set key reform measures and actions. The focus of the reform was to establish appropriate structures at different levels, strengthen sector management, and improve service delivery through deconcentration. The Table-1 below presents implementation status in brief on the proposed measures.

The implementation status of above table depicts that

Table-1: Policy reform measures, proposed actions and their status

Policy reform	Proposed policy actions/instruments	Implementation status*
Endorsement of management model for decentralization	Strategy for decentralization approved by 2004; Management functions delegated to regional level by 2006/07; Decentralization model implemented by 2006/07	Strategy was approved by cabinet in 2006. However, due to lack of costed plan and commitment from government the strategy never received adequate support
Restructuring of MOH	MOH restructured by 2005/06; Human Resources Development (HRD) policy finalized by 2005/06; District based planning, budgeting and performance management system developed by 2005/06; Joint planning system strengthened	New HRD and financial management division established without clear policy on HRD; No initiative in preparing district plan; Joint Annual Review of government and donors partially addressed the planning issues
Capacity Development	Carryout horizontal, vertical and internal analysis and agree on the division of labor and functions; Capacity building program designed & implemented	MOHP commissioned the study but the findings were not operationalized; Lack of complete package of capacity measures for implementation
Management of health facilities by Health Management Committees (HMCs)	Health facility (HFs) handover to local HMC in all 75 districts; 10% of health spending born by elected local bodies (LBs) by 2006/07; HMCs design the service packages	Only 1433 HFs of 28 districts handed over to HMCs; Health sector did not get proposed funding level; Lack of capacity among HMCs could not design the service package
Inter-sectoral coordination	Coordination with key line ministries established; Mechanism of coordination with donor partners to support district level delivery within a sector-wide approach	Lack of functional coordination mechanism; Donor coordination at district level issues are yet to be addressed
Provision of essential health care services	Prioritized services delivered by all health facilities; Quality criteria developed and implemented	Limited range of services available; Quality criteria available but not practiced

Source: NHSP-IP, 2004 *Based on review of key policy, action plan and interview with stakeholders

the majority of the reform measures planned by MOHP were not implemented.

DECENTRALIZATION VS. FEDERALISM

On 28 May 2008 the Constituent Assembly declared Nepal as Federal Democratic Republic. One of the important questions on the current decentralization policy is whether the policy is still relevant and does it fits to the new federal structure or not? Federally constituted states can be highly centralized and states constituted in a unitary fashion can be highly decentralized. The two terms federation and decentralization deal, hence, with different levels of decision making: federation refers to a trait in the constitutional level whereas the term decentralization describes a policy choice on the post-constitutional one. This implies that a federal structure can be used to implement a decentralization policy, the two are thus not mutually exclusive. But it also means that a federal structure is not a necessary condition to implement decentralization policies.¹⁶

MATERIALS AND METHODS

The study was conducted in Nepal at national and district level. At national level, the study focused on the role of the central government and donor partners with regard to formulation of the decentralization policy, and subsequent role in implementation. Chitwan district was selected to study implementation process and status. The district lies on the southern belt, about 155 km from the capital, Kathmandu. Criteria set for the selection of the district were that handover of health facilities taken place; a medium-term plan prepared with defined long term vision; and that it was characterized by a wide geographical and ethnic variation. Chitwan district is located in Nepal's south, 150 km from the capital.

The study adopted a qualitative research design with flexibility in selecting key informants (KIs) and interview questions for data collection and analysis. Primary data were collected using in-depth interviews, focus group discussions, observation, analysis of raw data and document analysis. Secondary data were collected from the literature and health facilities record reviews. The KIs for in-depth interviews were selected on ground of theoretical relevance and on their long experience in health and decentralization process.¹⁷ Altogether, 37 KIs from national, district and community levels participated in the in-depth interviews. Likewise, a total of seven focus group discussions (FGDs) were conducted in the district. The FGDs represented: (i) district line agencies, (ii) health management committees, (iii) service users and (iv) youth group. All data were taped to allow for uninterrupted discussion and for double check of any missing points in the notes.

An observation checklist was used for the purpose of compiling information on availability of services, management and monitoring practices, physical condition of health facilities, client-provider interactions and decision making processes. Two health facilities from each category of public health services were observed. Key policy documents on decentralization, research and evaluation reports and some clips from media reporting were reviewed. Health facility utilization data on priority health services such as safe motherhood, family planning, immunization, tuberculosis, and outpatient records before and after decentralization were compared and conclusions drawn.

RESULTS

Structure for decentralization

The dissolution of the elected government in July 2002 and non-extension of the mandate of LGBs raised issues of legitimacy of LSGA and Decentralization Implementation Monitoring Committee (DIMC). In the absence of elected representatives at District Development Committee (DDC) and Village Development Committee (VDC) health management committees are chaired by the Local Development Officer (LDO) at DDC and by a junior Secretary at VDC level. Constraints due to the lack of an elected DDC council, and poor management capacity of MOHP at central and district levels were mentioned as needing urgent attention. It was equally reported that lack of coordination between MOHP and MOLD hampered implementation momentum leading to duplication of resources. Lack of proper coordination structure at MOHP and Department of Health Services (DHS) level seriously hampered decentralization efforts questioning on the mandate and follow-up of planned activities.

Planning, financing and monitoring system

LSGA 1999 has clearly spelled out some guidelines on making planning and allocation processes at the DDC participatory and locally accountable. However, planning process in the health sector was characterized by respondent as highly centralized. There is no space for district authorities to further discuss and make adjustments to the plans. One of the ex-DDC members expressed her frustration with the current planning practice: "*During 2000 - 2002 local government bodies actively participated in DDC planning and had a strong voice about the development activities in their VDCs, however, at present, there is no participation of local people. It has become a ritual and an orchestrated show of only government bureaucrats*". Over 95.0% of the cost of priority health care services (EHCS) delivered from district health system was financed by the national government. The budget analysis of Chitwan district shows a continuous increment of the government share

Table-2: Decision making process of HMCs - before and after decentralization

Issues	Role of HMC	
	Before decentralization	After decentralization
Planning and monitoring	No involvement in planning and monitoring	MOHP continues sending centrally planned activities and targets for HFs.
Drugs procurement and management	Occasional inspection of packages sent by MOHP	HMC is occasionally consulted in local procurement.
Construction & maintenance of health facilities	HMC was more dependent on district health office	Issues are discussed more frequently in HMC meetings and solutions are sought jointly
Leave approval of staffs	No involvement	Approves leave of junior staff occasionally
Celebration of health events	Partly involved	HMC is involved in planning and organization of events together with health facility staffs

between 2001/02 and 2006/07 to finance public health programs. However, the respondents commented that the increased budget was mainly for salaries and allowances to the staff, leaving less than 15% for public health programs. The MOHP's budget was not based on real needs of the district and it also did not incorporate local plans in its annual planning. Likewise, the loss of revenues of HFs caused by the government decision to abolish user fees for essential health services and free maternity services from 2006/07 was not fully compensated by adequate drugs supply and budget. Respondents stressed however that in some aspects financial transparency and resource mobilization at local level improved after decentralization.

Human resource management (HRM) including capacity development

Absence of an appropriate policy at national and district level on human resources was identified by respondents as critical bottleneck in the overall management of health services in Nepal. The health workers interviewed expressed their reservation to the decentralization policy questioning to the legitimacy of the local government who could exercise their full authority in decisions on health service management and fear of losing their job if they would move under the control of local governments. Under the heading: "Strike cripples medical services", which was related to the government's decision on the decentralization policy, the media reported: "The indefinite strike called by health workers has brought the health services to a grinding halt. It is unfortunate that the 26,000 staff have taken the health services into their custody. The staff have demanded promotions, allowances and to put an end to the process of decentralization".¹⁸ It was reported that as the health workers were not under the control of the local

management committee there absenteeism in facility was high especially the in-charge and key technical people. We found that in some health facilities technical staffs were absent for more than 60 days in a year.

Health service delivery: access and utilization

Decentralization implementation in Chitwan did not show impressive changes in key health service indicators e.g. immunization and outpatient services. The implementation progress in priority health care services including safe motherhood, family planning, child immunization, T.B and outpatient services, in terms of centrally defined indicators and targets versus achievement was found poor. The analysis of the data from 2001/02–2006/07 showed a continuously decreasing trend of all major health indicators. For example, Chitwan reported during 2001/02 that (the base year for our research, one year prior to implementation of the decentralization policy) almost all immunization related indicators as above 80% whereas in 2006/07 immunization rates were below 70% (DPHO, 2007 & DHS, 2007). The only indicator which showed a positive trend was 'delivery conducted by health workers'. This achievement could be attributed to the high priority given to safe motherhood by both, government and donors in the past years and to the contribution of a large share of private medical colleges, NGOs and private clinics.

Role of Health Management Committee (HMC) in health service management

Only about 50% of the HMCs were found active and reported their engagement in the management of their health institutions. Their inactiveness was due to lack of support from local government bodies (VDC and DDC) and lack of cooperation of health personnel. The table below shows some changes on the role of HMC before and after decentralization was implemented.

Table-2: Decision making process of HMCs - before and after decentralization

The management committee was highly dominated in number as well as in decision making process by the male members. Female respondents expressed their dissatisfaction with the HMC's attitudes towards women as they did not consider them as equal members when designing programs and making decisions. *"We are just there in the committee to fulfill the quota, we are not consulted in any decision making process. The peoples' issues such as improving access of the poor to services are least discussed in the committee"* (a female FGD participant). Respondents equally complained about the poor organization and management of the public health services. One FGD participant expressed his concern: *"The health facility is closed at 2.0 pm. What if we need service beyond this time? Poor people of this community have to use expensive services from private providers. So we suggest that the government should enforce a system of opening health facilities at least up to 5.0 pm"*.

DISCUSSION

Lack of clear policy objectives and guidelines

The discrepancy between Nepal's decentralization policy objectives and actual implementation seems to be partly due to a lack of clarity in policy objectives and to poorly developed implementation guidelines. It is evident that for a policy to be effective, two conditions must be met. Firstly, the particular intervention should be able to produce the desired effect - *policy design issues*; and secondly, the policy should be followed as intended - *implementation issues*.¹⁹ In Nepal's case the challenge in implementation seems to lie both at - policy design phase and implementation phase. The "free essential health service delivery" and "maternity incentive scheme" policies were interpreted in a different way by different stakeholders because service packages and modality of implementation were not clearly defined.²⁰ In a paper assessing the implementation and evaluation of the health sector reform process, Gilson argues that implementation failure can be the result of stressing policy outcomes but virtually ignoring the policy process.²¹ It is important that guidelines and working procedures should be prepared in consultation and with the involvement of those who are in charge of implementation. Timely dissemination of policies and guidelines to key stakeholders facilitates smooth implementation.²² In Nepal's case, the HMCs and service providers were neither made part of the consultation process nor did they receive policy guidelines in time.²³ The existing organizational structure for decentralization was found inappropriate to support reform initiatives in general and decentralization in particular. As the roles of national and local level authorities were not adequately defined, MOHP continued to exercise both,

policy making and implementation roles.⁹ Experience shows that restructuring efforts are in general politically motivated rather than addressing real policy needs.²⁴

In Nepal's case decentralization did not seem to improve equity and access to essential health care services. The reasons for the poor performance of the District Health Office of Chitwan were related to potentially inappropriate decentralization process.²⁵ The process could not address the existing drawbacks of the district health system: unrealistic target setting, geographic disparity, inadequate funding and lack of positive attitude of health workers towards clients.²⁶ The facilities were having continuous shortage of drugs and commodities and high absenteeism of health workers. At a closer look, health service performance seemed to be much more determined by other factors than decentralization. For instance, one of the reasons given for poor service delivery was the political conflict which seriously affected timely access to services by the local population in the remote VDCs. HMCs were almost defunct and most of the outreach services (e.g. immunization, family planning, MCH, growth monitoring) were completely paralyzed.

Health sector financing, human resource policy and capacity issues

The budget process was more of an input-based (facilities and beds rather than e.g. disease burden). The per capita expenditure by Government in health has increased from five US dollars in 2004/05 to eight in 2007/08. Similarly, the proportion of health sector budget out of the total national budget has increased. However, poor financial performance caused by rigid financial procedures and lack of timely disbursements of budget in the public sector has created an imbalance between allocation and expenditure. Though, gradual improvement in this area has been observed since 2004/05.

Lack of a decentralized human resource policy is one of the critical issues in the overall management of human resources in Nepal's public health system. The country experiences of Mexico, Ghana, Indonesia and South Africa show mixed results in terms of human resource management at decentralized levels.²⁷ It has been cautioned that without a comprehensive human resource policy addressing skills, staff equity, staff motivation and performance under decentralization at different levels any attempt to decentralize human resources is unlikely to succeed. The hesitation and unwillingness of the health personnel to work under the local government shows clear resistance from the side of civil servants which might have unforeseeable implications for future policy decisions.¹⁸ However, the reason for unwillingness might partly be due to the timing of decentralization, political conflict, and absence of

legitimate committees. As neither DDC nor VDC representatives would have decision making authorities in terms of management, handing over of health facilities to local government would create further confusion and delay in implementation. Similar situations were reported from the Philippines, Chile and South Africa.^{28,29}

Participation, preparation and preparedness for implementation

Successful implementation of policies depends upon the nature of participation of the implementing organization and service beneficiaries during policy formulation and implementation process. Consultation with and participation of the implementers in the policy process is important for two basic reasons: firstly to improve the quality of change by incorporating the views and experiences of health sector staff and users, and secondly, to develop a sense of ownership among the same.²⁸ Therefore, it is stressed that implementers should be made part of the policy design process.¹⁹ Evidence from many countries indicates systemic weaknesses and negative unanticipated impacts, if decentralization is implemented without preparation and in haste. For example, the governments of many African countries were cautioned on the policy decision of removing user charges that could produce a negative impact, if it was not handled carefully. Along with political announcements there is need for thorough preparation for implementation especially, in terms of defining structure, ensuring adequate funds and human resources both at national and local levels²³. In Nepal's case, the implementation was pushed without adequate preparation and creating necessary conditions, i.e. preparing and building "itself" and preparing and building "others". Overcoming challenges posed by political, legal, financial, institutional, administrative and human resource are critical for implementation of policy on decentralization in Nepal.^{2,3}

Competing interests

The authors declare they have no competing interests. All authors read and approved the draft manuscript

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