



Nepal Family Health Program II Technical Brief #17 (Revised December 2009)

Health Facility Management Strengthening Program



Participatory game for team building among members of the Health Facility Operation and Management Committee.

BACKGROUND

The foundation of any effective health program is engaged members of the community. They are important as users, in mobilizing local resources, and reaching out to segments of the population which have not benefited from existing services. Communities have a right to quality health care and, at the same time, a responsibility to support government efforts in developing more effective community health services.

The vision of the Government of Nepal (GoN) for health and development focuses on self-reliance, community participation, and involvement of the private sector and nongovernmental organizations (NGOs). In 1999, the government passed the Local Self-Governance Act, based on which the Ministry of Health and Population (MoHP) decided to decentralize health service management to local bodies¹. The intention of this initiative was to encourage local communities to take greater responsibility in managing local health facilities and health programs.

Since its beginning in late 2001, the Nepal Family Health Program (NFHP) has been involved in strengthening the interface between communities and health facilities (HFs) and service providers. This support has enabled the community to be more involved in managing their health programs and services and thus benefit from local health services.

During 2003/04-2004/05², NFHP, mainly through its partners, Save the Children, US (SC/US) and CARE-Nepal, provided support to GoN in the initial formal hand-over of health facilities to their communities in its 17 core program districts (CPDs). Nationwide, this

process was initiated in 2002/03, and by during 2005/06³ was completed in 28 districts and involved 1433 HFs. Approximately half of these (736) were supported by NFHP. Following this formal process, during 2004-2006 three-day capacity assessments and strengthening trainings were given to 502 members of these new Health Facility Operation and Management Committee (HFOMC). In most of these cases (422), support provided from 2002-2006³ also involved use of the “partner defined quality” approach. This process involved assessing quality issues from the perspective of both HFs and the community and then jointly prioritizing and developing action plans. Through these inputs, NFHP sought to empower local communities to manage health services at the community level and strengthen the partnership between the community and the HF.

In 2006, NFHP assessed its input in this area over the first five years of the project and learned key lessons^{4,5}.

- Community members (including HFOMC members and HF staff) were generally not adequately informed to take up these new roles as envisioned by the new government policy. Lack of clarity on the expected functions, roles and responsibilities of various players e.g., Village Development Committee (VDC), District Development Committee (DDC) and District (Public) Health Office (D(P)HO) resulted in some confusion.
- Mere ‘hand-over’ of HFs to local bodies did not ensure achievement of the objectives of this initiative. Once HFOMC members were provided with support, enhancing knowledge, skills, and motivation, they were able to manage their HFs more effectively.
- The hand-over process and strengthening Program and other community mobilization initiatives need to be understood and implemented as a *process* not merely as a series of *events*.
- Active linkages between DDCs, D(P)HOs, VDCs and HFOMCs are indispensable for mobilization of local resources.
- HFOMCs require technical guidance if they are to focus to improving health (and health pro-grams) rather than focusing only on developing physical infrastructure.
- HFOMC need support and confidence- building to effectively support dalit and janjatis (highly marginalized / disadvantaged peoples) and women.

Programs and activities implemented under different names by different organizations were working in isolation. Consolidating efforts and developing an effective common capacity building package have helped to improve and streamline services.

In close cooperation with National Health Training Centre (NHTC) and other stakeholders engaged in capacity building of local health facilities, NFHP further refined its approach and in 2007 developed a modified approach called *Community and Health Facility as Partners* (CHFP) which was implemented in 8 core program districts. NFHP studies and lessons have been instrumental for this refinement.

Under the Nepal Family Health Program II (NFHP II), the CHFP approach has been continuously refined. In 2009, NFHP II changed the name of the program to the *Health Facility Management Strengthening Program* (HFMSp) to reflect more accurately the program's goals. As of late 2009, NFHP II has provided direct HFMSp support in four CPDs (Banke, Dang, Surkhet, Kanchanpur), covering 65 HFs, with full district coverage in Kanchanpur. NFHP II provides support to HFOMCs in the remaining CPDs through other organizations.

STRATEGIC APPROACH

Health Facility Management Strengthening Program

NFHP II's HFMSp approach seeks to improve the health of the community (with special focus on marginalized and underserved people) by empowering community members to manage their local HFs and other health programs. Key features of this approach include:

- Increasing community participation in decision - making in management of local health facilities.
- Involving disadvantaged groups (e.g., dalits) in health facility management decision-making.
- Delivering a complete package of interventions to develop knowledge and skills in managing health facilities, rather than one-time events like trainings.
- Using simple, community friendly tools, guidelines, and training methods.



HFOMC members develop a social map to identify the dalits and poor in their community.

- Focusing on building skills in organizational development, HF management, and health services provision using a phased-in model.

- Considering ways to scale-up from the very beginning of the program.

- Involving DDC/DPHO to developing their leadership in order to institutionalize the HFMSp approach.

- Sharing results and advocating for HFOMCs at the central level (i.e., among concerned ministries and external development partners).

PROCESS

The HFMSp approach involves a two year period of support (one year intensive implementation and one year limited technical support) including a three-day interaction session, periodic review meetings, regular follow up, and promotional activities. A brief account of major steps is described below.

Startup Activities

Four districts were selected out of NFHP II's 22 CPDs, prioritizing those with weaker health services performance and lower human development index status. From each district, VDCs were selected for special focus – 65 in total. After districts and VDCs were selected, NFHP II field officers and D(P)HO staff were oriented on HFMSp approaches and tools/guidelines in April-May 2008.

HFOMC Situational Assessments

In June-July 2008, NFHP II staff conducted situational assessments of HFOMCs, HFs, and community groups involved in HFOMC before implementing the HFMSp package. The purpose of these assessments was to understand better HFOMC membership, organizational capacity, and resource mobilization in each VDC.

Three-day Interaction Meetings with HFOMC

After situational assessment, district and HF staff conducts three-day interaction trainings for HFOMC members on HFOMC roles/responsibilities and the importance of representing and discussing existing health service problems in HFOMC meetings. Through training, HFOMC members develop needed skills to conduct effective meetings and prepare action plans to respond to problems/issues identified by their group. Another objective addressed in these meetings include ways to improve social inclusiveness in access to and use of health services.

Interaction sessions are designed to be very participatory and responsive to locally identified needs. Methods used include discussions and classroom teaching, and were tailored to the local context.

Technical Support Visits

After the three-day interaction sessions, NFHP field officers, together with D(P)HO staff, conduct monthly technical support visits (TSV) to observe, coach, and facilitate meetings of the HFOMC. In these TSVs, HFMS staff collects information regarding gaps in knowledge and skills of HFOMC members necessary to conduct effective meetings, implement action plans, and provide supportive supervision and follow-up to HF staff and HFOMC members.

Review Meetings

Every five months, HFMS staff also conduct training sessions to address gaps identified in TSVs. Focus is placed on increasing knowledge and building skills in topics including: resource mobilization; program monitoring and supervision; good governance; VDC health need assessment and plan; and conducting visioning activities.

Capacity of Dalit and Women HFOMC Members

Though the current composition of the HFOMC is intended to be inclusive, dalit and women members have tended not to actively participate. Therefore, strengthening the capacity of dalits and women members is given a high priority through assessment and coaching.

Community Mobilization Activities

During the three-day interaction meetings, detailed action plans are prepared. NFHP II provides technical support to HFOMC members to help implement their identified priority activities. They have tended to focus mostly on increasing use of services by those who are underserved. HFMS staff also conducts HFOMC promotional activities in order to create awareness among community members about the function of HFOMCs, the roles and responsibilities of HFOMC members, and the variety of services available at their HFs.

Advocacy Meeting at District Level

Advocacy programs with DDC and VDC secretaries are organized semi-annually to update them on HFMS progress, as well as to advocate for: resource mobilization for local health services; increased supervision, monitoring, and support to HFOMCs; and increased linkages between the VDC, DDC, D(P)HO, and HFOMC.

Progress monitoring and Next Steps

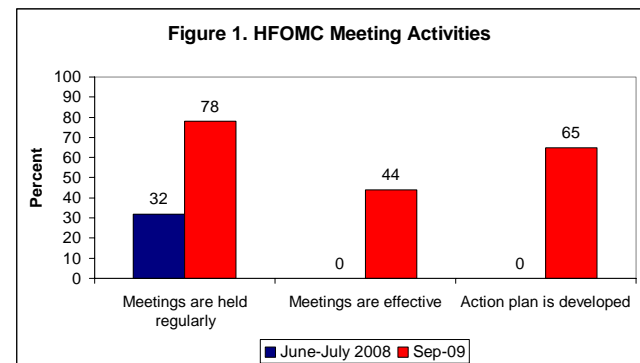
At the end of intensive HFMS implementation year, an assessment will be done in order to assess the status of HFMS-supported HFOMCs and to facilitate

development of strategies for future technical support (but more limited).

RESULTS

Key HFMS results till September 2009⁶ include:

- Regularity of HFOMC monthly meetings has increased from 32% in June-July 2008 to 78% in September 2009 (see Figure 1). The effectiveness of these meetings has also increased (from 0% to 44%), as measured by the occurrence of activities such as: issue identification and prioritization, problem root cause analysis, and action plan development.
- In more than 50% of VDCs, HFOMC have regular meeting with development and execution of action plan on their own with very limited technical support
- HFOMC priorities have shifted from basic infrastructure/medicine issues to more sophisticated service and program-related issues.
- Participation in HFOMC meetings by at least one dalit member has increased to 72%, from 34% at



baseline.

- HFOMCs are now actively involved in hiring and motivating staff members, mobilizing resources, planning infrastructure, and managing services. Within one year of the program, HFOMCs mobilized more than ten million rupees in 55 program VDCs.
- Client utilization of key family planning and maternal and child health services increased in 56% of HFMS-supported HFs.
- Dalit proportion among all HF clients vs Dalit proportion among catchment population has increased to 1.41 from the baseline 0.70. In other words, use of health services by “Dalits” is 1.4 higher than their share in the total population of the program VDCs.

LESSONS LEARNED

- **Local bodies can take longer than anticipated to pick up all the functions envisioned under decentralization.** To help facilitate this process, expected roles need to be clearly communicated, support is needed to build capacity, and the process must be regularly monitored during the initial phase. Decentralization needs to be understood and implemented as an ongoing process rather than an event.

- **Health facilities need on-going support after decentralization.** DDCs, VDCs, and municipalities generally have not given sufficient support to HFs once they have been handed over to local bodies. There is a need to further develop capacity of these local bodies.
- **A continuous focus on quality is critical.** Most HFOMC meetings have focused on issues of drug purchase, infrastructure development and human resources. Important as these issues may be, they have overshadowed health programs and provision of quality health care services.

**Developing a Vision through Training:
Vision Statement of Ghumkhare HFOMC,
Surkhet**

By 2012, the HFOMC will be able to do the following things:

- Hold regular monthly meeting;
- Collect issues from communities and share the decision of meeting with community people;
- VDC will have own health sector plan;
- Fill vacant staff positions and conduct staff motivation activities;
- Activities related to FCHV motivation;
- All community people will be made aware of HF services;
- Identify communities not using HF services and do activities to increase use;
- Increase coverage of health services (immunization, delivery by health workers) which are low;
- Improve HF environment (compound wall, garden, drinking water).

- **Targeted support for marginalized populations is key.** Regular coaching for dalits and female members on their roles and responsibilities has been very productive. The duration of such capacity building measures needs to be increased.

- **Motivated, competent** (or having the potentiality for competency), **and inclusive HFOMC committee members are critical** in order to maintain a spirit of active voluntarism and group empowerment.

- **Self-assessment by HFOMC** is helpful not only in helping to orient their work, but also in building self-efficacy thus promoting long-term sustainability.

- **Take a step-by-step approach**, moving from simpler activities to more complex ones, in order to slowly build HFOMC capacity over time. Create milestones to mark and celebrate small, incremental achievements.

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*This technical brief is one of a series seeking to capture key lessons learned from the USAID/ Nepal bilateral project, the Nepal Family Health Program II (367-A-00-08-00001-00), 2007-2012. The document was produced with support from the American people through the U.S. Agency for International Development.
The views expressed in this document do not necessarily reflect those of USAID.*

The Nepal Family Health Program II is implemented by JSI Research and Training Institute, Inc. and its partners – Save the Children, EngenderHealth, Jhpiego, World Education, Nepali Technical Assistance Group, Nepal Fertility Care Center, Management Support Services, the Nepal Red Cross Society, United Mission to Nepal, BBC World Service Trust, Digital Broadcast Initiative Equal Access Nepal, and Family Planning Association of Nepal.

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