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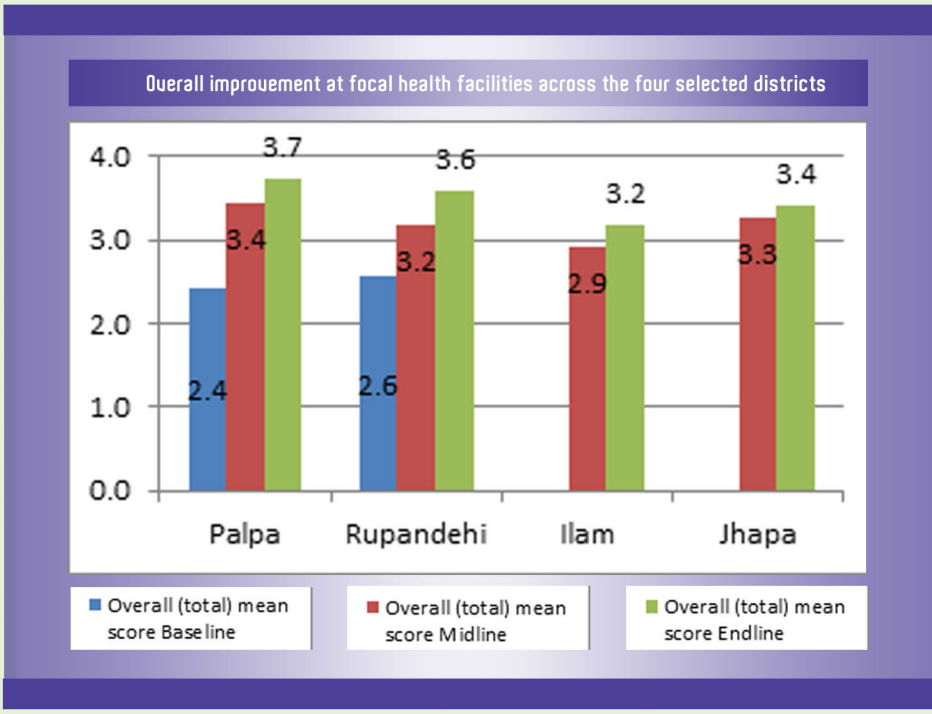
Social Audit Process Evaluation Report



HURDEC

NHSSP

Strengthening Health Systems-Improving Services

Social Audit Process Evaluation Report

Submitted to:

Primary Health Care Revitalisation Division, Department of Health Services

and

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Ministry of Health

Kathmandu, Nepal

Submitted by:

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EXECUTIVE SUMMARY

A. Background and context

The Ministry of Health (MoH) adopted social auditing as a demand side monitoring and accountability tool under the Second Nepal Health Sector Programme (NHSSP-2). In 2011/12, the Primary Health Care Revitalisation Division (PHCRD) of the Department of Health Services (DoHS) was made responsible for managing and overseeing social auditing across the health sector. With support from external development partners, PHCRD harmonised two existing social audit approaches and developed new harmonised guidelines for sub-health posts, health posts, primary health care centres and district hospitals. PHCRD piloted the harmonised guidelines in 21 facilities in Palpa and Rupandehi districts with NHSSP support and commissioned an evaluation of the pilot initiative in 2013. As of 2015, PHCRD has implemented the new harmonised guidelines in 802 facilities in 45 districts.

Against this background, in 2014 PHCRD requested the Nepal Health Sector Support Programme (NHSSP) to commission an independent process evaluation of the implementation of the harmonised social audit approach in a selection of sample districts. The objectives of the evaluation were as follows:

- Measure progress and the quality of implementing social auditing in a variety of district settings.
- Identify achievements of social auditing and enabling factors in a sample of facilities and districts.
- Identify whether MoH's Health Sector Social Audit Operational Guidelines (2013) need revising, and if so how.
- Inform PHCRD how social auditing can be strengthened and positioned in NHSP-3.

Fieldwork for the evaluation was carried out in two phases and used data from the 2013 pilot evaluation in Palpa and Rupandehi. The first phase (in 2014) covered 10 health facilities in Ilam and Jhapa districts, and the second phase (in 2015) covered 20 facilities in Ilam, Jhapa, Palpa and Rupandehi districts. The sample included sites from the earlier pilot areas in Palpa and Rupandehi, where NHSSP provided technical assistance from 2011–13. For Palpa and Rupandehi the evaluation tracked progress in service improvements from 2011/12 to 2014/2015. Social audit sites in Jhapa and Ilam were included that had not received external assistance. Ilam began health social auditing in 2011/12 while Jhapa began in 2013/14.

The evaluation consisted of a desk study and stakeholder interviews at central, district, village development committee (VDC) and health facility levels. It included the use of the Ladder of Change monitoring tool (Annex 2), which was developed by NHSSP as part of the 2013 evaluation. In addition focus group discussions were held with women at each facility, meetings were held with the health facility operation and management committees (HFOMCs), and the social audit process including mass meetings were observed by the evaluation team.

B. Key findings on the social auditing process

The evaluation identified key factors that affect the quality of the implementation of social auditing and how effective the process is in supporting improved access to and quality of health services, and the better management and accountability of health facilities.

Political pressure adversely affects the hiring and retention of competent NGOs — Such pressure usually comes through local development officers (LDOs) and district health offices/district public health offices (DHOs and DPHOs) and has been difficult to resist in some cases. The implications of the political influencing of NGO selection are to risk the quality of the social audit process, and to undermine the spirit of transparency and accountability integral to its very purpose.

The capacity of facilitating NGOs needs improving — The generally poor quality training ill-equips facilitating NGOs for the facilitation role they are hired to perform. In addition the prescribed process and tools are overly comprehensive and the information that the NGOs are expected to collect is not consistently collected, processed, analysed and concluded upon. Lack of know-how on how to process and analyse the information and reach conclusions was apparent in all the study districts.

Poor annual follow-up after initial social audits — The evaluation found mixed understanding among DHOs, DPHOs and facilitating NGOs on the importance of annual follow-up after initial social audits as set out in the guidelines. As a result, social auditing in Ilam and Jhapa district health facilities has not gathered momentum for change in the way that this was possible in Palpa and Rupandehi districts where the facilities had annually reviewed progress against action plans.

Involvement of health facilities in social auditing is sub-optimal — The management and staff of health facilities have not been sufficiently empowered to fully engage in social auditing. The Social Audit Guidelines have not been shared, the role of the in-charges has not been defined, and action plans resulting from social audits were not found in any of the sampled facilities.

Weak response of the centre to demands arising from social auditing — The standard annual work planning and budgeting (AWPB) system means that there is a lag in time between identifying problems at the local level and allocating budget from the centre to address them. From our analysis of financial support provided to the focal facilities, other than core programme support from MoH, additional needed funding is generally provided by VDCs and does not come from the central or district levels. Costly infrastructure improvements generally remain unimplemented. As social auditing is rolled out, the capacity of PHCRD to manage the programme and coordinate central responses to local problems as needed is being challenged, and will require strengthening.

Structural issues beyond the influence of social auditing — Some of the issues raised by the public at mass meeting events were found to be excluded from the action plans because they were considered 'structural' and beyond the influence of social audits. Such structural issues include the distribution of expired medicines. This can undermine public confidence in the process as it suggests that some issues of transparency and accountability are not up for discussion.

Women's participation — Community women reported that they felt positive about their participation in social auditing, and perceived that their issues were being considered and addressed in action plans as necessary. At some sites, women reported not being invited to earlier rounds of social auditing and suggested that financial incentives be provided to enable poor women to take time away from their daily chores and other work.

Wider institutional participation is needed — Several VDC officials highlighted the need for VDCs and other local organisations, including civil society organisations (CSOs) to more actively participate in social auditing. This was particularly linked to the need to consider the availability of funding when developing social audit action plans.

Coverage and continuity of social auditing — Ideally, social auditing should be implemented continuously once started in a facility. However, budgetary and capacity constraints make it difficult to do so. Social auditing began in Palpa, Rupandehi and Ilam districts in 2011/12. The results have been significantly better in Palpa and Rupandehi, where implementation has conformed more closely to the guidelines. With some exceptions, health facilities in these two districts, have achieved high scores on most monitoring indicators related to access, accountability and quality within the four years. An optimal trade-off between coverage and continuity for PHCRD would be to implement social auditing in a facility for, say, three years at a stretch, and thereafter repeat it once every three years. This gap of three years gives health facilities time to focus on activities such as physical infrastructure and large equipment purchases that require central or external support. This option could be a good balance between budgetary and management constraints on the one hand and gaining and retaining momentum for change at the health facility level.

C. Social auditing's contribution to improving health services

The findings of the evaluation show that the practice of social auditing has contributed to the improved governance of health services at the local level. In particular, social auditing has contributed towards:

- improved access to health services through, for example, increased provision of full Aama Programme and antenatal (ANC) care entitlements, longer facility opening hours, and more staff;
- improved quality of services, particularly fewer stock-outs of medicines, improved privacy and better toilet facilities; and
- improved accountability and management through, for example, the display of Aama and ANC beneficiary names, more regular HFOMC meetings and more active HFOMCs, and greater local initiatives to improve health services.

Achievements have been greater related to the access to services indicators than the quality and accountability indicators. Some areas such as staffing, physical infrastructure and equipment have been less easy to improve than actions that are within the control of health facilities and local actors. And accountability measures have been easier to take forward in Palpa than in other districts.

Gains have generally been greater in the Palpa and Rupandehi sites where social auditing has been more continuously practiced at the study sites than in Ilam and Jhapa, and the training and quality of NGO facilitation has been good and benefitted from past NHSSP support. The commitment and involvement of DHOs/DPHOs and the support of VDCs are other key enabling factors. Where implemented well, social auditing has strengthened the relationships between service providers and communities, increased the participation of women in health facility monitoring and improved the functioning of HFOMCs. In all locations, social auditing has acted as a forum to prioritise and mobilise support from communities, VDCs and other actors to improve health services.

D. Looking forward

The implementation of the 2014 Collaborative Framework between MoH and the local government ministry (MoFALD) has serious implications for how social auditing is managed in the future. There will clearly be a need for considerable capacity building and systems development if local bodies

are to take over the social auditing of health facilities from MoH. Further collaborative planning between the two ministries is needed to develop a plan for testing out whether and how local bodies can take on the responsibility of the social auditing of health facilities.

In the short to medium term while MoH remains responsible for social auditing the following areas need strengthening to increase the impact of social auditing and facilitate its replication in the remaining districts and health facilities:

- Updating the Social Audit Guidelines (2013) to include a simplified social auditing process and tools.
- Improving the quality of social auditing through the better training of partner NGOs and better mechanisms for NGO selection and retention.
- Improving the role of health facilities and in-charges by providing them with a copy of the Social Audit Guidelines, keeping a copy of action plans at facilities and including the role of in-charges in the guidelines.
- Ensuring social auditing is annually supported for a minimum of three years in facilities where it is introduced, and thereafter in three years' time.
- Revising budget allocations to cover the costs of implementing the social audit process as defined by the guidelines.
- Strengthening the capacity of PHCRD to manage the social auditing programme and coordinate central level responses to local problems and actions triggered by the social auditing process.
- Developing and implementing a transitional plan to gradually hand over the social audit function to local bodies.

E. Recommendations

The evaluation recommends that PHCRD implements the following priority actions:

- Revise the Social Audit Guidelines (2013) based on the findings of this report.
- Develop and enforce an appropriate mechanism to select and retain competent partner NGOs.
- Develop and enforce mechanisms to improve the quality of training to partner NGOs.
- Review and revise budget allocations to cover the cost of implementing the social audit process as defined in the revised guidelines, and ensure NGO facilitation costs are adequately covered.
- Develop and implement a 3 to 5 year transition plan to gradually hand over the social auditing function to local bodies.

CONTENTS

ABBREVIATIONS AND ACRONYMS

ANC	antenatal care
ANM	auxiliary nurse midwife
DFID	Department for International Development, UK
DoHS	Department of Health Services
DHO	district health office
DDC	district development committee
DPHO	district public health office
DWCO	district women and children's office
FHD	Family Health Division
FCHV	female community health volunteer
FY	fiscal year
GiZ	German Technical Cooperation
HFOMC	health facility operation and management committee
HP	health post
HURDEC	Human Resource Development Centre
LDO	local development officer
MoH	Ministry of Health
NCDC	Namsaling Community Development Centre
NFHP	Nepal Family Health Programme
NHSP	Nepal Health Sector Programme
NHSSP	Nepal Health Sector Support Programme
NPR	Nepali rupee
NGO	non-governmental organization
PHCC	primary health care centre
PHCRD	Primary Health Care Revitalisation Division
SHP	sub-health post
SN	serial number
ToR	terms of reference
VDC	village development committee
WHO	World Health Organization
VAT	value added tax

1. INTRODUCTION

1.1 Context and objectives of the study

The Ministry of Health (MoH)[1] adopted social auditing as a demand side monitoring and accountability tool under the second Nepal Health Sector Programme (NHSP-2). Prior to 2012, two different approaches were used each tailored to the requirements of individual government programmes:

- The Free Essential Health Care Services Programme followed the 2009/10 (BS 2066) guidelines developed by MoH's Management Division and implemented by the district health offices/district public health office (DHOs/DPHOs).
- The approach used by the Aama Programme for safer deliveries was developed by MoH's Family Health Division (FHD) and was facilitated by local NGOs contracted by FHD.

In 2011/12, the Primary Health Care Revitalisation Division (PHCRD) of the Department of Health Services (DoHS) was made responsible for managing and overseeing social auditing across the health sector. In 2012, the Nepal Health Sector Support Programme (NHSSP/DFID), GiZ and the World Health Organisation (WHO) supported the review and harmonisation of the two existing sets of guidelines. Production of new harmonised guidelines was overseen by a PHCRD-led technical committee with members from DoHS, MoH, GiZ, WHO, the Nepal Family Health Programme (NFHP) and NHSSP. The Ministry of Health approved the Health Sector Social Audit Operational Guidelines in 2013.

In 2012, NHSSP supported PHCRD to pilot the new harmonised guidelines in 29 facilities in Palpa and Rupandehi districts, and commissioned an evaluation of the pilot initiative in 2013. As of 2015, PHCRD has implemented the new harmonised guidelines in 802 facilities in 45 districts.

Against this background, PHCRD requested NHSSP to commission an independent process evaluation of the implementation of the harmonised social audit approach in selected sample districts. The purpose of the evaluation was to support PHCRD to evaluate implementation of the harmonised social audit approach. The objectives of the evaluation were as follows:

- Measure progress and the quality of implementing social audit in a variety of district settings.
- Identify achievements of social auditing and enabling factors in a sample of facilities and districts.
- Identify whether MoH's Health Sector Social Audit Operational Guidelines (2013) need revising, and if so how;
- Inform PHCRD of how social auditing can be strengthened and positioned in NHSP-3.

Through competitive bidding, PHCRD/NHSSP awarded the assignment of the social audit process evaluation to Human Resource Development Centre (HURDEC) Pvt Ltd, a Kathmandu based development management company.

[1] Until recently called the Ministry of Health and Population (MoHP)

1.2 Study methodology and steps

As per the terms of reference (ToR), the process evaluation was implemented through two rounds of data collection. The first round of data was collected in April–July, 2014, and the second round during April–August 2015. A field report on completion of the first round was submitted to PHCRD/NHSSP in July 2014. This report presents the full evaluation by the consultant incorporating information from both rounds.

1.2.1 Sample

The study drilled down into the experiences of selected sites that were chosen with the government to understand the range of experiences with social auditing, the quality of the process and achievements, and the constraints and challenges at different operating contexts.

The purposefully selected sample included sites from the earlier pilot areas in Palpa and Rupandehi, where NHSSP provided technical assistance for financial years 2011/12 and 2012/13 and a process evaluation happened in 2013. In addition, social audit sites in Jhapa and Ilam, which had not received external assistance and relied on government support were included. Jhapa is an eastern Tarai district which began social auditing in 2013/14, while Ilam is an eastern hill district where social auditing began in 2012/13.

For Palpa and Rupandehi the evaluation tracked progress on service improvements from 2011/12 to 2014/2015. Four of the selected health facilities in each of these districts had completed four rounds of social auditing. The evaluation also sheds light on whether the quality of social auditing has been sustained since NHSSP external technical assistance ended.

The sample includes four to six health facilities from each of the evaluation districts (Table 1.1).

Table 1.1: Sample size

District	Hill or Tarai	Initiated social auditing	External development partner support	2013 pilot evaluation: No. facilities sampled	2014 Round 1: No. facilities sampled	Round 2: No. facilities sampled
Palpa	Hill	2011/12	NHSSP	6		5
Rupandehi	Tarai	2011/12	NHSSP	4		6
Ilam	Hill	2012/13	None		5	5
Jhapa	Tarai	2013/14	None		5	4

As agreed with NHSSP, six of the selected health facilities in 2015 were new sites that were implementing social auditing for the first time while 14 were old sites that had started social auditing at least a year previously. Old sites in Palpa and Rupandehi were selected from a list of sites that have Ladder of Change[2] data collected during the 2013 process evaluation.

In each district, health facilities were selected according to criteria agreed with the DHO/DPHO and NHSSP (Table 1.2).

[2] The Ladder of Change was a tool used by NHSSP to support the process evaluations in 2013 and the current one. See Annex 2 for an outline of the Ladder of Change tool.

Table 1.2: Selected sample health facilities

District	Selected sample health facilities		
	2013 pilot evaluation	2014 round I	2015 round 2
Ilam		(i) Sankhejung health post (HP) (ii) Kanyam SHP (iii) Godak HP (iv) Fikkal primary health care centres (PHCC) (v) Panchakanya SHP	(i) Kanyam sub-health post (SHP) (ii) Godak HP (iii) Fikkal PHCC (iv) Laxmipur HP (v) Cheesapani HP
Jhapa		(i) Dhulabari PHCC (ii) Sanischare PHCC (iii) Pathamari (HP) (iv) Haldibari HP (v) Prithvinagar HP	(i) Dhulabari PHCC (ii) Sanischare PHCC (iii) Prithvinagar HP (iv) Shivaganj PHCC
Palpa	(i) Pokharathok HP (ii) Masyam HP (iii) Khanichhap SHP (iv) Tahun HP		(i) Pokharathok HP (ii) Masyam HP (iii) Khanichhap SHP (iv) Tahun HP (v) Kusumkhola HP
Rupandehi	(i) Maryadpur HP (ii) Kerwani SHP (iii) Majhgawa HP (iv) Pokharbhindi HP		(i) Maryadpur HP (ii) Kerwani SHP (iii) Majhgawa HP (iv) Pokharbhindi HP (v) Sakraun SHP (vi) Padsari HP
Total	8	10	20

1.2.2 **Methodology**

Desk study — Desk study of key documents included:

- MoH's Health Sector Social Audit Operational Guidelines (2013).
- Evaluation of the Social Auditing Pilot Programme in Rupandehi and Palpa Districts (Devkota et al., 2013)[3].
- NHSSP document on the Ladder of Change monitoring tool that was used in the 2013 pilot evaluation and in this process evaluation.
- Social audit reports for sample districts.

Central level meetings and consultations — Meetings and consultations were held with NHSSP and PHCRD to develop a common understanding of the terms of reference (ToR), particularly the methodology, tools and other details of the evaluation process. A fieldwork plan and checklists were also finalised during these consultative meetings. External development partners and (ex-) officials of PHCRD were also interviewed. Annex 1 lists all people interviewed for this evaluation.

[3] Devkota B, S Ghimire and BD Neupane (2013). Social Auditing Pilot Programme In Rupandehi and Palpa Districts: Evaluation Report. Kathmandu: Ministry of Health and Population and Nepal Health Sector Support Programme

1.2.3 **Fieldwork in Ilam, Jhapa, Palpa and Rupandehi**

Fieldwork was undertaken in 2014 and 2015. Researchers and women facilitators (engaged during round 2) were oriented on the context and background, methodology and checklists of the evaluation both in a classroom setting and in-the-field.

The fieldwork consisted of the following:

- Interviews with DHOs/DPHOs, district focal persons for social auditing, health facility in-charges and staff, representatives of partner NGOs including the social audit facilitators, VDC secretaries, representatives of municipalities, local development officers (LDOs), and representatives of ward citizen's forum (where available).
- Group discussions with health facility operation and management committees (HFOMCs) and female community health volunteers (FCHVs) and completion of the Ladder of Change monitoring tool for the selected health facilities,
- Focus group discussions with women in all the 20 selected health facilities during Round 2.
- Observations of the social audit process in six facilities that started social auditing in 2014/15 and in two facilities in Palpa and Rupandehi where social audit had been undertaken since 2012/13, particularly focusing on the mass meetings organized as the last event of the social audit process.

1.2.4 **Limitations**

There were several imitations to the study. The sample size was small, and no control sites were used. Of the 45 districts currently implementing social audit, only four districts were selected. Of the more than 800 health facilities implementing social audit, only 20 were studied. None of the districts where an external development partner (Health for Life) is providing technical and financial assistance to implement social audit, were included in the sample. The conclusions of the study should, therefore, be understood and interpreted within these limitations.

The study also faced some constraints. There were delays in fieldwork due to the 2015 earthquakes. This delay coupled with the mandate to complete the social auditing process before the end of the Nepali fiscal year (mid-July) put the DHOs/DPHOs, the partner NGOs, the health facilities and also the evaluators under time pressure. The pressure resulted in back and forth readjustments in health facility selection, social audit timing and the evaluators' field work schedules in all the districts.

1.3 Overview of social audit implementation in Nepal

Social auditing is currently being implemented in 45 districts (out of Nepal's 75 districts). In 40 districts, the programme is solely implemented by the Government of Nepal and in five districts of the Karnali Region, an INGO (Health4Life) provides technical support to the DHOs/DPHOs. Primary Health Care Revitalisation Division (PHCRD) of the Department of Health Services (DoHS) has the mandate for planning, implementing and evaluating social audit of health services. PHCRD selects new districts for social auditing based on budgetary provisions and its management capacity and advises districts on how many new facilities to introduce social auditing in each year. For 2014/15 a total budget of about NPR 20 million (less than the previous year) was allocated by MoH. Six planned districts did not carry out social auditing during 2014/15 and the budget set out for this there has lapsed.

MoH's Health Sector Social Audit Operational Guidelines (2013) guides PHCRD in its task of managing social auditing. The guidelines envisage social auditing as a regular activity to improve access, accountability and the quality of health services at the local level. By the end of fiscal year 2014/15 (Nepali year 2071/72), a total of 802 health facilities in 45 districts had been covered. Across the country, the health facilities implementing social auditing are mostly health posts (HPs) and sub-health posts (SHPs), and primary health care centres (PHCCs), plus the district hospital in Ilam. Clause 2.5 of the Social Audit Guidelines directs all district hospitals with up to 25-bed capacity to conduct social auditing — but implementation is particularly lagging here. The health facilities covered so far represent about 20% of the country's total health facilities. Clauses 3.3.1a and 2.1(2) of the Social Audit Guidelines mention the goal of covering 30% of health facilities by 2015. Clause-2.1(3) mentions about covering all facilities across the country by 2020.

2 KEY FINDINGS ON THE SOCIAL AUDIT PROCESS

In this chapter we present progress on implementing social auditing in each of the study districts and our findings on the quality of implementation and how practice complies with the Social Audit Guidelines. It is important to note that there is considerable variation in the political-economy and health sector contexts of the districts selected for this study and to some extent this has influenced how social audit has been implemented. In this chapter we identify a number of factors that affect the quality of social audit implementation.

2.1 The district social audit implementation process according to the guidelines

DHOs/DPHOs are tasked with the overall management of social auditing at the district level. District level social audit management committee headed by the LDO have oversight responsibility. These committees select one or more local NGOs based on open competition to facilitate social auditing as per the prescribed rules in the Social Audit Guidelines. The DHO/DPHO hires these NGOs.

According to the Social Audit Guidelines, the NGO with the assistance of the health facility in-charge will facilitate the collection of data and the participation of health facility management committee, providers, users and the public in the social audit process using the tools included in the guidelines. The NGO also mobilises public participation in the 'mass meeting event' which brings together the various stakeholders to review performance of the health facility, identify problems and constraints, and develop a plan of action to improve services at the health facility. The first time a health facility undertakes a social audit ('full version') the process is expected to take five to six days to complete. In subsequent years the social audit process reduces to two days at each participating facility and the focus is on reviewing progress and updating the action plan ('brief version'). Once a facility has undertaken a social audit it is expected that progress is reviewed each year.

After completion of the social audit, the NGO submits a social audit completion report to the DHO/DPHO including the action plans prepared for each health facility. The DHO/DPHO sends the reports from the NGOs to PHCRD. A one-day district level review and dissemination seminar is organized every year, where the social audit facilitating NGO presents its overall findings and areas for improvement. The seminar is attended by LDO and other stakeholders.[4]

The ministry's standard trimester (four monthly) and annual programme and progress are meant to carry out reviews include reviews of social auditing. Regional health directorates are also to cover social audits in their half-yearly progress reviews. However, in practice these reviews are usually limited to reporting the number of social audits completed rather than an analysis of results or quality of implementation.

2.2 District wise progress of implementation

Table 2.1 presents the coverage of social auditing in each of the study districts. In Palpa and Rupandehi, social auditing started in 2011/12 and the coverage has been about 80% and 50% of

[4] See section 3 of this report for key issues related to this provision in the guidelines.

facilities respectively. Ilam started social auditing in 2012/13, and the coverage is about 45%. Jhapa started in 2013/14 and the coverage is 26%.

Table 2.1: Coverage of social auditing in the study districts

	Year social audit initiated	Number of facilities undertaken social auditing by July 2015	Coverage of facilities
Ilam	20112/13	21	45%
Jhapa	2013/14	13	26%
Palpa	2011/12	38	80%
Rupandehi	2011/12	34	50%

2.3 Political pressure adversely affects hiring and retention of competent NGOs

Interviews with stakeholders revealed that strong political pressure was exerted by interest groups during the NGO selection process in the districts. The pressure usually came through the LDO and the DHO/DPHO and has been difficult to resist in some cases. Ilam and Rupandehi have so far been able to manage the political pressure and have retained the same experienced NGO partners since 2011/12. In contrast in 2013/14 and 2014/15, under pressure from the LDO, Jhapa resorted to using two NGOs while only contracting one and involving the second through an informal back-door arrangement (see Box 2.1). In Palpa two experienced NGOs with proven competence that had facilitated social auditing for three years were replaced by two new NGOs in 2014/15 who have divided the work between themselves by geographical area. The implications of the political influencing of NGO selection are to risk the quality of the social audit process, and to undermine the spirit of transparency and accountability integral to its very purpose.

Box 2.1: Two facilitating NGOs in Jhapa District

Two NGOs (Birat Samudayik Adhyan Kendra, Birtamod and Samudayik Bikash Manch, Kakadvitta) were selected to facilitate the social audit in four facilities each in 2013/14 in Jhapa District, though the official contract to facilitate social audit was signed with only one of them (Birat Samudayik Adhyan Kendra Birtamod). The officially selected NGO was asked to accommodate the second NGO through an informal backdoor mechanism. The apparent reason for involving two NGOs instead of one was to implement social auditing was the short period of time available (a month or so). However, the real reason behind selecting two NGOs is not clear. The LDO involved in selecting the NGOs in 2013/14 has been transferred. The current LDO reportedly opposed contracting with two NGOs. In 2014/15 the Birat Samudayik Adhyan Kendra was again selected through a competitive bidding process as the partner NGO. However, this officially selected NGO was asked by the DHO/DPHO to accommodate another NGO (Yuva Chetana and Netritwa Samuha, which had not previously been involved in social auditing), through a backdoor informal mechanism and distribute the workload and budget between the two NGOs.

Stakeholders proposed various solutions to counter such political pressure including the central hiring of the NGOs and improving the NGO selection and hiring process. Central hiring through the government is not, however, considered a workable solution both given the intention of government to decentralise and PHCRD's lack of management capacity to absorb this

responsibility. Improving the NGO selection and hiring process is a priority and will require two key changes in the guidelines:

- Inclusion of the provision of multi-year contracting (for minimum of three years) with the selected NGO.
- Elaboration of the NGO scoring and rating criteria to remove scope for score manipulation.

Such changes were also recommended by the pilot evaluation of social audit in Rupandehi and Palpa (2013).

2.4 Capacity of NGO partners affects quality of social auditing

2.4.1 Poor quality training

The capacity of NGOs to handle all aspects of social auditing effectively and efficiently, even after the orientation training, was found to be inadequate. It was reported that the training mostly consisted of reviewing the provisions of the Social Audit Guidelines. Observations of the performance of newly selected NGOs in Jhapa and Palpa and interviews with them found that the two-day orientation training had not sufficiently prepared them for the tasks. The suggestion of Palpa DHO/DPHO to reduce the duration of the orientation training to one day is not supported by field interviews and observations of the performance of social audit NGOs.

The NGO in Jhapa reported that during their training they were only provided the guidelines and asked to read them. In Ilam, the NGO was given a copy of an old version of the guidelines and asked to prepare based on this. The NGO developed its own simplified methods and tools for social auditing and replaced those recommended by the guidelines. They were not supervised or guided during the process.

Observations by the evaluators found insufficient analysis of information and poor reporting skills among the NGO personnel. The presentation skills of some of the facilitators were also insufficient. The quality of NGO orientation training needs to be a priority area for strengthening in future. Besides the process and tools, the training should also include analytical, presentation and report writing skills.

2.4.2 Overloaded tools and processes

Besides the quality of the NGO orientation training, there are other factors that affect NGOs' capacity. One issue raised by the NGOs and some DHOs/DPHOs was that the total time required to complete the prescribed tools was longer than the total of three days provided to NGOs for information collection. The evaluators observed that the information the NGOs are expected to collect is not consistently collected, processed, analysed and concluded upon. Lack of ideas or know-how on how to process and analyse the information and reach conclusions was apparent in all the districts.

The NGOs can effectively facilitate social auditing only when they are fully conversant with the different clauses of the Social Audit Guidelines. It is unrealistic to expect them to be fully conversant with the guidelines, which contain many tools and details, after attending inadequate two-day orientation training. We propose the following actions to increase NGO capacity and the quality of social audit implementation:

- Simplify the social audit process and tools prescribed in the guidelines.
- Prepare a quick reference tool kit that succinctly captures the key steps and tools to be used during the training and social audit process.
- Increase attention to analysis of data and report writing during NGO training.
- Create a roster of, and use well-trained and well-experienced social auditors from different districts to train social auditors in newly selected districts including on-the-job coaching.

2.5 Variable commitment and motivation of NGOs

Observation of the partner NGOs facilitating the social audit process in the study districts showed that partner NGOs in Rupandehi and Palpa took a missionary spirit to the task and are continuously motivating health staff in the various types of facility.

In the case of Ilam, the partner NGO implemented the task more as a contractual obligation. This NGO implements a wide range of development activities in collaboration with external development partners and government line agencies. As such, the annual contract with DHO/DPHO for social auditing is only a small part of their annual income. As the NGO representative remarked,

> *"we take up this assignment to maintain our good reputation in Ilam and not for monetary gains as such."*

The partner NGO in Jhapa is in the process of learning by doing. As the launch of social auditing in Jhapa coincided with the start of this evaluation, the partner NGO had the opportunity to consult with the evaluators on the process and tools and guidance was provided which would otherwise not have been available. This NGO was found to be following the guidelines more closely than their Ilam counterpart.

2.6 Poor annual follow up after initial social audits

The evaluation found a mixed understanding among facilitating NGOs of the importance of annual follow-up after an initial social audit as set out in the guidelines. The follow-up or brief version of auditing should include an orientation meeting, work plan review, observation and mass meeting event. The newly recruited NGOs requested better clarity in the Social Audit Guidelines of the 'follow up or brief version'. There was considerable variation in how the NGOs implemented the follow up social audits. In Rupandehi the NGO implemented the brief version almost like a full version. In Ilam the NGO conducted just a brief consultation regarding the progress of the action plan and prepared an updated action plan without a mass meeting event, though the latter event is key to building consensus and fostering community and provider support and commitment to action.

DHO/DPHO understanding of the follow up process was also mixed. In Rupandehi and Palpa districts, the brief version of social audits were carried out at each health facility every year once social auditing started at the facility. In Ilam the DHO/DPHO programmed the follow up version of social audit in only some of the facilities that have undergone an initial social audit. As a result, social auditing in Ilam health facilities tends not to gather momentum for change, as is the case in Palpa and Rupandehi districts. In Ilam the DHO/DPHO reported that the focus had been on expanding social auditing to new facilities rather than following up in those already covered. Jhapa is a relatively new district with only two rounds of social auditing and with the problem of NGO

selection (as discussed under section 2.3 above) and so it is too early to conclude whether the social audit process will gather momentum in the future.

2.7 Sub-optimal involvement of health facilities in social auditing

A copy of the action plan was not found at the health facilities in any of the sample districts, not even in Rupandehi and Palpa which have benefitted from technical support from NHSSP in the past. Health facility in-charges who had newly joined the facility were not aware of the plans of action prepared at the end of the social audits. In all districts the social audit plan of action was prepared by the facilitating NGO and submitted to the DHO/DPHO, who kept it in their offices.

This situation raises the question of the ownership of social auditing and the role of health facility in-charges and HFOMCs in the process. Notably, social auditing is not mentioned in the HFOMC guidelines and health facilities have not been provided with a copy of the Social Audit Guidelines. Earlier studies commissioned by PHCRD and NHSSP highlighted the importance of enabling service providers to be actively engaged in social auditing but current practice in this respect is weak[5]. Currently, the ownership of social auditing seems to be distributed among DHOs/DPHOs and partner NGOs although it is HFOMCs and in-charges and communities who are the primary stakeholders in the process and the agents of change.

We propose the following actions to strengthen health facilities' understanding of, participation in, and commitment to social auditing:

- Specify the roles of health facility in-charges in the social auditing process in the guidelines.
- Provide a copy of the guidelines to health facilities before starting social auditing.
- Ensure that copies of social audit action plans are kept at health facilities.
- Include social audits in revisions to the HFOMC operational guidelines.

The management of social auditing by DHOs/DPHOs also needs strengthening so that relatively simple gaps in implementation, such as lack of action plans at facilities, can be corrected, and more support is provided to facilities to implement actions.

2.8 Weak response of the centre to social audit demands

The implementation of the action plans prepared at the end of the social audit process often requires considerable funds. Support from the VDC (or municipality) and DHOs/DPHOs was found to be used to support some actions that do not require large funds. However, actions that require relatively large amounts of financial support generally remained unimplemented and there is a lack of investment in physical infrastructure, which in turn impacts the quality of services (see section 3.3.

A DHO/DPHO questioned,

> *"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?"*

[5] See the 2013 evaluation by Devkota et al.

One problem the PHCRD faces is the fact that by the time that social audit reports reach its office, the budget for the fiscal year has already been finalised and PHCRD's influence is limited.

The government's intention was for social auditing to be completed by the second trimester of the financial year so that reports from the districts reached PHCRD in time for budget to be allocated to support district action plans. This has, however, not happened mainly due to the perpetual delay in budget release from the central government so that funds for social audit typically arrive only in the second or third release (trimester). With the increasing number of social audits in a district, the timely completion of these audits will become more challenging in future. The government-wide annual planning and budgeting (AWPB) system means that there is inevitably a lag in time between identifying problems at the local level and allocating central budget to address them. As we see from our analysis of financial support to the focal facilities, other than core programme support from MoH, additional funding is generally provided by VDCs and does not come from the centre or district.

The capacity of PHCRD to address infrastructure or other gaps beyond its technical remit is also constrained, and in future it will need to play a more active coordinating role to leverage funding from other divisions. This will require strengthening the capacity of PHCRD to monitor social auditing and coordinate an enhanced central response to the problems and demands raised at the local level.

2.9 Structural issues beyond the influence of social audits

Some of the issues raised by the public at mass meeting events were found not to be included in the action plans because they were considered structural and beyond the influence of social audit. Such structural issues include the distribution of expired medicines (see Box 2.2). This can undermine public confidence in the process as it suggests that some issues of transparency and accountability are not up for discussion. There is a need for PHCRD to clarify how structural issues are to be included in the social audit action plans, how these issues are to be raised through government management systems, and how DHOs/DPHOs need to report back to communities that raise these issues. Concomitant training of DHOs/DPHOs and NGOs needs strengthening.

Box 2.2: Structural issues discussed at mass meeting events

The issue of date-expired free medicines was raised in the mass meeting event at most health posts, but has not been included in action plans. Respondents reported that often the DHO/DPHO representative participant explained that the problem started at the central level and was therefore beyond the control of the DHO/DPHO and the health facility.

In newly declared municipalities, municipal officers chair the local HFOMCs. However, some municipal officials interviewed were unaware of this responsibility, which has adversely affected the functioning of HFOMCs and health posts including funding problems for some health facilities in Ilam, Jhapa and Rupandehi. The respective DHOs/DPHOs need to take up the matter with the LDOs and initiate actions.

2.10 Women's participation in social auditing

Our observations of mass meeting events during an initial social audit and annual follow-up found that the participation of women, including FCHVs, was generally good in terms of numbers as well as the raising of issues and demanding action (Table 2.2). The issues raised by locals during mass

meeting events were generally incorporated in action plans or were clarified during the meetings, although structural issues, such as the case of expired free medicines, were not well managed.

> *We feel good about our participation in the social audit. There were as many women as men who came to know about the health staff and services. Weaknesses of the health facility were discussed openly. Everyone expressed their complaints. Commitments were made to improve things in the future." — Shivganja Health Post, Jhapa District*

From interviews with community women who had participated in social audit mass meeting events we heard that they felt positive about their participation in the process, and perceived their issues to have been considered and taken up into the action plans.

In Rupandehi and Palpa, we found a high level of understanding of social auditing among women participants, and in seven out of the eight sites women reported they has previously participated in the process. The situation was less positive in Ilam and Jhapa where women complained that they had not previously been invited to attend the social audit mass meetings in two of the three study facilities in each district. A group of women at Kanyam Sub-health Post, Ilam also emphasised the need to provide financial incentives to poor women, such as those who work in the tea gardens, to enable them to participate.

> *"They invite only FCHVs and their own people to events and we do not attend. However, they invited us today. We feel good about the participation and we came to know many things about health services." — Maryadpur Health Post, Rupandehi District*

> *"FCHVs should inform the women living away from the health post about the event despite their workload. Usually, only women living near the health post are invited."— Godak Health Post, Ilam District*

Table 2.2: Women's participation in social auditing

District	Number of 'old' social audit facilities	Number of facilities where women reported previous participation in social auditing	Barriers reported by women to participation
Ilam	3	1 (Fikkal PHCC)	Not invited. Need financial incentives for poor women to attend
Jhapa	3	1 (Prithwinagar HP)	Not invited
Palpa	4	4	
Rupandehi	4	3	Not invited

The level of women's involvement in social audit can be gauged from the answers they provided to the question: what do you understand by social auditing? Table 2.3 illustrates the understanding of social auditing and indirectly women's degree of involvement in the process. We see that women in the Palpa study sites had a strong understanding of social auditing as did women in some of the other district sites, but this was less consistent in the other districts than in Palpa.

Table 2.3: Women's understanding of social auditing among those who had previously participated in the process

District	Health facility	Women's understanding of social audit
Ilam	Fikkal PHCC	"I came to know about the presence of date-expired medicines"
Jhapa	Prithwinagar HP	"Social auditing is about discussing income and expenditure of the health post, staff positions and attendance, and review of action plan and budget."
Palpa	Pokharathok SHP	"Social auditing means to examine the extent of service provision to the society by the SHP."
	Khanichhap HP	"Social auditing means assessing whether the HP is providing its mandated services, whether the doctors come on time or not, whether things are as before or have changed, and whether medicines are distributed freely or not."
	Masyam SHP	"Social auditing means assessing whether local people received services from the health post; the behaviour of the service providers towards clients; the relationship between patients and the doctor; whether patients receive free medicines; who was on the HFOMC and what were they doing; and what services are provided by the facility."
	Tahun HP	"Social audit means assessing whether the services of the health post have reached the people and providing information about the services provided by the health post"
Rupandehi	Majhgawa HP	"Provision of health services to the society is social auditing."
	Pokharbhindi HP	"I participated last year. We did feel good about it and we know that we get free medicines and free check-up"
	Kerwani SHP	"Assessing relationship between the service providers and the clients, what services are provided by this health post, and getting knowledge about what medicines are provided free by this HP is social auditing."

2.11 Wider institutional participation in the process

Several VDC officials highlighted the need for VDCs and other local organisations, including civil society organisations, to more actively participate in social auditing. This was particularly linked to the need to consider the availability of funding when developing social audit action plans.

> *"The implementation of the plan of action prepared last year is discouraging. Social auditing can be further improved by allocating more for discussion of issues, making wider representation from institutions that might have a stake, more participation of the local community and a more active role of the PHCC chief." — Prithwinagar VDC Secretary, Jhapa*

2.12 Coverage and continuity

The target of starting social auditing in 30 percent of health facilities by the year 2015 (as specified in the Social Audit Guidelines) has not been met. PHCRD's human resource and management capacity, including the capacity to train district focal persons and partner NGOs, and capacity to monitor the programme is limited. Achieving the goal of implementing social auditing in all eligible health facilities by 2020 is highly challenging.

Ideally, social auditing as a good governance tool should be implemented continuously once started at a facility. However, budgetary and capacity constraints make it difficult to do this. Therefore a key question is how to optimise the achievements of social auditing within these constraints.

Comparing the social audit practices in Palpa and Rupandehi on the one hand with those of Ilam on the other reveals a contrast. Social auditing in Ilam has been carried out only once and virtually discontinued. A sample of facilities were included for the updating of action plans but this was conducted without the prescribed 'mass meeting' of local stakeholders. Among the different processes prescribed, the mass meeting events are the most important ones when it comes to bringing about desired changes. In Palpa and Rupandehi, the brief versions of the social audits are implemented with full-fledged mass meetings and discussions. The field observations have shown that these two districts were implementing social audit more seriously.

The lack of continuation of social auditing was one of the reasons for the poor performance of Ilam on a range of Ladder of Change indicators. This was confirmed by women's reports. In addition, community women in Ilam lagged far behind those in Palpa and Rupandehi in terms of their participation in and understanding of social audit. The case of Kanyam Sub-health Post is an example. It scored very low on quality and accountability and the community women in Kanyam had not seen any improvements over the years. The VDC and the newly formed municipalities have not provided any assistance to Kanyam Sub-health Post for the last two years. The physical infrastructure is in a very poor condition.

Rupandehi and Palpa districts have four years of experience in social auditing. With some exceptions, health facilities in these districts have been able to achieve high scores in most monitoring indicators related to access, accountability and quality as discussed in the next chapter of this report.

A look at the mean total scores for access, accountability and quality across districts (Table 2.4) shows that Palpa and Rupandehi (with four years of social auditing) have gradually increased the mean scores to more than 3.5 (out of four). (Note of caution: not all facilities are at the same level of achievement.) There is no monitoring information for the third year for Palpa and Rupandehi, but it can be postulated that three to four years is sufficient time for a health facility to improve its performance unless there are major barriers (for example a lack of adequate funding for physical infrastructure improvement) preventing its improvement.

Table 2.4: Mean total scores across selected districts based on Ladder of Change monitoring tool

District	Overall (total) mean score for access, quality and accountability indicators		
	Baseline 2011/12	Midline	Endline 2014/15
Palpa	2.4	3.4	3.7
Rupandehi	2.6	3.2	3.6
Ilam		2.9	3.2
Jhapa		3.3	3.4

Therefore, an optimal trade-off for PHCRD would be to implement social auditing in a facility say for three years at a stretch, and thereafter repeat it once every three years. This gap of three years

would give health facilities time to focus on activities that require external support such as physical infrastructure and large equipment purchases. This option could be a good balance between budgetary and management constraints on the one hand and gaining and retaining momentum for change at the health facility level.

2.13 Consequences of the collaborative framework between MoFALD and MoH

The collaborative framework between the Ministry of Federal Affairs and Local Government (MoFALD) and MoH (2014) envisages the harmonisation of health sector social auditing with local government public auditing. Stakeholders from MoH have expressed their concerns about this planned integration for the following reasons:

- The unproven ability of the local bodies to ensure the proper integration and handling of health-specific aspects (access, accountability and quality) if they were to take over the responsibility for social auditing.
- The local bodies are used to a simple version of social auditing that focuses mostly on project related income and expenditure, and this does not prepare them for health sector social auditing.
- The transition to a federal system of local governance may well take longer than expected and thus the effective takeover of social audit responsibility by local bodies might require a longer transition.

LDOs and other DDC officials expressed different concerns and suggestions:

- The harmonisation of rules, regulations, guidelines and practices across health, education, agriculture line agencies and local bodies will be necessary before such integration can happen.
- Preparatory work in terms of capacity building (training and support) of the local bodies including LDOs, municipal officers and VDC secretaries is necessary, as they are overloaded with work and responsibilities and many are not even aware of the collaborative framework. District level action plans and local interactions and sharing will be necessary prior to implementation.
- Priority in the initial phase of implementation should be given to local bodies that have better capacity and resources.
- The NGO selection criteria of the guidelines need to be elaborated with an objective scoring system, and NGO selection should be done at least at the district level.

One external development partner representative suggested handing over health facility social auditing to local bodies under the demonstration districts for the implementation of the Collaborative Framework (six districts in 2014/15 including Jhapa). However, the suggestion cannot be implemented until the tasks of harmonising guidelines, orienting local bodies and building their capacity to implement sectoral social audits are carried out. Given the need for restructuring local bodies according to the new constitution, the handover of health facility social auditing will need to be delayed until the new local bodies are in place.

3 CONTRIBUTION OF SOCIAL AUDITING TO HEALTH SERVICE IMPROVEMENT

MoH has adopted social auditing as a tool for improving the governance of health services provided by health facilities — sub-health posts, health posts, primary health care centres and district hospitals. The overall objective is to establish transparency and accountability in health facilities, and ensure access to quality health services particularly by the poor, women and other marginalised groups.

This evaluation used a variety of tools to collect evidence of changes in access to, quality and accountability of services.

- The Ladder of Change monitoring tool that was used in the NHSSP pilot districts of Palpa and Rupandehi in 2012/13 and contributed to the 2013 pilot evaluation was extended to all facilities that took part in this evaluation. Ladder of Change data from 2012/13 for focal facilities in Palpa and Rupandehi was also used in this study.
- Interviews and focus group discussions were held with key stakeholders including facilitating NGO partners, DHOs/DPHOs, VDC secretaries, health facility in-charges, HFOMC members and women to collect their perceptions of whether and how social auditing has contributed to improvements at health facilities and the delivery of services.
- Field observations of the social audit process, the quality of facilitation, and extent and nature of participation in the process.

In this chapter we first present an overview of changes in the thematic areas of access, quality and accountability based on Ladder of Change data. Secondly we drill down to examine changes in each thematic area by drawing on data from various sources to triangulate and explain changes.

3.1 Overview of changes in performance

3.1.1 Information from Ladder of Change monitoring data

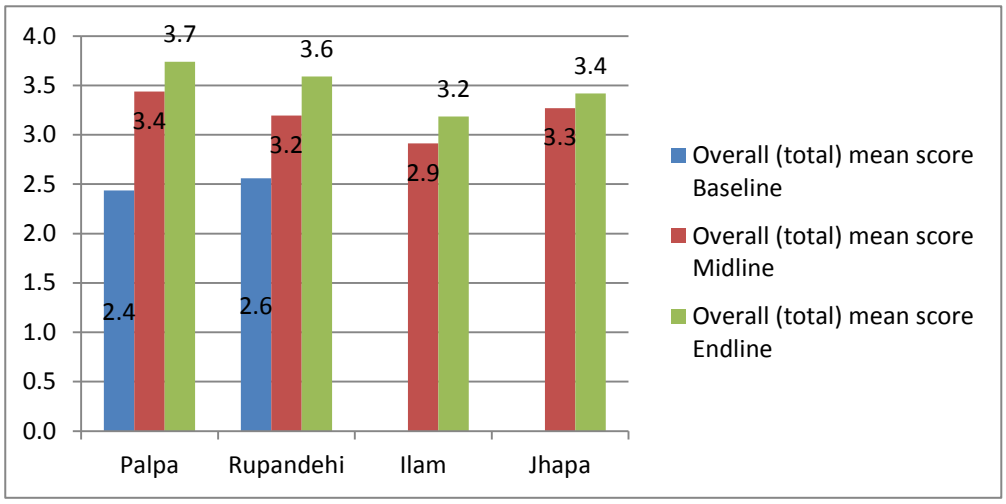
The Ladder of Change monitoring tool includes indicators for measuring access to health services, accountability and management, and service quality. Each of the indicators can be scored from 1 (lowest) to 4 (highest). For most of the indicators, objective criteria for scoring are provided as part of the monitoring tool (See Annex 2 for Ladder of Change tool).

Three rounds of monitoring data (baseline in 2012, midline in 2013 and endline in 2015) for selected facilities in Palpa and Rupandehi and two rounds of data for selected facilities in Ilam and Jhapa (midline in 2014 and endline in 2015) are available for analysis and comparison.

In all the facilities, the Ladder of Change scoring exercise was carried out by HFOMC members with external consultants facilitating the scoring process. During this evaluation, the scoring process coincided with the mass meeting events in some of the facilities and therefore FCHVs and other participants also participated in scoring. The scoring process involved intensive discussions among participants, and thus generally avoided being influenced by individuals with a vested interest. Nonetheless, the tool has limitations and some subjectivity in the scoring cannot be ruled out. Data presented later in this chapter highlight a number of cases where scoring seems to have been inconsistent.

Mean scores from the Ladder of Change tool for all three domains is shown in Figure 3.1. This is based on four facilities from each of Palpa and Rupandehi districts, and three facilities from each of Ilam and Jhapa districts where trend data was available.

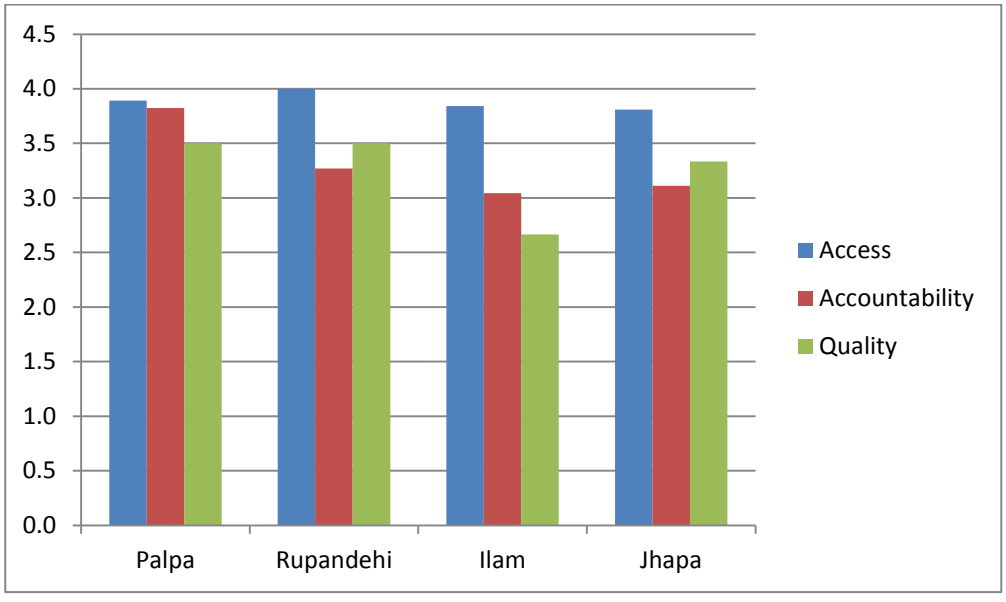
Figure 3.1: Overall improvement at focal health facilities across the four selected districts



The total mean scores for access, accountability and quality have increased consistently over time (Figure 3.1). Palpa ranks highest in terms of overall score, followed by Rupandehi with this ranking supported by stakeholder interviews, which are presented later in this chapter.

Further analysis of the data for 2015 for sites with trend data (Figure 3.2) suggests that improvements in accountability and quality tend to lag behind improvements in access in all the four districts.

Figure 3.2: Comparative improvements in access, accountability and quality



3.2 Access to services

The following sub-sections discuss progress related to access in each of the four sample districts of Ilam, Jhapa, Palpa and Rupandehi.

3.2.1 **Ilam District**

The Ladder of Change monitoring data collected in 2014 and 2015 for the three facilities (Godak HP, Kanyam Sub-health Post, and Fikkal PHCC) that participated in the evaluation in both years shows an improvement in the mean scores for access to services.

Table 3.1: Access to services — mean scores for three focal facilities in Ilam

Access to service indicators	Mean scores for three facilities	
	2014	2015
(i) Extent to which health staff posts are filled	3.0	3.7
(ii) Level of attendance of staff	3.7	4.0
(iii) Extent to which the facility is open during opening hours	3.7	3.7
(iv) Extent to which Aama entitlements are provided on time	1.0	4.0
(v) Extent to which Aama entitlements are provided in full	4.0	4.0
(vi) Extent to which ANC entitlements are provided on time	1.0	4.0
(vii) Extent to which ANC entitlements are provided in full	4.0	4.0

Fikkal PHCC which was the only facility that provided Aama and ANC entitlements out of the three facilities, improved its performance of providing these on time. Earlier delays were mainly due to the late receipt of funds from the DHO/DPHO. The HFOMC reported how after the 2014 social audit, the PHCC started providing the entitlements from its income if funds from the DHO/DPHO were delayed.

> *"Previously, the PHCC was not able to pay Aama and ANC entitlements on time due to delays in budget release, but now they pay the entitlements on time from its locally generated funds, in case of delay in budget release." — HFOMC member, Fikkal PHCC*

Similar findings were found in the 2013 pilot evaluation in Palpa and Rupandehi and suggest that social auditing can trigger health facility managers to more actively manage finances to fill temporary shortfalls in Aama and ANC entitlement budgets.

Kanyam Sub-health Post HFOMC reported better availability and attendance of health staff (Table 3.2). Community women endorsed this improvement although they were unable to say why this change had occurred.

Table 3.2: Selected access scores for Kanyam Sub-health Post, Ilam

Access to service indicators	Scores on the indicators	
	2014	2015
(i) Extent to which health staff posts are filled	Some staff positions are filled	All staff positions are filled
(ii) Level of attendance of staff	Staff are absent only sometimes	Staff are regularly present

Godak Health Post: Community people reported that access had improved over the past year. They attributed these changes to the initiatives of the health post in-charge.

An interview with the health post in-charge supported the community's attribution of improvements made. The in-charge had participated in and was highly impressed by a public hearing event at his previous health post, and fortuitously his transfer to Godak health post coincided with the introduction of social auditing there. The Godak in-charge prepared a five-year plan for the improvement of the health post on his own initiative and planned to conduct social auditing in the years to come. He publicly felicitated two very active HFOMC members and two FCHVs for their contribution to improvements.

> *"The services we used to get only from Ilam district hospital are now available at the health post. Medicines are distributed freely; ANC check-ups are done regularly; vaccine centres have been set up at ward level; and primary services for colds and coughs, fever and diarrhoea are available at the facility." — FGD women, Godak Health Post*

3.2.2 **Jhapa District**

Table 3.3 shows very high aggregate scores for the three focal facilities in Jhapa — Sanischare PHCC, Dhulabari PHCC and Prithwinagar Health Post. However these scores were not consistent with feedback provided by community people, and highlight the limitations of the Ladder of Change tool, which we will return to later.

Table 3.3: Access to services — mean scores for three focal facilities in Jhapa

Access to service indicators	Mean scores for 3 facilities	
	2014	2015
(ii) Extent to which health staff posts are filled	4.0	3.0
(iii) Level of attendance of staff	4.0	4.0
(iv) Extent to which the facility is open during opening hours	4.0	4.0
(v) Extent to which Aama entitlements are provided on time	3.3	4.0
(vi) Extent to which Aama entitlements are provided in full	4.0	4.0
(vii) Extent to which ANC entitlements are provided on time	3.7	3.7
(viii) Extent to which ANC entitlements are provided in full	4.0	4.0

Sanischare PHCC: community women reported no improvement in service during the last year.

> *"There is a doctor but we do not get his services. There is ANC check-up but no delivery service. There is a building but services are not available. We have to go to Damak for these services." — focus group discussion women, Sanischare PHCC*

Dhulabarri PHCC: Local women reported no improvement in health services during the last year, and some felt they had deteriorated. One-woman said

> *"They do not give good medicines; there are no staff at health posts as they are in their private clinics; and there is no good delivery service."*

The women's FGD gave the following suggestions for improvement:

- Staff should not quarrel among themselves and should be nice to clients.
- Doctors should not be allowed to have their own clinics and staff should not send patients to their private clinics for medicines and check-ups.
- There must be an ambulance service, delivery facility, and regular lab service.
- There must be strong monitoring of the PHCC by the DHO.

Prithwinagar Health Post: the in-charge noted that access to services had deteriorated during the past year due to a staff position becoming vacant and delays in providing Aama entitlements on time. In contrast community women in the FGD the mentioned improved availability of delivery service (which means they do not need to go to Damak or Bhadrapur anymore for these services), more medicines, lab services and staff availability as the main improvement over the year. This contradiction in perspectives illustrates the variance in perspectives of health staff and users and the importance of triangulating findings.

3.2.3 **Palpa District**

Both the Ladder of Change scores and reports from health providers, community people and district and VDC officers suggest an improvement in access to services in all four focal facilities since 2012 (Pokharathok SHP, Masyam SHP, Khanichhap SHP and Tahun PHCC). Table 3.4 shows that gaps in health staff posts filled continues to be a problem and has not improved, as well as staff attendance or opening hours or the timely provision of entitlements. This was said to reflect the lack of influence at facility level over staff postings.

Table 3.4: Access to services — mean scores for four focal facilities in Palpa

Access to service indicators	Mean scores on indicators for four facilities		
	Baseline	2013	2015
(i) Extent to which health staff posts are filled	3.0	3.3	3.3
(ix) Level of attendance of staff	2.0	3.5	4.0
(x) Extent to which the facility is open during opening hours	2.0	3.5	4.0
(xi) Extent to which Aama entitlements are provided on time	2.0	4.0	4.0
(xii) Extent to which Aama entitlements are provided in full	4.0	4.0	4.0
(xiii) Extent to which ANC entitlements are provided on time	2.0	4.0	4.0
(xiv) Extent to which ANC entitlements are provided in full	4.0	4.0	4.0

Masyam Sub-health Post: Community women at an FGD reported the following improvements over the years:

- Earlier people used to visit medical stores for services and now they come to the sub-health post for services as they trust this sub-health post.
- People know about medicines available here.
- Staff come to the sub-health post on time and distribute free medicines.
- ANC check-ups, vaccines service, malaria check-ups, free medicines and family planning methods are available at the sub-health post.

As discussed in Chapter 2, the women participating in the focus group discussion at Masyam Sub-health Post had previously participated in the social auditing process and were well aware of its objectives. They attributed improvements in health services to two factors: firstly the social audit process itself and secondly, unity among the community to mobilise resources and implement the action plan prepared by the HFOMC.

Khanichhap Sub-health Post: Table 3.5 shows how some of the access indicators at this facility have significantly improved over time. Though interestingly and as will be discussed later, Khanichhap has made less progress in terms of improving quality and accountability and management.

Table 3.5: Selected access to services scores for Khanichhap Sub-health Post

Indicators	2012	2013	2015
(i) Extent to which health staff posts are filled.	Most staff positions are filled	Most staff positions are filled	All staff positions are filled
(ii) Level of attendance of staff	Staff are mostly absent	Staff are absent only sometimes	Staff are regularly present
(iii) Extent to which the facility is open during official opening hours	There is no fixed time the facility opens (sometimes opens, sometimes does not open)	The facility is mostly open during prescribed opening hours	The facility opens during the prescribed opening hours

The women's FGD recounted wide ranging improvements in the behaviour of health staff, opening hours, availability of medicines and equipment at the facility, as well as a decrease in the number of malnourished children. The attributed these changes to the social audit facilitating NGO.

> *"Previously we were afraid of the doctors but now we are not. Previously they used to shout at us when we went to get medicines but these days they don't. Sometimes they used to say that there is no key for the store and at other times they used to leave the health post early (used to say that it was already 2pm). Now the staff stay from 10 am to 3 pm and the health post opens at 10 am. Previously we did not even get paracetamol, whereas now we get many medicines free." — Women FGD, Khanichhap Sub-health Post*

The facilitating NGO in Palpa reflected that there have been two widespread improvements since social auditing took place: the extension of opening hours to 3 pm, whereas earlier they used to close at 1 or 2 pm; and the provision of Aama and ANC incentives. The evaluation of the pilot social audit programme in Rupandehi and Palpa (2013) also found improved opening hours, typically extended by two hours a day, and improved staff attendance.

3.2.4 Rupandehi District

The Ladder of Change mean scores for access at the four focal facilities in Rupandehi suggest that there has been significant change. This picture is generally supported by district, facility and community stakeholders except in the case of Maryadpur Health Post.

Table 3.6: Access mean scores for four focal facilities in Rupandehi

Access to service indicators	Mean scores on indicators for four facilities		
	Baseline	2013	2015
(i) Extent to which health staff posts are filled	3.8	3.8	4.0
(ii) Level of attendance of staff	2.8	3.5	4.0
(iii) Extent to which the facility is open during opening hours	2.3	2.8	4.0
(iv) Extent to which Aama entitlements are provided on time	4.0	4.0	4.0
(v) Extent to which Aama entitlements are provided in full	2.5	4.0	4.0
(vi) Extent to which ANC entitlements are provided on time	3.0	4.0	4.0
(vii) Extent to which ANC entitlements are provided in full	1.5	4.0	4.0

Maryadpur Health Post: community women said that they did not trust the health post and instead preferred to go to nearby facilities across the border in India. This lack of community trust was

confirmed by health post staff, and was cited as the main reason for the health post's relatively poor performance on the accountability and quality indicators, which are discussed in later sections. However, the women did not dispute the progress concerning staff availability, attendance and opening hours (as shown in Table 3.7). Community people nearby Shivaganj PHCC in Jhapa District, which is near the Indian border, also reported not trusting the PHCC and choosing to go to a health facility across the border.

> *"There has been no improvement in health services during the last few years. They provide only paracetamol for every ailment, whether you have a headache or a fever. So we have to go to other hospitals for most cases. Due to proximity to Indian border, most go there for medicines." — Women FGD, Maryadpur Health Post, Rupandehi District*

Table 3.7: Selected access to services scores for Maryadpur Health Post

Indicators	Baseline	2013	2015
(i) Extent to which health staff posts are filled.	All staff positions are filled	All staff positions are filled	All staff positions are filled
(ii) Level of attendance of staff	Staff are absent only sometimes	Staff are absent only sometimes	Staff are regularly present
(iii) Extent to which the facility is open during official opening hours (explore official opening hours)	Mostly open but for less time than prescribed	Mostly open but for less time than prescribed	Open during the prescribed opening hours

Majhgawa Health Post: The In-charge and VDC secretary reported several improvements in health services since the introduction of social auditing. They attributed the improvements to the social auditing process. This included the establishment of a birthing centre, which was conducting over 550 deliveries a year. Community women shared their perception of significant improvements including the full staffing of the health post, but were unaware of the factors that had led to the changes.

> *"There has been much improvement in the services provided by the health post during the last few years. Previously, we used to go to Bhairahawa for health check-up whereas now the services are available here including blood check-up facilities (including diabetics and urine check-ups for NPR 50 each), mother and child check-ups, 24 hour delivery services, provision of clothes for mothers and their babies, NPR 900 provided as delivery incentive and NPR 500 for completing four ANC check-ups and taking iron pills, TB check-ups and free distribution of TB medicines." — Women FGD, Majhgawa Health Post, Rupandehi District*

Pokharbhindi Health Post: Significant improvements in access to services were reported by community people, including the availability of health staff. According to them, the reasons for these improvements were: implementation of social auditing for the last two-three years, social mobilization by the ward citizen forum member for health post improvement, construction and the donation of health post building by Sawitri Rana (previously there was no health post building).

> *"Previously, there was only one staff attending the health post whereas now four staff attend. Previously, they used to say that there were no medicines, but these days they provide free medicines. We get free check-ups, vaccines for children, ANC check-ups,*

nutrition education (via Suaahara) and iron pills." — Women FGD, Pokharbhindi Health Post, Rupandehi District

Kerwani Sub-health Post: women reported improvements in access to service and confirmed high scores for access as measured by the Ladder of Change tool. They attributed the changes to the efforts of the HFOMC, sub-health post staff and the in-charge.

3.3 Quality of services

Ladder of Change monitoring data, stakeholder interviews and field observations in the sample health facilities across the four districts show an improved quality of service, though lesser than in access to services.

3.3.1 Ilam District

Aggregated data in Table 3.8 for three facilities show that Ilam's performance on most quality indicators has been mixed with fewer medicine stock outs but stagnant and poor performance on indicators related to physical infrastructure. Scores on the adequacy of privacy provided to patients, availability of drinking water, availability of male and female toilets, and availability of waiting spaces are low and have not improved between 2014 and 2015.

Table 3.8: Quality mean scores for three facilities in Ilam

Quality indicators	Mean scores for three facilities	
	2014	2015
(i) Extent to which the facility suffers stock outs of essential medicines	3.3	3.7
(ii) Extent to which the facility provides free medicines	3.7	3.7
(iii) Overall cleanliness of the facility	2.3	2.7
(iv) Adequacy of privacy provided to patients	2.0	2.0
(v) Availability of drinking water	2.0	2.0
(vi) Availability of male and female toilets	2.0	2.0
(vii) Availability of waiting space	2.0	2.0
(viii) Way in which health providers communicate with clients, and respond to their concerns	3.0	3.0
(ix) Extent to which health providers treat people with respect and fairness	3.0	3.0

The partner NGO in Ilam reported that social auditing usually results in changes that do not require significant funds such as cleanliness, arranging displaced chairs in waiting rooms, placing and arranging inventory in the store systematically and cleaning dirty toilets. Lack of funding means that expensive improvements are less likely to be implemented. Information from Kanyam Sub-health Post and Godak Health Post (Tables 3.9 and 3.10) substantiate this view. In the other three districts scores for infrastructure-dependent indicators (for example, toilets and drinking water facilities) also tended to be lower than other quality indicators.

Kanyam Sub-health Post: Community women reinforced the need to improve physical infrastructure, but reported that the availability of medicines had improved over time. The scores

for Kanyam Sub-health Post on infrastructure related quality indicators have remained poor since social auditing was introduced in 2013/14.

The in-charge revealed that there had been no financial support to the sub-health post for the last two years due to a communication gap after the VDC came under the newly formed municipality. The municipality has not shown any interest in the health post's affairs. This case illustrates how rural health facilities can become neglected when they are absorbed into new municipalities. The minute book at the sub-health post shows that the HFOMC met in 2068 BS (2011/12) and then only in 2071 BS (2014/15) — only once in about three years.

Table 3.9: Select quality scores for Kanyam Sub-health Post

Quality indicators	Scores on indicators(poor, low, medium and high)	
	2014	2015
(i) Overall cleanliness of the facility	Poor	Low
(ii) Adequacy of privacy provided to patients	Poor	Poor
(iii) Availability of drinking water	Poor	Poor
(iv) Availability of male and female toilets	Poor	Poor
(v) Availability of waiting space	Poor	Poor

Godak Health Post: the situation here was not very different to Kanyam Sub-health Post, as the data in Table 3.10 shows and as indicated through women's demands for improvement.

> *"The health post requires additional staff, equipment and materials for check-ups and child delivery, a new building with physical space and furniture, a laboratory (for pregnancy and delivery check-up) and drinking water" — Women FGD, Godak HP*

Table 3.10: Quality indicator-wise scores for Godak Health Post

Quality indicators	Scores on indicators(poor, low, medium and high)	
	2014	2015
(i) Adequacy of privacy provided to patients	Low	Low
(ii) Availability of drinking water	Poor	Poor
(iii) Availability of male and female toilets	Poor	Poor
(iv) Availability of waiting space	Poor	Poor

3.3.2 Jhapa District

The Ladder of Change data (Table 3.11) show modest improvement in seven out of nine quality indicators for Jhapa. In the case of two indicators, availability of essential medicines and adequacy of privacy provided to patients, the scores have declined from last year.

Table 3.11: Quality indicator-wise district mean scores for three facilities in Jhapa

Quality indicators	Mean scores for three facilities	
	2014	2015
(i) Extent to which the facility suffers stock outs of essential medicines	3.3	2.7
(ii) Extent to which the facility provides free medicines	2.7	3.0
(iii) Overall cleanliness of the facility	2.7	3.3
(iv) Adequacy of privacy provided to patients	4.0	3.7
(v) Availability of drinking water	3.0	3.3
(vi) Availability of male and female toilets	2.3	3.0
(vii) Availability of waiting space	2.7	3.0
(viii) Way in which health providers communicate with clients, and respond to their concerns	4.0	4.0
(ix) Extent to which health providers treat people with respect and fairness	4.0	4.0

The poor performance of Prithwinagar Health Post and Dhulabari Primary Health Care Centre on the availability of essential medicines reduced the overall score for this indicator in Jhapa, a situation which the evaluation field visits in 2014 and 2015 confirmed.

Table 3.12: Scores for availability of medicines at Prithwinagar SHP and Dhulabari PHCC

Facility	Year	Extended periods of stock outs of essential medicines over the past 6 months.	Some periods of stock out of essential medicines over the past 6 months	Occasional stock outs of essential medicines	No stock outs of essential medicines
Prithwinagar SHP	2014				✓
	2015			✓	
Dhulabari PHCC	2014			✓	
	2015		✓		

Community women also reported no improvement in Dhulabari PHCCs services over the last year. Community perceptions of improvements at Prithwinagar Health Post related to access and not quality indicators. The VDC secretary in Prithwinagar SHP reported an increased sense of accountability and alertness about duties among sub-health post staff due to social auditing, but noted that implementation of the plan of action had been discouraging.

> *"There has been no improvement in services during the last year, rather the services have deteriorated: they do not give good medicines, there are no staff at health posts as they are in their private clinics, no good delivery service, PHCC staff have conflicts." — Women FGD, Dhulabari PHCC*

The reduction in the aggregate score on privacy for the Jhapa study facilities was due to inconsistencies in scoring at Prithwinagar Health Post, as no changes in the available physical facilities during the past year were reported.

HFOMC scoring of the behaviour of health staff towards clients was very high in Jhapa although reports from community women suggested there was room for improvement. At Sanischare PHCC women reported that the behaviour of health staff was poor and needed improving. In contrast the HFOMC scored this subject very highly. This is another example of the limitations of the Ladder of Change tool and the importance of triangulating findings.

3.3.3 **Palpa District**

Monitoring data (Table 3.13) show that there has been consistently improved performance on all but two quality indicators related to Palpa facilities' cleanliness and the availability of male and female toilets over the last four years.

Table 3.13: Quality mean scores for four facilities in Palpa

Quality indicators	Mean scores for four facilities		
	Baseline	2013	2015
(i) Extent to which the facility suffers stock outs of essential medicines	3.0	3.8	3.8
(ii) Extent to which the facility provides free medicines	3.0	3.8	3.8
(iii) Overall cleanliness of the facility	2.8	3.5	3.3
(iv) Adequacy of privacy provided to patients	3.5	3.5	4.0
(v) Availability of drinking water	1.8	3.0	3.5
(vi) Availability of male and female toilets	2.3	3.0	1.8
(vii) Availability of waiting space	2.5	2.8	3.5
(viii) Way in which health providers communicate with clients, and respond to their concerns	2.8	3.8	4.0
(ix) Extent to which health providers treat people with respect and fairness	2.5	3.8	4.0

Interviews with the DHO/DPHO and the facilitating NGO endorse improvements shown by the monitoring data vis-a-vis quality of care with reported widespread improvements at almost all facilities that had undertaken social audit.

> *"Now the health posts demand more medicines before the stocks are finished. Earlier, they did not bother about stock-out problems." — DHO/DPHO focal person, Palpa*

> *"Health providers' treatment of clients has improved. Whereas earlier they would often be rude with clients, (particularly poor ones), now they deal with clients politely." — DHO/DPHO focal person, Palpa*

> *"Last year's follow up in 23 facilities has shown that all of them except one made significant changes in the health posts with improved cleanliness, procurement, room arrangement for patients' check-up." — Partner NGO, Palpa*

Community women in all four study facilities also reported positive changes in the quality of health services including trust of health providers and provider behaviour.

> *"Earlier people used to visit medical stores for services and now they come here for the services, as they trust this sub-health post; people know about medicines available here; staff come to the sub-health post on time and distribute free medicines; ANC check-ups,*

vaccines service, malaria check-ups, free medicines, and family planning supplies are available." — FGD women, Masyam Health Post

"Previously we were afraid of doctors but now we are not. Previously they used to shout at us when we went to get medicines but these days they don't. Sometimes they used to say that there is no key for the store and at other times, they used to leave the health post early (used to say that it is already 2pm). Previously we did not even get citamol, whereas now we get many medicines free." — FGD women, Khanichhap Sub-health Post

"There is a good provision of lab reagents, supplies, instruments and medicines. There are more medicines than shown on the citizen's charter and people trust the health post. There is 24 hour service, nutrition education programme in schools and community, village clinics and vaccine programme. The community has supported in vaccination, vitamin A and other national programmes. The service providers are responsive to the clients. Delivery services are available with separate rooms for delivery and pregnancy checks." — FGD Women, Tahun PHCC

Scoring on overall cleanliness has fluctuated at Khanichhap Sub-health Post and Tahun Primary Health Care Centre since 2011/12 with both of them receiving lower scores in 2015 than 2013. Khanichhap Sub-health Post, Pokharathok Health Post and Masyam Health Post scored less in 2015 than in 2013 on the availability of male and female toilets. Although the physical availability of toilets has reportedly remained the same over time, stakeholders pointed out that lack of water and land is a problem in Palpa. Water shortages may have affected the hygienic condition of toilets and the cleanliness of facilities where staff find it difficult and time-consuming to access water — and this may have led to the lower scores in 2015. As scoring is based on perceptions inconsistencies are to be expected and hence the importance of data triangulation and field inquiry.

"Drinking water and sanitation (due to lack of water) is still a problem, despite support from the VDC and the community." — VDC Secretary, Tahun Primary Health Care Centre

"Lack of adequate physical infrastructure (too narrow building), and lack of materials and the remote location are the key constraints that affect improvement of health services." — In-charge, Khanichhap Sub-health Post

"Despite efforts by the HFOMC, the health post has not been able to progress on land acquisition and building construction. Service expansion has not been possible due to the lack of resources. The HFOMC does not meet regularly, but is active in managing health programmes organised by the health post and discussing the quality of service delivery. Clients have never complained about the services." — VDC secretary, Khanichhap

Regardless of the scores, a lack of toilets and inadequate drinking water facilities is a problem at several facilities in Palpa. These are infrastructure-related concerns that are difficult for the facility, the VDC and the district health authority to resolve.

3.3.4 **Rupandehi District**

The Rupandehi facilities have generally performed well on all indicators of the Ladder of Change tool except those related to male and female toilets and the availability of waiting space and

drinking water (Table 3.14). District stakeholders and community people confirmed improvements on various quality of care fronts at the focal facilities and those areas that are lagging.

Table 3.14: Quality indicator-wise district mean scores for four facilities in Rupandehi

Quality indicators	Mean scores for four facilities		
	Baseline	2013	2015
(i) Extent to which the facility suffers stock outs of essential medicines	3.0	3.3	3.5
(ii) Extent to which the facility provides free medicines	2.8	3.3	4.0
(iii) Overall cleanliness of the facility	2.3	2.5	3.0
(iv) Adequacy of privacy provided to patients	2.3	2.5	3.0
(v) Availability of drinking water	2.0	2.5	2.5
(vi) Availability of male and female toilets	2.0	2.5	1.8
(vii) Availability of waiting space	2.0	2.5	2.3
(viii) Way in which health providers communicate with clients, and respond to their concerns	2.3	3.0	3.8
(ix) Extent to which health providers treat people with respect and fairness	2.3	3.0	3.8

"Social auditing has made some health facilities more organized: for example, one large hall was partitioned and developed into separate rooms to ensure confidentiality during ANC check-ups; small scale repairs of the facilities were carried out (fixing locks in toilets); incinerator improved through the use of locally available drums and safety ensured. In some places, new incinerators and water tanks have been installed." — Partner NGO, Rupandehi

"There have been some improvements in quality of service at sub-health posts and health posts after the social audits by successfully campaigning for water filters at all the sub-health posts and health posts. Similarly, there have been improvements in the use of incinerators and autoclaves and waste disposal buckets." — DHO/DPHO focal person, Rupandehi

"The fund provided by the government as grant on behalf of patient registration charges (minimum of NPR 20,000 per SHP/HP) is being used for important activities such as building repairs, the purchase of furniture, instruments and medicines and the compensation of staff." (DHO/DPHO focal person, Rupandehi

"Previously, they used to say that there were no medicines, but these days they provide free medicines." — Dalit women FGD, Majhgawa Sub-health Post

Pokharbhindi Health Post: community women and the health post in-charge attributed the improvements in quality to social auditing and the support of local advocates and organisations including Satri Wara that provided a health post building. Importantly, the in-charge perceived improvement in the responsiveness and behaviour of staff to clients.

"Social auditing has generated a sense of alertness about their responsibilities among the staff. Health staff have become more responsive towards clients and have developed a

habit of responding to their queries, whereas the case was different before the start of social auditing." — In-charge, Pokharbhindi Health Post

However gaps remain at Pokharbhindi. While a new toilet for women was built as articulated in an early social audit action plan, the plan to improve drinking water has not progressed and the contribution of the VDC was felt by the in-charge to have been insufficient, which the VDC secretary explained was due to lack of resources. Pokharbhindi Health Post's experience illustrates how social auditing can help mobilise local resources for a common plan and the challenge of tackling physical infrastructure problems in a resource constrained environment.

Maryadpur Health Post and Kerwani Sub-health Post: Women at both facilities raised their demand for separate toilets for women at their mass meetings and this was included in the action plan. Other demands included improved cleanliness and a separate room for ANC check-ups. A new building is under construction at Kerwani Sub-health Post and will meet earlier action plan points to improve toilet facilities and provide waiting space. Notably the VDC secretary at Kerwani reflected on the importance of involving all concerned institutions in the social audit process and to ensure adequate funding for the activities planned, particularly those activities that require a relatively large amounts of funds.

"The Suaahara programme promised a water filter but did not provide it. As a result of implementing the action plan there is a new toilet for women. However the planned boundary wall construction, the fitting of barbed wire, and drinking water related activities have not been implemented. Similarly, the VDC has not provided funds for beds and furniture." — In-charge, Pokharbhindi Health Post

"The community is not fully supportive and therefore it is difficult to make the health post more effective. The community awareness centres are not active and operational." — VDC secretary, Pokharbhindi Health Post

"Social auditing is good and helps achieve quick results, but there must be the presence of all institutions concerned with the issues. This aspect must be considered while planning social auditing, and all relevant institutions need to be invited." — (VDC secretary, Kerwani

3.4 Management and accountability

Stakeholder interviews, field observations and the Ladder of Change monitoring data found some progress in accountability at the health facilities across the districts. However, there have been fewer improvements in accountability than on access to services and the progress has been less in Jhapa and Rupandehi than in Palpa and Ilam.

3.4.1 **Ilam District**

The aggregate accountability scores for three facilities were very good for the visibility of the Aama Programme and ANC beneficiary lists, and inclusiveness of the HFOMCs, but low for most other areas including visibility of the citizen's charter, regularity of HFOMC meetings, raising resources to improve health facilities and HFOMCs being responsive to the needs of women, poor, and excluded group people.

The findings from the Ladder of Change data were supported by the interviews and focus group discussions with district stakeholders (NGOs and DHO/DPHO) and community people, who did not report any improvement in accountability.

Table 3.15: Accountability mean scores for three facilities in Ilam

Accountability indicators	Mean scores for three facilities	
	2014	2015
(i) Availability/visibility of citizen's charter	2.3	2.7
(ii) Availability/visibility of the list of free medicines	3.0	3.3
(iii) Availability/visibility of the list of Aama beneficiaries	4.0	4.0
(iv) Availability/visibility of the list of four ANC beneficiaries	4.0	4.0
(v) Frequency/regularity of HFOMC meeting	2.7	2.7
(vi) Raising resources to improve health facility	2.7	2.7
(vii) Taking initiatives to improve service delivery	2.7	3.0
(viii) Extent to which HFOMC membership is inclusive of excluded groups	4.0	4.0
(ix) Extent to which HFOMC is responsive to the needs of women, poor, and excluded groups	2.3	2.7

The case of Kanyam Sub-health Post illustrates the lack of noticeable progress on accountability indicators in Ilam. The in-charge reported that the HFOMC met at the beginning of 2015 after a three year gap. The sub-health post has not received any financial support for the last two years from the VDC or the newly formed municipality. The sub-health post building is damaged and in very poor condition and there is no appropriate place to display the citizens charter.

3.4.2 Jhapa District

In Jhapa, modest improvements in some accountability indicators were reported through the Ladder of Change tool although the availability and visibility of the lists of four ANC check-ups and Aama beneficiaries is still a major challenge (Table 3.16).

Table 3.16: Accountability mean scores for three facilities in Jhapa

Accountability indicators	Mean scores for three facilities	
	2014	2015
(i) Availability/visibility of citizen's charter	3.0	2.7
(ii) Availability/visibility of the list of free medicines	3.0	3.3
(iii) Availability/visibility of the list of Aama beneficiaries	2.0	2.7
(iv) Availability/visibility of the list of four ANC check-ups beneficiaries	1.0	2.3
(v) Frequency/regularity of HFOMC meeting	3.3	3.3
(vi) Raising resources to improve health facility	3.0	3.0
(vii) Taking initiatives to improve service delivery	3.0	3.3
(viii) Extent to which the HFOMC membership is inclusive of excluded groups	3.3	4.0
(ix) Extent to which HFOMC is responsive to the needs of women, poor, and excluded groups	3.0	3.3

These improvements were not, however, supported by stakeholders. Community women in two of the three facilities (Sanischare and Dhulabari PHCCs) did not report any improvements in health services. At Prithwinagar Health Post the community perceived that the improvements were not related to accountability. District stakeholders (DHO/DPHO and partner NGO) did not report any specific improvements on management and accountability.

The interview with the health facility in-charge reported that Sanischare PHCC had not put up a citizen's charter, noticeboard or suggestion box as per the action plan due to lack of timely support from the DHO. However, the in-charge mentioned that they will be installed in the near future. The municipal representative emphasised the need for more support from the DHO for this facility.

Prithwinagar Health Post provides an example of how management and accountability measures are inadequate. Due to lack of appropriate space the health post had not displayed lists of ANC and Aama beneficiaries, although it had prepared such lists. It became clear that there is a lack of communication between the in-charge and the VDC secretary, and the HFOMC was not aware of its role and did not meet regularly.

Of the five activities planned after last year's social audit, only one (toilet construction) was completed, the rest were not implemented due to a lack of funds.

Table 3.17: Accountability indicator-wise scores for Prithwinagar Health Post

Accountability indicators	Scores on indicators	
	2014	2015
(i) Availability/visibility of citizen's charter	At right place and updated	At the right place and readable
(ii) Availability/visibility of the list of Aama beneficiaries	Not kept	Not readable
(iii) Availability/visibility of the list of four ANC check-ups beneficiaries	Not kept	Not readable
(iv) Frequency/regularity of HFOMC meeting	No evidence of meeting	Meets sometimes

3.4.3 **Palpa District**

Ladder of Change monitoring data shows significant improvement in almost all accountability indicators over the past four years in Palpa (Table 3.18). Except for Khanichhap Sub-health Post, the other three health facilities have reached full scores (4/4) by 2015 on almost all indicators.

Stakeholder interviews at the district and health facility level generally supported the findings.

> *"HFOMCs became aware of their roles and responsibilities and were reorganised and made inclusive as a result of the social audit process. Previously, they were inactive, non-inclusive and did not follow the government guidelines on inclusiveness. The DHO was instrumental in clarifying their roles. These changes were part of the action plans prepared at the end of the social auditing process. HFOMC meeting minutes were only kept in some facilities previously, whereas all of them keep minutes these days." — Partner NGO, Palpa*

"The health facilities have started regularly auditing their accounts. They also keep lists of free medicines (also in Devanagari Nepali Script in some places). The citizen's charter is commonly displayed in publicly visible places. Lists of mothers receiving government incentives are displayed regularly." — Partner NGO, Palpa

"Health providers' sense of responsibility and accountability has improved in general. The need to have regular meetings of the HFOMCs has been recognized. There is improvement in information sharing with the public through use of the citizen's charter and the complaint/suggestion box. They even post notices when a health post is closed for some time due to staff visits to other places for health service provision. Although many people do not care about the citizens' charter or the suggestion/complaint box and they are hardly even used, these are mandatory in the background of the government's drive for good governance." — DHO/DPHO focal person, Palpa

Table 3.18: Accountability mean scores for four facilities in Palpa

Accountability indicators	Mean scores for four facilities		
	Baseline	2013	2015
(i) Availability/visibility of citizen's charter	1.5	3.8	4.0
(ii) Availability/visibility of the list of free medicines	2.0	3.3	3.8
(iii) Availability/visibility of the list of Aama beneficiaries	1.0	4.0	4.0
(iv) Availability/visibility of the list of four ANC check-ups beneficiaries	1.0	4.0	3.0
(v) Frequency/regularity of HFOMC meeting	2.5	3.8	3.5
(vi) Raising resources to improve health facility	2.3	3.0	3.8
(vii) Taking initiatives to improve service delivery	2.0	2.8	4.0
(viii) Extent to which the HFOMC membership is inclusive of excluded groups	3.3	3.5	4.0
(ix) Extent to which HFOMC is responsive to the needs of women, poor, and excluded groups	2.0	3.3	3.8

Khanichhap Sub-health Post: This facility achieved full scores for five of the nine indicators. The four indicators for which the scores were below the full marks were:

- List of four ANC check-ups beneficiaries
- HFOMC meeting regularly
- Raising resources to improve health facility
- Extent to which HFOMC is responsive to needs of women, the poor, and excluded groups.

A steady improvement in accountability scores was seen at Masyam Sub-health Post where community women reported increased trust in the facility (Table 3.19). Accountability improvements were also endorsed by the VDC secretary who mentioned that the HFOMC met every month to discuss issues related to health and health post management. One HFOMC member had donated land to the health post. The evaluation team found the HFOMC active in managing events organised by the health post.

"Earlier people used to visit medical stores for health services but now they come to the sub-health post for these services, as they trust this sub-health post. People know about medicines available here." — Women FGD, Masyam

Community women attributed improvements in the facility to the social auditing and unity among the community to mobilise resources and implement the action plan prepared by the HFOMC.

Table 3.19: Accountability scores for Masyam Sub-health Post

Accountability indicators	Scores on indicators		
	Baseline	2013	2015
(i) Availability/visibility of citizen's charter	Not kept	At right place and updated	At right place and updated
(ii) Availability/visibility of the list of free medicines	Kept but not readable	At right place and updated	At right place and readable
(iii) Frequency/regularity of HFOMC meeting	Meets only when necessary	Meets regularly	Meets regularly
(iv) Raising resources to improve health facility	Some efforts to mobilise local resources	Regular efforts for local resource mobilisation	Concrete and remarkable efforts for resource mobilisation
(v) Taking initiatives to improve service delivery	Some efforts to improve service	Regular efforts to improve service	Notable efforts for service improvement
(vi) Extent to which the HFOMC membership is inclusive of excluded groups	Mostly inclusive	Mostly inclusive	Fully inclusive
(vii) Extent to which HFOMC is responsive to the needs of women, poor, and excluded groups	Some HFOMC members aware of the needs	Some efforts to address the needs	Efforts to remove barriers of access by the groups

3.4.4 Rupandehi District

The Ladder of Change data (Table 3.20) and stakeholder interviews showed a steady improvement in most accountability indicators in Rupandehi post-2012.

Table 3.20: Accountability mean scores for four facilities in Rupandehi

Accountability indicators	Mean scores for four facilities		
	Baseline	2013	2015
(i) Availability/visibility of citizen's charter	2.0	2.3	3.3
(ii) Availability/visibility of the list of free medicines	2.0	2.3	3.0
(iii) Availability/visibility of the list of Aama beneficiaries	1.0	3.5	2.5
(iv) Availability/visibility of list of four ANC check-ups beneficiaries	1.0	2.5	2.5
(v) Frequency/regularity of HFOMC meeting	2.5	3.3	3.8
(vi) Raising resources to improve health facility	2.3	3.0	2.8
(vii) Taking initiatives to improve service delivery	2.3	2.8	3.5
(viii) Extent to which HFOMC membership is inclusive of excluded groups	3.3	3.3	4.0
(ix) Extent to which HFOMC is responsive to the needs of women, poor, and excluded groups	2.0	2.0	3.8

Despite the improvements, the scores on some of the indicators related to visibility of Aama and ANC beneficiary lists, and raising resources to improve health facility were still low. While varying perceptions of the scorers over time may explain the movement up and down in these scores, the key message is that the display of beneficiaries of Aama and ANC entitlements was inadequate and needs improving, and that more could be done to raise local resources to improve the facility.

The partner NGO and the DHO/DPHO reported significant improvements in health services over recent years including an improvement in the display of citizen's charters, the display of free medicine lists, and the regularity of HFOMC meetings. One innovation reported by the in-charge at Majhgawa Health Post was the display of photos of all the FCHVs and their names and addresses at the facility to ease access to them and improve accountability. However, overall district and facility stakeholders and community people did not provide as many examples of improvement in accountability as was the case for improvement in access to or quality of services. In fact, the scores for access and quality tended to be higher than that for accountability in all the districts.

> *"HFOMCs meet regularly and their frequency of meetings has improved over the years." — Partner NGO, Rupandehi*

> *"The practice to write and place citizen's charter in visible and accessible place has been institutionalized mainly due to social audit. Similarly, SHPs and HPs now display lists of free medicines. Suggestion boxes are also kept at SHPs and HPs. Although many people do not read and bother about these, it is part of the Nepal government's good governance drive and we have to ensure this basic transparency." — DHO/DPHO focal person*

> *"Social auditing has increased the sense of accountability among health post staff and a suggestion box was installed as a result of the social audit. The health post has also kept photos of all FCHVs with names and addresses." — The In-charge, Majhgawa Health Post*

> *"Social auditing has improved the trust between service providers and the community. The community now consider service providers as their own." — The in-charge, Pokharbhindi Health Post*

3.5 Mobilising resources and stakeholders

The social audit process is a way of mobilising stakeholders to contribute to a joint plan of action. Observations of the mass meeting events in different locations and interviews with VDC secretaries showed that social auditing has acted as a forum to better prioritise support from the community, VDCs and other actors to improve access to, accountability of and the quality of health services at the local level. In Palpa and Rupandehi, partner NGOs also reported how overall improved awareness has spread to neighbouring health facilities and this has stimulated service improvements even before social auditing started in those facilities.

Currently, no external development partners are supporting the social audit process in the four study districts, although NHSSP provided support for two years (2011-13) in Palpa and Rupandehi. Financial and in-kind support to implement social audit action plans has mainly come from VDCs, communities and DHOs/DPHOs. Of the twenty facilities studied in this evaluation, there were just a couple of exceptions. One health facility in Rupandehi (Kerwani Health Post) received support from Care Nepal and the District Women and Children's Office (DWCO). Pokharathok Health Post in

Palpa received support from Lumbini Medical College and the Family Planning Association of Nepal. Two health facilities in Jhapa (Sanischare and Dhulabari PHCC) received funds as part of the piloting of the Cooperative Framework Agreement between MoH and MoFALD.

DHO/DPHO is the main agency initiating and managing social auditing in health facilities including the procurement of services from local NGOs to facilitate the auditing. In general, it has provided coordination support for land acquisition and service expansion (establishment of birthing centres, organization of vaccine camps), repair and maintenance and staff recruitment by facilities. Among the sample health facilities covered by the evaluation, monetary support from the DHO/DPHO was reported only for Fikkal Primary Health Care Centre, Ilam.

In Palpa, two communities and VDCs have provided land for health facility construction. VDCs have provided the most important, consistent and reliable support for implementing the action plans prepared during social auditing. While social auditing has not necessarily initiated VDC support to facilities, as they have been providing financial support since facility establishment and sometimes even helped establish them, social auditing has sensitised VDCs to the needs of their facilities and laid out plans and priorities through which VDCs can channel their funds.

Annex 3 shows the support provided by the VDCs and other partners to the focal facilities in 2014 and 2015. Table 3.21 below illustrates the key areas of support provided. Considerably more funding was leveraged in 2014/15 than 2013/14 (the amount doubled from 1.2 million in 2013/14 to NPR 2.4 million in 2014/15). Funds for FCHV incentives, staff salary and repair/construction make up the larger budget heads.

Table 3.21: Financial support provided to improve the 20 focal health facilities in the four districts 2013/14 and 2014/15

Category	2013/14 2070/71 (NPR)	2014/15 2071/72 (NPR)
(i) Repair and construction	VDC 50,000 DHO/DPHO 200,000	VDC 480,000 Care, DDC 490,000
(ii) Staff salaries	VDC 248,000	VDC 269,000
(iii) Furniture	VDC 205,000	VDC 27,600 MP's fund 100,000
(iv) FCHV incentives	VDC 246,000 DWCO 50,000	VDC 360.800 DWCO 50,000
(v) Health campaigns	VDC 188,000	VDC 67.000
(vi) Mobile clinics	0	VDC 17,000
(vii) Supplies	VDC 15,000	0
(viii) Lump sum grants	0	DDC 165,000 DHO 100,000 DHO/DPHO 165,000
(ix) Lab supplies	VDC 65,000	0
(x) Drinking water	VDC 5,000	VDC 105,000
(xi) VDC in kind support	Land acquisition	
TOTAL	1,272,000 plus land acquisition	2,396,400

Remarks:	*All values in NPR; no data available for Maryadpur, Shivganj, Kanyam*

A review of the social audit action plans in Ilam (Table 3.22) by the partner NGO (in 2014) shows that activities requiring relatively large capital outlays such as land acquisition, physical infrastructure and up-gradation of the health facilities are often not implemented due to a lack of funds. Activities around awareness and communication and quality of services are the most likely to be implemented. The evaluation of the pilot social audit programme in Rupandehi and Palpa also found less progress on physical environment and infrastructure than improving health worker behaviour.

Table 3.22 below prepared by the partner NGO sums up the status of social audit action plan implementation in Ilam district during 2012 and 2013.

Table 3.22: Activities planned during social audit and their implementation status by type of activities

Type of actions planned	No. of activities planned	No. of activities implemented	% of activities implemented
(i) Land acquisition and up-gradation of the facility	9	4	44
(ii) Physical infrastructure construction, repair and maintenance	14	4	29
(iii) Human resource management and female community health volunteer (FCHV) development	11	6	55
(iv) Medicine, tools, equipment, quality of service related	14	9	64
(v) Awareness, communication, promotion, complaints, feedback and management improvement related	15	9	60
(vi) Drinking water, electricity, toilet facilities related	10	5	50
(vii) Cooperation, collaboration and coordination	15	8	53
(viii) Planning, review and recording	12	7	58
Total	100	52	52

Source: 'Social Audit Field Report-2014', PHCRD-NHSSP/HURDEC, July 2014.

3.6 Community demands for further improvements

During our discussions with community women they identified priority areas for further health service improvements. Naturally their perceived priorities were based on the current status of the health facility and the needs of the community and so priorities differed. Table 3.23 categorises the demands by district.

Interestingly, the women in Palpa and Rupandehi listed more areas for improvement than in Ilam and Jhapa. As we found from our interaction with women participating in the mass meeting events, those in the Palpa and Rupandehi sites were more engaged and active than in Ilam and Jhapa and the higher quality and longevity of the social auditing process in the former sites may have contributed to this.

Table 3.23: Community demands by district

Category of demand	Ilam (3 facilities)	Jhapa (3 facilities)	Palpa (4 facilities)	Rupandehi (4 facilities)
(i) Building construction or expansion or improvement	✓✓		✓✓✓	✓✓
(ii) Provision of drinking water and/or toilets	✓		✓✓✓	✓✓✓
(iii) Lab service set up, expansion or improvement	✓✓	✓✓	✓✓	✓✓✓
(iv) Service improvement or expansion (village clinics, 24-hour service, birthing centre)	✓	✓✓	✓✓✓	✓✓
(v) Ambulance service	✓	✓		✓
(vi) Purchase of tools, equipment (stretchers, child weighing machine) and furniture	✓	✓	✓✓✓	✓✓✓
(vii) Additional staff/doctor	✓✓	✓	✓✓	
(viii) Provision of special attention to the poor, excluded and emergency cases			✓	✓✓
(ix) Other (better behaviour and attendance of care providers, better management of free medicines, extend service hours, better information on service)		✓✓	✓✓✓✓	✓✓✓

3.7 Broad patterns and change factors

3.7.1 Areas that are difficult to change

To identify which Ladder of Change indicators have been more difficult or relatively easy to change we calculated the mean scores of each indicator across four focal facilities in Palpa and Rupandehi each, and three focal facilities in Ilam and Jhapa each. The mean scores include three rounds of data (baseline, 2013 and 2015) for Palpa and Rupandehi, and two rounds of data (2014 and 2015) for Ilam and Jhapa. The mean scores highlight which aspects have been difficult to change, with overall lower mean scores indicating a higher level of difficulty in bringing about improvement (see results in Table 3.24). We found the following:

- Health facilities achieved 'provision of Aama entitlements in full' (an access indicator) and 'making HFOMC inclusive' (an accountability indicator) relatively quickly without much difficulty across all the districts and facilities. Achieving the Aama indicator is important and significant. The inclusiveness of HFOMCs is less straightforward to evaluate likely because there is a lack of official guidance on the preferred social representation of HFOMCs.
- Ensuring separate toilets for men and women (a quality indicator) has been difficult for Ilam, Palpa and Rupandehi. Jhapa appears to be the exception, possibly because the facilities selected were primary health care centres, which generally have better infrastructure.
- Jhapa and Rupandehi experienced difficulties making lists of Aama and ANC beneficiaries transparent. Rupandehi has additionally faced difficulty concerning use of the citizen's charter, list of free medicines, drinking water and waiting space.

- Ilam faced difficulty in ensuring the timely provision of Aama and ANC entitlements (access indicators) and ensuring cleanliness, privacy, drinking water and adequate waiting space (quality indicators).
- Two quality of service indicators related to the way in which health providers communicate and respond to clients, and the extent to which they treat people with respect and fairness, have consistently received the same scoring across all facilities during all rounds of monitoring. This raises the question as to whether the Ladder of Change tool is too blunt an instrument, especially given it is completed by the HFOMC itself, to classify the quality of staff behaviour towards clients, and should probably be dropped in future use.

Table 3.24: Subjects that are more difficult and easier to change

District	Subjects that have been most difficult to change (mean score of 2.5 or lower)
Ilam	*Access related indicators* • Extent to which Aama entitlements are provided on time • Extent to which ANC entitlements are provided on time *Quality related indicators* • Overall cleanliness of facility • Privacy provided to patients Availability of drinking water • Availability of male and female toilets • Availability of waiting space *Accountability related indicators* • Extent to which HFOMC is responsive to the needs of women, the poor, and excluded groups
Jhapa	*Access related indicators* • List of Aama beneficiaries • List of four ANC check-ups beneficiaries
Palpa	*Quality related indicators* • Availability of male and female toilets
Rupandehi	*Quality indicators* • Availability of drinking water • Availability of male and female toilets • Availability of waiting space *Accountability indicators* • Citizen's charter • List of free medicines • List of Aama beneficiaries • List of four ANC check-ups beneficiaries
Districts	**Subjects that have been easier to change (mean score 3.5 or higher)**
All districts	*Access indicators* • Provision of Aama entitlements in full *Accountability indicators* • Making HFOMC inclusive

3.7.2 **Attribution of improvements**

Attributing the reasons for the positive changes recorded by the Ladder of Change tool and reported by stakeholders and observed by the evaluators is not easy. All the positive changes are very unlikely to only be due to the practice of social auditing. There are other factors, although at many of the study sites social auditing has contributed to the change process.

As we heard from district, facility, VDC and community stakeholders, social auditing has had varying degrees of influence across the study sites. This variation has been influenced by the level of political and administrative support for social auditing, the initiative and commitment of health facility in-charges, the quality of NGO facilitators, the initiative and activeness of the HFOMCs, the participation and mobilisation of communities and local civil society organisations, the support of VDCs, and the commitment and capacity of the DHO/DPHO and the heads of these offices in managing the social audit process itself.

4 KEY ISSUES FOR THE FUTURE OF SOCIAL AUDITING

Interviews with partner NGOs, DHOs/DPHOs and central level stakeholders (including external development partners), and observations of the social audit process at different facilities have revealed key issues facing the social audit process as presented in Chapters 2 and 3. All these issues directly or indirectly relate to provisions in the Social Audit Guidelines. The effectiveness and efficiency of the social audit process in the future will depend on how well these issues are tackled, and this will require revising the guidelines. The proposed areas of revision and related feedback are grouped into three parts and discussed in the following sections:

- Revision of the prescribed processes
- Revision of the prescribed tools
- Ladder of Change tool and community scorecard.

4.1 Revision of the prescribed processes

The evaluators closely observed the process followed and tools used by the partner NGOs in the health facilities during the social auditing process. Through our observations we assessed:

- Whether the prescribed steps and tools were utilised
- Whether the partner NGOs understood the reason behind the steps and tools
- Whether the NGOs encountered problems in following the steps and tools
- Whether the prescribed steps and tools added value to the effectiveness of the process

The observations identified issues related to the prescribed process and tools. The list of issues were discussed and verified with the NGOs and DHOs/DPHOs. Besides expressing their views on the evaluator identified issues the partner NGOs and DHOs/DPHOs also provided additional feedback on the social audit process and tools. Some of these issues were also discussed intensively and verified with two ex-officials of PHCRD before concretising the feedback on the process and tools. The feedback presented here provides valuable inputs for revising of the Social Audit Guidelines to make them more relevant to the ground realities and to make the whole process of social auditing more efficient. The feedback has been organised following the sequential order of the clauses of the guidelines.

Chapter-2: Implementation strategy

a) The formation of a local social audit group/committee under clause **2.4.5.1 (i)** of this section is redundant.

b) Clause **(iv)** of this section is sufficient to ensure that the social auditors are properly assisted by members of the HFOMC.

c) Removal of clause (i) makes sections **2.4.5.2** (formation of local support group) and **2.4.5.3** (role of local support group) redundant.

d) The reference to local social audit support group under section **3.5.2** needs to be removed if the provision related to formation of this group is removed.

e) There is a provision of 15-day notice for inviting NGOs or individuals as the first step of the selection process under clause **2.4.6.1 (i)**. The NGO selection process is, however, too time consuming, taking more than two months and therefore measures must be taken to reduce the

time to ensure timely completion of social auditing. One option suggested by a focal person in one district health office was to reduce the notice period to 7 days from the current provision of 15 days, since the partner NGOs are selected from within the district. A strategic and longer term additional option would be to build provision of multi-year agreement with the selected NGOs for a period of three years, by taking approval from the Ministry of Finance. The current provision of "multi-party agreement" under clause **(v)** could be replaced by "multi-year agreement of three years." This proposed provision will also alleviate the negative impact of political pressures from interest groups during NGO selection process.

f) The provision to select individual auditors (clauses **2.4.6, 2.4.6.1**) needs to be removed since the selection of individual auditors is not feasible. Instances of individual auditor selection have never been reported from any of the 45 districts currently involved in social audit implementation. It is not likely that new districts in remote locations would go for individuals rather than an NGO.

g) One focal person (DHO/DPHO) also suggested modifying clause **2.4.6.2 (ii)** related to qualification required of an NGO, and recommended to have only social audit experience and removing "or social mobilisation experience" to avoid too many unqualified applications from NGOs, as all NGOs tend to have such social mobilisation experience. The concern is valid in the case of districts implementing social audit for one or more years. It is not clear whether there will be sufficient number of NGOs with social audit experience in new and possibly remote districts. Therefore the provision should be kept but the scoring system must be tightened up by an additional clause in the guidelines elaborating the scoring and rating of NGOs using prescribed criteria.

h) There are no clauses relating to deducting value added tax (VAT) from NGO payments. To be on the safe side, the DHO/DPHO Rupandehi has started deducting VAT from NGO payments. An additional clause is needed to clarify this issue.

i) Only one DHO/DPHO strongly opined that the District Level Social Audit Committee (clause **2.4.4.1**) was redundant, stating that a meeting with the LDO was usually very difficult to arrange and the NGO selection process was always delayed due to this. LDOs are very busy in all districts and arranging meetings with them is not an easy task. However, DHOs/DPHOs in other districts did not mention this issue. Given the likely future direction of social auditing in the light of the newly implemented collaborative framework approach between the MoH and MoFALD, the district social audit committees headed by the LDOs appear to be the only logical option to continue despite the problems mentioned by one DHO/DPHO.

j) The Public Procurement Act prescribes five technical criteria for the prequalification and selection of partner NGOs, but the Social Audit Guidelines under this section provides seven criteria. The last two criteria (number 6 and 7) under clause **2.5.1**are redundant and need to be removed, as they are well covered by previous criteria. Once the clause related to the use of individual social auditors is removed, this recommendation will not be required.

k) One partner NGO also suggested appointing facilitators with the minimum educational attainment of bachelor's level under clause **2.5.1 (ii)** to avoid unhealthy competition between NGOs and ensure quality work. However, no other NGOs and stakeholders raised this issue. The suggestion could be fine for some districts, but might create unnecessary problems in some (particularly the remote ones). Therefore some modification of the clause is suggested to

the effect that "candidates for social auditor should have a bachelor's degree and candidates with lower degrees can be accepted only if candidates with bachelor's degree are not available."

l) No instances of the mobilisation and use of local resource persons under clause **2.5.3** were observed during the evaluation. One of the auditors from the partner NGOs was doing the task prescribed for the local resource person by the guidelines. This clause is redundant given the marginal budget that the NGOs receive for their assignments and the usually short span of time for which the NGOs are hired.

m) Clause **2.7** (related to the mobilisation of mass communication media) is silent about the responsible agency for ensuring mass communication of the social audit process and outcomes. Either the DHO/DPHO should be made responsible for this with adequate budgetary support or the clause is better removed.

Chapter-3: Stages and process of social audit

Section 3.1 Time required for social auditing (first time)

a) Clause 3.1 (efforts required of social auditors for the first social audit) needs to be revisited. The budget for the NGOs' facilitating activities is insufficient considering the tasks, time and personnel required. The amount also does not consider the involvement of the NGO personnel at the one-day information sharing workshop at district level at the end of the social audit. The cost also does not factor in annual inflation over the year. Although, the guidelines provide scope for the DHO/DPHO to add days required for travel to (remote) health facilities, the social auditors have not been compensated for the extra efforts in Ilam or Palpa. None of the DHOs/DPHOs are budgeting for this extra cost despite the provision in the guidelines.

b) The budget should be re-worked out based on the revised process and tools for full social auditing and brief social auditing. A simple 'social audit reference framework' (see Table 4.1), could be prepared and used to simplify and cost the tasks of partner NGOs. (The 'tools/aids' need to be worked out. "Reference" refers to the annex number of the aid/tool to be developed by PHCRD if this recommended framework is accepted by them.)

Table 4.1: Suggested draft social audit reference framework

Steps and processes	Aids/tools	Reference
1. Create a baseline health facility fact sheet showing access, accountability and quality of health services		
1.1 Meet with HFOMC members and health facility staff		
1.2 Undertake group discussions with two relatively disadvantaged communities (wards/settlements) within the catchment area of the health facility		
1.3 Observe the health facility premises and conduct exit interviews with six clients		
1.4 Complete preparatory work for the mass meeting and draft a baseline health facility facts sheet		
1.5 Share and finalise draft baseline fact sheet with HFOMC and health facility staff, agree on the date for mass meeting event and agree on responsibilities for preparation of the mass meeting.		

Steps and processes	Aids/tools	Reference
2. Develop plan of action for health service improvement as part of the mass meeting		
2.1 Draft plan of action based on the baseline fact sheet		
2.2 Facilitate mass meeting event (start, present baseline fact sheet and then facilitate open discussions after the presentations)		
2.3 Update (add, delete, or modify) draft plan of action based on discussions and feedback		
2.4 Present and further modify, if necessary, plan of action at the plenary session and close the mass meeting		
2.5 Hold debriefing meeting with HFOMC and health facility staff to discuss next steps and roles. Leave copy of the action plan with HFOMC and in-charge.		
3. Report to DHO/PHO		
3.1 Organise NGO level reflection meeting involving all social auditors and document lessons for the future		
3.2 Draft assignment completion report		
3.3 Share and finalise the draft report with DHO/DPHO		
3.4 Submit request to DHO/DPHO for final payment as per the contract		
3.5 Settle accounts with the DHO/DPHO		

c) Clause 3.2 (efforts of social auditors for the abridged version of social audit) needs to be revisited. Although the guidelines have outlined the abridged version of social audit, new NGOs in Jhapa and Palpa were not clear as to what to do and how to do it. They asked the evaluating consultants about the provisions in the guidelines. There are obvious weaknesses in the orientation training provided to the NGOs. The conclusion here is that the social auditors were not adequately trained.

d) The 'old' NGOs in Palpa and Rupandehi had difficulty making the process brief as they more or less followed the steps of the full version. They were also not fully clear about this. The focal person in Rupandehi had suggested to the partner NGO not to put in too much effort and resources into the brief version. For the brief version, the partner NGO in Rupandehi organised the following three events:
   - Orientation to the HFOMC and health facility staff on the upcoming follow-up.
   - Meeting with the HFOMC and health facility staff reviewing the performance.
   - Mass meeting attended by as many people as would have participated in the first social audit.

e) During follow up, orientation is required only in cases where there is a new health post in-charge or new VDC secretary. Deciding on the date and time of the mass meeting can easily be done via phone or individual meetings. (In one facility in Rupandehi, the NGO staff spent three hours waiting for the HFOMC members to arrive for the orientation.)

f) The other extreme is the case of Ilam. The partner NGO in Ilam visited the health facility, reviewed the status of implementation of the previous action plan, drafted a modified version of the action plan and submitted it to the DHO/DPHO in its task completion report.

Clauses 3.6.1 and 3.6.2 (action plan preparation during one-day district level seminar)

g) Interviews with the NGO partners and DHOs revealed that the one-day district level seminar focused on sharing the key findings of social auditing. A district level action plan was, however, not prepared at the end of the seminars despite the directive in the Social Audit Guidelines to prepare a district level action plan.

h) The directive concerning action plan preparation and subsequent follow up of the action plan implementation in the guidelines is too ambitious for a one-day seminar attended by diverse participants (line agencies, civil society organisations, journalists, human rights activists, representatives of business associations and so on).

i) The two clauses are, however, useful if the aim is limited to disseminating information about social auditing conducted and promoting the social audit process, as an integral part of clause **2.7** (related to mobilisation of mass communication media). One option could be to task the DHO/DPHO office with developing an action plan for following up on social audits.

4.2 Revision of the prescribed tools

Different tools are prescribed in the Social Audit Guidelines, as annexes, and sometimes as tables and checklists within the main text. The practitioners (mainly partner NGOs tasked with implementation and reporting of social audit and the social audit focal persons in DHOs/DPHOs) have raised issues and concerns about some of the tools. The specific feedback on different tools are presented below following the sequential order of the annexes in the guidelines.

The tools or formats prescribed for information collection under section 3.6.2 of the Guidelines that require revision or removal include the following:

- Information about staff attendance
- Information as per Annex 3 (description of beneficiaries)
- Information about clients receiving various services
- Information as per Annex 6 (exit interview)
- Information as per Annex 8 (community interview)
- Information as per Annex 9 (findings presentation)
- Information as per Annex 10 (community scorecard)

a) *Information about staff attendance* — Checking the attendance record is not very useful as full attendances are often shown for staff even when they are absent. The staff sign their attendance records for several days at a time irrespective of whether they were really present or not. Some clients said that the staff come only three times a week but the attendance book shows that they are regularly present. The public has no way to verify if staff are really on deputation elsewhere or on approved leave or what. The information regarding presence of staff in health post is not only difficult to get but might also create a rift between NGO auditors and health facility staff. This issue could be built appropriately into some other processes and tools (exit interviews with clients, discussions with relatively disadvantaged groups, meetings with HFOMC and staff), and during the mass meetings.

b) *Annex 2. Inventory records of medicines* — All the NGOs in the four districts agreed that the task of getting information specified by this tool was extremely time consuming and not useful for the social audit participants. The health facilities do not keep the information properly.

When the social auditors approached for the information, they virtually ended up preparing the information themselves. The information regarding stock is not only difficult to get but might also create a rift between the NGO auditors and health facility staff. The problem was also been realised by the social audit focal persons and health facility in-charges. What actually matters to the participants of social audit mass meetings is the number of instances when they were refused the essential free medicines by the health facilities due to a stock out problem. This issue could be appropriately built into other processes and tools (exit interview with clients, discussions with relatively disadvantaged groups, meeting with HFOMC and staff), and during the mass meetings.

c) *Annex 3. Beneficiaries of vaccines, family planning and safer motherhood programme* — First of all, the information required is usually not available in most health facilities due to poor record keeping. For example, the number of women who get check-ups within 24 hours of child delivery is not recorded by health posts and getting reliable information on this is simply not possible. Only partial information is available in some of the facilities. Considering the time and resources required to compile this information and the final usefulness of the information, the tool is better replaced by a simpler one. Comparison of target achievements on vaccines, family planning and the Aama programme between two subsequent years as intended by the format is not viable. This issue needs to be addressed during the development of a new process with modified tools.

d) *Annex 6. Exit interviews with clients* — The NGO partners pointed out that the current format for exit interviews is loaded with too many questions and the format needs to be simplified by removing some of the questions (e.g. numbers 7, 9, 11 and 12). This issue needs to be addressed during the development of a new process framework with modified tools (as suggested in Section 4.1 and Table 4.1 above). The NGOs also found question 1 of Annex 6 (why did you select this health facility) redundant, as the villagers in most cases did not have a choice. Similar is the case with question 8 (how long did it take you to get the service). Questions like these could be fine for a quantitative survey. When the exercise is asking the question to five persons in a SHP or HP, as per the prescription of the guidelines, it is not possible to draw appropriate and workable conclusions. Asking a more general question such as “did you face difficulties in availing of services?” would be more useful.

e) *Annex 9. Presentation of findings by the NGO* — Based on issues described previously, the format for presentation by the NGO on the day of the mass meeting needs to be modified in line with the recommended process and tools.

4.3 Ladder of Change tool and community scorecard

4.3.1 **Community scorecards**

Ilam had not been using a community scorecard after a brief experimentation in two facilities at the beginning of social auditing in the district. During the evaluation process in 2015, however, they did use scorecards in two new facilities. Scorecards were not always used in Jhapa too. When the scores of different persons differ widely, its usefulness is doubtful.

There is a high possibility that scorecards will be filled in by persons who might not have taken services from the health facility and this might distort the picture. The people who end up filling in

community scorecards are often not representative of facility users in the strict sense, and usually are highly heterogeneous. Their views therefore tend not to be representative. Observation of the use of the tool during mass meeting events in the districts shows that it is more of a ritual than a useful tool for participants.

4.3.2 **Ladder of Change monitoring tool**[6]

A. Access to services

The indicators under part A of the tool (Access to services — see Annex 2) focus on (i) filled staff positions and attendance, and (ii) the full and timely receipt of delivery and ANC incentives by mothers. However, in many health facilities, birthing centres are not available. Other more important indicators of access to services such as access to village clinics, vaccines centres or other outreach facilities by all settlements or wards within the catchment of the health facility, could be added to the Ladder of Change. The formulations of the indicators in community scorecards (in Nepali) are much better and simpler than the ones in the English language Ladder of Change.

During the evaluation we found that scoring "the availability and attendance of health staff" was practically very difficult to do. NGOs have reported a mismatch between actual attendance of staff and what is recorded in attendance registers: the clients told how some staff members actually only attended three times a week when the attendance register showed daily attendance. For local people it does not matter whether the staff are on official leave, training or deputation in which case they are recorded as present but are actually not in post providing services. On the other hand, the health facility staff expressed that it is not practical to expect staff to work without leave, training or deputation opportunities. Another issue raised was whether staff attendance should be scored so high if the government-appointed permanent staff are absent for official reasons, but services are provided by contract staff hired to temporarily replace them.

The evaluators have the impression that whatever scoring related to staff attendance the participants agree on after a long debate or without any discussion, such scores are not useful. In similar situations, two health facilities are likely to be scored very differently. For local people, what mattered was the availability of staff during their visits to the health facility. The issue has been discussed in sub-section 3.2 when considering the Level of attendance of staff. The issue is pertinent as a discussion point during social audits (for example, whether some clients could not receive service due to absence of a health staff during the last one year) but not as an indicator for the Ladder of Change monitoring tool.

The scoring related to opening hours was also observed to be weak. A number of people did not even know the prescribed office hours for their health facility. The health staff thought that opening the office between 10 am and 2 pm was the standard, whereas some people expected it to be open till five pm. Some people even thought that it should be open around-the-clock. Therefore clarification is required on the standard for scoring before it can become useful. The wide dissemination of health facility opening times and working hours through the national media was recommended by the 2013 evaluation of the pilot social audit programme in Rupandehi and Palpa (Devkota et al. 2015.

[6] The Ladder of Change tool is not part of the social audit tool kit but is a monitoring tool introduced by NHSSP for evaluation purposes.

In Palpa and Rupandehi, the opening hours have been extended to 3 pm. In Ilam and Jhapa the opening time is up to 2 pm as in the rest of the country. A more practical way to formulate the question would be ”the official opening hours of a health post is 10am-2pm; given this how do you score the opening hours of this facility?”

B. Accountability and Management

Under accountability and management, scoring on the inclusiveness of the HFOMC was usually problematic. The health facility, as a government entity, follows its own rules of inclusion and it was observed that most of them were following the government prescribed rules. In the absence of a new rule to guide health facilities, the scoring is meaningless. For a government entity, following the government prescribed rules of inclusion is considered good enough and they would not like to go beyond these rules. Therefore a clarification regarding what percentage of which kind of people from which groups should be represented in the HFOMC (in line with the government rules) should be added to make the scoring meaningful.

The indicator related to HFOMC meetings needs to be rewritten. Many HFOMCs meet even 9 times a year (checking their attendance showed this), but scored themselves only ‘3’ (meets as necessary) instead of ‘4’ (meets regularly) due to confusion in the wording of the indicator. The scoring on the indicator could be formulated something like that given in Table 4.2.

Table 4.2: Suggested scoring criteria for regularity of HFOMC meetings

Scoring basis	Score
HFOMC met at least four times during the last year	4
HFOMC met three times during the last year	3
HFOMC met two times during the last year	2
HFOMC met at most one time during the last year	1

C. Quality of services

Under quality of services, the scores on the following two indicators has been consistently the same across all facilities in all districts during all rounds of monitoring due to the practical difficulty at community or health facility level to distinguish the subtle difference between the two:

- Way in which health providers communicate with clients, and respond to their concerns.
- Extent to which health providers treat people with respect and fairness.

Another issue was also observed while the HFOMCs were assessing these indicators. Some facilities have many staff and so how to assess the average behaviour? Some health staff’s behaviour will be good and other’s bad. How to rate, whom to rate? In the Nepalese context, it is advisable to merge the two into one issue along the following lines as per the community scorecard (Nepali version):

- How do you find the behaviour (the way they talk, the way they listen, the way they convince and so on) of the staff of this health facility?

Comparison of scoring in old and new facilities

A further complexity is the fact that new 2015 facilities in the study sample generally received higher starting scores than earlier sites. This could be the result of scoring errors, small sample size or that new facilities were less challenged than sites that had been selected for social audit in earlier rounds. Future evaluations will need to consider this.

5 CONCLUSIONS AND RECOMMENDATIONS

5.1 Conclusions

The evaluation of the social auditing process in four selected districts (in 10 sample health facilities during 2014 and 20 sample health facilities during 2015) clearly shows that the practice of social auditing has contributed to the improved governance of health services at the local level. In particular, social auditing has contributed to improving access, accountability, management, and quality of services at the majority of the evaluated sites to varying degrees. The access to services indicators have been faster to improve than quality or accountability.

Gains have generally been greater in the Palpa and Rupandehi sites where social auditing has been more continuously practiced than in the other two districts' sites,[7] and the training and quality of NGO facilitation has been good, and has benefitted from past NHSSP support. The commitment and involvement of DHOs/DPHOs and the support of VDCs are other key enabling factors. Where implemented well, social auditing has strengthened the relationship between service providers and local communities, increased the participation of women in health facility monitoring, and improved the functioning of HFOMCs. At all locations, social auditing has acted as a forum to prioritise and mobilise support from the local communities, VDCs and other actors to improve the provision of health services. The responsiveness of the central level has however been less than optimal and the capacity of PHCRD to manage and coordinate central level responses to local social audits needs strengthening.

The implementation of the Collaborative Framework between MoH and MoFALD has serious implications as to how social auditing is handled in the future. There a clear need for considerable capacity building and systems development if local bodies are to take over the social auditing of health facilities from MoH. Health sector stakeholders are concerned about losing the health-specific aspects of the social audit function if the local bodies absorb the process. Local bodies are concerned about their lack of preparedness and capacity for taking over such a responsibility. Further collaborative planning between the two ministries is needed to develop a plan for testing whether and how local bodies can take on the responsibility of the social auditing of health facilities.

In the short to medium term while MoH remains responsible for social audit, a number of areas need strengthening to increase the impact of social auditing and its effective replication in remaining districts and health facilities. These include the following:

- Updating the social audit guidelines, 2013 to include a simplified social audit process and tools.
- Improving the quality of social auditing through the better training of partner NGOs and better mechanisms for NGO selection and retention.
- Improving the role of health facilities and in-charges in the social auditing process by providing them with a copy of the social audit guidelines, keeping a copy of the most recent action plan at the facility and clarifying the role of in-charges in the guidelines.

[7] Ilam and Jhapa

- Ensuring social auditing is annually supported for a minimum of three years in facilities where it is introduced, and thereafter after three years.
- Revising budget allocations to cover the costs of implementing the social audit process as defined by the guidelines.
- Strengthening the capacity of PHCRD to manage the social audit programme and coordinate central level responses to local problems and actions triggered by the social auditing process.
- Developing and implementing an appropriate transitional plan to gradually hand over the social audit function to local bodies.

5.2 Recommendations

The evaluation recommends PHCRD to implement the following actions to improve social auditing:

- Revise the Social Audit Guidelines, 2013, considering the points discussed above in Sections 4.1 to 4.4.
- Develop and enforce an appropriate mechanism to select and retain competent NGOs.
- Develop and enforce mechanisms to improve the quality of training to partner NGOs.
- Review and revise budget allocations to cover the costs of implementing the social audit process as defined in the revised guidelines, and ensure NGO facilitation costs are adequately covered.
- Develop and implement a 3 to 5 year transition plan to gradually hand over the social auditing function to the local bodies

Annex 1: Persons Interviewed (Rounds 1 and 2)

	Name	Post and organization
Central level personnel		
1	Dr Ramesh Kharel	Chief, PHCRD
2	Achyut Lamichhane	Acting Director, NHTC
3	Rup Narayan Khatiwada	Department of Health Services, Teku, Kathmandu
4	Dr Bal Krishna Suvedi	Ex-chief, PHCRD
5	Shova Lama	Health4Life, Lalitpur
6	Dr Damodar Adhikari	Health4Life, Lalitpur
7	Sitaram Prasai	GESI Advisor, MoH, Kathmandu
8	Deborah Thomas	GESI Consultant, Options Co Ltd, London
Ilam District		
1	Raj Kumar Pokharel	DPHO Chief
2	Chhabi Lal Khatiwada	Focal person DPHO
3	Madan Koirala	LDO, DDC
4	Cholaraj Pokharel	Planning Officer, DDC
5	Mahendra Chauhan	Internal Auditor, DDC
6	Kamal Nepal	Focal person, NCDC, partner NGO
7	Rasmina Dhakal	Social auditor, NCDC
8	Pradeep Ghimire	Social auditor, NCDC
9	Prakash Khatiwada	Social auditor, NCDC
10	Subodh Niraula	Social auditor, NCDC
11	Parshuram Ghimire	Chairperson, Shakhejung HP HFOMC
12	Murari Prasad Dev	In-charge Shakhejung HP
13	Raj Kumar Yadav	In-charge Kanyam SHP
14	Pankaj Kumar Yadav	Acting In-charge Kanyam SHP
15	Damber Katuwal Nirvik	Principal, Shri Krishna Sharma School & member Kanyam SHP HFOMC
16	Hem Bahadur Fago	Chairperson, HFOMC PHCC, Fikkal
17	Gayetri Prasad Niroula	Assistant Health Worker PHCC, Fikkal
18	Gita Prasad Niroula	In-charge PHCC, Fikkal
19	Fajung Sherpa	Acting In-charge PHCC, Fikkal
20	Milan Sherpa	ANM PHCC, Fikkal
21	Dhan Bahadur Pakhrin	In-charge SHP Godak
22	Gobinda Prasad Adhikari	Member of HFOMC SHP Godak
23	Nirmala Rai	Office Assistant, SHP Godak
24	Padam Bahadur Katuwal	In charge SHP Panchakanya
25	Budha Bahadur Lopcha	Member HFOMC Panchakanya SHP
26	Bineswar Prasad Sah	In-charge, Cheesapani HP
27	Mr Ram Kumar Khadka	HFOMC Chair
28	Mr Puskar Kandel	In-charge Laxmipur HP
29	Kamal Bahadur Bhandari	HFOMC Chair, Laxmipur HP

	Name	Post and organization
Jhapa District		
1	Chandra Dev Mehata	In-charge DPHO
2	Brajesh Gupta	Focal person DPHO, Jhapa
3	Phanindra Dahal	LDO
4	Him Raj Sedai	SDO
5	Rudra Sitaula	Chairperson Birat Samudayik Adhan Kendra
6	Arjun Pathak	Focal person Birat Samudayik Adhan Kendra
7	Prem Newpane	Birat Samudayik Adhan Kendra
8	Dr. Sandarva Adhikari	In-charge PHCC Sanischare
9	Mohan Paneru	Chairperson HFOMC, PHCC Sanischare
10	Rudra Prasad Neupane	HFOMC Chair (2015), PHCC Sanischare
11	Rewati Raman Gautam	In-charge (2015), PHCC Sanischare
12	Som Raj Dhakal	Focal person Samudayik Bikash Manch
13	Hari Karki	Focal person Samudayik Bikash Manch
14	Krisna Prasad Panthi	Chairperson Management committee
15	Dr Raju Sedhain	In-charge PHCC Dhulabari
16	Sashi Kala Rai	Nurse PHCC Dhulabari
17	Indra Prasad Aryal	In-charge (2015) PHCC Dhulabari
18	Ram Narayan Yadav	In-charge Prithivinagar HP
19	Kumud Chandra Jha	Chairperson HFOMC Prithivinagar
20	Madan Kumar Kadel	Chairperson (2015) HFOMC, Prithivinagar
21	Netra Prasad Dahal	In-charge (2015) Prithivinagar HP
22	Tikaraj Bardewa	In charge Pathamari HP
23	Babu Ram Dhakal	Chairperson HFOMC Pathamari HP
24	BisheswarMandal	In charge Haldibari HP
25	Lakchami Pr Pokharel	Member HFOMC (teacher) Haldibari HP
26	Madan Kumar Kadel	Chairperson HFOMC Haldibari HP
27	Jayanath Chaudhary	In-charge, Shivaganj PHCC
28	Hari Prasad Guragai	Municipal chief, Chair HFOMC Shivaganj
Palpa District		
1	Rajendra Prasad Ghimire	In charge DPHO
2	Biswa Neupane	Focal person DPHO
3	Krishna Prasad Pandey	LDO, DDC
4	Bimala Gyanawali	Grameen Bikaska Lagi Sahayogi Hatharu (HRD)
5	Sangita Regmi	Grameen Bikaska Lagi Sahayogi Hatharu (HRD)
6	Bishnu Dev Khanal	In-charge, Kusumkhola HP
7	Ibindra Raj Basyal	Chair, HFOMC, Kusumkhola HP
8	Saroj Kafle	In-charge, Pokharathok HP
9	Khim Bahadur Rana	Chair, HFOMC, Pokharathok HP
10	Keshab Darnal	In-charge, Khanichhap SHP
11	Kul Prasad Aryal	Chair, HFOMC, Khanichhap SHP

	Name	Post and organization
12	Laxmi Narayan Basyal	In-charge, Masyam HP
13	Krishna Prasad Aryal	Chair, HFOMC, Masyam HP
14	Bishnu KC	In-charge, Tahun HP
15	Bimal Kumar Chaudhary	Chair, HFOMC, Tahun HP
Rupandehi District		
1	Rishi Prasad Lamichhane	In-charge DPHO
2	Thaneshwor Kharel	Focal person DPHO, Jhapa
3	DB Khati	Focal person, partner NGO, RCDC
4	Shiva Neupane	Social auditor, RCDC
5	Biswa Prakash Aryal	LDO, DDC
6	Kamala Bhandari	In-charge, Padsari SHP
7	Suman Chandra Thakur	Majhgawa HP In-Charge
8	Ram Niwas Chaudhary	Pokharbhindi HP In-Charge
9	Iswari Prasad Dhungana	Kerwani SHP In-charge
10	Tikaram Ghimire	Sakraun Pakadi SHP In-charge
11	Rakesh Kumar Mehta	In-Charge, Maryadpur HP
12	Achyut Bhattarai	Chair HFOMC, Padsari SHP
13	Hansaraj Chaudhary	Chair HFOMC, Majhgawa HP
14	Lekhanath Aryal	Chair HFOMC, Pokharbhindi HP
15	Ganesh Prasad Ghimire	Chair HFOMC, Kerwani SHP, Municipality Chief
16	Kulmani Basyal	Chair HFOMC, Sakraun SHP
17	Raju Sharma	Chair HFOMC, Maryadpur HP

Annex 2: Ladder of Change Monitoring Tool[8]

Name of health facility
Ladder of change monitoring tool for social auditing
Scores for retrospective baseline of the situation immediately prior to the social audit process

A. Scores for access to services (based on community perceptions and evidence from facilities)

Level	1	2	3	4
a. Availability and attendance of health staff	**Poor**	**Low**	**Medium**	**High**
Extent to which health staff posts are filled	Most health staff posts are not filled.	Some health staff posts are not filled	Most health staff posts are filled	All health staff posts are filled
Level of attendance of staff	Staff are mostly absent	Staff are often absent	Staff are occasionally absent	Staff regularly attend their posts
b. Opening hours				
Extent to which the facility is open during official opening hours (explore official opening hours)	Open only irregularly.	Generally opens fewer than the mandated hours per day	Generally open during official hours	Consistently open during official hours
c. Timely and appropriate provision of Aama incentive				
Extent to which entitlements are provided on time	Entitlements consistently provided late	Many reports and/or much evidence of entitlements not being paid on time	Few reports and/or little evidence of entitlements being provided late	No evidence or reports of entitlements being provided late
Extent to which entitlements are provided in full	Payments of less than the full amount consistently provided	Many reports and/or much evidence of entitlements not being paid in full	Few reports and/or little evidence of entitlements not being paid in full	No evidence or reports of entitlements not being paid in full
d. Timely and appropriate provision of 4ANC incentive				
Extent to which entitlements are provided on time	Entitlements consistently provided late	Many reports and/or much evidence of entitlements not being paid on time	Few reports and/or little evidence of entitlements being provided late	No evidence or reports of entitlements being provided late
Extent to which entitlements are provided in full	Payments of less than the full amount consistently provided	Many reports and/or much evidence of entitlements not being paid in full	Few reports and/or little evidence of entitlements not being paid in full	No evidence or reports of entitlements not being paid in full

[8] Source: Devkota B, S Ghimire and BD Neupane (2013). Social Auditing Pilot Programme In Rupandehi and Palpa Districts: Evaluation Report. Kathmandu: Ministry of Health and Population and Nepal Health Sector Support Programme

B Scores for accountability and management (based on community perceptions and evidence from facilities)

Level	1	2	3	4
a. Provision of information	**Absent**	**Limited**	**Good**	**Comprehensive**
Extent to which health facility displays accurate info. to public				
(i) Citizen's charter	Not displayed	Displayed but not accessible, e.g. in English or in a place which cannot easily be seen	Displayed and accessible	Displayed, accessible, and reported to be updated by health staff
(ii) List of free medicines	Not displayed	Displayed but not accessible, e.g. in English or in a place which cannot easily be seen	Displayed and accessible	Displayed, accessible, and reported to be updated by health staff
(iii) List of Aama beneficiaries	Not displayed	Displayed but not accessible, e.g. in English or in a place which cannot easily be seen	Displayed and accessible	Displayed, accessible, and reported to be updated by health staff
(iv) List of 4ANC beneficiaries	Not displayed	Displayed but not accessible, e.g. in English or place not easily seen	Displayed and accessible	Displayed, accessible, and reported to be updated by health staff
b. Functioning of HFOMC	**Poor**	**Moderate**	**Well**	**Exceptional**
Extent to which the HFOMC is functioning				
(a) Meeting regularly	Meetings reported never to be held	Meetings reported to be held rarely	Meetings reported to be held occasionally	Meetings reported to be held regularly
(b) Raising resources to improve health facility	No evidence or reports of local fundraising	Some evidence or reports of limited efforts to raise funds locally	Some evidence or reports of regular efforts to raise local funds	Some evidence or reports of concerted and exceptional efforts to raise funds
(c) Making efforts to improve service delivery	No effort made to improve service delivery	Minor efforts made to improve service delivery	Consistent efforts made to improve service delivery	Exceptional efforts made to improve service delivery
c. Inclusiveness of HFOMC	**Not Inclusive**	**Working towards Inclusiveness**	**Close to Inclusive**	**Fully Inclusive**
Extent to which HFOMC membership is inclusive of excluded groups	Membership is not inclusive	Membership is partly inclusive	Membership is close to inclusive	Membership is fully inclusive
d. Responsiveness of HFOMC	**Not responsive**	**Working towards responsiveness**	**Some responsiveness**	**Actively responsive**
Extent to which HFOMC is responsive to the needs of women, the poor, and excluded groups	Shows no awareness of the specific barriers faced by women, the poor, and excluded groups in accessing services	The HFOMC is aware of the barriers faced by some excluded groups in the catchment area but has not initiated any response to increase their access to services	HFOMC has initiated actions to increase access to services of women, the poor, and excluded groups	HFOMC is actively engaging with women, the poor, and excluded groups to understand the barriers they face in using services, and is actively seeking to reduce them

C. Scores for quality of care (based on community perceptions and evidence from facilities)

Level	1	2	3	4
a. Availability of medicines	**Poor**	**Low**	**Medium**	**High**
Extent to which the facility suffers stockouts of essential medicines	Extended periods of stockouts of essential medicines over the past six months	Some periods of stockout of essential medicines over the past six months	Occasional stockouts of essential medicines	No stockouts of essential medicines
b. Provision of free medicines	**Poor**	**Low**	**Medium**	**High**
Extent to which the facility provides free medicines	Limited provision of free medicines reported over the past six months	Reports of free medicines regularly not provided free of cost over the past six months	Reports of occasional non-provision of free medicines at no cost	Reports of regular provision of free medicines to patients
c. The physical environment	**Poor**	**Low**	**Medium**	**High**
Score the facility environment:				
(a) Overall cleanliness				
(b) Privacy provided to patients				
(c) Availability of drinking water				
(d) Availability of male and female toilets				
(e) Waiting space				
d. Health provider communication with clients	**Absent**	**Poor**	**Satisfactory**	**Excellent**
Way in which health providers communicate with clients, and respond to their concerns	Almost no information is provided to clients nor any encouragement is given to clients to express their concerns	Providers offer little information to users on issues such as preventing ill health, causes of illness, and appropriate treatment. Limited two-way communication	Providers offer basic information to users at point of service delivery. Some two-way communication	Providers communicate well with users, encouraging them to ask questions, and motivating them to change unhealthy behaviours
e. Health provider behaviour towards clients	**Rude**	**Poor**	**Satisfactory**	**Good**
Extent to which health providers treat people with respect and fairness	Providers reported to be rude. This may include discriminatory behaviour towards some sections of the community	Some staff are reported to treat some people with disrespect or unfairly	Staff are generally reported to treat people fairly and respectfully	All staff are reported to treat people with respect and fairness

Annex 3: VDC and Other Funding to Focal Facilities in 2013/14 and 2014/15

VDC (Health Facility)	Fund amount (in NPR) and purpose of the fund			
	FY 2070/71	Purpose	FY 2071/72	Purpose
Ilam District				
Cheesapani VDC (new site)	50,000	Repair/construction	50,000 10,000 25,000	Repair/construction Furniture FCHV incentives
Laxmipur VDC (new site)	35,000 15,000	Supplies	30,000	Staff salaries
Godak VDC	50000	Staff salary	50,000 17,000 30,000	Staff salaries Mobile clinic Repair/construction
Fikkal (municipality)	200,000	Repair/construction (DHO/DPHO fund)	200,000	Repair/construction
Kanyam (municipality)	0		0	
Jhapa District				
Shivganj-new site (municipality)	Not available		0	
Sanischare (municipality)	65,000	Furniture	100,000 (MPs fund) 165,000 (DDC) 100,000 (via DHO)	Furniture Lump sum grant Lump sum grant
Prithwinagar	53,800 130,000	FCHV incentives Staff salary	97,000 156,000 17,000	FCHV incentives Staff salary Health campaigns
Dhulabari (municipality)	Not available	Repair/construction (DHO/DPHO fund)	200,000 165,000 (via DPHO)	Repair/construction Lump sum grant
Palpa District				
Kusumkhola VDC (new site)	Not available		0	
Pokharathok VDC	70,000 32,400 5,000 In kind (individual)	Health campaigns FCHV incentives Drinking water Land acquisition	32,400 17,600 20,000	FCHV incentives Furniture Health campaigns
Khanichhap VDC	In kind (individual)	Land acquisition	0	
Masyam VDC	15,000	Furniture	54,000	FCHV incentives

VDC (Health Facility)	Fund amount (in NPR) and purpose of the fund			
	FY 2070/71	Purpose	FY 2071/72	Purpose
	32,400	FCHV incentives		
Tahun VDC	33,000	Staff salary	33,000	Staff salary
Rupandehi District				
Padsari VDC (New site)	125,000 25,000	Furniture FCHV incentives	75,000 50,000	Drinking water FCHV incentives
Majhgawa VDC	65,000 40,000	Lab supplies FCHV incentives	40,000	FCHV incentives
Pokharbhindi VDC	13,000 32,400	Health campaigns FCHV incentives	30,000 32,400	Health campaigns FCHV incentives
Kerwani VDC	50,000 (DWCO)	FCHV incentives	490,000 (Care, DDC and community) 50,000 (DWCO)	Repair/construction FCHV incentives
Sakraun VDC (New site)	30,000 105000	FCHV incentives Health campaigns	30,000 30,000	FCHV incentives Drinking water
Maryadpur VDC	Not available		Not available	