Nepal Health Sector Support Programme (NHSSP)

Health Systems Analysis with focus on provincial and local level governments

A study of health systems functions in Lumbini and Madhesh provinces

Date: June 2022

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Acronyms

ANC	Antenatal care
AWPB	Annual Work Planning and Budgeting
AWP	Annual work plan
CAO	Chief Administrative Officer
CAPP	Consolidated Annual Procurement Plan
DHIS2	District health information system, version 2
DH	District Hospital
DHO	District Health Offices
DPHO	District Public Health Office
e-LMIS	electronic Logistics Management Information System
FAA	Functional Analysis and Assignments
FCHV	Female Community Health Volunteer
FY	Financial year
HFOMC	Health Facility Operation and Management Committee
HMIS	Health information system
HO	Health Office
KI	Key Informant
KII	Key informant interview
LGOA	Local Government Operation Act
LLG	Local Level Government
MoFAGA	Ministry of Federal Affairs and General Administration
MoHP	Ministry of Health and Population
MoSD	Ministry of Social Development
MSS	Minimum Service Standards
NCD	Non-communicable disease
NDHS	Nepal Demographic and Health Survey
NHSSP	Nepal Health Sector Strengthening Programme
NHS-SP	National Health Sector Strategic Plan
NHSS	National Health Sector Strategy
OnM (or O&M)	Organisation and Management Survey
PHLMC	Provincial Health Logistics Management Centre
PL	Provincial level (government)
SBA	Skilled birth attendant
SuTRA	Subnational Treasury Regulatory Application
TA	Technical Assistance
VDC	Village Development Committee
WHO	World Health Organization

Executive Summary

Introduction:

The Government of Nepal introduced a new Constitution in 2015 to replace a unitary government with a federal system, governed by three levels: federal; seven newly create provinces and 753 local level governments (municipalities), removing the district layer. This study, conducted by the Nepal Health Sector Support Programme (NHSSP), examined how the health system is performing at provincial and local levels of government under the devolved system.

Methods:

This qualitative study took place in Lumbini and Madhesh provinces, adopting a political economy analysis approach to understand how the relationships and inter-linkages between actors contribute to the effectiveness, efficiency, and challenges in health systems functions. We conducted 74 one-to-one interviews with sub-national key informants, actors within the health- system and 6 semi-structured discussions with federal-level stakeholders. We used process maps in 6 subnational workshops as a tool to understand relationships, identify bottlenecks and gaps that affect the performance of each health system's function and refine a shared view of each function.

Key findings are summarised around 6 themes:

Actors, roles, and dynamics:

Sub-national levels of government, especially local levels, appreciate the transfer of responsibilities to them in terms of decision-making authority and for them. At the local level of government, health has been politicised as a result of federalism with little no or little separation between technical and political decision-making. This can be beneficial for the health sector when political interests and technical advice coincide but may distract from evidence-informed prioritisation. Current expertise of the local level Health Section Chief is not commensurate with the expectations from the role. Some technical capacities exist and are under-utilised at Health Offices. Local recruitment and management of staff at local levels in temporary contracts has eased some HR pressures but has led to complex power dynamics , particularly between permanent and contract staff.

Leadership and governance:

- Where there are formal policies, laws, and mandates, these are followed when functions are exclusive.
- Lack of formal lines or guidance mandating communication and coordination between the different levels of government persists, especially where concurrent functions are assigned.
- Sub-national levels of government feel the federal level retains control of authority that constrains local and provincial governments' decision-making ability and contributes to a sense of distrust.
- Delays in the legislative framework to enable recruitment of experienced health staff at facilities and in government roles perpetuate employment of contract (rather than permanent) staff creating tensions between permanent and contract staff.

Planning and budgeting

- Lack of formal lines or guidance mandating communication and coordination between the different levels of government persists, especially where there are concurrent functions assigned.
- Conditional grants issued from the federal level flow to the provincial level and directly to the local level; whilst this strengthens communication on some issues between the local

and federal levels, information sharing with, and therefore, the influence of the provincial level is limited.
- Timely management and spending of the health budget are hampered by the late issuance of grant guidelines.
- Health is not always prioritised and relies on elected officials understanding health priorities and needs and balancing this with their other priorities, including what is considered to be popular by constituents. The involvement of health officials in planning and budget discussions relies on personal networks and is not systematic. As a result, the level of budget allocated to health is often not made based on evidence and therefore not commensurate with need.
- Local level planning at the ward or municipal level can work well with wide consultation when leadership is strong, but this is not consistent.

Procurement and supply chains

- Local level autonomy and purchasing authority have reduced stock-outs, however, this may be at the expense of reduced quality for the price (cannot benefit from economies of scale).
- Concurrent purchasing by different levels of government compounded by limited communication and coordination means that there is a lack of knowledge or clarity on who is purchasing which medicines and what is currently in stock at facilities, local levels or at the Health Office.
- Quantification is usually based on the previous year's purchase and use of supplies, rather than actual need – there is a lack of accurate data for proper needs assessment and planning is haphazard. This is compounded by a lack of trained staff in the procurement and supply of medical commodities.
- Contracts with local suppliers are sometimes thought to be influenced by personal interests and financial gain or favour.

Health management information system

- HMIS data are more widely available through the online platform to anyone with s login rights.
- Lumbini hosts a functional data management team that regularly and systematically reviews data, from which lessons could be learnt.
- Despite the scale-up of electronic reporting systems, many facilities still lack the required infrastructure for online data entry, or health staff have not received the required training.
- Data monitoring and accountability at local levels is weak, health data is rarely reviewed for quality and meaning during monthly Health Section meetings, and Health Offices lack recognition of their potential to support local level health sections on these issues.
- No reliable data are available from private sector health providers are shared with or at local and provincial levels of government.

Quality of Services

- Access to services has improved, and examples of positive interventions to for marginalised or 'at risk' groups have been implemented (e.g., establishing more birthing posts, posting female community health volunteers). Some barriers remain, including a lack of road infrastructure and cultural barriers.
- Some investments in health projects by elected officials are considered more popular by constituents, and not necessarily informed by evidence.
- However, existing quality improvement mechanisms at local levels are not adequately funded and therefore insufficient and inconsistent.
- The Federal MOH actors feel disempowered to ensure standardisation of national-level guidance and feel it relies greatly on individuals wanting to 'do the right thing' rather than being mandated to do so. Quality, therefore, can slip through the cracks.

Suggested recommendations for the short to medium term for all levels of government

- Create incentives for stronger coordination and communication across all levels of government and all health system functions to tackle the lack of institutionalised vertical and horizontal planning, coordination, and coordination across all levels of government.
- Fill gaps in public health expertise at the local level by identifying ways to incentivise LLGs to draw technical advice from Health Offices, at least in the short term to encourage better use and distribution of health expertise in planning, coordination at subnational levels.
- Invest in building the capacity of local level Health Sections through creating opportunities for skills-building for Health Section Chiefs to build their confidence to have greater influence on local level planning decisions and budget allocation
- All levels of government need to be supported to agree clearer mandates that outline where different roles lie with regard to quality improvement initiatives, so that facilities at local levels can be supported to prioritise and implement standardised quality improvement mechanisms for health services, including regular conduct of assessments and allocating resources to address issues identified as gaps in quality of care.

Longer term implications and wider considerations for Government of Nepal

Longer-term implications to be considered include:

- The Government of Nepal needs to **consider whether conditional funds flow through provincial governments to local levels or remain as a direct transfer** from the Federal level. This needs to be done in a way that is not perceived as reinforcing a hierarchy that does not sit easily with subnational governments.
- **Conditional grants could have increased flexibility to better meet local needs**. This could be achieved by having more flexible grants linked to broad areas of technical priority and over time to performance and outcomes (e.g., output based conditional grants).
- The **role of the Health Office in the longer term** needs to be discussed and whether there should be re-investment or phase-out needs to be resolved. For Health Offices to be recognised as having a non-authoritative technical role, it will require their new place in the federal system to be defined through wide consultation and clearly laid out. Provincial governments can assess whether investing in Health Offices would help strengthen their reach to LLGs, as well as in terms of making technical expertise and co-ordination support accessible to LLGs.
- Government **could revisit procurement of medical drugs to understand better whether devolved procurement should continue**. A possible alternative to the current system be a hybrid model which combines aspects of the federal framework contracts with actual local purchase (for example, a nation-wide list of pre-approved suppliers with pre-set prices, approved by federal level) ensuring that LLGs retain the 'authority to purchase' locally.

Implications for Technical Assistance through NHSSP

- **Adapt current provincially based TA modalities** to provide increased expert public health support directly to local governments through a cluster system. For the longer-term, pilot a system of internal TA from within governments.
- **Enhance capacity for improved health budget literacy, advocacy and tracking** starting at ward level including with the Health Section Chiefs. In the longer-term, TA could extend to local health partners to strengthen budget advocacy.
- **Promote investments to improve the quality of health services** through a TA model that works with a cluster of local level governments enabling a ‘hub’ within the

government for draw-down specialist technical support to drive initiatives to improve quality.

- **Strengthen frameworks for quality improvement at the provincial level through the technical hubs** to provide TA to the Provincial Health Directorate and the Provincial Health Training Centre to establish clear strategies and guidelines to develop and enlist mentors, manage supervision systems, and support implementation of quality improvement action plans.
- **Expand the net of people who can interpret readily available data and evidence and facilitate cross-municipality learning,** through expanding the scope of TA to newly elected representatives and elected officials to other technical areas to improve use of evidence to guide resource allocation for roll out of the Basic Health Services package.
- **Strengthen coordination mechanisms within and between spheres of government,** including short term TA such as revised job descriptions, and to work with all levels of government to design and implement a cross-government coordination mechanism, which makes the essential links for the whole health system in Nepal as well as a framework for specific functions.

Introduction and background

Background

In 2015, Nepal replaced a unitary government with a federal system governed with three levels: a federal level; seven newly created provinces, each with its own legislature; and 753 local governments, each with their own elected governing body [1]. This was done through the adoption of a new constitution with significant devolution of power and resources. As such, federalism opens opportunities to better address local health needs through devolved decision-making, planning, budgeting, and local accountability.

Since 2015, considerable work went in to defining health sector responsibilities and functions at each of the three levels of government [2]. These were put in place following the local elections in 2017 whilst the structures and functions of the three levels of government in reality were still nascent. In 2018, the UKAid supported Nepal Health Sector Support Programme (NHSSP) [3] undertook a policy stock-taking exercise to examine the existing health sector policies and their relevance for the federal context and made several recommendations including a review of health policies against the functions assigned to the three tiers of government [4]. In 2020, NHSSP carried out a review and assessed the alignment of the health sector policies vis-à-vis functions defined for the respective governments [5]. This assessment was done primarily from a theoretical perspective.

Given the scale of the transition through federalism to seven Provinces and 753 Local Governments, the massive challenges to the sector from the 2015 earthquakes and the continuing Covid-19 pandemic, the adoption of new functions for each level of government has been relatively smooth. But after four years of devolution, it is important to understand how the assigned functions and responsibilities are working in practice within the health sector and to understand the scope and incentives to improve coherence both vertically between province and local levels, and horizontally across local levels, working within the framework of the federal constitution.

The federal Ministry of Health and Population (MoHP), provincial and local governments have prioritised analysis of health sector performance and generation of evidence to integrate into overall sectoral reform perspectives from all spheres of the government, especially focussed on the subnational levels. NHSSP aimed to support this through the study described in this document. This study aimed to build on the previous NHSSP reviews[6]to develop a 'real world' understanding of how the devolved health system is functioning following devolution. The study aimed to identify what is working well and understand how the formal and informal ways in which decision-making capacities and resources are distributed and are affecting health functions. This understanding could contribute to shaping the strategies that could help provincial and local level governments to deliver effectively on their mandates. This study was an exploratory qualitative study to understand the perspectives of a range of primarily provincial and local level government actors, and it also sought perspectives from selected national level stakeholders.

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[1] Government of Nepal. 2015. The Constitution of Nepal (English translation from MOHP website [accessed 28 April2022]

[2] Government of Nepal (2017), Report on Functional Analysis and Assignments, Government of Nepal (2017), Business Rules (*Karya Bibhajan Niyamawali)* 2074 (2017), Nepal Gazette, Government of Nepal (2018), Local Government Operation Act 2074 (2018).

[3] The Nepal Health Sector Support Programme (NHSSP) is an initiative of the Nepal Federal Ministry of Health and Population (FMoHP), funded by UK Aid, to build a resilient health system and deliver quality health services in the federal context.

[4] NHSSP. 2018. Report on Stocktaking the Health Policies of Nepal (April, 2018)

[5] Gautam G, Khanal K & Bondurant T. 2020.
An analysis of the health sector functions of all three levels of government as per Functional Analysis and Assignments and relevant polici es. Microsoft Word - 2020 Analysis of FAA and Health Policies - web version (nhssp.org.np)

[6] Gautam G, Khanal K & Bondurant T. 2017. An analysis of the health sector functions of all three levels of government as per Functional Analysis and Assignments and relevant policies. Available here.

This study was timed to contribute evidence to the development of the forthcoming Nepal Health Sector - Strategic Plan (NHS-SP) 2023-2030 which will be finalised by July 2022. Preliminary findings from this study were shared with the NHS-SP Technical Working Group in May 2022.

Contextual background

Please refer to Annex 1 for a full background drawn from our review of literature and all citations; we present a summary of key points in this section.

Nepal has made considerable health gains in recent decades. Between 1990 to 2017, life expectancy has risen by 12.6 years from 58.3 to 70.9 years. The proportion of all deaths from communicable, maternal, newborn and nutritional diseases dropped by two-thirds (63%) in 1990 to 21% in 2019 (although still amounting to 40,793 deaths) [7]. Non-communicable diseases (NCDs) are the leading cause of death and in 2019 accounted for 71% of all deaths, a rise from 35% in 1990 [8].

On the cusp of federalism, Nepal's health system has faced and managed the devastating earthquakes in April 2015. The health system was able to rapidly resume basic health services and preventive health care, such as basic hygiene and risk communication, effective surveillance, and outbreak monitoring, although there was widespread interruption to birthing centres, neonatal care, and vaccination services in some rural areas.

The COVID-19 pandemic further challenged the health system, and services were affected in the initial months. The Health Emergency Operations Centres at the federal and provincial levels have been the core bodies for the COVID-19 response. Testing capacities were made available in all provinces and vaccines were rolled out quickly. As of June 2022, 87% of the population over the age of 12 had been fully vaccinated.

Private health care providers are an important group in the provision of health services in Nepal, particularly in the Terai and some urban Hill areas. People use private facilities frequently regardless of their economic status. Some private facilities that provide maternal and child health services, are subsidised for their services through the Aama Surakshya programme. Out of pocket payments are generally high accounting for nearly 55% of the health expenditure.

Health is a fundamental right under the Constitution and requires the health sector to respond to the political devolution to achieve the vision to better address local health needs, giving every citizen equal access to health services and to make quality health services widely available and staffed with health workers. Health functions therefore had to be transferred to the three devolved levels. To facilitate the transition at the sub-national levels, the erstwhile District Health Offices were retained as co-ordinating bodies but without the authority and resources that it previously held. These were re-named as Provincial Health Offices (known simply as Health Offices).

The Constitution, the Functional Analysis and Assignments (FAA) and the Local Government Operation Act (LGOA) are the three main documents which lay down the mandates for each level. And health being a concurrent responsibility, sub-national governments have the authority to develop their own policies and laws within the frameworks defined by the federal level.

The federal system presents an opportunity for the health system to strengthen governance to achieve the vision for locally- driven, needs based health care in the federal republic. Whilst it is still relatively early in the devolved system, there is a growing body of learning emerging, which we summarise in Annex 1, organised by health systems functions.

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[7] Ministry of Health and Population, Nepal Health Research Council, Institute for Health Metrics and Evaluation, UKaid Nepal Health Sector Programme 3 (2021) Nepal Burden of Disease 2019: A Country Report based on the 2019 Global Burden of Disease study. August 2021.
[8] Pandey et al (2020) *ibid*

Aims and objectives of the study

The study presented here aimed to examine how a selection of health systems functions are performing under the devolved system and identify progress and challenges since decentralisation.

Objectives:

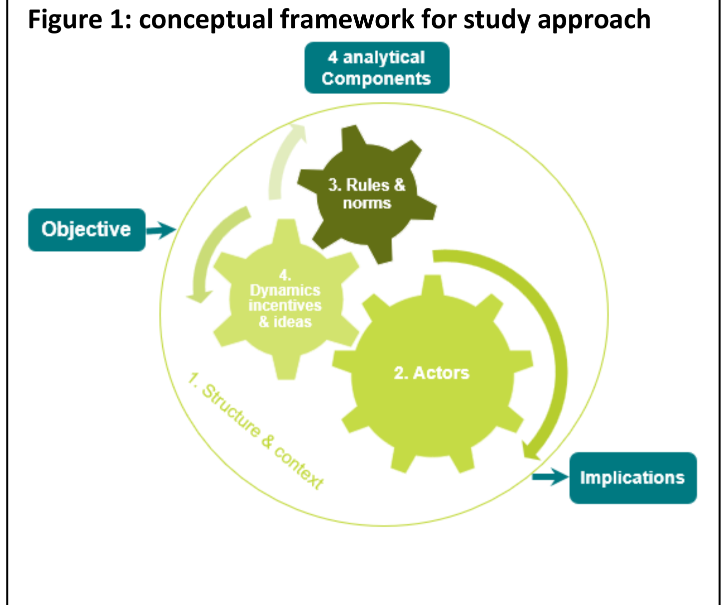
- To better understand how selected health system functions are performing under the devolved health system
- To identify which actors are involved in the sub-national health system i.e., Local Government and Provincial Government (including the influence of the federal government) and their roles and responsibilities
- To understand how the relationships and inter-linkages between these actors contribute to the effectiveness, efficiency, and challenges in health systems functions.
- To identify opportunities to influence change and address challenges within the heath system and identify lessons that can be shared across settings in Nepal.

See Annex 2 for an adaptation of the WHO health systems pillars that we refer to as functions.

Methods

The study methodology is described in brief below – for further detailed information, please refer to Annex 2. We designed the assessment to help us understand which values and norms influence peoples' interaction with and experience of the health system, how power operates within it and which rules, rights and relationships govern all of this. See Figure 1 for the conceptual framework for the study approach and Annex 2 for definitions of the framework core themes.

Figure 1: conceptual framework for study approach



Study scope

We aimed to investigate how the health system is operating since federalisation through detailed assessment of health systems levels, functions, geography/setting and actors.

Health systems levels

We assessed linkages across **facilities, local government, and provincial government levels**, also recognising the need to gather data from the ***federal level*** since this influences the ability to make and enact decision-making at sub-federal levels.

We also explored the relationships that the ***Health Offices (HOs)*** have on the health system. Since decentralisation, the former District Health Offices/District Public Health Offices (DHOs/DPHOs) are now called the Health Offices. Although districts are no longer an administrative unit and Health Offices do not hold any financial authority, they do hold the relationships and influence to help coordinate.

Health systems functions

We collected evidence across the following health systems functions through the lens of **governance and leadership**:

- ***Planning and budgeting:*** budgeting & financial management since this enables or hinders all other functions.
- ***Medical products, vaccines, and technologies:*** procurement of medical supplies and drugs as a key requirement for quality care.
- ***Information systems:*** Initial focus on the MOPH Health Management Information System (HMIS) as this is used to gather and share data on ***all*** programmatic areas, but this evolved to cover a more holistic view of 'health information' including the flow and availability of information.
- ***Service delivery:*** we focused on quality of services in particular quality improvement initiatives as important measures of motivation to improve health outcomes and service experiences. We explored two QI processes in detail: minimum service standards (MSS) and on-site coaching for skilled birth attendance (SBA).

We included questions to explore how provinces and Local Level Governments (LLGs) [9] experience HRH issues and aimed to understand what level of influence actors felt they have or do not have on the management of HRH.

We also explored how the health system and its actors were affected by and adapted to the **Covid-19 pandemic** as a crosscutting issue.

Geographical focus

The study focused on two of the provinces where NHSSP provides intensive technical assistance (TA); Madhesh and Lumbini provinces. See Annex 2 for a map and description of key characteristics of these provinces.

We gathered data from key informants (KIs) in a sample of LLGs ensuring representation of both urban and rural LLGs. We purposively selected more rural LLGs as they are more numerous than urban and selected an equal number of NHSSP and non-NHSSP supported LLGs. Sampling included representation from different districts so that linkages between the different district offices and health system functions could be explored (see Annex 2 for LLGs included in the study.

Sampling of key informants

We interviewed a selection of key informants from all spheres of government including hospitals and health facilities (see Annex 2). We tried to ensure equal representation in Lumbini and Madhesh although have not reported the numbers interviewed by respondent type to ensure confidentiality.

Data collection steps and tools

The following key steps were taken for primary data collection – please see Annex 2 for additional details on each step, process map description, interview guides, study tools and frameworks.

> **Step 1:** 71 key informant interviews at LLG and provincial level.
>
> **Step 2**: Developed 5 process maps of selected health system function by NHSSP team.

[9] Otherwise known as municipalities, or palikas (both rural and urban

Step 3: Validated and refined key process maps through 6 group process map workshops with KIs at provincial and local level.

Step 4: 6 federal level consultations with key informants.

Step 4: Consolidating process maps and group discussions through extensive consultation with NHSSP technical specialists.

Ethical considerations

We conducted the study using internationally recognised approaches, including seeking voluntary informed consent from all stakeholders at sub-national level. Since the sub-sample of federal level interviewees was small, we did not seek permission to avoid potential to identify individuals.

The study was agreed with the Ministry of Health and Population which also issued a formal letter to the provinces and LLGs about the study. We also presented our intended approach and methods to the External Development Partner's technical working group (EDP TWG) in March 2022. Please see Annex 2 for further details including management of informed consent and data storage practices.

Analysis

All transcripts from the KIs were uploaded to an excel workbook. Transcript extracts and quotes were coded thematically using dropdown code lists created with Excel's Data Validation 'list' function.

Extensive internal discussions took place to interrogate the findings and identify emerging findings involving all NHSSP senior thematic leads, the Team Leader facilitated by the two external consultants. Early emerging implications were discussed and elaborated and refined through a subsequent 1-day meeting with the NHSSP senior management team.

Assessment limitations

Aside from federal level interviews, key informants were selected from just two (Madhesh and Lumbini) of the seven provinces in Nepal. NHSSP is active in these two provinces, and its support may influence the functioning of the health system in these geographies, and therefore findings compared to other provinces. Additionally, the findings may not be entirely generalisable to other areas which may experience different constraints for example due to location (e.g., some of the more remote provinces).

Only government actors and stakeholders or EDPs were included in the respondent list. We did not have scope to include representatives from the private sector, citizens, or stakeholders from the ayurvedic health system who may hold alternative perspectives. Also, some of our respondents were very senior e.g., Chief Administrative Officers and Medical Superintendents and were extremely busy, meaning there were constant interruptions for their time during interviews, sometimes curtailing their responses. Researchers also reported that some (more senior respondents were guarded in their responses).

Findings

In this section, we start by describing the key actors in the health system at local levels of government and how they link with provincial level actors and give an overview of the dynamics affecting the key roles and responsibilities. Next, we present the findings by health system function shown and for each, present the final process map and share the qualitative findings from the process map workshops and key informant interviews.

Actors, roles, and dynamics

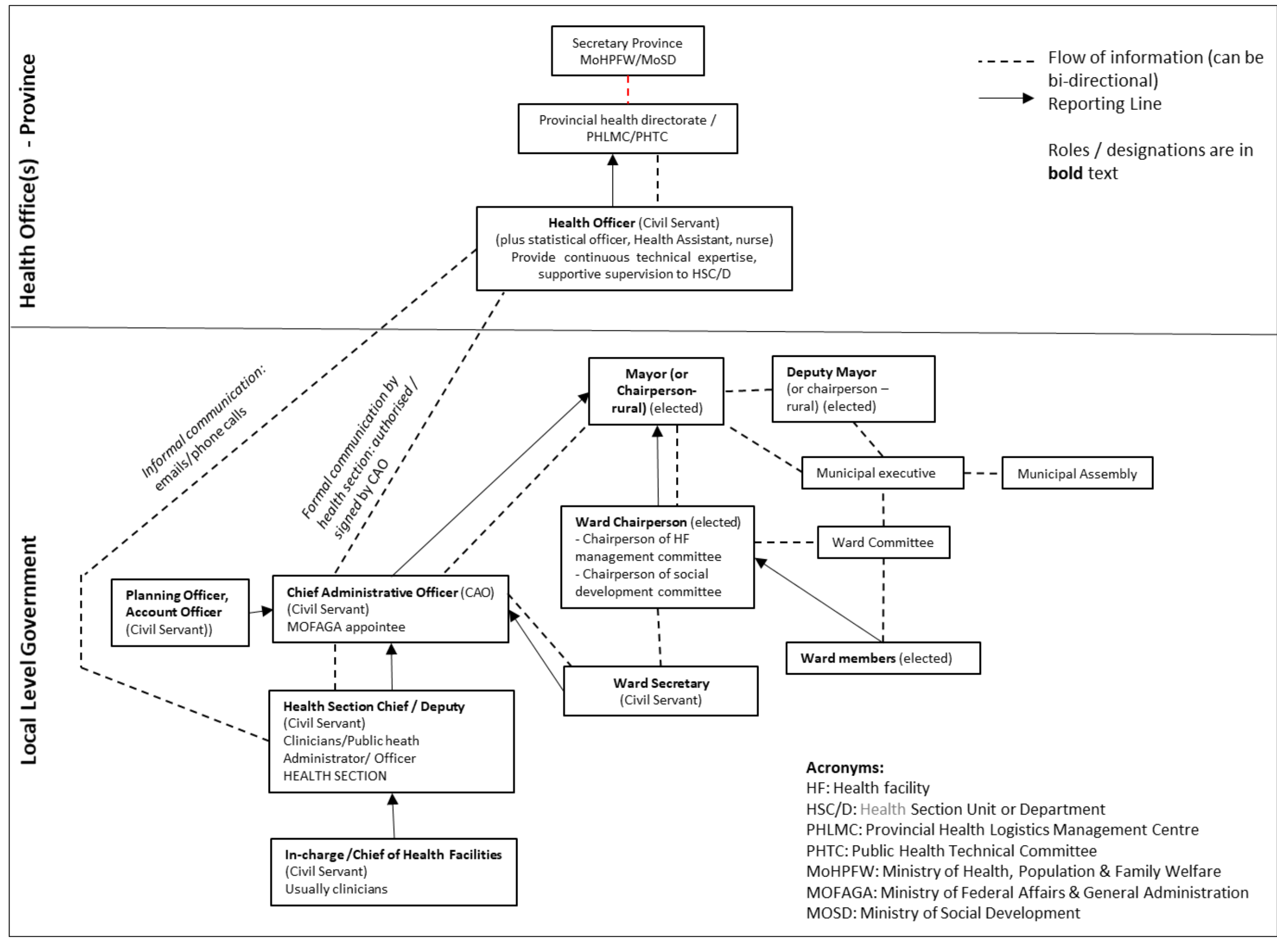
Key messages

- Sub-national levels of government, particularly at the municipality and ward level, appreciate the transfer of responsibilities to them in terms of decision-making authority and for them, this has generally been well accepted.
- At the local level of government, health has been politicised as a result of the federalism structure and there is no or little separation between technical and political decision-making.
- This can benefit the health sector when political interests and technical advice coincide but may distract from evidence-informed prioritisation.
- Current expertise of the local level Health Section Chief is not commensurate with the expectations from the role, and for which they are not adequately trained.
- Local recruitment and management of local level staff in temporary contracts has eased some HR pressures, but led to complex power dynamics, particularly between permanent and contract staff.
- Some technical capacities exist at Health Offices but are an under-utilised resource, where skilled human resources for health are scarce nationally.

An overview of key roles and responsibilities in the health sector

In order to put our findings into context, please see below Figure 2 that shows an organogram of the main roles, reporting lines and flow of information from one post holder to another in the health system.

Figure 2: Organogram showing the main roles, reporting lines and information flows in the health sector



Decision-making: actors, influences, incentives, and motivations

Elected officials

Local level governments (LLGs) adhere to the planning and decision-making processes when these are laid out in the various official documents. Elected officials report that they arrive at decisions at the local level through consultative and democratic processes. Mayors have the executive authority following formal processes, but also have significant informal influence over decision-making Within the health sector the decisions about resource allocations may be considered worthy or 'of need' and may not necessarily be grounded in evidence and data.

> "*For endorsement of activities, it should be presented in general assembly and pass-through majority. In our palika our trend is to conduct three times executive committee meeting in each month of palika. All the decision are made on majority and group effort and decision are not made on personal opinion and views*." Elected official, rural LLG

Respondents described that, decisions may be influenced by commitments made while running for office, a need to ensure continuity of programmes, and/or by what was considered to be 'politically advantageous.

> *"Programs of government, which is also influenced by their political commitments to people in manifesto, also sets the priority. continuity of programs is a key criterion besides above; political interests of provincial MPs play a huge part in the prioritisation generally and even at operational level. There is even pressure to do new things which is not formally a part of annual programs*." MJa01P, Senior Government Official, PL.

> "*Plannings are made but they aren't sustainable. Many elected representatives are spending a lot of money for cheap popularity. Much expenditure is made for."* LMa05L, Health Worker, rural LLG.

> "*Mayor focuses on infrastructure and other development programmes which are visible."* MLa01L, Health Official, rural LLG.

> *"The political leaders are more focused to the work that will be seen by public but the input in health reflect its output after so many years. So, less interest of politician toward soft programme i.e., health and education."* MHa06L, Government official, urban LLG.

The pace of decision-making may be influenced by how convinced the elected officials are on issues requiring decisions, which is often a mix of a desire to serve people, political orientations, and interests and what is seen or considered a need.

> *"I am autocratic sometime but action oriented. For example, if any household do not have drinking water facility, at that time leader should not wait for the formal decision process. They should take prompt action. Because we palika have such right to make decision and act. We have big budget with legal authority for its utilization from the constitution*." MHa05L, Elected official, urban LLG.

Some decisions about health investments were influenced by the personal interest in health or specific health issues, or through influence of health officials where those relationships are strong.

> *".. the mayor is so active in every sectors. We appointed MBBS [a surgeon], radiology and laboratory service from our internal budget of palika. We have hired staff in contract for Basic health care centre. This change is due to mayor vision and our coordination with mayor".* MHa01L, Health Official, LLG

> "There *is a Deputy Mayor pregnant women programme in which the deputy Mayor herself visits the pregnant women door to door and provides nutritional foods*..." Lbu04L, Health worker, urban.

Not having a Mayor or elected official who is informed and interested in health and who has or is open to responding to and understanding health issues was a concern expressed by some. Not having such a Mayor in post, this poses a risk to health planning, and examples were shared where decisions were not driven by data / evidence.

> *"If the visionary mayor is not elected in coming election, the palika health system will be collapse.* MHa01L, Health Official, LLG.

The degree of authority afforded to a Deputy Mayor, however, is variable and in some instances been limited. The reasons for this are mixed and include the lack of clear guidance in the first term of elected positions. The significant majority of mayors were men and deputy mayors were women in the first team of LLGs. The relationship between the mayor and their deputy is also determined how empowered a Deputy Mayor is including by level of formal education (this was notably lower among participants in this study in Madhesh province). The dynamic can be impacted by different party affiliations.

> *"Deputy mayor is the most challenging position because Deputy Mayor also makes commitment to people like Mayors, but no financial authority has been given to Deputy Mayor which is a huge impediment. Deputy mayor has been given authority but there is no institutional support system to perform effectively, a lot depends on how Mayor thinks about Deputy Mayor's role…and about empowering Deputy Mayor or not. I did not understand the full scope of the role and potential influence in the beginning as it was our first tenure, but for new Deputy Mayor it will be easier … as we have some years of experience, we learned about what needs to be done".* MJa03L, Female Deputy Mayor.

Government officials

Senior government officials at local levels who are not elected also hold some influence in decisions, especially the Chief Administrative Officer (CAO) who reports is a to the federal government appointee. While the overall accountability of the CAO is to the Ministry of Federal Affairs and General Administration (MoFAGA), regular reporting and coordination on the daily basis is with rather than the Mayor. This is a senior supportive role to the Mayor and is key to any policy and decision-making processes for any work across the municipality. So, lack of continuity poses challenges to smooth administration. Respondents have reported that There have been frequent transfers of the CAOs have posed challenges to smooth administration post.

> "*We have frequent transfer of CAO which hamper us in planning and implementation of activities.*" MYa03L, Elected official, sub-metro LLG.

At provincial level, in addition to the elected officials such as the Minister of MoSD, other government officials who may influence and are key to decisions about resource allocations in health include the Health Director, PHLMC Director, Secretary of MoSD or MOPH and the Chief of Policy Planning and Public Health Division in some cases through wide consultation.

> "*For endorsement of activities, it should be presented in general assembly and pass-through majority. In our palika our trend is to conduct three times executive committee meeting in each month of palika. All the decision are made on majority and group effort and decision are not made on personal opinion and views.*" Elected official, rural LLG.

Role of the Health Section

The many health sections in all rural local levels and urban palikas are small with typically 2-3 staff should be posted in the unit and sub-metropolitan and metropolitan palikas have up to 4 staff posted in the unit; but this is often fewer in due to vacancies. This limits the technical expertise available at within any the one health section, particularly in the most rural and urban palikas with only the Health Section Chief bearing the entire responsibility. Additionally, The Health Section Chiefs come are Grade 6 level staff (Health Assistants or Auxiliary Health Workers) who primarily have from clinical background expertise and often are not trained may

have had some in public or facility level health management experience but lack the complete breadth of knowledge and skills needed for the health sector management.

Health Section Chiefs have to manage facility In-Charges within the palika, including those of the Primary Health Care Centres and the 15-bed hospitals, who may be medical doctors and belong to a higher grade. The difference in qualifications and grades affects how others perceive and accept their authority, in turn affecting how effective the Health Section Chief can be in his/her role; and may not be skilled or therefore empowered to operate in a highly political environment. The political environments at the municipality level require abilities to understand planning dynamics and political orientations of elected officials. Thus, their ability to do work with elected representatives and influence elected officials' decisions is often limited.

> *"There is lack of coordination on the part of the Health Section and the Palika. For example, I was the head of the Health Section before, but I had no access to the Mayor, Deputy Mayor and CAO. Party politics is also affecting the health sector. We don't know what is decided by the Health Section now." MDh03L, Health Staff (urban LLG).*

The role of the Health Section at the local level in decision-making varied across settings and depended on three main aspects: the relationship of the Health Sector Chief with the Mayor (more so than with the Ward Chairs); the managerial skills of the Health Sector Chief; and availability or capacity (skills and knowledge) within the health section to fulfil their role. At local levels of government, there were examples who Health Section Chiefs felt their Mayors demonstrated leadership and interest in decision-making, especially in municipalities where there was a good relationship with the Health Section, but this was not necessarily a universal finding:

> *Political influence can make change in budget distribution because most of the politicians are focused to the infrastructure development where they can get more commission, but our mayor is very understanding. I have good interpersonal relation with him. He cannot skip my request towards health.* MHa01L, Health Section Chief.

With the lack of substantive authority due to the official Grade/rank, as well as the inexperience and lack of political savvy, the Health Chiefs neither feel empowered nor exude much confidence to operate in a highly political environment. Health section chiefs sometimes have to manage staff who are senior to them in hierarchy, for example, some doctors who manage health facilities or hospitals have a higher professional grade or cadre than those in post as Health Section Chiefs. This seniority affects their legitimacy and how confidently they can manage those staff more senior to them by cadre. The overall remit of this Health Section Unit Chief is vast, demanding a wide range of skills thus seems unrealistic for one post holder to effectively manage all dimensions of the portfolio.

The extent of involvement of health section chiefs in annual work planning and budgeting (AWPB) process varies, and depends on their individual skills, experience, and influence. Many of whom were interviewed reported not being involved across all stages of planning, but although this may not be always the case across all palikas.

During one of the process map validation workshops, we observed that in two sub-metro municipalities in Lumbini, the Health Sector Chiefs were clearly fully plugged in involved with planning process and have a strong influence in decision- making because they have had the required technical and political skills. In most other cases, however, this was not the case on most other occasions as Health Section Chiefs largely were not very engaged due to their lack of required expertise in planning and budgeting processes.

Most Health Section Chiefs, through their monthly meeting with health facility In-Charges and other periodic review meetings, had kept a good knowledge of the health facility level of needs in health facilities, which they regularly gathered through their monthly meetings with Health Facility In-Charges and other periodic review meetings. Some Health Section Chiefs also actively worked to identify and understand ahead of the planning process by asking health

facilities about their needs and advocated for appropriate budget allocations when opportunities arise arose in the planning processes within municipality.

Health Office Role

The Health Office has held the role for coordination in health, as well as direct technical and management support to health facilities (Please see Annex 3 for more information). Since devolution, their authority has diminished, roles are not clear and there are no formal rules to explain how they could coordinate and contribute to planning for health. Further, the lines of communication have broken in many settings.

> "*We have district Health Offices, closer to the local level Palikas, but Palikas are not accountable to Health Offices. There is broken chain-of-command which has created issues in coordination and uniformity of actions between governments. Federal government made it weak. Removing them altogether would have been disastrous, they need empowerment, they are understaffed, they don't have all skills; …. There is problem with 'district' word in health; but there are District Court, District Admin Office; Health Offices should be made proper people's health offices with more staff, training, public health officers. We need to add permanent staff through Public Service Commission recruitment."* MJa05P, Government Official, PL.

Generally, the expertise available at the Health Offices, even though their staff have diminished, and are not utilised fully because of this 'broken chain of command'.

> "*The gap is that we do not have the certain guideline from government for the easy coordination between the palika and district and even between palika and province or federal*" MMa01D, Government Official, HO.

However, the Health Offices were widely acknowledged for playing a key role in the response to COVID-19 and they were highly commended.

> "*Health Office played great role during the COVID-19. During the first wave of COVID-19, they supported and helped in the tests (PCR and Antigen Test), coordinated with the federal government for the vaccination and planned the vaccination in coordination with the local levels. Later in the second wave and even at present, they have been coordinating and supporting in COVID-19 vaccination*. LBu01L, Elected official, sub-metro LLG.

Please see Annex 3 that elaborates evidence on perceptions about the role of the Health Office.

Staff availability, performance, and motivation

There is other general widespread acknowledgement of shortages of adequately trained staff in the health sector, both among health professionals and among other actors who lacked sufficient knowledge of health issues. The policy and legal bottlenecks to this are discussed in the next section, 'Leadership and governance'.

> *"human resources …are not adequate…there are unfilled vacancies, DHO is also weak due to lack of human resources. Their weak coordination with Palikas is also due to limited human resources - we can't afford these human resources from our resources. There are no Public Health Officers in most of the DHOs. Overall, provincial health departments are understaffed.*" MJa01P, Senior Government Official, PL.

A key motivation for staff in the federal system reported during our process map workshops has been their placement in their hometown or placements close-by their homes.

There are reports that many who are hired through the short-term contracts receive jobs due to patronage and carry political clout. Some health facilities In-Charges and other permanent staff report being demotivated as they find this challenging and feel limited in being able to manage the staff and have any authority over them due to potential repercussions. However, contractual staff on the other hand feel demotivated because their terms and conditions are

generally not as good or have job insecurity and poor contractual terms as that of permanent staff.

> *"The Palika appoints staff members and extends their contracts every six months. Now, the extension is also becoming difficult, and some good staff hired by the Palika did not continue because of disagreements on salary. That also affected the service delivery. There is no motivation for staff members to work better."* MSa06D, Health Staff, District Office.

> "*Mostly, employee who are near to and aligned with political parties are free from punishment even if they do not have good performance."* LYa03L, Health staff, rural LLG.

Local short-term contracts have been given to local people through the local networks and patronage as mentioned above, which weakens accountability. This has led to a general sense of despair amongst existing permanent staff. These factors de-motivate staff and also weaken their accountability.

> "*Staff come and leave health facility according to their wish; nobody listens to me. It is hard for me to get things done from my subordinates. I initiated strict rule on coming and going on time, but it didn't work well because of lack of sense of accountability*. "MJa02L Health staff [in position of managing other health staff), sub-metro LLG.

Often the training and skill development opportunities are reportedly influenced by political connections, with political leaders applying pressure to decision-making staff to nominate certain their favoured staff to for training opportunities.

> *"If someone has a little bit of political protection, he will get a good easy access and good space everywhere; whoever does not political connection will not get easy access.*" LBa01D, health staff, district level.

Health facilities in local governments have poor infrastructure, equipment and supplies that are needed for smooth functioning. Working in such difficult environments is also reported as a demotivator by for staff particularly when salaries and other benefits are not regularly paid. Generally low salary also works as a demotivating factor.

> "*We need motivation. For this, we should be provided our salary and allowances on time. When we are not given salary and other allowances, we feel bad and make us feel unwilling to work. There is lack of physical structure, unavailability of electricity, internet. We do have the computer, but it is not in use due to electricity cut-off and weak internet connection. We do not have the proper water supply in this health post. So, if all these facilities were managed, it would be easier for us to do our work properly.*" LSi03L, Health staff, rural LLG.

During COVID-19, health staff faced additional challenges related to risk of exposure to COVID-19, including being ostracised from families for fear of contagion, and having to work long hours with no breaks and in some cases facing stigma if they had contracted the virus. Health staff were offered promised additional incentives compensation to for the work they did during COVID-19 pandemic, but due to delays in budget flows many local governments did not get receive their COVID-19 the amounts on time, delaying disbursements to the health workers in some cases in time demotivating staff.

> "*The health staff have double responsibilities during Covid-19, and they feel excluded from the society too due to Covid-19. They have to work hard in high risk of Covid-19, but they do not get their incentive and salary in time. The quarantine with food and logistics management was done by palika. The health staff do not meet the target population in health service delivery. They and their family are stigmatised by the community people.*" MHa01L, Health Official, LLG.

I was infected with COVID-19 but still I provided services to the people. I have a lot of work pressure since I am alone here. I have to work on field work as well as have to manage work on the health post. Being a nursing staff, I have a big workload. I can't even get a day leave from work. ...People used to go far from us thinking that we will transmit COVID-19 since we are health workers." LSi03L, Health Staff, rural LLG.

Although this was not always the case:

"*The xxxx rural municipality respected the FCHVs, health workers, frontliners. They gave COVID incentives as well. I don't know about other institutions of xxx but we received it on time*" LMa05L, Health Staff, rural LLG.

Role of the private sector

The private sector was cited by respondents from urban settings to be used widely used by wealthier segments of the population and reasons given were critical of public facilities:

"*… most of the people who come to the governmental facilities for taking services are the poor and those who have poor economic conditions, wage workers. Those who can afford the services prefer going to the private sectors."* LBu02L, Health Official, urban LLG.

"… *economically well-off people prefer to take services from the private health service providers. One of the reasons for this is that they are comparatively cleaner than the government health facilities."* MSa06D, Senior health Staff, District Hospital, urban LLG.

There were examples of private partnerships in the provision of care, including for on-call services during the COVID-19 crisis and to provide cataract eye surgery:

"*I have found good coordination with the private health facilities of palika during covid-19 as we coordinated with doctor of private hospital for on call service for covid patient and for maternity service*." MHa06L, Government Official, urban LLG.

The municipality has started a partnership with xxxx Eye Foundation, a private health facility, for cataract surgery by providing Rs. 1000 per client" MBi02L, Government Official, urban LLG.

Some municipalities have taken begun to take an initiative to systematise the registration of private sector health facilities. For example, a large metropolitan municipality in Madhesh has prepared a Private Health Facility Registration and Renewal Guideline. The municipality has started to conduct monitoring of private health facilities based on the guideline. Attention to monitoring is generally drawn when health facilities apply for renewal (see Annex 4 for more details on private sector engagement, registration, and monitoring).

"*There are many private health service providers in metropolitan city. We have prepared private health facility registration and renewal guideline. Monitoring of private health facilities i.e., hospital, policlinics up to 15 bedded. The monitoring and renewal are done based on this guideline. On need basis, partnership is ongoing with private sector* "MBI02L, Government Official, urban LLG.

Communication between health actors

Actors are adapting their communication and coordination mechanisms with the advent and wider availability of internet access. Alternative modes of remote and digital communication became more commonly used through necessity during COVID-19 travel restrictions. Social media platforms, e.g., WhatsApp and Facebook groups are increasingly used as a channel of communication and help circumnavigate or supplement and speed up more cumbersome formal requirements for letters sent through a poor postal service.

“*I send face book messenger invitations, scanned formal letters, when I have to ask health facility staff to nominate people for some training or to send staff to attend some meetings. After a few days I call some of them to check they have read it. I don't send paper letters when it is not formally required. When such letter is sent, one person may see it and file it, and not seen by others in health facilities. However, if in messenger, it is seen by every staff in health facility because we have an all-staff (health sector) messenger group. Letters normally used to remain at desks for long as some people needed to be found to take letters to health facilities or they had to be posted which took long time for delivery*.” Health Official, LLG.

Leadership and governance

Key messages

- Where there are formal policies, laws, and mandates, these are followed when functions are exclusive.
- Lack of formal lines or guidance mandating communication and coordination between the different levels of government persists, especially where there are concurrent functions assigned.
- Lower levels of government perceive that the federal level retains control of authority that provincial and local levels of government feel constrains their decision-making ability and contributes to a sense of distrust.
- Conversely, Federal MOH actors feel disempowered to ensure standardisation of national level guidance and feel it relies greatly on individuals wanting to ‘do the right thing’ rather than being mandated to do so.
- Delays in the legislative framework to enable recruitment of suitably experienced health staff at facilities and in government roles and perpetuating the employment of staff in contract (rather than permanent) posts creating tensions between permanent and contract staff.

In this section, we present findings related to the extent to which decision makers (see box 1, above) at sub-national level are able to provide oversight and accountability in health with the relevant actors.

Rules and norms

Our study found that where functions and responsibilities are clearly written, generally they were followed without contention at the local level. Federal level guidance is followed in all cases, and where there has been a need or possibility, these have been adapted for context and additional local level acts, policies and guidelines have been developed. These are implemented under the oversight of the Chief Administrative Officers (CAOs). These adaptations follow formal processes based on constitutional mandates, the Local Government Operation LGOA, 2017, local policies and laws and other relevant federal policies and acts.

“*We have fulfilled the responsibilities provided to the local level during our tenure. We are very clear about the role of three levels of the government and have worked accordingly to fulfil the responsibilities given to the local level*.” LBu01L, Elected Official, sub-metro LLG.

“*We spend the budget as per the rules and guidelines of the municipality. There are guidelines for budget allocation and expenditure, so this is not challenging*.” LBu02L, Health official, sub-metro LLG.

“*There is no provision of local level Act yet. We conduct activities as per the federal Act*.” MLa03L, elected official, rural LLG.

“*CAO and health section chief are responsible to ensure policy and norms are followed properly for health service delivery at local level.”* MYa02L, Health official, rural LLG.

> *“Mayor and I are responsible for overall follow up policy and guidelines to ensure effective implementation. Health section conducts continuous follow of implementation of policy and guideline related to health. We ensure it by close supervision and monitoring in ward and facility level. Recently, I have visited all health facilities of metropolitan city for monitoring and ensure health programme activities are conducted on timely basis*” MBi02L, Government Official, metro LLG.

Provincial level government officials, however, demonstrated a mixed picture, in some respects.

> “*Not much problem on decision-making. Like Health Service Act was prepared following due process with provincial parliament/elected officials and staff doing their work*” MJa01P, Senior Government Official, PL.

But on other aspects, even the same respondent described less clarity with regard to planning and budgeting processes compounded where legal frameworks cannot be implemented with Acts still awaiting their passage through parliament.

> *“Constitutional mandate is not strong and there is no adequate authority even within constitutionally mandated areas; province has revenue generation authority, but it has not been able to generate significant revenue, so it is reliant on federal grant; health infrastructure is not adequate even within ministry to exercise authority like we don't have enough rooms for departments. Five provincial ministries are located in one building; we can't even post available human resources to required duty stations as concerned staff have brought 'stay order' from court on staff adjustment which allows them to remain stationed in their desired place and not in a place where they need to be; lack of federal Civil Service Act [pending in parliament] is creating uncertainty at province level as to whether implement the Provincial Civil Service Act prepared, as all provincial Acts need to be within the parameters of federal Act. Thus, though we have created Act we have not prepared regulations due to the situation.”* MJa01P, Senior Government Official, PL.

Respondents point to the gaps in the coordination and relationships and ability to access information and advocate for resources, that are affected by challenges in coordination with other levels of government. Local level perception that provincial and federal levels have retained a greater control over resource allocations and spending has contributed to distrust and tension among local level elected representatives. Where mandates related to authority about allocation of resources are concurrent, they report feeling constrained to make some decisions due to a ‘recentralisation’ of powers at federal level. Provincial level government officials said they felt that they have very little authority is given to them and that there is federal level reluctance to ‘let go’ of power. There is thus a general sense of low empowerment among provincial government actors.

> *“The federal government holds the more rights, power and the budget and allocates or distributes fewer rights to the province and the local levels. Even after the federalism, the federal government doesn’t want to share the power and rights to the local level and has centred the power and the rights at the federal level. Even the budget allocation to the local level isn’t adequate as per the need due to which there are some difficulties to fulfil the responsibilities to local level*” LBu01L, elected official, PL.

KIIs showed that federal level officials harbour a level of distrust with regard to the capacities and knowledge of the health priorities at the local level. For example, concerns were expressed that ensuring adherence to clinical protocols or quality assessment initiatives was

challenging to ensure since local levels of government are autonomous and therefore feel that they are independent from federal guidance. Federal MoHP also feel that as they cannot 'enforce' national level guidance, they had relied on individuals at the facility level being motivated to follow such technically sound guidance. This was very likely to be compromised in the transition phase as local governments continued to have several capacity gaps.

Formal frameworks governing roles and responsibilities in the health sector

Many permanent positions are unfilled and vacant at provincial and local government levels while the Civil Service Act is yet to be passed in the parliament. Without this, provincial governments are unable to undertake permanent recruitment for filling permanent positions at local and provincial levels. Even when the province is preparing its own civil service law but not implementing this because federal law will need to bring certain provisions to the broader framework. Constitution mandates provincial laws to be within the framework of federal laws.

> "*Though we have provincial Civil Service Act we have not been able to prepare regulation so we could not implement the Act. Unless federal Civil Service Act comes, there won't be desired clarity*." MJa02P, Senior Government Official, PL.

The Organisational and Management Survey (O&M survey) is the assessment tool used to determine staffing needs in Government, including in the health sector, but this has not yet been completed across the country. This raises the risk of ineffective or inappropriate allocation of resources.

> *"We must do human resource management assessment but till now our Palika haven't done. We do not have any mechanism to ensure the right person in right place taking into account patient, nurse, paramedics ratio. We do these things randomly*." (MHa06L, Government Official, urban LLG.

During group process map validation workshops, respondents described some instances of overstaffing, usually related to accessible areas, typically urban municipalities, and described gaps in human resources particularly in more remote settings and facilities. One key informant described how some staff resist transfers using legal means:

> "*we can't even post available human resources to required duty stations as concerned staff have brought 'stay order' from court on staff adjustment which allows them to remain stationed in their desired place and not in a place where they need to be; lack of federal Civil Service Act (pending in parliament) is creating uncertainty at province level as to whether implement the Provincial Civil Service Act prepared*" MJa01P, Senior Government Official, PL.

Where there are gaps, local governments hire contractual staff since they cannot recruit permanent staff. The hiring was reportedly often politically influenced (more so at LLGs than PLs) so not all individuals recruited are considered appropriately skilled and experienced (as discussed in the earlier section, 'Actors, Roles and Dynamics). Even when permanent positions are filled, there not enough health staff because human resources planning is not done based on population size but more on resources available and expressed needs, the decision of which is also mixed in local government political dynamics.

> *"Not all positions are filled. There is a lack of qualified human resources. There are no adequate SBAs, which has affected the service delivery. In a birthing centre … there are only* 2." MDh01L, Health official, urban LLG.
>
> *"Out of 19 positions, only 11 are filled and other staff members are taken from the Palika on a contractual basis [and they] are not skilled and trained."* MSa06D, Senior Health staff, District.

Planning and Budgeting

Key messages

- Lack of formal lines or guidance mandating communication and coordination between the different levels of government persists, especially where there are concurrent functions assigned.
- Conditional grants issued from the federal level flow to provincial level and directly to the local level; whilst this strengthens communication on some issues between the local and federal levels, information sharing with, and therefore, influence of the provincial level is limited.
- Timely management and spending of health budget is hampered by late issuance of grant guidelines.
- Health is not always prioritised and relies on elected officials understanding health priorities and needs and balancing this with their other priorities. The involvement of health officials in planning and budget discussions relies on personal networks and is not systematic. As a result, the level of budget allocated to health is often not made based on evidence and therefore not commensurate with need.
- Local level planning at ward or municipal level can work well with wide consultation when leadership is strong, but this is not consistent.

Coordination in planning processes

Coordination remains a huge challenge by a lack of institutionalised mechanisms vertically between federal and provincial and local governments. This starts at the federal level where there is no formal mechanism for coordinated planning with provincial and local governments, as can be seen clearly in the process map for planning and budgeting (refer to the process map, Figure 3, at the end of this section to see the formal processes in place).

> *"We do not have any coordination mechanism with district, province, and federal and other stakeholders"* MHa05L, Elected official, LLG.
>
> *"We do not have any mechanism to avoid duplication of programme/activity. We do not know how provincial government is working and what are their plans*" MJa01L, Health official, LLG.

The issues in coordination and lack of effective consultations taking place run through all levels of the government, including at local levels where it can result in the lack of priority given to health issues or needs:

> *"Coordination has not been so effective as it does not address the [health] issues rather, they focus on infrastructure and things which can be physically seen."* MYa02L, Health official, rural LLG.
>
> *"The lead [in decision-making processes] in ward is done by ward chairperson and palika is done by mayor. For the decision-making process, some planning recommendations are taken from the lower level through people which are then passed from the ward. This is what needs to be done but it does not happen 25% of the times.*" LSi02L, elected official, rural LLG.

Coordination can be challenging between the provincial and local levels, and with relation to budgeting, this is partly linked to the flow of the conditional grant, which goes direct from federal to provincial and from federal to local levels. Thus, the provincial government is not aware of the amount of resources made available to local governments and are bypassed in communication since LLGs communicate directly with the federal level in relation to the conditional grants. This negatively affects the provincial level authority to contribute to streamlined planning.

"*Palika are better coordinated with federal government because they get budget from federal so federal has budget leverage, province can't do anything as we don't have budget leverage, so Palikas don't listen to us. We don't know what federal government is providing to Palikas which impedes our decision-making; we have limited budget as we use conditional grant from federal government. Our budget goes to Health Office and hospitals. There is poor coordination with Palika of Health Office*." MJa02P, Senior Government Official, PL.

However, there were reports of attempts made by the federal level to improve coordination with provincial governments in relation to planning through their involvement in ministerial planning forums. One initiative for example, whereby the MoHP at federal level has introduced a practice of conducting a pre-budget discussion at least once a year inviting secretary of the Social Development Committee (for health, where a separate ministry has been formed, as in Lumbini province) Ministry and Provincial Health Director.

We found some examples when local level leadership is strong of initiatives to improve coordination at local level, for example where the Health Unit Chief is involved in meetings to prepare plans, or an initiative to establish a Mayor's Club to exchange.

"*At first, we conduct ward level convention which includes health representatives, FCHVs. After that, they discuss with health sections and final discussion is done by Social Development Committee with Health section in which the procedures are finalised. Till now we didn't feel any pressure regarding decision-making. ......First thing the convenor of Social Development Committee is good. The leadership is good.*" LSa03L Health Official, urban LLG.

"*Federalism has contributed to a lot of contribution to us, and it has strengthened our local level and we have own priority and interest of the people. Some of the amendment should be done in constitution for strengthening local level. Now in federalism it has made competing environment, 'Palika to Palika' and all palika works for betterment and development learning from each other. Three palikas are adjoined to our palika territory and we work coordinating with neighbouring palika. We have formed "mayor club" of all 18 palika chief at xxxx district and we conduct meeting once in a month and we share problems and achievement in that club."* MYa03L, Elected official, rural LLG.

Use of evidence and expertise for health planning

There is generally a lack of health evidence being made available to decision-makers at planning forums, compounded by the lack of evidence-informed advocates for planning forums. This can result in health not being prioritised:

"*How health budget is allocated] is arbitrary; political interests work; health budget is less any way and even then, priorities are diverted, and vested interests work. Some factors influence like elections are coming; so, there is no full time in implementation [because of] delayed budget release, no adequate budget, inappropriate allocation, no allocation based on what we suggest.* MJa05P, Health official, PL.

Health budget is insufficient especially in FCHV programme, drug procurement, remuneration to contract-based staff etc. The main reason behind insufficient budget is that it is programme planning is not done as per need and evidence." MYa02L, Health official, rural LLG.

"*We have data in DHIS 2, eLMIS but we don't discuss about the health-related needs and plan according to it. Overall, the elected representatives feel that the federal government must look at the health sector. They think that the conditional budget includes all the health-related programs. The ward levels also don't give priority to health-related planning. The prioritization is based on which sector the elected representatives feels that it must be prioritised. They have the knowledge that*

medicines must be present in the curative aspect but don't focus on the preventive, promotive and palliative part. The elected representatives plan the activities that are distributive type and visible by the eyes which can be a political agenda" LMa01L Health official, urban LLG.

Our respondents reported that it is common for Mayors to have no or limited understanding of health and how to understand health priorities. The health section chiefs have the remit to provide oversight to public health in each municipality and should be the post holders at local level who are the health advocates and who equip the Mayors and other decision makers with the relevant evidence and information to understand health issues and allocate resources to them.

"Educated and active mayor matters a lot in the local level health system. The section chief must be technically strong with good knowledge and skill to convince the mayor." MHa01L Health official, rural LLG.

However, the Covid-19 pandemic has given Mayors and other non-health actors in the health system reasonable exposure to the importance of the health sector and health issues as they were intensely involved in planning and responding to Covid-19 for almost 2 years. This has helped raise the profile of the health sector.

Local level budgets and budgeting

At the local level, conditional grants are the biggest share of health budgets received from both the federal level and to a lesser extent provincial government (see process map for planning and budgeting at end of this section, Figure 3). These were often reported to be inadequate and not based on needs assessments and therefore not reflective of need and differences in contexts. For example, larger sub- or metropolitan municipalities do not see a proportionate increase in their grants compared to rural municipalities with smaller populations. Respondents cited inadequate funds to cover salaries for staff or to recruit health personnel, sometimes having a knock-on effect of reducing ability to implement activities on time (and therefore spend).

"*We have limited budget because neither conditional grant is sufficient, nor we have adequate internal budget. Federal conditional grant is sent equally to all the palika without proper mapping.*" MLA01L, Health official, rural LLG.

"*We are sub-metropolitan city, but we receive conditional grant like rural municipality. We mostly have shortage of budget in health system*". MJa01L Health official, sub-metro LLG.

"*We utilise conditional budget according to the guideline and mainly for staff salary from internal source. Because budget from federal was only sufficient for 6 months' salary of staff at basic health care service centre.*" MHa01L, Health official, urban LLG.

A common bottleneck to the timely management and spending of conditional grants is the guidelines for budget preparation not being shared from federal level with enough time to plan effectively.

"We *get federal conditional budget which includes the guidelines too. So, it is easy to use the budget, but a key difficulty is that the guidelines are not timely sen*t. LSa03L Government Official, urban LLG.

This can result in delays in ability to implement activities and under-spending. Since the subsequent year's grant is normally based on the current years' expenditure, the late implementation of activities has the knock-on effect of a reduction in the next years' budget (see box 2 for example).

Box 2: Consequences of late transfer of resources

Respondents at a process map workshop reported federal government provided funding for a Rural Ultrasound Operation Programme in 2077-78 (2020).

"*However, the Province did not provide portable ultrasound machine and training for human resources until towards the end of 2077-78. It was too late for us, so budget froze. In 2078-79, the federal government cut the budget … as we did not spend last year. Last year's spending plays an important role in this year's budget allocation. This means we had money but no equipment and training last year but this year, we have equipment and training but no money. A better coordination in planning and budgeting would have avoided this kind of situation.*"

[Field notes from workshop, 18 April 2022.]

Raising funds through local revenue was easier for some municipalities with revenue base than others. Some local governments have developed guidelines planning of local sources of funds whilst others have not.

> "*In order to make local government independent, we can collect tax and increase the scopes for tax collection. We can even generate income through tourism sector in xxxx, xxxx.*" LSi01L, elected official, rural LLG.

> "*For the internal budget activities, we prepare the proposal and get approved from CAO. We also prepare some guidelines to implement the health-related activities.*" LMa01L, Health official, LLG.

> "*Moreover, we do not have other documents/guidelines apart from conditional grant operation guideline.*" MJa01L, Health Official, urban LLG.

The main review mechanisms in the health sector at the local level are the monthly HMIS/DHIS2 data verification meetings attended by Health Facility In-charge and Health Section staff and local governments also organise six monthly and annual reviews. The extent to which these reviews influence municipality-level planning and budgeting depends on planning dynamics (already described above), and on how influential a Health Section Chief is. Their involvement in these budget planning forums is not systematic and often lacking. Further, health sector chiefs lack capacity to influence the budget allocation in favour of health before locally defined budgets are approved.

> "*Budget is not allocated for health-related programme from internal source of palika. …Health section staffs need capacity enhancement training on planning and budgeting process at palika level.*" MYa02L, Health official, rural LLG.

> "*We have regular monthly review meetings with the health facilities, but the issues raised by health facilities in those reviews don't come usually through the [seven-step] planning process.*" LBu03L, Health official, PL.

Provincial level budgeting

At the provincial level, respondents described following guidelines for planning and budgeting for grants flowing from federal level, but also described how a lack of or late coordination between the three levels of government creates challenges in being able to sequence planning budgets logically and prepare thoughtful plans and budgets to avoid duplication or gaps.

> "*There are mechanisms for budget making at…all three levels including provincial but there is no sharing among levels governments. Sequential process among governments would be good; there is no communication about what federal government is planning to provide to local levels. We don't know yet what is coming to province for next fiscal year though we are in Chaitra month [about three months before*

federal budget is due to be announced] ... if budget of every government could be shared in advance it will help as all levels of government would know what others have." MJa01P, Government official, PL.

"*elections are coming so there is no full time in implementation due to …delayed budget release, no adequate budget, inappropriate allocation, no allocation based on what we suggest. We can't give much to Palika as federal government retains the budget. Palikas expect from us but we don't have money so they don't listen to us, and it weakens any influence that we could have on local governments. Federal government does not care much about this situation of provincial government*." MJa05P, Health Official, PL.

Provincial level respondents also reported inadequate amounts of grants received from federal level. This limits the amount they can pass on to municipalities and this, weakens their influence and authority with local governments.

"*There is no formal mechanism in health sector for a coordinated or integrated planning*." MJa02P, Government Official, PL.

"*The annual review meeting is organised every year where we plan the activities according to the gap in the indicators palika wise. We provide feedback to the province and federal government, but they do not plan the conditional grant activities according to the feedback which would reflect the Palika [or] district needs."* MMa01D Government Official, PL.

Duplication in programmes

The lack of coordination between levels of government can result in duplication of activities or delay in programme decisions by local and provincial governments. As a result of delays in issuing conditional grant guidelines and because they go directly from federal to provincial and directly to local levels, this can contribute to poor coordination and communication in planning. This in turn results in some cases to duplication of activities, requiring last-minute budget adjustments at local levels.

"*There is work duplication…The budget of the Province should have been different but both federal and province level budget are similar to each other…. Similarly, some programs planned by the province and the federal government but have low budget, we allocate the budget for those programs as well though the activity is duplicated. We have a committee which reviews the budget and activities whether it is duplicated or not*". LBu03L Government Official (sub metro), LLG.

Federal conditional grant tends to be the top priority for municipalities as it makes up the greatest share of municipal health budgets. There is pressure to spend against the conditional grant activities and this is considered sometimes not to be aligned with local needs. Additionally, there is pressure to spend because funds may be frozen if they are not spent within the fiscal year, affecting the amount that will be allocated in the subsequent year.

In the process map for planning and budgeting, there is no formal role given specifically to Health Section Chiefs of Health Offices. They do feature in the flow of health information in the HMIS process (see Annex 5), and in theory HMIS information should be reviewed by all levels of government and feed into AWPB processes. However, evidence from our process map workshops revealed that this does not happen in reality, in neither annual nor other review forums.

Effect of COVID on health budget

Local level respondents provided many examples of how budgets were affected by COVID, reflecting their enormous response to implementing COVID-related activities. Budgets were diverted from other programmes in health and other sectors to the response.

“*During COVID we could not conduct other programs. We had to allocate more budget in the covid management as we managed the quarantine and isolation facilities, but we could not provide curative cure properly. Health programme was given priority and most of the budget was allocated for COVID management*.” LBu03L, Government Official (sub metro), LLG.

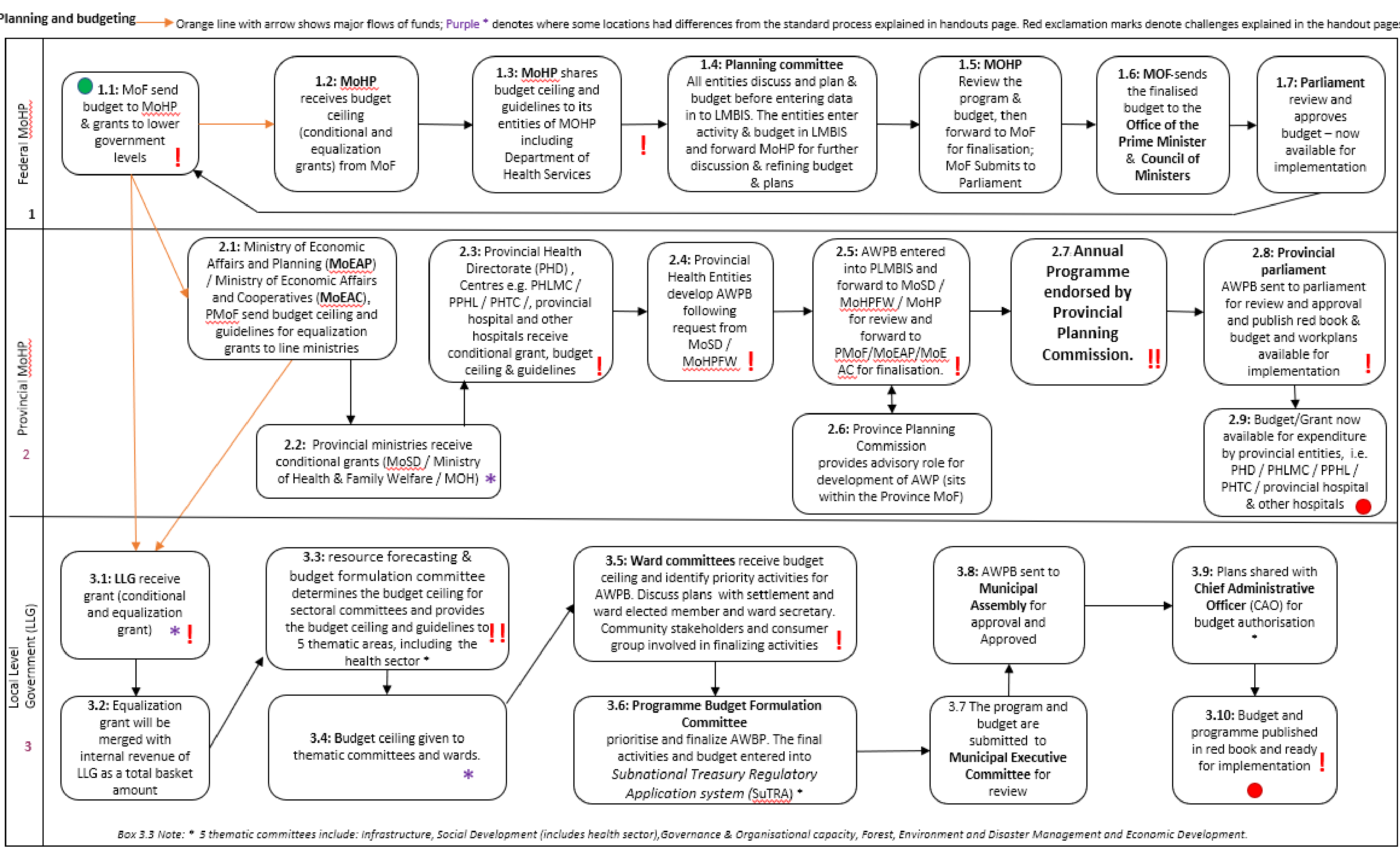
COVID placed a great burden on the health system and health staff paid a great toll. Despite these challenges, the pandemic was perceived to have shone a torch on the importance of the health sector and has the importance of planning for crisis response. Budget revisions led to some improvements in hospital infrastructure and managing budget planning improved for the second wave response.

“*Mindset of people here is development of infrastructure is only the real development. COVID context has brought a slight change with priority in health sector.*” LSa05L Government Official, urban, LLG.

“It did impact much on the budget expenditure. We could not do many activities allocated by the conditional budget and we could not even do many activities of our internal budgeting (samanikaran). … Due to COVID, there has been improvements in the internal infrastructures.” LMa01L, Government Official, rural LLG.

“in second wave, we learned to mobilise our staff, we separate budget for covid 19 and handle all the other activities of palika very systematically. Also have hired the doctor for covid-19 response.” MHa06L, Government Official, urban LLG.

Figure 3 showing process map for planning and budgeting *(Please see Annex 5a for PowerPoint with handout page that details the bottlenecks and suggested solutions identified by process map workshop participants)*



Procurement and supply chains

Key messages:

- Increased purchasing authority at local level appears to have led to reduced stock-outs, however this may be at the expense of reduced quality for the price (cannot benefit from economies of scale).
- Limited communication, coordination and unclear procurement roles and responsibilities across the spheres of government leads to lack of clarity on who is purchasing what and often results in concurrent purchases and duplication.
- Quantification is usually based on the previous year's purchase and use of supplies, rather than actual need – there is a lack of accurate data for proper needs assessment and planning is haphazard.
- Decisions on local suppliers is sometimes influenced by personal interests and financial gain.
- There is a lack of trained staff in procurement and supply, and Health Section Chiefs, for example, are untrained in this area.

The procurement process starts with federal MoHP sending the procurement budget ceiling to sub-national entities (provincial and LLG) based on which each entity develops an annual procurement plan, and the budget is prepared (see process map., Figure 4, at the end of this section). Many LLGs do not prepare a formal annual plan at the time of the annual planning process but only allocates a nominal budget. They instead prepare a plan ahead of launching the formal procurement process.

Province / Health Office role

Whilst procurement responsibilities have mostly been devolved (see process map in Annex 5 that lists commodities procured by each level of government), roles and responsibilities for procurement of medical supplies across the spheres of government are unclear and there is a lack of coordination. At the provincial level, the Provincial Health Logistics Management Centre (PHLMC) is responsible for quantification and procurement of basic health medicines (as are LLGs, see below). This sometimes results in **duplication** at provincial and local levels.

> *"There is confusion on purchase about which level of government should buy what types and quantities of medicines as there are not clear guidelines. For example, there is no formal clarity about who purchases free essential medicine, emergency drug, IM, NCD drugs, maternal health medicines; vaccine and family planning are clear; which level should do what is not clear; free medicine purchase should be done by local; equipment purchase should be done by provincial and vaccine, family planning purchases should be done by federal governments. "* MJa04P, Health official, PL.

Respondents reported a number of challenges within the PHLMC procurement unit (responsible for quantifying supplies needed) affecting needs-based quantification and procurement. Firstly, the procurement budget received is mostly inadequate. Also, there is a lack of real data available for quantification, estimates are usually based on orders from the previous years and what was used, rather than need. The Health Office and PHLMC are not aware of what the local governments are planning to purchase due to lack of coordinated planning.

There are also high variations in cost estimate and bid amount, and participants from our process map workshops reported that there is no practice or consideration of life-cycle cost (maintenance, running cost, operation cost etc.) during planning and cost estimation. Respondents reported that some sanctioned posts in the PHLMC that are responsible for maintaining inventory functions are vacant. Relevant staff do not always have the skill or capacity in developing the standard bidding document resulting in various regulatory and operational complications.

Provincial level hospitals are unable to develop timely annual work budgets partly related to a delay in preparation of procurement plan due to staff turnover **and lack of access to PLMBIS.**

At the Health Office, monthly health update meetings should be held with LLG and health facility staff to review all health programmes as well as supply (broad management function, not solely related to procurement), however this meeting is not usually held, reducing opportunities for coordination and collaboration.

A common complaint from Health Offices was the receipt of drugs close to expiration, and this was compounded by lack of adequate storage facilities, and linked to waste of drugs:

> *"One challenge identified is sometimes we are given medications that are nearer to expiry date for distribution which causes problems. We cannot even finish the medications before the time requirement so if there was supplementary equipment for its storage or any other things it would be easier."* LAr0D, Health official, PL.

Local Level Government role

The federal government provides conditional grants to local level governments for medicine purchase. This is a lump-sum amount and **not based on needs assessment** of specific local government requirements. Respondents reported that the **budget sent is generally inadequate** meaning that local governments need to supplement it with their own internally raised resources.

Local governments have the authority to purchase over 100 types of 'free essential medicines' through a procurement unit which is led by a municipality's senior official (other than CAO who leads the procurement committee). The procurement unit includes staff from accounts, administration, and a technical person. **No dedicated procurement committee exists for the health sector** - the same committee is responsible for all procurement undertaken by local government. This means the responsible 'technician' often comes from engineering or other non-health background, because infrastructure related procurement usually constitutes a bigger share of procurement. Thus, the procurement officers are not necessarily aware of the requirements and quality issues specific to medical products and drugs.

However, local levels seem clear on their mandates in terms of procuring drugs:

> "*We have a Procurement Committee, and we have the Social Development Committee therefore there is no difficulty in procurement process. Prior to the federal arrangement, the procurement and supply processes were handled by District Public Health Office. Now, the procurement is easily done by the Procurement Committee at the Palika level. There is no problem in procurement and supply since the Municipality is given exclusive authority for this.*" MDh01L, Health official, urban LLG

Some, but not all Health Section Chiefs are involved in the procurement process, however they do not have specific training in this area, and there was a general lack at local levels on the wider procurement and supply chain management system. There are instances of the Health Section Chief being duly involved and not in the procurement process. In one municipality, the Health Section was found to take all the required responsibilities for medicine procurement due to the Chief Administrative Officer delegating the authority (except for final sign off) to the Health Section Chief, but it's unclear to what extent this helped the process.

> *"CAO, accountant and health staffs are more involved in procurement of medicine. Sometimes medicine has been purchased without involving health section."* MYa02L Health official, LLG

> *"I don't know about the procurement and supply. There is a procurement and supply committee for this, and Health Section Chief is not involved in it."* LSi05L, Health official, *rural LLG.*

Medicine purchase receives reasonable prioritisation at the local level. Local governments generally remain keen to maintain some level of autonomy to purchase medicines locally, one

key motivational factor being more control over **medicine supply regularity** to mitigate **stock-outs**.

> "*Some of the positive aspects of federalism are that we can purchase as per our need and availability throughout the* year." MYa02L, Health official, rural LLG.

However, personnel interests alleged to have also fuelled an interest to buy locally, with frequent reports of purchases being made from close contacts (usually of senior staff bureaucrats, elected officials, or even procurement committee members) usually with a financial gain.

> *"Procurement of drug was jeopardised just because they want to procure it from the mayor's relative."* MJa02L, Health staff, sub-metro LLG.

In some cases, some business interests attempt to try to influence local medicine and equipment buying at the planning stage. Some local medicine suppliers were also reported to lobby municipalities during annual planning processes to keep a higher budget for purchases.

While local government prefer local purchasing, buying in small quantities and from local suppliers, there will be losses in terms of economies of scale.

Challenges in procurement and drug supply at subnational levels

Availability of drugs to facilities

Health facilities receive drugs from the Health Office via a push and pull system. Due to inadequate budget in the local governments and inadequate supply from the federal and provincial governments, the supply generally tends to be less than what is demanded. Some health facilities have small funds to purchase medicines locally, in cases where ward offices receiving budget ceiling in the annual planning process retain budget for purchase of medical supplies.

Stockouts of drugs were reported by respondents, pointing to issues with quantification and forecasting. Drugs referred to as shortages included paracetamol, Vitamin A, anti-D.

> "*but we are lacking important drugs like Paracetamol. Sometimes we will have large amount sometime not. Palika uses to send nearby expiry drugs. I don't know what is working here. We also use commodities requisition form and send to palika, palika send by their supply system as requested but again we cannot receive in time. Sometimes we must send clients with empty hands."* LYa03L Facility staff, rural LLG

> *"The supplies received from the Palika are in low quantity, but we get more from the Province as compared with our demands. The supplies are not available on time and that affects service delivery."*

Some respondents in Lumbini (but also known to occur in other places) described a practice of 'reverse logistics' – an informal but important process whereby when some medicines are overstocked (or, very low consumption, or near expiry) at a Health Office or health facility, they are pulled back to the Health Office and sent to other places where the stock is very low or out of stock. This process happens (occasionally) when the logistics staff are well versed in their jobs and the eLMIS functions properly.

Lack of capacity for quantification and forecasting

> *"We provide based on quantification and forecasting but the Palikas demand haphazardly." MSi07D Health official, District.*

The Health Section remains generally aware of health facility medicine needs through attendance in monthly meetings with health facilities. Local level quantification of medicines is not always based on need, but rather based on historical consumption patterns of the previous year and based on any knowledge that the Health Section would have acquired through their interaction with health facilities i.e., more on a hunch than scientific calculations / evidence-

based. There is a need for more widely available and up-to-date data, which the eLMIS offers to do.

Though eLMIS coverage is rapidly expanding, the system is not yet functional for all health facilities to complete online data entry, not all people who need to use it are fully familiar with this and there are weaknesses in data quality and completeness. For example, some facilities are still awaiting login rights to be provided ("*We requested username and password of e-LMIS but we did not receive yet, but it is in process*" LBa01D Health staff, district hospital). The workload of municipality Health Section staff generally does not allow them to do the quantification thoroughly in the absence of instant data available online or offline, compounded by their inability to fully use the system yet,

> *"eLMIS is not fully embedded at local level; not everyone is trained"* MJa04P, Health Official, PL.

As alluded, there is widespread lack of capacity to fully use the eLMIS: the Health Section Chief and other staff are not trained on legal, technical, and other aspects of procurement processes so even if they manage the workload, they cannot provide effective support in all aspects of procurement including in needs assessment, quantification, and forecasting.

However, the digitisation of data on eLMIS was appreciated, data with some incentives to submit data in a timely manner, notwithstanding the challenges in software, hardware, and internet connectivity:

> "*If there weren't DHIS and LMIS, then there would not have been proper recording of the reports and data and we would have to refer to the handwritten register (Dadhha paltayera), so I think it is well managed and the data are stored properly in it. We can get access easily to data when we want. There is in time reporting as the concerned authority feel that they have to report it on times else they will receive less number in their evaluation, we can also get access to the monthly and quarterly reports easily. It is also easy to provide the feedbacks easily. It is also easy to do the data analysis. There might be problems in internet access, lack of trained manpower, lack of computers laptops*." LMa01L, Health official, rural LLG.

Ad-hoc practice in medicine delivery

Although LLGs are responsible for managing transport of medicines from the Health Office medical store, the Health Office or LLG **rarely have the resources to deliver medicines**. Sometimes municipality vehicles are requested by the Health Section to deliver medicine, and on occasion the local government pays if it has the allocated budget, but not all local governments retain adequate money to collect medicine from the Health Office. This often results in medicine deliveries being delayed, even after a Health Office has allocated them to a specific municipality. Although somewhat haphazard, transport of drugs was not presented as a challenge.

> *"Today itself, we took 4 vehicles of municipality to provide the vaccines. It's not that challenging to supply the medicines, we send the vehicles to the district Health office, and they send the medicines to* us." LBu02L Health official, LLG.

Store management at local government

Due to lack of adequate medical storage facilities, local governments try to distribute medical commodities to health facilities as soon as they are received from the Health Office (although medicines requiring cold storage are usually managed and retained at the Health Office store due to lack of freezers in most facilities).

> "*We give to Palikas but the Health Sections at the Palikas don't have store management. The Health Office also doesn't have transport costs*." MSi07D, Health official, District.

There is a lack of trained personnel in dealing with medical supplies for example skills in safely loading and unloading medical commodities and storing them as per instructions to ensure their integrity and quality e.g., avoiding direct sunlight for certain commodities, not storing some packages upside down.

Lack of coordination and unpredictable supplies

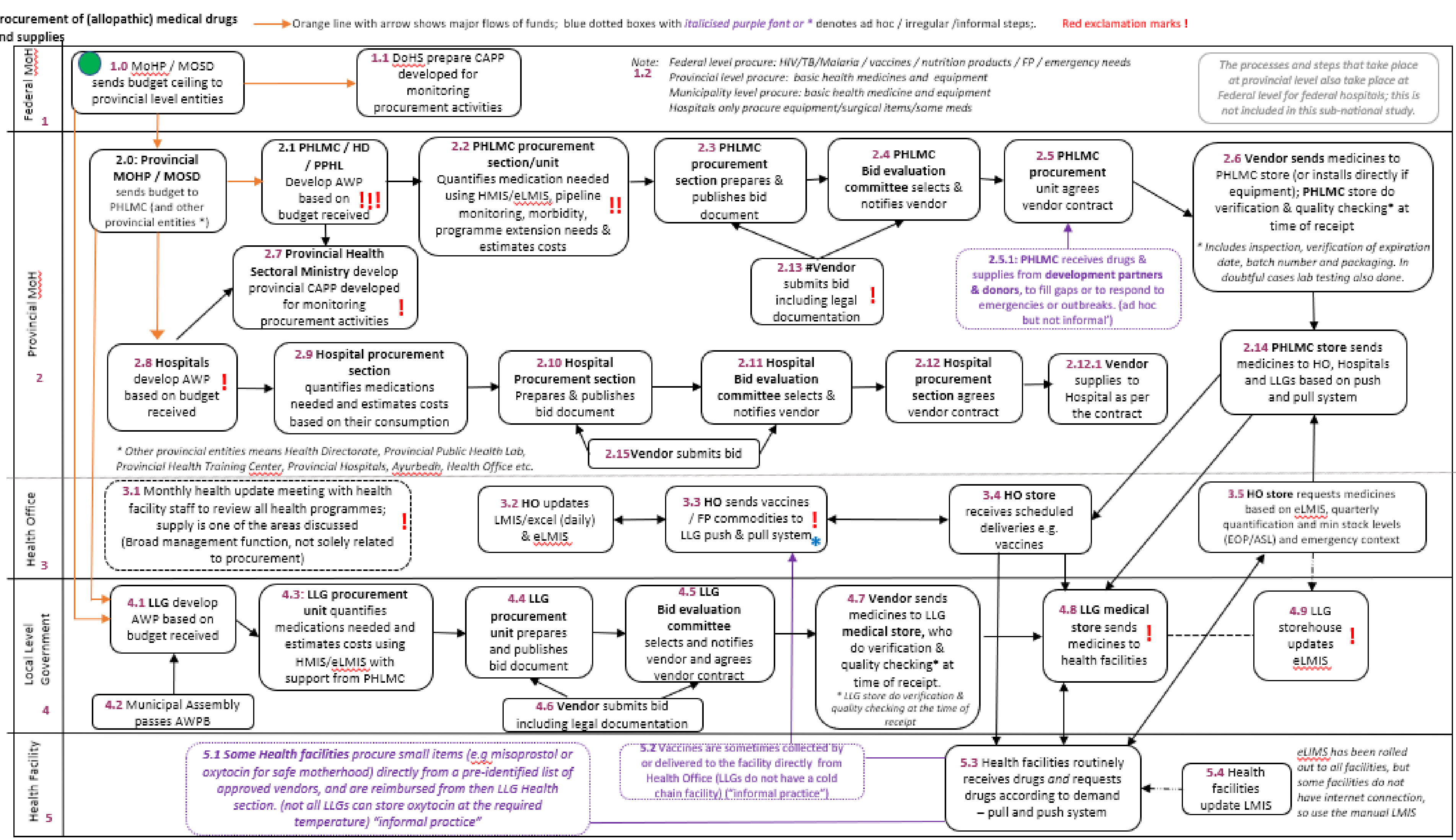
Concurrent purchasing across different levels of government is compounded by limited communication and coordination means that there is a lack of knowledge and clarity on who is purchasing which medicines and what is currently in stock at the local level and health office, and when supplies will arrive. Local governments do not know the quantities and timing of medicines to arrive from the Health Office sent by federal and provincial governments. This unpredictability at different levels sometimes results in medicines close to the expiry date being supplied.

> *"We have procurement committee at palika who are responsible for all the procurement and tendering process. We do not coordinate with district, province, and federal government for procurement process."* MHa06L, Government official, urban LLG.

> *"Federal said they would send some medicine and asked our local government not to buy the medicine, so we did not, but later faced shortage. We don't know what medicines Health Office has. If there was a clear-cut coordination between federal, province and local level programs before the fiscal year, it would be much easier for the implementation of programs. But they did not consider it and we face duplication and insufficiency.*" LSa03L Health official, LLG.

> *"District Health Office has not adequately provided municipality with contraceptives such as depo, pills, condoms. We placed our requisition in the eLMIS system for 5,000 units of depo, but they sent us only 500 units."* MDh01L Health official, LLG.

Figure 4: Process map for procurement of medical drugs *(Please see Annex 5b for PowerPoint with handout page that details the bottlenecks and suggested solutions identified by process map workshop participants)*



Health management information system

Key messages:

- Reporting through digital HMIS is steadily increasing, and with the data available online, anyone at any level of government with the relevant administrative rights can access HMIS data.
- Despite the scale-up of electronic reporting systems, many facilities still lack the required infrastructure for online data entry, or health staff have not received the required training.
- Data monitoring and accountability are weak, and health data is rarely reviewed for quality and meaning during monthly Health Section meetings.
- Health Offices lack the authority to strengthen data quality and timeliness of data entry at the local level.
- Lumbini hosts a functional data management team that regularly and systematically reviews data, from which lessons could be learnt.
- No reliable data are available from private sector health providers are shared with or at local and provincial levels of government.

Data capture and quality

The expansion of electronic reporting through HMIS is steadily increasing, and with the data available online, anyone at any level of government with the relevant administrative rights can access HMIS data. This, in theory, means the data on the HMIS system is widely available.

However, many health facilities remain without the required infrastructure such as computers, internet, and consistent electricity supply. Such facilities complete paper forms and submit them to the health office for data entry, however, there were reports of facilities not always having the required tally sheets. When paper reports are used, many local level governments reported late submission of receiving HMIS tally sheets on time.

Data entry typically starts around the 7th day of each month so that the online submission deadline can be met. Please see Figure 5 at the end of this section which illustrates the process map for the flow of health management information. Workshop participants reported that even where infrastructure exists, at this time, users often experience problems with the server (assumed to be because of the number of users entering data at the same time), posing a challenge to timely data entry. HMIS and DHIS2 electronic training also need to be fully scaled up as many respondents reported not yet receiving this. Lack of training also means that data completeness and therefore quality can be an issue.

> *"Everyone has not received HMIS and DHIS-2 training so they don't correctly do entry which creates issues while making report. In ward no 2 of xxxx Rural Municipality, there is no electricity they can't use these systems."* LSi05L, Health official, LLG.

> *"Sometimes we lack tally sheet. We do not enter HMIS data in DHIS2 in health facility as we don't have computer or internet and training. Budget is not allocated for information system at health facility level."* MJa02P Health staff.

Data review and analysis

Whilst respondents acknowledged some gains in the availability of HMIS data online, there was also a recognition that some data quality processes were lost. Previously, when paper-based reporting was in place, the District Health Offices had a role in collating information from all health facilities in their area. At this point, they would quality assure the data, liaise with facilities to address gaps or issues, and be aware of the evidence in their districts. There is now no clear active mechanism in place for local governments or municipal health sections to systematically review, quality assure data and take corrective action, or indeed, to ensure data are communicated to decision-makers and planning forums.

"After the implementation of federalism, the local governments run the health facilities therefore information flow has decreased through the Health Section. At times, we feel that information is blocked when the Health Section does not timely convey messages of the Health Office and Provincial government. This has caused delays in reporting. There is no clarity on which information should go to which staff [at the] Health Section, District Health Office and Province." MDh03L, Health staff, urban LLG.

Respondents at the facility level reported no major issues at their level with completion and submission of HMIS data, but they rarely get feedback on it.

Data use for health service review and planning

Despite the wider availability of HMIS data on the server, the use of data for monitoring and accountability purposes was highlighted as a gap, particularly sharing of information between local and provincial governments, resulting in limited meaningful data review and analysis. The HMIS process map shows the points at which data review meetings should take place, but they are often blighted with bottlenecks. Workshop participants shared that although the Health Section leads monthly meetings at local levels, (attended by health facility in-charges) intended for health data review, but in practice, the meeting is often limited to data entry and collection, not allowing time for review, analysis and use of the data to track progress or health issues in the monthly meeting.

Many Health Sections struggle to meaningfully verify data due to their workload. Local governments are not provided with disaggregated and analysed data which would help with evidenced-based planning. Also, no guideline exists for conducting the monthly meeting, which may otherwise facilitate improvements in this area.

"We prepare eLMIS report but there is lack of feedback mechanism. In monthly meeting, the details of the HMIS forms are not verified so data quality cannot be ensured." MJa02L Health Facility staff, sub metro LLG.

When data is available, it is not always used.

"*For instance, …we receive programs of spraying insecticides and bleaching [for malaria] and two lakhs budget is allocated for it. …but in [this rural palika], it has been we haven't entered a single case of malaria in DHIS 2 …in 10 years …and this data can be seen at the federal level.*" LMa01L, Health staff, rural LLG.

Where health issues revealed in health data are identified during the review of reports by the health section, they are not systematically linked to the AWPB process. Participants felt that using semi-annual review findings for AWPB would be more effective.

Accountability is not helped by the lack of authority held by the Health Office. If local governments do not provide data in time or data quality is unsatisfactory, the Health Office or other provincial authorities are unable to do anything about it, with their authority limited since this role is not outlined or mandated.

"We do not have M&E mechanism at district level to support local governments because Health Office and local governments don't have any binding document - policy, plan and guideline for monitoring and supervision. This is the big gap in health system." MMa01D, Health official, urban LLG.

There are some exceptions, however, in both provinces. In Lumbini province, for example, a provincial-level data management committee has been formed and is functioning in which it regularly and systematically reviews data (see boxes 2.2 and 2.3 in the HMIS process map, Annex 5). The committee is chaired by the Provincial Data focal person, other members include the HMIS focal person and development partners who are assigned to specific health programme data to review. A virtual monthly meeting is helped done with the provincial health offices to provide feedback on findings and to improve data quality.

“We see the indicators at the district level through DHIS-2, eLMIS, MSS. Based on the major indicators, we analyse and provide feedback. We use eLMIS for requisition before we send off supplies to local governments. We have appointed a focal person. The information management is done online and timely. We don't have any difficulty at the district level but at the local level, there are difficulties related with data completeness and timeliness.” MSi07D Health official, sub-metro LLG.

Private sector reporting remains a key issue and is linked to the issues around limited engagement with the private sector (discussed under ‘Roles & Responsibilities’). Local and provincial governments do not receive data from private sector health facilities and there is no accountability system of private health facility to provide data. Many small private facilities at local levels are not registered with local governments and those who are, generally do not provide data to local governments.

“Health information system is getting better; reporting is good; private sector reporting needs to be improved. We don't have budget for private sector orientation on information system. MSS is reasonably working well which tells us about where the gap is and where we need to focus.” MJa01P, Health official, PL.

“All private sector health facilities are not covered by information systems; some of those covered also don't report thus we don't have reliable data from private sector. For example, many cases of TB and malaria go to private health facilities, but we don't know about that.” MJa05P Senior Health official, PL.

The effect of COVID-19 on the health information system

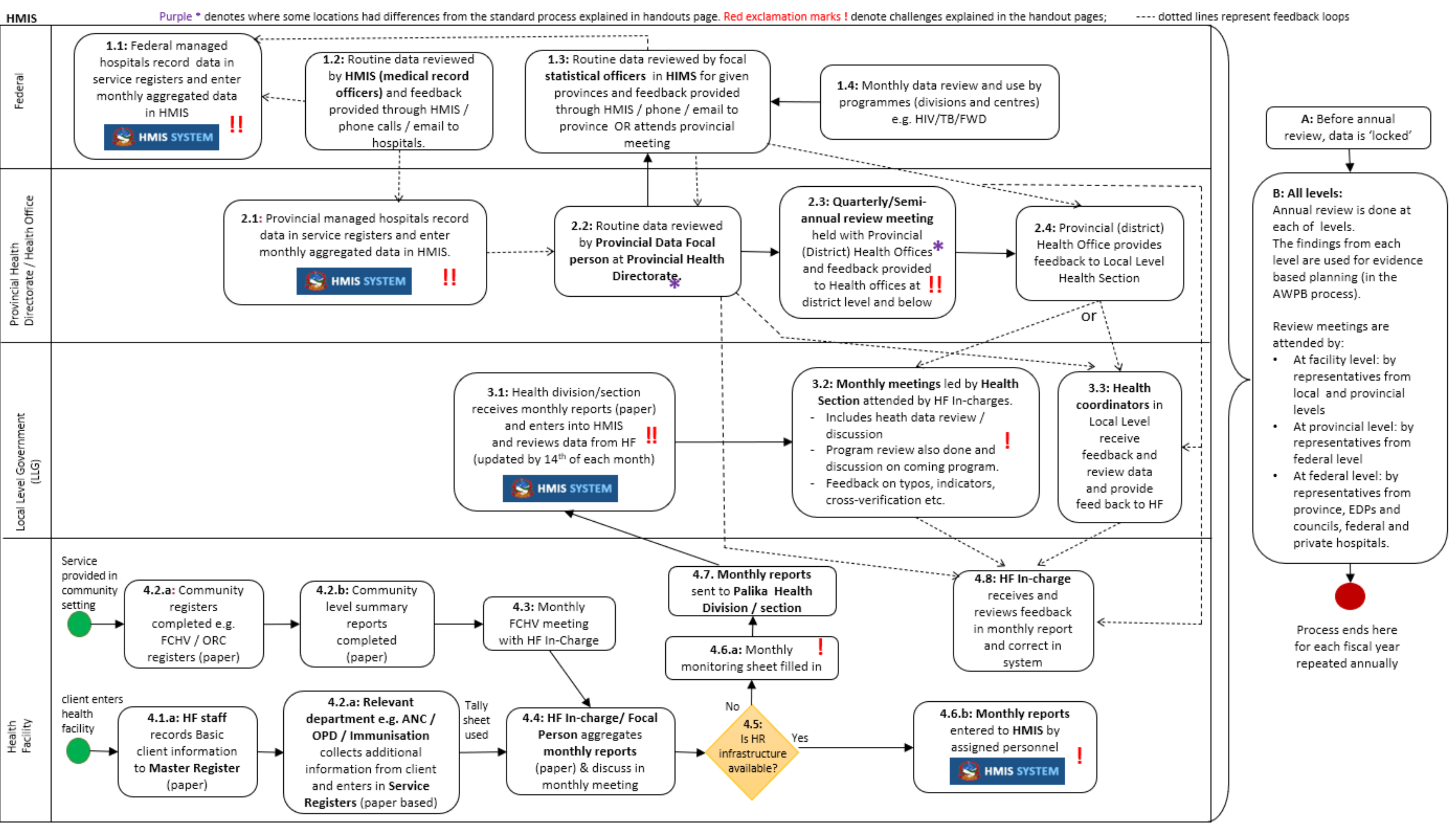
COVID-19 affected the regular health information system in various ways. A parallel COVID-19 information system was introduced nationally with a need to provide daily data on COVID-19 cases and other information like number of deaths, number of people in isolation centres, quarantine centres, regular and temporary hospitals, etc. Many staff were infected, some could not report to work due to deaths in family, some health staff also died. The combination of factors reduced the number of active health workforce causing delayed reporting. As COVID-19 subsided, regular reporting resumed.

“During COVID-19, staff were less, so information uploading could not be done on time. We were highly focused on providing information on COVID-19 which was not done through regular health information systems.” MJa03P, health staff, PL.

“COVID affected the reporting process. We could not update data on time.” LBu04L Health staff, metro LLG.

“COVID related data was entered in DHIS2 rather than other health related data.” LBa02D, Health official, PL.

Figure 5: Process map for Health Management Information System *(Please see Annex 5c for PowerPoint with handout page that details the bottlenecks and suggested solutions identified by process map workshop participants)*



Quality of Services

Key messages:

- Access to services has improved but not together with quality – quality improvement is yet to find a reliable home within the health system and focus by some elected officials is more on expanding infrastructure (in line also with political interest) without due consideration to ensure than providing quality of services provided.
- Existing quality improvement mechanisms are insufficient and inconsistent.
- Challenges with implementing the MSS include delayed funds and budget constraints (affecting scale up), lack of monitoring and accountability and the tools not appropriately adapted for all types of facilities
- Challenges with the onsite SBA coaching and mentorship scheme include inadequate or delayed budget, no feedback mechanisms, and insufficient clinical mentors.

Please refer to Figure 6 at the end of this section for two process maps for quality improvement initiatives aimed at strengthening service delivery, i.e., the minimum service standards assessment (a checklist for facilities) and Figure 7 for on-site coaching and mentoring for skilled birth attendance at a health post.

Roles and responsibilities for quality improvement

Generally, respondents reported improved access to services since federalisation, highlighting the opening of new hospitals and health facilities including birthing centres, improved health infrastructure including diagnostics, more staff training and increased budget in real terms (although percentage allocation to health has not significantly increased) as some of these improvements.

> *"There is a lot of difference since the federalism. Changes can be seen in the physical infrastructures, medical equipment, self-reliance for the electricity and water charges. This might be because the local government is closer to people and health facilities. The geographical area for the monitoring for the local government or health section has also been small. Previously, one district health office had to look after 80 to 81 institutions but now health section has to look only after eight health facilities."* MBi01L Health staff, metro LLG.

> *"Overall, after federalism, …trained human resource in health sector has slightly increased, birthing centres have increased, vacancies are provided at least by contractual staff and people have easy access to inquire about services. Palika allocates its own budget in health. Basic hospital is in operation and another hospital is being constructed."* LYa03L Health staff, rural LLG.

However, under the federal system, it is not clear where the responsibility for quality improvement of health services lies. Previously, this lay firmly in the hands of the District Health Offices with directives provided by the national MOH. Now, local levels are autonomous and have health sections but there are no health sub-sectoral specialists at local levels. The Health Offices now are not systematically involved in ensuring the quality of services, and the previous practice of drawing on skilled expertise from Health Offices no longer happens, and the local levels are also not practiced at drawing on provincial, or federal level for support where needed. As one federal stakeholder explained, quality improvement relies on "goodwill" and individuals wanting and knowing how to do the right thing for quality improvement.

Availability of health staff was mixed, with many participants expressing concerns over the lack of health professionals, partly due to the lack of updated evidence on which to base human resources needs, but also because of issues around changing disease patterns and expertise and staff preference to work in urban settings.

"We have sufficient paramedic, but we lack SBA trained human resource. So, we can say that there is lack of mixed skilled human resource. SBA trained nursing staff are overloaded with work, they have to do duty 12 hour without leave." MLa01L, Health Official, urban LLG.

"Human resources in hospitals of 50-100 bed are not adequate; they were adequate for 25-30 years ago; population has grown." MJa01P, Senior Government Official, PL.

"No, we don't have enough human resources. It is a 200-bed approved hospital, but we run up to 386 beds; we have 24-hour service. During staff adjustment, many staff left hospital to go to new places but not many came to hospital… The sanction post of the hospital is quite old and need to be upgraded based on the current population it is serving." MJa05P, Senior Health official, PL.

"*Our organogram is 25-30 years old; population has significantly grown in the period. …Also, disease patterns are also changing like non-communicable diseases are on increase. We are understaffed, number of bonafide human resource is less. OnM survey was not done for years, [but] we need more human resources than [the number of] sanctioned posts. In more accessible places hospitals are overstaffed because staff want to live in accessible places or cities so there is unequal distribution of staff. Many hospitals in remote are understaffed as staff don't want to go to those places." MJa05P*, Senior Health official, PL.

Local level government

Many local governments have invested their own resources in setting up municipality hospitals and birthing centres, and to supply health facility costs such as staff, equipment, utilities etc, supplementing insufficient federal government funds. While this is a positive development, the change in municipality leadership in many local governments after May 2022 local elections could present challenges as new leaders may not have the same level of exposure and commitment to health sector issues brought about by COVID-19.

Quality improvement mechanisms and processes

Under the unitary system, the District Health Offices had a remit to oversee quality and conduct and support quality assessments at local levels falling under their geographical responsibility. They functioned using guidance and standard operating procedures led by the central MOH. Since the removal of district-level authority from the political governance, and therefore health system, there does not appear to be a reliable 'home' for oversight for quality improvement and implementation of quality improvement initiates has been inconsistent. Federal-level respondents shared that since LLGs are devolved bodies, there is no mandate for quality improvement initiatives to be enforced and that this relies on individuals being driven to 'do the right thing' and not because there is a clear line of responsibility (or 'line of command'). Similarly, Health Office participants in group workshops were unclear of their role in terms of ensuring the quality of services.

Participants generally felt that existing quality improvement mechanisms and processes are insufficient. Local-levels' challenges include delays in funding disbursements hampering quality assessment activities, lack of adequate resources or lack of clarity on the use of available funds, lack of mentors, dedicated focal persons and un-familiarity with tools for lower-level facilities.

"There is no quality improvement mechanism. So, no one is responsible to ensure quality health services. The service delivery mechanism is not much effective due to lack of physical infrastructure and human resources." MJa04L, Elected official, rural LLG.

"Annual health review of palika is recommended to happen every year but it happened only once in these five years." MJa02L Health staff, sub-metro LLG

Some local governments reported having Quality Improvement Committees led by the ward chair, but many were reported as being inactive. Respondents from some local governments (e.g., Lakshminiya, Madhesh Province) reported that the HFOMC was the only existing mechanism to ensure the quality of health services. Where active, HFOMCs at the local level are expected to provide monitoring of health service delivery, including staff attendance and punctuality.

> "*Due to the presence of HFOMC Management Committee, Health Committee of the Palika, mothers' groups, FCHVs, the work is going well. The regular meetings of HFOMC the Management Committee, mothers' groups and the home visits of FCHVs are effective.*" MDh03L, Health staff, urban LLG.

However, HFOMCs frequently lack sufficiently skilled members with adequate health knowledge, with the exception of Health facility in-charge and Female Community Health Volunteers (FCHV). As a result, even if active, they are often not fully equipped to work on all technical dimensions of quality improvement. However, many HFOMCs are reported to be in-active with meetings not conducted regularly (sometimes due to minor issues such as lack of refreshments), due to factors such as lack of budget and active members, and elected officials feel limited authority to enforce the group to work.

> *"We have HFOMC committee at ward level for regulating and monitoring the health facilities but not so active formally. The challenge is that we ward chair do not have legal authority to cut their attendance if they are late. I feel pressure and politically insecure to make them pressure to work. Because we politician have directly linked with the election and vote." MHa03L*, Elected official, urban LLG.

> "*Neither elected officials visit health facilities for monitoring and supervision. In addition, due to lack of snack cost in HFOMC, regular meeting could not be held."* MJa02L, Health staff, urban LLG

> *"Many HFOMC member are not literate and not aware about health sector issues thus quality improvement does not get priority." MYa05L, Health staff, rural LLG.*

> *"We also cannot have regular HFOMC meeting. I used to call meeting, but members do not give time. This is one of the trustful mechanisms, but I want to say that it is not working well. May[be] because the members were not clearly known about their roles and responsibilities, or they have busy schedule always."* LYa03L, Health staff, Rural LLG.

> *"We do not have any formal mechanism. Even, HFOMC meeting is not conducted regularly due to lack of budget." MJa04L*, elected official urban LLG.

When elected officials are more familiar with quality improvement issues, this enables better investments in quality. The Ward Chair leading the HFOMC alongside the Health Facility In-charge offers potential for the health sector to receive more attention and priority within overall planning and budgeting processes.

Various routine local-level meetings also provide a potential forum for quality improvement. For example, local governments organise monthly meetings of health facilities with the Health Section, six-monthly and annual review meetings. Findings indicated that the monthly meetings happen in nearly all local governments, however, the six-monthly meetings were not taking place in all local governments. Annual meetings generally happen, but with exceptions. The extent to which these reviews influence local government decisions and priorities on quality improvement rely on the involvement and influence of health section chiefs (discussed under 'roles and responsibilities').

Minimum Service Standards

Initiatives such as the Minimum Service Standard (MSS, a checklist to identify gaps in quality of services of facilities) have the potential to contribute to quality improvement and some LLGs

are making progress in implementing it. See Annex 5 for the process map outlining the formal steps in conducting MSS at health posts and key challenges.

> *"We have MSS mechanism, and we follow it. MSS guides how much you are prepared to serve. We generally get a good MSS score. We have a quality improvement community; we are also conducting meetings for quality improvement."* LBa01D, health staff, district level.

However, MSS is yet to be scaled up fully and overall needs more effective implementation. Some LLGs (e.g., Lakshminiya, Madhesh Province) have not yet started using MSS and findings from process mapping validation workshops indicated a number of challenges limiting its potential to improve quality, indicated below:

- *Lack of monitoring and accountability*: MSS reports are rarely sent 'up the levels' for example to health office, provincial health directorate, curative services division and sometimes not even to LLG. The tools are not currently linked to the HMSI/DHIS2 mechanism.
- *Exclusion on review meeting templates*: HO annual review meeting template does not include a space to report on MSS findings.
- *Unfamiliarity with MSS:* not all HOs know about the MSS, and many Health Section Chiefs are not totally familiar or comfortable with the MSS tool, and there is a limited understanding on using the data for ongoing improvements.
- *MSS tool needs adjusting to allow for health facility differences:* for example, some facilities don't have lab services, and most diseases listed on MSS are not diagnosed at health facility level
- *Lack of hardware:* Computers are not available in all health facilities, yet there are often insufficient hard copies (paper) MSS assessment tools.
- *Budget constraints:* In Madhesh, respondents explained budget is insufficient to implement MSS in all health facilities.
- *Lack of orientation on tool:* some LLGs not given proper orientation on MSS tool by Health Office (given by a LLG in Arghakhanchi district, Lumbini province)
- *Lack of personnel:* Sanctioned positions not all filled causing some delays in implementation e.g., an LLG in Arghakhanchi and Malangwa LLG both in Lumbini.

Onsite clinical coaching/mentorship for MNH service providers

Respondents reported during process map workshops that there was a lack of funding and mentors available to conduct onsite coaching for SBA, which was reported to be more frequent when support was provided through district health offices. This was also attributed to a lack of expertise to provide the coaching, but also that the Health Office sometimes stepped into provide this support, including to focal persons to build their capacity to provide coaching:

> "*During district health office all the medicine and equipment were available and there were frequent training and onsite coaching."* MJa04L, Health staff, rural birthing post.

> "*In health section of the metropolitan city, there is lack of health expert (i.e., nursing staff), so we have some problem in monitoring and onsite coaching*. …*The role of health office is for coordination of health programme…. sometimes they support in coaching and mentoring in family planning and maternal health programme*." MBi03L Health official, urban LLG.

During the process map workshops, a number of challenges were highlighted during the process map validation workshops, largely grouped around inadequate budget and feedback mechanisms, as detailed below:

- Budgetary challenges:
    - In all LLGs mentorship could only usually be conducted once per year due to inadequate budget, and in some, there was only a sufficient budget for one health facility (e.g., in Kalaiya in Madhesh province).

  - LLGs does not always release the budget in a timely manner for the activity to take place e.g., in Kalaiya, and in Malangwa (both in Madhesh), this is believed to be partially linked to political influence for selecting BC; additionally, the LLG staff are not orientated on the programme.
  - Training budget is insufficient e.g., no budget for anatomical dummies for simulations not provided in Malangwa.
  - Insufficient budget to address gaps or follow up on actions identified in the quality of care identified through coaching visits.
  - Budget not usually available to conduct refresher reviews, and an LLG in Dang district (Lumbini province), the HO was unaware budget allocation was needed for this.
- Feedback loops and follow-up mechanisms:
  - Although reporting is completed (entered in ODK) and available at federal level, there is no feedback loop from the Family Welfare Division at federal level to respond to findings and reports.
  - Action plans are not mentioned in the reporting mechanisms: an action plan is developed in a separate 'action plan' sheet that should be discussed with the LLG or province (depending on what the action is, or on the amount of money needed to address it).
  - Action plans resulting from mentoring visits are developed to address broad quality improvement needs across the facility but are often not included in the AWPB process (e.g., in Malangwa).
- Other:
  - Only one clinical mentor is available in some LLGs, reducing the number of staff that could be trained, but also means the participant ratio for the mentorship sessions cannot be maintained.
  - LLG directly contacts with a mentor instead of coordinating with the health office. The Health Office as the coordinating body is expected to know how man mentors are available and receive grants to find and organise for mentors. When LLGs bypass the health office then the funds available with the Health Office are unused as a result of the lack of coordination between the LLG and health office.

Communities at risk and neglected health areas

We asked all respondents (i.e., health actors involved in the supply side of services, and not community representatives) about groups or segments in the community who are marginalised from health care, and about any health issues that are neglected.

Respondents identified groups who were at risk and included the poor, those with lower formal education levels, people from "lower" castes, rural dwellers, people with mobility challenges, the elderly and in some settings, people from different ethnic groups or Muslims. Respondents commonly reported that initiatives were taken to get health services to them (see quotes below and Annex 6[†††]).

> "*At present, there is no such community or groups that are left behind or better served. The disadvantaged groups such as Dalit have received the health services. They do come regularly to get health … We can identify which caste groups have come more to receive health services by looking at the OPD."* LSi04L, Health Facility In-Charge.

> "*In our health facility, infrastructure is poor that affect in quality as well. Due to public transportation facility, there is not much issue for accessibility to get heath service.*" MBi03L, Facility In-Charge, urban LLG.

[†††] Annex 6 lists the groups of people who were considered at risk, groups where issues were identified and health services were not reaching them, and health issues believed to be under-funded and inadequately addressed, and areas where investments were reported.

There were, however, issues raised about the inequity in accessing and paying for quality services, especially for more specialised care. There were also occasional issues perceived about poorer clients being treated differently by health workers.

> "*The second issue federal government must make policies through which those people who cannot afford medicines such as for heart patients, Diabetic, high blood pressures get health services. For example, if I get sick and as I had…health insurance, I didn't have to spend much money but those who go to private have to spend a lot of money, who will look after it? Our health insurance is good but there is the doctors do bias …. They treat the patient who have health insurance and who don't in a different way. Similarly, they also treat those who have come in private and in public differently. We have to look after how we will develop good ethics of doctors."* LBu03L Government official, sub metro LLG.

Barriers perceived to be challenges to accessing health services included roads (infrastructure), cultural barriers leading mistrust of health facilities. Initiatives to address challenges were described (see Annex 6), including establishing birthing units, posting FCHVs, regular home visits for the elderly.

Figure 6: Process map for minimum service standards *(Please see Annex 5d for PowerPoint with handout page that details the bottlenecks and suggested solutions identified by process map workshop participants)*

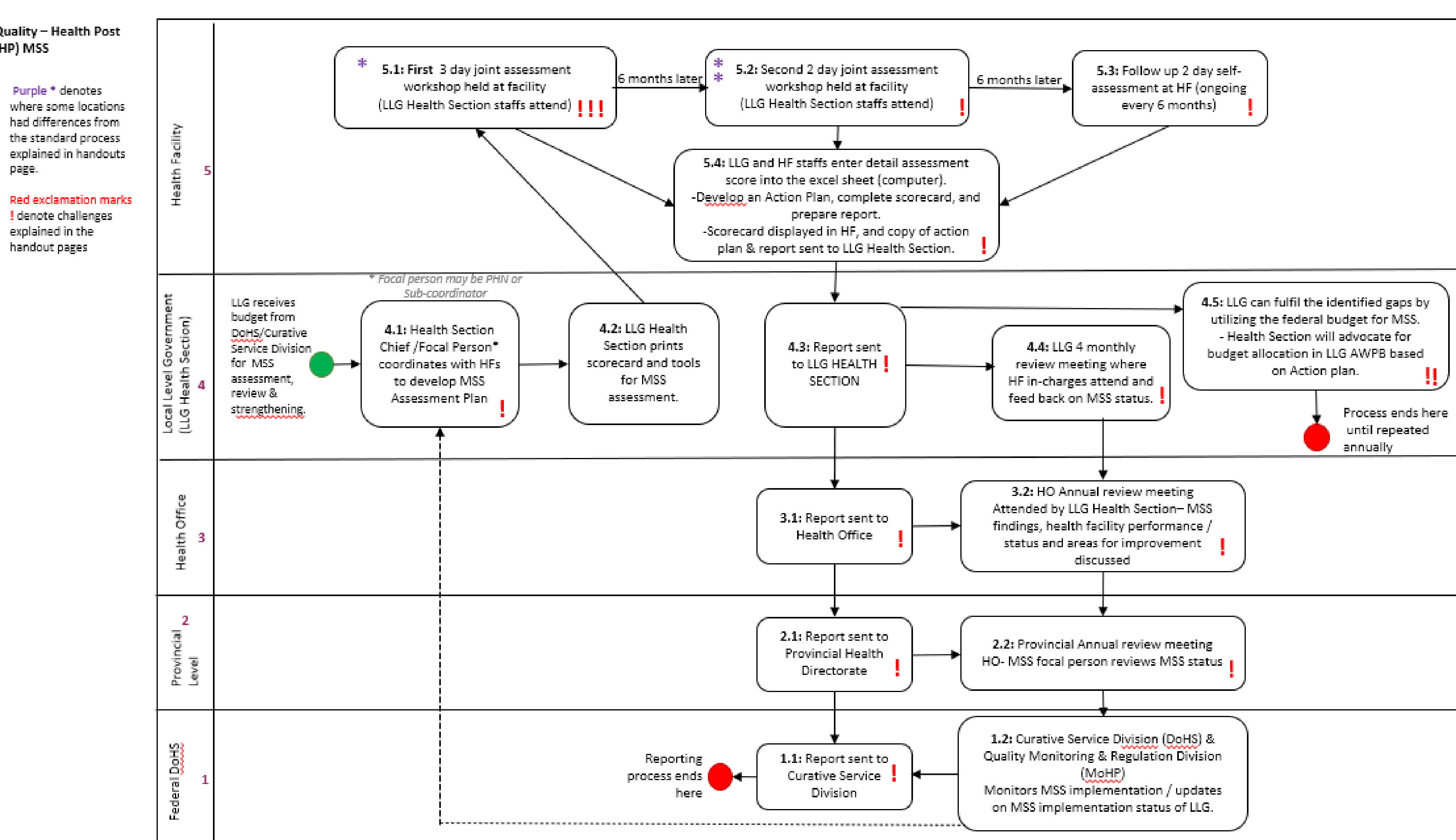
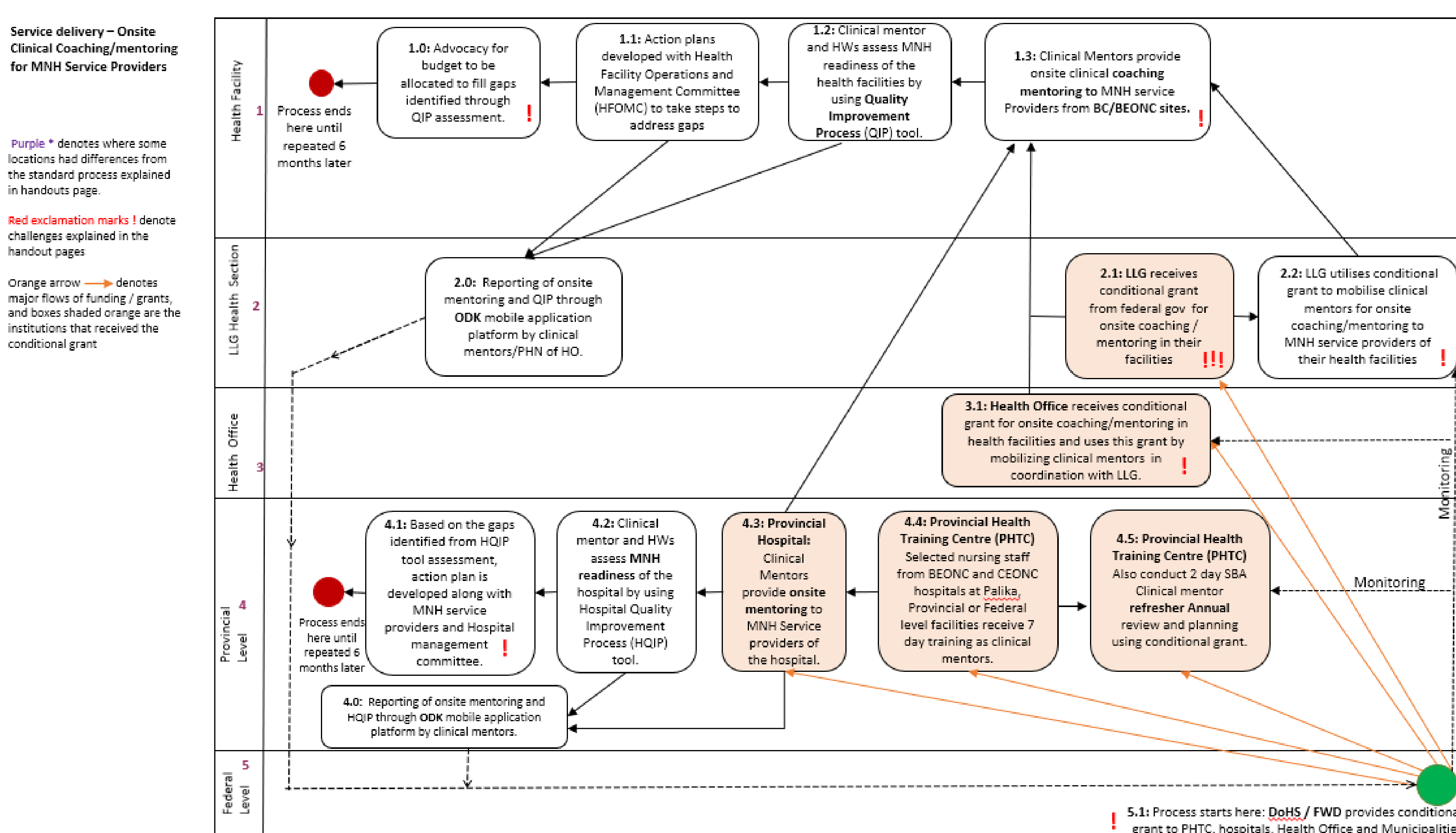


Figure 7: onsite coaching and mentoring for skilled birth attendance at health posts *(Please see Annex 5d for PowerPoint with handout page that details the bottlenecks and suggested solutions identified by process map workshop participants)*



Discussion - Progress Towards the Vision of Devolution

Nepal's move to federalism has been rapid and ambitious. It has created opportunities to the health sector in terms of the potential for more localised policies and accountability. Conversely, there are concerns that the technical efficiencies of a centralised system may be at risk through devolved authority to such a large number of diverse local governments. However, whilst federalism is still being embedded, the health system has demonstrated resilience and capacity to continue providing essential health services despite two major shocks: the earthquake of 2015 (the year the new constitution was implemented) and the Covid-19 pandemic.

Our study provides evidence on emerging issues, and highlights progress and some areas of tension as the health system strives to achieve the vision of federalism, that is, the expectation that decentralisation will lead to improved local accountability. Findings around the formal and informal processes, dynamic and incentives or disincentives related to the performance of health systems functions are summarised in the table that follows:

Rules and institutions	Norms and processes (formal and informal)	Dynamics (actors and factors)	Incentives/Disincentives
Local governments have the power to make their own decisions, policies, and laws	Federal guidance is generally being followed and implementation is monitored where policies and guidelines are clear for certain health systems functions. Policies are being drawn up at local level but primarily only when there are capacities available or if there is political will. No universal practice or process is followed, and, in a few cases, local levels have taken a 'copy-cat' approach.	Elected representatives at the local level show high levels of motivation, authority, and decision-making. But the lack of robust technical capacities and evidence-based planning driving these decisions are affecting quality of services although this effect is neither fully recognised nor acknowledged.	There is gradual but growing ownership of the health sector and a recognition that local levels have to deliver on their mandate. This has been partly triggered by the COVID-19 pandemic and the imperative to respond. In some places, elected officials display an overt desire to be recognised as proactive and acknowledge the need to perform.
Local governments are responsible to deliver quality basic health services and sanitation	Services have continued to be delivered largely as result of federal grants and have not yet seen significant revival or improvements initiated at the local level. Local governments have prioritised some components within the health services	Elected officials (ward members and Chairpersons/Mayors) have the final prerogative to make investment decisions, but their exposure to technical issues on health is limited. Health Section Chiefs lack confidence and power to execute decisions on service improvements, or to	Understanding of 'quality' is limited amongst decision-makers and any investments into service improvements is driven by other compulsions such as end-of-year closing of accounts (leading possibly rapidly implemented activities with less attention to quality), patronage or political interest amongst ward representatives.

Rules and institutions	Norms and processes (formal and informal)	Dynamics (actors and factors)	Incentives/Disincentives
	based on local needs often mixed with political interests (e.g., drugs and equipment) but other programmes have seen a setback (e.g., family planning) during the transition.	influence key individuals. The expertise the current pool of Health Section Chiefs have is not commensurate with the expectations from the role.	Elected officials are partly responding to community 'asks and prioritising services that have political traction (e.g., establishing a new facility, announcing contributions for social health insurance premium payments).
Federal government provide resources to local levels through various types of grants to implement basic health programmes **Provincial governments provide some limited resources and technical support to local levels to supplement any federal support.**	Grants are made directly to local levels by federal and provincial governments do not have complete information on allocations. There is duplication of some efforts due to the sequencing of budget processes and lack of formal communication channels. Grant amounts are also not tailored to specific local contexts at times resulting in under-resourcing of certain geographies or allocations to programmes that are not required.	Federal government continues to hold significant power and works more like a deconcentrated system (i.e., lower-level units are seen as sub-ordinate) than a devolved system (i.e., lower-level units are autonomous). The federal level largely relies on conditional grants as mechanism to ensure local governments adhere to delivery of key programmes. Provincial governments have limited authority or resources to create any leverage with local levels. Lack of adequate flexibility and context-specificity of the grant mechanism frustrate local government efforts. This contributes a general perception that federal level is 'trying to control/retain' power leading to mutual distrust among all sides. In addition, local level health sections lack relevant expertise and	The need for federal level to ensure services at local level align to national and global priorities and commitments, and that the health gains made so far are protected. Provincial governments motivation for action is affected by the level of engagement that is invited from the local levels. Initiatives that have province-wide or cross-LLG applicability, are limited in their uptake (e.g., referral services) as provinces either lack the mandate, or are too distant to respond to local contextual needs.

Rules and institutions	Norms and processes (formal and informal)	Dynamics (actors and factors)	Incentives/Disincentives
		capacity and are not involved in decision-making.	
Local levels can allocate additional resources to increase the per capita spend on health for their citizens	Local resource allocations for health are increasing gradually but primarily for infrastructure projects and human resources and less so for programmes.	Elected representatives are responding to a need to show incremental progress on services that have been initiated (e.g., need to allocate resources for staff as a follow on to establishing a new health facility). Technical rules can be seen as limiting decision-making freedoms received through political devolution	There is a growing recognition of 'health' partly triggered by the need to respond to COVID-19, which created a 'new normal' emergency mode of work, quicker decision-making and provided exposure to LLG leaders on health sector issues. However, there are also political incentives to provide local patronage (e.g., opening health facilities in ones' constituency, creating jobs). In some cases, the technical rules are seen as overly technical and restrictive and thus limit the decision-making freedoms local levels have received through political devolution.
Recruitment and deployment of permanent staff (HRH) is currently a federal responsibility due to lack of a federal Civil Service Act and structures & institutions required for devolution remain unresolved.	Due to the lack of a clear mandate or specific functions being defined for local level regarding HR recruitment and management, local levels are compelled to temporarily recruit locally to fill in HR gaps caused following the 'staff adjustment' process, in areas where local governments are investing in HR through their own resources	Recourse to local level contracting has created unintended complex power and accountability challenges as over-dependence on contractual staff has encouraged local political allegiance and patronage. Relationships between elected officials and locally recruited staff and permanent staff imbalanced as mutual resentments build up and staff morale affected.	Building and sustaining political relationships has favour from elected officials and members of their political patronage network, as creates opportunities for jobs in those networks leading to potential political gains.

Rules and institutions	Norms and processes (formal and informal)	Dynamics (actors and factors)	Incentives/Disincentives
Health is a concurrent area, and all three levels have a joint responsibility to ensure services are delivered and require coordination and collaboration across levels.	Each level has a reasonably good understanding and engagement with most functions and responsibilities required of their respective levels, but formal mechanisms of cross-governance sphere linkages, communication and coordination are lacking or weak.	There is an over-reliance on informal relationships and personal networks to seek information needed for formal/official decision-making.	There may be some incentives for lack of coordination between (or across) levels of government where this can help some actors retain resources, power, and influence. On the other hand, the lack of coordination can be frustrating when actors want information to inform resource allocation action and decisions.

In line with other research[11, 12] and the government of Nepal's own assessment [13], our study found that greater clarity is needed to delineate the roles of each level of government, particularly where there are concurrent mandates[14,15]. The MoHP itself confirmed that coordination and alignment of health sector functions across the three levels of government was one factor affecting the implementation of the NHSS [16]. In particular, guidance is needed to rectify the lines of communication and information sharing vertically from one level of government to another, and horizontally, within the levels of government. When the rules of engagement are not clearly delineated, individuals including decision-makers act based on their interpretation of roles and processes.

Local and provincial governments perceive federal-level mandates such as conditional grants being a way to retain central-level power, leading to tensions between government spheres. Similar to findings from other studies[17 18], our respondents reported that they felt limited in their authority and space to make decisions. These tensions in authority play out, particularly in the management of conditional grants which flow to local levels from both federal and provincial levels and are a major mechanism for health financing at subnational levels. As highlighted in other studies[19 20] this reduces the provincial level's influence and awareness of related health activities and contributes to duplication of funding i.e., where some activities are funded through the conditional grant and where subnational levels have also allocated additional budget.

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[11] World Bank, UNDP. 2019. Nepal Capacity needs assessment for the transition to federalism. Jul 10, 2019.
[12] Nepal Federal Health System Team (2022). Nepal Health Sector Strategic Plan 2022-30: Recommendations from the Nepal Federal Health System Project.
[13] Government of Nepal. 2015. The Constitution of Nepal (English translation from MOHP website
[14] Pact. (2020). *Social accountability mechanisms and their impact on the health sector: an applied political economy analysis*. Social Accountability in the Health Sector (SAHS); UKaid/Nepal Health Sector Programme 3 (NHSP3).
[15] Gautam G, Khanal & Bondurant A. 2020. An analysis if the health sector functions of all three levels of government as per Functional Analysis and Assignments and relevant policies. NHSSP: Kathmandu
[16] Ministry of Population and Health joint annual review (December 2021)
[17] Pact. (2020). *ibid*
[18] Nepal Federal Health System Team (2022). Nepal Health Sector Strategic Plan 2022-30: Recommendations from the Nepal Federal Health System Project
[19] NHSSP III. Strengthening Local Planning and Budgeting to Deliver BHCS . December 2020.
[20] Nepal Federal Health System Team (2022). *ibid*

Other challenges associated with the conditional grant highlighted in our study and in other literature[21, 22] include late issuance of guidance and funds from federal to lower levels affecting planning and ability to fully utilise the budget, lack alignment to local needs and limited local authority to adapt accordingly. How conditional grants are managed at federal level's needs to be reconsidered in consultation with subnational governments and there needs to be a stronger mechanism to reassure federal-level actors that local governments could be capacitated to have more flexibility in how grants are used. For example, by finding ways to ensure or incentivise a) the better use of appropriate health data in planning and decision-making forums, and b) decisions are made by a relevant panel through consultation.

Due to a lack of guidance and expertise in using health data and evidence for decision-making resource allocation is often influenced by 'best judgement' rather than evidence. Approaches are needed to share evidence-based health information with decision makers to encourage the appropriate (resource) prioritization of health and to relieve the burden of non-health experts having to make decisions on health budgets. To achieve this, health experts need to be either drawn from district offices or developed in health section units to be routinely involved in health sector reviews, planning and budgeting forums, so mechanisms need adjusting to ensure this happens.

A challenge remains that health section staff, although experienced clinicians, generally do not have the required capacity to interpret health data and understand its implications or to operate in politically driven decision-making and planning forums. Key federal level informants described initiatives intending to build the capacity of health section staff, specifically health section chiefs, to hold this type of public health management role. However, there would still likely be value in sharing expertise across local levels since it would not be feasible to have a technical expert for all health or public health specialities to be housed in one health section of each local government.

Health expertise currently largely lies at the Health Office level, although no longer a governance layer in the federal system, Health Offices have retained some of the health expertise required for this role. This expertise is largely under-utilised, and workable mechanisms are needed to build linkages with health sections and encourage or incentivise the draw down of technical expertise from Health Offices to support health sections with evidence-based planning etc. [23]. This will also be needed to address recommendations to assign focal persons for thematic areas at local levels [24] (and find ways to share expertise across local governments). Such linkages would need to support local level authority, maybe as advocates working with and on behalf of the health sections, whilst the capacity of health section staff is built to adopt this role.

Study findings support the suggestions made by Sharma (2018) [25] to strengthen citizen accountability on health, through investing in upgrading the capacity for transparent sharing of evidence on health system performance and responsiveness. This has not been achieved systematically. When leadership is strong, local level planning at the ward or municipal level can work well with wide consultation, but this is inconsistent. Similar to other reports [26], we found that HFOMCs were often not functioning well, but can play a positive role and offer accountability, including through support with quality improvement initiatives.

Workable and flexible mechanisms for better coordination between the levels of government need to be implemented but action to address this through policies, legislation and guidelines is lagging. A 2018 study identified limitations including the lack of goals, targets, and

[21] NHSSP III. 2020. *ibid*

[22] Nepal Federal Health System Team (2022). *ibid*

[23] Nepal Federal Health System Team (2022). *ibid*

[24] NHSSP III. 2020. *ibid*

[25] Sharma J, Aryal J & Thapa GK. 2018. Envisioning a high-quality health system in Nepal: if not now, when? Comment. 6:11. E1146-E1148, NOV 01, 2018. . http://dx.doi.org/10.1016/ S2214-109X(18)30322-X

[26] Status of Citizen Engagement in Local Governance Processes in Nepal, Social Accountability in Health Sector (SAHS) project (Pact), British Embassy Kathmandu, Feb 2022

timeframes in most policies; contradictory policy statements and inadequate use of evidence to inform approaches and strategies and poor implementation [27]. Since then, a great deal of work has been conducted in revising and elaborating health policies and strategies (see Annex 7). However, progress has been slow in passing some federal level legal and policy frameworks to enact the constitution e.g., federal Civil Service Act and O&M survey, contributing to inefficiencies and tension between health actors at subnational and facility levels.

Human resources for health are a major issue that underpins all other issues in the health system. In 2015, two thirds of Nepal's total number of sanctioned posts were filled, and for health facilities, this ranged greatly by type of facility from just 32% in urban health centres to 52% of general practice medical doctors in district hospitals [28]. Lessons from Pokhara metropolitan city and Dhangadhimai Municipality [29] demonstrate how the use of evidence on workload informing readjustment and redistribution of health workers based on need can be applied to other settings.

In terms of service and health data, investment is needed in equipment, digital infrastructure and training in data entry and use. Approaches to improve data quality and accountability, and to strengthen feedback loops is also needed. This discussion should go hand in hand with considering how to strengthen the capacity of health sections and the use of technical expertise at the Health Office.

We found accountability for assessing and ensuring quality of health services, the role formerly held by Health Offices, to be weak. Discussions are needed to identify a coherent and technically focused quality improvement system that all actors at all levels could subscribe to without threatening autonomy at local levels of government.

We identified an improvement in health sector devolution in terms of drug procurement addressing to an extent the challenges anticipated in the procurement system[30]. Local levels are increasingly allocating their own resources allowing responsiveness to some important context specific health issues and to mitigate drug stock outs. On the other hand, in 2020, as with our study, periodic drug stockouts and other inefficiencies such as oversupply of certain drugs are still being reported [31], often very close to expiration. Local level purchasing has led to a reduction in quality of drugs as LLGs cannot costs as cannot benefit from economies of scale due to small order quantities. An effective quality assurance system is needed as other than basic checks on the integrity of packaging at local store, no quality checks are done. Establishing nationally or provincially approved list of suppliers with pre-agreed cost ceilings could be considered within the scope of the *Transformation of the Procurement Improvement Plan into Public Procurement Strategic Framework* [32].

Despite challenges in the first five years of the federal system, there is progress, and opportunities exist to raise the profile of the health system. Building on the lessons from this study and others, there is scope to create an appetite among newly elected decision makers to demand health evidence and make health a politically important and appealing issue, and to relieve the burden of individual decision-making to broader accountability and planning forums. The role of technical experts, including at district offices and among external development partners, can play a pivotal role in ensuring health expertise is available and made stronger at local levels to equip Health Sections and Health Offices work together to contribute to lasting legacies of stronger systems for improved health.

[27] [27] NHSSP. 2018. Report on Stocktaking the Health Policies of Nepal (April, 2018)

[28] MOHP.2021. National Strategy for Human Resources for Health of Nepal

[29] NHSSP III. 2020. *ibid*

[30] Thapa R, Bam K, Tiwari P, Sinha TK, Dahal S. Implementing federalism in the health system of Nepal: opportunities and challenges. Int J Health Policy Manag. 2019;8(4):195–198. doi:10.15171/ijhpm.2018.121

[31] NHSSP. Strengthening Local Planning and Budgeting to Deliver BHCS: Lessons from selected local levels. December 2020.

[32] Government of Nepal, MOPH. 2021. Progress of the Health & Population Sector, 2020/21. National Joint Annual Review Report 2021

Implications

The implications proposed below include short-to-medium term suggestions for the various levels of government that can be made without the need for any major reforms and constitute practical adjustments to improve systems within the current framework and rules.

These are followed by some questions that the Government of Nepal, might need to consider for the longer term and the trade-offs that might involve. And finally, we lay out the considerations for NHSSP technical assistance going forward.

Suggested recommendations for the short to medium term for the different levels of government

1. The lack of institutionalised vertical and horizontal planning and coordination across the levels of government could be tackled by creating **incentives for stronger coordination and communication across all levels of government and all health system functions.** Specific measures for this could involve:
    - The **federal level government** initiates a process that improves coordination, transparency, and better time sequencing of AWPB (including sharing of fund allocations and flows) at each level of government to allow visibility on which activities are funded across the levels, and avoid activities being missed out or duplicated.
    - **Federal and provincial levels** improve the communication flows and guidance for use of evidence at every level by incentivising the use of evidence and review of data at the right forums/meetings, and ensuring evidence is available to the right people at the right time, to make decisions, and to track progress towards universal health coverage, quality improvement and better health, for example:
    - o **Federal level** provides funding (and training) to the provincial levels to establish and manage coordination and communication platforms (e.g., events, online mechanisms, committees, working groups) that enable better evidence-use, information-sharing, and working together.
    - o **Provincial levels** undertake consultations to inform the short-term scope of work for technical experts at Health Offices to maximise the use of their skills and fast-track diffusion of expertise and TA.
    - o **Local levels** create platforms for focused evidence processing (e.g., sub-national 'knowledge café type events) that are organised through support from Health Offices.

2. The current gaps in public health expertise at the local level could be filled by **incentivising better use and distribution of technical health expertise in planning, budgeting, and implementation.** Draw-down technical expertise from Health Offices at least in the short term could be supported by put the 'purchasing power' (e.g., via conditional grant / earmarked funds) at the local levels and fuelling demand rather than imposing technical support. A few defined steps could help build this support for the local level:
    - **Federal level** can define a roadmap to ensure LLGs can access adequate technical public health expertise, ensuring acceptability to both provincial government and LLG. This needs to be based on up-to-date evidence from O&M Surveys. For this to happen, the O&M survey tools for each location need to be updated and rolled out (ensuring the standards / human resource needs match current needs and public health situation).
    - As mentioned above, **provincial levels** can be made responsible for strengthening Health Office expertise in the short-term to supply services (e.g., specific technical areas, cross-palika exchange and implementation of shared actions). Health Offices could be enabled to expand their support beyond just coordination and supply of vaccines and FP commodities, to also providing technical support or assistance.
    - **Federal and provincial levels** should consider guidelines that lay down how Health Offices in the short-term could be involved in facilitating planning processes, data review meetings, training /coaching activities, and contributing to action plans

development. This guidance could be included in any existing planning and programme implementation guidelines.
- In addition to capitalising on the existing technical expertise available at the Health Offices, **federal government** needs to enact the Federal Civil Service Act as soon as possible to allow recruitment of permanent staff at sub-national levels through fair and transparent mechanisms through the provincial Public Service Commissions.

3. Since the Health Section Chiefs are often clinicians with limited or no management or public health expertise, they need opportunities to develop the required skillset to effectively fulfil the wide-ranging requirements of their role (combining strategic, operational, clinical, and networking skills). **There is a need to invest in building the capacity of Health Sections and empower the Health Section Chiefs to have a greater influence on local level planning decisions and budget allocation.** This capacity building could include:
   - Building budget literacy and networking skills among Health Section Chiefs to advocate and coordinate with ward chairs to respond to contextual needs
   - Providing training & confidence building on how to interpret, communicate & use data (e.g., could be linked to career recognition and opportunities for progression).
   - Incentivising Health Offices to support/mentor Health Section Chiefs to develop evidence briefs or packages and present in formats that can be easily understood and used by elected representatives and non-health officials to guide planning (including investment cases).
   - A key consideration could also include making a definitive decision whether the seniority of Health Section Chiefs should be raised and if so, carefully planning how to make the portfolio of work feasible and manageable with access to complementary technical expertise, alongside capacity development from Health Office.

4. **Quality improvement mechanisms for health services need to be prioritised and implemented.** There is a need to communicate greater clarity among local and provincial levels of government where their responsibilities lie with respect to standard and federal level quality improvement mechanisms and standards. Strengthening more standardised implementation could include:
   - **Federal level** identifies ways to fund quality improvement interventions to allow them to be implemented across all health facilities and regularly and as frequently as required, and to respond to gaps identified in quality through assessments. Funding could be redefined to incentivise QI mechanisms, for example, linking greater funding with sustained and systematic implementation of assessments and action plans.
   - With the **leadership of the federal level**, all governance levels could develop and agree clear terms of reference and job descriptions for Health Section Chief, Health Offices, and provincial levels for responsibilities around overseeing or implementing quality improvement standards and assessments.
   - **Federal and provincial governments** could consider developing Provincial Health Training Centres (PHTC) as the apex body for training, developing, and enlisting mentors, managing supervision systems, and supporting QI action plans at the province level, to be delivered via the Health Offices.
   - **Federal government** could consider providing a conditional grant to the Provincial Health Directorate to drive preventive and promotive health through the Health Offices
   - **Provincial governments** with support from Health Offices could facilitate sharing of expertise and lessons across LLGs within a province to increase public health skills and capacities, for example through cross-municipality visits, symposiums, meetings, informal learning platforms. Enabling peer-learning and exchange can help diffusion of good practices from a well-performing municipality.
   - **Local levels** could strengthen quality and timeliness of provision of data, and conduct of data quality assessments, for example through developing case studies showing

how different municipalities have used up-to-date data that has led to better allocation of resources to meet health needs, and importantly, share lessons on how improvements and change have been achieved. (i.e., what actions were taken and who was involved).

Longer term implications and wider considerations for the spheres of government

There are longer-term implications and decisions on these are dependent on wider considerations including those that may be beyond the remit of the MoHP. We outline these ‘bigger picture’ questions here.

a. Should conditional funds flow through provincial governments to local levels or remain as a direct transfer from the Federal level?

Transfer of funds to provincial level could have benefits, including the potential to foster improved planning and coordination between provincial and LLGs, and greater recognition of Provincial governments by LLGs due to much higher volume of resource contribution, and to strengthened accountability (and awareness of activities) of LLGs to provincial government on grant areas. However, that this could be perceived as reinforcing a hierarchy that may not sit easily with all local level governments.

b. Should conditional grants have increased flexibility to better meet local needs?

Devolved authority of more flexible conditional grants to local levels would need to ensure that local political interests do not create diversions from national priorities and results (e.g., achievement of Sustainable Development Goals, Universal Health Coverage). This could be achieved by having more flexible grants linked to broad areas of technical priority and over time to performance and outcomes (e.g., output based conditional grants).

Potential improvements could result in grant allocations that are better tailored to the context and needs (rural / urban; population size; mountain / hill / terai) with a potential knock-on effect of improved health gains.

c. What role should the Health Office play in the longer term – should there be re-investment or phase-out?

LLGs, health facilities and provincial officials recognise the role played by the Health Office, and particularly their invaluable support to the COVID-19 pandemic response when the Health Offices were able to put their expertise to good use. However, in the federalised system, their office is 'district-level' and is not mandated by the new Constitution[33] (and can sometimes be perceived as ‘anti-federal’, as one federal level interviewee described). LLGs often see the presence of district level offices as infringement on their own authority. If Health Offices are shifted from their previous office of authority to a technical role it will simultaneously require a significant change in perceptions of and among the Health Offices of their new place in the federal system. Provincial governments can assess whether investing in Health Offices would help strengthen their reach to LLGs, as well as in terms of making technical expertise and co-ordination support accessible to LLGs. Solutions can therefore be applied at such discretion depending on, for example, the extent which provinces can reach out to remote LLGs on a regular basis.

d. Should procurement of medical drugs be reorganised (e.g., through a federal level framework contract) or should devolved procurement continue?

Devolved procurement is welcome among local level to mitigate the unreliable supply of drugs and supplies, as the increased autonomy enables them to procure items locally and rapidly and reduced stock-outs. This is a motivation for retaining local level procurement and fuels different local interests for local purchase, some of which may not be driven by efficiencies. However, there are concerns about the loss of economies of scale with smaller quantities of

[33] The Constitution of Nepal 2015, Annex 4

items being more expensive than bulk-purchases, and there is a lack of effective systems to ensure quality assurance of items. However, local level governments may be concerned about loss of autonomy should federal level consider a centralised procurement system.

A possible alternative could be a hybrid model which combines aspects of the federal framework contracts with actual local purchase (for example, a nation-wide list of pre-approved suppliers with pre-set prices, approved by federal level) ensuring that LLGs retain the 'authority to purchase' locally.

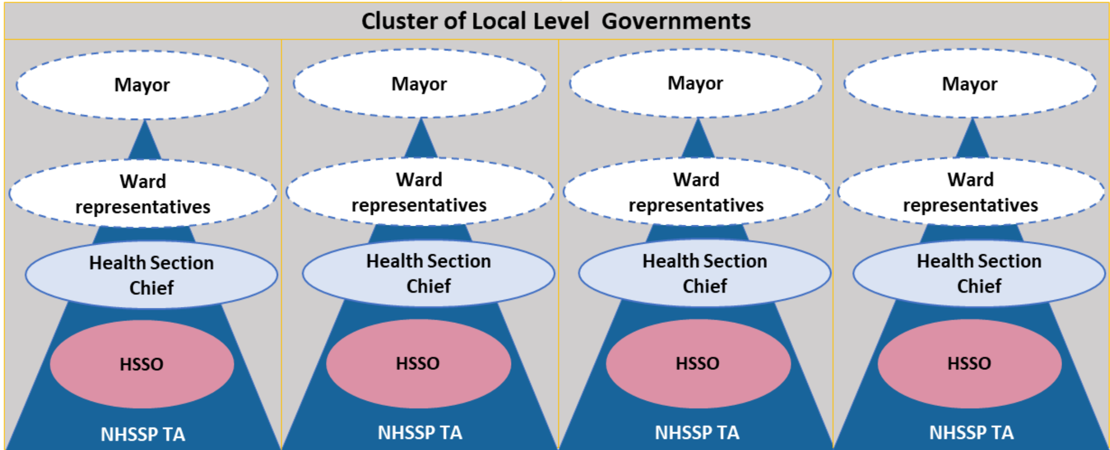
Implications for Technical Assistance through NHSSP

Adapt TA modalities

The current model of subnational TA is one Health Systems Strengthening Officer (HSSO) placed at each of the programme palikas in focal provinces (Madhesh, Lumbini and Sudurpaschim). Each HSSOs works closely with the Health Section Chief, based in the Health Section Office. HSSOs are graduates in public health with relevant work experience. They are supported by a small team of specialists placed at provincial level in each of the focal provinces. This team works within the province ministries and local level governments, offering expertise in governance, data, procurement and public financial management, and quality improvement.

Learning from this study suggests the TA model could be adapted to increase the support direct to local governments for strengthening the local level health system. Local level governments want to fulfil their responsibilities to their constituents for health care, but most do not yet have the capacity, especially the smaller rural LLGs. For the latter, there may be efficiencies of scale of cooperating for some health functions in a cluster of two or more adjoining LLGs. Given this, it may be worth testing an adapted model of TA. HSSOs would continue to be placed at LLGs as the continuity of support and trusting relationships are important for capacity enhancement. In addition, more specialised TA could be brought closer to the local level by placing TA at cluster level (which may or may not be the former district level) who would provide visiting support to LLGs on a demand or rotational basis. They would also be able to facilitate cluster level health functions for small LLGs if asked (See Figure 8 below).

Figure 8: Adapted TA Model for Local Levels



To create longer-term, sustainable support for LLGs over the next decade, NHSSP TA could also facilitate a system of internal TA from within governments. For example, metro and sub-metro local level governments who may have a larger pool of expertise could offer visiting support to rural LLGs. Where expert human resources are available at Health Offices under the Province, they could support local levels on a demand-basis from the local level. This might be incentivised by grants to local levels to cover costs associated with travel by the Health Office staff.

Enhance capacity for health budget advocacy and budget tracking

An important finding from this analysis is that advocacy for prioritisation of budget allocation for health within the local level budget, needs to begin at the ward level. This is in the context of an increasing trend in internal resources as a share of the health budget at local levels[34] which creates the scope for more flexible, needs-based spending than the conditional grants. The planning process begins at the ward level, so decisions on the prioritisation of internal resources for health are important to increase the health share of the total local level budget. Similarly, throughout the next steps in the annual planning and budgeting process, internal advocacy for the share of the health sector activities is important.

Analysis of roles and dynamics finds that the Health Section Chief should be the internal advocate for health throughout the Annual Work Planning and Budgeting (AWPB) process. However, most in this post do not have the skills and influence to advocate for health priorities at the various stages of the AWBP. In fact, often Health Section Chiefs said they were not invited to AWPB meetings at any stage.

NHSSP could fine-tune TA to work more closely with ward representatives to understand their concerns and priorities (reflecting what matters to the electorate). An HSSO visiting wards within the LLG, together with a governance expert based (as currently) at the provincial-level

[34] Final Budget Analysis of Health Sector-Five Years of Federalism.pdf (nhssp.org.np)

or (in the future) at the cluster level, could work with the Health Section Chief, planning officers and elected representatives to enhance their capacity on evidence-based advocacy and budget literacy to increase the voice of the health sector in budget decisions.

In the longer term, if requested, TA could expand budget advocacy capacity building to local health partners. The purpose would be to gradually increase resources allocated for the health sector and for activities through other social sectors which address the wider determinants of health, through a collaborative governance approach.

TA can also support local levels on how to use the budgets allocated in the AWPB as sometimes they are unclear on execution, and to track and review their expenditure using the Subnational Treasury Regulatory Application (SuTRA).

Promote investments to improve the quality of health services

Analysis has also shown that the understanding of quality amongst elected representatives is inadequate, and service quality improvements are largely limited to investments into new hospitals and health facilities, new health infrastructure including diagnostics. The Health Section Chief and facility level providers too are barely familiar with the use of some of the quality improvement tools and lack clarity on how they can use them for service quality. While clinical competency training receives some attention, there is little focus on ongoing monitoring and supportive supervision. Quality has taken a backseat partly also because of the lack of mentors, dedicated focal persons, lack of adequate or flexible resources, or lack of complete clarity on the use of available funds.

NHSSP TA support to the Health Section Chief and ward representatives with regard to understanding budgets and improving allocations, could also help focus on investments that focus on quality improvements. With a TA model that works with a cluster of LLGs and enables a 'hub' within the government that provides draw down specialist technical support, NHSSP can support local levels to gain a better understanding as well as skills on making quality improvements with facilities. These may include concrete steps that drive changes at the facility level, such as developing annual quality improvement action plans, enabling better use of MSS assessments, or mentoring health workers to provide respectful care.

Simultaneously, NHSSP could work at the provincial level with the Provincial Health Directorate and the Provincial Health Training Centre to establish clear strategies and guidelines to develop and enlist mentors, manage supervision systems, and support the implementation of quality improvement action plans. These strategies could be actioned through the specialist technical hubs, and local levels could be incentivised to avail this support.

Expand the net of people who can interpret data and evidence and facilitate cross-palika learning

Although there is a greater cognizance of information systems and better data inputs to the government databases, but platforms, where these data can be thoroughly analysed and understood, are limited. The evidence that is regularly generated, is not necessarily "processed" (used/understood) well enough to inform local-level programme choices. Weak formal mechanisms and knowledge exchange opportunities at the sub-national level, and the over-reliance on informal networks to source information that can guide decisions is a key area that NHSSP TA could address at the sub-national level.

Use of evidence for planning certain specialist areas such as forecasting and quantification of drugs and equipment, training and deployment of health workers, rationalising infrastructure investments and addressing equity concerns can contribute to more efficient use of resources. NHSSP TA has been orienting newly elected representatives and health officials with budgeting frameworks and processes and can expand this TA to include other technical areas. HSSOs and the team of specialists could, for example, enable cross-palika peer learning through knowledge cafés, conduct evidence use workshops, and support Health Section

Chiefs to triangulate and understand information so that his/her decisions, actions, and advocacy is evidence-informed.

In the context of the imminent roll-out of the Basic Health Services package, there is a higher need for duty bearers to have a greater comprehension of the health system needs, and clarity on the pressures of using limited resources to deliver as mandated. NHSSP TA at the federal level has so far supported setting-up standards, protocols, operating procedures, monitoring frameworks and quality data gathering mechanisms. This TA support could be taken forward/transitioned to help sub-national levels 'implement' this backed by plans based on rigorous evidence.

Strengthen coordination mechanisms within and between spheres of government

The findings indicate that coordination within the LLGs is often weak, with gaps in key information exchange between the health section and the palika/municipality office. A lack of clarity on roles and/or barriers for health section staff to be engaged in the right conversations also inhibits good coordination. Whilst it is difficult for TA to address any power dynamics which inhibit interaction and coordination, TA can help strengthen the fundamentals such as making sure that staff have up-to-date Job Descriptions (JDs). JDs should be made available to all (online or off) and discussed for shared expectations. This is transactional TA but is important to help connections within the palika to operate more smoothly and may enhance the confidence of Health Section Chiefs to perform their roles fully.

At the transformational TA level, there is a huge opportunity to improve health system functioning across the three spheres of government. Responsibility for health functions has been 'cut' horizontality, but health system functions flow up and down the spheres of government. The process mapping showed health actors only have sight of their piece, few people have the big picture to steer health functions across all stages. If requested by MoHP, TA can work with all the spheres of government to design and implement a cross-government coordination mechanism, which makes the essential links for the whole health system in Nepal as well as a framework for specific functions.

List of Annexes

Annex number	Title	Embedded document
1	Contextual background to the federalised health system in Nepal	Annex_Contextual background to the fe‹
2	Detailed methods (Including tools)	Annex-detailed methods_.docx
3	Description of the role of Health Office by assessment respondents	Annex_Description of the role of Health Offi
4	Engagement among government respondents with private sector	Annex_Engagement among government r‹
5	Process maps for health systems functions:	
5a	*Planning and budgeting*	P and B_13jun2022.pptx
5b	*Procurement of medical drugs*	Procurement process map_08june2022.pptx
5c	*HMIS*	HMIS_03jun2022_final.pptx
5d	*Service delivery – MSS and SBA coaching*	SD_QI_MSS_SBA_06jun2022_final.pptx
6	Groups identified as marginalised and with poor access to health	Annex_Groups identified as marginal
7	Health policies, acts, guidance, and strategies that NHSSP has contributed to since 2019 by status and topic.	Annex%207%20-%20Policieslist.xlsx