



स्थानीय सरकार सबलीकरण



The Asia Foundation

The Australian Government - The Asia Foundation Partnership in Nepal

LOCAL HEALTH GOVERNANCE: SITUATIONAL AND POLITICAL ECONOMY ANALYSIS REPORT

Final Report

By

Public Policy Pathshala, Kathmandu, Nepal

May 2020

ACKNOWLEDGEMENT

The situational and political economy analysis team is grateful to the participants from different municipalities across Nepal who provided their valuable time, views and opinions, often at a short notice. The team would also like to recognize the continued cooperation and guidance extended by The Asia Foundation Nepal office, particularly its senior program officer Ashray Pande in carrying out this analysis.

Situational analysis team and authors of the report:

Amit Bhandari

Sudip Pokhrel

Pratap Paudel

Krishna Rijal

Sabina Sigdel

Ranju Bista

Disclaimer:

This situational and political economy analysis report has been funded by the Australian Government, Department of Foreign Affairs and Trade – The Asia Foundation partnership on Sub-National Governance in Nepal.

The findings and views expressed in this document are those of the authors and do not necessarily reflect the views of the Australian Government or those of The Asia Foundation.

Recommended Citation:

Bhandari, A., Pokhrel, S., Paudel, P., Rijal, K., Sigdel, S., and Bista, R. (2020). *Local Health Governance: Situational and Political Economy Analysis Report*, Kathmandu, Nepal: Public Policy Pathshala and The Asia Foundation.

ABBREVIATIONS

ARS	Ayurveda Reporting System
CAO	Chief Administrative Officer (of municipalities)
CGAS	Computerized Government Accounting System
DFAT	Department of Foreign Affairs and Trade, Australian Government
DHIS2	District Health Information Software 2
DH/PHO	District Health / Public Health Office
DIN	Drug Information Network
DoHS	Department of Health Services
EHCS	Essential Health Care Services
FCGO	Financial Comptroller General's Office
FCHV	Female Community Health Volunteer
FMIS	Financial Management Information System
GoN	Government of Nepal
HFOMC	Health Facility Operation and Management Committee
HIIS	Health Infrastructure Information System
HMIS	Health Management Information System
HRH	Human Resource for Health
HuRIS	Human Resource Information System
KII	Key Informant Interview
LMIS	Logistics Management Information System
MIS	Management Information System
MoHP	Ministry of Health and Population
MoSD	(Provincial) Ministry of Social Development
NGO	Non-Government Organization
OAG	Office of the Auditor General
PEA	Political Economy Analysis

PHCC	Primary Health Care Center
PHC ORC	Primary Health Care Outreach Clinic
PHD	Provincial Health Directorate
PLAMAHS	Planning and Management of Assets in Health Care System
PPP	Public Policy Pathshala
PSC	Provincial Service Commission
RHD	Regional Health Directorate
SHSP	Social Health Security Program
SNGP	Sub-National Governance Program
SuTRA	Sub-national Treasury Regulatory Application
TABUCS	Transaction Accounting and Budgetary Control System
TIMS	Training Information Management System
VDC	Village Development Committee

Table of Contents

ACKNOWLEDGEMENT	i
ABBREVIATIONS	ii
1. INTRODUCTION	2
2. OBJECTIVES	4
3. METHODOLOGY	4
4. FINDINGS	6
4.1 Local health service delivery and system – past and present.....	6
4.1.1 Governance and institutional arrangements.....	6
4.1.2 Service delivery structure and functions.....	7
4.1.3 Information management.....	11
4.1.4 Health financing and financial management.....	12
4.1.5 Human resource management.....	13
4.1.6 Procurement and supply chain management.....	14
4.2 Local Health Governance	15
4.2.1 Policy and legal landscape	15
4.2.2 Governance analysis	18
4.2.3 Effectiveness of service delivery	21
4.3 Political economy analysis (PEA) of local health governance	22
4.3.1 Brief summary of the current status.....	22
4.3.2 Stakeholders and actors – people and institutions	23
4.3.3 Health as an agenda at the local level	23
4.3.4 Roles and interactions of different levels of government in local health ...	25
4.3.5 Dynamics within the municipalities.....	26
4.3.6 Drivers vs barriers and opportunities vs threats regarding good local health governance and effective service delivery	27
5. RECOMMENDATIONS	28
5.1 Government (all spheres): Better manage transition, minimize disruptions.....	28
5.2 Development partners: Leverage catalytic resources, focus on strengthening local capacity	29
Annex:.....	31
Authority and responsibilities of local government - Exclusive and Concurrent....	31

1. INTRODUCTION

Nepal formally adopted federalism with the promulgation of a new Constitution in 2015, subsequently restructuring the state into a federal government, seven provincial governments and 753 local governments comprising 293 urban municipalities and 460 rural municipalities¹. The Constitution has established health as a fundamental right and stipulated public health as a concurrent function amongst all three levels of government. The Constitution has also designated specific public health responsibilities and authorities to each level of government. For example, it is solely the local government's task to deliver basic health care services while functions such as setting national-level goals and standards are under the jurisdiction of the federal government. The exclusive authorities of the local governments and their concurrent authorities with the federal and provincial governments with regards to health are defined in the Local Government Operations Act 2074.

The 'impressive' turnout² of people in the 2017 local elections held between May and September 2017 reflected the high enthusiasm of people to elect their local representatives. The previous local elections had been held in 1997 and local government bodies had been devoid of elected representatives for almost one and a half decade. However, in the two years since the local elections, the transition to federalism has been slower than expected, mainly because of a lack of adequate progress in fully defining the authorities and functions of the various levels of government and in defining their institutional structures. Key acts such as the Local Government Operations Act 2017 and Public Health Service Act 2018 have been promulgated but the required rules, regulations and guidelines which further define the provisions in the Acts have not been developed, creating a lack of clarity and leaving room for confusion. Many provincial and local government leaders have expressed their dissatisfaction of the federal government in managing the transition to federalism (Sapkota, et al., 2019)³. Only two local elections had been held since the restoration of democracy in 1990. Therefore, there had been a limited experience with having local bodies in a multiparty democracy. Thus, a significant number of local government leaders do not have adequate political and administrative experience in local governance, which means that they lack experience in local health governance as well. The sluggish transition toward federalism has left many local governments without adequate support from the federal and provincial governments for institutional setup, infrastructure and capacity

¹Urban municipalities include Metropolitan (*Mahanagarपालिका*), Sub-metropolitan (*Upa-mahanagarपालिका*) and Municipal (*Nagarपालिका*) units. For the purpose of this report, urban municipalities and rural municipalities (*Gaunपालिका*) are collectively referred to as *Municipalities*.

² "Despite pre-election uncertainties around the electoral calendar and longstanding contestation over constitutional amendments, all three phases of the election saw impressive voter turnout... 14,054,482 people were eligible to vote in all three phases, with ECN putting the average voter turnout at 74.56%; 73% in first phase; 73.69 in second phase; and 77% in third phase." Source: Observation of Nepal's Local Elections 2017 Final Report, Democratic Resource Center (https://www.democracyresource.org/wp-content/uploads/2017/11/DRCN_Local-Election-Final-Observation-Report_Eng.pdf)

³Sapkota, Rewati, and Bharat Koirala. 2019. *The Himalayan Times*. 25 February. Accessed May 05, 2019. <https://thehimalayantimes.com/nepal/political-leadership-is-responsible-for-problems-in-implementing-federalism/>.

development necessary to deliver on their constitutionally mandated responsibility of providing basic health services. Furthermore, many institutions and subordinate authorities of the previous central government such as the District Health / Public Health Offices (DH/PHOs), which were responsible for delivering health care services at the community level, have been disbanded and replaced by provincial and local authorities. However, it is not yet sufficiently clear how their previous roles and responsibilities will be reorganized.

There are serious concerns that these gaps will not only diminish Nepal's past public health gains but also weaken the country's health systems' ability to address emerging public health challenges (Thapa, et al., 2019)⁴. Because local governments across Nepal had functioned without elected representatives for over a decade and half, people's expectations of their elected local leaders regarding good governance and quality health care services are very high. At the present, the public health sector exists in a socio-political environment characterized by great optimism among elected local representatives who face high expectations from their constituencies but amidst slow progress in transition management and limited capacity of the local governments.

The Preamble of the Constitution of Nepal envisages ensuring good governance through a federal democratic system. The Constitution has devolved significant authorities, including law and policy making powers, to local governments. As there is a strong correlation between good governance and good health care systems, a decentralized health system under a federal arrangement with significant authorities devolved to local governments can better address the health needs of local communities and be more accountable to the citizens. For the federal model to effectively promote health governance, the authorities, roles and responsibilities of each of the three levels of governments need to be clearly defined and there must exist clarity regarding processes for coordination and practice of solidarity between them. The federal government can play the role of a steward to build the required clarity and sense of solidarity across all levels. However, the slow progress on drafting and enacting the legislations, rules and regulations required to clarify constitutional provisions and authorities of different levels of government, an apparent reluctance on the part of the federal government and its political leaders to devolve significant power to the other levels of government, and notable examples that indicate a tendency towards centralizing certain powers already devolved to provincial and local governments call into question the intent and commitment of the federal government towards devolving power in accordance with the spirit of the Constitution. The federal government is yet to take concrete steps towards capacitating sub-national levels on strengthening health governance and health systems.

It is in this context that The Asia Foundation and Public Policy Pathshala (PPP), as part of their Sub-National Governance Program (SNGP) funded by Australia Government,

⁴Thapa, Rajshree, Bam, Kiran, Tiwari, Pravin, Sinha, Tirtha Kumar, and Dahal, Sagar. 2019. "Implementing Federalism in the Health System of Nepal: Opportunities and Challenges." *International Journal of Health Policy and Management* 195-198.

Department of Foreign Affairs and Trade (DFAT), have conducted a situational and political economy analysis (PEA) of Local Health⁵ Governance.

2. OBJECTIVES

The overall objective of this situational and political economy analysis is to contribute to the knowledgebase on the situation of local health governance in the emerging context of a transition into a federal system, while highlighting the underlying political economy which affects the governance of local level health services delivery in the restructured state.

The specific objectives are to:

- Describe and compare local health service delivery and system before and after the adoption of federalism,
- Assess the current status of local health governance,
- Examine the underlying political and economic drivers and barriers – interests, incentives, power structures, and relations among and between different actors and institutions – that shape the policy and practice of local health governance, and,
- Identify opportunities and practical entry points for actions to improve local health governance.

3. METHODOLOGY

This situational and political economy analysis built on the Policy Landscape and Local Health Governance Assessment (April 2019), conducted by The Asia Foundation and PPP. The assessment covered 23 rural and urban municipalities representing the topographical and demographical variance of Nepal, including in all seven provinces. In addition to these, the assessment was also informed by an interaction meeting with officials of all 136 municipalities of Province 2⁶. Further data was collected from two of the 23 municipalities sampled for the assessment and analyzed⁷. Approaches and tools available on the web were used to inform the PEA. The analysis adopted a problem or issue-focused approach⁸ aimed at the sub-sector, namely local health. Under this approach, different tools and techniques for data collection, analysis and interpretation, drawing from problem-driven as well as sector-level PEA methods, along with tools used by different donor agencies⁹, were deployed to:

⁵For the purpose of this study, local health encompasses the leadership, organization, and management of basic health services delivery to their constituents by local governments (*municipalities*) as per their constitutional mandate and citizens' expectations.

⁶This was part of PPP's separate work on increasing awareness on safe motherhood and newborn health among local governments of Province 2. The project was supported by Save the Children.

⁷ The additional data collection and field consultations were held from March to September 2019 and may not reflect the current context post Covid-19 pandemic.

⁸Adapted from the 'Problem-driven governance and political economy analysis: Good practice framework' of the World Bank

⁹DFID, World Bank, DFAT (Australian Government)

- Define the issue,
- Examine governance and institutional arrangements, and,
- Examine underlying political economy drivers.

This study primarily scrutinized the individuals and organizations with a stake in local health governance, along with their interests, incentives, power structures and relations which formally or informally have a bearing on how basic health services are organized and delivered to the constituents. In doing so, the analysis identified not only barriers to be addressed, but also opportunities in the form of practical potential entry points and levers for change for the Foundation and PPP. The opportunities identified could also be useful for other development partners interested in supporting municipal health care service delivery.

4. FINDINGS

This section briefly lays out the findings of the analysis. The first subsection describes and compares the local health service delivery and system prior to and after the adoption of federalism. The second subsection outlines the present situation of local health governance¹⁰, and the final subsection presents the political economy analysis, including the drivers of, and barriers to, good governance and effective service delivery.

4.1 Local health service delivery and system – past and present

4.1.1 Governance and institutional arrangements

Prior to the transition into federalism, basic health service delivery at the district and community levels was organized within the district health system led and managed by a District Health Office (DHO) in 55 districts or a District Public Health Office (DPHO), in 20 districts¹¹. The DH/PHOs were responsible for planning and implementing essential health care services (EHCS), and monitoring and reviewing activities and outputs of district hospitals, primary health care centers (PHCCs), and health posts. They provided technical guidance and support, along with managing finances, logistics, human resource and information, and providing supportive supervision to health facilities in the districts.¹² They were also responsible for the registration, licensing and monitoring of private health facilities, including up to 25-bed hospitals within their jurisdiction.¹³ They reported to the Regional Health Directorate (RHD) in their respective Development Region¹⁴ and, through RHD, to the Department of Health Services (DoHS) at the center. All human, financial and material resources for local health service delivery were allocated and provided or funded by the Ministry of Health and Population (MoHP) through DoHS and its different Program Divisions. Local bodies like municipalities and Village Development Committees (VDCs) were represented in the Health Facility Operation and Management Committees (HFOMC) for PHCCs and Health Posts and provided varied resources and support to these facilities. But they had limited or no role in planning, managing, implementing or monitoring service delivery. Local-body officials chaired the HFOMCs in many health facilities, but not in all. Each hospital board had a chairperson nominated by the MoHP. As part of the annual budget development, the health planning followed a 14-steps planning process in place at the time, originating at the ward-level in beneficiary communities and culminating in the relevant ministries.

The structure has now changed from a district health system to what may be termed a municipal health system, with local governments (metropolitan, sub-metropolitan,

¹⁰ The assessment is based on the data collection and field consultations from March to September 2019 and may serve as a baseline of local health governance pre-Covid-19

¹¹ Department of Health Services (DoHS) Annual Report 2014/15

¹² DoHS Annual Report 2016/17

¹³ Ministry of Health and Population (MoHP) Guidelines for Establishment, Operation and Upgradation of Health Facilities 2014

¹⁴ Five development regions existed before the new Constitution was promulgated.

municipality and rural municipality – referred together as *municipalities* in this report) being responsible for leading, organizing and managing basic health service delivery. In line with the 2015 Constitution, the Local Government Operation Act 2017 enlists basic health and sanitation service delivery as the exclusive authority of local governments¹⁵. The Act makes municipalities responsible for registering, licensing and monitoring private health facilities, including primary-level hospitals. The Government of Nepal (GoN) has promulgated the Public Health Service Act 2018 to create a federal legal framework for public health. Each municipality can develop a local health Act in line with the federal Act(s) to institute its own legal framework to execute its responsibility of delivering basic health services¹⁶. However, many municipalities have not yet developed the Act. This has left room for obscurity and confusion, preventing municipalities from effectively delivering on their role as enshrined in the Constitution and related laws. In their annual planning process, municipalities are expected to plan and budget for local health services through federal ‘conditional’ grants for basic health care packages along with their own resources, which may include locally generated revenue and ‘unconditional’ grants received from the federal and provincial governments. However, in practice, the budget and most activities for local health services are determined at the federal level by DoHS and its divisions and centers. The MoHP then provides such budgets to the municipalities as ‘conditional’ grants to implement various public health programs which cover basic health care packages and may provide additional services.

Under the current setup, the Mayor or Chairperson of a municipality chairs hospital boards in their municipality, while the Ward Chairperson of the locality of the facility chairs the HFOMC of PHCCs and health posts.

There is a disconnect between technical and governance structures at the province-level, the erstwhile district-level and the new municipal-level health systems. The DH/PHOs were disbanded and 35 new health offices were created in 2017 to provide technical support to municipalities. The federal government, however, decided in 2018 to retain one health office in each of the 77 districts, this time under the respective Provincial Health Directorates (PHDs). The seven PHDs come directly under each province’s Ministry of Social Development (MoSD) and are responsible for providing technical reinforcement and program monitoring to district health systems.¹⁷ However, given the changes, district health systems are fragmented in practice.

4.1.2 Service delivery structure and functions

Before the transition into federalism, health services were delivered through a hierarchy of health facilities such as district hospitals or their equivalents, PHCCs, and health posts, and through community structures such as cadres of Female Community Health Volunteers (FCHVs), primary health care outreach clinics (PHC-ORC), and immunization clinics. In 2014/15, there were 75 district or equivalent hospitals in the

¹⁵ Article 11 (I) of Local Government Operation Act 2017

¹⁶ Article 102, Local Government Operation Act 2017 “ Rural and Urban Municipalities can prepare legislation in the sectors within their jurisdiction”

¹⁷DoHS Annual Report 2017/18

75 districts across Nepal.¹⁸ These hospitals, of up to 50 beds in capacity, provided emergency, outpatient, and in-patient clinical services, including laboratory and radiological diagnostics, along with limited surgery facilities. They also provided public health services like immunization, family planning, safer motherhood, disease treatment and control, etc., and acted as referral centers for PHCCs and health posts in their district. PHCCs provided limited emergency, curative and diagnostics services in addition to public health services, while health posts primarily provided public health services and limited curative services for minor ailments and injuries. Health posts were the first institutional point of contact for basic health services and the lowest-level health facility to support and monitor community-based activities, such as those of FCHVs and those services delivered through PHC-ORCs and immunization clinics.¹⁹ There was at least one health post in each VDC and one PHCC in each parliamentary electoral constituency.

With federalization, these facilities, including primary level hospitals,²⁰ have come under the authority of the municipalities. There is a plan to have at least one health post in every ward and one primary hospital in each municipality, by upgrading existing PHCCs and establishing new ones as required. Community-based services continue to be run under the supervision of existing health posts. However, as needed, Community Health Units and Urban Health Clinics are also run by some municipalities.²¹ The municipalities have to implement the full package of basic health care services defined at the federal level. The federal government provides local governments with the funding for the basic health care package. Municipalities are free to locally adjust and include additional interventions and services to the federally defined package if they can be funded with municipal own resources. Although the structures and services of the PHCCs and health posts and other health care institutions have not seen much of a change since the transition into federalism, municipalities continue to face challenges due to their limited capacity to fund and manage erstwhile district-level hospitals, many of which have now been classified as primary-level hospitals.

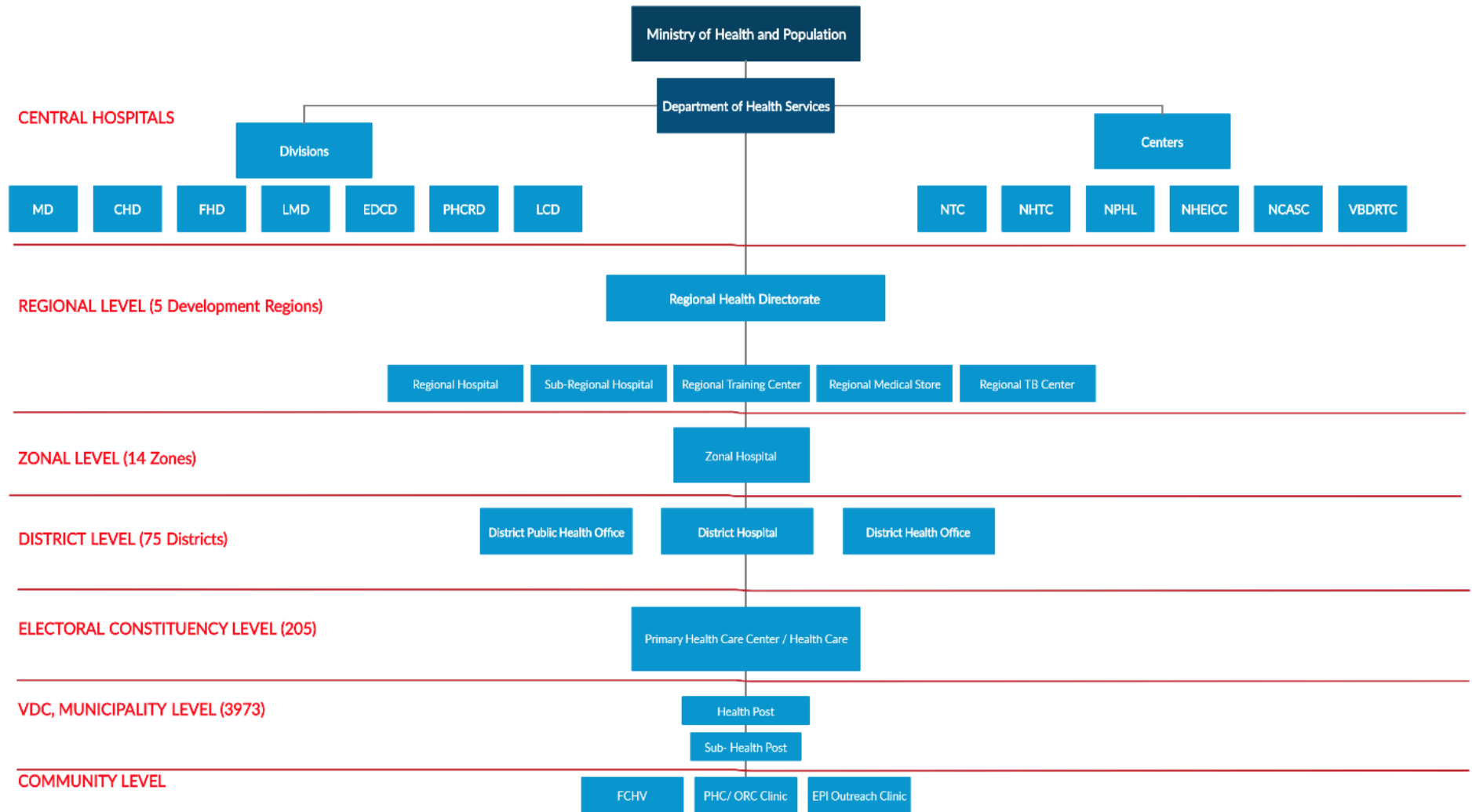
¹⁸DoHS Annual Report 2014/15

¹⁹DoHS Annual Report 2016/17

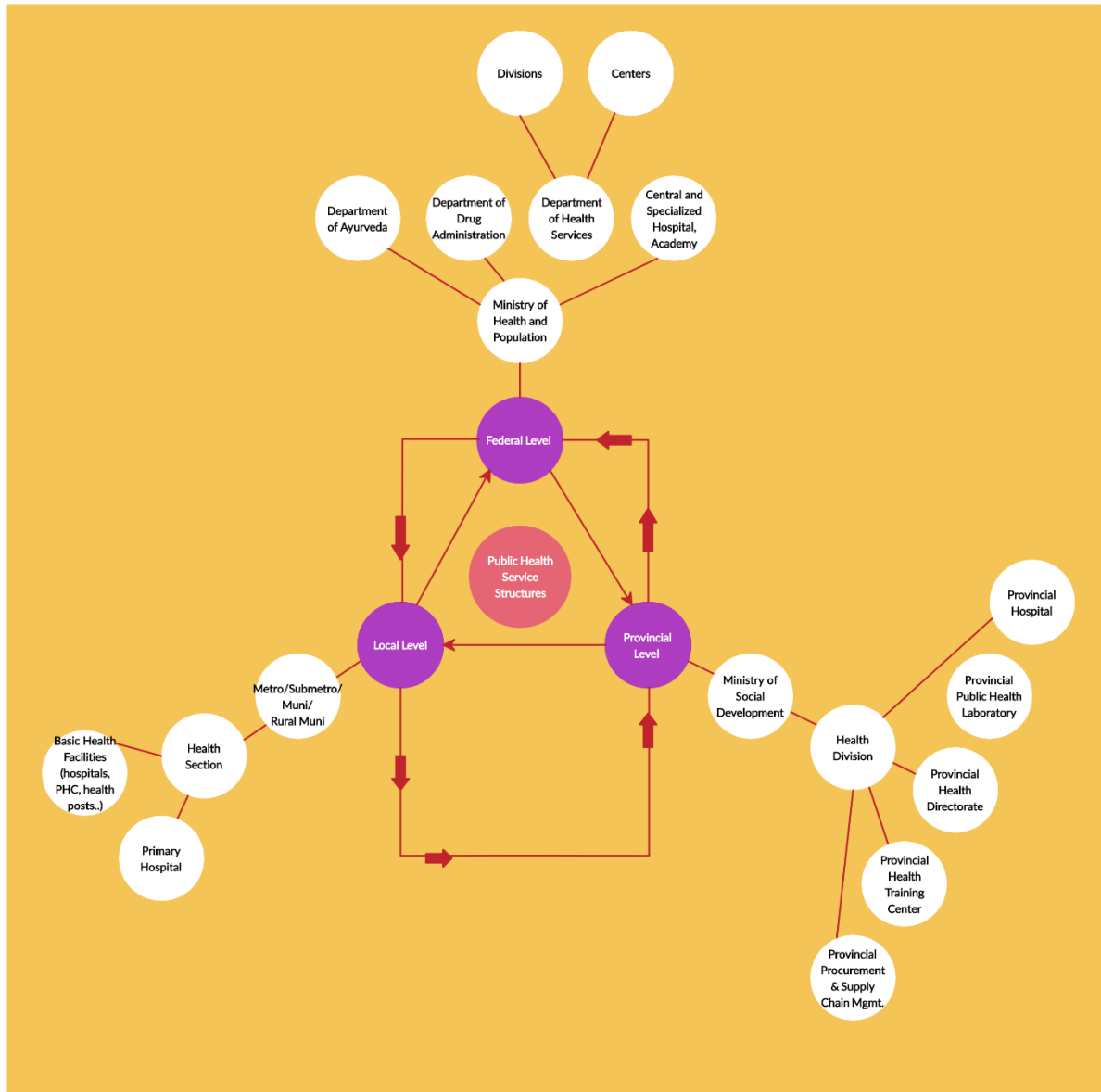
²⁰ Classified in the MoHP's National Health Infrastructure Development Guidelines 2017 as Category 'A' Primary Hospitals for municipalities, sub-metropolitan and metropolitan cities and Category 'B' for rural municipalities. The hospitals are no longer classified by their bed-capacity. National Health Policy 2019 envisages establishing and operating at least one primary hospital in each local government level.

²¹DoHS Annual Report 2017/18

Box B: Organogram of pre-federalism public health service structures



Box C: Organogram of public health service structures under federalism



4.1.3 Information management

Before federalization, information management was done through the national health management information system (HMIS) section within the Management Division of the DoHS. The DH/PHOs were responsible for collecting, entering, assuring quality and analyzing data for district-level use, and for sharing data with the DoHS/HMIS section for aggregation, analysis and use at the regional and national levels. Each health facility collected service-level data against a defined set of indicators and reported on paper-based forms to the DH/PHOs where the data was entered into the District Health Information Software 2 (DHIS2)²² online platform to be reported to DoHS/HMIS section. Private health facilities reported on paper forms to DH/PHOs, though the timeliness and completeness of their reports was usually poor and always an issue.

Electronic reporting through DHIS2 had been expanded gradually to health facilities-level; over 600 facilities were reporting electronically at the end of fiscal year 2016/17. The HMIS section collected, collated and provided information to all DoHS divisions, centers, regional directorates and DH/PHOs on the activities undertaken at the district-level.

Though HMIS was meant to be an integrated system, there were other information systems which reported on other aspects of the health system. The other main health-sector Management Information Systems (MISs) included the Logistics Management Information System (LMIS), the Financial Management Information System (FMIS), the Health Infrastructure Information System (HIIS), the Planning and Management of Assets in Health Care System (PLAMAHS), the Human Resource Information System (HuRIS), the Training Information Management System (TIMS), the Ayurveda Reporting System (ARS) and the Drug Information Network (DIN).²³ Annual performance review workshops, based on information generated through the HMIS and other information systems, were conducted in all districts, regions and at the national level. An annual report was published each year by DoHS with national and regional-level analyses. However, the use of information and evidence in district or local-level health planning and decision-making was not strong.

The HMIS on the DHIS2 platform has been updated to accommodate the latest federal structure. Health facilities now report on paper forms to the municipalities where data is entered electronically into DHIS2. The number of health facilities reporting electronically had expanded to over 1,200 facilities by the end of the fiscal year 2017/18. Private facilities are meant to report through the municipalities. However, many facilities continue to report to the Provincial Health Office at the district, adding to the fragmentation in information management.

Due to a lack of clarity on, and capacity for, data management, the reporting from municipalities is often late, incomplete, poor in quality, or non-existent in some cases. The use of data and evidence from the information system at the local level remains poor. There is a disjoint in reporting to provincial and districts levels, which are

²² District Health Information Software 2 (DHIS2) is an open source, web-based health management information system (HMIS) platform. Today, DHIS2 is the world's largest HMIS platform, in use by 67 low and middle-income countries. (<https://www.dhis2.org/about>)

²³DoHS Annual Report 2016/17

bypassed in the reporting system. A July 2019 Cabinet of Ministers decision has made it mandatory for municipalities to report through the provinces to the DoHS/HMIS section. This is expected to address the specific issues that have arisen due to the transition into federalism.

4.1.4 Health financing and financial management

Before federalization, health services in the public sector were funded largely by the central government and development partners including multilateral, bilateral and international organizations, and national NGOs. VDCs and municipalities contributed some resources locally to the health facilities, but these were inconsistent and varying. This included direct funding of the service delivery to provide free services (e.g., essential drugs, vaccines, contraceptives, safe delivery services, curative services at health posts and PHCCs, etc.), or at a subsidized rate (e.g., diagnostic services at PHCCs and hospitals, safe abortion care, surgical procedures, etc.), as well as providing social health protection such as incentives to cover travel costs for women delivering at a health facility under the *Aama Suraksha* (Safer Motherhood) program.

Service users and their families also contributed to finance basic health care, mainly curative services and drugs outside of the essential list which are provided free of charge, through contribution of pre-payments made to the Social Health Security Program (SHSP), or out-of-pocket payments at the point of service delivery.

A trial health insurance scheme was started with the National Health Insurance Program in the fiscal year 2011/12 in a few districts. With the adoption of National Health Insurance Policy in 2014, SHSP implementation began in three districts in the fiscal year 2015/16 and was gradually expanded to 15 districts by the end of the fiscal year 2016/17.²⁴

DoHS's Finance Section was the focal point for financial management for all DoHS programs before federalization, including programs delivered through district health systems. Their functions included ensuring preparation of annual budgets, disbursement of funds to spending units, and providing accounting, reporting and auditing services needed to support the implementation of health programs at various levels. At the district-level, only the DH/PHOs and hospitals were the spending units and had their own finance sections; PHCCs and health posts received funds and support through the DH/PHOs.

In addition to the Financial Management Information System (FMIS) of the GoN/ Financial Comptroller General's Office (FCGO), which tracked a per-item budget and expenditure, MoHP used a customized system – Transaction Accounting and Budgetary Control System (TABUCS) – to track program-specific budget and expenditure from its spending units. TABUCS tracked nearly 90% of all health expenditure in 2017.²⁵ There was no separate audit for the district health systems, but the audit by the Office of the Auditor General (OAG) of MOHP covered them as well.

²⁴DoHS Annual Report 2016/17

²⁵DoHS Annual Report 2017/18

Since the transition into federalism, health services have been funded by all three levels of government and development partners, including multilateral, bilateral and international organizations, and national NGOs. Though basic health care services delivery is an exclusive authority of local governments, the federal government is responsible for providing the funding. Basic health care services are still being planned and budgeted for by the federal government under different public health programs and funded through ‘conditional’ grants to the municipalities. Provincial governments do not provide direct funding to the municipalities. However, they fund activities, such as trainings, through their health offices at the district-level, which benefit the local health system and service delivery.

Municipalities also plan and budget, allocating funds from their own revenues and other sources, e.g., ‘unconditional’ grants such as equalization grants, and complementing and supplementing activities and programs from the federal government under ‘conditional’ grants. However, funds allocated by municipalities are not reflected in federal plans or budgets, and are not reported either. Service users and their families continue to contribute financing health care through direct out-of-pocket payment at the point of service delivery, and pre-payments to what is now called Health Insurance Program, managed by a semi-autonomous Health Insurance Board, which had been expanded to 36 districts by the end of the fiscal year 2017/18 and with expansion planned to an additional 11 districts over the fiscal year 2018/19, with the ultimate aim to expand the coverage across the country.²⁶

Each level of government has its own financial management systems. The municipalities use software called Sub-national Treasury Regulatory Application (SuTRA), whereas the provincial governments use the Computerized Government Accounting System (CGAS). DoHS Finance Section is limited to the financial management of federal-level funding only. MoHP and DoHS use FMIS as well as TABUCS. TABUCS is now limited to spending units under the federal government only, and does not record any health expenditure made by provincial and local governments. For local health delivery, along with hospitals, municipalities and wards are the spending units, covering PHCCs and health posts. Each level of government has its separate audits by the OAG. Thus, the system has become fragmented in the absence of an integrated financial management and reporting system, and this fragmentation has made it difficult to track and compare health budgets and expenditures across different executing and spending levels.

4.1.5 Human resource management

Before the transition into a federal system, personnel to all permanent positions within district health systems for local health service delivery were recruited centrally through the Public Service Commission, based on the needs of MoHP. Some of these recruitments to fulfill vacancies in the region also happened at the regional level through regional offices of the Public Service Commission. The personnel thusly hired could also be transferred to other regions by MoHP. Hospital boards or HFOMC were also allowed to hire locally contracted staff to fill critical gaps in hospital and PHCC personnel using locally raised revenues. Personnel administration of PHCC and Health Post staff, including records management, salary payment and leave approval, and

²⁶DoHS Annual Report 2017/18

temporary deputations or transfers within the district was done by the DH/PHOs. Hospital personnel were managed by the hospital administration. Any transfers out of the district were done by RHD, DoHS and MoHP, and upgrading or promotion was done by DoHS and MoHP only. Unlike other civil servants who were managed under the Civil Service Act 1993, health and technical staff under MoHP were managed under the Nepal Health Service Act 1997.

Since the transition into federalism, a personnel adjustment process across the civil services has been underway since 2018, and has not yet been completed for the health and technical staff at the time of writing this report. All existing health and technical staff will be assigned to one of the three levels of government. The process has faced relatively more complications in the health sector, and has taken a long time to complete. Any new hiring for staff under municipalities is to be done by respective provincial service commissions based on the need of the municipalities. All provinces have passed, or are in the process of passing, laws pertaining to their respective public service commission, but there is no such commission functional at the time of this report.

As local service delivery from primary-level hospitals to health posts is the responsibility of municipalities now, personnel administration and management, including that of FCHVs, is a function of the municipalities. Health workers deployed under the provincial service after the personnel adjustment or through new recruitment may be transferred within the province only. Each municipality has at least a Health Coordinator and a deputy who are responsible for providing technical and managerial leadership on planning, budgeting, implementation and monitoring of local health service delivery, and for supervising the health facility staff. The Health Coordinator reports to the Chief Administrative Officer (CAO). Health facility in-charges supervise health workers and staff in their respective facilities and report to the Ward Chairperson. The Health Coordinator is responsible for their technical supervision and support. Most of these health managers and workers were recruited through the central ministry before federalization and, since the personnel adjustment process has not been completed, there is still confusion among many of them regarding lines of accountability.

4.1.6 Procurement and supply chain management

Prior to federalization, procurement of essential medicines, supplies and medical equipment for local services delivery was done by Logistics Management Division of DoHS, with some procurement also carried out by RHDs, DH/PHOs and district hospitals. The DH/PHOs and health facilities had little influence over predetermining the quantity of medicines and supplies required for their districts or facilities. The supply chain management was handled by DH/PHOs through medical stores in their districts which received supplies from different sources to be distributed to the health facilities where the supplies were further stored and used or dispensed as necessary. There was no reverse logistics system to return expired drugs and supplies from facilities and dispose them properly at the district level. Disposal of expired drugs and supplies were usually managed locally without following due environmental procedures. Real-time inventory management system was in use in all medical stores at the district-level and above, but this didn't keep track of stocks at the facility-level.

Procurement of certain medical drugs, e.g., for tuberculosis, supplies such as vaccines and contraceptives, and certain equipment still remains a function of the federal government. The reasons are several -- to achieve an economy of scale; the highly specialized nature of the products; single or limited number of manufacturers; requirement for international bidding, which may not be within the capacity of local governments; etc. However, most essential drugs and supplies within the free drugs list are now procured by municipalities through 'conditional' grants from MoHP/DoHS, as well as with their own resources where required.

Lack of local procedural guidelines for procurement and supply of drugs and medical commodities (outlined in section 6.2.1), and poor capacity and lack of experience in such procurements have led to delayed and inadequate procurement at local levels. Provincial governments also procure some medicine and supplies for province-level hospitals as well as for hospitals and facilities managed by municipalities. Though each municipality has a number of facilities under them, most of them lack proper warehouses or storage facilities for drugs and supplies. In the fiscal year 2018/19, electronic LMIS (eLMIS) was implemented to cover 22 districts and 23 health facilities in Province 5 and Karnali Province, with a plan in place to gradually expand to all districts and facilities across Nepal. This is expected to boost facility-level real-time logistical information.²⁷

4.2 Local Health Governance

4.2.1 Policy and legal landscape

The Constitution of Nepal 2015, relevant Acts and Policies provide an enabling framework for ensuring equitable health outcomes for the people of Nepal, mainly the women and children, and the poor and marginalized. Article 15 of the Constitution enshrines health as a fundamental right. It stipulates the following as the rights of the citizens:

- Free basic health services
- Assurance of emergency health services
- Information about one's treatment
- Equal access to health services
- Clean water and sanitation

The Constitution recognizes that health is shaped and determined by other social factors as well, underlining the importance of including health in other sectoral policies of the state. These other rights enshrined in the Constitution are important social determinants to ensure the health of citizens:

- Article 30: Rights to clean environment: rights to live in a healthy and clean environment
- Article 31: Rights to education – rights to school health services
- Article 36: Rights to food security

²⁷DoHS Annual Report 2017/18

- Article 38: Rights of women – safer motherhood and reproductive health
- Article 39: Rights of children– living with dignity, healthy upbringing and care, health and nutrition
- Article 40: Rights of Dalits – health and social protection
- Article 41: Rights of senior citizens
- Article 42: Rights to social justice
- Article 44: Rights of consumers – receiving quality service
- Article 46: Rights to constitutional treatment
- Article 47: Implementing the fundamental rights by promulgating relevant Acts within three years of the promulgation of Constitution

In line with Article 47, Public Health Service Act, Safer Motherhood and Reproductive Health Rights Act, Act relating to Children, Social Protection Act, Consumers Act, Food Security Act, Environment Act, etc. were endorsed by the federal parliament by October 2018. However, Rules, Operational Guidelines and Standards and relevant legal instruments to further define the provisions in the individual Acts have not yet been developed in many cases, for instance, for the Public Health Service Act and Safer Motherhood and Reproductive Health Rights Act.

Schedule 8 of the Constitution enshrines ‘Basic Health and Sanitation’ as exclusive authority of local governments and Schedule 9 lists health as a concurrent authority with the federal and provincial governments. Concurrent authorities are those that local governments can exercise through local laws and policies in accordance with the provisions and within the parameters defined by federal and provincial laws. For concurrent authorities, any provision in a local law or policy which conflicts with federal and provincial laws would become null and void to the extent to which they are in conflict.

Local Government Operation Act 2017 outlines the exclusive as well as the concurrent authorities and responsibilities of the local governments (see box A and B in Annex). However, due to absence of legislations, rules and regulations, the authorities and responsibilities of the three levels of government are yet to be clearly unbundled and defined.

Each municipality can make relevant laws to govern, organize, manage and regulate local health services delivery within its jurisdiction. However, while a few of the sampled municipalities had enacted a Local Health and Sanitation Act²⁸, some had just started the drafting process while some others had not done anything about it. Lack of understanding of what should be in the local act and lack of capacity to draft the act were common reasons behind not drafting the act. A few municipalities had prepared Rules or Operational Guidelines without an act, which means such instruments have no legal basis to operate except in cases where federal or provincial laws provide the basis for them until local laws are formulated. Among municipalities which had passed an act, some had not referenced relevant federal laws to ensure that they were in alignment and not in conflict, particularly with respect to concurrent authorities. Those who had passed an act had not been able to develop legal instruments for concurrent authorities

²⁸ Most of the partner municipalities of The Asia Foundation had developed and adopted their respective act with the help of the template act and technical assistance provided by PPP under the SNGP.

due to a lack of federal rules and operational guidelines to provide the basis for operation.

Municipalities need federal and provincial legal framework and instruments, as well as technical advice and support, for them to be able to develop and promulgate acts and legal instruments effectively and in a timely fashion.

Some examples of where legal instruments were deemed urgently necessary for local governments to carry out their health-related responsibilities smoothly are:

- In the absence of procedural guidelines for procurement and supply of drugs and medical commodities, the procurement process in the municipality is being guided by the National Public Procurement Act. Even though all public sector procurements are expected to adhere to the National Public Procurement Act, the procurement and supply of drugs and health commodities entail integrated and complex processes across the national health system that demand an additional procedural guideline at the municipal level.
- The absence of procedural guidelines on regulation and operation of public and private health institutions has weakened the ability of local governments to effectively regulate and manage the health sector at large. In this environment, both the public and the private sectors continue to operate without adequate stewardship and supervision from their local governments.
- Procedural guidelines on health information management are important since the use of information and evidence in health planning and decision making has been a perennial challenge. Devolution of public health responsibilities to local governments is seen as an opportunity to improve evidenced-based planning because the health planning and decisions will be made closer to the communities. However, developing an integrated approach to health information management at the local level requires standard approaches and procedures.
- The growing adoption of digital health technologies in recent years has increased the trend of the government collecting personal health information, which needs to be safeguarded through appropriate legal provisions on data confidentiality and data sharing.
- Due to the lack of legal instruments and guidelines on public financial management in the health sector, coupled with the lack of adequate capacity and experience, many financial decisions regarding public health appeared to have been made through ad-hoc executive decisions by locally elected leaders. This has given rise to concerns that local governments face high probability of financial irregularities, making urgent the need for formulation and implementation of relevant legal instruments and guidelines at the local level.

The federal government has adopted the National Health Policy 2019, replacing the one from 2014. The 2019 Policy embodies the provisions and spirit of the Constitution, and of the Public Health Service Act, Safer Motherhood and Reproductive Health Rights Act, and other relevant Acts. Some important aspects of the policy are:

- Ensuring that the health-related rights guaranteed by the Constitution are implemented – e.g., free basic health care, access to emergency health services by all

- Reorganizing and expanding health systems in line with the state restructuring into three levels of government
- Ensuring universal health coverage
- Health in all policies and multi-sectoral coordination and collaboration
- Strengthening social health protection mechanisms to include even the most marginalized groups and population

Municipalities may customize the national policy to their own context. However, none of the sampled municipalities had a health policy in place.

Different social and economic sectors such as education, agriculture, labor, finance, infrastructure, environment, etc., influence and determine a population's health outcomes, which calls for a strong collaboration among the different sectors for effective health outcomes of the population. This has been recognized in the Constitution, and in legal documents and policies, promoting a multi-sectoral approach to health and Health in All Policies. Despite the wider recognition that such collaboration is much more likely to be effective at the local-level, very limited or no meaningful coordination among different sectors was found. Health-sensitive policies were largely missing from other sectors. This limited opportunities for multi-sectoral actions to tackle existing or emerging health hazards, such as rise in cancers linked to rampant pesticide use, or respiratory and other diseases linked to industrial pollution, as noted in some of the sampled municipalities.

4.2.2 Governance analysis

The analysis looks into the capacity and capability, authority and accountability, and responsibility and responsiveness to assess the strengths and weaknesses of the governance of local health service delivery.

4.2.2.1 Capacity and Capability

Municipalities benefit from many existing systems, structures and skills of the erstwhile district health system, which is an opportunity for them to build upon and strengthen local health service delivery. Each municipality has health posts, many of them have PHCCs, and mostly those that were district headquarters also have hospitals. These facilities continue delivering basic health services and can be upgraded as necessary and in line with federal policies and plans. The information system (HMIS), though facing issues as described in the Information Management sub-section, is still functional and is the main practical link between the local health system and the provincial and federal governments. However, the management of logistics pertaining to procurement, storage and distribution appears to be a weak link as there is hardly any infrastructure for storage and distribution and experience, e.g., of specialized procurement of medical supplies, at the municipal level. Local health workers possess the pool of skills needed to deliver basic health services.

Since health services require specialized skills and high level of competence, local governments need to ensure, in coordination with provincial and federal levels as necessary, that the skills of the existing health workers are refreshed and updated. They will also need new skills if municipalities decide to add on to the basic package of

health services to address local diseases and health conditions. Once the personnel adjustment process across the civil service is completed and provincial service commissions are in place, municipalities will be able to assess and determine their need for health workers, and recruit through their respective commission accordingly.

The lack of skills in prioritization, planning, budgeting, organizing, implementing and monitoring public health programs and intervention across all sampled municipalities is a stark constraint. A municipality's health system is a smaller version of a district health system. However, municipalities have just two technical staff members – a Health Coordinator, and a deputy – to lead and manage health programs. In comparison, a DH/PHO had several technical officers, with at least one supervisor-level personnel to lead on each of the major public health programs and interventions such as immunization, family planning, safer motherhood, nutrition, HIV, tuberculosis, leprosy, malaria, vector-control, logistics management, information management, cold-chain management, health training, health information education and communication, etc., and a team of administrative and finance personnel to support program delivery.

Health Coordinators and their deputies in municipalities are usually level 5 or level 6 health workers (junior officers) who report to the CAO. They provide technical supervision to health teams at PHCCs and health posts. Some of them were engaged in other “non-related” administrative work in the absence of sufficient human resources in municipalities. Almost all of coordinators and deputies have worked as health workers and, in some cases, as health facility in-charge of PHCC or health posts. Except a very few who have also worked as supervisors at DH/PHO, they have little to no experience of public health planning, budgeting, implementing and monitoring, and none has received any induction or training from the municipality or the erstwhile DH/PHOs on their new roles. All of them reported learning-by-doing since they have occupied this role. This fact is strongly reflected in the lack of any significant health activities and services planned at the local level.

As described in previous sections, most health activities implemented at the local level are through ‘conditional’ grants from the federal government, which come with operational guidelines. Only few activities are planned and funded locally by the municipalities, and in most cases these are limited to subsidies, allowances and distributions to pregnant women or new mothers, children and the elderly. These are mostly influenced by individual and party-affiliated political interests of the elected officials to do something visible and tangible for their constituents. The coordinators and deputies do not have the capability to correctly advise the local government and guide the process of developing and planning rights-based and needs-based health interventions. There is hardly any engagement from the Provincial Health Offices at the district-level, because such offices are still trying to gain clarity on their changed roles and responsibilities towards providing technical support to the local governments.

4.2.2.2 Authority and Accountability

The municipalities have strong political mandates as they are autonomous governments. As local representatives are elected directly by the constituents, they have not only executive power but also legislative power to create and enact local laws and policies, as well as judicial power. This and the constitutional and legal provisions like the Local Government Operation Act 2017 and Public Health Service Act 2018 – their

exclusive and concurrent authority and responsibilities – confer on them the power to lead, manage and ensure basic health services within their jurisdiction. They can do this through health institutions within the municipality health system and, if required, in partnership with provincial and federal government, the private sector, or non-governmental organizations. For example, a municipality can partner with another municipality or a private sector institution to co-finance and operate a specialized service like a neonatal intensive care unit in a hospital outside their administrative jurisdiction. However, due to a lack of clarity in the absence of local Acts and legal instruments, there were examples where municipalities were wary of exercising their authority, for example, to register, license and regulate private health institutions or pharmacy; to define basic health package in the context of their municipality; to plan and invest in health services through their own resources; and to establish municipal hospital or pharmacy, etc.

Local governments are accountable to the people of their municipality. There was a consensus among the local government representatives that federalism has made the government more accessible and accountable to local people. The municipal and ward officials are closer and more accessible to the communities than the erstwhile DH/PHOs who were responsible for health governance within the district. Elected officials now lead or chair hospital boards and HFOMCs that operate and manage health facilities. Apart from direct contact with their constituents, these boards and committees provide platforms to listen to the issues and feedback on health service delivery and utilization, and take necessary actions. Some municipalities were also found operating grievance-handling mechanisms related to local service delivery. As at the federal and provincial levels, the local level has an executive, a legislative and a judicial arm, although how they are constituted varies from the other two levels. They are meant to introduce a check and balance of power and ensure greater accountability.

The policies and annual plans of the municipalities are prepared by the executive and presented to and approved by the municipal legislative assembly. However, though almost all of the sampled municipalities had a health-related committee in the executive arm, usually chaired by the deputy mayor or deputy chairperson or a ward chair, none of them had such a committee in their legislative arm. The latter, if and where present, can be expected to advise and influence the formulation of related legislations as well as monitor the implementation of related acts, policies, and plans. The judicial arm does not have any defined responsibility specifically pertaining to health care services.

Accountability arrangements from the local to the provincial or federal governments is limited to service reporting through the HMIS and financial reporting through SuTRA for the programs funded through ‘conditional’ grants. There is no formal requirement for sharing or reporting for locally funded programs.

4.2.2.3 Responsibility and Responsiveness

The roles and responsibilities of municipalities related to the health sector are outlined in the Constitution and relevant acts. However, there is a need to unbundle and define these further in the related legal instruments being created or to be created at all three levels of governance. Despite high enthusiasm and optimism among local government representatives, they were deeply concerned over the ambiguity regarding roles and

responsibilities, and regarding the poor coordination among the three levels of government, which could lead to significant gaps in guaranteeing quality health care services to people. The lack of comprehension and clarity among the municipalities has meant that they have not yet taken on the full responsibility of local health governance and service delivery.

Very few municipalities were found to have done some kind of assessment to understand the health situation in their jurisdiction, let alone respond to the disease burden, important public health conditions and needs and gaps of the local populace. Municipalities are still reliant on the planning, budget and guidelines from the federal government to implement health programs locally. Anything prioritized and planned locally were not in response to needs, gaps and disease burden identified at the local level, but were mostly guided by individual interest or political interest along party lines to do something visible or tangible – something that can be directly handed over or distributed to key population groups, e.g., pregnant women, new mothers, children, or the elderly. There is no formal link between the health-related planning and budgeting at the federal and provincial level and at the local level. Each level sets its own priorities and plans and budgets with little or no input from other levels. There is no mechanism to ensure that the plans and budgets from different levels implemented locally are coherent, complementary and responsive toward comprehensively addressing the needs of the people.

4.2.3 Effectiveness of service delivery

Most of the local government representatives were optimistic about municipalities being able to tackle existing gaps to provide more equitable health care services to the citizens. Except for a few interventions targeted at women, children and the elderly that have been implemented by municipalities with their local resources, local health service delivery is still largely the continuation of health programs implemented through the district health system that existed before federalization. Barring a few examples, e.g., the operation of municipal pharmacy, introduction of school health nurse, etc., the scope of basic health services generally has not been expanded by municipalities in response to local needs.

The transition into federalism presents an unprecedented opportunity to reorganize and improve health service delivery, given the authority and resources local governments have to strengthen local health governance. However, the ‘in-limbo’ role of health offices at province and district level; the prolonged personnel-adjustment process and the inability of municipalities to recruit new health workers in the absence of functional provincial service commissions leading to staff shortages; fragmentation in supply chain management; broken links in information management; profound capacity gaps in planning, budgeting, organizing and managing health systems and services; lack of proactive efforts by municipalities and district and provincial offices to coordinate, seek and provide technical support; etc., have negatively impacted local health service delivery.

Many well performing programs such as immunization and safer motherhood program have seen dips and fluctuations in service coverage indicators over the last couple of

years²⁹. It may be too early to evaluate the impact of federalism on health service delivery. However, if issues arising from the transition are not managed in a timely and effective manner, early signs suggest that this could bite into the health gains made so far by the country, fragmenting and weakening the systems, structures and mechanisms that have been institutionalized over many decades.

4.3 Political economy analysis (PEA) of local health governance

This analysis was conducted to provide a deeper understanding of emerging political economy drivers enabling -- or barriers blocking -- good governance for effective delivery of basic health services by municipalities as per their constitutional mandate, entitlement of people, and popular expectations. A problem or issue-focused approach³⁰ looking at local health governance in the emerging context of federalism was adopted to conduct this PEA. Attention was focused on:

- Assessing the policy and legal environment, and governance and institutional arrangement, of local health service delivery in the emerging context of state restructuring to understand the issue better
- Examining the underlying political and economic drivers and barriers – interests, incentives and power structures and relations amongst and between different stakeholders and actors (people and institutions) – that shape policy and practice of local health governance
- Identifying opportunities and practical entry points for actions to improve the effectiveness of local health governance

4.3.1 Brief summary of the current status

Assessment of the current status of local health governance in terms of policy and the legal landscape; structures and institutional arrangements; governance; and service delivery is a key part of the PEA.

Municipalities hold the constitutional mandate and are responsible for local health governance and service delivery. They have unprecedented authority and much more financial resources to do so than they had before federalism was implemented. They also have reasonable infrastructure and technical capacity, thanks to the legacy of the erstwhile district health system, which was firmly institutionalized to deliver basic health services. However, glaring lack of skills for planning, budgeting, managing and monitoring of health programs; limited accountability to other levels of government; sub-optimal take-up of responsibilities entrusted by the Constitution and relevant Acts; and absence of responsive policies and plans which are coherent and supplemental with planning at other levels of government, have rendered local health governance weak.

²⁹ For example: The proportion of fully immunized children was 71%, 73% and 70% in fiscal year (FY) 2015/16, 2016/17 and 2017/18 respectively; deliveries conducted by skilled birth attendant 54%, 52% and 52% respectively; contraceptive prevalence rate (unadjusted) 43%, 43.6% and 40% respectively; etc. [Source: DoHS Annual Report 2017/18]

³⁰ Adapted from the ‘Problem-driven governance and political economy analysis: Good practice framework’ of the World Bank

4.3.2 Stakeholders and actors – people and institutions

The stakeholders of local health governance were mapped. People and institutions which have a stake or potential stake in the organization, management, delivery and impact of basic health services by municipalities were considered stakeholders³¹ for the purpose of this analysis. Those who are able to use their position of power, resources, skills and knowledge to significantly influence, and whose presence is deemed essential for local health governance, were termed key stakeholders. The term ‘primary stakeholders’ was applied to those who, although not formally essential, directly influence and are directly affected by local health governance. Those who are involved indirectly or temporarily, and have little influence if any, were termed ‘secondary stakeholders’.

Key stakeholders	<ul style="list-style-type: none"> • Local government (municipalities) • MoHP • Hospital boards and HFOMC • Health facilities under a municipality (primary-level hospitals, PHCCs, health posts)
Primary stakeholders	<ul style="list-style-type: none"> • Provincial Ministry of Social Development • Provincial Health Directorate • Provincial Health Office at district • Federal Parliament • Federal ministries (Finance, and Federal Affairs and General Administration) • Local-level project implementing partners (where present) • Media
Secondary stakeholders	<ul style="list-style-type: none"> • Citizens and community groups (e.g. mothers’ groups) • Secondary and tertiary hospital which are not under municipalities • Professional councils • Association of local governments (Municipality Association of Nepal, National Association of Rural Municipalities in Nepal) • Multilateral and bilateral development partners • Private sector • District Coordination Council • Chief District Officer

Only some key and primary stakeholders were included in further analysis with regards to their interest, power and relationships, as described in the following sub-sections.

4.3.3 Health as an agenda at the local level

Health is generally accepted by local governments as a high priority area and elected officials are vocal in their intention to improve the health status of their constituency. They acknowledge their constitutional mandate for guaranteeing basic health of the

³¹Adapted from Internal Stakeholder Map, Capacity WORKS, GIZ

citizens. The governance philosophy and system of local health service delivery has changed with the transition into federalism.

However, the understanding among the local government bodies of the gravity and the highly specialized nature of the health sector, for instance, of the demographics, health situation and determinants, burden of diseases, evidence-based interventions and services, specialized types of human and physical resources such as vaccines, contraceptives, diagnostics and medicines, etc., is poor.

Local governments have benefitted from the legacy of erstwhile district health systems. Health services delivery still rely largely on the existing facilities, human resources and programmatic inputs from the federal government, with little change from pre-federalism times.

Even though local government officials say that health is a high priority, there is no evidence to substantiate this. In practice, the deliberation, time and effort channeled by local governments towards health care governance is limited. Health Coordinators, who lead the health care portfolio in municipalities, do not have the professional profile or confidence in influencing elected political leaders, who in turn lack technical knowledge and do not have the political incentive to prioritize health. Infrastructure development, by far, remains the higher priority: both in terms of demand from people and allocation of resources by municipalities. Though some municipalities had hired health workers on temporary contracts with local resources, allocation of significant budget from their resources to health care services was not evident. Thus, no significant change is seen between before and after federalization in terms of priority accorded to health care services.

There is complacency and indifference when it comes to prioritizing investing in health. Comparatively few elected officials, mainly the Mayors and Chairpersons and their deputies, think investing in health generates political capital for them. Many perceive health as being low in terms of ability to generate political dividends since the impact of the investments in health care may not be immediately visible. They tend to focus more on investing in other, more tangible, sectors like constructing roads, erecting physical infrastructure, energy, etc., where there is direct demand and pressure from the public as well. Even within the public health portfolio, many tend to focus on more tangible aspects, for example, upgrading health facilities and providing health subsidies rather than investing in more long-term solutions like strengthening systems or improving quality of delivered service.

Many stakeholders also saw a general lack of awareness among the population about their rights to health and the importance of their local government investing in health care as a factor for this behavior. With centrally funded and guided programs through 'conditional' grants still the mainstay of health service delivery at local levels, there is little incentive or urgency to prioritize investments in health care, let alone focusing on evidence-based, contextualized and systematic planning. Without awareness amongst the political leaders as well as the general population about the economic and developmental value and return of investing in health care, which might require perseverant advocacy, prioritizing health broadly and systematically in local government's planning and budgeting is less likely to happen.

4.3.4 Roles and interactions of different levels of government in local health

Federal government, represented by MoHP for the health sector, has the responsibility of ensuring the constitutional mandates to guarantee health of citizens, as well as fulfilling international commitments such as the Sustainable Development Goals, Universal Health Coverage, etc. MoHP is also the responsible entity for defining the federal-level policy and strategy landscape, setting national standards for health service delivery, and strengthening systems to ensure equitable access to quality health care services to all, without creating huge financial burden for the poor and marginalized.

Free basic health services are a mandate of the local government. This requires devolution of significant health related functions from the federal to the local level. However, there is a strong perception at the local level that many actors in MoHP want to retain as much authority as possible at the federal level, and therefore the required authority for local governments to discharge public health functions has not been devolved. Many local government officials believe that MoHP is interested more in highlighting the weaknesses in the capacity of local governments in order to reestablish and retain authority at the federal level.

The federal government is perceived to have been inefficient and ineffective in managing the transition of the health sector from a unitary to a federal system. For example, the personnel adjustment process has dragged on for far too long and is riddled with controversies, creating dissatisfaction among health workers at all levels. This has further compounded the human resource situation in the health sector, resulting in shortages of health workers and inadequate skill-mix of available human resources at the local level³².

The role of the provincial level in local health delivery is less clear. Provincial health offices at the district level do not have the all-encompassing mandate that their previous iteration, DH/PHOs, had. They do not have political, financial or management power, but they still possess more knowledge and technical capacity than municipality health teams. Local government officials generally perceive that the district-level health offices still want to maintain the status quo of pre-federalism years by controlling key public health functions of the erstwhile DH/PHOs, such as planning, programming, procurement, monitoring, and supervision.

Though the new roles are still not clearly defined, health offices are expected to provide technical support to municipalities to effectively deliver health services. However, there are several barriers to that. They do not have the resources. For instance, the budget from the provincial government is limited, and they do not have a say over local budgets. They also lack the incentive to provide technical support. There is a general sense amongst the municipalities that, since they are autonomous governments and have the authority and control over financial resources, they do not need to approach and seek support from or report to provincial authorities. This has also encouraged a blame game -- local governments accuse that provincial and federal governments don't support them, but also seldom making the effort to proactively liaise for cooperation. In turn, local governments are accused of being 'egoistic' about their autonomous status

³²Thapa, R., Bam, K., Tiwari, P., Sinha, T., and Dahal, S., 2019. "Implementing Federalism in the Health System of Nepal: Opportunities and Challenges." *International Journal of Health Policy and Management* 195 -198.

and resourcefulness, and refusing any monitoring, supervision or support from the district-level health offices despite local governments' lack of capacity to effectively discharge public health duties. These attitudes have prevented interaction and cooperation between these two entities. Municipalities which are also district headquarters were more likely to have better interactions and cooperation with district-level health offices due to physical proximity and ease of participating in each other's activities.

4.3.5 Dynamics within the municipalities

Elected Mayors and Chairpersons and their deputies of municipalities exercise extensive power in relation to health care services as they have executive as well as legislative authorities. They have the mandate and authority to determine priorities and allocations, devise local legal, policy and strategic framework, lead planning and delivery, set standards and regulate, and monitor and account for health service delivery within their jurisdiction. The daily operations and staff leadership is provided by CAOs who manage and supervise the Health Coordinator and the health section. The Health Coordinator is the technical lead of local health service delivery.

When it came to prioritizing and investing in health, rifts within political leadership were common, for instance, between Mayors and Chairperson on one side and their deputies on the other. Such rifts were more intense where the heads were from one party and their deputies were from another party. There were rifts between elected officials and staff leadership, for instance, with the former accusing the latter of not facilitating issues prioritized by elected officials, while the latter accused elected officials of trying to breach norms and due processes to force their political interests. There were rifts between health teams and senior officials where elected officials expressed that the health personnel were still carrying the 'hangover' of DH/PHOs in exercising authority, still being loyal to provincial or federal health officials, and trying to maintain the status quo. This was at least in part because of the ambiguity resulting from the protracted personnel adjustment process.

In some municipalities where the Mayor or Chairperson and Deputy Mayor or Vice-Chairperson belonged to different political parties, elected leaders did not always get along on many issues, including on public health. While it is understandable for leaders from different parties to differ on issues, in many municipalities it was found that elected leaders from different political parties were unsupportive of each other and could not get in agreement, often pushing forward individual and party-affiliated political interest instead of trying to find a common ground. There were a few exceptions: there was better cooperation and constructive dialogue in municipalities where elected leaders maintained more positive attitudes towards each other.

As the personnel adjustment process had not concluded, there was an environment of distrust between the municipal staff, viz., the Chief Administrative Officer and Health Coordinators on one side and elected municipal officials on the other side in many municipalities assessed. Despite the devolution of public health functions to the local governments, elected leadership in some municipalities expressed that the civil servants are maintaining accountability to 'their' federal ministry, rather than being accountable to local governments. The frequent transfer of civil servants by the federal government also hampered efforts to build a rapport between civil servants and elected leaders.

Health Coordinators rank relatively low within the civil service hierarchy. Their capacity to lead health planning, budgeting, delivery and monitoring is generally poor. This has limited their role to mere administrative functions of the health section. They do not have direct managerial roles at health facilities which report to the Ward Chairperson in the case of PHCCs and health posts or to the Mayor or Chairperson in the case of hospitals and select PHCCs. Elected municipal heads appear to ‘dictate’ what should be planned for that particular facility or area. Lacking the knowledge or skills-set necessary to lead the municipal health sector, and the scope and recognition of their role being limited, Health Coordinators are not motivated or confident enough to advise the elected leadership on public health functions.

4.3.6 Drivers vs barriers and opportunities vs threats regarding good local health governance and effective service delivery

Analyzing the findings in above sub-sections, a list of drivers vs barriers and opportunities vs threats has been identified as conclusions, which are briefly listed in the table below.

Drivers / Opportunities	<ul style="list-style-type: none"> • Progressive legal and policy landscape; favorable policy and legal framework • Unprecedented and significantly more authority and financial resources closer to the people than before implementation of federalism • Availability of reasonable infrastructure and skills-pool for basic health services • Availability of Provincial Health Offices at each district – potential to get regular technical support and reinforcement • Provision to partner with other levels of government, including neighboring local governments, the private sector, NGOs and development partners to ensure and expand basic service delivery
--------------------------------	--

Barriers / Threats	<ul style="list-style-type: none"> • Slow process of formulating necessary Acts, legal instruments and policies by all levels of government • Confusion and lack of comprehension and clarity around roles and responsibilities among different levels of government • Personal and party-affiliated political interests and focus on investing in more tangible sectors like constructing roads, physical infrastructure, energy; also within health care services, interest not focused on improving systems or quality and scope of service delivery, but on tangible short-term measures • Perceived hangover from the past to retain authority and power by federal and provincial governments or districts • Poor capability of local governments to plan, budget, manage and monitor health programs • Fragmented and incoherent prioritization, planning and budgeting across different levels of government • Potential for corruption and poor checks and controls, e.g., in procurement • Continued shortage of human resources and prolonged personnel adjustment process, slow recruitment
---------------------------	---

5. RECOMMENDATIONS

In light of these findings and conclusions, this sub-section lists possible key actions that the government and broader group of development partners could prioritize in order to better manage the transition and to strengthen local governance for effective delivery of basic health services.

5.1 Government (all spheres): Better manage transition, minimize disruptions

- Formulate relevant acts and legal instruments, and appropriate policies and strategies in a timely manner. [*All levels*]³³
- Accelerate the process of defining and formulating standards, e.g., basic health service package, and divisions of roles and responsibilities, e.g., the role of province health office at the districts. [*Federal level*]
- Expedite and conclude the health worker adjustment process. [*Federal level*]
- Develop frameworks for capacity assessment and capacity development plan which can be used by municipalities to assess their existing health sector capacities to subsequently plan capacity development measures. [*Federal level*]
- Orient elected officials as well as staff at the provincial and local levels on:
 - the constitutional and legal mandates and obligations, authorities, roles and responsibilities of local governments with regard to health care service delivery [*Federal and Province levels*];

³³The targeted level of government for a particular recommendation is given within the [*parentheses*].

- evidence-based public health planning [*Federal and Province levels*]; and
- the importance of investing in public health for overall socio-economic development. [*Federal and Province levels*]
- Facilitate a dialogue among different sectors such as education, agriculture, labor, finance, infrastructure, environment, etc., on inter-sectoral collaboration on health care services and develop a health-sensitive budget framework that may be used by other sectors at the local level. [*Federal and Provincial levels*]
- Establish Provincial Service Commission and make them functional [*Province level*]
- Assess the needs and gaps in HRH and expedite the recruitment process, including interim measures to mitigate the urgent human resource crisis [*Local and Province levels*]
- Introduce systematic induction and capacity-building of local health managers and coordinators to enable effective planning, budgeting, monitoring and management of health services delivery, including health systems components such as procurement and supply chain management and information management [*Province and local levels*]

5.2 Development partners: Leverage catalytic resources, focus on strengthening local capacity

At the strategic level:

- Re-focus engagement with the government – emphasize on the local level.
- Channel resources to local levels directly or through efficient mechanisms.
- Prioritize support for induction and capacity-building of local health managers and coordinators, as well as other local officials.
- Continue advocacy for swift transition, particularly at federal level, asking for timely formulation of necessary acts and legislations, and provide necessary capacity-building of local governments to do the same.
- Advocate for practical mechanisms among the three levels of government to foster regular policy dialogues and effective coordination for policy and practice to improve local health system and delivery.

At the more operational level (technical partners particularly those working or intending to work directly with the local governments could, as examples, consider):

- Design, develop and implement orientation package for local leaders in municipalities – focus on prioritizing and investing in public health for overall socio-economic development; and on the rights and responsibilities of municipalities and their authority and duties to effectively implement constitutionally guaranteed health rights of citizens.
- Develop and implement induction package for health managers and administrators on prioritization, planning, budgeting, implementation/management and monitoring of health programs by municipalities.

- Design and develop model legal instruments and local health policies and support adoption and enactment by municipalities.
- Refine the orientation and induction packages and model legal instruments and local health policies based on the implementation experience and provide them to MoHP, provincial governments and interested municipalities to scale-up their use.
- Design and develop a health census at municipality level covering socio-demographics, social determinants of health, burden of disease, etc. in partnership with other research organizations.
- Help municipalities to utilize the data from the health census in local health policy formulation and prioritization and strategic health planning.
- Create models from such experience that can be replicated by others engaged or interested in strengthening local health governance.
- Conduct public policy dialogue and advocacy at different levels on topical issues on health governance as identified by local governments, including citizen awareness programs on their health rights and entitlements.
- Carry out issue-based analytical studies, including PEA of specific critical issues such as procurement of medicines at the local-level.
- Conduct review and research and develop comprehensive analyses based on available evidence and experience of working on local health governance, focusing on local health reforms to inform national policies and strategies (such as the next five-year Nepal Health Sector Strategy (NHSP4) which will be implemented from 2020).

Annex:

Authority and responsibilities of local government - Exclusive and Concurrent

[Source: Local Government Operations Act 2017 (*unofficial translation*)]

Box A: Exclusive health-related rights and responsibilities of local governments

i. Basic health and sanitation

1. Formulation, implementation, monitoring, evaluation and regulation of policies, laws, standards and plans related to basic health, sanitation and nutrition
2. Operation and promotion of basic health, reproductive health, and nutrition services
3. Establishment and operation of hospitals and other health institutions
4. Physical infrastructure development and management of health services
5. Setting of standards for clean drinking water and food, and control and regulation of air and noise pollution
6. Awareness raising on sanitation and management of health-related wastes
7. Collection, recycling, processing and disposal of health-related wastes, and determination and regulation of these services
8. Blood transfusion service, and local and urban health services
9. Permission, monitoring and regulation of pharmacies/medicine shops operation
10. Coordination, collaboration and partnerships with private and non-governmental sectors for management of waste produced from sanitation and health sectors
11. Service delivery, permission, monitoring, and regulation related to family-planning and mother-child welfare
12. Reduction, prevention, control and management of malnutrition in women and children

Box B

Concurrent health-related authority and responsibilities of local governments shared with federal and provincial governments

b. Health

- (1) Determination of local level health targets and standards as per the federal and provincial targets and standards
- (2) Clinic registration, operation license and regulation of general hospital, nursing home, diagnosis center and other health institutions
- (3) Production, processing and distribution of medical plants, herbs and other medical goods at the local level
- (4) Health insurance and other social security program management,
- (5) Determination and regulation of minimum price of medicines and other medical products at the local level
- (6) Proper use of medicines at the local level and anti-microbial resistance minimization
- (7) Purchase, storage and distribution of medicines and medical equipment at the local level,
- (8) Management of local level health information system
- (9) Public health surveillance at the local level
- (10) Operation of promotional, preventive, curative, rehabilitative and palliative health service at the local level
- (11) Promotion of health lifestyle, nutrition, physical exercise, yoga, following health circle, panchakarma and other public health service
- (12) Control and management of pests and diseases
- (13) Control of the use of tobacco, alcohol and drugs and awareness raising

(14) Ayurvedic, Yunani, Aamchi, homeopathic, natural medicine and other traditional medical treatment service management

(15) Public health, emergency health and epidemic control plan and enforcement

(16) Disease control and prevention

(17) Emergency health service supply and local service management