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HEALTH FOR LIFE **TECHNICAL BRIEF**

STRONGER SYSTEMS, HEALTHIER LIVES JANUARY 2017

Collaborative Framework for Strengthening Local Health Governance: Results to Date

Background

To address the many root causes of public health issues in Nepal, multiple sectors must work together, communities must be involved in managing health services and services must be tailored to meet community needs. A national collaborative framework, supported by various ministries, would help to ensure that health is a priority in every village's local development agenda. On December 1, 2013, the Ministry of Health (MoH), with technical assistance from USAID's Health for Life project, signed a historic agreement with the Ministry of Federal Affairs and Local Development (MoFALD), marking the first time that a formal agreement has been reached between two ministries in Nepal and setting into practice one of the more promising reforms to the Nepali health sector in recent memory. The Collaborative Framework is meant to integrate public health into MoFALD's existing local platform for discussing and planning development in the community, linking it to other sectors such as women's empowerment, education and water & sanitation. The expected result is better, more equitable health services, particularly for marginalized groups.

Health for Life, as a health system strengthening project, has been deeply involved in ensuring that the Collaborative Framework is being used effectively by communities to identify, plan and budget for local health needs. In the years since the Collaborative Framework was signed, Nepal ratified a new constitution that sets up a federal structure, greatly expanding local governance. Thus, the Collaborative Framework and Health for Life's involvement in its implementation comes at an opportune time for Nepal.

The Collaborative Framework was rolled out nationwide in 2014, and has received technical assistance from Health for Life in 28 districts—14 districts of the Mid-western and Western Regions, four additional demonstration districts and ten earthquake-affected districts.

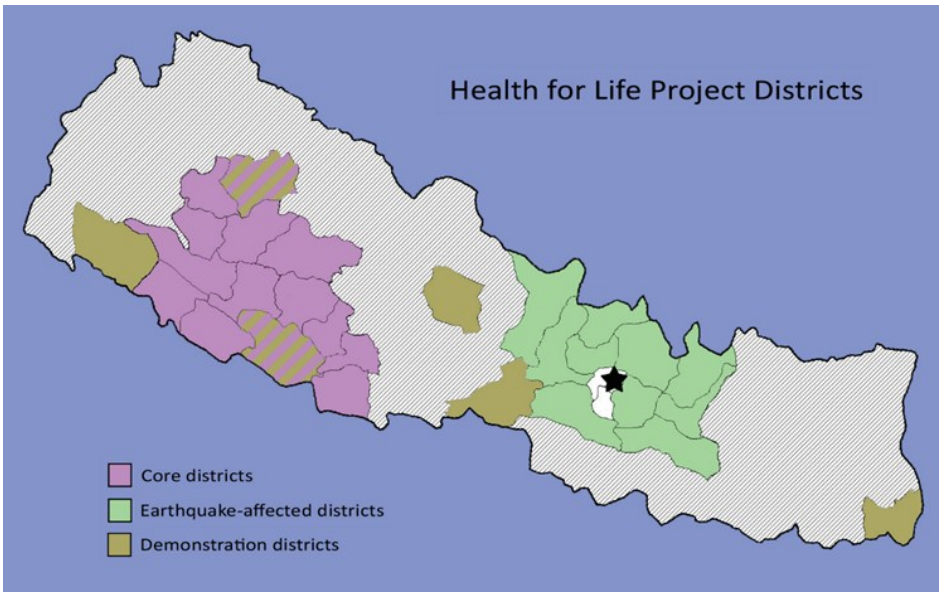
How communities are supported to address local health issues through a participatory process.

Implementation

In theory, every Village Development Committee (VDC), along with municipal and district government units, collects health data from their jurisdiction and prepares a resource map as a prerequisite for the planning process. Unfortunately, this step was largely overlooked prior to the Collaborative Framework.

At its core, the Collaborative Framework is meant to build the capacity of Health Facility Operations and Management Committees (HFOMCs) to review, prioritize, plan and fund health-related activities at the community level. These activities are facilitated by conducting a Village Health Situation Analysis Report (VHSAR) followed by the development, funding and implementation of a Local Health Plan. The VHSAR is prepared by the HFOMC based on evidence taken from a number of sources, including Health Management Information System (HMIS) data, gaps identified in the Quality Improvement (QI) Team's Health Facility Assessment Report, and recommendations made in the Social Audit Report. It is meant to provide a clear picture of the demographic makeup of the ward, their health needs and utilization patterns, as well the health workers' performance to standards, the physical state of the health facility, availability of amenities, medicines and supplies, and functioning of equipment. The VHSAR also contains information on maternal, newborn and child health and family planning service utilization by ward and caste/ethnicity, which plays a key role in the planning process.

The Annual Health Plan is a working document based on the findings of the VHSAR that prioritizes the community's health needs, allocates funds, assigns responsibilities, defines deliverables and sets a timeline.



Health for Life has been providing technical assistance to the HFOMCs in order to make the Annual Health Plan evidence-based, integrated into the larger development plan, adequately funded, responsive to local needs and effectively supported. Improved and funded plans were achieved by working closely with HFOMCs in gathering evidence and ensuring that the evidence was correctly interpreted and integrated into the planning process. To secure resources, Health for Life staff advised the HFOMCs to attend community meetings along with community health workers, Mothers' Group members and others involved in community health so that Ward Citizens Forums could be persuaded to provide funding for local health needs. One technique that Health for Life trained the HFOMCs in was to use the evidence they had collected for the VHSAR to advocate for funding. Health for Life has also recently begun tracking expenditures to ensure that gaps identified in the health system are being addressed.

Health for Life has also been involved in addressing the need to monitor and support HFOMCs, since there is still no formal system in place. Health for Life was instrumental in forming District Health Governance Strengthening Task Forces (DHGSTFs), whose role it is to ensure that the HFOMCs are meeting regularly, to monitor plan implementation and to provide technical and financial assistance to the HFOMCs.

Results

Health issues are integrated into the annual development planning process

Out of the 141 high-priority VDCs, 140 VDCs were able to complete the Annual Health Planning process; one VDC in Jumla drafted an Annual Health Plan, but was unable to submit it to the Village Council for approval on time. Similarly, all 237 VDCs in demonstration districts completed VHSARs, with 227 of them completing Annual Health Plans.

In the ten earthquake-affected districts where Health for Life works, a similar process has been introduced to produce Health

Recovery Plans. Both VHSARs and Health Recovery Plans have been prepared in all 108 high-priority earthquake-affected VDCs. As of December 2016, 49 local health recovery plans have been endorsed, with allocations totaling NPR 14,372,398 (USD 151,288). While the average for 4 ANC visits per protocol in the high-priority earthquake-affected VDCs stood at only 30 percent in July 2016, that number has grown to 52 percent as of December 2016. Furthermore, this increase has mainly occurred among Dalit and Janajati women, thereby reducing disparities in service utilization between wards. Similarly, the rate of institutional delivery in the high-priority earthquake-affected VDCs, which was 16 percent in July 2016, had reached 43 percent by December 2016. Users of modern family planning have also increased in all ten earthquake-affected districts. The contraceptive prevalence rate (CPR), which was below 12 percent in July 2016, increased to 18 percent by December (including pills, injectables, implants and IUCDs).

Another result of Health for Life's technical assistance is that unlike earlier, health issues are now being included in discussions during the annual planning process. Since 1999, communities have begun the annual development planning process in November where they discuss how to prioritize development within the community. Health, because it fell under the jurisdiction of the Ministry of Health, was isolated from other development sectors, meaning that annual development plans made no provision for health-related issues in the community. Instead, health plans were developed at the Central level, with the result that they were seldom able to address local health needs.

With the signing and implementation of the Collaborative Framework, issues related to health have been included in the annual development planning process, particularly in Health for Life's high-priority VDCs. The HFOMC drafts the Annual Health Plan, and seeks recommendations from the Ward Citizens Forum. Along with the Annual Development Plan, the approved health plan is then submitted to the Village/Municipal Councils for approval and funding. One key difference from the Annual Development Plan is that the financial allocations for health have not yet been decentralized, as provisioned in the Local Self-Governance Act of 1999. Essentially, funds are earmarked based on targets set at the Central level and cannot be reallocated once they have been disbursed to the districts. While this does not entirely prevent funds from being spent based on each VDC's health plan, it does mean that there is virtually no flexibility, curtailing the effectiveness of the funding.

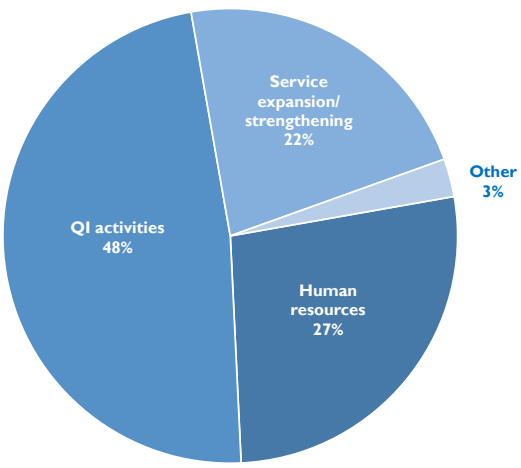
Local resources are being committed to health

As health issues are integrated into the broader development discussion at the local level, a key indicator of success has been the ability of local communities to mobilize resources to address the issues put forth in their Annual Health Plan. This fiscal year as well as the previous one, high-priority VDCs in Health for Life's 14 districts of the Mid-Western and Western Regions committed over $320,000 to their annual health plans, and in this fiscal year the VDCs in the six demonstration districts committed about $460,000. The ability to make hiring decisions locally is another benefit of implementing the Collaborative Framework, with high-priority VDCs committing an average of 27 percent of their budget to human resources.

Plans and budgets address top priorities

In addition to developing plans and mobilizing resources, the VDCs that have worked with Health for Life to implement local health planning are demonstrating that said plans and funds are indeed addressing the top priorities, as they have defined them.

Health expenditure at high-priority VDCs



The chart on the left shows in which areas Councils have budgeted for health in FY 2016/17, with the majority of allocations falling into three broad categories: quality improvement (replenishing the emergency QI fund, facility construction/improvements/maintenance, medicines, etc.), hiring personnel, and service strengthening/ expanding (child health, immunization, safe motherhood promotion, female community health volunteer training, engaging mothers' groups and incentives for reporting, conducting outreach clinics). This last part is of particular interest to the project because strengthening and expanding services specifically aim to address inequality in service utilization, particularly among marginalized and disadvantaged groups. This is the real purpose of evidence-based planning that Health for Life has been advocating.

Although Health for Life has only recently started tracking expenditures, the initial results are encouraging. In Baraula VDC in Pyuthan, for example, $930 was budgeted for health in 2015/16 to assemble pregnant women and conduct mothers' group meetings to raise their awareness of antenatal care, institutional delivery, postnatal care and family planning, These activities increased antenatal visits by 8 percent, institutional delivery and postnatal care visits by 9 percent and use of family planning methods by 6 percent. Similar increases were seen in Chumchaur VDC in Jumla, Subarnakhal VDC in Arghakhanchi, Laluthantikot in Kalikot and Suryapatawa VDC in Bardiya.

Active Task Forces are in place

Health for Life helped to form District Health Governance Strengthening Task Forces (DHGSTFs), multi-sector coordinating teams that review health plans and monitor health facilities to help them implement those plans. Additionally, they are responsible for allocating flexible health funds, a Ministry of Health's funding mechanism for demonstration districts granted entirely on the merit of the Annual Health Plans. The logic in forming the DHGSTFs is twofold: first, they address the need to approach health outcomes as the result of many sectors, not health alone; the DHGSTFs bring partners from several sectors together to address health concerns. Second, the DHGSTF provides local support for the planning and budgeting process. DHGSTFs have been active in the majority of core program districts and in all demonstration districts.

Conclusion

The Collaborative Framework is being implemented at a time when governance structures are being revolutionized in Nepal, and where there is a growing sense that health services should be available to all segments of society in an equitable manner. It represents a new approach to health governance and to community responsiveness and responsibility in the health sector. HFOMCs have made significant strides in documenting the health needs of their communities, using the information to develop actionable health plans that meet those needs, mobilizing the funds for implementing their plans, and integrating health into the larger discussion on local development, all within three years.

While still in the early stages, there is reason to be hopeful as Nepal moves to a federal structure. The MoH has already made clear that it plans on implementing the provisions of the Collaborative Framework nationwide.

Recommendations

In order for the Local Self-Governance Act of 1999 to be fully integrated, and for the Collaborative Framework to reach its full potential, budget allocations must be decentralized. To thoroughly institutionalize the Collaborative Framework, HFOMC guidelines should be updated to incorporate leveraging local resources.

Currently, the Ministry of Health sets targets for each district that are not based on local health plans. So while the amount of the funds may be sufficient, they are not fungible, thus districts do not have the authority to distribute funding according to the needs identified in the Annual Health Plans. Districts should have the authority to plan and allocate according to local needs, as specified in the Nepal Health Sector Strategy (2015-20).

Health for Life

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