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Ministry of Health & Population

NHSSP

Designing Federal Structures In Nepal

Analysis of Health Sector Functions and their Assignment to Levels of Government

A Methodological Review for the Ministry of Health and Population

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EXECUTIVE SUMMARY

A. INTRODUCTION

Background — The Government of Nepal is preparing for a transition from a unitary system of to a federal system of government with central, provincial and district levels of government. Thus, in early 2012 the government requested its sectoral line ministries to define their main functions and to propose how these might be assigned under the new three-tier system.

Literature review — In 2012 the Ministry of Health and Population (MoHP) and the National Health Sector Support Programme (NHSSP) commissioned a review of the literature on international experiences relevant to the institution of federal health structures in Nepal. The purpose was to assist the review of existing arrangements. This report offers helpful information and criteria to guide policy makers and planners.

Uncertainties — This work took place at a time when issues to do with the health-related content of the new constitution, the role of district level governments (DDCs) and the arrangements for fiscal flows had yet to be decided. And, as this report was being finalised the Constituent Assembly was dissolved (on 27 May 2012) for being unable to reach agreement on the remaining contentious issues. It is thus uncertain when a federal system with provincial governments will be introduced.

Document structure — The discussion in this document first looks at the overall task of planning for federalism and what is involved in the process of assigning functions to health structures at different levels of government. It then considers how functions could be formulated, discusses the criteria that may be used in assigning functions to the three levels of government and presents a suggested assignment of functions.

The process of change — An initial important point to consider is that the reassignment of functions should go ahead without disrupting the provision of health services. This is especially so given that resources for Nepal's health sector are limited and for maintaining the recent large efficiency and effectiveness gains in health care provision.

B. THE TRANSITION PROCESS

Rapid or phased transition — It is recommended that a slower phased approach to change is adopted that allows for changes and adjustments along the way. A rapid transition to a federal set-up has a number of potential disadvantages.

Participatory approach — It is important that any changes to the health system are well understood by a wide circle of stakeholders including from government, health service providers and civil society.

Maximising administrative capacities —There is very little experience in Nepal of operating under sub-national provincial governments with a powerful role in governing large parts of Nepal's population. This report recommends that the changeover be facilitated by augmenting the existing responsibilities at the regional level under the present system (Nepal is currently split into five administrative regions), to provide the opportunity for officials to gain wider experience and for

them to better understand the new demands that will be placed on them under a new federal system.

Communication strategy — A communication strategy should be developed by the MoHP to assess and recommend means of communicating change and to provide information about changes as they occur. There also needs to be mechanisms to inform staff who will be affected and the general public about the proposed changes and to get their feedback. It is very important to have a two-way means of communication and for the authorities to appropriately respond.

Management of change — Also, more will need to be done to manage the large changes including planning to shift functions, dealing with the human resource implications of change and dealing with changes in the available financial resources. To achieve a well-managed change process it is proposed that MoHP creates an 'office for the oversight of transition to federal structures' to steer change and carry out reviews and recommend adjustments as changes are implemented.

C. DEFINING FUNCTIONS

Principles — The first task to be undertaken to move towards a federally governed health system is to define all the functions of MoHP and the entities under it. The Technical Committee of the Constituent Assembly (2008–2012) identified the following principles for identifying functions and activities in a federated structure:

- functions and activities must be mutually exclusive and comprehensive;
- all functions, activities and sectoral activities must be included;
- there are no overlapping functions or activities and no concurrent responsibilities;
- functions are as detailed as required but not too detailed so as to hinder analysis; and
- all functions and activities are consistent with the public administration system and public expenditure management protocols.

Anything less than an all-inclusive description of the sector and what it does runs the risk of officials hesitating to carry out tasks that are necessary but fall outside the written description of their functions.

Proposed selection method — The list of proposed functions and activities should attend to all the following considerations and in particular that functions and activities are mutually and collectively exclusive.

- **Constitutional provisions for health** — Federal constitutions define the key features to be taken into account for the decentralisation of functions. Such constitutions are long-term documents that should not lightly be changed. It is recommended that the new constitution does not give too detailed specifications on citizens' rights to health as it is best to avoid over-specifying and thereby create inappropriate exclusions from health care services.
- **Obligatory functions** — Governments may stipulate that certain functions of sub-national governments are obligatory. For example, it could be considered necessary to make the implementation of the Aama programme obligatory. This approach ensures that a similar basic level of service is offered in sub-national governments nationwide; but it can under-

mine the autonomy of sub-national governments. One way of avoiding this issue is to specify what needs to be provided or achieved, without specifying how it should be done.

- **Asymmetric functional assignment** — It is possible that in allocating functions, the government decides to decentralise to a different extent in different sub-national governments. This might be done if the government deems administrative capacity to be weak in certain provinces. However, this can be counter-productive as decentralisation is not only about recognising existing local capacities, but also about allowing such capacities to develop. Also, more attention needs to be given to the role of urban local governments.
- **Functions should dictate the shape of organisations** — When defining functions it is important to consider the range that is necessary for the health sector as a whole and not to look at MoHP's current organisational structure. Functions should dictate the shape of organisations and not current organisational structures.
- **Functions are not projects or schemes** — Functions and activities are the categories within which time-limited plans might be made and are not categories describing these plans.

D. ASSIGNING FUNCTIONS

Criteria for assigning functions — Once a list of functions and activities has been established, it is necessary to systematically decide at which level of government particular functions should be assigned. This requires establishing and applying a set of criteria for making the choices. There may well be differences of opinion on the assignment of functions. It is therefore very important that all concerned have access to information on how choices are made in allocating functions. The process needs to be transparent and easy to comprehend.

Criteria for assignment — The following are criteria that could be applied for assigning functions for Nepal's health sector. It is not a list of all possible criteria. The selection process should prioritise criteria that relate to existing policy priorities:

- **Subsidiarity** — Subsidiarity is the principle that, all else being equal, governments should seek to ensure that decisions are made as close as possible to the citizen. However, subsidiarity is only meaningful if there is real accountability and governments are representative and responsive to local needs. There is also the consideration of the validity of local government decisions. A potential problem in attempting to achieve subsidiarity is that of funding from external development partners (EDPs). Much donor funding to Nepal's health sector is budgetary support where donors grant or loan funds directly to the treasury. However, where fiscal decentralisation is weak, as has been the case in Nepal, donor funding is often fed through vertical programmes to by-pass sub-national governments. Vertical programmes thus tend to constrain local autonomy and undermine sub-national governments.
- **A national voice** — In other areas national coherence is required, as for example in maintaining a unified policy stance. A national voice is important to make policy statements apply across all federal provinces.
- **Equity** — Any mode of resource distribution between different levels of government will require attention to the allocation of resources. The government's current health policy (NHSP 2) prioritises providing high-quality and affordable health care services to all. The principle of equity should therefore figure prominently among criteria for assigning functions. It is important to note that some provinces will have more resources than others and it is therefore crucial that measures are taken to reduce inequities that will result in the resulting

differential quality and provision of health services. Only central government intervention can prevent such differentials. This can involve the transfer of funds. Attention also needs to go to how external development assistance for health is allocated and distributed. Such funding could be directed at one particular sub-national government. However, this will reduce the chances of ensuring that funding goes where it is most needed should the government fail to communicate its priority needs adequately to the external development partner, or if external development partners fail to work collaboratively.

- **Administrative capabilities** — There is a tendency to assert that certain sub-national governments are not equipped to handle particular areas of responsibility. The opposite point of view is, however, that decentralisation is all about empowering sub-national governments to give them the opportunity to rise to the challenge of carrying out new tasks. Officials may limit their decision making roles when in fact they have a greater scope for independent decision making. The point here is to make officials fully aware about their *de jure* decision spaces and to encourage all local officials to take responsibility for making decisions. This should happen alongside support for building their capacity.
- **Technical capabilities** — In resource-poor sub-national governments, technical expertise may be at a greater premium and this is usually difficult to augment in the short term. If the pool from which expert advice can be drawn is limited, some functions may only be practicable if retained at the national level. For example the task of elaborating a strategy for the control and treatment of a disease and the provision of expensive medical technologies could be more cost-effectively undertaken and provided at the national level.
- **Cost-effectiveness** — It is not worth investing in expensive technical inputs that can be shared between sub-national governments. This also relates to the purchasing of drugs, where cost effectiveness calls for carrying out this function nationally.
- **Systemic coherence** — Systemic coherence involves ensuring that health systems fit together coherently, with organic links between local and community levels and the most sophisticated levels of care. An important requirement is to enable the referral of patients from local basic care upwards. Linkages need to be bi-directional as patients who have been treated at a referral facility should return home with information about the diagnosis, prognosis and level of follow-up support needed. Nepal needs to avoid the experiences of Nigeria where responsibilities for different levels of health care have been given to different levels of government with no coordination between the different levels.
- **Facilitate prompt decision making** — It is often important for decisions to be made promptly including for planning decisions for infrastructural development or permits for NGOs to initiate activities. Local government may be able to expedite decision making more rapidly and may have useful insights that more remote levels of government are unaware of. Also, serious consideration needs to be given to avoiding more 'red tape' under the new system.
- **Need for sectoral integration** — Sectoral activities may have cross-sectoral effects and where possible inter-sectoral collaboration should be pursued. The Local Self-governance Act, 1999 provides ample room for inter-sectoral collaboration in district level activities and planning. Collaboration is essential given that some areas with large health implications come under other sectoral ministries.
- **Efficiency and effectiveness gains** — Where activities are closely linked it is often best to assign them to the same level of government as for example with the construction, operation and maintenance of health facilities. This could promote a more holistic approach and could make health facilities more fit for purpose.

- **Consideration of location of present powers** — Functions should be allocated bearing in mind that there is an existing system with DDCs, municipalities and VDCs that have defined powers under the Local Self-governance Act. These powers should not be taken away lightly as this would invite local resentment and could create a negative environment for introducing changes under federalisation.

E. SUGGESTED ALLOCATION OF HEALTH FUNCTIONS

Suggested allocation — The report finally suggests how health governance functions could be assigned between the central state level, the federal provincial level and the local district levels of government. Sixty-two functions are assigned under eight subject areas.

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ACRONYMS

CA	Constituent Assembly
DDC	district development committee
FSP	Federalism Support Programme
GTZ/GIZ	German Development Cooperation
HSSP	Health Sector Support Programme
MoGA	Ministry of General Administration
MoF	Ministry of Finance
MoHP	Ministry of Health and Population
MoLD	Ministry of Local Development
NHSP-II	Nepal Health Sector Programme-II
NGO	non-governmental organisation
NHSSP	National Health Sector Support Programme
NPC	National Planning Commission
PMO	Office of the Prime Minister and Council of Ministers (Prime Minister's Office)
PSC	Public Service Commission
VDC	village development committee

1. INTRODUCTION

The Government of Nepal is preparing for a transition from the present unitary system of government promulgated under the 1990 constitution to a federal system of government with central, provincial and district levels of government. Box 1 outlines the progress towards a federal system in Nepal. This expected major change calls for a review of existing arrangements and provisions in Nepal's government institutions.

Box 1: Progress towards a federal system in Nepal

The Interim constitution of Nepal, 2007 was produced after the end of the ten year conflict between the government and the Communist Party of Nepal (Maoist). It was interim in so far as the two parties had agreed that a Constituent Assembly would be soon elected to produce a new constitution for the more inclusive sharing of powers across ethnic, caste, religious, regional and other groupings.

The assembly began work in May 2008. However, several deadlines passed and at the time of the commissioning of the current study the deadline for completion was 27 May 2012.

The political parties agreed from the start that the new constitution would introduce a federal system of government with considerable powers devolved to provinces at the sub-national government level. It would be a three-tier system with central government at the top and then the provinces and the districts. The identification of the number, the boundaries and the names of these provinces has been the most difficult issue to resolve in the constitution building process. At different times the political parties have proposed splitting Nepal into between 6 and 14 provinces.

This report was being finalised as the final deadline for producing the constitution passed on 27 May 2012, without the Constituent Assembly agreeing on the remaining contentious issues, principally the delineation of the new provinces. The assembly was thus dissolved and the Prime Minister called for a new assembly to be elected in six months time. It is thus uncertain when a federal system with provincial governments will be introduced in Nepal.

With the expected introduction of a federal system in the near future (prior to 27 May 2012) the line ministries of the Government of Nepal were requested in early 2012 to define the main functions of their sectors and to propose how these might be assigned under the new three-tier system.

This review of the literature on federalism and health is by no means exhaustive; nor is it intended to be. Rather, it reviews selected literature that in the author's view documents international experiences relevant to the institution of federal health structures in Nepal. The examples and experiences quoted in this report are judged by the author to offer helpful information and criteria that will guide the way forward for policy makers and planners.

As this work was being undertaken in 2012 at an early stage in the federalisation process, several areas of uncertainty must be faced (but see Box 1 for later developments):

- As of May 2012 the new Constitution is being drafted and the only indications of its likely health-related content are the references to health issues in the Interim Constitution, 2007. There is little other documentation on what health in a federal structure in Nepal will look like.

- The existing legislative framework for local government is the Local Self Governance Act, 1999, which devolves powers to the local bodies (district development committees [DDCs], village development committees [VDCs] and municipalities). There are potentially as yet unspecified legal provisions regarding federalisation that may alter the role of district level government (DDCs) in relation to the newly established provinces.
- The arrangements for fiscal flows from the Treasury to the different levels of government (central government and the new sub-national governments [provinces]) have yet to be specified. The route for funding sectoral programmes (from central government or provincial level) will be significant in determining the control of resources and their use, as well as the extent to which the provincial governments control health resources allocated to them and at the local levels.

The following discussion looks first at the overall task of planning for federalism and what is involved in the process of assigning functions to health structures at different levels. It then considers how functions could be formulated, and finally discusses the criteria that may be used in assigning functions to the various levels of government.

Before embarking on this substantive task, it is important to discuss the process of change required to establish the new system. The Ministry of Health and Population (MoHP) has stated that the ultimate objective for the transition process should be to avoid disrupting services. Such a disruption would be a major threat to public health and needs taking seriously.

A disruption of services could result from the process of change itself, involving as it will, staff transfers and establishing new levels of administration. Another major threat to health services is the question of economic viability. Presently, MoHP is concerned as a priority to increase the levels of efficiency and effectiveness in health care provision. This is obviously an urgent need given that the rate of population growth has in recent years outstripped the rate of increase of budget allocations for the government health sector. In real terms MoHP's budget has increased only marginally in the past 10 years. However the urgency is further increased by the fact that budget ceilings are likely to be held at current rates in the near future. This means that all service provision and the costs associated with the transition process will have to be met with what is in effect a shrinking budget.

The accomplishment of a smooth transition will be of utmost importance for all public sectors, but especially so for the health sector.

2. THE TRANSITION PROCESS

2.1 TIMESPAN

It is known from accounts of federalisation elsewhere that transitions to a new system of government do not happen overnight. However, reviewing how long the process has taken in other countries is of little help here as each case is different and quite different challenges have been faced in making required changes. In general, however, it can be said that such transitions take more than a year or two, and that after initial restructuring, a review of the new set-up and further adjustments are often necessary.

[RECOMMENDATION] It would be wise to allow for a lengthy transition process and one that allows for some changes and adjustment after the initial set-up phase. The need to prepare for transition is stressed in the current Nepal Health Sector Programme, NHSP 2 (2010–2015).[1]

2.2 ENSURING A PARTICIPATORY APPROACH

It is important that any changes made to the health system are well understood by as wide a circle of stakeholders as possible and NHSP 2 recognises the requirement for consultations among those who are professionally involved in the sector. In the case of MoHP, stakeholders include the heads of divisions and departments of the ministry at the central level, staff in senior positions at the regional level, and selected district staff. Other concerned parties include national bodies such as the Nepal Health Training Centre; the National Health Education, Information and Communication Centre; the professional councils of doctors, nurses and other health personnel; and autonomous bodies such as the National Health Research Council. Consideration also needs to be given to how the opinions of civil society might be sought.

Beyond the sector itself, it will be important to build the understanding of a range of national bodies including the Ministry of Local Development (MoLD), the Ministry of General Administration (MoGA), the Public Service Commission (PSC), the National Planning Commission (NPC), the Office of the Prime Minister and Council of Ministers (PMO or Prime Minister's Office for short) and the Ministry of Finance (MoF). These are the most obvious organisations that will need to understand the way in which MoHP wishes to steer the sector.

2.3 MAXIMISING ADMINISTRATIVE CAPACITIES

Presently there is little experience in Nepal of working with local administrations that are responsible to a locally elected government. Regional level administrations do not have a significant role under the Local Self Governance Act, 1999. There is thus very little experience of operating under sub-national governments that represent a number of districts and therefore have a relatively powerful role in governing large parts of Nepal's population.

Under the proposed new federal system it is to be expected that a number of civil service functions will be shifted from the current central level responsibility to the provincial level. This will lead to some central government officials being transferred to provincial postings, possibly with promotions on offer due to enhanced responsibilities. However, if a significant number of functions are

[1] Government of Nepal, Ministry of Health and Population (2010). Nepal Health Sector Programme II (NHSP-II), 2010-2015.

transferred from the current single location at the centre to the however many provincial governments then more officials capable of working at this sub-national level will be needed. This implies that attention needs to be urgently given to increasing available administrative capacity.

[RECOMMENDATION] The most obvious way to do this is to augment the existing responsibilities at the regional level in the present system (Nepal is currently split into five administrative regions), to provide the opportunity for officials to gain from the wider experience and the new demands. This arrangement will still fall short of the demands that will likely be placed on provincial level officials in the new federal set-up. But this arrangement could provide the most immediate means of broadening experience and supporting capacity enhancement.

[RECOMMENDATION] The possibility of supporting this move with the provision of management training for selected cadres should be explored.

2.4 COMMUNICATIONS STRATEGY

Documentation produced by GTZ/GIZ[2] under its Nepal Health Sector Programme proposes the development of a communications strategy for the government as a whole. This would be produced to assess and recommend means of communication, both to explain to interested parties what MoHP is proposing to do to implement a plan for federalisation, and to provide on-going information about changes as they are made, including progress towards new organisational arrangements. Such a strategy would probably suggest the need for the following communication tools:

- pamphlets;
- a website;
- radio programmes about the changes, including in local languages; and
- briefings and updates for Constituent Assembly (CA) members.

There should also be:

- opportunities for staff who will be affected by the changes to be better informed and to give feedback about the changes; and
- opportunities for the authorities to get feedback from the wider public on the changes including through public meetings, letters and the internet.

Whatever means of communication are used it is very important to put in place means of communication that are two-way; not merely to send out information but also to receive opinions. The next step would be for the authorities to appropriately respond to such feedback.

2.5 MANAGEMENT OF CHANGE

Major organisational changes create extra work. In addition, changes are often seen as a threat by employees, and time and effort must be devoted by the authorities to ensuring that individual concerns are heard and attended to. In recent years, the management of change has been recognised as an important aspect of management and a field of expertise in its own right.[3]

[2] GTZ/GIZ (Sept. 2009). Functional Assignment in Multi-level Government Vol.1 Conceptual Foundation of Multi-level Assignment, Sector Network Governance Asia, Eschborn, Germany.

[3] See for example Reynolds, M. and Holwell, S., eds (2010). Systems Approaches to Managing Change: a practical guide.

The above proposals for developing a participatory approach, efforts to increase capacity and for a communications strategy are actions needed to manage change within MoHP. However, more will need to be done including planning to shift functions. Many employees may feel threatened by change and unsure about how it will affect them, and there will be a need for provisions to deal with the human resource implications of change both for groups of staff and individuals. Furthermore, changes in the available financial resources and careful costing and budgeting will be needed, as well as attention to finding sources of the required funding. While there are a range of people who could support this process, it will be important to have a focal point for coordinating efforts and for ensuring that changes are implemented and difficulties are dealt with sympathetically. In addition, a mechanism and administrative structure for the on-going review of the process of allocating functions will be needed as further adjustments will be needed in the light of experience as the implementation of change proceeds.

[RECOMMENDATION] To achieve a well-managed change process, it is proposed that MoHP creates an 'office for the oversight of transition to federal structures'. The scope of work of this office should transcend divisions and departments, and its core responsibility will be to steer change. Such an office will be needed for at least two to three years. It will need a high quality of leadership and backing from the highest organisational levels within MoHP.

2.6 RAPID OR PHASED TRANSITION?

One important strategic issue is to decide whether to make a rapid or a phased transition from the current to the new federal set-up. These alternative approaches are explained in Box 2.

Box 2: The two options for change

Approach 1: Rapid with a one-stage transition to the optimal new distribution of functions between layers of government.

This approach is to be taken if it is considered that the federalisation process will be undertaken with haste across government and presents a one-off opportunity for reform.

Advantage:

- A one-stage transition allows the move to be planned in an integrated way.

Disadvantages:

- MoHP (and all line ministries) will be asked to rush to undertake a task in a few weeks that has elsewhere taken several years of planning and preparation.
- The rapid approach could imply that there will be a need for new legislation, and developing this could take time, especially if other ministries are doing the same. This could cause uncertainty about how to move things forward.
- By moving ahead rapidly, there will be no chance to monitor whether changes are proving appropriate, and to adjust accordingly.
- The management of change of all aspects of the health sector's work at one time may not be feasible.
- The handover of multiple functions all at once – especially to newly created provincial governments – will put huge pressure on all concerned and will make it difficult to give attention to important areas of capacity building. Therefore, the potential for disrupting the availability and quality of health services would be large, with probable negative effects on public health.

Approach 2: Phased, with a phased transition plan, starting with a conservative approach to reallocating functions and restructuring.

The proposal here is that an initial plan is developed for restructuring to happen in phases. The total time for this should be decided with a view to considering what the central government is likely to find acceptable. MoHP should proactively develop a strategy for the health sector transition, and ensure that this is understood by the central government. Sectoral voices will need to be heard and heeded if the transition period is to allow adequate time for all crucial steps to be carried out. The plan would allow time for a considered handover and the briefing of new officials – especially at the provincial level, and for support to be provided in adapting central government systems for optimal working in the new context. Training schemes may well be necessary to ensure that there is adequate capacity, especially in terms of management. It would also allow for adjustments to be made within the longer transition period, as new arrangements are tried out and monitored.

A further possibility in the context of a more phased transition is to adopt a somewhat conservative policy of change. To the extent that existing functions, and especially those that are legally defined, can be maintained at least in the short term, then the simpler will be the transition arrangements.

If the proposed criteria for assigning specific functions to different levels in the ministry (functional assignments) are taken seriously, it may be that some of the functions presently allocated to district or even village level government (VDCs) could be judged to be in the wrong place (e.g. if economies of scale can be achieved by moving certain functions to a higher administrative level where they can be performed for larger populations). This may be something to be reviewed in time. In the initial transition period it may be wise to see what changes, if any, are to be made to legislation, such as concerning local governance. It may also be politic to introduce changes that have the potential to threaten those at the lower level (if they perceive loss of power) over time and with considered debate. Such changes should not be hurriedly introduced.

[RECOMMENDATION] We propose that if practically possible, the slower more phased option for change is adopted. This needs to be decided before work to assign activities proceeds.

3. DEFINING FUNCTIONS

The first task to be undertaken to move towards a federally governed health system is to define all the functions of the Ministry of Health and Population and the entities under it. This section considers some of the major relevant issues here. These issues have also been discussed and analysed in documents prepared by the Health Sector Support Programme (MoHP/GIZ) and the Federalism Support Programme (FSP), which is supported by GIZ. These are referred to in the following text.

The Technical Committee of the erstwhile Constituent Assembly (2008–2012), which was responsible for organisational restructuring for the proposed new constitution, defined functions in the following three ways:

1. The responsibility identified in order to achieve a certain output, outcome or desired condition.
2. A commitment that is not automatically implemented itself.
3. No desired output is attained without completing the responsibility identified, and no desired outcome is achieved without attaining the output.[4]

The Technical Committee further defined activities. Activities are generated by a breakdown of the functions into more detailed components thus:

- Activity leads commitment.
- Activity is the responsibility to complete a job.
- Activity produces services and goods for a target group.
- The determined function remains incomplete unless the activity is complete.
- Services and goods produced by the activity contribute to the desired impact.

The Technical Committee specified eight principles for identifying functions and activities (see Box 3).

Box 3: Eight principles for identifying functions and activities of different levels in a federated health structure

1. Functions and activities must be mutually exclusive.
2. They must be collectively exhaustive (comprehensive)
3. All potential functions and activities need to be identified and enlisted; none should be left off the list.
4. The inclusion of all sectoral areas is a must.
5. There should be no overlapping within functions or activities, and no overlapping between functions and activities.
6. No concurrent responsibilities (no overlapping) while addressing functions and activities.
7. Make functions as detailed as required and precise but not too detailed (sufficient to help while analysing but not so detailed as to hinder analysis).
8. All functions and activities identified should also be consistent with the public administration system and public expenditure management protocols.

Note: Point 8 alludes to a level of definition that the author is not qualified to provide and therefore the Technical Committee in MoHP will need to scrutinise the proposed lists.

[4] Technical Committee (23rd Jan 2012). Interaction on Functional Analysis, Powerpoint Presentation, Administrative Restructuring Unit, Office of the PM and Cabinet, Kathmandu.

The first two principles set out by the Technical Committee (see Box 3) stipulate that identified functions and activities describe discrete areas of responsibility, and that when all the functions and activities are taken together, they will represent a comprehensive coverage of the entire sector – the list will be 'mutually exhaustive'. In other words, there needs to be an all-inclusive description of the sector and what it does. Anything less creates the risk of officials hesitating to do something that is necessary but falls outside the written description of functions assigned to them. The potential treatment of specific types of human rights as laid down in the Interim Constitution, 2007 illustrates this point well.

The author's understanding is that functions are the broad categories that, taken together, describe the entire government health system. Activities are the components of each function. In some instances, a function will be the responsibility of only one level of government. In other instances, some activities contributing to the fulfilment of a particular function may be located at one level, while others are best located at another level.

3.1 CONSTITUTIONAL PROVISIONS FOR HEALTH

It is essential to consider how health will be treated in the new constitution. In unitary states, such as Nepal under its 1990 constitution, the provision for the decentralisation of functions is governed mostly by formal, legislative acts. These can be revised or replaced by new legislation if the central government wishes. However a federal constitution defines the key features to be taken into account. The constitution, once in place, is intended as a statement of the goals and objectives of the state (the country), and is a long-term document that cannot lightly be changed. Changing a constitution is a complex process involving central and sub-national government entities and requires the agreement of all.

In 2011, the Health Sector Support Programme (FSP/HSSP) produced a publication that discusses how the Interim Constitution, 2007 defines and treats health.[5] The fundamental rights of citizens under the Interim Constitution include the right to health in terms of five specific rights. Although not included in the Interim Constitution, further specifications were suggested by the responsible committee and are mentioned in the FSP/HSSP document. These further specifications are discussed and a warning offered against over-specification. Any over-elaborate attempt to describe all the health service actions to which citizens have rights could well create a problem because it is impossible to cover all likely examples and instances.

For example, emergency care was specified as including inter alia, treatment for snake bites. As Schwefel points out, this begs the question of dog bites, or the emergency of a child trampled by an elephant. Over–specification means these emergencies could not be dealt with within the terms of the new constitution.

Likewise, in current practice, basic (or rather essential) health services is the term used to describe all health care below the district level, and this is covered by the Free Health Care Policy, 2009. The fundamental rights committee of the Constituent Assembly has however produced a new definition. This has some strange categories; for instance it includes under basic health services, primary mental

[5] Schwefel D Jan (2011).Federalism and the Health System in Nepal, FSP and HSSP, GTZ, Kathmandu.

and dental care, but not physical medical care. It also includes reproductive health as a service category under basic services although reproductive health has been defined as a separate right per se, for all.

As these illustrations show, it is all too easy to over-specify and thus to create inappropriate exclusions from the health care services on offer in Nepal.

3.2 OBLIGATORY FUNCTIONS

It is not uncommon for governments to stipulate that certain functions of sub-national governments are obligatory. This may be considered necessary if technical knowledge and experience make it clear that a local preference may ultimately conflict with the best interests of the population served. Local governments may prioritise the 'wrong things', in which case some central level intervention may be justified. An example from India is quoted in a recent article[6] that reports that increased community participation in the oversight of hospital services had a negative impact on the provision of immunisation. Another example comes from Pakistan, where it was found[7] that the high burden of non-communicable disease, clearly shown in demographic surveys, was being neglected (though this arguably was also a fault at the central level). A study in South Africa[8] found that the high level of autonomy given to provinces was allowing them to neglect equity considerations in allocating funds to districts, and advocated that the central level should have more powers in this regard.

In Nepal it could be considered necessary, for example, to make obligatory the implementation of the Aama programme, which provides incentives for mothers to give birth in health facilities. Specifying some functions as obligatory has the advantage that it provides a way of ensuring that a similar basic level of service is offered in sub-national governments nationwide. However, the other way to look at this is the importance of recognising the considerable autonomy of sub-national governments in decision making.

One way to avoid this issue is to specify what needs to be provided or what should be achieved, without specifying how it should be done or how much spent. It is most important that sub-national governments are not asked to fulfil responsibilities for which they are not funded. Thus, the basic package of services might include a series of outputs to be achieved but would not list the inputs that must be provided to do so. The sub-national governments concerned would need to design the means of delivering the basic package that maximises cost-effectiveness in their particular situation.

In order to render a service obligatory, it is necessary to put in place either inducements or sanctions that can be applied if needed. Eldon and Waddington[9] argue that the most effective approach, as evidenced by the experience of mature federations such as Canada, is to create conditional or ear-marked funding to ensure compliance with national standards.

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[6] Yoong (2007) "Does decentralisation hurt childhood immunisation?" Stanford University, quoted in Thomas John Bossert, Andrew David Mitchell (2011). Health sector decentralization and local decision-making: Decision space, institutional capacities and accountability in Pakistan. *Social Science & Medicine* 72 39-48.

[7] Dr Sania Nishtar (undated). "Health and the 18th Amendment: retaining national functions in devolution." No publisher.

[8] Okorafor O A and Thomas S (2007). "Protecting resources for primary health care under fiscal federalism: options of resource allocation." Health Policy and Planning 22 415-426.

[9] Eldon J and Waddington C (2007)."Federalism, sub-national financing and aid effectiveness." Technical Approach Paper, HLSP Institute, London.

Just as a list of obligatory functions may define the functions that must be fulfilled to achieve the core objectives of a sector, it is also possible to allow for discretionary functions that sub-national governments decide are necessary in terms of provincial or local needs. For example in the Philippines a 'right to initiative'[10] allows for this possibility.

3.3 ASYMMETRIC FUNCTIONAL ASSIGNMENT

It is quite possible that in allocating functions, the government decides to decentralise to a different extent in different sub-national governments. This might be done if, for example, the government deems administrative capacity to be weak in certain provinces, and so wishes to reduce the weight of responsibility to be shouldered.

However, and as the GTZ/GIZ work (2009) identified, this can be counter-productive. Decentralisation is not only about recognising existing local capacities, but also about allowing such capacities to develop. Officials can rise to the occasion when given the opportunity to be creative and take the initiative. The GTZ/GIZ (2009) advice, then, is only to use an asymmetric approach when there are issues in one or another area concerning specific issues related to minority rights or conflict resolution. In this phase of work, and given that this type of consideration has not been included in the briefing of the Technical Committee, it is not recommended by this report to consider any need for functional assignment on these grounds. This issue may be reviewed later.

However, one form of asymmetry already exists in Nepal, and it will be necessary to learn how this will be treated in any new legislation. This is the rural–urban asymmetry created by virtue of the Local Self Governance Act, 1999. Presently, urban areas are defined as municipalities. Large urban centres like Kathmandu have municipal corporations with a considerable degree of autonomy. Smaller municipalities are treated in law as being at the same level of local government as villages, with both categories being defined as the tier lower down from district development committees (DDCs).

However, while village development committees (VDCs) must rely primarily on funding for local health services from their DDCs, municipalities raise a significant proportion of their health funding from certain categories of local taxes and their grant income is disbursed directly from the central government, not DDCs. This can create an inequitable situation, for instance one in which funding has differential conditionalities with different constraints on how various types of funding can be spent. This situation would create complications in terms of MoHP controlling the effects of fiscal flows on policy. It also creates the administrative burden of an added layer of complexity for the central government in its dealings with sub-national governments.

The lack of attention that the municipal level of health care has received in policy analysis globally is noteworthy.[11] A series of case studies of the decentralised health system in Russia has shown that the ability of the Federal Ministry to exert influence on municipalities was very limited, and that regional governments had little power to introduce change. Little attention has been given to this by governments or donors, despite the fact that municipalities play a central role in all health care

[10] GTZ/GIZ (Sept. 2009). op cit.

[11] Kirill Danishevski, Dina Balabanova, Martin Mckee and Sarah Atkinson (24 February 2006). The fragmentary federation: experiences with the decentralized health system in Russia. doi:10.1093/heapol/czl002 Advance Access publication.

provision and cover a growing proportion of countries' populations. This particular form of asymmetry needs attention in order to ensure that municipal health care structures have a well-defined place alongside other sub-national governments, and that whatever arrangements are made take due account of equity in the provision of services.

3.4 FUNCTIONS SHOULD DICTATE THE SHAPE OF ORGANISATIONS NOT VICE-VERSA

As GTZ/GIZ (2009) points out,[12] it is not helpful to begin by thinking of functions in terms of the categories presently used to describe the MoHP's organisational structure. What is important is to consider the range of functions that are necessary for the health sector as a whole, and then to think about how best these might be organised in a new structure. The advice of the Technical Committee[13] does mention organisational charts along with other sources such as treaties (legislative tools) and public orders (as being documents that may help in identifying functions and activities. However, it is understood that this means that considering present categories of work is only one among other sources that will help generate ideas for discussion. Functions should dictate the shape of organisations not vice-versa.

3.5 FUNCTIONS ARE NOT PROJECTS OR SCHEMES

Functions and activities are the categories within which time-limited plans might be made. They are not categories describing these plans. It is important, and a useful check, to review a list of proposed functions and activities and ensure that all important current initiatives, as well as those envisaged for the future, can be categorised somewhere. For instance, presently only limited work is done on quality assurance (QA) and regulation for private health facilities. To ensure this is included in future organisational design it will be essential to have a quality assurance function and it may be that quality assurance, or regulatory methods, will be different in dealing with the private sector to those used in the public sector. There might therefore be a category for 'regulation of the private sector'. This should not be presented as a project, e.g. 'establish regulatory system for private sector' as a project is not an on-going activity. Functions are not projects or schemes.

3.6 PROPOSED SELECTION METHOD

In the list of functions and activities proposed in Section 4 of this document, attention is given to all the foregoing considerations and in particular, to principles (1) and (2) of the Technical Committee (see Box 3). To keep the length of the list as manageable as possible and to avoid double counting, management functions that in fact are cross-cutting with the functions listed are not listed separately but assumed to be part of the essential construction of systems that underlies any activity.

MoHP is well aware that many of its functions are dependent on relationships with other ministries and government bodies. These are assumed to therefore be things that will happen as needed, and are thus not described as separate functions or activities (which they are not).

[12] GTZ / GIZ (Sept. 2009).op cit, p.17.
[13] Technical Committee (23rd Jan 2012).op cit, see p.9.

4. ASSIGNING FUNCTIONS

4.1 THE TASK OF ASSIGNMENT

Once a list of functions and activities has been established, it is necessary to take a systematic approach to deciding at which level of government the responsibility for particular functions may lie. This requires establishing a set of criteria for making the choices, and then applying these criteria.

In developing criteria, it is important to think both about factors that should influence decision-making on the assignment of functions, and about how these might be used. It should be recognised that there may be differences of opinion about which criteria are the most important. In terms of change management, all those concerned should have access to information about how choices were made in allocating functions. In other words, the process needs to be transparent and should also be reasonably easy to comprehend.

The following sections 4.2 to 4.12 of this report list the criteria that might be selected and applied for assigning functions for the health sector in Nepal. It should be noted that this is not a list of all possible criteria. It had been generated from the experience and knowledge of the author in combination with a list reproduced in a GTZ document.[14] Lists of criteria used in various countries can be found elsewhere in the literature and only a short list is presented here derived from some of these sources of information. However, as literature evaluating the utility and applicability of criteria used elsewhere is limited, there seems little point in quoting the numerous examples.

In selecting criteria, it is important to prioritise any that relate to policy priorities already defined for the Nepal health sector.

4.2 SUBSIDIARITY

Subsidiarity is the principle adopted in the European Union, and increasingly in other federal contexts, that in all areas governments should seek to ensure that decisions are made as close as possible to the citizen. In other words, all else being equal, the choice should always be in favour of greater decentralisation. Of course, all else is rarely equal and therefore other criteria are required.

Subsidiarity is only meaningful if there is real accountability to a government that is representative and responsive to local needs. There is also the consideration of the validity of local government decisions. If a sub-national government has a legislature, it can back decisions with judgements about the legal framework in which they fit. If not, questions will arise about which legal body (country level legislature) can have authority over the country level health executive.

A potential problem area in attempting to achieve subsidiarity is that of funding from external development partners (EDPs).[15] Much donor funding to Nepal's health sector is budgetary support where donors grant or loan funds directly to the treasury. However, where fiscal decentralisation is weak, as has been the case in Nepal, donor funding tends to end up being fed through vertical programmes. Such arrangements by-pass sub-national governments, and it is important to stress

[14] GTZ / GIZ (Sept. 2009). Functional Assignment in Multi-level Government Vol. 2: GTZ-supported Application of Functional Assignment, Sector Network Governance Asia, Eschborn, Germany.
[15] Eldon J and Waddington C (2007).op cit.

that while district health teams may have a minor say in how vertical programmes are handled, such programmes are generally removed from the jurisdiction of the actual government. As such, vertical programmes tend to constrain local autonomy and undermine the functioning of sub-national government in setting priorities and planning service delivery.

4.3 A NATIONAL VOICE

While in some respects subsidiarity is important, in other areas national coherence is required. One such area is that of having a unified policy stance, meaning an agreed way of interpreting the constitution. It is the responsibility of the central government to develop such a stance and ensure its adoption.

The existence of a national voice is important in terms of making policy statements that apply across all federal provinces. It is also essential that the national government is able to venture out into the international arena and state national sectoral policies with confidence.

4.4 EQUITY

As noted earlier, fiscal flows and funding at various levels within the federal state are yet to be clearly defined. However, any mode of resource distribution between entities within a federal state will require attention to resource allocation and the basis on which it is conducted. The Government of Nepal's current main health policy, NHSP 2, prioritises providing equal opportunities to all to receive high-quality and affordable health care services.[16] The principle of equity must therefore figure prominently on the list of criteria and considerations to be taken into account when assigning functions.

As of May 2012, the number of provinces and their geographical demarcation in a federal Nepal remains to be defined. However, it is almost inevitable that no matter how the map is drawn, inequities will be found between provinces, with some having more resources than others. Within a federal state, if no consideration is given to the different abilities of sub-national units to generate income, then such differences could increase over time. Rich provinces will benefit from higher levels of tax income than their poorer neighbours, enabling them to invest in better services and improved infrastructure. This will create honey-pots as certain areas attract greater investment in production and commerce, and even greater wealth results in these. In these areas services are likely to benefit from greater investments and such areas will tend to attract the best health workers. If they are able to, such wealthier areas will also attract the best personnel by offering higher salaries and terms and conditions of service.

It is only really central government intervention that can prevent such differentials. The transfer of funds between different levels of government (inter-governmental fiscal transfers) can be used to equalise the situation, and this is essential to the success of federal governments.

In countries such as Nepal that receive large amounts of funding from external development partners, attention should also be given to how, within a federal system, such funding is allocated and distributed. External development partner funding might be directed specifically at one

[16] Government of Nepal, Ministry of Health and Population (2010) Nepal Health Sector Programme 2 (NHSP-2), 2010-2015.

particular sub-national government. However, this will reduce the chances of ensuring that funding goes where it is most needed should the government fail to communicate its priority needs adequately to external development partner, or if these partners fail to work collaboratively concerning where funding from each donor is targeted. The latter situation can lead to gaps and duplication.

4.5 ADMINISTRATIVE CAPABILITIES

The criterion of administrative capacity of sub-national governments is often highlighted, although as noted earlier, care is needed in working in this area. The tendency when assigning functions is often to assert that certain sub-national governments are not equipped to handle particular areas of responsibility. The opposite point of view is that decentralisation is all about empowering sub-national governments to give them the opportunity and to rise to the challenge of carrying out new tasks.

Bosser and Mitchell (2011) in their Pakistan study examined the scope that managers in different parts of the country had to take decisions independently — the extent of their 'decision space'. The authors found that, although managers were subject to the same rules and conditions, in practice the amount of decision space they had varied. In other words, what some perceived as the limit of their powers was actually less than what was potentially possible. This deficiency came down to the local institutional capacity and also, to some extent, to accountability to locally elected officials. The authors concluded that it is likely that in all systems that are implementing decentralisation, efforts should be made to encourage greater knowledge of the *de jure* decision space and to encourage all local officials to take responsibility for making decisions oriented towards better performance. This should happen alongside support for building the capacity of sub-national government personnel, which should open up local creativity and the ability to take the initiative.

4.6 TECHNICAL CAPABILITIES

In resource-poor sub-national governments, technical expertise may be at a greater premium than administrative expertise. Technical expertise tends to be much more difficult to augment in the short term. If the pool from which expert advice can be drawn is severely limited, some functions may only be practicable if retained at the national level. Examples might include the ability to elaborate a strategy for the control and treatment of a disease. While sub-national governments may be well placed to make judgements about the importance of a particular disease to their constituent communities, the work of elaborating a strategy for dealing with it, which demands up-to-date knowledge of approaches and therapeutics, may be something that would be far more cost-effectively undertaken at the national level for the benefit of all sub-national governments.

Another example is those areas of medical care that rely on sophisticated and possibly expensive medical technologies. If expensive equipment is needed, it is important to judge whether it is actually necessary to have this installed at multiple sites or perhaps only to install it centrally. In some instances the latter may be the only option, especially if the technology requires not only equipment but also highly trained technicians to operate it.

4.7 COST-EFFECTIVENESS

The foregoing discussion about technical capability is in part an issue of cost effectiveness as it is not worth investing in expensive technical inputs if these can be shared between sub-national governments. However, it is also important to consider the broader issue of cost-effectiveness.

For example, the purchasing of drugs may be an area where cost effectiveness calls for organising a function nationally. Technical knowledge is required in drawing up the composition and specifications of tender documents, and such skill may be in short supply and best deployed nationally. A possibly more compelling point is the potential for economies of scale through bulk purchasing. This can make a very significant difference to the effective purchasing power of a country.

4.8 SYSTEMIC COHERENCE

The term 'systemic coherence' refers to the important issue of ensuring that health systems fit together coherently, with organic links between the most local and community-oriented and the most technologically sophisticated levels of care. Of course, there equally needs to be coherence in the approach employed in all government health services, so that the public service is itself systemically coherent. However, as demonstrated below, the health sector requirements are particularly prone to widespread misunderstanding.

An important requirement of health systems is that they enable the referral of patients from local basic care up to whatever level of technical capacity is needed to provide appropriate treatment. The required organic linkages between organisational levels also need to be bidirectional as patients who have been treated at a referral facility should be able to return home with information about the diagnosis, prognosis and level of mental and physical follow-up support that they need.

In other sectors, such as education, it is relatively easy to divide services between different levels of sub-national governments; for instance by simply allocating the responsibilities for providing primary education, secondary and so on. An unfortunate mistake made in some countries is to simplistically transfer such an approach to the health sector.

The federal state of Nigeria is a prime example of the above. There, the federal government has responsibility for tertiary medical care and teaching hospitals, the state government for secondary medical care and local government for primary health care. The result is widely considered to be catastrophic, with no coordination of service provision, no control over referrals (which are practically non-existent), and no control at the state level of the allocation of resources to create an integrated and functional health care system. Funding flows from the centre to each level of health care pass separately with no provision for dialogue in this regard. Local level services thus tend to be badly organised and neglected as local governments in the Nigerian system are largely ignorant of how health services should work, and are often antagonistic to what they consider as interference from state governments.

4.9 NEED TO FACILITATE PROMPT DECISION MAKING

In health systems it is often important for decisions to be made with reasonable speed (while allowing for necessary consultation and the seeking of expert opinions). Often these are planning decisions, e.g. about the go-ahead for or the siting of infrastructural developments. Other examples

might relate to permits or requests to initiate activities, for example where non-governmental organisations (NGO) seeking advice on and approval for launching new programmes in certain areas. Local people may well be able to expedite decision making more rapidly than sending matters up through a bureaucratic system. Local people may also have useful insights that more remote levels of government would be unaware of.

Indeed serious consideration needs to be given to avoiding the negative effects of establishing a new provincial level of government in so far as this could lead to more red tape. This could for example happen as NGOs and INGOs will have to negotiate a new level of bureaucracy to get permission to work in at the district level.

4.10 NEED FOR SECTORAL INTEGRATION

Sectoral activities may have cross-sectoral effects, and where possible inter-sectoral collaboration should be pursued. Current local government legislation in Nepal provides ample room for inter-sectoral collaboration in district level activities and planning. Indeed collaboration is essential given that some areas of responsibility are assigned beyond the health sector but have direct health and health care implications. Examples of this include the care of the disabled as well as issues such as gender awareness and domestic violence.

It is often argued that inter-sectoral links can best be exploited at the local level, and certainly it is at this level of implementation that collaboration becomes most needed and most meaningful.

4.11 EFFICIENCY AND EFFECTIVENESS GAINS

Where activities are closely linked there is good sense in considering whether they should be assigned to the same level. An example is investment in buildings. Defining the operation and maintenance of health facilities and the building of health facilities as activities located at the same level will promote a more holistic approach to health facility development and operation. This could make health facilities more fit for purpose.

4.12 CONSIDERATION OF LOCATION OF PRESENT POWERS

In allocating functions under a federal system it is important to bear in mind that there is an existing system. Existing legislation gives specific powers of decision making to district development committees, municipalities and village development committees. These powers cannot and should not be taken away lightly. Doing so would invite local resentment and popular protest, and create a negative environment for introducing changes under federalisation.

5. *PROPOSED ALLOCATION OF FUNCTIONS UNDER THE MINISTRY OF HEALTH AND POPULATION*

Table 1 presents this report's proposed allocation of health governance functions between the central state level, the federal provincial level and the local district levels of government. Sixty-two functions are assigned under eight subject areas.

Note: Certain functions are not assigned to a level of government and the most appropriate level for these needs careful consideration.

Table 1: Proposed allocation of functions under the Ministry of Health and Population

Function	Activities	State	Federal	Local (district level)
1. Policies				
	a) Policy concerning role of government in health service provision		√	
	b) Policy concerning non-governmental providers		√	
	c) Policy concerning resource allocation		√	
	d) Policy concerning approach to programming (vertical vs. integrated programmes)		√	
	e) Policy concerning all recognised systems of medicine: allopathy, ayurveda, homeopathy		√	
	f) Health financing policy		√	
	g) Policy on charging for vs. providing free medicine		√	
	h) Policy concerning external aid		√	
	i) Policy concerning human resources		√	
	j) Policy concerning drugs and procurement		√	
	k) Policy concerning the rights of patients		√	
	l) Policy concerning the rights of health workers		√	
	m) Policy concerning the referral system		√	
	n) Policy concerning hospital autonomy		√	
	o) Policy on urban health care		√	
2. Planning				
	a) National strategic planning		√	
	b) Provincial level three year rolling plans	√		
	c) Local level planning and liaising with local government planning			√
	d) Human resource planning			
	e) Capital planning			
	f) Planning for major emergencies and disasters	√		

3. Implementation of NHSP 2 including service provision				
	a) In partnership with concerned entities, public health provision for a safe living environment	√		√
	b) Full implementation of prescribed vaccination and prophylaxis schemes	√		√
	c) Organisation of disease control schemes and annual work plans	√		
	d) Implementation of recommended programmes related to disease control	√		√
	e) Health promotion activities to create awareness of healthy lifestyles			√
	f) Maximisation of access to health care for all citizens, with an emphasis on ensuring opportunities for the poor and excluded			√
	g) Management of health facilities to provide curative care appropriate for each level of facility	√		√
	h) Provision of care for infectious diseases, non-infectious illness and chronic conditions			√
	i) Systematic equipping of health facilities with the appropriate level of health technology	√		
	j) Development of an integrated health care system that can treat cases or identify referrals	√		
	k) Provision of an effective referral system	√		
	l) Rehabilitation as appropriate and support for community rehabilitation programmes			√
	m) Disaster preparedness and management	√		√
	n) Maintenance of a cost-effective national procurement system for drugs and essential medical equipment		√	
	o) Distribution and storage systems for supplies of drugs, essential medical equipment and materials to all health facilities	√		
4. Human resource development and management				
	a) Elaboration of detailed training schemes for new health workers based on national planning priorities for service	√		
	b) Implementation of training in each designated location	√		
	c) Development and application of strategy and norms for upgrading staff			
	d) Operation of quality assurance systems for all training		√	

	e) Maintenance and strengthening of training information system			
	f) Performance appraisal of sector employees based on acts and rules of the civil service and the health service			
	g) Development and implementation of upgrading plans and career development paths for health workers			
	h) Operation of personnel management system			
	i) Development of rules concerning norms for overall terms and conditions of service			
	j) Development of rules for hiring and use of contract service employees			
5. Research				
	a) National policy concerning research priorities and funding allocation		√	
	b) Research ethics policy and regulations		√	
	c) Promulgation of a research culture among health service workers	√		
	d) The carrying out of research		√	
	e) Research clearance for external and international researchers		√	
	f) Dissemination and utilisation of research findings	√	√	
6. Regulation				
	a) Development of standards and norms for service provision and technologies		√	
	b) Development and operation of quality assurance functions	√		
	c) System for regulation of private sector practice and standards	√		
	d) Development of channels and norms for community surveillance			√
7. Health surveillance				
	a) Surveillance policy and norms for monitoring		√	
	b) Routine surveillance of disease patterns and outbreaks	√		
	c) Vital events surveillance	√		
8. External relations				
	a) Liaising with World Health Organisation and international health agencies		√	
	b) Information exchange and cooperation among regional neighbours		√	
	c) Cross-border regulation and monitoring	√		