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NHSSP Nepal Health Sector Support Programme

Regional Health Directorates System Strengthening Programme: a Rapid Review

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DFID Options

Strengthening Health Systems-Improving Services

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Acronyms

BCC	Behaviour Change Communication
CE	Capacity Enhancement
DDA	Department of Drug Administration
DFID	UK Department for International Development
DHO	District Health Office
DoHS	Department of Health Services
EDP	External Development Partner
FGD	Focus Group Discussion
GESI	Gender Equality and Social Inclusion
GIZ	Gesellschaft fur Internationale Zusammernarbeit (German Aid Agency)
GoN	Government of Nepal
HR	Human Resources
MNCH	Maternal, Neonatal and Child Health
MoHP	Ministry of Health and Population
MoLD	Ministry of Local Development
NFHPII	Nepal Family Health Programme II
NHSSP	Nepal Health Sector Support Programme
PHC	Primary Health Care
PMO	Prime Minister's Office
RD	Regional Director
RHCT	Regional Health Coordination Team
TWG	Technical Working Group
RHD	Regional Health Directorate
VfM	Value for Money

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EXECUTIVE SUMMARY

This report is the output of a short consultancy conducted over a week in February which aimed to provide a rapid review of the regional capacity enhancement (CE) activities conducted by the Nepal Health Sector Support Programme (NHSSP).

The report provides an overview of this key area of the NHSSP work - the CE activities aimed at the regional (and through this, district) levels of the health sector. It sets this against the experiences and challenges faced by many low-middle income health systems which are undertaking, or have undertaken, a decentralisation process.

The formal existence of regions, coupled with the widespread recognition of their current low capacity and status within the wider health system, suggests the need for the type of institutional capacity enhancement activities on which NHSSP focuses. It is clear that this work faces considerable challenges. A number of these are those commonly shared by health systems in other low-middle income countries attempting to decentralise. However, in addition, the programme's strategy of capacity enhancement faces the challenge of a lack of adequate counterparting arrangements. It is also being carried out during a period of considerable uncertainty over the future decentralisation.

Despite these challenges it is apparent that although the regional work has only effectively been operational since the posting of Regional Advisers six months ago, there is useful work being conducted through the programme.

However, the challenges and the federal agenda suggest that it would be appropriate for the NHSSP to revisit the detailed balance of their activities at the regional level. This is predicated on a view that a) a health system of the size and complexity of Nepal will inevitably require a mid-level tier of management; b) the current mid-level tier is largely ineffective and ideally, would require a major functional assessment and re-engineering to make it fit for purpose; and c) a recognition that the political agenda of federalism makes major changes, other than through the federal agenda, unfeasible.

Three broad complementary strategies are set out (see box below) with examples of the activities related to each and it is recommended that a review of the relative balance between these activities be conducted by stakeholders to maximise the impact of this work and contribute to the future federalism agenda.

In particular the following specific recommendations are made:

1. NHSSP and the Government of Nepal (GoN), including the Regional Health Directors, should review the strategic approach to CE in regions and decide on the balance between the three broad strategies set out in the report.
2. GoN and NHSSP should discuss the form of any input NHSSP can provide to the design of the role and functioning of future provincial health departments and use experience with working at the regional level to inform this input. The functional analysis consultancy recently carried out would provide one potential entry point for this.
3. As a minimum, NHSSP should pay particular attention to ensuring that the CE work, particularly that related to systems and structure development in the Regional Health Directorates (RHDs), is well documented.
4. NHSSP should recognise that it may be necessary to carry out some transactional activities; where this is being considered, clear criteria should be agreed with GoN and

RHDs, and provided to the Regional Specialists for deciding on whether to engage in such activities or not.

5. NHSSP should ensure that all areas of its work take account of the (potential) roles of regions and ensure that this is included in the ToRs of all short-term specialist consultants.
6. NHSSP and RHDs should seek opportunities to raise the role of regions with the MoHP, DoHS and External Development Partners (EDPs), alerting them to the potential disadvantages of programme work that ignores the RHDs.
7. NHSSP, RHDs and EDPs should seek to find ways of building a culture of inter-regional level working and sharing of good practice through, for example, organising exchange visits and regular meetings of RHDs, Specialists and their counterparts and between different EDP initiatives.
8. EDPs who are involved in direct district support should consider the provision of appropriate support (with, at a minimum, shared information about their activities) to the RHDs, given that the mandate of RHDs is to develop and support districts.

Potential strategies and examples of the related activities

Strategy	Examples of activities	Comment
A: Raising Regional profile/advocating for changes to regional institutions		
	Raising issue with MoHP, DoHS and EDPs Raising regional profile through development of Regional mapping, Regional strategy etc Setting up processes for inter-Regional meetings Advocacy for filling posts either permanently or on contract basis Ensuring the role of RHDs be considered in all NHSSP work and built into future national systems such as planning	Seems unlikely to achieve major structural change at this time, but opportunities to continue to raise importance of middle management tier need seizing Some resources needed
B: Strengthening current regional institutions		
	Supporting development of management processes and procedures e.g. supervision schedules and processes, calendars Enhancing formats to monitoring reports Working alongside staff to incorporate GESI approach, management training for Regional Directors (RDs) Approaches to district supervision, support (coaching, mentoring) and monitoring by regional staff Seeking and setting up processes for a small regional budget (similar to the proposal made by World Bank for small district discretionary budgets) Identifying issues for Operations Research and finding resources for such studies Programme resources for regional coordination Encouraging and supporting processes for inter-sectoralism Supporting any of the functions referred to in Box 2, permitted under the current Act	Current approach but major drawback is the critical lack of staff; continued advocacy to fill posts useful but probably not likely to achieve change Where 'transactional' work is conducted, important to consider whether it leads to sustained institutional change Some training resources needed Unclear how regional discretionary budget would work and, though showing potential for regional initiatives, could be counter-productive Different regions could focus on different areas and share best practice

C : District institution strengthening		
	Work on integrated technical guidelines Support to districts in accessing Local Government funds Supporting approaches to 'strategic' thinking in planning and in approaches to supervision, and monitoring, especially of Gender Equality and Social Inclusion (GESI) Identifying issues for Operations Research and finding resources for such studies Support to idea of district discretionary budgets Setting up mechanism for sharing best practice among districts	Activities could either be with individual districts or through clusters of districts Different regions could focus on different areas and share best practice Most likely to show short-term VfM results
Other: Supporting the preparation for federalism		
	Work on identifying steps in setting up federal health structures and opportunities and risks Work on identifying likely functions post Federalism and transitional processes Costing of functions	Could be implicit in particularly Strategy A or explicit with government agreement (perhaps as follow on to PMO functional analysis work) Could be done in conjunction with other initiatives such as GIZ's

Each of the three strategies should, if successful, have an effect on the ability of the health system to deliver district level services in an efficient manner. In assessing their relative merits there are four major considerations: the relative feasibility and sustainability of the strategies, the resource implications and costs of each strategy, the timescale of results, and the ability to clearly measure outputs.

1 BACKGROUND AND TOR OF ASSIGNMENT

The Nepal Health Sector Support Programme to the GoN is based on a framework of capacity enhancement (CE) to the Ministry of Health and Population (MoHP), the Department of Health Services (DoHS) and Regional Health Directorates (RHDs) using an organisational development approach to CE.

NHSSP has conducted detailed assessments of capacity to identify systems gaps. This has led to strategies for technical support for capacity enhancement of regional health directorates. Three Specialists have been posted to each region (in Maternal, Neonatal and Child Health [MNCH], GESI and Health Systems Strengthening) since about August 2011. They are based in the regional health office and work with the counterparts assigned to them by the Regional Director.

One focus of these assessments was the level of RHDs, which occupy a mid-level governance position within the health sector. However, the effectiveness of RHDs is widely viewed as being limited due to constraints, including a shortage of resources and clarity over role. This ineffectiveness is compounded by the current debate as to the form of, and timetable for, federalism to be adopted in Nepal.

In the run-up to the transition to federalism, it is important for MoHP to plan appropriate responsibilities and authorities for the different levels of the health system. The NHSSP has been providing direct CE activities to the five regions for over six months through Regional Specialists. A rapid review of the role of the NHSSP in this area, and its value for money, was seen as appropriate given both the regional capacity constraints and the uncertainties over the precise form and pace of the movement to federalism. The consultancy focused on the support to this mid-level tier.

The assignment objectives are provided in Box 1.

Box 1: Terms of Reference

The precise assignment objectives were to provide support to the NHSSP team by:

Making initial suggestions on the CE approach to RHDs: Hold initial discussions with the NHSSP Senior Management Team and key government counterparts and EDPs on CE needs of the RHDs. The consultant will focus on:

- How best to focus work at RD level to fit within current strategic priorities of government and EDPs;
- What could be feasible overall objectives for NHSSP regional support, assuming no substantive moves to federalism will occur within the next two years;
- Analysing current progress on federalism and, in this light, indicating a possible direction for RHD development that NHSSP might support; and
- What further consultancy inputs may be required to monitor CE at RHD level.

Reviewing NHSSP's approach to VfM: Assess how VfM can best be conceptualised and demonstrated (to GoN and EDPs) and where improvements in VfM of the approach could be made.

2 APPROACH TO ASSIGNMENT AND REPORT

The approach to the assignment had three elements. Whilst in Nepal (11-19 February 2012) I was provided with a number of documents by NHSSP and other organisations visited (see Annex 1), which gave an overview of policies and programme areas relevant to decentralization. (See Annex 2 for full list of people met.) In addition I attended a regional review and planning meeting in the Western Region and a meeting of national stakeholders focusing on MDGs and NHSP-2 and the AWPB for the year 2012-2013 at which I gave, on request from the MoHP, a presentation[1].

The draft findings underpinning this report were presented to, and discussed at, a meeting of NHSSP staff at the end of the week's in-country meetings.

The rest of the report begins with a brief overview of decentralisation in health systems in general and the challenges frequently encountered in decentralisation. This is followed by an analysis of the current situation in Nepal concerning decentralisation.

3 EXPERIENCE OF DECENTRALISATION IN INTERNATIONAL HEALTH SYSTEMS

Most national health systems of countries the size, and the complexity, of Nepal recognise the need for an intermediate tier of governance between the central level and the operational level (often called the district). Indeed the development of decentralisation has been on the reform agenda of many health systems since the 1990s. Health systems have different forms of decentralisation, with the two major differentiating features being the *functions* assigned to the levels and the *governance arrangements* assigning forms of authority to the different levels. This section discusses these two elements and then sets out the challenges frequently experienced in the development of decentralisation internationally.

3.1 HEALTH SYSTEM FUNCTIONS

All health systems have a number of functions which they have to perform (see Annex 3 for a well-known example of this from WHO). A key requirement for a successful decentralised system is clarity on the level at which these functions are performed. Box 2 sets out a summary list of these different functions with illustrations as to how they might be carried out at different levels in the health system. It should be noted that the table is illustrative and is not intended to be comprehensive.

Box 2: Examples of potential functions in a multi-level health system

Function	Authority level		
	National	**Regional**	**District**
Development, and dissemination of policy, plans, technical guidelines and standards	National policy and standards setting and dissemination Provision of technical guidance	Dissemination and contextualisation of national policy Region-specific policy setting Regional Planning	Provision of information about needs relevant to national policies District planning Implementation of plans
Support to, and monitoring of policy, plans,	Monitoring of and technical support for lower level	Monitoring of and technical support for lower level	Provision of services Collection and analysis of district HMIS

[1] The presentation, entitled Valuing Health Systems, focused on the challenges facing health systems.

technical guidelines and standards	performance Oversight of HMIS and research	performance Management and analysis of regional HMIS	
Generation of financial resources for the health system	Setting and implementation of national policies on resource generation	Regional resource generation within national guidelines	Collection of fees
Allocation of financial resources	Liaison with EDPs and INGOs Allocation of resources aligned with plans to regional levels	Allocation of resources aligned with plans to district levels	Setting of district budgets within regionally set budget ceilings
Management of resources including staff	Provision of national management guidelines Direct management or contracting of national level services	Direct management of regional level services including hospitals, stores and Training Centres Direct management of logistics including procurement, buildings and equipment maintenance	Direct management of district level services
Coordination of lower level activities and other providers	Coordinating inter-regional activities Approval and monitoring of non-public actors' activities	Coordinating inter-district activities Approval and monitoring of non-public actors' activities in region	Approval and monitoring of non-public actors' activities in district
Intersectoral Action for Health	Coordinating national level action on wider determinants of health	Coordinating regional level action on wider determinants of health	Coordinating district level action on wider determinants of health
Capacity and system strengthening	Setting vision for capacity strategies nationally and supporting CE at all levels	CE activities at regional and district levels	CE activities within district

An effective health system requires clear specification of which management level is responsible for which function or sub-function. Unfortunately, the incremental way in which many decentralisation models have developed means that there is rarely a single place in which these functions are documented and kept up-to-date. Even where there is a clear legal instrument such as a law setting out the legal parameters of decentralised functions, it may not provide details of the functions and sub-functions. Such a lack of clarity can lead to inconsistency or overlap between different levels as to where responsibility lies, to the detriment of the proper implementation of that function.

Related to this is the need for clearly specified interrelationships between the functions to ensure consistency of purpose and management activity. For example, it is important that

human resource planning is closely meshed with strategic planning and the allocation of budgets for staffing. Yet many health systems suffer from a failure to define these inter-relationships and ensure such consistency.

Within the different functional activities, the roles of the two 'outside' levels are the most easily defined and recognised. The national or central level is usually associated with setting national policy and plans and allocating resources, whilst the lower (district or equivalent) level operationalises these plans and primarily has an implementation role. The role of intermediary levels (known variously as regional, provincial, state or zonal) is however, often less clearly specified. There are several rationales for the existence of this level between the central and local levels. These may include:

- A response to the practical difficulty of centrally 'managing' multiple and different, and often remote, lower levels;
- Recognition of distinctly different local needs of a defined area which warrant different treatment and the contextualisation of national policies.

These rationales may lead to different models of 'regionalism' with different health systems. The types of roles for a regional tier may, however, typically include those set out in Box 3.

Box 3: Example of typical roles for a regional management tier

- Dissemination and contextualisation of national plans and policies to regional and district levels
- Setting of regional policies
- Development of regional plans
- Coordination of districts in planning and management
- *Resource allocation to, and budgeting approval for, lower levels
- Management of resources including staff at lower levels
- Coordination of training
- Technical and management support to lower levels
- Public health functions such as control of epidemics, coordination of emergencies
- *Direct management of regional specialist services including hospitals, stores, training centres, specialist services such as laboratories or blood banks
- Direct management of logistics
- Monitoring of district performance
- *Audit
- Liaison with and approval/monitoring of non-public actors' activities
- Liaison with health-related agencies such as water and education
- Liaison with EDPs and INGOs
- HMIS and research

(* RHDs in Nepal are authorised to carry out many of these functions, although some are done to a limited extent only. They are not authorised to carry out the starred functions.)

Such functions are often conceptualised as being ones that have been delegated by the centre and as such may retain a top-down rather than bottom-up nature. Thus, in practice, middle level tiers less frequently have an explicit advocacy or representational role to the centre in which they may represent the needs of districts within a region to the centre. Such a representational role has implications for ensuring that regions are both clear about the importance of this function and given opportunities at the centre (for example by membership of relevant committees) to exercise this role.

The various potential combinations and functions may be carried out through different governance models. Annex 3 sets out the key features of the main models though it should be stressed that there are variations on these.

3.2 CHALLENGES TO EFFECTIVE DECENTRALISATION

Whilst many health systems have set out a policy of decentralisation, often under the wider umbrella of either Primary Health Care (PHC) polices or health sector reform or wider administrative reform, the effectiveness of the resultant decentralisation has varied. A number of different causes for this failure of implementation can be seen and are outlined below.

Unclear, inconsistent or inappropriate definition of new roles

The first group of challenges may arise from what may be seen as a failure of design and may manifest itself in various ways. It was pointed out above that frequently the roles to be undertaken by different levels are not clearly defined, or are inconsistent with each other. The former may lead to a failure to achieve genuine decentralisation when there is uncertainty over the relative responsibilities of levels or specific offices; this may be aggravated at times of political uncertainty when officers are reluctant to take initiative which may appear to expose them.

Inconsistency of functions may lead to duplication of roles or even conflict between two offices each believing they had a particular responsibility for specific function(s). This may not only be inefficient but, potentially more important, may lead to a failure to carry out the function effectively.

Inappropriate definition of new roles is the third element in what may be seen as design failure. In this instance, the new roles may not reflect the desired intent to decentralise or may be inconsistent with wider governance principles in government. An example of the former may occur where lower levels are required to develop plans but the decentralisation processes do not provide for the provision of resource guidance as to the overall budget constraints within which to work.

Lastly, design of decentralisation may focus primarily on governance structures in terms of the offices responsible for the newly defined set of functions. However governance is a combination of such structures and related processes. The development of regional plans may, for example, be seen as the responsibility of the regional planning office. However, the development of such plans needs to be the result of processes that involve a variety of different actors, at the different levels of government. Failure to consider such wider processes may lead again, to ineffective decentralisation.

Lack of confidence of the centre in lower levels

The second broad challenge may occur where the centre has little confidence in the ability of the lower levels to carry out the intended decentralised functions effectively. There may be concerns both about technical ability and about probity. In such situations the centre may be reluctant to pass on responsibilities to lower levels. Such concerns may be well-placed – in which case one might expect a strategy of capacity enhancement, or they could be a cloak for a reluctance to relinquish power.

Lack of capacity for new roles at both lower and higher levels

Decentralisation may be ineffective where the different levels of the health system are not adequately prepared for the new roles they have been assigned. Though most attention on enhancing capacity in decentralisation is focused, perhaps understandably, on the lower levels and their new responsibilities, it is important to recognise that decentralisation also requires changes in the roles of the central levels and related capacity enhancement. For example a shift in role from direct management to technical advice will require new skills and a change in attitude.

Such capacity can be seen as both ensuring a sufficient set of skills *and* related resources. For example, a regional supervisory role requires both competent and respected supervisors *and* resources to travel to districts.

Resistance from the centre to loss of power

One of the major causes of ineffective decentralisation can be traced back to a reluctance of officers at the centre to what is perceived as a loss of direct power over decision-making. This may be for entirely appropriate reasons. However, it could also be caused by a desire to retain power and the benefits that power may bring.

Failure by EDPs to recognise and channel resources through new structures

A final challenge to decentralisation may arise from a failure of development partners to recognise the new roles in decentralisation and continue to channel resources and communications through pre-existing routes, thus undermining the attempts at new structures and processes.

None of the above challenges are insurmountable. However, in designing decentralisation insufficient attention may be paid to them in a naïve belief that the transfer of powers is a simple administrative matter. The reality is that the development and implementation of effective decentralisation is a highly complex process.

The following section turns to the specific context of Nepal and the place of the regional health system within the current and likely future governance systems.

4 CURRENT NEPAL REGIONAL HEALTH SYSTEM AND WIDER CONTEXT

This section gives a brief overview of the current health system governance related to decentralisation with a particular focus on the regional level[2].

Nepal has had a regional level of governance for a number of years. According to some sources, the original rationale behind the development of regions was a recognition that the diversity and complexity of Nepal made supervision (and in particular technical supervision) from the Department of Health Services impractical. As such the conception was to develop mini-Departments of Health Services in each region to look after the functions of all three central departments i.e., DoHS, Department of Drug Administration (DDA) and Department of Ayurveda. Indeed one account suggested that the central Department of Health Services was expected to disappear. Key legal and policy instruments which relate to decentralisation are the Interim Constitution of Nepal (2007), the National Health Policy (1991), the Second Long-

[2] See Mittal et al (2011) Regional support: Draft Capacity Assessment for Health Systems Strengthening, NHSSP, for further details.

Term Health Plan (1997-2014), and the Decentralisation Act (1991). Annex 4 sets out a statement of the roles and responsibilities of Regional Health Directorates in a (translated) excerpt from the DoHS Operational Manual.

Whether in practice the regions ever really exercised this level of authority is unclear. However, it is apparent that there is a perception that regions have significant authority on paper which, in practice, is not currently exercised. A recent NHSSP document drawing on the DoHS Operational Manual (2004) refers to six roles assigned to RHDs:

- Technical support for local level planning to D(P)HOs;
- Supervision, monitoring and evaluation of programme activities implemented by districts;
- Personnel management including recruitment, promotion, deputation and transfer of assistant level staff;
- Logistic support;
- Coordination within and with other health sector organisations; and
- Oversight of regional health system including public, private and NGO sector.

What is generally accepted, however, is that the RHDs currently exercise few genuine powers. Even the list above gives little sense of authority with words such as coordination, support and oversight suggesting little actual authority. Meetings with regional directors of education and agriculture suggest that this disempowerment was not confined to health but spanned across government[3]. Even in the areas where powers *may* exist, and particularly through the function of staff transfers, there is uncertainty over the real and accepted level of such authority. This leads to frustration and a sense that regional offices are career backwaters.

The prime activities currently carried out by RHDs referred to in meetings held during the consultancy are set out in Box 4.

Box 4: Current Regional Health Directorate functions referred to in meetings

- Monitoring of district level services
- Coordination of other health care providers through mechanisms such as regional networks
- Support to public health camps
- Organisation of health emergency-related activities (such as disasters and epidemics)
- Limited involvement in staff transfers (up to Grade 6 between districts within the region) and staff appraisal processes
- Capacity enhancement of districts through mechanisms such as NHSSP
- Limited approval of small private nursing homes/hospitals with a capacity of less than 50 beds

Box 5 compares the powers in Box 2 (those often found in international health systems) with the current formal powers and the current practice[4]. This suggests firstly that there are significant gaps in the powers accorded to (or practiced by) regions compared to the situation in many health systems. Key examples of this referred to during the consultancy include the lack of power to allocate resources, to approve or even comment on district plans, the lack of authority over regional services such as hospitals, stores and training centres and the inability

[3] A suggestion was made that the Roads Department had greater actual authority at the regional level through its role in construction; this was not confirmed.

[4] It is recognised that the assessments made in Box 5 are highly subjective and readers are invited to make their own judgements.

to approve/regulate the activities of private and NGO providers. Interestingly, however, all people consulted stated support for the regional tier of health governance and recognised the need for greater effective powers for that level. The assessment also suggests that appropriate activities are often conducted by the RHDs, but not systematically. Lastly, it is clear that often the degree to which such functions are carried out depends on the existence and proactivity of a good leader at the regional level, rather than on the system itself.

Box 5: Functions and current formal powers and actual practice[5]

Function	Current formal power	Current practice
Dissemination and contextualisation of national policy	Exists	Not in practice
Setting of regional policies	Non-existent	Not done
Development of regional plans	Exists	Not practiced systematically
Coordination of districts in planning and management	Exists	On ad hoc basis rather than as a system
Resource allocation to, and budgeting approval for, lower levels	Non-existent	Not done
Management of resources including staff at lower levels – maintain personal records; manage transfers and provide incentives and sanctions for staff of 6th level and below; manage leave for office heads; maintain leave records of all staff	Exists	Not properly done
Coordination of training, especially supervision/monitoring of training centres and selection of mid-level workers for training	Exists	Not practiced on a regular basis
Technical and management support to lower levels	Exists	On ad hoc basis rather than as a system
Public health functions such as control of epidemics, coordination of emergencies	Non-existent	Support to health camps
Direct management of regional level services including hospitals, stores and Training Centres	Supporting function exists but not direct management	Not in practice
Direct management of logistics including procurement, buildings and equipment maintenance	Non-existent	Not done
Monitoring of district performance, including financial transactions	Exists	To a certain extent
Monitoring of implementation of district Audit reports	Exists	Unclear
Liaison with and approval/monitoring of non-public actors' activities	Exists	On ad hoc basis rather than as a system
Liaison with health-related agencies	Non-existent	Minimal

[5] Compiled from information from Dr Pathak, interviews and from the DoHS Operational Manual, 2004.

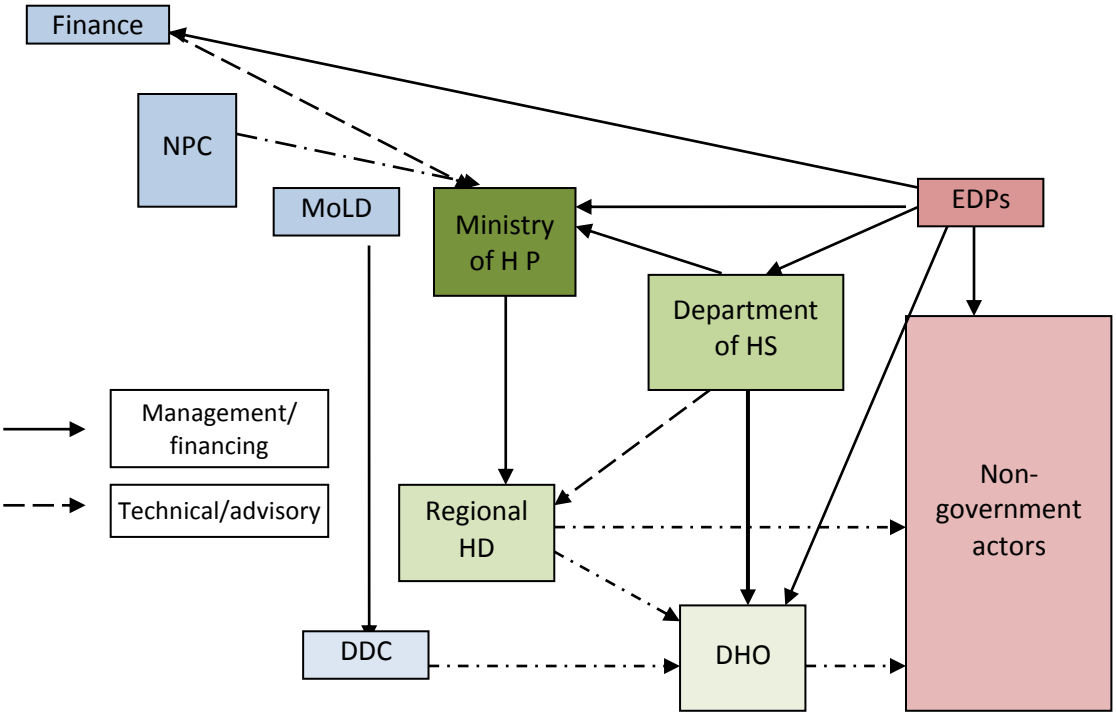
such as water and education		
Liaison with EDPs and INGOs	Exists	On ad hoc basis rather than as a system
HMIS and research	Exists	On ad hoc basis rather than as a system
Limited approval of small private nursing homes/hospitals with a capacity of less than 50 beds	Exists	In practice
For construction and repair of physical facilities, coordinate with the DHO, prepare budget estimates and request central office	Exists	Not in practice
Purchase essential drugs and supply to health institutions	Exists	Not in practice
Supervision/monitoring and reporting of activities and institutions related with DDA and Dept. of Ayurveda	Exists	Not in practice

Regions clearly face significant capacity constraints even to carry out the limited functions set out in Box 4. This is particularly reflected in the vacancies in posts, and inadequate budgets even for accepted activities such as district monitoring. These constraints make it impossible for regions even to implement those activities which are generally accepted as legitimate, let alone demonstrate their potential through new initiatives (for example through the development of regional situational analyses or plans). This lack of capacity leads inexorably to a vicious circle whereby regions are unable to function effectively and, thus are viewed as ineffectual and hence ignored. As a result, it is apparent that three key central level actors continue largely to bypass the regions. These are the MoHP (for example through its lack of a role for regions in the planning system), the DoHS (for example through its failure to effectively delegate technical supervision to this level) and EDPs (through their failure both to recognise and involve regions in their activities and to invest in them). This has led to regions being seen as 'cc offices'.

This bypassing and 'ignoring' of the regional tier of government contrasts with the growing roles for Local Government at the district level and below and their potential for providing resources to district health offices.

Figure 1 provides a graphic interpretation of the current relationships.

Figure 1: Relationships between government levels and departments and other actors



All the above has also to be seen against the context of the federalism agenda, the shape of which is currently unclear. This uncertainty appears to be contributing to reluctance, perhaps understandably, on the part of central government to make significant changes to the powers of the current regional level or, less understandably, to enhance their resources to allow them to exercise these limited powers effectively. This has led to what is often known as planning blight[6]. This is in some ways ironic, as regions may form the platform on which future provincial governments are built. This is discussed later.

Despite the above rather negative account, there *are* examples of the role of the regions being enhanced. In particular reference was made to attempts by the RHDs to lead activities to coordinate other health care providers through the (re-)activation of regional networks and through hosting regional review and planning meetings. RHDs have prepared an annual calendar of operations and annual supervision plans, mapped unreached areas and populations, and begun GESI programming (see Annexes 5 and 6 for further details). There have also been programmes supported by EDPs which include elements of regional support. GIZ in particular have been supporting regional level functioning in both Far-West and Mid-West Regions. For example, they helped regions develop the regional plan and supported setting up a regional web-site.

[6] Planning blight can be defined as 'the harmful effects of uncertainty about likely restrictions on the types and extent of future development in a particular area on the quality of life of its inhabitants and the normal growth of its business and community enterprises'. (Source: Collins English Dictionary – Complete and Unabridged © HarperCollins Publishers 1991, 1994, 1998, 2000, 2003 cited http://www.thefreedictionary.com/planning+blight)

However, regional roles are bound to remain weak in the absence of significant change to the effective authority of RHDs including control over and access to resources and authority, for example in terms of approval of NGO work or of district plans.

In summary, it appears that despite general, in principle, support for the role of regions as a mid-level tier in the health system, the decentralisation process faces many of the challenges faced in other health systems as set out in Section 3.2. These challenges have existed for some time but are now exacerbated by the federalism agenda, which effectively is leading to a freeze on initiatives to develop the regions prior to the finalisation of the form of the new federal arrangements. This raises questions about the activities of NHSSP in attempting to enhance the regional and district roles and the next section explores these issues.

5 NHSSP AND OTHER EDP WORK IN REGIONS

NHSSP has a mandate to include a regional level component to its CE work. This is entirely appropriate for a variety of reasons. The formal existence of regions, coupled with the widespread recognition of their current low capacity and status within the wider health system, suggests the need for the type of institutional capacity enhancement activities on which NHSSP focuses. This rationale is underpinned by the fact that, as discussed in Section 3, many international health systems recognise the importance of a middle management level as an efficient and effective means to develop and support needs-based operational services at the district level and have invested in this tier of governance. The final broad reason for the investment of programme resources at this level is the impending federalism which, despite the current uncertainties over its precise design, will inevitably give greater powers to a level lower than the national, state level. As such, investment in this level could usefully feed into the new structures or even inform their precise design within the health sector.

Regional focused NHSSP activities were designed following an assessment of the capacity of regional health directorates by NHSSP[7]. The strategies are summarised in Box 6. Subsequently three embedded Specialists (to cover the fields of Planning, Monitoring and Health Systems Strengthening; Essential Health Care Services; and Gender Equality and Social Inclusion) were appointed to work with each region. Their work started around six months ago.

[7] Mittal, O et al (2011)Regional Support Draft Capacity Assessment for Health Systems Strengthening: An assessment of capacity building for health systems strengthening and the delivery of the NHSP-2 results framework

Box 6: Current regional capacity enhancement strategies[8]

- Fill vacant posts in the RHDs, working with the RHDs, and also within the Policy Planning and International Cooperation Division of MoHP, to assist policy development that supports effective regional human resource planning and management;
- Strengthen the internal organisation of RHDs, focusing on organisational and institutional development;
- Strengthen the technical capacity of District Health Offices (DHOs) through RHD and programme functionaries, focusing on planning, monitoring, health systems strengthening, Essential Health Care Services and Gender Equality and Social Inclusion, in line with the NHSP-2, and building on lessons from previous technical assistance; Strengthen the control and management functions of RHDs, working with both the MoHP and the RHDs to develop action plans and to enable RHDs to fulfill their mandated role;
- Build coalitions with all players working for health system strengthening to build the capacity of RHDs to work with EDPs and I/NGOs supporting aid effectiveness at the regional level;
- Support the RHDs to strengthen Health Facility Management Committees as the first level of decentralisation;
- Work with the RHDs and the DHOs to develop strategies focused on remote areas/disadvantaged populations;
- Support the piloting of the MoHP's Local Health Governance Decentralisation Programme in the Western Region.

An internal description of this aspect of NHSSP was written earlier this year[9] providing details of the activities in each of the CE areas.

There are other initiatives which may complement this work – in particular the Local Health Governance Strengthening project (a pilot project of MoHP and MoLD supported by NHSSP, NFHP, GIZ, Plan international and WHO in different districts assigned by MoHP). This project focuses particularly at the district and sub-district level, though it has also included regional strengthening activities and the GIZ work to support regional coordination and profiling in the Far-West and Mid-West Regions. Reference has already been made also to work at the district levels supported by GIZ, which has regional elements.

The NHSSP focus at the region, in common with the overall programme focus, is clearly aimed at enhancing the institutional capacity of the Regional Health Directorates and through them the district level. Discussions held during the consultancy with NHSSP staff and with government officials recognised the current low capacity and position of regions, as discussed in Section 4, and the need for enhancement strategies. However, it was also recognised that the current federalism debate inevitably led to an impasse making institutional change difficult to achieve. One specific difficulty raised was the high vacancy rate in the regions, which not only reduced the capacity of the regions but made the assignment of appropriate counterparts for the NHSSP Specialists difficult to achieve. This has led to concerns that the balance of the work of such Specialists may have shifted too far in the direction of transactional rather than CE work.

In the discussions with both Regional Specialists and the RHD of one region, a number of useful activities and achievements were highlighted. These were also shown in the reports provided to NHSSP by the Regional Specialists which set out a variety of useful CE activities. These included the development of schedules and mechanisms for district supervision and the reactivation of regional networks for other health providers. It is clear however, that the

[8] Ibid
[9] NHSSP (2012) Regional Health System Strengthening Programme

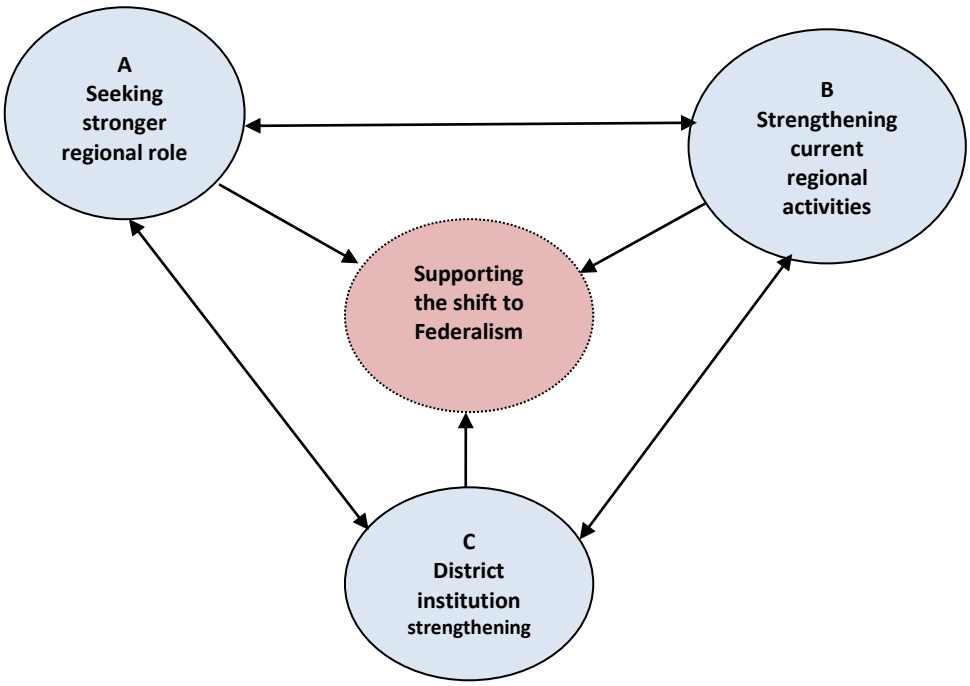
Regional Specialists face considerable challenges including most obviously, the lack of (and motivated) counterparts.

It was recognised that, after the initial six months and given the particular challenges referred to above, consideration of the existing and potential NHSSP strategies to maximise the value of the Specialists was appropriate. The following section sets out a number of alternative strategies in the light of the existing situation.

6 POTENTIAL FUTURE FOCUS FOR NHSSP REGIONAL ACTIVITIES

The previous sections have outlined the current low capacity of the Regional Health Directorates in Nepal and the current work recently started by NHSSP to strengthen them. However the 'planning blight' referred to, resulting from the federalism policy, suggests that it may be necessary for NHSSP to re-evaluate the balance of the focus of its work. In this section I outline three broad strategies that NHSSP could pursue, all of which relate to the goal of enhancing decentralisation. The activities associated with the strategies are not new – elements of each are currently part of the work of the Specialists; however it is helpful to recognise their strategic differences. Figure 2 presents out these three strategies graphically. Before exploring each in more detail, it is important to make three preliminary points. First, the three strategies are not mutually exclusive – pursuit of any one does not preclude either or both the other two. Indeed it is likely that NHSSP will continue to engage in elements of all three strategies. However it is helpful to distinguish between them as NHSSP needs to decide the relative weight to give to each. Second, each of the three is likely to affect the other two – they are symbiotic. Lastly, all three have the potential to contribute to the federalism agenda, both through developing capacity at the level at which provinces will function, and by contributing to the detailed design of the provincial functions and means of operating through assessment of the experience of regions. How explicit this linkage is, will depend on the direction provided by the MoHP.

Figure 2: Potential strategies for NHSSP regional focus



6.1 STRATEGY A: SEEKING STRONGER REGIONAL ROLE

The first potential strategy would be to seek to develop a stronger regional role than that currently existing. In particular it would assess the potential for new functions at the regional level and advocate for these at the central level, both within the health sector and more broadly through central ministries and EDPs. Given the current limited functional ability of regions compared to the situation in many health systems, were it not for the impending federal shift, this work would be essential to enhance the overall capacity of the health system. However, the current reality is that this option will be heavily constrained by the federalism process. The work of assessing potential functions could be seen to feed constructively into the development of a provincial role.

This work could not only involve the current regional Specialists in assessing the institutional potential and needs at the regional level, but also NHSSP's thematic Advisers at the central level in the development of sectoral processes such as planning. Indeed the current work on the development of the planning system would provide a good entry point for broadening the regional role in this area and there would appear to be some support nationally for this.

Though the strategy is couched as assessing new roles for the regional level it should be recognised that changes in regional functions would also lead to changes in central and district level functions; as such the strategy would require complementary activities at these levels alongside regional capacity enhancement activities.

The current uncertainties surrounding the roles of future provinces suggest that, if accepted by the MoHP and more broadly, this is could be an extremely useful activity. By the same token, however it should be recognised that the current state of planning blight may mean that this is unfeasible as a major strategy for NHSSP.

6.2 STRATEGY B: STRENGTHENING CURRENT REGIONAL ACTIVITIES

The second strategy is to strengthen the existing portfolio of regional activities. This is currently the main focus of NHSSP work at the regional level, focusing on planning, monitoring and evaluation, service delivery and mainstreaming GESI. One of the clear constraints to this work at present is the lack of capacity at the regional level which, as discussed earlier, both affects the ability of the region to conduct its work and of the NHSSP to pursue a CE model through counterparting arrangements. This suggests the need for continued advocacy to fill technical posts at the regional level.

However, the reality is that it is unlikely that many (if any) of the current counterpart posts will be filled in the short term. As such, it is inevitable that one consequence of this strategy at present is that Specialists will have to engage in 'transactional' work. It is however, suggested that this is not inappropriate, as long as the work conducted is seen to contribute to clear medium-term institutional strengthening. Thus, if for example, a Specialist is asked to organise a regional planning meeting (a task more appropriately performed by regional staff) this could be done, if it results not only in a well-organised meeting, but also written guidance on the preparation for such meetings in the future.

Such work could also feed into the development of longer term provincial roles if the experiences at the regional level are clearly documented and a mechanism for feeding into the institutional functional analysis and design is established.

6.3 STRATEGY C: DISTRICT INSTITUTION STRENGTHENING

The third strategy would involve focusing directly on strengthening the district level institutions and services, albeit from the regional base. A major (though not sole) rationale for strengthening the regional institutions through Strategies A and B is to strengthen the mid-level in the health sector to enable it to support and guide the operational level of districts in their service delivery role. However Strategies A and B rely on a more indirect approach – the strengthening of regions to enable *them* to carry out this task. Strategy C differs from this in that it accepts that the capacity constraints at the regional level are both so severe and unlikely to be improved over the lifetime of the programme that the regional focus should shift and work directly with districts either on an individual basis or through clusters of districts. Such work would still focus on institutional strengthening but at this level rather than the regional level directly. This strategy would still involve work with regional staff and institutions but with a less direct objective of strengthening their institutional capacity. It would include development of guidelines, tools and manuals for use by districts.

It is recognised that the resources of NHSSP would not allow direct support to all districts. However by working with a small number or through clusters, it would be possible to develop such guidelines for wider use in the regions.

This approach is less likely to have direct effects on the federalism agenda; however it may produce faster and more explicit benefits in terms of the sorts of outputs the Value for Money agenda of EDPs seeks.

Box 7 sets out examples of the type of work that NHSSP could engage in under the different strategies. This list is not exhaustive, and it is expected that the staff (particularly the regional Specialists) currently most closely associated with this work, would adjust this list. However it provides a starting point for a discussion on the relative merits and risks of each of the strategies. It is again stressed that it is likely that a combination of all three strategies is the most appropriate – but that deliberation over the relative weight and hence specific objectives of this part of the NHSSP work would be helpful. It is also important to recognise that it may be appropriate for different regions to have different balances of strategies depending on factors such as local needs and existing capacity.

Box 7 also includes activities related to support to developing provincial functions though these would, as discussed above, emerge through the different strategies.

Box 7: Potential strategies and examples of the related activities

Strategy	Examples of activities	Comment
A: Raising Regional profile/advocating for changes to regional institutions		
	Raising issue with MoHP, DoHS and EDPs Raising regional profile through development of Regional mapping, Regional strategy etc Setting up processes for inter-Regional meetings Advocacy for filling posts either permanently or on contract basis Ensuring role of RHDs considered in all NHSSP work and built into future national systems such as planning	Seems unlikely to achieve major structural change at this time, but opportunities to continue to raise importance of middle management tier need seizing Some resources needed

B: Strengthening current regional institutions		
	Supporting development of management processes and procedures e.g. supervision schedules and processes, calendars Enhancing formats to monitoring reports Working alongside staff to incorporate GESI approach, management training for RDs Approaches to district supervision, support (coaching, mentoring) and monitoring by regional staff Seeking and setting up processes for a small regional budget (similar to the proposal made by World Bank for small district discretionary budgets) Identifying issues for Operations Research and finding resources for such studies Programme resources for regional coordination Encouraging and supporting processes for inter-sectoralism Supporting any of the functions referred to in Box 2, permitted under the current Act	Current approach but major drawback is the critical lack of staff; continued advocacy to fill posts useful but probably not likely to achieve change Where 'transactional' work is conducted, important to consider whether it leads to sustained institutional change Some training resources needed Unclear how regional discretionary budget would work and though showing potential for regional initiatives, could be counter-productive Different regions could focus on different areas and share best practice
C : District institution strengthening		
	Work on integrated technical guidelines Support to districts in accessing Local Government funds Supporting approaches to 'strategic' thinking in planning and in approaches to supervision, and monitoring, especially of GESI Identifying issues for Operations Research and finding resources for such studies Support to idea of District discretionary budgets Setting up mechanism for sharing best practice among districts	Activities could either be with individual districts or through clusters of districts Different regions could focus on different areas and share best practice Most likely to show short-term VfM results
Other: Supporting the preparation for Federalism		
	Work on identifying steps in setting up federal health structures and opportunities and risks Work on identifying likely functions post federalism and transitional processes Costing of functions	Could be implicit in particularly Strategy A or explicit with government agreement (perhaps as follow on to PMO functional analysis work) Could be done in conjunction with other initiatives such as GIZ

6.4 RELATIVE COST-EFFECTIVENESS AND VFM OF STRATEGIES

Each of the three strategies should, if successful, have an effect on the ability of the health system to deliver district level services in an efficient manner. As such they would be seen to be cost-effective strategies. However in assessing their relative merits there are four major considerations.

First, consideration needs to be given to the relative *feasibility and sustainability* of the strategies particularly given the current uncertainties over the federalism agenda. Strategy C seems the most feasible, in part because it is furthest 'removed' from the federal agenda. This does not suggest by itself that it is the most appropriate strategy, but the relative risks of successful implementation do need to be considered.

Second, the relative *resource implications and costs* of each strategy need to be considered. This was not possible to undertake during this short consultancy, but is clearly an important consideration in setting targets for the rest of the NHSSP lifetime.

Third, the *timescale* of results will vary among the three strategies, with some leading to very immediate improvements but others taking longer to show results. Again, this is not an argument for focusing entirely on short-term results; a mix is more likely to be appropriate.

Last, it is important to recognise that some of the effects of this capacity enhancement work will lead to clearly attributable and measurable *outputs* of the type that are attractive to some EDPs. For example, work at the regional level to minimise duplication between providers, to share resources and to achieve economies of scale fall into this category. However, other activities, such as improving the quality of supervision to and at the district level, may be equally important in achieving improvements in quality of services and ultimately health, but may be harder to measure.

6.5 IMPLICATIONS OF THE STRATEGIES FOR SUPPORT TO NHSSP STAFF

The decision on the balance of strategies for regional work will have implications for the type and level of support to NHSSP staff – particularly, but not solely, those working at the regional level.

The process for developing the strategies is important, with engagement by the key stakeholders including MoHP, DoHS, RHDs and the current NHSSP staff.

It is also critical that any decision on the balance between the three strategies outlined is clearly communicated both to NHSSP staff and to related stakeholders including regional and district staff. As part of this it is important that there are clear guidelines on when transactional work is acceptable within the wider context of capacity enhancement, as discussed above. Such criteria might include for example, the opportunity cost of such work (in terms of detracting from other CE activities), the impact of such work on the functioning and reputation of regions and the degree to which such work can be 'systematised' and as such enhance the overall institutional capacity of the RHD. For example, support to the management of the annual regional district planning and monitoring workshop could be seen as a 'normal' activity for the RHD. However by engaging in, and supporting such work, there is (as was demonstrated) clear potential to develop a more productive and sustainable system.

The capacity enhancement strategies chosen will inevitably have implications for the mode and content of supervision/support at two levels – of the Specialists themselves, and of the regional and district staff by DoHS staff supported by the Specialists. This may suggest the need for the development of specific training on supportive supervision for a variety of staff.

During the visit to the region, Specialists made the point that they themselves may need their capacity enhanced, particularly if their role changes. Such needs should be picked up and responded to during regular staff appraisal. However, it is also important to recognise that the Specialists do not need to be technical experts in all the areas that they are involved in, but need to recognise how to access appropriate support for their counterparts and other staff.

Their own particular expertise should lie in facilitating capacity enhancement and development of system responses to the institutional needs identified. However, it is also recognised that their credibility may depend on demonstrating technical expertise in an area in addition to capacity enhancement.

As part of the decision about the balance between strategies and resultant work plans of activities, resource requirements need to be identified.

One specific mechanism that could be useful for all the above strategies is to encourage greater inter-regional exchange and meetings both between Specialists and between their counterparts and RHDs. This would allow sharing of good practice and help to develop a culture of regional identity.

7 CONCLUSION AND RECOMMENDATIONS

The preceding has provided an overview of a key area of the NHSSP work, the CE activities aimed at the regional (and through this, district) levels of the health sector.

International experience suggests that a health system of the size and complexity of Nepal will inevitably require a mid-level tier of management. Indeed there is strong support for such a tier within the Nepal health system. However, the current regional level is largely ineffective and unsupported by the current governance structures. Under any other circumstances the ineffectiveness of the current mid-level tier might suggest a need for significant re-engineering of the formal roles of the regions (including, for example, changes to the DoHS Operational Manual to give it greater formal powers in areas such as budget allocation and control) to make it fit for the purpose. However the reality of the political agenda of federalism makes such an approach unfeasible.

Whilst the RHDs face significant constraints under the current lack of resources and clear authority in certain areas, it is also the case that there are a number of places where strong individual leadership from RHDs can lead to enhancement of the (albeit limited) regional role. The report has identified a number of areas where there is good practice occurring in the regions, suggesting the potential for widening this within the existing structural constraints.

The NHSSP approach to CE within the regions is through Regional Specialists posted to work with counterparts at the regional level. It is apparent that there is useful work being conducted through the programme. However it is also clear that this work faces considerable challenges. In addition to the challenges frequently encountered in decentralisation (as set out in Section 3.2) the programme faces a considerable challenge through the lack of adequate counterparting arrangements. The considerable uncertainty over the future decentralisation arrangements in the country also make it a particularly difficult environment to work within.

However, any CE work conducted at the regional level could not only have immediate effects on the performance of the health system but also have useful benefits for both the functional design and performance of a future provincial level of a federal system.

As such NHSSP needs to find a way of supporting and enhancing current activities, whilst contributing to the redesign of the health system post-federalism. Three broad strategies for this were identified. It is not suggested that only one of these should be followed. Indeed it is expected that a mix of all three is likely to be appropriate. However, it is suggested that the NHSSP together with GoN consider the appropriate balance between them.

The following recommendations relate to this broad objective:

1. NHSSP and GoN, including the Regional Health Directors, should review the strategic approach to CE in regions and decide on the balance between the three broad strategies set out in the report.
2. GoN and NHSSP should discuss the form of any input NHSSP can provide to the design of the role and functioning of future provincial health departments and use experience with working at the regional level to inform this input. The functional analysis consultancy recently carried out would provide one potential entry point for this.
3. As a minimum, NHSSP should pay particular attention to ensuring that the CE work, particularly that related to systems and structure development in the RHDs, is well documented.
4. NHSSP should recognise that it may be necessary to carry out some transactional activities; where this is being considered, clear criteria should be agreed with GoN and RHDs, and provided to the Regional Specialists for deciding on whether to engage in such activities or not.
5. NHSSP should ensure that all areas of its work take account of the (potential) roles of regions and ensure that this is included in the ToRs of all short-term specialist consultants.
6. NHSSP should seek opportunities to raise the role of regions with the MoHP, DoHS and EDPs, alerting them to the potential dangers of programme work that ignores the RHDs.
7. NHSSP, RHDs and EDPs should seek to find ways of building a culture of inter-regional level working and sharing of good practice through, for example, organising exchange visits and regular meetings of RHDs, Specialists and their counterparts, and between different EDP initiatives.
8. EDPs who are involved in direct district support should consider the provision of appropriate support (with, at a mimimum, shared information about their activities) to the RHDs, given that the mandate of RHDs is to develop and support districts.

Annex 1: Documents consulted

Barker et al (2010) Health Policy and Planning: Draft Capacity Assessment for Health Systems Strengthening

Barnett et al (2010) Monitoring and Evaluation: Draft Capacity Assessment for Health Systems Strengthening

Collins et al Developing Health Sector Decentralisation

Department of Health Services (undated) Operating Manual (unofficial translation of selected pages)

DfID (2011) DFID's approach to Value for Money

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Gerein (2011) Strengthening of Regional Health Directorates: Issues for Discussion by EDPs

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Government of Nepal (1991) National Health Policy

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Martineau et al (2010) Human Resources for Health: Draft Capacity Assessment for Health Systems Strengthening

Mittal et al (2011) Regional Support: Draft Capacity Assessment for Health Systems Strengthening NHSSP

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NHSSP (2011) Quarterly Report Apr – June 2011

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NHSSP (2011) Inception Report

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Pokharel (2000) Decentralisation of Health Services

Pokharel et al (2006) Health Service Decentralisation in Nepal

Regmi (2004) Report on Health Sector Decentralisation Strategy for the MoH Nepal

Schwefel, D et al (2011) Federalism and the Health System in Nepal

Thomas et al (2010) Gender equality and social inclusion: Capacity assessment for Health Systems Strengthening

Annex 2: Schedule and Persons consulted

Sunday 12 February

Briefing by Dr Gerein and Dr Pathak

Dr Praveen Mishra, Secretary

Dr Marasini, Head Health Sector Reform Section, PPICD

Dr Dinesh Chapagain, Senior Public Health officer, Management Division, DoHS

Dr Pradhan, DG

Debrief Drs Gerein and Pathak

Monday 13 February

Dr Barker, NHSSP Health Planning consultant

Maureen Dariang and Chhaya Jha, NHSSP Specialists

Ramchandra Man Singh, NHSSP Adviser

Dr B.K. Suvedi, PPICD

Tuesday 14 February

Attendance at Regional Review and Planning Workshop, Western Region

Khadga Bahadur Kamal, Acting Regional Director, Regional Educational Directorate

Mrs Nirmala Gurung, Acting Regional Director and team, Regional Educational Directorate

Visit to Health Post

Wednesday 15 February

Attendance at Regional Planning workshop for districts, Western Region

Dr Giridhari Sharma Paudel, NHSSP Regional Specialist (PMSS)

Bhoj Kumari KC, Regional Specialist (GESI)

Basanta Kumari Shah Chand, Regional Specialist (MNCH)

Dr Chitra Wagle, DHO Arghakhanche,

Dr Megh Bahadur, DHO Gulmi

Dr Bishow Raj Khanal, Regional Health Director, Western Region

Thursday 16th February

Stakeholders meeting focusing on MDG/NHSP-2 and AWPB for the year 2012-2013

Dr Susanne Grimm, GIZ

Atma Ram Pandey, National Planning Commission

Dr Matt Gordon, DfID

Natasha Mesko, DfID

Friday 17 February

Discussion of preliminary findings with NHSSP staff

Ashok Shrestha, NFHP

Robin Houston, NFHP

Saturday 18 – Sunday 19th February

Document review and preliminary report writing

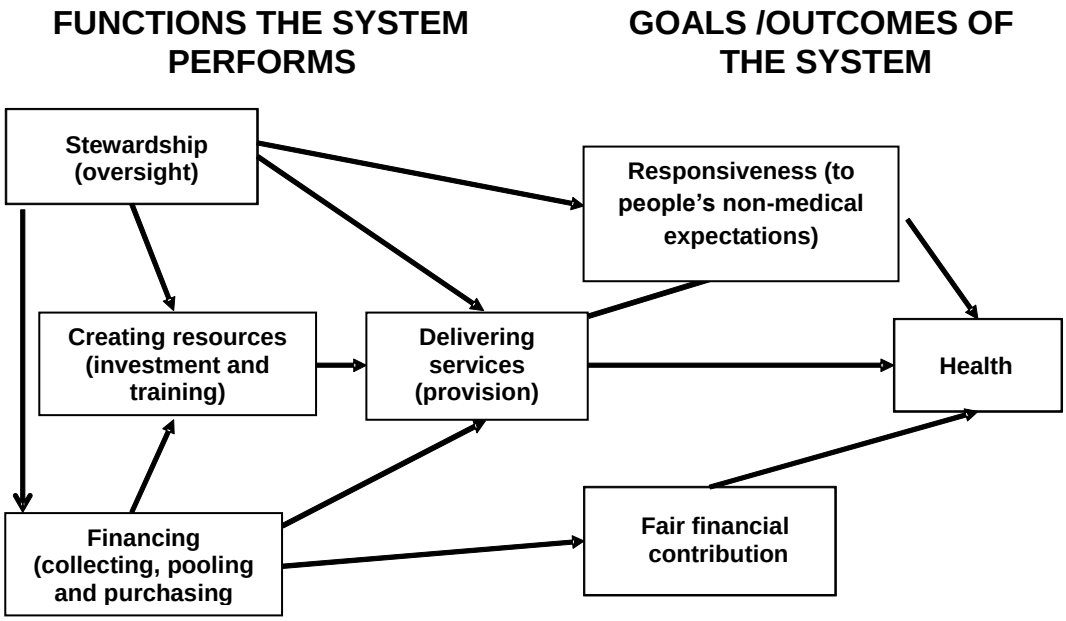
Annex 3: Selected examples of models of health system decentralisation[10]

The development of decentralisation has been on the reform agenda of many health systems since the 90s. Health systems have different forms of decentralisation with the two major differentiating features being the *functions* assigned to the levels and the *governance arrangements* assigning forms of authority to the different levels.

All health systems have a number of functions which they have to perform. There are various sources which describe these including the WHO Health System model which sets out 6 broad functions. A key requirement for a successful decentralised system is clarity on the level at which these functions are performed.

Figure 3: Relations between functions and objectives of a health system

Source: WHO (2000) Figure 2.1 p 25.



[10] This annex and the figures draw on Collins, C and Green, A (forthcoming) Valuing Health Systems Sage India.

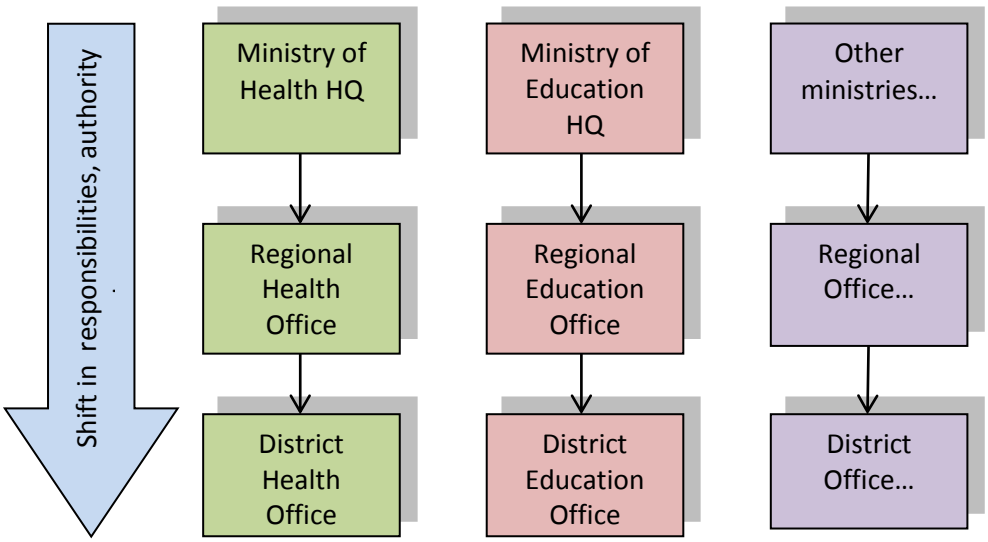
An effective health system requires clear specification of which management level is responsible for which function or sub-function. There are various governance models and Box 8 summarises the key features of the main ones. This is followed by a more detailed analysis of the main forms of decentralisation under a unitary government.

Box 8: Different governance models under decentralisation

Governance model	Key features
Federalism and confederalism	An allocation of powers between a central national government and state/provincial governments. Both systems recognise the overall role of the nation state but there are greater powers provided to the central government under federalism than under confederalism. Federal states such as India, Pakistan and USA allocate roles for the health sector differently.
Devolution under unitary state	An allocation of powers through a legal instrument between the central unitary state and lower levels usually involving elected lower assemblies
Deconcentration under unitary state	An allocation of powers through the transfer of workload from the central to lower levels, often known as functional deconcentration. One specific form of this is integrated deconcentration involving both the technical ministry and a more general administrative process.
Delegation	The transfer of powers, usually through a contract, to another body. The contracted body is in effect semi-autonomous.

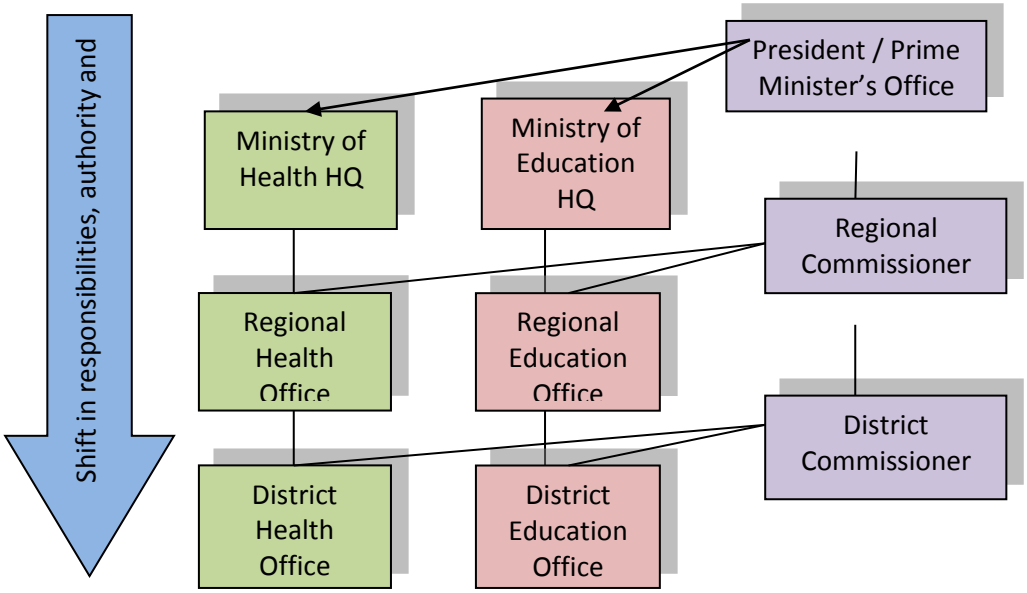
Deconcentration (and particularly functional deconcentration, see Figure 4) refers to the transfer of workload to lower levels whilst retaining line management control from the Ministry of Health. The lower levels are given authority, responsibilities and resources to act on defined issues.

Figure 4: Decentralisation as functional deconcentration



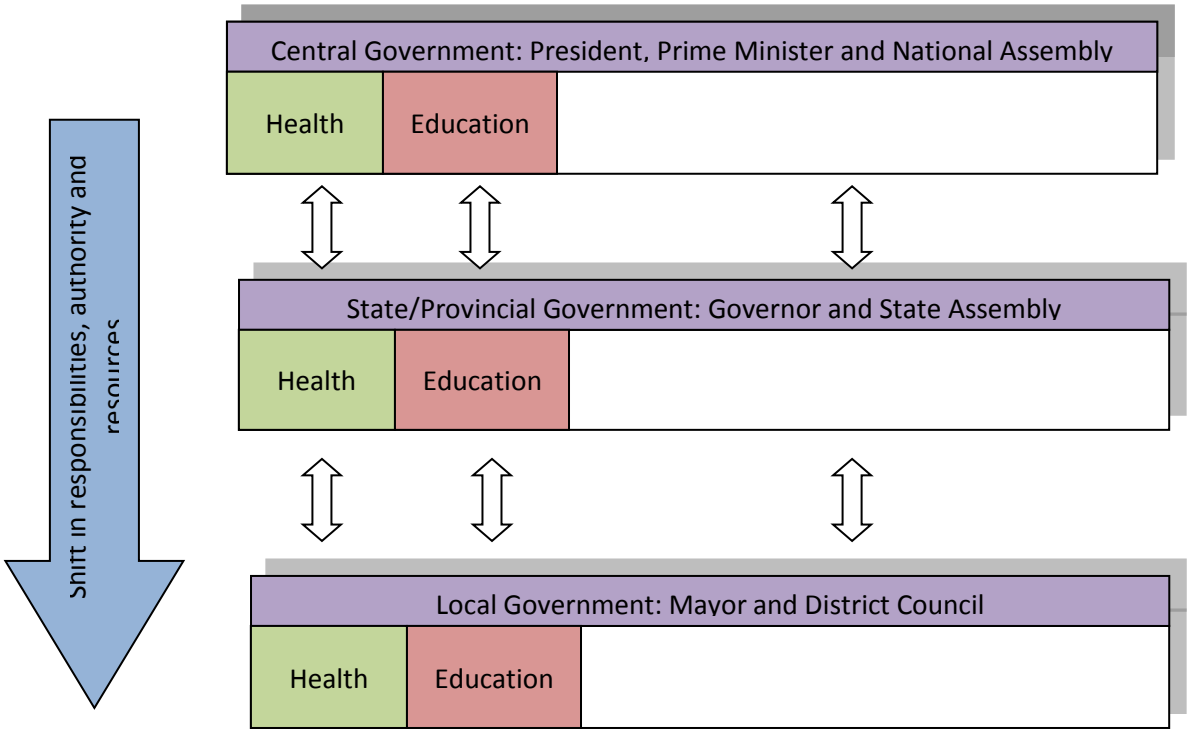
Integrated deconcentration (see Figure 5) is a variation on this. Here, the regional and district health officers lie under the authority of both the Ministry of Health and a separate line of central administrative control (such as the president or the Prime Minister or Ministry of Local Affairs). This may promote a more integrated approach at the decentralised level but raises challenges for operationalising such dual authority.

Figure 5: Decentralisation as integrated deconcentration



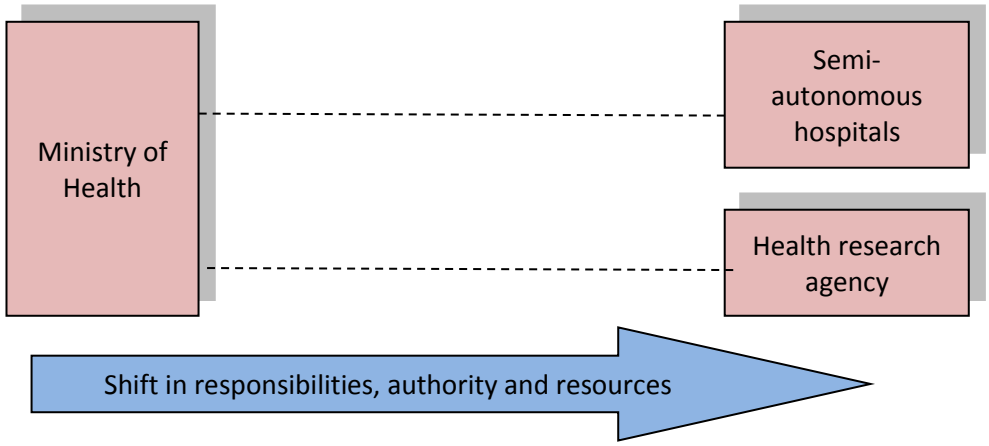
Devolution (see Figure 6: Decentralisation as devolution) refers to the transfer of authority between levels of government that have a legal identity, income and are not subject to the line management authority of the higher level of government. Normally the different levels would involve some elected authority. This allows greater local accountability and democracy but can raise questions about the level of cohesion between the levels of the government system and the capacity at the local level.

Figure 6: Decentralisation as devolution



The third model, delegation, is when an agency is attached to, but semi-autonomous from, the parent organisation with no line management authority between the two. Instead a contract or service level agreement may be made between the two – as a separate funding organisation and a different provider agency. Figure 7 gives an example of a semi-autonomous hospital and a health research agency).

Figure 7: Decentralisation as delegation (example of a semi-autonomous hospital and health research agency)



Annex 4: Excerpt from Operating Manual for the Department of Health Services[11]

b) Objectives

As per the policy set by the Ministry of Health and Population (MoHP), preventive, curative and promotional health services are delivered through various health delivery outlets operational in various levels. Such services are aimed to bring the services up to the door steps of general population. Monitoring and supervision of the services are essential for ensuring that all the services provided from regional, zonal and specifically from district or lower levels are being implemented smoothly and effectively. To achieve this objective and to decentralise the implementation of the activities, Regional Health Directorates are established.

c) Working Area

As per the decentralisation policy of the Government of Nepal, local organisations are provided more authority. According to this policy all five Regional Health Directorates are given the responsibility of monitoring, evaluation and quality control of allopathic, alternative and Ayurvedic treatment, drug management as well as all health services provided and activities conducted by health institutions run by governmental and private sectors in the regions. All regional, sub-regional, zonal, district, ilaka, and village level health organisations under the three divisions of MoHP will come under the Regional Health Directorate.

d) Activities

1. Develop annual work plan following the policy directions of MoHP.
2. Assist to implement national policy by analysing the available health services in the region.
3. Develop the regional level programmes considering the district level programmes and report to the central authority.
4. Conduct necessary monitoring and supervision of district level programmes and provide feedback.
5. Collect and compile monthly progress reports of the health programmes from all district public health offices. Follow up with the districts that do not send monthly progress reports on time and report to the central level.
6. Consult and coordinate with all private and non-governmental organisations in the region and provide support to them. Monitoring and supervision of existing programmes in the region.
7. Develop working relationships with national and international organisations and coordinate with Department of Health Services if formal agreements are to be made with the organisations consulted.

[11] Non Official Translation of page 116 and 117 provided by NHSSP

8. Identify basic and refresher training needs of various level health workers in the region and consult with the relevant training division at the centre for the arrangements for training from the regional health training centre or national health training centre.
9. Regarding the construction and repair of physical facilities, coordinate with the district health offices, prepare budget estimates and request to the central office.
10. Maintain personal records of the staff within the region. Manage staff transfer in the region following the existing policy of MoHP.
11. Manage leave applications of all office heads from the region except for special leaves and study leaves. For these two types of leave recommend to related divisions in the centre.
12. Provide incentives and/or penalise 6th and below level staff within the region as per the health service law/regulation and inform the Department of Health Services of the action.
13. In case of officer level staff in the region, recommend for incentives/or penalties to the central divisions. If necessary recommend for transfer also.
14. Maintain and update the leave records of all staff within the region.
15. Recommend for scholarships/foreign tours/observation tours etc. using the criteria set by MoHP.
16. Monitor and control the financial transactions in the district level as per need. Enforce the implementation of audit reports and take action against those who do not clear their advances and audit findings as per the existing financial rules or recommend to the centre for necessary action.
17. Purchase essential drugs and supply to health institutions within the region through medical stores.
18. Print and distribute the forms provided by “Supply Management Division” to district health offices.
19. Appoint non-officer level staff to the vacant positions if the Public Service Commission transfers this authority.
20. Similarly, if non-officer level staff positions are vacant or new positions are created and if Public Service Commission transfers the authority, promote qualified staff to these vacant positions.
21. Provide administrative leadership to all health offices under the regional health secretariat.
22. Monitor and supervise the health organisations under the Department of Drug Administration and the Ayurvedic Division as per the authority provided by respective divisions. Send the M&E report to respective divisions.

Annex 5: Changes in the RHD system supported by NHSSP[12]

SN	Activities	Baseline Status	Current Status- Achievements	Remarks
Planning System:				
1	Annual Calendar of Operation	Ad hoc basis	Annual COP FY 2068/069- Developed and being implemented	Annual COP is now available at the RHD
2	Annual supervision plan, Quarterly work plan of the region (based on the annual COP)	Partial (ad hoc basis)	Supervision plan & quarterly work plan of the region Developed and being followed	
3	Mapping of unreached areas/population for planning purpose/initiating specific intervention	Not in practice	Identified unreached areas & population through mapping exercise both zooming at districts and VDCs level (documentation available at RHD)	Being practiced together with the regional counterparts in the selected districts
4	Issue-based planning in programme review meetings	Not in practice	Institutionalised developing of issue based plan of action in the programme performance reviews (i.e. *RH, Immunisation to offset district specific gaps)*	
5	GESI responsive programme and planning	Not in practice	Initiated inclusion of GESI elements in local level planning process (DDC, VDC planning)	
6	Annual work plan of the district	Partial (ad hoc basis)	GESI sensitive annual work plan developed in some selected districts	
7	Documentation system	Partial	Initiated documentation system in the RHD	Copies of all updated information, progress & feedback reports, meeting minutes, protocols/guidelines are available at the regional office
Monitoring & Evaluation System:				
8	Preparation of report and written feedback system after supervision visit	Partial (ad hoc basis)	Functional practice of report writing and written feedback system from RHD to the districts after each supervision visit	Documentation of reports at RHD
9	Analysis of Human Resources (HR) composition of the region by sex, caste and ethnicity	Not in practice	Collected HR information of the region and districts and initiated analysis of the composition by sex, caste & ethnicity	Details of HR composition by sex, caste and ethnicity is now available at the RHD

[12] Supplied by NHSSP

10	Review the process and outcome of programme performance reviews at RHD/districts *(quarterly, half yearly and annual)*	Not in practice	Practiced through internal coordination meeting among the regional team members at RHD	Discussion among the regional team on the steps to be adopted for better outcome in the next programme reviews
11	Monitoring profile for regional and district focal persons	Does not exist	Developed monitoring profile for the regional and district focal persons (*EPIO, FPOs & PHNs)*	Copy of the monitoring profile is available at RHD
12	Routine internal review and planning meeting at RHD	Partial (no documentation)	Practice initiated at RHD	Agreed by the regional team to tie up with the monthly coordination meeting and make it functional
13	Routine data analysis and provide feedback to the districts	Not in practice	Initiated data analysis on monthly basis and provide feedback to the districts	This was discussed and agreed with the RD
Information Management System:				
15	Use of statistics at district and regional level	Partial	Practice initiated at RHD during review and planning meetings	Encouraged team approach to use and manage statistics both at the district and regional level
16	Disaggregated service data by sex and ethnicity	Not in practice	Collected/analysed sample of disaggregated data of service receivers by sex and ethnicity from Mechi Zonal hospital and shared with the district managers	This exercise is under process in a few other hospitals within the region
17	Update HR inventory of the region by district, sex, caste and ethnicity	Annual update without disaggregation	Updated HR inventory of the region by district, sex, caste and ethnicity, and analysis is under process	
18	Update profile information of the region and districts including service centres/sites	Partial (ad hoc basis)	Profile information of the region and districts updated Institutionalised the process of update on quarterly basis	Documentation available at the RHD
Coordination System:				
19	Profile of GOs, I/NGOs and EDPs of the region and districts involved in health sector	Does not exist	Developed profile of GOs, I/NGOs and EDPs of the region and districts and initiated analysis	Analysis to be done in line with coordinating programmes and utilisation of resources in the region
20	Monthly coordination meeting at RHD		Functionalised monthly coordination meeting among the regional team with defined agenda	Documentation of the decisions made and follow up for execution of the decisions
21	Coordination meeting with EDPs	Partial (ad hoc basis)	Regularised coordination meeting with EDPs with defined agenda and documentation of the minutes	
22	Regional Health Coordination Team (RHCT)- Formation and made functional	Structure does not exist	Formed Regional Health Coordination Team (RHCT) with defined TOR and Task Force Committee to outline the roles and future direction – includes	Division of roles on RHD system strengthening among the EDPs is under process

			EDPs and I/NGOs in the region Functionalised RHCT meetings with documentation of the minutes	
23	Intra-sectoral coordination	Not in practice	Initiated coordination meetings with the government line agencies (with agenda and documentation of minutes)	Meeting with Women Group Network in presence of WDO officials for organising BCC/advocacy programmes Meeting with DDC officials in presence of DHOs for coordinating programmes and resource allocation for district level planning

Annex 6: Examples of Areas of Capacity Enhancement supported by NHSSP

Areas for Capacity Enhancement				
Areas	Activities	Baseline Status	Current Status-Achievements	Remarks
Tools	Vulnerability mapping	These tools rarely used in the districts and region	Initiated use of this tool by the districts during local level planning (DDC, VDC)	Being practiced by the regional and district counterparts
	Focus Group Discussion (FGD)		Initiated use of this tool for scanning of the situation at different levels	
	Monitoring profile		Initiated use of monitoring and analysis profile by the district and regional focal persons	
	Coordination meetings		RHD team initiated taking ownership and accountability to regularise coordination meetings with different actors working in the health sector and make them functional	
Skills	Preparing issue based plan of action	Limited skills among the counterparts (region, district)	Regional counterparts developed confidence and skills to facilitate the process of preparing district specific plans of action in the programme review meetings	
	Vulnerability mapping zooming at district and VDCs		District and regional counterparts developed skills to undertake vulnerability mapping	
	Focus Group Discussion (FGD)		District and regional counterparts are able to undertake FGDs to capture the voice of excluded people using FGDs	
	GESI responsive programme and planning		The regional and district team/structures *(staff members, GESI TWG members)* developed understanding and skills to facilitate GESI responsive planning	
Staff & Infrastructure	Updating HR inventory	Not considered as priority	RHD team was involved and provided their full efforts to update HR inventory of the region and district by gender and caste disaggregation	

Structure, roles and system	RHCT	Not considered as useful forum	RHD team initiated taking full accountability for the RHCT related activities	
	GESI TWGs (RHD, districts)	-	GESI TWG members both in the regions and districts initiated work as a catalyst for facilitating GESI responsive planning/programming	