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Social Auditing Pilot Programme in Rupandehi and Palpa Districts

Bharat Deukota
Santosh Ghimere
Basu Deu Neupane

Strengthening Health Systems-Improving Services

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The evaluation process took us to various VDCs in Palpa and Rupandehi districts, where we were well received by communities and local officials eager to share their stories and hopes. We would not have been able to complete this task without generous support from Mr Jhalak Sharma, Palpa District Health Office, Mr Maheshwor Shrestha, Rupandehi DPHO, and the social audit focal persons of these two districts. We noted the stiff challenges faced in grounding a robust social audit process. We were struck by the dedication, fortitude, and creativity of community members and local officials, as they laboured under very difficult circumstances, facing many limitations. We hope that our report will contribute to strengthening their efforts and give them the encouragement to meet the aspirations of the poor.

Basu Dev Neupane
Santosh Ghimire
Bharat Devkota

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EXECUTIVE SUMMARY

A Background

The Government of Nepal aims to improve the utilisation of essential health care and other services, especially by women, the poor, and excluded people, under the Second Nepal Health Sector Programme (NHSP-2). External development partners are supporting NHSP-2 and providing technical and capacity building support to help the Ministry of Health and Population (MoHP) deliver against the NHSP-2 Results Framework. Governance and accountability is an important feature of NHSP-2, of which social auditing is a key intervention.

Recognising the importance of social auditing in promoting accountability and transparency, MoHP has adopted the process as a demand-side monitoring and accountability tool under NHSP-2. In 2011/12, the Primary Health Care Revitalisation Division (PHCRD) was given the responsibility of designing, piloting, and scaling up a harmonised social audit approach. The guidelines have been piloted in 29 health facilities in Palpa and Rupandehi Districts. The first round of social auditing took place from February to June 2012 and a second round took place between May and July 2013.

An evaluation of this initiative was carried out in March 2013 to analyse and document the implementation of social auditing and to make recommendations on how the process might be improved.

Six health facilities in Palpa and four in Rupandehi, covering all three types of sub-district facilities (primary health care centre [PHCC], health post [HP], and sub-health post [SHP]), and one district-level hospital (Rampur, Palpa) were identified with the government as sample facilities for in-depth investigation.

The evaluation team employed a variety of qualitative methodologies, and a review of monitoring and background documentation was performed. Given the inclusive objective of social auditing, a special effort was made to ensure that women and poor and excluded people participated in the evaluation. This was reasonably well achieved.

The major findings of the evaluation are given in the three sections of this report:

- The first section elaborates on the status of social audit implementation in focal health facilities.
- The second section presents the key changes that have taken place in the facilities as a result of social auditing, grouped under the themes of availability and access, quality, accountability, transparency, and community mobilisation.
- The last section explains the most important lessons learned, conclusions, and recommendations.

Each health facility that underwent the social audit process in 2012 had developed an action plan during the mass meeting that concluded the process. The assessment of the status of social auditing in the focal health facilities found that four of the six Palpa facilities had fully implemented their action plans while the other two had completed all but one point, whereas, in Rupandehi, the status of implementation was poorer.

PHCRD, at the central level, and the district health office (DHO) in Palpa, took the initiative to provide the necessary regulatory instructions for successful implementation of the action plans.

Palpa DHO and Rupandehi district public health office (DPHO), with the help of health facility operation and management committees (HFOMCs) and village development committees (VDCs), filled 26 positions for vacant health workers in nine health facilities under local contractual arrangements.

B. Findings

Data were collected from a range of stakeholders to triangulate perceptions of improvements in the delivery of services since social auditing was introduced.

Opening times — Based on this feedback, it was found that in terms of improved availability and access to health facility services, the opening times of health facilities had been extended on average by two hours per day. The services in nine health facilities had been regularised by opening the facility every day, except on weekends and public holidays. Eight out of ten sample facilities had substantially improved the attendance of health workers.

Quality of care — Significant improvements were found in the quality of health services recorded. Communities and clients reported improvements in the timely availability and sufficiency of medicines at facility level, and in reduced incidences of stockouts. Also, seven of the nine health facilities that did not have separate toilets for men and women before the social audit process had gone on to install one. The number of facilities with adequately furnished waiting spaces increased from two before social auditing to seven afterwards. Six facilities were reported by communities to be clean after social auditing compared to none beforehand. While there was mixed progress on improving the physical environment, improvements in the behaviour of health workers were significant. Their behaviour in terms of interpersonal communication and respect towards clients was reported to have improved in the nine facilities where their behaviour had previously been reported as poor.

Accountability — Health facilities were found to have gradually become more accountable towards the general public. Eight facilities were found to be properly displaying the updated citizen's charters, compared to only two beforehand, and seven had newly installed complaint boxes. However, these boxes were not opened regularly to check for complaints and address grievances, and people still prefered to flag their grievances informally. Four of the six health facilities with birthing centres had started disclosing the name list of incentive recipients as a result of the social auditing carried out in 2012. The list of free medicines provided by the health facilities was being newly displayed in Nepali in seven of the health facilities.

Community mobilisation — It was found that social auditing had contributed substantially to mobilising local communities by extending coordination and establishing linkages with other local institutions. Two key actors for this have been VDC secretaries and head teachers, in their roles within the HFOMCs. The community forestry user groups (CFUG) and drinking water users' committee contributed to the improvement of the waiting spaces and provided safe drinking water. Social auditing had encouraged local communities to support their health facilities with finance and materials.

Process and participation — In terms of the quality of the social audits, it was found that the social audit organisations (NGOs) had generally been good facilitators and had generated reasonably diverse participation in the process, taking into account the stipulated requirement for representing women, the poor, and excluded people. However, feedback suggested that they lacked detailed knowledge of health service delivery and were not proactive enough promoting coordination with agencies conducting social audit in other sectors at the VDC level. They were found to be successful in maintaining neutrality by striking a balance in relations between health facilities, the community, and other stakeholders. Participation in mass meetings was inclusive.

Perceptions — Local communities perceived social auditing to be a good process to help hold health workers to account, and to raise local people's awareness of health service provision. Three quarters of the health workers interviewed said they appreciated social auditing as it did not humiliate service providers, which they felt happened with some other types of public hearing. The process was an eye opener for HFOMCs: they are now more aware of their own roles and responsibilities. The DHO and DPHO reported that the process contributed substantially to empowering service providers and recipients. The process had inspired local bodies, which had been prompted to replicate the process in other sectors, as seen in several VDCs.

C. Conclusions and recommendations

The social auditing pilot programme has delivered good initial results that can be attributed to the individual efforts of a variety of actors. The challenge now is to sustain the resulting changes. This will only be possible if social auditing is established as a culture at the community level and institutionalised at district and central level through government mechanisms.

Key recommendations from this process evaluation include:

- the wide dissemination of health facility opening times and working hours through the national media;
- opening the attendance register of health workers for public scrutiny;
- the provision of a small flexible fund at the district level to improve service delivery;
- engaging social audit organisations for a longer duration;
- ensuring district-level gatherings of stakeholders to disseminate comprehensive social audit results; and
- revising HFOMC guidelines to ensure that these committees are socially inclusive.

The study team faced several limitations in carrying out the study including its rather early timing since social auditing has only been implemented for a year. The evaluation team recommends that a more comprehensive study be carried out that measures the impact of social auditing in a variety of contexts, over a longer duration and in comparison to control sites, and includes an assessment of the cost-effectiveness of social auditing. This initial process evaluation study can contribute to the design of such a comprehensive evaluation.

CONTENTS

ACRONYMS

4ANC	Four Antenatal Care Visits
AHW	auxiliary health worker
ANC	antenatal care
ANM	auxiliary nurse midwife
AWPB	annual work plan and budget
BCG	Bacillus Calmette-Guérin
CFUG	community forestry users' group
D(P)HO	District (Public) Health Office
DAG	disadvantaged group
DDC	district development committee
DEO	District Education Officer
DFID	Department for International Development (UK)
DHO	district health office
DoHS	Department of Health Services
DPHO	district public health office
DPT	diphtheria, polio and tetanus
EHCS	essential health care services
FCHV	female community health volunteer
FGD	focus group discussion
FHD	Family Health Division
FY	fiscal year
GiZ	German Development Cooperation
GoN	Government of Nepal
HF	health facility
HFI	health facility in-charge
HFOMC	health facility operation and management committee
HP	health post
HQ	headquarters
HR	human resources
HW	health worker
LDO	local development officer
MD	Management Division
MNCH	maternal, neonatal and child health
MoHP	Ministry of Health and Population
NFHP	Nepal Family Health Programme
NGO	non-governmental organisation
NHSP-1	First Nepal Health Sector Programme
NHSP-2	Second Nepal Health Sector Programme
NHSSP	Nepal Health Sector Support Programme
NPR	Nepalese rupees
PHCC	primary health care centre
PHCRD	Primary Health Care Revitalisation Division
SA	social auditing

SBA	skilled birth attendant
SHP	sub-health post
TA	technical assistance
VDC	village development committee
VHW	village health worker
WHO	World Health Organization

1 INTRODUCTION

1.1 BACKGROUND

Upon successful implementation of the first Nepal Health Sector Programme (NHSP-1), the Government of Nepal (GoN) and its development partners decided to design a second phase, with the specific aim of improving the utilisation of essential health care and other services, especially by women and poor and excluded people. The Nepal Health Sector Support Programme (NHSSP), the technical assistance (TA) to the Second Nepal Health Sector Programme (NHSP-2), is providing technical and capacity building support to help the Ministry of Health and Population (MoHP) deliver against the NHSP-2 Results Framework. Governance and accountability is an important feature of NHSP-2 and, within this, social auditing is a key intervention.

Social auditing is used across various development sectors in Nepal. It is a participatory tool that facilitates service users and service providers to review the planned and actual provision of services and related expenditure. It promotes accountability and transparency and is a way of improving service provision and helping to ensure that funds are properly spent. It also helps to manage the expectations of users on the services available and of health personnel on their individual responsibilities.

MoHP has adopted social auditing as a demand-side monitoring and accountability tool. Up to 2011, two different approaches were used for social auditing in Nepal's health sector:

- The Free Essential Health Care Services (EHCS) Programme followed the 2009/10 (2066) guidelines developed by MoHP's Management Division (MD), with support from German Development Cooperation (GiZ), and implemented by district public health offices (DPHOs) and district health offices (DHOs).
- The approach used by the Aama Programme for safe deliveries was developed with support from the UK Department for International Development (DFID) following guidelines developed by the Family Health Division (FHD). This approach was implemented by local non-governmental organisations (NGOs) contracted by FHD.

In 2011/12, the Primary Health Care Revitalisation Division (PHCRD) of the Department of Health Services (DoHS) was made responsible for managing and overseeing social auditing across the health sector. PHCRD is now responsible for designing, piloting, and scaling-up a single approach to social auditing.

In 2012, GiZ, the World Health Organization (WHO), and NHSSP supported the review and harmonisation of the two sets of guidelines. The preparation of the updated guidelines was overseen by a PHCRD-led technical committee with members from DoHS, MoHP, GiZ, WHO, the Nepal Family Health Programme (NFHP) and NHSSP. In 2013, the Health Sector Social Audit Operational Guidelines, 2968 (2013) were approved by the health minister.

The new guidelines detail the process for carrying out social audits in health facilities as follows:

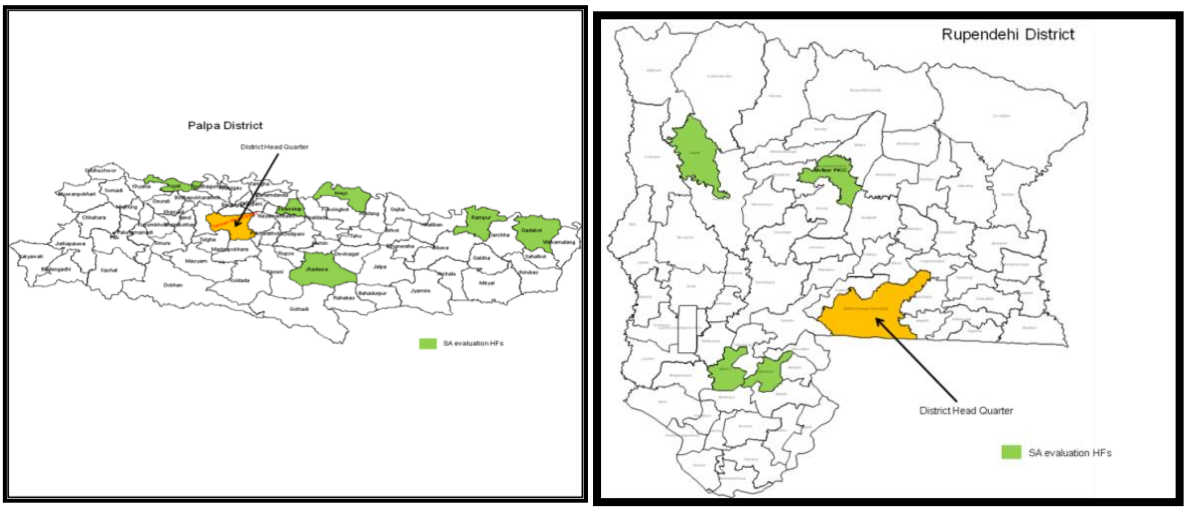
- Audits are to be overseen by DHOs and DPHOs.

- District social audit committees are to be formed.[1] They will produce annual district social audit action plans that specify which health facilities will be audited each year.
- One or two NGOs are to be appointed per district as social audit organisations to carry out the audits.
- Health facility operation and management committees (HFOMCs) are to play a central role in supporting audits.

The health facility-based audits are facilitated by social audit organisations interacting with health personnel and users to review how well services are being delivered. At each health facility, the audit process concludes with the production of a social audit action plan that lists activities to be carried out and commitments made by various parties to address issues of concern.

The field-testing of the harmonised social audit approach was undertaken in Rupandehi District in 2011. Subsequently, the new guidelines were piloted in 2012 in 29 health facilities (eight funded from PHCRD's annual work plan and budget [AWPB] and 21 by NHSSP in two districts (13 in Palpa and 16 in Rupandehi[2]) (see Figure 1). It should be noted that MoHP also funded social auditing in an additional 20 districts from its AWPB.

Figure 1: Locations of social audit pilot health facilities evaluated in Palpa and Rupandehi districts (= VDCs shaded in green)



The monitoring of progress made against the social audit action plans in the 29 health facilities was undertaken by independent consultants in March 2013. This initially involved a one-day visit by an external facilitator to each facility to review progress made against each action plan. During this visit the ladder of change monitoring tool was completed with the HFOMC.[3] This input was in additional to assessing the Implementation Plan as set out in the government's operational guidelines and was undertaken to support learning from the pilot.

[1] The guidelines provisioned for committees to be made up of members from: local development officer (LDO), DDC – coordinator; members: – social development officer; district education officer (DEO); women development officer (WDO); district (public) health officer – member secretary

[2] Eight from TA; eight from AWPB.

[3] See Annex 1 for the Ladder of Change Monitoring Tool.

A second round of assessments in the 29 facilities in Palpa and Rupandehi was implemented between May and July 2013. This involved two-day exercises to follow up on implementation of the action plans.

Since social auditing is relatively new to Nepal's health sector, PHCRD felt that it was essential to assess its effect on:

- the availability and quality of local health care service provision;
- the extent to which facility-based social auditing is triggering district- and higher-level
- government responses to address health care delivery constraints; and
- raising public demands through, for example, local government (village development committees [VDCs] and district development committees [DDCs]) and media channels to improve health services.

1.2 OBJECTIVES

The main objective of this assignment was to assess the outcomes, and analyse and document the implementation process, of social auditing in selected health facilities of Rupandehi and Palpa districts, and to make recommendations to improve the social auditing process.

The specific objectives were to:

- assess the effectiveness and functionality of the social audit implementation process;
- identify perceptions from a range of stakeholders in government, and among NGOs and communities, of how social auditing has enabled, and led to changes in, health service delivery, and how far it has been relevant and useful; and
- examine whether there have been any improvement in service utilisation, quality and accessibility of services, management, and community mobilisation following the first round of social auditing.

1.3 SAMPLE AND METHODOLOGY

To answer the evaluation's research questions, it was decided to focus on a small number of sites to allow for in-depth investigation. Ten health facilities were selected:

- six in Palpa, a hill district which has comparatively poor accessibility in terms of mobility, and
- four in Rupandehi, a Terai district, which is considerably more accessible.

These were identified in consultation with officials from PHCRD at the central level and Rupandehi DPHO and Palpa DHO and the district social audit committees in the study districts. A mixture of well-performing and not-so-well-performing health facilities were purposefully included in the sample. A mix of all three types of sub-district level health facilities, primary health care centres (PHCCs), health posts (HPs), and sub-health posts (SHPs), were included in the sample. The health facilities in each district included a mix of those close to, and far from, the district headquarters. The health facilities selected and their locations are shown in Table 1.[4] The DHO and DPHO teams agreed on the parameters for measuring performance.

[4] Refer to Annex 3, the Evaluation Framework, for the complete methodology, tools, and process of evaluation.

Table 1: Details of sampled health facilities

Health facilities	Type of facility	Distance from district HQ	Performance
PALPA DISTRICT			
Hungi	HP	**45km** (2.5hr drive in public transport – rough road)	Good
Jhadewa	HP	**45km** (2.5hr drive in public transport – rough road)	Very good
Khanichap	SHP	**15km** (2hr walk)	Satisfactory
Argeli	SHP	**50km** (1.5hr drive in public transport (blacktop road)	Satisfactory
Gandakot	HP	**70km** (4hr drive in public transport and 2hr walk – blacktop half way then rough road)	Good
Rampur	Hospital	**60km** (4hr drive in public transport – blacktop half way then rough road)	Good
RUPANDEHI DISTRICT			
Gajedi	HP	**50km** (1hr drive in public transport – blacktop road)	Need to improve
Motipur	PHCC	**40km** (45min drive in public transport – blacktop road)	Satisfactory
Majhagawa	HP	**20km** (30min drive in public transport – blacktop road)	Good
Sipawa	SHP	**30km** (45min drive in public transport – blacktop road)	Need to improve

The evaluation employed a variety of qualitative methods, reviewed monitoring reports and the scores of the ladder of change monitoring tool, and studied background documentation. The methodologies employed for collecting information included focus group discussions (FGDs); key informant interviews (KIIs); interactions with government stakeholders at central, district, and community level; the analysis of health service utilisation data gathered at the health facilities; exit interviews with clients and the physical observation of the health facilities. Care was taken to include a range of methods to collect data from a variety of stakeholders to allow for the cross-verification of findings. The evaluation did not rely on information from only one source. Table 2 presents details of the methodology applied and the respondents involved.

Table 2: Methods, tools, and respondents

Methods and tools	Respondents	Expected outcomes
KIIs	Health facility in-charges (HFI) VDC secretaries	• Functionality and effectiveness of social audit process assessed • Improvements in health service delivery captured • Perceptions collected of whether and how social auditing helped to achieve changes to health services • Initiatives and responses explored of government to address the issues and concerns of people
FGDs Review of Ladder of Change Monitoring data	Members of HFOMCs Health workers Local support committees	
FGDs	Inclusive groups of community members	
Semi-structured interviews	Social audit organisation	
	Members of district social audit committee: Local Development Officer (LDO), District Education Officer (DEO), Women Development Officer (WDO), and others	
Client exit interviews	Users of services from health facility	
Service utilisation data collection	Health facility personnel	
Stakeholder interactions	DHO, DPHO, HFI, PHCRD Director and staff	

A specific effort was made to ensure that women, and people from poor and excluded groups participated in the evaluation in order to meet the inclusion objective of social auditing. As Table 3 illustrates, this was reasonably well achieved in the interactions with community members.[5]

[5] See Annex 2 for a complete list of participants and respondents

Table 3: Distribution of respondents in terms of gender, caste, and ethnicity (BY NUMBER)

Tools	Female	Male	Total	Dalit	Janajati /other DAGs	Muslim	Brahmin, Chhetri & others	Total
Interaction between HFOMC and health workers	25	54	**79**	8	26	1	44	**79**
FGDs with local communities	64	44	**108**	10	63	0	35	**108**
Client exit interviews	18	15	**33**	7	17	0	9	**33**
Interview with HFIs	0	10	**10**	1	0	1	8	**10**
Interviews with VDC secretaries	0	9	**9**	0	3	0	6	**9**
Total	**107**	**132**	**239**	**26**	**109**	**2**	**102**	**239**
Percentage (%)	45	55	100	11	46	1	43	100

Note: DAGs = disadvantaged group people

1.4 LIMITATIONS

The timing of the process evaluation was planned to coincide with the implementation of the second round of social auditing. This allowed the evaluation team to observe social auditing in the field and reduced the demands the study placed on the health facilities and district management teams. It also allowed the evaluation to be undertaken prior to the end of NHSSP's technical assistance to the social audit pilot. However, this meant that the study was undertaken at the end of the fiscal year (FY) when health personnel were busy with year-end closing business. Secondly, the busy cultivating season reduced the number of local community people available to participate in the evaluation process.

Two limitations to the design of the study that need to be considered in interpreting the results are:

- it is very early (after only one year of implementation) to assess the effectiveness of the social auditing process; and
- although the small sample size allowed the team to collect rich data from a range of stakeholders and provided insights into the magnitude and types of change triggered by social auditing, a larger study of both pilot and non-pilot and control sites will be necessary to measure the full impact of MoHP's social auditing programme.

It should be noted that after just one year of implementation the current study does not, and did not aim to, measure impact.

2 KEY FINDINGS

2.1 STATUS OF SOCIAL AUDITING IN SAMPLED HEALTH FACILITIES

Social audit action plans had been developed at all ten sample health facilities in mass meetings held during the initial social audits in 2012. In Palpa, four of the six facilities had fully implemented their action plans while the remaining two had completed all but one point. In Rupandehi, the status of implementation was poorer, with weaker efforts made to implement plans. In Palpa, the DHO had introduced robust monitoring of the implementation process (see Box 1).

Box 1: Audit follow up by DHO Palpa

The Palpa district health officer and the social audit focal person had taken the initiative and personally visited most of the health facilities to monitor the action plans developed during social auditing. They encouraged locals to scrutinise the opening hours of the facilities, and the timeliness and regularity of health workers, urging them to file any complaints with the district health officer, who shared his personal cell phone number.

2.2 AVAILABILITY OF AND ACCESS TO HEALTH SERVICES

This evaluation found that the availability of health services had improved significantly at the sampled health facilities, as follows:

- the opening times of the health facilities had been extended by an average of at least two hours;
- the attendance of health workers had substantially improved; and
- local communities reported improvements in the behaviour of health workers in general and HFIs in particular.

Opening hours and regularity in service delivery

The social audit in 2012 revealed that nine out of the ten health facilities were not opening from 10am to 5pm as per government rules. The only facility that was opening for the required period was Jhadewa health post, Palpa. All nine facilities committed to increase their opening hours. In general, it was reported by community members, health workers and VDC secretaries that the opening hours of the sample health facilities had extended by at least two hours a day as a result of the social auditing. However, on further investigation, the HFOMC, community, VDC secretary, clients, and HFIs confirmed that while the facilities were physically open until 4 or 5pm, health services were only available up to 2pm or 3pm, except for emergency or delivery cases (see example at Box 2). Unless health workers are present and available to provide services, the benefits of an open health facility are limited.

Box 2: Conflicting claims

Staff at Gajedi (Rupandehi) health post claimed to be opening their facility from 10am to 4pm each day; but community people and the VDC secretary contradicted this saying that health services were only available up to 2pm, or at most up to 3pm, although the facility was physically open.

On this point, most health workers claimed that there is no policy on health service delivery duration and opening times for facilities below the district level. This is a policy issue that needs to be clarified.

Besides extending their opening hours, the health facilities had also increased the frequency of their opening compared to the past. The frequent closure of facilities was a common problem recorded in the 2012 social audits. It was reported that as a result of the social audits, five of the facilities had regularised their opening hours. Health workers often claimed that the reasons for closing the facilities were either to visit the DHO or DPHO, or to attend workshops or training events or outreach and immunisation clinics; but the local people were generally unaware of such reasons. Three facilities have now started notifying their communities when they are to be closed.

Nine facilities had contracted additional staff from the district to meet human resource gaps using funds from their HFOMC's budgets, or from resources provided by VDCs, in order to regularise the availability of services. Recognising the importance of the health facility having regular and full-time opening hours, a 48-year-old male Brahmin client in Gajedi VDC (Rupandehi), who was attending the health facility for treatment said:

> *"Up until last year, it was like winning a lottery to find a facility open but now it is open regularly".*

Now it is open every day, except weekends and public holidays. Another client attending Gandakot (Palpa) health facility reported that they used to check whether the health facility was open by telephone before visiting, as it was not open regularly. But they had become confident about its opening hours and now came without calling ahead beforehand.

Regular attendance of health workers

Except for Jhadeba (Palpa), where health workers attended the facility regularly before social auditing, all other nine facilities had committed to regularise attendance of their staff during the initial social audits in 2012. According to the HFOMCs, communities, VDC secretaries, health workers and clients all nine had substantially improved staff attendance. During the first round of auditing, the attendance register of most facilities indicated no absences — a finding contested by local people, as health workers were rarely available at facilities. The situation has improved significantly in most facilities in both districts. Table 4 below shows the changes in health workers' attendance, as scored in the ladder of change monitoring results.

Table 4: The attendance of health workers before and one year after social auditing (ladder of change scoring)

	Health facility	Position pre-social audit and one year afterwards	Level of attendance of staff			
			Mostly absent	Often absent	Occasionally absent	Regularly attend
Palpa district						
	Hungi HP	Baseline:			X	
		Monitoring:				X
	Jhadewa HP	Baseline:				X
		Monitoring:				X
	Khanichhap SHP	Baseline:	X			
		Monitoring:			X	
	Argeli HP	Baseline:		X		
		Monitoring:			X	
	Gandakot HP	Baseline:			X	
		Monitoring:				X

	Rampur Hospital	Baseline:		X		
		Monitoring:			X	
Rupandehi district						
	Gajedi HP	Baseline:			X	
		Monitoring:				X
	Motipur PHCC	Baseline:			X	
		Monitoring:				X
	Majhagawa HP	Baseline:			X	
		Monitoring:				X
	Sipawa SHP	Baseline:		X		
		Monitoring:			X	

Fulfilment of sanctioned positions of health workers

Fulfilling the sanctioned positions of health workers cannot generally be addressed by DPHOs and DHOs alone, as it requires regional and central decision making. However, Palpa DHO and Rupandehi DPHO are committed to filling sanctioned positions and contracted staff locally for this purpose. The district authorities said that they had brought the human resources deficit to the attention of regional and central officials. The provision of health workers made under contract is, however, an ad hoc arrangement made possible under programme budgets, but is not seen as a permanent solution. Accordingly, in some cases the HFOMC budget and VDC support were mobilised to fill staff gaps and ensure uninterrupted health service delivery. At Jhadeba and Khanichhap (Palpa), and Sipawa and Majhgawa health facilities (Rupandehi) all staff positions were filled after the first round of social auditing, in most cases through contractual arrangements.

During the mass meetings attended as part of the evaluations, local communities expressed their appreciation of the initiatives taken by the authorities to fill vacant positions; and in the case of Argeli, expressed their gratitude for the provision of uninterrupted services.

24-hour birthing centre services

The relevant health workers were found to be providing 24-hour services in four of the six birthing centres (Majhgawa and Motipur (Rupandehi), and Rampur and Jhadewa (Palpa)), whereas facilities in Hungi and Gandakot (Palpa) were providing delivery services on call during off-hours and holidays. Thus there appears to have been no change in the 24/7 availability of birthing centre services since the introduction of social auditing. It was noted that Gandakot (Palpa) health facility does not have a residential quarter and its auxiliary nurse midwife (ANM) is also on contract, so 24-hour services are available on call only. At Hungi (Palpa), the ANM lives very close to the facility and so local people reported satisfaction with the on-call service.

Awareness of health services

As reported by most focus group discussion participants at all sample facilities, the social audit process had raised the level of awareness among communities, in particular, of opening hours, antenatal care (ANC) incentives, free medicines, new services, and immunisation, nutrition, and family planning services. Most community respondents, including clients at health facilities, reported that their main sources of health information were the social audit process itself, female community health volunteers (FCHVs), health workers, and tea shop gossip.

Timely and full payment of 4ANC and Aama incentives

As confirmed by local people, clients, health facility in-charges, and HFOMCs, the distribution of the four antenatal care visits (4ANC) incentives has improved at all ten health facilities, especially since social auditing, as this issue had been discussed at mass meetings (see Box 3 and Table 5).

Box 3: Paying the antenatal care incentive

We were not serious about distributing antenatal care incentives, but social auditing has sensitised us and raised the awareness of people about it. They have started demanding so we are now regularly paying.

Health facility in charge, Majhagawa HP (Rupandehi)

Table 5: Changes in timely and full payment of 4ANC incentive

		Before social auditing	1 year after social auditing	Remarks
1	Entitlements consistently provided late	0	0	
2	Entitlements consistently provided less than full amount	2	0	Motipur and Majhagawa not providing 4ANC incentive before social audit but now providing full amount on time
3	Many reports and/or much evidence of entitlements not paid on time	1	0	
4	Many reports and/or much evidence of entitlements not being paid in full	0	0	
5	Few reports and/or little evidence of entitlements being provided late	0	0	
6	Few reports and/or little evidence of entitlements being provided at less than full amount	0	0	
7	No evidence or reports of entitlements being provided late	3	6	
8	No evidence or reports of entitlements being provided which are less than the full amount	4	6	

However, community and health workers testified that Aama delivery incentives were already being handed over to clients in full and on time at most facilities prior to social auditing. With regard to Aama payments, in Motipur PHCC and Majhagawa HP of Rupandehi District, an amount used to be deducted from the Aama incentive to cover cleaning costs. However, since this issue was raised and discussed at the social audit mass meeting, full incentives have been paid to women who have delivered at these facilities.

At Hungi of Palpa District, it was reported that, prior to social auditing, the Aama incentive had not been being paid on time, as the DHO had not been allowing facilities to give Aama payments in advance of their receiving the budgeted funds for from the district. However, this situation has been resolved by the HFOMC, which is providing an advance from its own fund, which is being reimbursed later by the DHO.

2.3 QUALITY OF SERVICES

The main elements assessed when evaluating quality of services were:

- availability of medicine and basic equipment;

- cleanliness of surroundings and examination rooms;
- adequately furnished waiting space;
- privacy during check-ups; and
- the behaviour of health workers.

Note that the quality of clinical care was not covered by the evaluation.

The findings of the ladder of change monitoring tool were reviewed and updated. In 2012, nine health facilities held out-of-stock medicine. This situation had improved at all nine facilities during the 2013 evaluation visits. The local people and clients reported that there had been a substantial improvement in the distribution of free medicines. Interaction with HFIs and HFOMCs also suggested that they have become more sensitive and serious about making timely demands for medicine supplies from their DHO/DPHO. Furthermore, the HFIs said that the DHO/DPHO had become more serious about maintaining sufficient stocks at health facilities, resulting in an improvement in the timely availability and sufficiency of medicines at facility level, and a reduction in the number of stockouts. The mass meetings had had a significant impact (Box 4).

Box 4: Impact of mass meetings	
In Mityal HP, Palpa, the HFI was committed to changing his behaviour, and to regularising the attendance of all health workers, including his own. Local people had raised these issues at the social audit mass meeting in 2012. At this meeting the HFI had realised his weakness and opted to be transferred elsewhere rather than change his behaviour and stay in the same facility.	"The credible voice of people in raising persuasive issues during the proceedings of the mass meeting organised as a concluding event of the social auditing has awakened us. We, as responsible members of the health facility management committee, were influenced to work in favour of the people." Bishnu Prasad Bhandari, HFOMC, Hungi Health Post, Palpa

Substantially improved facilities have come about at the sample health facilities since the social auditing was carried out (see Table 6):

- The first social audit in 2012 found that nine health facilities did not provide separate toilets for men and women. All nine committed to addressing this problem and by the time of the 2013 evaluation, seven had provided separate toilets.
- In 2012, only two facilities had a properly managed waiting space. By 2013, an additional three had addressed this problem.
- Prior to social auditing, privacy for check-ups was reported to be properly maintained in only three facilities; with seven committing to making improvements in their 2012 action plans. Four successfully met this commitment.
- No facilities had a good standard of cleanliness in 2012 and all ten facilities committed to improving this situation. Six were judged to have improved the situation by 2013.
- Safe drinking water, properly purified by either filter or other methods, was available only in one facility prior to social auditing. Nine of the social audit action plans committed to address this situation, but only three had implemented this.

Table 6: Comparisons of different quality of care indicators before and one year after social auditing

	No stockouts of essential medicines over past 6 months	Separate toilet for men and women	Properly managed waiting space	Privacy maintained	Good cleanliness	Available of safe drinking water	Good behaviour by health workers
Before social auditing	1	1	2	3	0	1	1
1 year after social auditing	9	7	3	3	6	3	9

There were also significant improvements in the behaviour of health workers in terms of how they interacted with patients, e.g. listening to them, showing respect, responding to queries without getting irritated and, most importantly, encouraging patients to tell them their medical history, and providing counselling whenever required. The behaviour of health workers was reported to have improved in the nine facilities where this was earlier reported to have been poor.

Gandakot HP had provided furniture and some reading material in the waiting space to help clients pass the time while waiting for services. In Rampur (Palpa), local people reported a significant change in the behaviour of the health workers. One villager said:

> *"It is hard to believe that these are the same health workers who are behaving so well with us who used to get irritated when responding to our queries."*

The issue of quality of health services, mainly the behaviour of health workers, cleanliness, and waiting space, was discussed in the mass meetings attended by the research team. The participants, while expressing satisfaction about the changes, reiterated their expectation that the changes would be sustained in the future. The mass meeting at Hungi HP (Palpa) committed to acting as a watchdog to sustain the improvements.

Box 5 shows the large positive impact of social auditing on one Palpa health post.

Box 5: Social auditing – a powerful instrument to improve health service delivery. The example of Hungi Health Post, Palpa

Hungi HP is in the north-east of Palpa District. Social auditing was conducted at this health post as one of the facilities selected for the social audit pilot in 2012. The District Social Audit Committee selected the NGO Helping Hands for Rural Development as the social audit organisation for Palpa. This NGO Hands was instrumental in gathering information and data, such as general perceptions of the health facility's service delivery mechanisms, from various sources. These were analysed and synthesised before being presented to the mass gathering at the health post — an event held to complete social auditing.

Participants were encouraged to raise issues and concerns about the facility's overall management and service delivery practices. The major issues raised in the mass meeting included: the facility's limited opening hours (from 10am to 2pm), pressure from health workers to purchase medicines from the pharmacy outside the health facility, unused HFOMC funds, lack of toilets, the unmanaged waiting space, lack of a citizen's charter, and the inadequate supply of free medicines.

Within a short period, health service delivery had improved:

- The facility is opening regularly from 10am to 5pm (an extension of three hours per day).
- The Aama and ANC incentives are distributed to recently delivered mothers at the time of discharge by advancing money to health workers from the HFOMC fund to avoid delays due to receiving this money late from the DHO.
- An updated citizen's charter has been posted in an appropriate place to safeguard people's right to information. The list of free medicines is also posted in Nepali in a visible place.
- Transparency demonstrated by posting a list of mothers who have received the Aama incentive.
- The duration of stock outs of free medicines has been reduced by demanding them from the DHO on time. The DHO has been very supportive in meeting these demands on time.
- No subsequent complaints about being forced to purchase free medicines from the nearby pharmacy were made.
- The facility is cleaner, with safe drinking water, clean toilets, and an adequately furnished comfortable waiting space.
- Most importantly, health workers are now behaving in a friendly manner with patients.

These positive changes could be attributed to:

- the proactive initiatives of the HFOMC;
- the positive attitude of health workers in accepting and committing to address issues; and
- support from other stakeholders, including the DHO, other line agencies, and local organisations.

The DHO has assisted by providing health workers on contractual agreements, producing a model citizen's charter and a list of free medicines in Nepali, and issuing a letter to the HFI instructing him/her to open the facility from 10am to 5pm. The local community forest user group offered their support in the form of 12 chairs for the waiting space, and the district water office facilitated the supply of clean water to the HP.

HFOMC member Bishnu Bhandari sees social auditing as a key factor in bringing such remarkable improvements as it brought these issues to the attention of the concerned people, who took them positively and started addressing problems. He further argued that continuous review is necessary to sustain improvements.

2.4 ACCOUNTABILITY

Provision of citizen's charter and noticeboard

Government rules say that all health facilities must post a citizen's charter at an appropriate location. The charter should list the following up-to-date details: (i) services provided and opening hours, (ii) duties of service recipients when receiving services, (iii) conditions of receiving services (whether free or fee based), (iv) all services provided, (v) the process of receiving services and (vi) the person responsible for managing grievances.

Before social auditing:

- four of the ten health facilities had posted their citizen's charter but had not updated them in line with the new requirement for more extensive information;
- two had not displayed it properly; and
- four did not have a citizen's charter;

After social auditing, it was found that eight of the ten sample health facilities had a properly displayed citizen's charter. Two facilities (Gajedi and Sipawa of Rupandehi) had failed to meet their commitments to post a charter. Two of the facilities (Motipur and Majhagawa of Rupandehi) had posted a charter but had not updated it. Although Khanichap SHP, Palpa, had updated its charter, it was not displayed in an appropriate place for people to read. Table 7 shows the situation before and after social auditing in the 10 sample facilities.

Table 7: Status of citizen's charter before and one year after social auditing

Status of citizen's charter	Before auditing	1 year after auditing
No citizen's charter	4	2
Not displayed in an accessible location	5	1
Displayed in accessible location but not updated	1	2
Updated and displayed in an accessible location	0	5
Total	**10**	**10**

Grievance redressal mechanisms

Generally, local people reported that they were apprehensive about formally raising individual grievances and preferred to raise issues informally: they were afraid to do so, and in their experience, formal complaints were not effective. This fear could be attributed to prevailing social practices influenced by the culture and characteristics of a feudal society. The social audit process in fact proved to be an effective platform on which to bring common issues to the attention of the people responsible, so that there was a better chance of them being addressed properly. Three facilities in Palpa and two in Rupandehi had installed a properly placed complaint box as a result of commitments made during social auditing.

Seven of the ten facilities were found to have a complaint or suggestion box, which is considered the formal route of lodging a grievance. However, most focus group discussion participants pointed out that complaints dropped in the box are rarely opened, and grievances are seldom addressed appropriately.

In the second round of social auditing, three facilities had committed to addressing such complaints grievances properly, and two committed to registering all grievances in a register.

Transparency

Aama incentive recipients — The evaluation found that the six out of the ten facilities with birthing centres were all correctly displaying a list of Aama incentive recipients in a visible place — a finding confirmed by HFOMCs, VDCs, and local people. Four of the six facilities were said to have begun to display the name lists as a result of concerns raised at the 2012 social audit. Table 8 shows the situation before and one year after social auditing.

Table 8: Changes between pre-social audit and one year later on health facilities displaying Aama incentive recipients in an accessible location (ladder of change scoring)

	Health facility	Position pre-social audit and after one year	Display and accessibility of list of Aama beneficiaries			
			Not displayed	Displayed but not accessible, e.g. in English or in place not easily seen	Displayed and accessible	Displayed, accessible & reportedly updated by health staff
Palpa District						
	Hungi HP	Baseline		X		
		Monitoring				X
	Jhadewa HP	Baseline	X			
		Monitoring				X
	Gandakot HP	Baseline	X			
		Monitoring				X
	Rampur Hospital	Baseline	X			
		Monitoring				X
Rupandehi District						
	Motipur PHCC	Baseline			X	
		Monitoring			X	
	Majhagawa HP	Baseline		X		
		Monitoring				X

List of free medicines — The list of free medicines available from the health facility was displayed in Nepali in the seven health facilities that had updated citizen's charters. The three facilities that had not updated their charters either did not display a list or displayed in English, which is not user-friendly. Before the 2012 social auditing, all the facilities had displayed these lists only in English. However, following the social auditing, the facilities are more aware of the need to respond to the needs of local people, and the majority have started displaying them in Nepali. This was helped in Palpa District by the DHO providing the list of free medicines (and the citizen's charter) in Nepali.

2.5 HEALTH FACILITY MANAGEMENT COMMITTEES

Inclusiveness

Of the ten sample health facilities, nine had functional health facility operation and management committees (HFOMCs) and one facility (Rampur Hospital, Palpa) had a support committee which is not a mandated facility management body. It was found that not all HFOMCs had, as required, one-third women membership nor geographical representation across all the wards of each VDC.

Only five of the nine sample HFOMCs were found to be inclusive with at least one-third women membership and one Dalit member. The four other HFOMCs had not been restructured to become more inclusive, even after they had committed to do so at the social audit mass meeting. The argument given by these HFOMCs for the lack of change was that the guidelines did not stipulate more inclusive membership. However, as some health facilities have changed their membership without being directed to do so by higher authorities, the lack of action at others suggests a lack of commitment and understanding of the importance of inclusiveness, and that the absence of policy may be being used as an excuse.

Issues related to HFOMCs were hardly discussed at the mass meetings observed, and did not appear a priority of local people.

Decisions in favour of women and poor and excluded people

It was found that most HFOMCs were not fully aware of the problems and issues of women and poor and excluded people, and had not been oriented on these issues. Most members of HFOMCs also indicated that they were not fully aware of their own roles, responsibilities, and duties. As a consequence, most HFOMCs had failed to make formal decisions in favour of women and poor and excluded people, with no such decisions seen in the minutes of any HFOMC. However, a few HFOMCs (Rampur, Gandakot, Argeli, and Hungi of Palpa) had taken affirmative decisions to allow priority health check-ups, without standing in line, for pregnant women, people with disabilities, senior citizens, patients in a serious condition, and people who had travelled long distances to attend.

Regularity of HFOMC meetings

Provisions in the HFOMC guidelines suggest that HFOMCs should meet every three months. HFOMCs, VDC secretaries, and HFIs confirmed that eight HFOMCs met quarterly and seven of them had started to regularise their meetings, as committed to during the round one social auditing. The HFOMCs at Motipur PHCC (Rupandehi) and Rampur hospital (Palpa) were yet to take this step. The Sipua SHP (Rupandehi) HFOMC had never met before the social auditing, but had started to do so regularly afterwards, as confirmed by the majority of its members.

2.6 CENTRAL AND DISTRICT-LEVEL SUPPORT FOR IMPLEMENTING SOCIAL AUDIT ACTION PLANS

The DHO and DPHO in the two districts had brought the main issues raised during social auditing to the attention of the central level PHCRD. The PHCRD also monitored the implementation of action plans, and encouraged facilities to implement activities as committed and planned. The PHCRD director and focal person visited Palpa and Rupandehi districts. They attended the application of social audit tools such as a health workers' meeting. They also provided guidance to the health facilities and DHO/DPHO to recruit health workers on contracts to fill vacant positions.

The PHCRD reported that it had done its best to address issues brought to its attention that are within its authority. However, the division is not in a position to address issues needing departmental and ministerial intervention, including, for example, the non-contractual filling of vacant health workers posts. It appeared to the evaluation team that:

- issues raised in social audits were not being brought to the attention of the department in a systematic way; and

- it was difficult for the division to act on issues raised as the department had not yet studied and internalised the results of social audits in the health facilities.

To support action plan implementation, the Palpa DHO had, in a formal letter, instructed all health facilities to open as per government regulations from 10am to 5pm. A sample citizen's charter and a list of free medicines in Nepali were also provided to all health facilities.

At the social audit mass meetings in both districts, officials had committed to filling sanctioned positions in health facilities, but not formally, as this is beyond the authority of DHOs and DPHOs. The DHO and DPHO did, however, appoint 30 health workers in Rupandehi and Palpa under contract, of which 23 were fulfilled by the DHO/DPHO and seven by HFOMCs. The VDCs also gave financial and moral support for filling vacant positions by hiring health workers under contract.

The following commitments were made during the mass meetings in both pilot districts:

- build new health facility buildings to address the increasing need for space;
- build compound walls for better safety;
- designate HFOMCs to take the lead in the third party monitoring of all health facility-related building work contracted by the government at the central level;
- build roads to increase access to health services; and
- build toilets in all health facilities.

The reasons given for not achieving all objectives included policy bottlenecks (prevailing policy does not allow DHOs and DPHOs to fulfil sanctioned positions, fund building construction etc.), the limited authority of DHOs/DPHOs, a lack of local initiative and support, and a lack of funds.

2.7 COMMUNITY MOBILISATION

At the VDC level, coordination and linkages between health facilities and VDCs and local schools was reported to have improved substantially, especially in Palpa, following the first round of social auditing. Although it should not be solely attributed to social auditing, the process had certainly contributed to strengthening such linkages. The improvements in coordination with schools and VDCs had helped improve the quality of health services and promoted the national campaign for improving health governance. The relationship between, and involvement of, VDC secretaries, who is the HFOMC chair, and a school teacher as an HFOMC member, had been instrumental in these improvements. There were many ways in which it had proved beneficial to leverage these relationships, indirectly prompted by social auditing, to fulfil the commitments made during the social audit process. Beneficial relationships had also been established with the CFUG and drinking water user committee that contributed to improvements at Hungi (Palpa).

Social auditing had encouraged local people to support health facilities with both finance and materials as people became more aware of the problems and needs to be met to improve the quality of services. The Nepali culture of making a donation, in kind or cash, to celebrate a special event, such as a birthday or the birth of a new child, provided an opportunity for individuals to support local services. Thus social auditing had mobilised communities to support health facilities and health services. Ultimately, it had enhanced social capital:

- In Hungi (Palpa) health facility, according to the district social audit focal person, local people were encouraged to contribute drinking water filters after the social audit mass meeting.
- In Argeli (Palpa) VDC, an old man celebrating his 84th birthday (a special event in Nepali culture), donated a bed to the health post — a need identified during the mass meeting. As a result of the social auditing, the HFOMC is promoting the concept of locals choosing to give religious donations to the health facility instead of to the priest.
- In Khanichap (Palpa), the VDC had adopted social auditing to monitor its general activities, although improved coordination is still needed. The VDC secretary is planning a VDC social audit for next year.

2.8 QUALITY OF SOCIAL AUDITING PROCESS AND PARTICIPATION

Social audit organisations

In terms of how well each social audit organisation facilitated the social audit process, particularly during mass meetings, most respondents, including the DHO and DPHO, health workers, and VDC secretaries, reported that the social audit organisations had performed well. The critical observation of the mass meeting by the evaluation team also found that it was well facilitated, with scope for minor improvements in synthesising the analysis. The social audit organisations were found to be successful in maintaining neutral, constructive relationships with health facilities, communities and other stakeholders. However, the HFI and HFOMC indicated that some representatives of social audit organisations lacked important knowledge of health service delivery, and were not proactive in promoting coordination with agencies conducting social audits for VDCs (Khanichap, Palpa).

Mass meeting facilitation

The evaluation team's critical reflections on the effectiveness of the six mass meetings it attended are detailed below. The team could not attend the meetings at the other four due to time limitations.

Inclusive participation — Two of the health facilities were generally good in ensuring inclusiveness at mass meetings where most stakeholders including politicians, teachers, health workers, FCHVs, women, and children, participated. The number of women participants was very high, and Dalits and other excluded group people participated. However, in Khanichap (Palpa), far-off wards were not represented, and at Majhagawa (Rupandehi), there was little representation of the general public. The mass meeting was mostly made up of health workers, HFOMC members, and FCHVs. It seems that the demands of farming prevented the general public from attending.

Opportunity to express — Most participants were given the opportunity to express their views: facilitation was good and time was allocated for interaction. Women were deliberately encouraged to express their opinions. Substantive issues were raised and contributed to developing the action plan. Health workers, HFOMCs, and facilitators were positively receptive to people's concerns and also encouraged participants to speak out.

Responses to queries — The government stakeholders were seen to be positive and receptive, and not defensive, for example, in responding to issues where it was beyond their scope to respond. In one case, the health facility referred a problem raised by local people to a higher authority.

Complementarity of issues raised and community report cards — The community report or scorecard, a tool used in social auditing, attempts to capture community perceptions of the relevance of social auditing, and the effectiveness and efficiency of health services. At the mass meetings, a comprehensive simple card was distributed randomly to small interest groups identified by the facilitators. The small group, after brief discussions, were asked to rate the health services according to various indicators, such as appropriateness of location of health facility, behaviour of health workers, quality of health care, opening hours, and attendance of health workers. The scores were compiled and then shared at plenary sessions. In most VDCs, the issues raised by the people were consistent with the results of community reports and scorecards.

2.9 STATUS OF SERVICE USE

The critical review of service utilisation status in all ten sample health facilities revealed an uneven improvement in the utilisation of services within the one-year period of 2011/12 to 2012/13 (FY 2068/69 to 2069/70). Hungi HP and Rampur Hospital had seen significant improvements in the use of some maternal, neonatal, and child health (MNCH) services; further, the take-up of 4ANC had improved in eight of the ten sites. While it is not possible to directly attribute increases in service utilisation to social auditing, the reported improvements in the availability of services and quality indicators suggest that social auditing may well have contributed to triggering increased demand. Table 9 shows changes in service utilisation for a selection of services before and after social auditing.

The data also revealed that:

- no home deliveries were conducted by skilled birth attendants (SBAs);
- safe-motherhood-related indicators are on an increasing trend in eight of the facilities; and
- the performance of the Palpa health facilities is relatively better than Rupandehi facilities.

Table 9: Progress from FY 2011/12 to 2012/13 against service utilisation targets (number)

	Positive trend		Negative trend

Health facilities	Immunisation coverage						Safe motherhood							
	BCG		DPT		Measles		No. women completing ANC visits		No. deliveries conducted by SBAs		No. institutional deliveries		No. women attending first postnatal care visit	
	Before	After	Before	After	Before	After	Before	After	Before	After	Before	After	Before	After
Khanichhap SHP	27	17	54	45	43	48	41	28	6	0	N/A	N/A	6	0
Argali HP	35	41	58	73	58	53	5	12	0	0	N/A	N/A	0	0
Hungi HP	45	55	69	91	79	91	30	64	0	0	9	9	9	9
Gandakot HP	73	82	78	85	76	78	11	18	0	0	9	9	9	9
Rampur Hospital	84	103	103	121	94	119	31	43	0	0	100	118	100	118
Jhadewa HP	46	53	73	81	74	81	38	40	0	0	5	12	5	15
Gajedi SHP	91	92	100	87	99	89	78	86	0	0	N/A	N/A	0	0
Sipawa SHP	109	98	113	107	109	104	97	100	0	0	N/A	N/A	0	0
Majhagawa HP	134	124	141	135	129	128	460	344	0	0	318	283	318	283
Motipur PHCC	130	106	147	102	147	112	79	95	0	0	157	203	157	203

2.10 DIFFERENCES IN STATUS OF HEALTH FACILITIES BEFORE AND AFTER SOCIAL AUDITING

According to reports from a range of stakeholders, social auditing appears to have contributed to bringing about changes on several dimensions of health governance as explained earlier. Table 10 summarises the before and after situation at the ten health facilities.

Table 10: Situation before and after social auditing in 10 health facilities in Rupandehi and Palpa districts

Before social auditing (First round of auditing)	One year after social auditing (Evaluation findings)
1. Sipawa SHP, Rupandehi	
• No citizen's charter • No HFOMC meeting • Irregular attendance of health workers, especially HFI • Facility only opened 11am to noon • Firewood kept in the toilet • Behaviour of health workers not good • No drinking water facility • Registration, ANC examination, and dispensary service operated from one room • Record keeping not properly managed.	• No citizen's charter • HFOMC meeting regularly • Attendance of health workers regular, as reported by HFOMC, VDC secretary, clients, and community • Facility opening 10am to 3pm, as reported by health workers, HFOMC, and VDC secretary • Toilet clean and open for use • Behaviour of health workers improved as reported by clients, local people and the HFOMC • Hand pump built • No change in infrastructure. Registration, ANC exams, and dispensary services still all provided from one room • No change in record keeping.
2. Gajedi HP, Rupandehi	
• No regular attendance of health workers • No citizen's charter • No toilet • No free medicine list • No regular meeting of HFOMC • Facility not opening on time • No waiting space for clients • Poor behaviour of health workers.	• Health workers keep more regular hours, as reported by HFOMC, VDC secretary, clients, and community members • Citizen's charter not displayed • No toilets — health workers use VDC toilet • Free medicine list not displayed • HFOMC meeting regularly • Facility opens on time with services available until 2pm • Waiting space same as before • Health worker behaviour better than before but still needs to improve, according to community members.
3. Majhagawa HP, Rupandehi	
• No suggestion box • Displayed non-updated citizen's charter in a visible place. • Non-inclusive HFOMC: FCHV was only female member • Aama incentive recipient names not displayed • ANC incentives not provided • Health facility closed at 2pm • Sanction position not fulfilled • Boundary wall not completed.	• Suggestion box placed in an accessible location • Citizen's charter not updated • HFOMC same as before • Aama incentive recipients' name list displayed in visible place • ANC incentives provided • Facility opening hours extended to 4pm, as reported by health workers, HFOMC, and the community • Sanctioned position fulfilled • Boundary wall still not completed .

Before social auditing (First round of auditing)	One year after social auditing (Evaluation findings)
4. Motipur PHCC, Rupandehi	
• No regular meeting of HFOMC • Citizen's charter updated but not displayed in visible place • ANC incentives not provided • Health workers' behaviour needed improving • Sanctioned position of medical officer vacant • Poor cleanliness of toilet and in general.	• HFOMC meeting still not regular • No reformation of HFOMC • Citizen's charter displayed in a visible location • ANC incentives provided in a timely way • Health workers' behaviour improved • Medical officer now on duty • Cleanliness (of the toilet and in general) improved.
5. Khanichhap SHP, Palpa	
• No citizen's charter • No HFOMC meeting • Irregular attendance of health workers • Only opened 11am to noon • No toilet • Health workers' behaviour not good • No drinking water • No health facility signboard.	• Citizen's charter updated but not displayed in accessible place • HFOMC meeting regularly • Health workers attend facility more regularly, as reported by HFOMC, health workers, VDC sec., clients, and community • Facility opens on time and services available until 3pm, as confirmed by HFOMC, health workers, VDC secretary, clients, and community • Health workers' behaviour improved, as reported by clients and community • Safe drinking water now available • Separate toilets for men and women • Signboard in place • List of free medicines (in English and Nepali) prepared but not displayed in accessible place.
6. Argali HP, Palpa	
• Facility only opened from 10am to 2.30pm • No citizen's charter • Irregular attendance of health workers • Behaviour of health workers was poor • List of free medicines only in English • No toilet facilities • Physical environment poor (sanitation, waiting space, privacy of clients).	• Facility open from 10am to 5pm as reported by health workers and HFOMC • Updated citizen's charter in a visible place • Health workers attend facility more regularly, as reported by HFOMC, clients, health workers, VDC secretary, and community • Improved behaviour of health workers, as confirmed by community • Separate toilets for men and women • List of free medicines displayed in English and Nepali in a visible place • Physical environment improved (sanitation, waiting space, privacy of clients) • Reduced stockouts of free medicines.

Before social auditing (First round of auditing)	One year after social auditing (Evaluation findings)
7. Hungi HP, Palpa	
• Facility only opened 10am to 2pm • No citizen's charter • No health facility signboard • No list of HFOMC members displayed • Irregular attendance of health workers • Poor behaviour of health workers • List of free medicines only in English • Poor physical environment (sanitation, waiting space, privacy of clients) • HFOMC met irregularly.	• Facility opens 10am to 5pm, as reported by health workers, HFOMC, and community • Updated citizen's charter in a visible place • Health facility signboard in place • List of HFOMC members in place • Health workers attend facility more regularly, as reported by health workers, clients, community, and HFOMC • Behaviour of health workers improved, as reported by HFOMC, health workers, clients, and community • Physical environment improved (sanitation, waiting space, privacy of clients) • Separate toilets for men and women available • HFOMC meeting regularly.
8. Jhadewa HP, Palpa	
• List of Aama beneficiaries not displayed • List of free medicines only in English • Citizen's charter not updated • HFOMC meeting irregularly • Complaint box not in place.	• List of Aama beneficiaries displayed regularly • List of free medicines (in English and Nepali) displayed in visible place • Updated citizen's charter in place • HFOMC meeting regularly • Complaint box in place.
9. Rampur Hospital, Palpa	
• List of Aama beneficiaries not displayed • List of free medicines only in English • Citizen's charter not updated • Health workers post not filled • Poor health workers' behaviour • List of Aama beneficiaries not displayed • List of free medicines only in English.	• List of Aama beneficiaries displayed regularly • List of free medicines (in both English and Nepali) displayed in visible place • Updated citizen's charter in an accessible location • Two medical officer posts filled but positions of four staff nurses, one medical officer and one lab technician still vacant • Health workers' behaviour improved, as confirmed by clients and community • List of Aama beneficiaries displayed regularly.
10. Gandakot HP, Palpa	
• Citizen's charter not updated • List of Aama beneficiaries not displayed • Complaint box not in place • List of HFOMC members not displayed.	• Updated citizen's charter in a visible place • List of Aama beneficiaries displayed regularly • Complaint box in place • List of HFOMC members displayed • Reduced stockouts of medicines • Health workers attend facility more regularly, as confirmed by HFOMC, health workers, clients, and community.

2.11 PERCEPTIONS OF SOCIAL AUDITING

Community people

The evaluation team found that local people perceived social auditing as a good thing that has helped improve the quality of health services. They believe it has helped to:

- establish people's awareness of their rights to health services;
- hold health workers more accountable to local people; and
- encourage HFOMCs to improve the responsiveness of health services to local people's needs.

Communities' awareness of health service provision has also been raised as they are now more aware of the types of services provided by health facilities and their opening times. One old woman from Gandakot VDC expressed her satisfaction with the health services provided:

> *"As the quality of service has improved the health facility is now like our mother."*

People are now better empowered to express their feelings and views in front of government workers. It has promoted self-evaluation by both communities and health workers, and has fostered a sense of community ownership of their health facilities. Most people called for social auditing to be carried out annually as it had given such good results.

In general, the communities reported that they were satisfied with the improvement in health facility services brought about by social auditing. It is difficult, however, to define satisfaction as this is a subjective and relative term.

Local people reported that social auditing had served as a platform to bring community issues to the attention of service providers. Previously, service providers were not aware of people's concerns. The local people reported that social auditing had contributed to improving service delivery, especially in the behaviour of health workers, health facility opening times, the distribution of free medicines, and the regularity of health workers' attendance.

Health workers

More than three-quarters of the health workers interviewed appreciated the social auditing process. They felt, in particular, that it provided a congenial atmosphere in which to express ideas rather than being a process intended to humiliate service providers, which they felt was the case in some other kinds of public hearings. They felt that social auditing had provided an opportunity to assess their personal behaviour and working style and acts as a mirror for health workers to reflect back on and improve the quality of services. They also believed that social auditing had encouraged DHOs and DPHOs to focus on maintaining a regular supply of medicines and supplies.

Health facility management committees

One HFOMC member in Khanichap, Palpa, said:

> *"We were not aware of the required opening hours of health facilities before the social auditing last year. But we found out and were empowered to pressurise our health workers to open the facility as per the provisions."*

Social auditing has also pressurised HFOMC members to become more proactive as they know they will be scrutinised at the next social audit. Several examples of HFOMCs following up on actions identified in social audit action plans were found, including around health worker attendance.

DHOs and DPHOs

From the perspective of the DHOs and DPHOs, social auditing is perceived as an opportunity to regulate health governance by engaging people against the context of a continuing lack of elected local government representatives (since 2002). They reported that social auditing was an effective mechanism for democratically regulating health facilities and health workers, as they were forced to listen to people's voices in public. Specifically, the process helped health workers to internalise their own duties and responsibilities. The district health officer in Palpa said,

> *"Now it is difficult for health workers to ignore limitations and weaknesses of health service delivery mechanisms brought to their attention. After social auditing most health facilities are showing initial signs of improvement as the health workers are becoming more accountable towards local people's concerns."*

Local government

The evaluation team feels that the involvement of district development committees (DDCs) in the social auditing of the health sector has encouraged local bodies (the DDC and VDCs) to promote this process in other sectors. In Palpa, social auditing had been replicated in the agriculture and veterinary sectors following the health sector initiative. The evaluation team believes that serious attempts are needed to harmonise sector-focused social audits towards comprehensive social audits at the district level. The lessons learned gathered from the health sector will be helpful to achieve this.

The local development officer (LDO) in Palpa felt that social audits conducted at the VDC level are often just carried out as a ritual; but with greater experience local people will become more proactive in scrutinising services and results. DDC representatives felt that a significant achievement of the social auditing was to regularise the opening hours of health facilities as per government rules.

The secretary of Gajedi VDC said:

> *"It is not only to raise financial issues; social auditing also brings social, financial, and managerial issues to the attention of service providers, and helps improve the quality of services at the health facility."*

The secretary of Sipawa VDC said:

> *"Everyone has their own limitations and weakness, social auditing helps internalise all limitations and weakness and this is an opportunity to improve."*

3 COST OF SOCIAL AUDIT PILOTING

Cost is a crucial factor in the proposed carrying out of social auditing in a large number of health facilities around the country. A quick review of the per unit cost incurred for social auditing at the NHSSP pilot sites shows it to be NPR 31,600 (Nepalese rupees) per facility. This is calculated on the basis of expenses incurred by NHSSP through social audit organisations in the two districts, amounting to the entire cost of social audit facilitation by the social audit organisations at district and community levels. Table 11 gives a breakdown of the costs.

Table 11: Implementation costs for piloting social auditing in 21 health facilities in Rupandehi and Palpa districts

District	MoHP support	NHSSP support (NPR)	Total costs (NPR)	No. health facilities	Unit costs (per health facility, NPR)
Palpa	0	413,500	413,500	13	31,808
Rupandehi	0	251,500	251,500	8	31,438
Average cost (per health facility)					**31,623**

The above costs only include the direct costs and do not include the technical support provided during the pilot programme, including:

- consultancy costs incurred in the initial review of social audit practices in Nepal;
- the mobilisation of central stakeholders at meetings and workshops;
- the development of the Comprehensive Social Audit Guidelines;
- the initial training of the DHO/DPHO teams and the NGO social auditor (district team, including central representatives) from pilot districts;
- the junior consultant, who supported and monitored the NGO social audit organisation in pilot districts;
- observation and monitoring by PHCRD and NHSSP staff;
- monitoring by the external junior consultant (after eight to nine months of social audit piloting); and
- consultants for evaluating the pilot (one senior and two junior consultants).

4 COMPARISON OF MONITORING DATA BEFORE AND AFTER AUDITING

A ladder of change monitoring tool was designed by NHSSP to monitor changes in availability, access, quality, and accountability of health service provision at the health facilities over the course of the social auditing. The tool was 'populated' prior to social auditing and between eight and ten months after the first social audit action plans were developed. Data was provided by the HFOMCs and verified by the evaluation team through interactions with local people.

The ladder of change monitoring data from the 29 sites were analysed to provide context to the findings from the in-depth investigations at the ten sites. The ladder of change format (see Annex 1) is structured around the scoring indicators to measure the availability, access, quality, and accountability of service provisions and services at health facilities. Data from the ladder of change tool was entered in an ordinal rating scale indicating 1 as the minimum and 4 as the maximum value for all variables. Being a pre-test to post-test design, analysis was performed using the Wilcoxon signed-rank sum test at $p<0.05$ significance level for testing the hypothesis that no change occurred as a result of the intervention. Tables 12, 13 and 14 show the progress made against each indicator.

Key:
Changes that are significant *(p*<0.05)
Changes that are close to significant *(p*<0.1)
Changes that are not significant *(p*>0.1)

Table 12: Availability and access to health services at 29 sample health facilities before and after social auditing

	Pre-test (mean rank)	Post-test (mean rank)	Change (%)	*P*
Filled sanctioned posts	3.07	3.19	3.91	0.558
Attendance of staff	2.59	3.52	35.91	<0.001
Opening hours	2.15	3.04	41.40	<0.001
Timely payment of Aama incentives	3.58	3.92	9.50	0.083
Full payment of Aama incentives	3.50	3.92	12.00	0.180
Timely payment of ANC incentives	3.00	3.92	30.67	0.066
Full payment of ANC incentives	3.62	4.00	10.50	0.317

For the 29 pilot sites in Rupandehi and Palpa, the ladder of change monitoring data suggests significant changes in many indicators related to the non-clinical aspects of quality of care, and accountability. Availability and access to services, in terms of opening hours and attendance of staff, also appear to have improved. Reports from the ten evaluation sites line up with these aggregate findings and help explain why some indicators have been more receptive to change than others. For example, there has been a lack of progress in filling sanctioned posts and increasing the inclusiveness of HFOMCs, but health facilities have seen improvements in staff attendance and the behaviour of health workers towards clients.

Table 13: The situation of governance and accountability at 29 sample health facilities before and after social auditing

	Pre-test (mean rank)	Post-test (mean rank)	Change (%)	*P*
Citizen's charter displayed	1.78	2.85	60.11	<0.001
Free medicine list displayed	1.85	2.37	28.11	0.009
Aama beneficiaries list displayed	1.42	3.83	169.72	0.004
4ANC beneficiaries list displayed	1.27	3.42	169.29	0.006
HFOMC meeting regularity	2.59	3.33	28.57	<0.001
Resource generation for health facility	2.11	2.59	22.75	<0.001
Initiatives taken to improve service delivery	2.15	2.48	15.35	0.013
Inclusiveness of HFOMC	3.33	3.41	2.40	0.414
Responsiveness of HFOMC to the needs of women, the poor, and excluded groups	1.96	2.33	18.88	0.004

Table 14: Quality of care at 29 sample health facilities before and after social auditing

	Pre-test (mean rank)	Post-test (mean rank)	Change (%)	*P*
Availability of free medicine	2.89	3.48	20.42	0.002
Cleanliness	2.04	2.81	37.75	<0.001
Privacy	2.69	3.30	22.68	0.003
Availability of drinking water	1.88	2.81	49.47	<0.001
Availability of male and female toilets	1.81	2.56	41.44	<0.001
Adequate waiting space	2.23	2.70	21.08	0.003
Communication with clients	2.33	3.19	36.91	<0.001
Respect to clients	2.30	3.33	44.78	<0.001

According to this analysis the largest changes (improvements) in the three areas were in opening hours (see Table 12), Aama and 4ANC beneficiaries lists displayed (Table 13) and the availability of drinking water (Table 14).

Notable and important changes have taken place. However, given the design of the external monitoring and evaluation process and the non-inclusion of control sites, it is not possible to claim that improvements are a result of social auditing. However, findings from the ten evaluation sites which triangulate responses from HFOMCs, clients, and the local people (communities) suggest that social auditing has contributed to the reported improvements.

5 LESSONS LEARNED

Social auditing, although not a panacea, can make major contributions towards improving the governance of health service delivery and use.

The following lessons can be drawn from this evaluation:

1. **Health worker behaviour changes** — The significant behavioural change among health workers that has occurred as a result of the social auditing indicates an improvement in the accountability of health workers to the communities they serve. This is a major achievement and asserts that it is possible to increase health workers' sense of accountability to local communities. In contrast, it has not been possible to make progress with some other commitments made, in particular those which depend on factors such as policy and guidelines change, budget increases, and the authority of the centre.
2. **Managing communities' expectations** — Social auditing has significantly raised the expectations of local people, as witnessed by demands for ambulances, X-ray machines, large buildings, specialist medical doctors, and sophisticated equipment in the health facilities. While encouraging people and providing them with the space to make demands is an inherent aspect of social auditing, there is a risk that if such expectations are not managed and tempered early on, communities will feel frustrated and the sustainability and effectiveness of social auditing could be affected. It is therefore important that district health officials attend mass meetings and other social audit events to help educate people about each health facility's scope of work and limitations, so that unrealistic expectations will not lead to frustrations later on. Social audit organisations also need to become more competent in mediating demands and reasoning why different levels of service are available at different types of facility.
3. **Resources for social auditing** — The social audit process should be led by a team at the district level, and needs to be provided with central-level support, adequate budget, the timely release of funds, and proper and timely guidance from the regional level if it is to be implemented to plan.
4. **Appointment period of social audit organisation** — Changing the social audit organisation every year has impacted negatively on the quality of social auditing as it undermines the building of rapport and relationships with all stakeholders, which is a crucial feature of social auditing.
5. **Health system functioning** — Most management practices in the health system were found to be largely dependent on individuals and not guided by the system. The proactive involvement of the district health officer in Palpa has shown good results that could be replicated elsewhere. The lack of institutional memory in the system resulting from various factors, including the lack of handover when a health worker is transferred, disrupts implementation at all levels. This is an important issue that limits health service delivery. All these factors affect both the social audit process and the implementation of the health facility-wise action plans prepared at the mass meetings.
6. **Subjective indicators** — Some of the indicators used to assess the effectiveness of social auditing are subjective, such as community perceptions of a health facility's quality of service provision and related levels of satisfaction.

7. **Enabling role of DHOs and DPHOs** — DHOs and DPHOs should take the lead in addressing small demands raised at social audits, such as the installation of a water filter and minor repairs to facilities, by mobilising local resources and influencing HFOMCs. Despite the limitations of district health authorities in fulfilling community demands, as shown by Palpa DHO, they can play a key enabling role.
8. **Cross-sectoral social auditing** — DHOs and DPHOs have a vital role to play in enabling district-level social audit committees to function. The expectations from this committee should be limited to district-level involvement in the process. However, there are ample opportunities to synergise social auditing across sectors with greater efforts needed from district-level social audit to achieve this.
9. **The hiring of social audit organisations** — There is an inherent conflict of interest in having the NGO social audit organisation hired by DHOs and DPHOs. This potentially reduces the impartiality of the demands and advocacy by the NGO towards the DHOs/DPHOs.
10. **Feedback to the central level** — Local communities and district social audit organisations are not well placed to transfer demands from the local level to the centre. There are presently no mechanisms for demands to be communicated up through the levels of government. Structures, channels and mechanisms need to be created above the district level for advocacy on important issues raised by social audits.
11. **Ripple effect** — Examples from this evaluation show that social auditing can have a ripple effect, improving governance and service delivery outside the facilities where they are implemented (see Box 6). This is important as the government plans to launch social auditing in further districts across Nepal.

Box 6: Nayar SHP commits to change after seeing improvements elsewhere

At Nayar SHP in Palpa the information related to health services was displayed in a comfortable waiting space, two clean filters provided safe drinking water for patients, there was a beautiful flower garden by the waiting space, and clean separate toilets for men and women with sufficient water. The patients expressed satisfaction about the services received from the health facility.

However, the situation in the facility was not like this a few months back. It was Salik Ram Pahari, the in-charge of the health facility who was ignited with the news of social audit being conducted in other neighbouring health facilities and triggered the initiative to improve health service delivery at his facility. He said "I met the other in-charges at a meeting and came to know about the changes brought in their facilities by addressing the social audit findings. I understood that satisfaction of clients is a key factor. Then I visited all nine wards of the VDC to explore the needs of clients. The people suggested to provide a toilet, clean drinking water and a comfortable waiting space and most importantly that the behaviour of the health workers should be friendly to clients. Though I did not know about the technicalities of social auditing, I started to address the issues raised by local people. I find people are satisfied with the changes we have made."

6 CONCLUSIONS AND RECOMMENDATIONS

6.1 CONCLUSIONS

The evaluation of the social audit pilot programme in Palpa and Rupandehi districts indicates good initial results and some positive change. This appears to be the result of individual efforts from a range of stakeholders including at the central level, at DHOs/DPHOs, health workers, local government representatives, NGO facilitating agencies, and community people. It is crucial to sustain the changes instigated by social auditing, which will only be possible if it is established as a culture at community level and institutionalised at district and central level through government mechanisms. The government should continue prioritising social auditing for some time as it takes time to institutionalise the process. Furthermore, it is essential to take into account the relatively large efforts and investments needed to achieve the initial successes and build on them in future rounds of social auditing. Further analysis of the costs of social auditing and outputs in both with and without technical assistance, will help to assess the cost-effectiveness of the model.

6.2 RECOMMENDATIONS

1. Social audit organisations should be involved for a longer period of time to allow them to facilitate the process of bringing important issues to the attention of district-level authorities, and subsequently to the central level.
2. The district-level workshops that are held to disseminate facility-level social audit results should be strengthened to ensure they are organised properly. Alongside this the mass media should be encouraged to bring issues to the attention of all stakeholders.
3. A small flexible fund at the DHO/DPHO level should be established to address health facilities' needs to improve service delivery, as committed to in social audit action plans.
4. The mandated opening times of health facilities below district level should be widely disseminated through the national media. Attendance registers of health workers need to be made mandatory, and open to public scrutiny. Discrepancies should be reported to the district level. Mobile health (M-health) technologies could be introduced to connect patients with health workers via mobile communication devices to extend the reach of health services.
5. HFOMCs should be strengthened and made more accountable by providing them with additional training and mentoring and revising the HFOMC guidelines to make committees more inclusive in terms of gender, social equity, and geographical coverage.
6. The involvement of local line agency representatives in VDC-level mass meetings should be encouraged to promote better coordination and linkages with other sectors.
7. Since MoHP is scaling up social auditing in parallel with the pilot programme, a separate comprehensive study needs commissioning to measure the results from social auditing at health facilities in pilot and non-pilot sites across a range of districts. This study could assess the variations in cost, process, time, and results, including the spill-over effect generated by social auditing. Such a study should be carried out prior to the government rolling social audit out more widely.

ANNEX 1: LADDER OF CHANGE MONITORING TOOL

Name of health facility
Ladder of change monitoring tool for social auditing
Scores for retrospective baseline of the situation immediately prior to the social audit process

A. Scores for access to services (based on community perceptions and evidence from facilities)

Level	1	2	3	4
a. Availability and attendance of health staff	**Poor**	**Low**	**Medium**	**High**
Extent to which health staff posts are filled	Most health staff posts are not filled.	Some health staff posts are not filled	Most health staff posts are filled	All health staff posts are filled
Level of attendance of staff	Staff are mostly absent	Staff are often absent	Staff are occasionally absent	Staff regularly attend their posts
b. Opening hours				
Extent to which the facility is open during official opening hours (explore official opening hours)	Open only irregularly.	Generally opens fewer than the mandated hours per day	Generally open during official hours	Consistently open during official hours
c. Timely and appropriate provision of Aama incentive				
Extent to which entitlements are provided on time	Entitlements consistently provided late	Many reports and/or much evidence of entitlements not being paid on time	Few reports and/or little evidence of entitlements being provided late	No evidence or reports of entitlements being provided late
Extent to which entitlements are provided in full	Payments of less than the full amount consistently provided	Many reports and/or much evidence of entitlements not being paid in full	Few reports and/or little evidence of entitlements not being paid in full	No evidence or reports of entitlements not being paid in full
d. Timely and appropriate provision of 4ANC incentive				
Extent to which entitlements are provided on time	Entitlements consistently provided late	Many reports and/or much evidence of entitlements not being paid on time	Few reports and/or little evidence of entitlements being provided late	No evidence or reports of entitlements being provided late
Extent to which entitlements are provided in full	Payments of less than the full amount consistently provided	Many reports and/or much evidence of entitlements not being paid in full	Few reports and/or little evidence of entitlements not being paid in full	No evidence or reports of entitlements not being paid in full

B Scores for accountability and management (based on community perceptions and evidence from facilities)

Level	1	2	3	4
a. Provision of information	**Absent**	**Limited**	**Good**	**Comprehensive**
Extent to which health facility displays accurate info. to public				
(i) Citizen's Charter	Not displayed	Displayed but not accessible, e.g. in English or in a place which cannot easily be seen	Displayed and accessible	Displayed, accessible, and reported to be updated by health staff
(ii) List of free medicines	Not displayed	Displayed but not accessible, e.g. in English or in a place which cannot easily be seen	Displayed and accessible	Displayed, accessible, and reported to be updated by health staff
(iii) List of Aama beneficiaries	Not displayed	Displayed but not accessible, e.g. in English or in a place which cannot easily be seen	Displayed and accessible	Displayed, accessible, and reported to be updated by health staff
(iv) List of 4ANC beneficiaries	Not displayed	Displayed but not accessible, e.g. in English or place not easily seen	Displayed and accessible	Displayed, accessible, and reported to be updated by health staff
b. Functioning of HFOMC	**Poor**	**Moderate**	**Well**	**Exceptional**
Extent to which the health facility MC is functioning				
(a) Meeting regularly	Meetings reported never to be held	Meetings reported to be held rarely	Meetings reported to be held occasionally	Meetings reported to be held regularly
(b) Raising resources to improve health facility	No evidence or reports of local fundraising	Some evidence or reports of limited efforts to raise funds locally	Some evidence or reports of regular efforts to raise local funds	Some evidence or reports of concerted and exceptional efforts to raise funds
(c) Making efforts to improve service delivery	No effort made to improve service delivery	Minor efforts made to improve service delivery	Consistent efforts made to improve service delivery	Exceptional efforts made to improve service delivery
c. Inclusiveness of HFOMC	**Not Inclusive**	**Working towards Inclusiveness**	**Close to Inclusive**	**Fully Inclusive**
Extent to which HFOMC membership is inclusive of excluded groups	Membership is not inclusive	Membership is partly inclusive	Membership is close to inclusive	Membership is fully inclusive
d. Responsiveness of HFOMC	**Not responsive**	**Working towards responsiveness**	**Some responsiveness**	**Actively responsive**
Extent to which HFOMC is responsive to the needs of women, the poor, and excluded groups	Shows no awareness of the specific barriers faced by women, the poor, and excluded groups in accessing services	The HFOMC is aware of the barriers faced by some excluded groups in the catchment area but has not initiated any response to increase their access to services	HFOMC has initiated actions to increase access to services of women, the poor, and excluded groups	HFOMC is actively engaging with women, the poor, and excluded groups to understand the barriers they face in using services, and is actively seeking to reduce them

C. Scores for quality of care (based on community perceptions and evidence from facilities)

Level	1	②	3	4
a. Availability of medicines	**Poor**	**Low**	**Medium**	**High**
Extent to which the facility suffers stockouts of essential medicines	Extended periods of stockouts of essential medicines over the past six months	Some periods of stockout of essential medicines over the past six months	Occasional stockouts of essential medicines	No stockout of essential medicines
b. Provision of free medicines	**Poor**	**Low**	**Medium**	**High**
Extent to which the facility provides free medicines	Limited provision of free medicines reported over the past six months	Reports of free medicines regularly not provided free of cost over the past six months	Reports of occasional non-provision of free medicines at no cost	Reports of regular provision of free medicines to patients
c. The physical environment	**Poor**	**Low**	**Medium**	**High**
Score the facility environment:				
(a) Overall cleanliness	Poor			
(b) Privacy provided to patients		Low		
(c) Availability of drinking water	Poor			
(d) Availability of male and female toilet	Poor			
(e) Waiting space	Poor			
d. Health provider communication with clients	**Absent**	**Poor**	**Satisfactory**	**Excellent**
Way in which health providers communicate with clients, and respond to their concerns	Almost no information is provided to clients and encouragement if given to clients to express their concern	Providers offer little information to user on issues such as health prevention, cause of illness, and appropriate treatment practices. Limited two-way communication	Provider offers basic information to users at the point of service delivery. Some two-way communication	Providers communicate well with users, encouraging them to ask questions, and motivating them to change unhealthy behaviours
e. Health provider behaviour towards clients	**Rude**	**Poor**	**Satisfactory**	**Good**
Extent to which health providers treat people with respect and fairness	Providers are reported to be rude. This may include discriminatory behaviour towards some sections of the community	Some staff are reported to treat some people with disrespect or unfairly	Staff are generally reported to treat people fairly and respectfully	All staff are reported to treat people with respect and fairness

ANNEX 2: LIST OF RESPONDENTS

SN	Name of respondent	Designation and Address
Central level		
1	Dr Anand Shrestha	Director, PHCRD, Teku
2	Mr Rup Narayan Khatiwoda	Section Officer and Social Audit Focal Person, PHCRD Teku
District-level stakeholders, Palpa		
3	Mr Jhalak Sharma Paudel	DHO, Palpa
4	Mr Min Bahadur Bista	Social Audit Focal Person, DHO Palpa
5	Mrs Sangeeta Regmi	Social Audit Coordinator (Auditor), Helping Hands for Rural Development, Palpa
6	Mrs Bimala Gyawali	Social Audit Facilitator, Helping Hands for Rural Development, Palpa
7	Mrs Shanti Nepal	Chairperson, Helping Hands for Rural Development, Palpa
8	Mr Dirgha Bahadur Pokharel	LDO, Palpa
9	Mrs Tulasa Aryal	WDO, Palpa
10	Mr Prem Nath Paudel	DEO, Palpa
Khanichhap		
11	Mr Keshab Darnal	HFI, Khanichhap SHP, Palpa
12	Mr Kul Prasad Aryal	VDC Secretary, Khanichhap VDC Palpa
13	Mr Him Raj Neupane	VDC Assistant, Khanichhap VDC, Palpa
14	Mrs Devi Gaha	HFOMC member, Khanichhap SHP, Palpa
15	Mr Puran Bahadur Darlami	HFOMC member, Khanichhap SHP, Palpa
16	Mrs Durga Adhikari	Social Mobiliser, Khanichhap VDC, Palpa
17	Mrs Sukmaya B.K.	HFOMC member, Khanichhap SHP, Palpa
18	Mrs Rambha Suryabansi	HFOMC member, Khanichhap SHP, Palpa
19	Mr Chandra Bahadur Saru	HFOMC member, Khanichhap SHP, Palpa
20	Mr Bhoj Bahadur Magar	HFOMC member, Khanichhap SHP, Palpa
21	Mr Khadka Bahadur Suryabansi	HFOMC member, Khanichhap SHP, Palpa
Argali		
22	Mr Binod Singh	HFI, Argali HP, Palpa
23	Mr Tulsiram Pandey	VDC Secretary, Argali VDC, Palpa
24	Mr Durga Dutta Regmi	HFOMC member, Argali HP, Palpa
25	Mrs Saraswati Gaire	HFOMC member, Argali HP, Palpa
26	Mr Narayan Nepal	HFOMC member, Argali HP, Palpa
27	Mrs Meena Sahi	HFOMC member, Argali HP, Palpa
28	Mrs Birmaya Thapa	HFOMC member, Argali HP, Palpa
29	Mrs Draupada Bastola	ANM, Argali HP, Palpa
30	Mrs Menukala Gyawali	Village Health Worker (VHW), Argali HP, Palpa
Hungi		
31	Mr Giriraj Bhandari	HFI, Hungi HP, Palpa
32	Mr Ram Krishna Subedi	VDC Secretary, Hungi VDC, Palpa
33	Mr Bisnu Prasad Bhandari	HFOMC member, Hungi HP, Palpa
34	Mr Damodar Dhakal	HFOMC member, Hungi HP, Palpa
35	Mrs Durga Pachhai	ANM, Hungi HP, Palpa
36	Mrs Kalpana Pokharel	ANM, Hungi HP, Palpa
37	Mrs Shiv Kumari Pachhai	VHW, Hungi HP, Palpa
38	Mrs Bisnu Prasad Hamal	Office Assistant, Hungi HP, Palpa
39	Mr Madhav Gyawali	HFI, Jhadewa HP, Palpa

Jhadewa		
40	Mr Khim Bahadur Rana	VDC Secretary, Jhadewa VDC, Palpa
41	Mr Tara KC	HFOMC member, Jhadewa HP, Palpa
42	Mr Phaneswar Pokharel	HFOMC member, Jhadewa HP, Palpa
43	Mr Tula Bahadur Saru	HFOMC member, Jhadewa HP, Palpa
44	Mrs Til Kumari GC	HFOMC member, Jhadewa HP, Palpa
45	Mrs Juna Hitaru	HFOMC member, Jhadewa HP, Palpa
46	Mrs Sita Sunar	HFOMC member, Jhadewa HP, Palpa
47	Mr Bir Bahadur Rana	HFOMC member, Jhadewa HP, Palpa
48	Mr Tuk Bahadur AC	Social Worker, Jhadewa VDC, Palpa
49	Mr Tanknath Panthi	Ward Citizen Forum Coordinator, ward 9, Jhadewa Palpa
50	Mr Gajendra Panthi	Joint Secretary, Journalist Federation District Committee, Palpa
51	Mrs Kiran KC	Senior ANM, Jhadewa HP, Palpa
52	Mr Keshab Bahadur GC	Senior Auxiliary Health Worker (AHW), Jhadewa HP, Palpa
53	Mrs Sushmita Shrestha	ANM, Jhadewa HP, Palpa
54	Mr Basant Raj Shrestha	Office Assistant, Jhadewa HP, Palpa
55	Mr Hemraj Budhathoki	Office Assistant, Jhadewa HP, Palpa
Gandakot		
56	Mr Majibur Rahaman Sekh	HFI, Gandakot HP, Palpa
57	Mr Raj Kumar Pariyar	HFOMC member, Gandakot HP, Palpa
58	Mrs Maya Thapa	HFOMC member, Gandakot HP, Palpa
59	Mr Tank Nath Pokharel	HFOMC member, Gandakot HP, Palpa
Rampur		
60	Dr Santosh Pokharel	HFI, Rampur Hospital, Palpa
61	Mr Tirtha Dhugana	AHW, Rampur Hospital, Palpa
62	Mr Dirgheswar Shrestha	HFOMC member, Rampur Hospital, Palpa
63	Mrs Dhana Shrestha	ANM, Rampur Hospital, Palpa
64	Mr Dhan Bahadur Saru	AHW, Rampur Hospital, Palpa
65	Mr Raju Prasad Shrestha	HFOMC member, Rampur Hospital, Palpa
66	Mrs Laxmi Devi Pokharel	ANM, Rampur Hospital, Palpa
67	Mrs Narayani Bhujel	Office Assistant, Rampur Hospital, Palpa
68	Mr Bhabeswar Pandey	Office Assistant, Rampur Hospital, Palpa
69	Mrs Durga Devi Pokharel	HFOMC member, Rampur Hospital, Palpa
70		VDC Secretary, Rampur VDC, Palpa
District Level Stakeholders, Rupandehi		
71	Mr Dinesh Paudel	Executive Director, Namuna, Rupandehi
72	Mrs Gyanu Paudel	President, Namuna, Rupandehi
73	Mr Maheswar Shrestha	District Public Health Officer, Rupandehi
74	Mr Thaneswar Kharel	Social Audit Focal Person, DPHO, Rupandehi
Majhagawa		
75	Mr Keshab Giri	HFI, Majhagawa HP, Rupandehi
76	Ms Bhagawati Rawat	Staff Nurse, Majhagawa HP, Rupandehi
77	Mr Bishownath Chaudhary	AHW, Majhagawa HP, Rupandehi
78	Mr Alim Pathan	HFOMC member, Majhagawa HP, Rupandehi
79	Mr Chingud Dharikar	HFOMC member, Majhagawa HP, Rupandehi
Gajedi		
80	Mr. Surendra Raj Bastola	HFI, Gajedi HP, Rupandehi
81	Mr Chandra Kumar Chaudhary	VDC Secretary, Gajedi VDC, Rupandehi

82	Mr Om Bahadur Thapa	HFOMC member, Gajedi HP, Rupandehi
83	Mr Tikaram Dhakal	HFOMC member, Gajedi HP, Rupandehi
84	Mr Bhuwan Dhakal	HFOMC member, Gajedi HP, Rupandehi
Motipur		
85	Dr Arun Gyawali	HFI, Motipur PHCC, Rupandehi
86	Mrs Uma Thapa	HA, Motipur PHCC, Rupandehi
87	Mrs Sita Panthi Paudel	Staff Nurse, Motipur PHCC, Rupandehi
88	Mr Prem Narayan Subedi	AHW, Motipur PHCC, Rupandehi
89	Mr Rajesh Gauli	AHW, Motipur PHCC, Rupandehi
90	Mr Salikram Pandey	VDC Secretary, Motipur VDC, Rupandehi
Sipawa		
91	Mr Bisnu Nepal	HFI, Sipawa SHP, Rupandehi
92	Mr Jagadish Prasad Barma	VDC Secretary, Sipawa VDC, Rupandehi
93	Mr Tribhuwan Sahani	AHW, Sipawa SHP, Rupandehi
94	Mrs Pushpa Shreevastav	ANM, Sipawa SHP, Rupandehi
95	Mrs Kikhaladevi Nau	HFOMC member, Sipawa SHP, Rupandehi

Note: The names of respondents from the client exit interviews (33 respondents) and participants in the focus group discussions (108 respondents) are not included in this list.

ANNEX 3: SOCIAL AUDIT EVALUATION FRAMEWORK

The evaluation framework used to guide the study is presented here. The range of informants and variety of research methods employed allowed for triangulating data, and enabled researchers to cross-verify information in the field with different stakeholders.

Figure A3: The evaluation framework

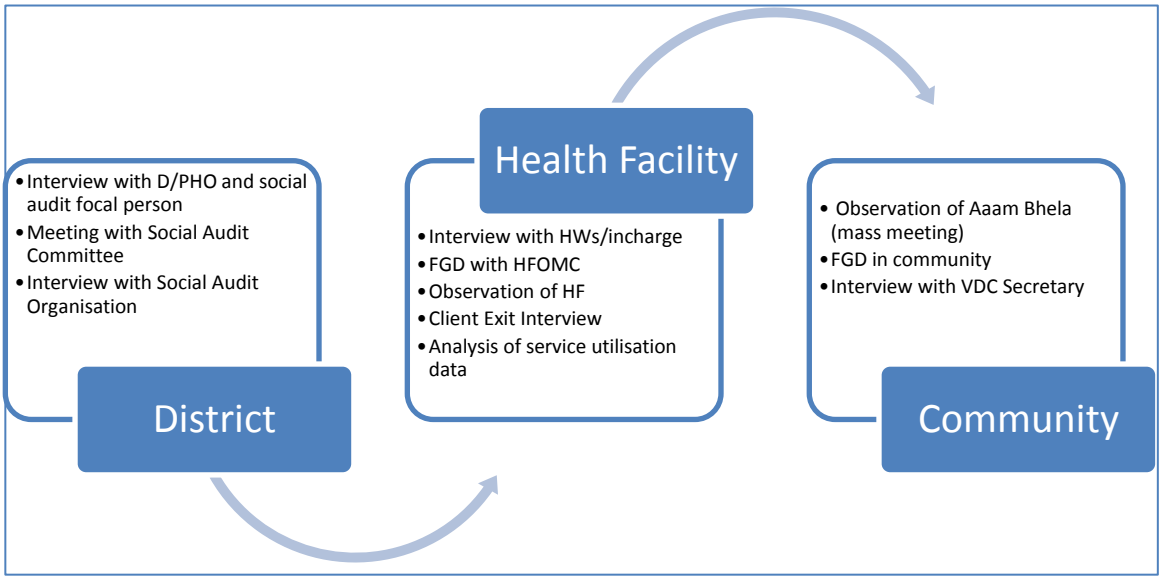


Table A3.1: Methods, tools, and respondents

Activities	Objective	Expected outcome	Tool	Process
DISTRICT LEVEL				
Meeting with DHO/DPHO	To gather perceptions of relevance and contribution of social audit to improving health services and health governance	• Effectiveness of social auditing in improving services at facility level will be explored • DHO/DPHO initiative in addressing community concerns will be assessed • Seriousness of DHO/DPHO in fulfilling commitments made during mass meeting will be assessed • Challenges in fulfilling commitments and seriousness identified	Semi-structured interview	Discuss with DHO/DPHO and social audit focal person in two pilot districts
Meeting with District Social Audit Committee	To assess effectiveness and functionality of the committee	• Committee's perceptions of social audit process and its contribution to ensuring good governance in health sector will be explored • Challenges, and how they can be addressed, identified • Plans for replication and continuation and key enabling factors for this	Interview checklist	Discussion with available members of District Social Audit Committee will be initiated. Ensure participation of LDO, the chair of the committee.

Activities	Objective	Expected outcome	Tool	Process
HEALTH FACILITY LEVEL				
Interview with HFIs	To assess contribution of social audit in improving health service delivery	• Changes in delivery, availability, quality, and accountability of health services resulting from social audit will be explored • Challenges in addressing the social audit results will be explored • Perceptions of changes in user expectations and examples of new demands and support from the community resulting from social auditing • Support received from district, regional, and central level as a result of and/or in response to social auditing	Interview checklist	Discuss with HFI in each sample health facility
FGD at health facilities including HFOMCs	To identify perceptions of how social audit has enabled and led to changes in health service delivery	• Information from recent monitoring will be triangulated • Further information about recent changes will be identified	Ladder of change monitoring plus discussion of the findings to identify why the changes have taken place and any links to social auditing	Facilitate the FGD at health facility. Participants of FGD should include health facility staff, HFOMC members, members of local support groups and FCHVs
Client exit interviews	To gather information on current quality and experience of health services	• Information about quality and availability of health services, including health workers' behaviour, gathered; issues relating to gender and social inclusion will be explored • Gaps and weaknesses in service delivery will be captured and tallied with social audit action plans and reported improvements in services by health workers (triangulation) • Difficulties faced in improving health services will be identified	Semi-structured interview	At least 10 clients who received the services from the health facility will be interviewed in a convenient and private place away from the facility
Service utilisation data collection	To gather service utilisation data	• Updated data on health service utilisation at the health facility level will be collected	Review and observation of Health Management Information System (HMIS)	Seek access to HMIS at facility level that could be triangulated at central level. Few focal indicators to be tracked from pre-social audit

Activities	Objective	Expected outcome	Tool	Process
On-site observation of health facilities	To observe the current state of the health facility	• Situation of current infrastructure, service delivery process, and other necessary conditions of the health facility will be observed	Physical observation	Observation of all sample health facilities.
IN COMMUNITIES				
FGD with health service users in the community	To capture community perceptions of recent changes in health service delivery	• Community perceptions of quality, availability and accessibility, and accountability of the health services will be captured • Community perceptions of seriousness of health facility in addressing popular concerns and in implementation of service improvement action plan will be explored • Challenges as perceived by the community will be explored	FGD Thematic Guide	Facilitate the FGD at a community at least one hour away from health facility, preferably in the same community that was covered during last year's social auditing
Interviews with VDC secretaries	To assess improvement in health service delivery after first round of social audit	• The information from health facility on availability and quality of services will be triangulated • Use of social audit skills in conducting mandatory social audit by VDC will be explored	Discussion checklist	The VDC Secretary in each sample VDC will be interviewed separately. The VDC Secretary who is also HFOMC Chair should not be included in the FGD in health facility
Observing mass meeting at VDC	To assess effectiveness of VDC-level mass meeting	• Compliance of all steps proposed in the guidelines will be assessed • Effectiveness of mass meeting facilitation will be examined • Observation of the level of community participation: who participates (women, men, young, old, Dalits etc.); the form of participation (listening, asking questions, demanding answers, engaging in debate, leading debate, etc.), duration of participation • Observation of responses to community participation from health facility	Steps of mass meeting A checklist needs to be prepared to capture the level and form of participation in the mass meeting from both the community side and the health facility side	The mass meeting being organised at VDC level on completion of the second round of social audit will be observed

Activities	Objective	Expected outcome	Tool	Process
		staff/D(P)HO (e.g. defensive, respectful, engages with topics, dismissive, etc.) • Recording community perceptions of progress made against social audit action plans and consensus on future priorities. Researchers to record outcomes and how health facility staff engage with the process		

Table A3.2: Key focus areas during discussions and interviews with health facility staff, HFIs, VDC secretaries, clients, and community people

Key themes	Sub-themes
1. Management of health facilities	• Good management practices • Managerial areas of improvement required and agreed in social auditing • Areas of cooperation and support received from other stakeholders • Areas of challenges and threats from other stakeholders
2. HFOMC	• Inclusiveness • Regularity of meetings • Decision-making process • Expenditure • How does the community perceive the effectiveness of the HFOMC? Are there improvements in the functioning of the HFOMC that the community and clients would like to see? • How has social audit affected the functioning of HFOMCs?
3. Infrastructure	• Sufficiency and additional requirements • Optimal use • Efforts made to fulfil infrastructure needs outside government budget • Community and client perspectives on the quality of infrastructure
4. Regular attendance of health workers	• Number of approved positions (*darbandi*) — available number of health workers • If this issue was raised in earlier social auditing, was it referred to the D(P)HO and subsequently to the central level? Was it addressed? • Irregularity in attendance; reasons, efforts made to regularise attendance; changes in how the community, VDC, D(P)HO, DDC, or central level have reacted to irregular attendance over past year • Community views on staff attendance and how this needs to improve
5. Inclusiveness of clients	• Are services delivered inclusively and how? • Changes over the last year • Efforts made, if required, to improve the inclusiveness of clients, and any links to social auditing • Efforts made to make health services more gender-sensitive, if necessary, and how social audit supported or prompted such efforts • Do clients believe services are delivered equitably? If so, how? Who needs special attention to improve their access to services?
6. Health workers'	• How do health workers behave towards clients? Are they respectful,

behaviour towards clients	empathetic, patient, informative, caring? • How do health workers behave towards very poor and excluded communities? • Has there been any change in health worker behaviour? Why do you think this is so?
7. Awareness and receipt of entitlements	• Awareness of Aama and 4ANC entitlements • From health workers: are Aama and 4ANC payments made on time? If not, why not? • From clients and communities: is receipt of entitlements in full and on time? • Any changes in practice and, if so, why?
8. Opening times	• What is official opening time of the health facility? • Is the facility open according to these times, and, if not, why not? • Has there been any change in the timings of the facility, and, if so, why?
9. Stockouts	• What is the stock-out position over the past year? • Has there been any improvement in supply management, and, if so, why? • From clients: have there been any stockouts in the past year and, if so, of what? Where did you source supplies? Has situation improved, and, if so, why?
10. Cleanliness	• Do you think the health facility maintains a good standard of cleanliness, and, if not, why not? • Has cleanliness changed in the past year, and, if so, why?
11. Grievance collection mechanism	• Standard mechanism of collecting grievances from clients • Grievance-addressing process • Types and number of grievances received in last 12 months • Number and types of grievances addressed over last 12 months • How do clients prefer to convey complaints to health workers and HFI? • What has been the experience of using formal and informal routes of grievance? Any redressal?
12. Management of financial resources	• Source of income • Area of expenditure • Has there been any difficulty in getting financial resources from the D(P)HO in advance? • How you manage incentives if you have not been getting money in advance? • Government budget, areas of insufficiency • Efforts made to address insufficiency, if any
13. Response from higher authorities	• How does the D(P)HO and the central level support the facility? • How and why has this changed since social audit was introduced? • How do the community perceive support from the district and centre? Are they aware, do they think sufficient support is given, and has this changed since social auditing?
14. Perception of value of social auditing	• How do health workers, HFIs, and the community perceive the value of the social audit process? • Perception of health workers on community support and cooperation in delivering health services or otherwise • What have been significant changes, if any, and why have these happened?
15. health facility observations	• Observe situation of Citizen's Charter, list of free medicines, and compare with earlier situation • Observe health workers' behaviour • Observe state of infrastructure