DISCLAIMER

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Foreword

It is my great pleasure to introduce this report ‘Best Practices and Lessons from Pilot Project on Human Resources for Health in Nepal’. This report is based on the result of a pilot initiative implemented (March-November 2013) in five districts covering one each of the development regions and ecological belts. Local civil society organisations in each of the piloted district were engaged along with the Society for Local Integrated Development (SOLID) Nepal in implementing the pilot project. The pilot project and this report was funded and supported by the European Union and the Ladham Trust.

The report from the pilot initiative is a narrative which should be helpful for strengthening the human resources for health management initiative. The report encourages local civil societies to advocate, sensitise and play a constructive role to help create a conducive environment to address the challenges faced on issues related to human resources in the health sector. We believe the report of the pilot initiative should help facilitate improve the efficiency and regularity of services provided by the human resources in the health sector.

Recommendations in the report to engage civil society organisations to fill the void and vacant spots in the manpower needs in health care facilities is something that could help service seekers in the short run. Likewise, points for attention to be considered to help attract, motivate and retain health workers across the board in both rural and urban environment are advocacy references mentioned in the report.

We believe that this publication should not only serve to inform people of the outcome of the pilot project for sharing purposes, but also be used constructively by civil society to support the government to take the initiative at scale across the country.

Jagat Khadka
Deputy Country Director - Program Operation
Save the Children
14 February 2014
Preface

We are pleased to present this publication on ‘Best Practices and Lessons from Pilot Project on Human Resources for Health in Nepal’. This best practice documentation consists the results and learning of pilot initiatives implemented under the project “Support to Health Workforce through Civil Society Engagement”. The nine months pilot was jointly designed and implemented by local civil societies in five districts one in each development region and ecological belt of Nepal. Local civil societies were provided technical and programmatic support from Society for Local Integrated Development (SOLID) Nepal and HRH project team (Merlin and Save the Children). The pilot project and this documentation was made possible with the financial assistance of the European Union and the Ladham Trust.

The documentation of these pilot initiatives contains the background, design, inputs, results and learning which should be helpful for strengthening the Human Resources for Health (HRH) management in Nepal. The document will be helpful to local civil societies and other stakeholders to advocate, and play a constructive role to help create conducive environment to address the challenges faced on issues related to HRH. We believe the documentation of the pilot initiative should help to facilitate improve the efficiency and regularity of services provided by the human resources in the health sector.

The recommendations outlined in the document are very much relevant not only for these five pilot districts but also for other remaining districts of the country. The report demonstrated tremendous achievements especially to fill the vacant positions encouraging local hiring in the human resource needs in health care facilities, which is something that could help service seekers in the short run. Similarly, the report highlighted roles of civil societies to attract, motivate and retain the health workers across the health institutions so that regular and quality services would be available.

We would like to express our heartfelt thanks to all team members engaged in the designing, implementing and documenting the pilot initiatives for HRH management in Nepal. We are very hopeful that this document will be helpful in informing relevant stakeholders about the importance of the pilot. Furthermore, the document will also serve as a reference while doing similar kind of advocacy work in other districts.

Raj Kumar Mahato
Programme Manager – Health and Nutrition
Save the Children
February 14, 2014
Human Resources for Health (HRH) is a serious issue of the present world especially the third world country like Nepal. Not only to achieve the health related millennium development goals (MDGs) but also to meet other nationally set health and development targets, the role of HRH is inevitable and critical. At the same time without supportive environment maintained by the local community or civil society, smooth and quality service delivery is also not possible. Therefore, the mutual and cordial relationship between health workers and local civil societies has proved to bring positive changes in the society.

This report on “Best Practices and Lessons from Pilot Project on Human Resources for Health in Nepal” intends to express the result of combine efforts of all civil society organizations, social leaders, government authorities, local bodies and committees, and individuals in bringing changes in health service delivery at local level.

We would like to sincerely acknowledge District (Public) Health Offices and the entire staffs, health workers, members of the health facility operation and management committees (HFOMCs), CSO/NSA Alliances on HRH at district and regional levels, and each and every individual of the particular community of five districts in which the HRH pilot projects were carried out smoothly and completed with success.

I would like to take this opportunity to thank the Ministry of Health and Population (MoHP), Department of Health Services (DoHS), CSO/NSA Alliance on HRH at the national level for their steady support and encouragement.

I would like to thank European Union, former Merlin team; Save the Children HRH team; and five local CSOs: Astha Forum of Infrastructure Development (AFID), Sankhuwasabha; Rural Institution for Community Development (RICOD), Lalitpur; Indreni Social Development Forum (ISDF), Kapilvastu; Mallarani Rural Development Concern Center (MRDCC), Pyuthan; and Community Rural Development Society Nepal (CRDS-Nepal), Darchula and their entire staffs for their meaningful collaboration, dedication and support to implement the pilot projects and to earn these significant lessons. My particular thanks go to Mr. Raju Prajapati, Ms. Anita Tako, Mr. Binod Kumar Maharjan, Mr. Arjun Subedi, Mr. Bhuwan Baral, Mr. Anant Nepal and Mr. Raj Kumar Mahato for their hard work to give this report a final shape. Finally, my deep gratitude goes to the whole team of SOLID Nepal for handling the overall process and providing the necessary technical and practical support in accomplishing this report.

Dr. Khem Bahadur Karki
Executive Director
SOLID Nepal
Executive Summary

Human Resources for Health (HRH) is a multi-sectoral issue worldwide but inadequately addressed. According to a definition by World Health Organization (WHO) any individual who is directly or indirectly connected to health and healthy behaviour of human beings, is a human resource for health in one way or the other.

Nepal is one of the 59 countries of the world where there is crisis of human resources of health (HRH). One of the reasons for this crisis is an ineffective management of HRH at local level. In our context, health facility operation and management committee (HFOMC) has a great role to manage HRH at local level for providing quality essential health care services. Society for Local Integrated Development Nepal (SOLID Nepal) in partnership with Save the Children and local civil society organizations (CSO) had initiated a pilot project in March 2013 in five selected VDCs of five districts viz. Sankhuwasabha, Lalitpur, Kapilvastu, Pyuthan and Darchula for nine months with the main aim to strengthen local health facility through civil society engagement. The pilot project started in March 2013 for the period of nine months could succeed to trap some of the improvements in the intervention area even in a short period of time.

First of all, HFOMC of each VDC was reformed or reactivated; the internal conflicts were managed; and made the members aware of the roles and responsibilities. All the members of HFOMCs were provided management related training and reactivated for action. They conducted series of meetings, drafted action plans, and conducted public hearing at health facilities. Through different advocacy activities concerned local government authorities were sensitized; community people were made aware; media persons were oriented; and thus built the public opinions on the situation of the local health facilities and ways of improvements.

The health facilities were provided different supports. The major supports, the CSOs provided to local health facility through the pilot projects were the temporary recruitment of human resource like auxiliary nurse midwives (ANM), X-ray Machine Operator, Lab assistant etc. by exploring resources of HRH management available at local (VDC/DDC) level. Similarly, the need based supports like Materials & equipments /instruments, refrigerator, cupboard, wheel chair, autoclave, renovation of infrastructure like office set-up materials were provided. They also coordinated for SBA training to health workers.

As a result of the pilot initiatives, there were increments in the number of human resources for health (HRH) in comparison to the baseline study conducted in each of the intervention VDCs just before pilot project. The number of health service providers (all types) was increased by 15% in total. Four new health facilities were upgraded as birthing centres. Similarly, nine SBA trained health workers were recruited in the health facilities of the intervention area.

There was remarkable change found in the ANC visit as well. The first ANC visits increased by 15% and other indicators like SBA assisted delivery, PNC visits were also in the increasing trends. There used to be only 12% institutional delivery against expected pregnancy in total but after pilot project initiation, it reached to 16%, the more increase can be seen in Darchula district where institutional delivery increased by 17%. Availability of health workers and medicines/vaccines at local health facilities regularly, the immunisation coverage found increased to a large extent. As of expected number of children aged <1, immunisation coverage was increased by 29% in total. The BCG coverage was 91 percent i.e. increased by 15%; DPT/HepB/Hib-3 coverage was 105% i.e. increased by 29%. Similarly, OPV-3 and Measles coverage was increased by 29% and 14% respectively.

Improvement in quality and service was also felt by the local people in the intervention VDCs. People opined ‘this project has awakened the health facility staffs as well as the District Health Office.’ Further they said, ‘After the implementation of the project, the health workers are regular, and the members of HFOMC have also realized their duty, responsibility, working field and rights’.

The pilot project has encouraged that CSOs at local level can be instrumental to strengthen the local health facilities and the HRH situation there by to achieve the universal access to and utilisation of quality essential health care services.
Acronyms

AFID Astha Forum for Infrastructure Development
AHW Auxiliary Health Worker
ANC Antenatal Checkup
ANM Auxiliary Nurse Midwife
ARI Acute Respiratory Infection
BCG Bacillus Calmette Guerin
BP Blood Pressure
CBOs Community Based Organizations
CRDS Community Rural Development Society
CSOs Civil Society Organizations
DDC District Development Committee
DHO District Health Office/r
DPAC District Project Advisory Committee
DPHO District Public Health Office/r
DPT Diphtheria Pertussis Tetanus
EDPs External Development Partners
FCHVs Female Community Health Volunteers
FP Family Planning
HepB Hepatitis B
HF Health Facility
HFOMC Health Facility Operation & Management Committee
Hib Haemophilus Influenzae
HPs Health Posts
HR Human Resource
HRH Human Resources for Health
HWs Health Workers
INGOs International non-governmental Organizations
ISDF Indreni Social Development Forum
MCH Maternal and Child Health
MDGs Millennium Development Goals
MMR Maternal Mortality Ratio
MoHP Ministry of Health and Population
MRDCC Mallarani Rural Development Concern Center
MVA Manual Vacuum Aspiration
NGOs Non-governmental Organizations
NHSP-IP Nepal Health Sector Programme- Implementation Plan
NSA Non-state Actors
OPV Oral Polio Vaccine
PHCCs Primary Healthcare Centers
PHC-ORC Primary Healthcare - Out Reach Clinic
PNC Postnatal Care
PPP Public Private Partnership
RICOD Rural Institution for Community Development
SBA Skilled Birth Attendant
SHPs Sub-Health Posts
SOLID Society for Local Integrated Development
S'sabha Sankhuwasabha
VDCs Village Development Committees
WHO World Health Organization
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1.1 Background of the Project

With global targets for major health improvements, fast approaching, including achieving the health-related Millennium Development Goals (MDGs) by 2015, and the recognition that these goals cannot be achieved without building up the capacity of health workforce, many countries need to develop or re-assess national health workforce plans, policy and strategy. The development of appropriate health workforce as well as broader health sector strategies, is receiving particular attention through regional and global initiatives such as the International Health Partnership, as well as the Global Action Plan on Human Resources for Health.

Government of Nepal has developed a Nepal Health Sector Program Implementation Plan (NHSP-IP) which aims to develop competent human resources for all health facilities and to strengthen training centres and academic institutions to produce human resources for health. However, the current Health Policy was designed in 1991 and has not been updated to mitigate with the population increment and disease burden, and thus lacks HRH requirements. A revised policy, under the new Nepal Health Sector Program Implementation Plan (NHSP-IP II 2010-2015), has been designed but the Ministry of Health & Population (MoHP), and external development partners (EDPs) lack precise data and information on the HRH situation, especially from remote areas. HRH needs have not been analysed in depth and without proper consultation with health workers, civil society organisations (CSOs) and other non-state actors (NSAs) whom too have a limited role to play in HRH often filling gaps or supporting national programmes (capacity building of health workers, etc).

There is a major need to understand the current barriers to an effective HRH situation that will support appropriate policies development. Better monitoring of HRH strategies and policies needs to be in place while the role of civil society organisations in supporting HRH needs to be put into practice. One of the major challenges is also to find alternative solutions to address the lack of health human resources at the facility. Limited facilities, absenteeism, high staff turnover, lack of regular supervision and proper HR management, lack of specialised staff, limited involvement of non-state actors in the health system, and little motivation for qualified persons to work in remote areas, are also some of the constant challenges that need to be understood. The lack of skilled birth attendants (doctors, nurses, midwives) as one of the factors contributed to the highest maternal mortality ratio (MMR) in the South Asian Region. In Nepal, the reported MMR is 229 per 100,000 live births.\(^1\)

Several documents produced on the situation of HRH in Nepal have recognised the need to address the shortage of health workers. Though roles of CSOs have been recognized, in practice their influence is extremely limited and the decision making process remain at central level. The framework that formed the different national policies, strategies and plan constantly emphasises the public-private partnership (PPP) principle. This acknowledges the limited capacity of the MoHP to cope with health related issues on a national scale by itself. With regards to HRH issues, the lack of consultation from civil society organisations or even a wider spectrum of stakeholders represents an important gap. Similarly only with the support of non-state actors and the private sector sustainable solutions will be found and implemented.

In this regards, SOLID Nepal in support of Merlin (now Save the Children) has implemented a European Union funded project ‘Support to Health Workforce through Civil Society Engagement’ since December 2010 to improve the delivery of healthcare in Nepal through strengthened HRH policy development and implementation. The project action focused on enhancing engagement of civil society in policy development, implementation and monitoring for HRH. More specifically the project aimed to engage civil society in policy development, implementation and monitoring for HRH through:

1. Improved knowledge and understanding of HRH situation in Nepal
2. Enhanced advocacy capacity and knowledge of civil society on HRH, and
3. Improved HRH situation in five districts of Nepal through pilot projects in collaboration with CSO/NSA

1.2 The HRH Pilot Project

Overall improvement in the health systems is pre-requisite for delivering health services and achieving global health targets for health improvements in many developing countries like Nepal. The production of appropriate health workforce in adequate numbers, their proper distributions and retentions in the working places are the parts of broader health sector strategies, and the government of Nepal is receiving particular attention through regional and global initiatives such as the International Health Partnership, as well as the Global Action Plan on Human Resources for Health. However, government of Nepal has not updated human resources for health policy to respond the changing population dynamics and disease burden. In one hand, government is being criticized for being negligent towards people’s health by not recruiting the adequate number of health workers, and on the other hand available health workforce are frequently criticized for being irresponsible to the community they serve.

The human resources for health (HRH) needs have not been analyzed with proper consultation with health workers, civil society organizations (CSOs) and non-state actors (NSAs). Limited number of health workforce, lack of adequate facilities, absenteeism, high staff turnover, lack of regular supervision and monitoring or proper HR management, lack of specialized staff, limited involvement of CSOs and NSAs in the health system, and little motivation for qualified persons to work in remote areas are some of the constant challenges for proper and regular health service delivery. Similarly, limited knowledge and understanding of HRH situation and the lack of consultation by Civil Society Organizations or even a wider spectrum of stakeholders especially health facility operation and management committee (HFOMC) also represents an important challenge in proper management of HRH in the local settings.

Objectives

The objective of the pilot project was ‘Improved HRH situation in five districts through pilot projects in collaboration with non-state actors’.

Anticipated Outcomes

- Availability of human resources for health (HRH) in the piloted village development committees (VDCs) increased to 90%.
- Twenty Health Facility and Operation Management Committee (HFOMC) have a plan in place to address HRH issues at VDC level.
The Process of Implementing HRH Pilot Project

Implementation of pilot project in five selected districts was the third expected outcome of the overall project “Support to Health Workforce through Civil Society Engagement”. As per the project guidelines, five CSOs from five of the 15 research sampled districts were selected for the pilot phase in February 2013. The selection was made based on the programmatic and financial proposals submitted by the CSOs and field visit of the short-listed organizations by the central selection team of SOLID Nepal and Merlin.

A preparatory meeting of 5 selected CSOs was conducted in February 2013 in Kathmandu. The meeting finalized the operation plan (core activities), budget, and introduced the reporting system. With the signing of contractual agreement between SOLID Nepal and the CSOs, the piloting phase was implemented at the field level. (Figure 1).

The selection of five CSOs represent all three ecological belts and five developmental regions of Nepal. Astha Forum for Infrastructure Development (AFID) represented eastern mountainous district Sankhuwasabha, Rural Institution for Community Development (RICOD) represented central hilly district Lalitpur, Indreni Social Development Forum (ISDF) represented western Terai district Kapilvastu, Mallarani Rural Development Concern Center (MRDCC) represented mid-western hilly district Pyuthan and Community Rural Development Society-Nepal (CRDS-Nepal) represented far-western mountainous district Darchula. (Figure 2).

---

**Figure 1.** Flowchart Showing Steps of Implementing HRH Pilot Project.
The five CSOs in each intervention district selected five village development committees (VDCs) for the implementation of pilot project at the field level (Table 1). Following criteria were considered while selecting the VDCs:

- Unavailability of maternal and child health related HRH in the local health institutions;
- Village Development Committee with poor maternal and child health indicators [like: immunisation coverage, institutional delivery, antenatal care (ANC) and postnatal care (PNC) visits, use of family planning (FP) methods, delivery attended by skilled birth attendant (SBA) etc.]
- Problems related to HRH [retention problem, conflict between health workers and service users, poor infrastructure, security concerns etc.]
- Problems in functioning of HFOMCs [irregularity in meetings, problem implementing the decisions, poor coordination with concerned stakeholders.]

![HRH pilot project implemented districts](image)

**Figure 2. Pilot Project Implemented Districts**

<table>
<thead>
<tr>
<th>SN</th>
<th>Name of Pilot project implementing CSOs</th>
<th>Implementation Districts</th>
<th>Village Development Committees (VDCs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Astha Forum of Infrastructure Development (AFID)</td>
<td>Sankhuwasabha</td>
<td>Baneshwor, Num, Nundhaki, Matsyapokhari, Siddhapokhari</td>
</tr>
<tr>
<td>2</td>
<td>Rural Institution for Community Development (RICOD)</td>
<td>Lalitpur</td>
<td>Chaughare, Dalchwoki, Khokana, Lamatar, Lele</td>
</tr>
<tr>
<td>3</td>
<td>Indreni Social Development Forum (ISDF)</td>
<td>Kapilvastu</td>
<td>Ganeshpur, Hardauna, Harnampur, Labani, Mahendrakot</td>
</tr>
<tr>
<td>4</td>
<td>Mallarani Rural Development Concern Center (MRDCC)</td>
<td>Pyuthan</td>
<td>Khalanga, Kochiwang, Liwang, Puja, Swargadwari,</td>
</tr>
<tr>
<td>5</td>
<td>Community Rural Development Society Nepal (CRDS)</td>
<td>Darchula</td>
<td>Gwani, Huti, Khandeshwori, Kharkada, Shankarpur</td>
</tr>
</tbody>
</table>

**Table 1. Name of the Selected CSOs along with the Districts and VDCs**

<table>
<thead>
<tr>
<th>Targets</th>
<th>Total Population</th>
<th>MWRA (15-45 years)</th>
<th>&lt;5 years population</th>
<th>&lt;1 year population</th>
<th>Expected pregnancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Sankhuwasabha</td>
<td>18366</td>
<td>4377</td>
<td>2022</td>
<td>417</td>
</tr>
<tr>
<td>2</td>
<td>Lalitpur</td>
<td>33948</td>
<td>9615</td>
<td>2319</td>
<td>977</td>
</tr>
<tr>
<td>3</td>
<td>Kapilvastu</td>
<td>28320</td>
<td>7166</td>
<td>4549</td>
<td>759</td>
</tr>
<tr>
<td>4</td>
<td>Pyuthan</td>
<td>24936</td>
<td>5938</td>
<td>3485</td>
<td>565</td>
</tr>
<tr>
<td>5</td>
<td>Darchula</td>
<td>18298</td>
<td>4251</td>
<td>2288</td>
<td>429</td>
</tr>
<tr>
<td>Total</td>
<td>123868</td>
<td>31347</td>
<td>14663</td>
<td>3147</td>
<td>3803</td>
</tr>
</tbody>
</table>

*Source of targets: Targets given by respective District Public/Health Office (D/PHO)*
Initially, the pilot project was designed for six months starting from March 2013. However, because of the high demand from the local community for the extension of the project and at the same time there was savings of the budget due to foreign currency exchange gain, the second phase of the piloting was extended for 3 months more. New field level activities (core activities) were set again by the CSOs in consultation with SOLID Nepal and Merlin, and the project was extended till the end of November 2013.

1.3 Situation Analysis at District Level

The HRH situation of Nepal is not satisfactory and it has got adverse effect on achieving the MDGs. Still there is less number of doctors, nurses and mid-wives as recommended by the WHO to achieve MDGs. Besides, there exits other problems on HRH like limited facilities, absenteeism, high staff turnover, staffs schedule to come to health facility in turn, office time is ignored etc. There were many factors to create these problems like lack of timely delivery of the medicines and instruments, no deployment of the sanctioned staffs, no residence facility for health workers to provide 24 hours service delivery, and most importantly the security of the health workers.

Before implementation of the pilot project activities at field level, situation analysis was carried out to know the exact HRH situation of piloting VDCs. The situation analysis also analysed selected maternal and child health indicators. The situation analysis of HRH showed that only two-third (66%) of HRH positions were filled permanently compared to their sanctioned number. (Figure 3).

![Human Resources for Health (HRH) Positions Sanctioned Vs Filled permanent](image)

**Figure 3.** Status of HRH in five VDCs of each piloted district

Government health facility is the only health service providing institution in the VDCs. These health facilities lacked sufficient number of health workers and at the same time, the available health workers were also remained absent during office hours. Similarly, there were no NGOs, INGOs or CBOs working in improving health service delivery in the VDCs. Also, the HFOMCs were not found active enough to bring the health workers in their places for regularity of services.

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The analysis of maternal and child health indicators showed that the total average antenatal care (ANC) coverage (1st visit) was 50.6% as of expected pregnancy which was parallel below national average (83%). Similarly, the postnatal care (PNC) visit was 19% which was also below the national average (51%). The immunization coverage was also found less than 80% while the national average is almost 90% and more.\(^1\) Institutional delivery was found functional in some of the PHCCs but almost no HPs and SHPs had such facilities in the intervention VDCs. (Table 2).

### Table 2. Maternal and child health indicators before HRH pilot project implementation

<table>
<thead>
<tr>
<th>SN</th>
<th>Maternal and child health indicators before HRH pilot project implementation</th>
<th>Total Average</th>
<th>Sankhuwasabha</th>
<th>Lalitpur</th>
<th>Kapilvastu</th>
<th>Pyuthan</th>
<th>Darchula</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Number of 1st ANC visit as % of expected number of pregnancy</td>
<td>50.6</td>
<td>62.4</td>
<td>18.3</td>
<td>74.5</td>
<td>64.3</td>
<td>61.9</td>
</tr>
<tr>
<td>2</td>
<td>Number of institutional delivery as % of expected number of pregnancy</td>
<td>11.6</td>
<td>14.6</td>
<td>3.2</td>
<td>4.2</td>
<td>19.7</td>
<td>34.7</td>
</tr>
<tr>
<td>3</td>
<td>Number of delivery assisted by trained SBA as % of expected number of pregnancy</td>
<td>12.0</td>
<td>14.6</td>
<td>2.1</td>
<td>7.6</td>
<td>19.7</td>
<td>34.7</td>
</tr>
<tr>
<td>4</td>
<td>Number of PNC visit as % of expected number of pregnancy</td>
<td>18.9</td>
<td>14.6</td>
<td>10.0</td>
<td>25.2</td>
<td>20.8</td>
<td>34.7</td>
</tr>
<tr>
<td></td>
<td>Number of immunized children as % of under 1 year children</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>BCG</td>
<td>75.8</td>
<td>94.7</td>
<td>17.8</td>
<td>114.6</td>
<td>117.9</td>
<td>65.5</td>
</tr>
<tr>
<td>2</td>
<td>DPT/HepB/Hib -3</td>
<td>76.4</td>
<td>90.9</td>
<td>22.8</td>
<td>103.7</td>
<td>114.9</td>
<td>85.1</td>
</tr>
<tr>
<td>3</td>
<td>OPV -3</td>
<td>76.4</td>
<td>90.9</td>
<td>22.8</td>
<td>103.7</td>
<td>114.9</td>
<td>85.1</td>
</tr>
<tr>
<td>4</td>
<td>Measles</td>
<td>70.7</td>
<td>90.2</td>
<td>25.8</td>
<td>95.8</td>
<td>109.7</td>
<td>58.3</td>
</tr>
</tbody>
</table>

[Note: the percentage indicates the total of 5 selected VDCs only and NOT the whole district]

Health facility operation and management committee (HFOMC) was just for the name and only for the sake of social recognition of the local leaders. The HFOMC meeting was called at times when health facility in-charge needed something to pass or approve. Therefore, there were hardly five meetings in a year instead of 12 monthly meetings, which was mandatory. The figure below showed only one third of meetings (99 out of 300) held in a year before pilot project in intervention VDCs. (Figure 4).

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## 1.4 HRH Pilot Project Strategies and Activities

The pilot project strategy focused on three major key intervention areas viz. community awareness; strengthening health facilities; and empowering the HFOMCs and health staffs with the core activities as shown in the figure below (Figure 5).

<table>
<thead>
<tr>
<th>Areas of Intervention</th>
<th>Core Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Awareness</td>
<td>• Public hearing on HRH issues</td>
</tr>
<tr>
<td></td>
<td>• Advocacy and awareness programmes</td>
</tr>
<tr>
<td></td>
<td>• Media mobilization</td>
</tr>
<tr>
<td></td>
<td>• Orientation to mothers group and ward citizen forums</td>
</tr>
<tr>
<td></td>
<td>• Interactive meeting with local leaders, civil societies and social leaders</td>
</tr>
<tr>
<td></td>
<td>• Formation of district Alliance on HRH</td>
</tr>
<tr>
<td></td>
<td>• Social audit</td>
</tr>
<tr>
<td>Health Facility Strengthening</td>
<td>• Situation Analysis</td>
</tr>
<tr>
<td></td>
<td>• Recognition of MCH related Health Workers</td>
</tr>
<tr>
<td></td>
<td>• Equipments and Logistics Support</td>
</tr>
<tr>
<td></td>
<td>• Management of temporary HRH recruitment from local resources</td>
</tr>
<tr>
<td>Empowering HFOMCs and Health Staffs</td>
<td>• Meeting with HFOMC and develop action to Address HRH Issues</td>
</tr>
<tr>
<td></td>
<td>• Support HFOMC to implement the action plan</td>
</tr>
<tr>
<td></td>
<td>• Conduct regular monthly meetings of HFOMC</td>
</tr>
<tr>
<td></td>
<td>• Engagement of HFOMC members in district project advisory committee (DPAC)</td>
</tr>
</tbody>
</table>

**Figure 5** Framework of HRH Pilot Initiatives
2.1 Reformed and Reactivated Health Facility Operation and Management Committee (HFOMC)

The situational analysis of piloted VDC revealed that health facility operation & management committees (HFOMCs) were formed at each health facility. However, in some cases, there were two HFOMCs claiming themselves as the authentic one. Similarly, the data also showed that HFOMCs meetings were held very rarely and hardly discussed on improvement of health services (Table 3) though the HFOMC is an authentic body for the management. Mostly, the HFOMC meetings were called by health facility In-charge to approve the bills and to make decision in favour of health workers. In addition, the HFOMC members were completely inactive for they were unaware of their roles and responsibilities. In some VDCs the members indulged in internal conflicts. One of health workers expressed his fear as, “we know that it’s the health facility (HF) In-charge who will inform the HFOMC and call meeting but the HF staff feared that they would face the problems if HFOMC became active and alert.”

Hence, the HFOMCs were reformed and reactivated. For instance, only one authentic HFOMC was formed where there were two, regularised monthly meetings, developed action plans and oriented on their roles & responsibilities which encouraged for their active participation.

As the result, the members of HFOMCs became more active and participated actively in their regular meetings. The number of HFOMC meetings were conducted nearly two times more after the initiation of the pilot project (Table 3).

<table>
<thead>
<tr>
<th>HFOMC</th>
<th>Status</th>
<th>Total</th>
<th>S’sabha</th>
<th>Lalitpur</th>
<th>Kapilvastu</th>
<th>Pyuthan</th>
<th>Darchula</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of HFOMC meetings held</td>
<td>Before Pilot Project</td>
<td>99</td>
<td>26</td>
<td>20</td>
<td>25</td>
<td>20</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>After Pilot Project</td>
<td>194</td>
<td>31</td>
<td>38</td>
<td>27</td>
<td>56</td>
<td>42</td>
</tr>
<tr>
<td>Number of HFOMCs with Advocacy Action Plan</td>
<td>Before Pilot Project</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>After Pilot Project</td>
<td>25</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
</tbody>
</table>
Reactivation of HFOMC for HRH Management in Baneshwor HP, Sankhuwasabha

The Situation
The Baneshwor Health Post (HP) is in Sankhuwasabha District. The health facility operation and management committee (HFOMC) of Baneshwor HP was formed in 2056 but remained inactive since there was no coordination and communication between HFOMC and the HP Incharge or staffs. HFOMC even did not know whether the in–charge or staffs have gone somewhere or stayed at home on leave.

Baneshwor Health Post is under the shadow due to carelessness of HFOMC. During a public hearing, it was raised that it was the HP in-charge who should inform the HFOMC but on the contrary, the HP staff feared that they would face the problems if HFOMC became active and alert.

Recently, AFID has launched the Pilot Project of Human Resource for Health because of which the HFOMC and local people have become enthusiastic. They opined, “This project awoke the HP staffs as well as the District Health Office.” They further said, “After the implementation of the project, the health workers are regular, and the members of HFOMC have also realized their duty, responsibility, working field and rights.

The Change
Though participation of local people for the physical and qualitative development of Local Health Post and to receive health services are the fundamental rights, Baneshwor Health Post was unable to provide quality services in the lack of awareness and vigilance. Before the project’s intervention, the HP was not receiving people’s acceptance, assistance and cooperation but now the situation has improved a lot.

Changes observed after the implementation of the project activities
- Reformation of HFOMC,
- Decision to regularize HFOMC monthly meeting that is 4th of every month,
- It was decided that the audit of last 4 years’ financial transactions to be done by 14th, Asad 2070,
- The HP In-Charge has to call the HFOMC meeting,
- VDC and HFOMC have corresponded the concerned agencies to initiate the birthing center, VDC committed to support even after the project’s exit, and the meeting of DHO and AFID decided to proceed for the appointment of an SBA,
- Income and expenditure of the Health Post has been publicized,
- It was decided to manage the problem of drinking water within a month.
2.2 Public Hearing and Social Audit

According to the Right to Information Act 2007, every citizen shall have access to the information held in the public bodies. However, most of the information related to health is not properly delivered among community until and unless they take initiation by themselves.

There were not any such types of activities related to sharing of the information were conducted in the piloted districts before. Hence, the local CSOs initiated public hearing and social auditing in their respective VDCs.

Public hearing was conducted in the beginning of the project to make local health institutions more transparent and accountable with the participation of local people including VDC Secretary, health workers, HFOMC members and media persons. Public raised the issues of irregularity of the health workers, unevenness in the health service delivery and irresponsiveness of the HFOMC. Majority of the HFOMC members expressed that they were aware neither of their roles & responsibilities nor of the health workers activities. Likewise, health workers showed their dissatisfaction towards unavailability of the proper medicines, instruments as well as poor infrastructure of the health facilities which led to difficulty in providing quality services.

As a result, each of the concerned authorities promised that they would do their best part. The health workers promised to be regular, provide health service smoothly, and to make outreach clinics accessible. Several delegations were made to D(P)HOs and other district level authorities for providing strict directives, regular monitoring and fulfilment of the vacant sanction positions.

Social audit was conducted at the end of pilot phase to review the project achievements in terms of transparency. The CSOs highlighted project activities, outcomes and financial transactions in-line with the allocated budget. The participants appreciated for the sound activities and justifiable financial transactions. It was suggested that social auditing should be done by each health institution every year.

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Dalchok Sub-Health Post (SHP) of southern Lalitpur district was not adequately equipped with minimum number of staffs, materials and infrastructure. The SHP was providing service by only two health workers (i.e. 1 AHW and 1 ANM). The HFOMC members were not regularly meeting and they were unaware of their roles and responsibility.

After implementation of HRH pilot project, it was decided to start out reach clinic in ward nos. 2 and 7. For that, they decided to recruit one health worker from the VDC resource which would be supported by RICOD through HRH pilot project too. The HFOMC started to meet regularly and succeeded to develop action plan for the development of SHP infrastructure and managed adequate number of HRH. During public hearing, community forest users group of Dalchoki VDC decided to provide required land from their forest area to construct new SHP building. In the same public hearing program, a local resident donated 1000 rupees instantly to purchase donation box which was kept in SHP for the fund raising to construct the building.
2.3 Formation of HRH Alliance in District

Advocacy is recognized as one of the best strategies for improving HRH situation. An independent alliance of non-state actor (NSA) or civil society organization (CSO) is recommended to interface between government and other groups. Therefore, local CSO initiated to form a district level CSO/NSA alliance to advocate HRH issues at local level. The alliance members included local NGOs, clubs, non-state actors, local leaders, mothers’ group, female community health volunteers (FCHVs) and other likeminded organizations.

The district alliances developed advocacy action plans for 2-3 years and carried out activities accordingly. The activities included delegations to concerned government authorities at local levels for fulfilling the vacant positions, demanded for safety and security for health workers and availability of regular services at health facilities. With this, local hiring was encouraged; deputations were cancelled; safety and security committee was formed to support to health facilities in providing 24 hours services. Moreover, the alliance has continued as the watchdog for effective health service delivery at local level.

2.4 Advocacy Activities

Though advocacy is an inevitable strategy for addressing HRH issues, it has been firstly introduced in Nepal. For this, the local CSOs were capacitated on advocacy and HRH. Basic and refresher trainings were provided to more than 30 CSOs across the country. Based on the developed action plans of all CSOs and alliances, various advocacy activities were conducted.

The advocacy activities included public hearing, social audit, dissemination of HRH issues through media, celebration of health related days, delegations to concerned district authority for limiting/cancellation of deputed staff to their postings, local hiring on need based and for fulfilling vacant positions.

Thus, CSOs played important roles in smooth running of the health facility in the intervention VDCs besides facilitating district health authorities to fulfil the HRH gaps and for smooth service delivery in other health facilities of the district through adequate number of health workers.

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Sub-Health Post Channelized in Kochiwang VDC, Pyuthan

Kochiwang VDC is in the south-west part of Pyuthan district. Unfortunately, Kochiwang VDC is only one VDC in Pyuthan district which is deprived transportation and electricity till date. The VDC has 3602 population and one sub-health post in ward number 1 to provide health services. During the study in March 2013, a shocking case was found that the sanctioned position was 100 percent vacant. Later it was also found from District Health Officer of Pyuthan that there were two health workers working in deputation. The villagers thought that sending health workers in Kochiwang was like a punishment. So, there was a difficulty in providing MCH related services because there was only one ANM and she was also not doing her work properly.

Through the project, the CSO advocated the community stakeholders to regularise health workforce in Kochiwang. With the regular advocacy and delegation with DHO, one auxiliary health worker (AHW), was sent the VDC. The HFOMC developed action plan, and advocated for changing the worse situation of health facility in Kochiwang.

Since April, there was a new AHW transferred to Kochiwang Sub-Health Post by the DHO. Similarly, from June 2013, the same ANM also started to work properly so the MCH service users were increased and vaccination program as well as PHC-ORC clinic also started to run properly.
2.5 Encouraged Local Hiring

Research studies have recognised that the positions of health staffs remained vacant due to cancellation of advertisements because of contradictions in health service act and civil service act, long term deputations, trainings, study leaves etc.\textsuperscript{6}

The provision of the local hiring has been practiced by District Public/Health Office. However, it has not been able to fill the vacant positions especially in remote areas. Local government bodies like District Development Committee and Village Development Committee have unrestricted fund which has been utilised for other purpose. Therefore, the CSOs strongly advocated for fulfilment of the vacant positions on need based. In some cases, the CSOs provided fund for short-term recruitments and ensured the sustainability through local level commitments. In this way, various positions which remained vacant for longer time durations have been fulfilled during the pilot phase.

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**PHCC Run Its Services Full-fledged in Harnampur VDC, Kapilvastu**

Harnampur Primary Healthcare Centre (PHCC), located in Harnampur VDC of Kapilvastu district covers eight VDCs through its service. Though the PHCC was well equipped with sufficient infrastructure, the dispute among health facility operation and management committee (HFOMC) had hampered the smooth delivery of health services. For the last 7 months, the HFOMC could not hold any meeting to discuss on issues of health facility. In addition to that, one ambulance driver and security guard recruited under internal resource of PHCC were not getting their salary payment for last 3 months. The centre was not able to provide 24-hour delivery service though there was a birthing unit. Out of total 13 sanctioned staffs, only 10 staffs were fulfilled. The reasons behind the ineffectiveness of service delivery of centre were lack of staffs as per the sanctioned, irregularity of available staffs and disputes among HFOMC members.

After the implementation of pilot project, remarkable changes were observed.

In Harnampur PHCC, the orientation/sensitisation programme sorted out the disputes among management committee and created an amiable environment of reconciliation. This made ease to draft plan of action of the HFOMC with active involvement of the members. According to the action plan, a public hearing was held in the month of Jesth, 2070 BS to collect the views of local people in improving the health service.

An ANM was recruited temporarily from local resources to start the birthing centre from Ashad, 2070 BS. An interaction programme was also organised to explore the resource from local authorities within the VDC and to make the civil society more responsible and accountable. Now, the HFOMC was working out to operate 24 hrs delivery services. As the effect of program, coordinator of ambulance management committee, Bali Mohammad has committed to change PHCC into 15-bedded hospital. In this way, PHCC Management committee of Harnampur has headed towards the transformation.

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2.6 Mass Media Mobilisation

Mass communication media as an important social institution of modern society has the power to direct people’s attention towards certain issues; provides considerable amount of information and has the power to sensitise the policy makers. Recognizing as the most influential stakeholder, the CSOs effectively engaged media as a tool and media persons for advocating HRH issues at different level.

The activities related to media were published various articles in different level’s newspapers, investigative reported through media persons, broadcasted HRH issues and interview from local FM radios and prepared video documentary presentation. The example of issues broadcasted haphazard deputation of health workers and irregularity of the health workers at health institutions. The media also encouraged community people for their rights to get services from local health facilities and reinforced health workers for their duties to provide appropriate services.

Examples of Media Publications on HRH Issues

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2.7 Construction and/or Renovation

The situation analysis carried out by local CSOs indentified various needs of local health institutions which led to difficulty in providing effective services. Though different health institution had different needs, infrastructure maintenance is one of the common needs for them. Moreover, lacks of electricity supply, drinking water supply, furniture i.e. office tables and chairs, delivery beds, screens and few basic equipments were also required.

The CSOs themselves provided, and encouraged other local groups to support basic needs such as basic medical equipments (autoclave, nebulizer, BP sets, MVA sets, Ambu-bag, weighing machine and gloves), refrigerator, cupboard, wheel chair, and screens. The support also included small renovation of health institution building, maintenance of water supply pipeline, floor maintenance and, toilet and placenta pit constructions. Moreover, the CSOs coordinated relevant organisation for Skill Birth Attendance (SBA) Training to health workers. With these, the health workers perceived easiness to provide regular and quality services from local health institutions. As a result, the numbers of service users were increased significantly.

Examples of Equipments Supports to Health Facilities

Photos : SOLID Nepal
Mahendrakot Sub-Health Post in Kapilvastu - a Hospital for Rural People

Mahendrakot Sub Health Post (SHP) is situated in Pattharkot, ward no. 7 of Mahendrakot VDC. The SHP provides basic healthcare services to two adjoining VDCs, Dubiya and Balwaad along with peoples of bordering Arghakhanchi district.

In the past, the SHP was a primary health-care center (PHCC). However, it was demoted to SHP by political influence against the upgrading system of health institution from lower level to higher. This was an irony. Despite its demotion to SHP, it has been running a birthing center with the help of one Auxiliary Nurse Midwife (ANM) recruited temporarily by District Health Office (DHO). This was possible only due to high commitment of health facility operation and management committee (HFOMC) to support SHP. But, the condition for providing services was reeling under the shortage of attached toilet and placenta disposal pit. Despite the regular sitting of management committee meeting, there had not been any move from the local level for improving health services.

After the implementation of pilot project on human resources for health (HRH), the community people, HFOMC and health staffs were sensitized on need of the favorable condition for effective and quality healthcare that could be delivered from the SHP level. During the public hearing meeting and other stakeholders meeting, the community stakeholders of Mahendrakot VDCs committed to contribute from their individual level to improve better services through provision of 50% share from the budget allocated for the empowerment of women and children. The HFOMC had developed an action plan related to HRH with clearly defined roles of local stakeholder. To implement the plan, the VDC had allocated more than NRs 100,000.00 (hundred thousand) for recruitment of human resource (HR) and toilet construction.

As a result, one ANM and a helper were recruited and working since May 2013. A placenta disposal pit was built within the premise of SHP in coordination with District Health Office. In addition, a toilet was renovated attached to the labour room. At the same time, they are seeking help from community forest consumers committees. In this way, Mahendrakot SHP is working under the support of local authorities and civil society and is approaching towards success.
3.1 Improved Systems in Health Facilities

Smooth service delivery through health facility was the main objective of the pilot project. Keeping the identified needs at the centre, different resources available at local levels were mobilised to fulfil those needs.

Different physical and moral supports provided by the CSOs through pilot project observed significant changes in the health facilities’ infrastructures and service delivery which resulted increased service utilisation and the better feeling towards local health facilities.

3.1.1 Improved Maternal and Child Health Status

The focus of the pilot project was to improve maternal and child health status. Selected quantitative indicators of maternal and child health were analyzed comparing the status before & after the pilot project. The comparison between before and after pilot showed significant increase in maternal and child health status.

In nine months pilot, four new health facilities were upgraded as the birthing centres (Figure 6). Similarly, there was also increased in the number of SBA trained health workers available at the local health facilities (Figure 7).
Due to the increased number of birthing centres and SBA trained staffs, a significant number of service users visited local health facilities. The first antenatal care (ANC) visits increased by 15% and other indicators such as SBA assisted delivery, post-natal care (PNC) visits were also in increasing trends (Table 4).

Moreover, the rate of institutional delivery was increased (Figure 8). There used to be only 12% institutional delivery against expected pregnancy in total but after pilot, it reached to 16%. The increasing trend could be seen in four districts. However, there was no any change found in Lalitpur because of tertiary hospitals located in the Kathmandu valley.

<table>
<thead>
<tr>
<th>SN</th>
<th>Maternal Health</th>
<th>Status</th>
<th>Total (%)</th>
<th>'sabha (%)</th>
<th>Lalitpur (%)</th>
<th>Kapilvastu (%)</th>
<th>Pyuthan (%)</th>
<th>Darchula (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Number of 1st ANC visit</td>
<td>Before Pilot Project</td>
<td>51</td>
<td>62</td>
<td>18</td>
<td>75</td>
<td>64</td>
<td>62</td>
</tr>
<tr>
<td></td>
<td>After Pilot Project</td>
<td>66</td>
<td>68</td>
<td>22</td>
<td>113</td>
<td>84</td>
<td>73</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Number of delivery assisted by trained SBA</td>
<td>Before Pilot Project</td>
<td>12</td>
<td>15</td>
<td>2</td>
<td>8</td>
<td>20</td>
<td>35</td>
</tr>
<tr>
<td></td>
<td>After Pilot Project</td>
<td>13</td>
<td>15</td>
<td>1</td>
<td>5</td>
<td>29</td>
<td>36</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Number of PNC visit</td>
<td>Before Pilot Project</td>
<td>19</td>
<td>15</td>
<td>10</td>
<td>25</td>
<td>21</td>
<td>35</td>
</tr>
<tr>
<td></td>
<td>After Pilot Project</td>
<td>22</td>
<td>21</td>
<td>14</td>
<td>21</td>
<td>23</td>
<td>47</td>
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</tbody>
</table>
With the regular services available at pilot VDCs, the immunisation coverage was remarkably increased. The data showed children below 1 year, increased by 29% in total. Similarly, the data showed that the BCG coverage was 91% (increased by 15%) and DPT/HepB/Hib-3 coverage was 105% (increased by 29%). Similarly, OPV-3 and Measles coverage was increased by 29% and 14% respectively. (Table 5).

### 3.1.2 Improved HRH Status

Almost all sanctioned positions of health workers in 25 VDCs were filled after pilot initiatives. Apart from sanctioned positions, additional need based positions were filled by local hiring. In totality, the number of staffs (all types which include permanent, temporary and contract/daily wages) in the piloting health facilities in five districts were increased by 15%, i.e. there were only 93% of the sanctioned positions filled but after the pilot project it was reached up to 108% (Figure 9). The maximum increment observed in Kapilvastu district where permanent staff increased by 27% and temporary staff increased by 21%.
3.1.3 Perceived Changes in The Community

There were two types of changes: ‘felt’ and ‘seen’ or ‘observed’.

Participation of local people for the development of local health facility is fundamental requirement. However, almost all the health facilities were not in condition to provide regular and quality services. This was because of lack of awareness which led to lacks of basic infrastructure and equipments. Health facilities were not receiving people's acceptance, assistance and cooperation, and the number of service users was very less. However, the situation has been improved as the community and health workers built mutual trust, cooperation and understanding. Another aspect is health workers felt safety and providing regular services from local health facility. Now, they have not felt any lacks of basic infrastructure and equipments.

After the pilot initiatives, the HFOMC and local people became enthusiastic towards getting quality services. One of the community people opined, 'This project has awakened the HF staffs as well as the District Health Office.' Further he said, 'After the implementation of the project, the health workers are regular, and the members of HFOMC have also realized their duty, responsibility and the rights'. It concludes that vigilance and zeal have been created among the people as a result of the advocacy activities.
Ranju Tharu, 24, lives in Fachgaiya, a village at Mahendrakot VDC-1, Kapilvastu. The village is dominated by poverty and illiteracy. Her family labors hard in agriculture and to meet the needs of her family of 8, she works in other's field as well. Here is the story that Ranju shared.

"I have completed my 6th standard but I have no knowledge about reproductive health. Most of the women in our village do not go to health posts for ANC check up and delivery and I followed the same but later, Lagani Tharu, a neighbourhood sister, had suggested me to go to the health post.

I have been going to Mahendrakot sub-health post (SHP) to take health services since last two years. I had gone to the SHP for prenatal checkup for 4 times. I have noticed improvements in the service provided by the SHP in the last few months. I have heard that HRH pilot project is being implemented in this SHP. Two months ago, I gave birth to a healthy baby boy. During my labour, the nurse here took good care of me. I am also healthy. If the situation remains like this, I have decided that every time, I come across any health problem; I go to the SHP to receive appropriate treatment.

There is an outreach clinic in our village that runs regularly. Now a days, my other friends also go the SHP to take medicine and for check up. All the health staffs respond nicely to the patients. There was a rumor about the lack of medicines at the SHP but it is not true. We are getting medicines in time and the services at the SHP are regular. We are so lucky because a sub health post is providing us 24 hour delivery service. If there was no health facility as such, we would have been deprived of proper health care because going to the hospital was not possible due to the lack of money for transportation. May be, this is a SHP for others but for poor people like us, this is a nursing home or a hospital."
A Blissful View of a Doctor

“I have been working here as an acting Chief of District Health Office, Darchula for more than one year. Since then I have been facing HRH problem in the district. Mainly, the paramedical positions are vacant here. Mostly, the paramedics who come from Terai region and out of this district do not stay in the health institutions for longer period as they try for transfer since their postings. So, they spend more time on how to get out of the duty station as soon as possible. On the other hand, the paramedics who are from this district also want to be in place of their favour and start creating pressure for favourable transfer and the results the local paramedics work in deputed positions.

Things have changed since the implementation of pilot project on human resources for health (HRH) in this district. Due to the continuous advocacy activities and efforts conducted by CRDS-Nepal, deputation of staff for longer period has been discouraged and the trend decreased remarkably. Another good achievement of this project is the formation of district chapter of alliance on HRH. Most of the alliance members contribute voluntarily for the effective management of HRH within the district. I have heard that they have also made action plans to advocate on HRH issues. I hope this alliance will play crucial role in sustaining the best practices of the pilot initiatives for days to come. The pilot project sensitized the HFOMCs and local government for recruiting health staffs by using the local resources especially from VDCs and DDC. The temporary fulfillment of staff also contributed a lot in providing regular services from the health institutions. So, I think, it would be very good to replicate this type of project in the remote areas of Nepal where availability of staffs has become a major problem for providing basic healthcare services.”

– Dr. Rameshwor Devkota, DHO Darchula
One of health workers, during a public hearing, expressed his fear as, “we know that it was the health facility (HF) In-charge who would inform the HFOMC and call meeting but the HF staff feared that they would face the problems if HFOMC became active and alert”.

There were many views came up from the above expression and from it we could learn the relationship between HFOMC and the health service providers as well as how much responsible were the health workers towards effective health service delivery.

Pilot itself is a learning of a new practice. Its achievements and drawbacks were analysed. The period of pilot phase was for only 9 months and the greater changes could not be expected. However, it has demonstrated various remarkable achievements and of course some learning for the relevant stakeholders:

- **Insufficient Period of Piloting**

  As mentioned, sufficient duration is required to see the desired changes or impacts. In shorter period we can expect no more than some of the outputs though they indicate whether the targets being reached as it’s like ‘the morning shows the day’. However, a debate would be how long should be an appropriate period for the pilot project. The initial agreements with local CSOs were only for six months, but later, three more months extension was agreed. Though it has been demonstrated various achievements, institutionalizing those achievements was left over.

  Sometimes, the pilot period of two fiscal years would be very much appropriate to incorporate the budget and action plan in VDC and DDC council meeting. It would help to ensure required resources available for its continuation. This would also help to recognise CSO’s and HFOMC’s role in strengthening the health facilities. The relation among health workers, community peoples and local CSOs could be established efficiently.
• **Insufficient or Inappropriate Inputs**

Since the pilot period was only for nine months, the inputs in terms of human resources and financial support were limited. The pilot focused on strengthening health facility and operation management committee in line with health institution management. However, strengthening a health facility or bring improvements in health system in short period was a challenge in itself. Moreover, the requirement of different health facilities has been different and the entire requirement could not be fulfilled. For instance, the project, with its budget limitation, could not build an additional room for delivery or a staff quarter. Neither the project, by its own source, could recruit the required health workers for a longer period of time.

• **District Project Advisory Committee (DPAC)**

A project advisory committee at district level was formed to provide constructive suggestions and assistance for the successful completion of the pilot. The Representative from District Development Committee (DDC), and Regional Health Directorate (RHD), District Public/Health Office (DP/HO), District Women Development Office, piloted VDC Chairman, Save the Children (the then Merlin), SOLID Nepal, and local CSOs were the members of this committee. The committee would evaluate the pilot project and provide suggestions however; it could not play a vital role in those aspects as expected due to late formation of committee. The committee could also be facilitated to the selection of pilot VDCs of respective districts.

Photo: AFID Sankhuwasabha
The pilot project implemented in twenty five selected VDCs of five districts across the country from March to November 2013. An operational research revealed that where civil society is an active and supportive to health workforce, they have retained for longer time as they feel more secure there.8 Therefore, the pilot project had aimed to strengthen the roles of local CSOs i.e. HFOMC, VDC and Mother Groups.

Though, the period for piloting has only for 9 months and with limited resources, it had brought remarkable changes and established HFOMC’s roles on health institution management. There were not only changes in quantitative figures but also changes on perception of community people towards health workers and health institutions. The pilot became an interface to link among community peoples and health workers, as a result, the significant number of people receiving different health services has increased.

Indirectly, it has recommended a tangible and possible change with minimum support and mobilising local resources. The best practices could also be replicated into other settings where the similar problems are experienced.

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