GOVERNANCE AND HEALTH

Case Study: Linking Governance and Empowerment to Improved Maternal and Newborn Health Services in Nepal

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As the global community strives to reach the Millennium Development Goals (MDGs), there has been a renewed dedication to improving the health of women and children. Specifically, MDG 5 calls for reducing maternal mortality by 75 percent and achieving universal access to reproductive health services.

There is broad agreement on the technical interventions needed to improve maternal health, including access to quality, affordable health systems and services. However, focus on technical interventions alone is not enough. Barriers to improving maternal health include limited availability and quality of health information and services; and gender and social norms, cultural acceptability, cost and distance which reduce utilization even when services exist. A critical strategy to address many of these barriers is meaningful engagement of citizens, particularly the most marginalized, in shaping health policies, programs, and practices. This involves the establishment of systems of mutual accountability that are participatory, equitable and accountable and that support interaction between the community, health facilities and the government — the foundation for good governance.

CARE is continually striving to integrate governance into our maternal health efforts. This case study explains how we have worked with a variety of actors in Nepal — including the Government of Nepal, Health Facility Operation and Management Committees, Female Community Health Volunteers and community-based organizations — to develop a participatory governance process that fosters increased access to and utilization of maternal health services. Because political systems and social contexts vary by country, it is important to consider the unique adaptation and integration of governance in the country-specific setting.

BACKGROUND

Governance is a complex, dynamic political process through which decisions are made, conflicts are resolved, diverse interests are negotiated and collective action is undertaken. CARE defines good governance as "the effective, participatory, transparent, equitable and accountable management of public affairs guided by agreed upon procedures and principles to achieve the goals of sustainable poverty reduction and social justice."[1]

Based on our global experience on the ground, CARE has developed a governance programming framework that focuses on the relationship between government, citizens and their respective rights and responsibilities. This framework is based on the idea of "negotiated development," which argues that to achieve desired outcomes:

- Governments must be effective, accountable and capable to engage their citizens.

- Citizens must have the knowledge and capacity to exercise their right to participate in public decision-making.

- There must be a safe and inclusive space for citizens to negotiate their individual and collective interests with regard to managing public affairs.[2]

By challenging unequal power dynamics, this framework aims to ensure participatory decision-making, hold stakeholders mutually accountable and promote transparency to improve health outcomes. Our experience operationalizing the framework for health demonstrates that health service providers are critical stakeholders in governance and health care systems. Therefore, CARE aims to connect government officials (and other power holders), health care providers and empowered citizens to address some of the most urgent health issues, increase demand for quality services and increase the utilization and delivery of quality health services (See Diagram 1).

Diagram 1: CARE's Governance Programming Framework for Health
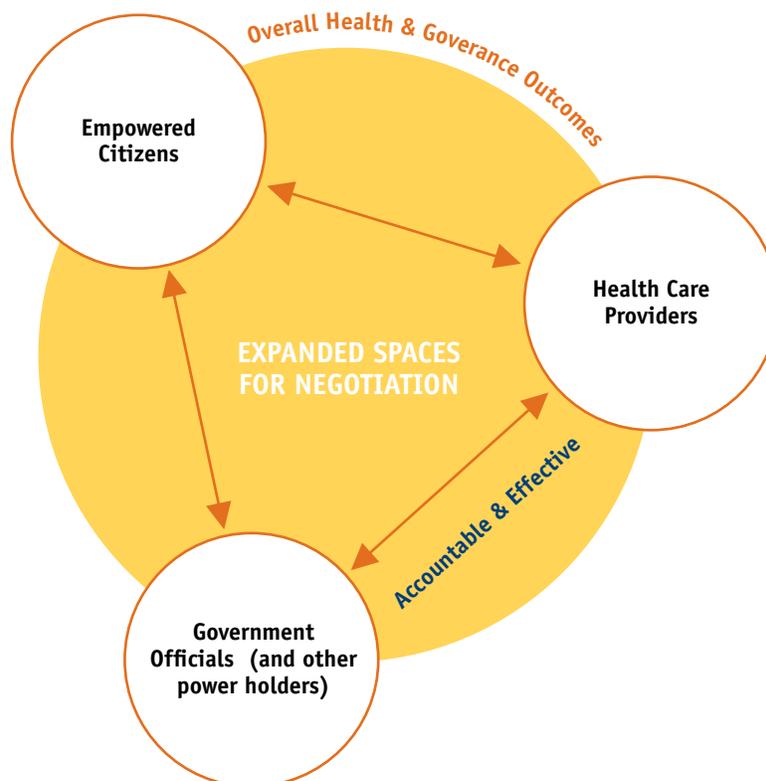
NEPAL: COUNTRY CONTEXT

Given the framework for how governance can influence the development of programs to improve health outcomes, it is important to understand the challenging situation facing Nepal's nearly 6.6 million women of reproductive age (ages 15–49).[3] Despite significant reductions in maternal mortality rates since 1990 (estimated at more than 50 percent), the country's maternal mortality ratio remains high: 281 per 100,000 live births.[4] More than 80 percent of women in Nepal deliver without a skilled provider; this increases to almost 95 percent among the poorest women.[5] Female community health volunteers (FCHVs) provide family planning in the form of condoms and oral contraceptive pills, yet approximately 50 percent of married women still do not use contraception. Recognizing these challenges, the Government of Nepal (GON) is committed to improving the health of women and children, which includes working to ensure that women have access to skilled care before, during and after pregnancy.[6]

In 1999, the GON implemented a decentralization policy to promote self-governance, which transferred power and authority to local bodies called Health Facility Operation and Management Committees (HFOMCs). These committees were created to: serve as a bridge between government and local communities, communicate the concerns of community members to health facilities and village development committees (VDC),[7] provide information to communities on new services or modifications to the health care system, help develop and monitor action plans, and help manage local health facilities.
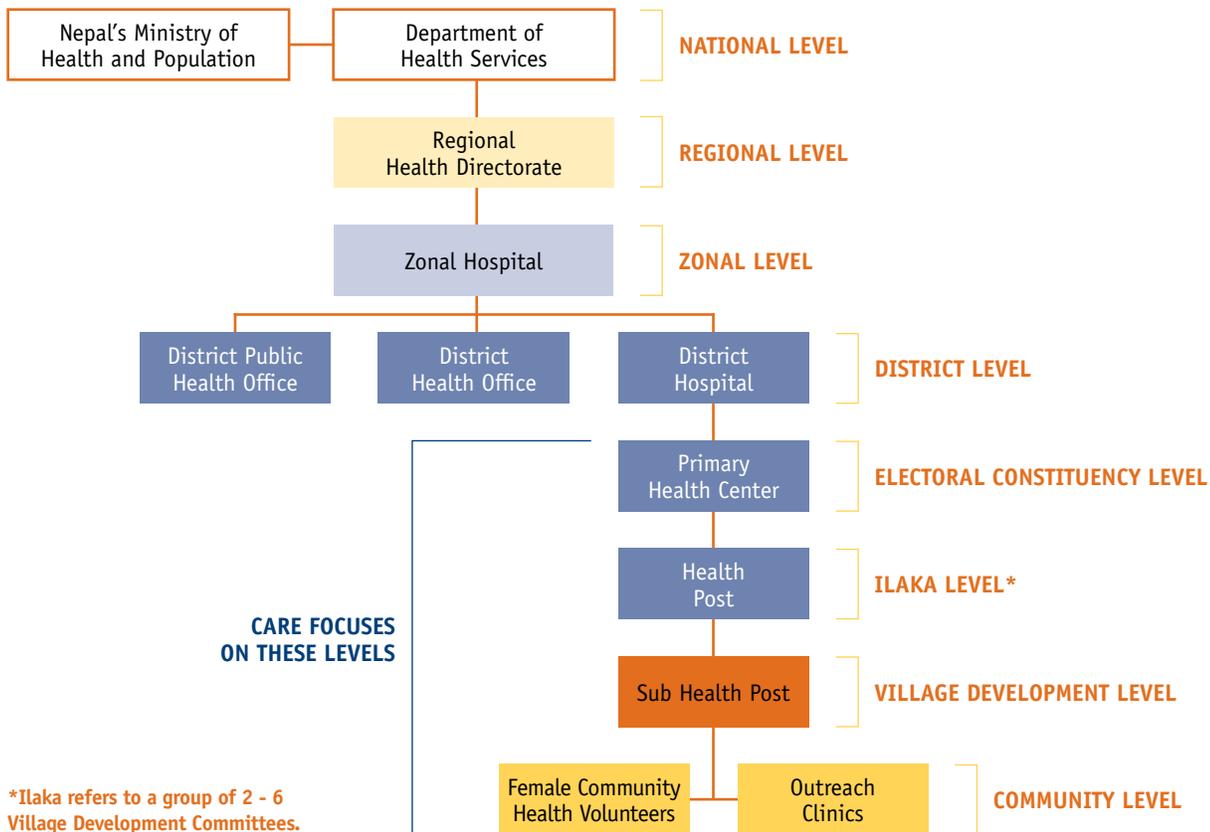
Nepali Health System

To understand the steps taken to improve maternal health outcomes in Nepal, it is important to first understand the country's complex, decentralized health care system, which oversees and manages multiple components of programs and service delivery at the national, regional, zonal, district, village and community levels. Given our commitment to community participation and reaching the most vulnerable populations, CARE focuses its efforts at the village and community levels (See Diagram 2).

Box 1: The Role of FCHVs

FCHVs are responsible for monitoring the health status of pregnant women and their newborns. This includes ensuring that the women receive ante-natal care and the recommended number of iron tablets, and that they make arrangements to deliver at a birthing center with a skilled birth attendant. FCHVs also monitor newborn health, which includes following up on immunizations and ensuring that mothers seek post-partum care. With support from CARE, local partners and the government, each FCHV is expected to reach and support at least 200 households.[8] CARE works with FCHVs to make sure they have updated information on birth-planning preparedness and dangers signs, and that they are equipped with tools to monitor pregnant women (e.g., community maps and registries).

Diagram 2: Overview of the Healthcare System in Nepal

Box	Level
Nepal's Ministry of Health and Population — Department of Health Services	NATIONAL LEVEL
Regional Health Directorate	REGIONAL LEVEL
Zonal Hospital	ZONAL LEVEL
District Public Health Office — District Health Office — District Hospital	DISTRICT LEVEL
Primary Health Center	ELECTORAL CONSTITUENCY LEVEL
Health Post	ILAKA LEVEL*
Sub Health Post	VILLAGE DEVELOPMENT LEVEL
Female Community Health Volunteers — Outreach Clinics	COMMUNITY LEVEL

CARE FOCUSES ON THESE LEVELS

*Ilaka refers to a group of 2 - 6 Village Development Committees.

Adapted from the World Health Organization, Country Health System Nepal, (2007, August 6). Available at www.searo.who.int/en/Section313/Section1523_6866.htm.

## CARE'S ROLE IN STRENGTHENING GOVERNANCE IN NEPAL

To reduce maternal mortality and increase family planning services, CARE collaborated with Nepal's Ministry of Health and Population and District Public Health Offices (DPHOs) to implement the Nepal Family Health Program (NFHP). CARE's contributions included building the capacity and strengthening the role of the HFOMCs, disseminating health messages and improving accountability of health service providers and supporting FCHVs (See Box 1). Together, these activities help form an efficient, responsive health system. Community members now have an open forum in which to voice their needs and concerns to their local HFOMC, which then channels this information to VDCs and DPHOs for resolution, while ensuring that the community receives feedback. Local CARE staff have encouraged community members to participate in decisions on health service delivery through the HFOMCs, VDCs and community-based organizations. In addition, CARE has promoted the inclusion of historically marginalized and vulnerable groups, such as the Dalits, Janjatis[9] and women in general, thus empowering communities to ensure that health services address the diverse needs of all their residents.

The HFOMC: Creating Participatory Governance Systems

Within the decentralized Nepali Health System, CARE worked at the village and community level to link government officials, health service providers and empowered citizens so they could discuss and resolve health-related issues — and thus improve health outcomes. (Diagram 3 shows how these village- and community-level actors engaged with one another.)

Diagram 3: Improved Maternal Health Service Delivery through Local Governance Networks
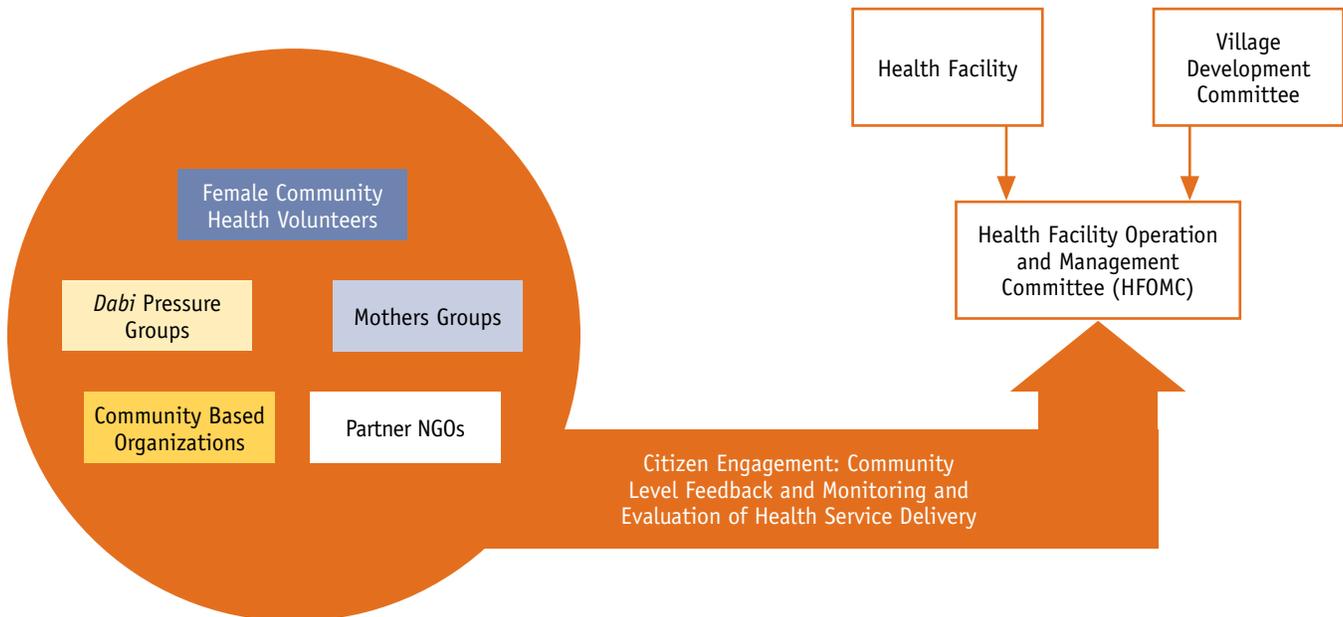
Adapted from Child Health and Nutrition Beyond Sustainability: Rights-based Approach Empowers Marginalized Communities in Nepal Child Survival Project. A Case Study. Working Paper Series No. 1, August 2009, p. 8.

When the GON implemented its national policy decentralizing health services, it created HFOMCs to manage local health facilities. CARE played an integral role in building HFOMC capacity by: 1) developing a training program outlining members' roles and responsibilities and 2) providing guidance on budget management, resource development, conflict management, monitoring, quality assurance, reporting and leadership.

HFOMCs are formal bodies that actively engage community members, FCHVs and traditional birth attendants around issues of health service delivery and decision-making, while monitoring and evaluating service delivery. Through their coordination with FCHVs, the HFOMCs ensure that communities have access to health services, such as outreach clinics. HFOMCs also enable inclusive relations between community members and public authorities by facilitating regular meetings and creating an open space for discussion about health services.

HFOMCs articulate issues related to service quality, availability, customer satisfaction and logistics to health facilities so they can be addressed and resolved. Community members gather to discuss health-related issues in informal spaces such as mothers' groups and dabi (pressure) groups,[10] which are facilitated and coordinated by FCHVs and community-based organizations. HFOMCs then share concerns, ideas and other information generated through these informal structures with local health facilities, VDCs and other relevant institutions. HFOMCs are responsible for keeping the community informed about actions being taken to address their needs and concerns, including modifications to the health care delivery system. HFOMCs are designed to address and support infrastructure improvements (e.g., upgrading health facilities into birthing centers), improving quality of services (e.g., ensuring that trained providers are available to meet community health demands) and providing general oversight.

Through HFOMCs, local health facilities have been able to recruit additional auxiliary nurse midwives in two districts where CARE works. In another district, a health facility had the resources to recruit temporary staff to support administrative activities during the summer, when the outpatient case load increases and sometimes exceeds 200 patients a day.[11, 12]

As mentioned earlier, CARE also promoted the inclusion of historically marginalized and vulnerable groups in the HFOMCs. Though the committees were designed to have a diverse membership of 7–9 community representatives,[13] they initially lacked representation from the poor, women and marginalized ethnic groups. CARE was influential in encouraging local women's leaders and mothers' groups to get involved with HFOMCs, stating in the HFOMC guidelines that women should comprise 40 percent of HFOMC membership.[14] In 2006, CARE conducted an evaluation of the NFHP implemented in seven districts and found that historically marginalized individuals and women accounted for 27 and 39 percent of HFOMC membership, respectively. While the goal was to have these groups represent at least 40 percent of HFOMC membership, it was a notable improvement from early HFOMCs, where few, if any, women and marginalized individuals were included.

SUCCESSES AND KEY LESSONS LEARNED

CARE has worked in Nepal to link formal entities, including health service providers and government officials, to informal groups of engaged and empowered citizens, with the goal of raising awareness about health issues — in particular, proper ante-natal and post-natal care and the value of institutional deliveries with the support of trained providers. CARE helped train female community health volunteers (FCHVs) on the importance of ante-natal and post-natal care, proper nutrition and immunizations, which they relayed to pregnant mothers during home visits and monthly mothers' groups meetings. CARE has also been instrumental in involving communities, particularly the most marginalized members, in making decisions about health services, ensuring that community concerns

are addressed and that residents are informed about changes to health facilities and service delivery. By raising community awareness, residents have begun to learn more about their rights to access health services; demand for services has thus increased, as has utilization of those services. While CARE continues to gather evidence to strengthen the link between governance and improving health outcomes, there are already some broad lessons learned that show how HFOMCs increase community engagement, increase inclusion and empower communities.

EMPOWERING COMMUNITIES

HFOMCs enabled community members to participate in health service decision-making by incorporating their feedback into meaningful solutions and high-quality service delivery. Community members report feeling empowered and included, and have noticed positive changes in health service delivery. Now that community members are more aware of their health rights and needs, they demand regular and timely health services from local health facilities and outreach clinics. They report feeling ownership and community cohesion regarding the mobilization of resources to improve service quality. This includes communities uniting to demand that

local government bodies allocate funds to construct additional rooms in health posts or upgrade health posts into birthing centers (See example of facility upgrade in picture on right). In one community, this resulted in the VDC contributing Rs 10,000 ($140 USD) to support upgrades to the local health facility, while another local partner contributed an equal amount to support an emergency fund for pregnant women. Communities are actively engaged in monitoring service delivery by following up with patient satisfaction surveys, monitoring the operating hours of health facilities, monitoring the availability of drugs and equipment at health facilities, and ensuring that these services meet community needs.

INCREASING SOCIAL INCLUSION

Prior to HFOMCs, marginalized populations, including women in general, were underrepresented in the health care system. When guidelines were established defining how HFOMCs should operate, CARE led the effort to ensure that at least 40 percent of committee membership would consist of women and other marginalized individuals. In one district where CARE works, the HFOMC has 19 members, despite only needing seven; committee members had agreed that seven was not a representative group.

COMMUNITY-LEVEL GOVERNANCE

In addition to strengthening the role of HFOMCs, CARE has been instrumental in ensuring that communities are active stakeholders in the governance process. An important link to the community is the FCHV, who assists with implementing national health programs, including maternal and child health, family planning, nutrition and referral services. FCHVs are self-motivated, unpaid community members who receive training on health services and health issues (e.g., vaccination, nutrition, family planning) and serve as a link between the health facility and the community. Many FCHVs who collaborate with CARE have been volunteering for more than a decade, some for much longer.

In addition, FCHVs report maternal and newborn deaths and complications to local health facilities through the Pregnancy Outcome Surveillance System. Follow-up investigations on maternal or neonatal deaths can lead to additional onsite job training and supervision for health staff. Relevant information on preventing maternal and newborn deaths is communicated to community members through mothers' groups and FCHVs. After a FCHV completes the appropriate health registry, the information is compiled and analyzed by CARE and then shared with the local DPHO.

SUMMARY

Nepal has made significant progress toward improving overall maternal health as well as transferring decision-making power and representation to local bodies in order to improve and provide equitable access to health service delivery. The number of health facilities upgraded to birthing centers to support institutional deliveries has increased, the quality of health services is continually being addressed, and a process for oversight and accountability involving the government, health service providers and community members is in place. CARE will continue to work with all of these actors to improve the health of women in Nepal and to demonstrate more systematically how governance and empowerment are linked to improved health outcomes.

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END NOTES

[1] CARE Governance Programming Framework, 2010–2011 (p.2).

[2] IBID.

[3] Nepal District Health Profiles, 2007.

[4] Ministry of Health and Population (MOHP) [Nepal], New ERA, and Macro International Inc. 2007. Nepal Demographic and Health Survey 2006. Kathmandu, Nepal: Ministry of Health and Population, New ERA, and Macro International Inc.

[5] IBID.

[6] WHO. (May 2010). Nepal. Country Cooperation Strategy at a glance.

[7] A village development committee (VDC) is the lower administrative office within Nepal's health system. VDCs are divided into wards, which are established based on the population of each district. On average, each VDC services nine wards. (GON, Ministry of Local Development, www.mld.gov.np/vdc.htm.)

[8] In the mountainous and more remote districts, FCHVs usually travel on foot and are therefore expected to reach only 75 households.

[9] Dalits are the lowest caste in the Hindu religion and are sometimes referred to as "untouchables." Janjatis are indigenous people who have faced racial discrimination.

[10] Dabi groups (pressure groups) are local advocacy groups open to any member of the community. Dabi groups gather to discuss a variety of issues, raise awareness about those issues and ensure that community members are aware of their rights.

[11] The number of patients, 200, was shared verbally during a site visit with the HFOMC and FCHV in this community January 2011. They estimated that on a busy summer day, up to 200 patients would visit this clinic; this estimate was not verified independently.

[12] Personal communication, January 2011.

[13] A HFOMC includes the VDC chair, health facility in-charge, one ward member serving as the chair person of the VDC's population development sub-committee, 1–2 FCHVs, two mothers (1 Dalit), one school headmaster, one civil society representative, and Dalit and Janajati representatives.

[14] It was determined by the HFOMC that one third would be considered a fair representation for marginalized groups, so the target was set at 40%, just above the one-third mark (33%). According the 2001 Census in Nepal, the population includes: Upper caste 27%, Dalit and Janjati 38% and other unspecified 33%. Ethnic groups: Chhettri 15.5%, Brahman-Hill 12.5%, Magar 7%, Tharu 6.6%, Tamang 5.5%, Newar 5.4%, Muslim 4.2%, Kami 3.9%, Yadav 3.9%, other 32.7%, unspecified 2.8% (Central Bureau of Statistics, Nepal).

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