Leaning into Local: Impact of Federalisation on Social Accountability Processes in the Health Sector of Nepal

Social Accountability in Nepal’s Health Sector (SAHS)
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Abstract

Pact, an international non-profit organisation working in 40 countries, has implemented the Social Accountability in the Health Sector (SAHS) project in Nepal since 2017, funded by UKAid. Over three years, this project has analysed how ongoing federalisation reforms have impacted the health sector and its impact on health-focused social accountability mechanisms. This paper distils the main trends and lessons from eight of the fifteen studies conducted from 2017-2019, with nearly 1,500 respondents consulted across seven provinces and twenty-two districts. Results show that as federalism continues to be operationalised throughout Nepal, a series of practical challenges, complicated by individual and institutional incentives, will need to be overcome in transferring the capabilities, knowledge, and staff necessary for local governments to fully inhabit their new mandates. Existing capacity deficits have had material impacts on both local social accountability efforts and on the health sector more broadly, with one effect being confusion around the commitment of local governments to social accountability mechanisms. Despite these challenges, there remains a persistent sense of optimism around the federalisation process and its ability to foster an inclusive society, as citizens view elections and elected representatives as providing accountability and serving as an “equalising” force across socio-economic, caste, and gender divides. The Government of Nepal (GON), donor-funded projects, and civil society can build on this knowledge base. In the future, applied research on citizen perceptions, information flows, responsive local feedback loops would provide important insights into the local citizen-state relationship. Results of this further research could also strengthen efforts to develop the capabilities of local governments and build durable support for social accountability mechanisms.

Introduction

In 2017, Nepal held its first open local elections in a generation, accelerating a federalisation process that was years in the making. Federalism in Nepal was fundamentally aimed at enabling accountable governance by shifting public decision-making to elected representatives responsive to local communities. After successive Constituent Assembly elections in 2008 and 2013, Nepal’s leaders promulgated a constitution in 2015 aimed at establishing three equal tiers of government at the federal, provincial, and municipal levels. Given Nepal’s history of highly centralised governance, the establishment of municipal and provincial governments represented a re-centring of political authority away from Kathmandu. By moving the locus of power closer to communities, many Nepalis hoped to address the country’s long history of exclusion and marginalisation, which they viewed as primarily responsible for a decade-long civil war (1996-2006) and continued social and political division.

There were, and remain, hopes that federalism could foster improved performance in service delivery in sectors such as health. Despite improvements in key indicators such as under-five

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mortality, at the advent of federalism health sector service delivery remained chronically below standard. Federalism offered the chance for greater social accountability – i.e. increased citizen ability to hold state agents accountable for performance – by bringing citizens and service points (such as health facilities) closer to powerholders.

The local elections of 2017 set in motion the large-scale and challenging federalisation process, tasking the Government of Nepal (GON) with establishing a host of new practices. These included instituting norms for local elected bodies, assigning authorities across the three levels of government, transferring resources to municipal and provincial governments, and redeploying federal civil servants into municipal and provincial service. This undertaking was contentious, bringing to the surface in-built tensions across the nascent federal system and, in many cases, challenging entrenched political and bureaucratic interests.

To understand the lived reality of the federalisation process to date – and the degree to which it has begun to foster greater accountability – it is helpful to focus on specific sectors where new practices and authorities are being defined. Under the UKAid-funded Social Accountability in the Health Sector (SAHS) project, we have tracked how federalisation has been experienced in the health sector. Since 2017, we carried out a series of 15 qualitative research studies directly or indirectly aimed at answering the following question:

**How is the federalisation process impacting the prospects for social accountability within the health sector in Nepal?**

These studies examined how the establishment of local governments affected opportunities for citizens to give feedback on governance performance, including in the health sector. This report synthesises three years of findings from eight of these studies and presents the main trends and observations, examining how the disruption of the federalisation reform process is creating near-term opportunities and risks for promoting social accountability in the health and other service sectors. Our research found that a wide range of stakeholders remain optimistic that political federalism can promote accountable governance and service delivery, including in the health sector. The studies also illuminated the challenges associated with the federalisation process, such as delays in the deployment of human resources and the steep learning curves experienced by newly elected leaders, which present clear risks for ensuring an accountable health sector. Three years into the reform process, the newly federal system continues to offer opportunities for promoting a more responsive health sector, but key questions related to the long-term commitments of local governments to ensuring social accountability remain.

**Background**

Nepal has made progress in expanding access to health services and improving health outcomes over the last generation. The number of hospitals, primary health care centres, and health posts increased significantly in the twenty years preceding local elections in 2017.¹ There have been corollary and significant improvements in neonatal, infant, and under-five morality, with the latter dropping from 118 per 1,000 live births in 1996 to 39 in 2016.²,³ Improvements have extended well beyond maternal, new-born, and child health. For example, 69% of households have access to drinking water on their premises, compared to 9% in 1996, and 62% have access to improved toilet facilities compared to 23% in 2016.⁴,⁵ These and other successes contributed
to overall gains in life expectancy, with a 20% increase in life expectancy from 1996 to 2020 to 70.82 years.\textsuperscript{6}

Despite these achievements, numerous challenges remain related to the delivery of quality healthcare. Prior to the beginning of federalisation, only half of health facilities had access to soap, running water, and regular electricity, while absenteeism of health staff was a chronic feature of the health system.\textsuperscript{7} Citizens and healthcare officials complain of frequent shortages in essential drugs, limited emergency services, and poor quality of care.\textsuperscript{8} Inadequate access to services within government-run facilities is seen as key driver of Nepalese citizens into the growing private healthcare system.

**Figure 1: Progress and Challenges in Nepal’s Health Sector\textsuperscript{9}**

The GON’s National Health Sector Strategy 2015-2020 (NHSS) aims to achieve “improved health status of all people through an accountable and equitable health service delivery system.”\textsuperscript{10} The Ministry of Health and Population (MOHP) has a multifaceted approach to reaching this outcome, including expanded access to primary and tertiary care facilities, extending networks of community-based volunteers, influencing behaviour change and health-seeking behaviour of citizens, and investing in the capacity of health personnel and technology of the larger health system. The MOHP’s strategy also includes maintaining a set of social accountability-oriented structures and processes for capturing and responding to feedback from citizen-users.

**Evolution of social accountability in the health sector and beyond**

Investments in community-level structures that promote social accountability predate the emergence of political federalism and, in many ways, were an effort to compensate for the absence of elected local governments. The Local Self-Governance Act (1999) provided a legal basis for constituting local government bodies and deconcentrating key governance functions.
However, elected local governments were discontinued in 2002 at the height of the Maoist insurgency and the Act never fully implemented. In the absence of elected local government, donors, NGOs, and even the GON turned to citizen groups and related structures to engage citizens in civic processes and provide some degree of oversight over local powerholders. During and following the conflict, citizen groups represented one of the only forms of non-military social organisation, particularly in rural areas.\(^{11}\) The then-Ministry of Federal Affairs and Local Development (MOFALD) implemented a participatory planning process to guide annual development plans, which leveraged citizen groups and community-based organisations (CBOs), fostering feedback through a range of tools and processes such as public hearings, public audits, and social audits.

In the decade prior to the establishment of a federal governance structure, efforts within the health sector to promote citizen-user feedback mirrored broader national strategies around social accountability. Beginning in the early 2000s, the MOHP formed Health Facility Operation and Management Committees (HFOMCs) to provide local-level oversight to health facilities, with hospital development committees (HDCs) providing a similar function for hospitals. HFOMCs were directly linked to networks of Female Community Health Volunteers (FCHVs) and mother’s groups, which were envisioned to provide a feedback channel to local communities. Furthermore, the centrepiece of the MOHP’s social accountability strategy included holistic social audits aimed at gathering comprehensive feedback from citizen-users, which were rolled out to more than 2,100 health facilities in all 77 districts by 2017-18.\(^{12}\)

By the mid-2010s the GON and the MOHP had made significant progress in institutionalising these initiatives to foster citizen engagement and capture community feedback into local governance and service delivery systems. However, persistent challenges remained. Many user groups, including HFOMCs, were underutilised or even inactive. Furthermore, processes such as like health facility social audits were often treated like “rituals,” falling short of established guidelines and failing to inform higher level policymaking and resource decisions (see \textbf{Results}, Figure 2). At the start of the federal era, therefore, a key question was whether existing, hard-earned social accountability practices in the health sector and beyond would be retained and strengthened.

\textbf{Selected global evidence related to decentralisation, federalism, and accountability}

Proponents of federalism in Nepal argue that the combination of elections, local control over public decision-making, and the creation of smaller administrative units closer to communities will foster responsive and accountable governance. Prior to initiating primary research in 2017, we reviewed selected meta analyses that examined the relationship between decentralisation and similar federalisation processes and accountable governance service delivery. One analysis found that “leader selection” for local government is preferable to systems of appointment for local officials.\(^{13}\) Local elections support the legitimacy of local leaders, contribute to increased provision of public goods and more effective targeting of poor households, and increase community willingness to contribute to collective action efforts. Importantly, however, elections appear to be most effective in “high information environments,” in which voters know those running for office and their policy preferences, as well as in communities with dense networks, conditions that may not be met in many contexts in Nepal. Another analysis found that the creation of smaller administrative units can lead to “information benefits,” with local leaders being better connected to citizens, while larger units are better positioned to achieve economies of scale.\(^{14}\) Evidence around the impact of administrative unit size in developing countries, however, is scant. Thus, while there is notable evidence to support the contention that local
elections can contribute to more effective and responsive governance, there remains significant uncertainty about its precise impact in the Nepali context. Furthermore, there exists even greater ambiguity about how establishing smaller federal units in the form of municipalities (753 in total) will bolster social accountability.

Methods

SAHS collaborates closely with the Nepali Ministry of Health and Population and other stakeholders in the health sector to promote learning and best practices to effectively promote social accountability. In addition, SAHS provides a platform that brings together stakeholders including government, practitioners, civil society, media, and health professionals to share lessons and insights to that end. SAHS sought to strengthen social accountability efforts in the health sector on the local level through Civil Society Organisations Advisory Groups (CSOAGs) and Multi-Stakeholder Social Accountability Forums (MSSAFs). Underpinning this work are a series of analytic reports designed to help practitioners understand the current state of social accountability in Nepal, and the opportunities and challenges to marshalling it for better health outcomes.

The qualitative research studies analysed for this report were conducted between May 2017 and November 2019. These studies included three Situation Analyses describing the state of social accountability processes and mechanisms within the health sector as well as within the larger governance system in Nepal. We also conducted three Applied Political Economy Analyses (APEAs) examining factors that influence the functionality of existing social accountability practices. While the situation analyses provided a surface level review of what exists in terms of social accountability within the health sector, the APEA studies sought to uncover why certain practices, opportunities, and constraints exist. In addition, we applied a political economy lens to nine case studies examining specific issues that emerged from these wider studies. The case studies included in this report explored the shifting role of HFOMCs, the role of citizen engagement in the health sector during the early stages of the federalisation process, the social accountability of public and private health service providers, and the impact of federalism on inclusion in the health sector.

Each of these studies directly or indirectly examined how the federalisation process (and the federal structure itself) influences social accountability practice in Nepal. By placing federalisation near the centre of each analysis, we were able to track changes in how the reform process was experienced within the health sector over time and its implications for accountability. We used common definitions of key terms across our qualitative research, understanding social accountability as activities other than voting that citizens carry out to hold governments accountable. More descriptively, social accountability refers to “the broad range of actions and mechanisms beyond voting that citizens can use to hold the state to account, as well as on the part of government, civil society, media, and societal actors that promote or facilitate these efforts.”

Our analyses focused on the institutional structures and processes that have developed in Nepal to foster accountable relationships between state institutions and citizens, including user group structures such as HFOMCs and facilitated engagement processes such as social audits. While SAHS focused specifically on social accountability, state-society relations exist within a broader ecosystem that reflects other dimensions of accountability. These include political
accountability, the ability of constituents to hold government office holders accountable through elections and related processes, and administrative accountability, or the ability of a system or bureaucracy to promote desired behaviour, including through the combined use of rewards, sanctions, and norms.17

We reviewed each of the above-mentioned research studies to prepare this synthesis, focusing on identify key trends that emerged across the individual studies. Each study included a desk review, with research teams consulting a mix of academic sources and “grey” literature. However, given the focus on understanding existing practices and the contemporary political economy (topics not adequately covered in existing literature), research teams relied on primary data collection for each analysis. Researchers conducted semi-structured key informant interviews (KIIs) and focus group discussions (FGDs) with diverse cross-sections of stakeholders, including MOHP staff, local government officials, community representatives, civil society, academics and policy experts, and others. KIIs and FGDs were organised around interview guides fitted to individual stakeholder groups. Researchers received written or verbal informed consent prior to conducting all interviews.

Within the geographic area of SAHS – seven provinces and 22 districts† – 1,483 respondents participated in KIIs and FGDs (see Map 1).

Map 1: Geographies Covered by SAHS Research

Although some respondents participated in multiple studies (reducing the number of unique respondents engaged), the research team prioritised capturing a diversity of perspectives and

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† SAHS conducted research in the following provinces (districts included follow in parentheses): Province No. 1 (Morang, Sunsari); Province No. 2 (Bara, Dhanusha, Siraha); Bagmati Pradesh (Bhaktapur, Dolakha, Kathmandu, Makwanpur, Nuwakot, Ramechhap); Gandaki Pradesh (Lamjung, Kaski); Lumbini Pradesh (Banke, Bardiya, Kapilvastu); Karnali Pradesh (Surket, Dailekh); Sudurpashchim Pradesh (Dadeldhura, Kailali, Kanchanpur)
geographies in each report. We presented the results to key actors including MOHP and other national health actors, CSOs, elected leaders, municipal officials, other local stakeholders, as well as development partners including the WHO, UNDP, USAID, World Bank, UNFPA, and the British Embassy Kathmandu. The feedback from these dissemination activities positively informed ongoing research activities, and ensured the studies presented actionable insights and recommendations for stakeholders seeking to improve the quality of social accountability in Nepal.

Results

We have explored the impact of the federalisation process on discrete processes and structures aimed at facilitating social accountability, particularly how practices and tools such as health facility social audits and mechanisms like HFOMCs have been affected by ongoing reforms. Our research studies also survey how the federalisation process has impacted the ability of elected local governments to affirmatively act (i.e. execute policies and commit resources), a necessary pre-condition for government responsiveness, and by extension, social accountability. This includes, for example, describing how human resource deficits potentially limit the responsiveness of municipal authorities.

This report presents the results of this research as broad lessons and trends from the initial years of the federalisation process. These lessons are interrelated and reinforce the continued appeal of federalism, suggesting that meaningful relations are being formed between elected officials and other key stakeholders, including local citizens. However, the federalisation process has been disruptive and left unresolved questions about commitment to social accountability within the health sector.

Diverse stakeholders have been optimistic about the potential for federalism to yield more responsive service delivery, but that optimism is increasingly under strain

The process of federalisation and decentralisation filled a void in local governance that persisted for nearly two decades. A diverse range of stakeholders have remained optimistic that bringing government to the local level would bring accountability and responsive service delivery. This optimism seems rooted in two overarching beliefs about decentralisation: first, that electing local level officials who hail from the communities they represent will be incentivised to perform better than officials appointed by Kathmandu, and secondly, that the federalisation process will result in smaller jurisdictions that will increase accountability. One FCHV summarised the sentiment that existed circa 2017: “local government will ensure transparency at their work as they represent the people; they will be more responsible.”18 The optimism identified at the start of the federalisation process was amplified by a sense of fatigue and frustration with the poor state of service delivery under the previous governance system. Local community groups who sought to meet urgent healthcare needs lamented stockouts of medicine, the scarcity of qualified staff, and overall low level of care that plagued community healthcare facilities.

While stakeholders appeared generally enthusiastic about federalism, they were not naïve about the challenges. Instead, their optimism was tempered with concerns about how federalisation would unfold in practice, including how it would impact service delivery. In 2017, stakeholders noted concerns that the unclear roles and responsibilities between different levels of government, misuse of public resources, and lack of skilled health professionals might continue,
negatively impacting health outcomes on the local level. As one district-level NGO worker put it at the time, “risks go hand-in-hand with the opportunity.”

Multiple factors over time have strained the optimism that existed in the wake of local elections. By 2019, continued confusion over the precise roles and concurrent powers of different levels of government, as well as slow and uneven progress in drafting local legislation such as policies concerning health, sanitation, emergency and disaster management, and cooperative related acts resulting in frustration among some stakeholders. Furthermore, multiple perceived scandals involving elected officials – including their focus on salaries and allowances for themselves – impacted perspectives on the degree to which federalism is contributing to accountability. Our research shows that, over time, a divergence emerged between elected representatives and community representatives over the degree to which they see federalism as contributing to positive, public-interest oriented outcomes. Local officials remain optimistic about their progress while demand-side stakeholders convey a sense of being let down. The Executive Director of one NGO explained, “federalism is not progressing as per people’s hopes and expectations. The implementation side is weak.”

There is nothing in our research to suggest that frustrations with elected representatives or the federalisation process led to significant disillusionment with the federal system, or a view that the old centralised system better-promoted accountability. The cognitive dissonance between elected officials and demand-side stakeholders over government performance is perhaps normal within any democratic system but could represent a point of disequilibrium that over time may undermine collective confidence in the local governance system.

**Elected local officials and other stakeholders have faced a steep learning curve in understanding their roles and responsibilities within the federal governance system**

Accountable governance and responsive service delivery requires a government that can execute clearly defined functions. Our research found that local elected representatives, civil servants, and community representatives were slow in understanding their roles and responsibilities. The challenges that municipal officials face in comprehending key components of their job are a constraint on their performance and, therefore, a barrier to their accountability to local constituents. However, this research also signals that experiential practice has begun to augment the knowledge and skills of stakeholders.

In 2017, local officials repeatedly explained that they had insufficient guidance in drafting and passing legislation and performing key administrative functions. One Ward Chief summarised the views of many in complaining that “...if the guidelines from the top came, then we’d be in a better position. Instead they [federal government officials] are blaming us for not being able to do things in the first two to three months.” In many cases, local representatives felt that they understood their broad, constitutionally mandated roles, but lacked an understanding of how to fulfil those functions. A deputy mayor from Dolakha district explained that “we are very clear on our role and responsibility as stated in the constitution of Nepal based on which we have started work... but there is a need for policies and guidelines to implement our role and responsibilities more effectively.” The gap in understanding and executing their legislative functions has limited the extent to which municipal governments have addressed health-sector legislation. While authorised under the Local Government and Operations Act (2017), municipal governments have not prioritised the formulation of local health policies and legislation. Municipal Health Unit staff in multiple municipalities noted that local legislation would help clarify roles, responsibilities, and systems at the municipal level.
This knowledge deficit has also dampened social accountability efforts; many officials do not understand health sector social audits, limiting the extent to which they make use of their results. As seen in Figure 2 below, social audits are an intensive process that is often not executed according to protocol, but as a perfunctory requirement (see Background). It is possible that the complexity of social audits is not well-understood due to this learning curve, thereby dampening the impact of MOH’s primary social accountability effort.

**Figure 2: Social Audit Process in Principle and Practice**

<table>
<thead>
<tr>
<th>FORMAL PROCESS</th>
<th>REALITY</th>
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<tbody>
<tr>
<td><strong>1. PREPARATION, INFORMATION COLLECTION AND ANALYSIS: 3 DAYS</strong></td>
<td><strong>1. PREPARATION AND DEVELOPMENT OF ACTION PLAN</strong></td>
</tr>
<tr>
<td>On-site observation, information collection and exit interviews with clients</td>
<td>Contractor requests Health Facility In-Charge to prepare key documents, including budgets and facility plans</td>
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<tr>
<td>Preparation for mass meeting (participants, venue, issues for discussion and roles of stakeholders)</td>
<td>Based on document review, contractor prepares initial findings and action plan</td>
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<tr>
<td>Collection of information from community (group discussion, interview and meeting with program beneficiaries)</td>
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<tr>
<td>Analysis of information</td>
<td></td>
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<tr>
<td>Sharing of preliminary findings with HFOMC and health service providers and preparation of draft action plan</td>
<td></td>
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<tr>
<td><strong>2. CONDUCT MASS MEETING AND PREPARATION OF ACTION PLAN: 1 DAY</strong></td>
<td><strong>2. CONDUCT MASS MEETING</strong></td>
</tr>
<tr>
<td>Facilitation of mass meeting (organise, present findings, open discussion)</td>
<td>Contractor asked Health Facility In-Charge to invite participants to mass meeting; Mass meeting held</td>
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<tr>
<td>Present and revise action plan</td>
<td></td>
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<tr>
<td><strong>3. PREPARE REPORT AND DEVELOP FUTURE ROAD MAP: 1 DAY</strong></td>
<td><strong>3. PREPARE REPORT</strong></td>
</tr>
<tr>
<td>Submit action plan to the health facility and discuss with HFOMC and service providers to agree on future roadmap</td>
<td>Action plan submitted to the health facility and final report prepared</td>
</tr>
<tr>
<td>Prepare a brief report</td>
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The steep learning curve in understanding the norms, mechanisms, and procedures of the developing federal system extends beyond elected officials. In 2017, long-standing members of community-based structures such as citizen awareness centres (CACs) and ward citizen forums
(WCFs) were uncertain about whether they still had a role within the governance system. As discussed below, both structures were disbanded, thereby limiting an important source of feedback into the local governance system, including the health sector. Furthermore, new members of HFOMCs struggled to understand their own roles in ways that mirrored the experience of ward and municipal leaders.

While confusion over how to fulfil roles and responsibilities was unsurprisingly deepest at the beginning of the reform process, practical knowledge developed progressively, albeit inconsistently. By 2019, local officials explained that formal workshops and trainings had built their capacity in key areas, but many of those sessions have been generic and not tailored to the needs of specific positions. Thus, it was through “learning by doing” that they had begun to build an understanding of how to carry out their functions. As one Ward Chair explained, “I am yet to be fully clear. I have found that the knowledge comes from doing.” This practical, “muddling through” approach to knowledge formation has led to local governments move forward with planning, administrative, and legislative tasks.

Municipal government staffing has been contentious and slow-going, but essential to responsive governance

Social accountability presupposes a government that has the institutional capability to respond to the stated interests and demands of citizens, requiring adequate human resources to absorb, process, and respond to feedback. Following the inaugural local elections in 2017, it became clear that the staffing of municipal governments, including for service delivery sectors, would become a key constraint in realising effective and accountable local governance and service delivery. Three years on, nearly all the provisional gains in government performance have depended upon addressing this concern.

Staffing was one of the most cited concerns of municipal governments following local elections. For many municipal leaders this took on almost an existential quality, with mayors, deputy mayors, and ward chairs complaining that they could not effectively deliver on their administrative and legislative responsibilities without adequate staff in place. Prior to 2017, federal ministries were expected to depute staff to the municipal level, and those governments were able to make a limited number of hires on a short term, contract basis. Multiple policies and laws were established in 2017 to govern the staff “adjustment” process, i.e. the transfer of staff from federal to municipal and provincial government services. The aim of laws such as the Staff Equalisation Act was to make transferred, or “equalised,” staff permanent at each level of government based on an organisation and management (O&M) survey.

However, several factors complicated this staff transfer. Staff transfer faced direct opposition from public sector unions and civil servants, many of whom feared placement in undesirable municipal locations. Transfer to municipal (or even provincial) service represented a loss of status and a threat to the career trajectory of many civil servants, with some transferred technical staff reporting to lower-ranked administrative staff in their new posts, offending the sensibilities of those shaped by a hierarchical civil service. This caused multiple challenges in the first years of the federal structure. Across municipal governments, local leaders complained of deputed staff not reporting to their new post or failing to respect newly established lines of authority. In 2017, one mayor in Lamjung district described deputed staff as non-cooperative, noting “we feel that the bureaucrats are not happy with local elected representatives.”
The MOHP made quicker progress deputing federally employed staff to municipal governments compared to other technical sectors, in part because of its longer history with deconcentrating services, which dates to the early 2000s in line with the LGA. The primary challenge for the sector became moving District Health Office (DHO) staff to health units within municipal government administrative offices. By 2019, municipalities reported significant (if inconsistent) progress in staffing but noted continued shortages in technical staff across sectors. In the health sector, officials acknowledged that the deputation process concluded with 4,800 staff filing complaints about their placements; news sources reported continued challenges with deputation throughout the year.27 Continuing technical vacancies mean fewer staff to monitor and support health facilities, respond to social audits and complaints from HFOMCs, and guide municipal governments to craft health-focused legislation.

At the local level, wards have made clear gains in staffing despite continued challenges around staff adjustment. Citizens and public officials described improvements since 2017, with at least one ward staff consistently available. Previously, Village Development Committee (VDC) and ward secretaries were known for “carrying their office in their bag” (rarely found in their office).28 Thanks to a sustained, visible presence of staff, many respondents described improved human resources and more responsive government at the ward level.

**Commitment to the use of social accountability mechanisms remains uncertain**

Prior to federalisation, the GON had established a range of formal social accountability processes, including in the service delivery sectors. These included networks of community-based structures, such as CACs, which provided opportunities for vulnerable communities to engage local authorities, as well as WCFs, which represented the foundational structure for local planning. Within the health system, HFOMCs provided community oversight, while FCHVs enabled communication between local communities and the health service delivery system. Most notably, the MOH established social audits as the primary tool for gathering and responding to citizen perspectives on health service quality. By 2018, 51,420 FCHVs had been mobilised, 4,217 HFOMCs had been established, and the MOH conducted 2,138 social audits.

The federalisation process cast in doubt whether key social accountability structures and processes would continue. Following local elections, the longstanding CAC and WCF structures were disbanded. Although not focused in the health sector, CACs and WCFs provided well-established mechanisms for generating multisector citizen feedback, particularly from vulnerable and underrepresented groups. In their place, local councils have recognised tole/lane organisations (TLOs) as community-based structures. TLOs represented a throwback to structures created in certain municipalities in the mid-2000s under a United Nations Development Programme (UNDP) intervention. Additionally, they represent a purposeful break from CACs, WCFs, and other citizen groups established pre-2017, which were viewed by some elected officials as alternative community-based power centres. TLOs have yet to be established in many locations and, until this point, remain less connected to disadvantaged communities.
Figure 3: Changes Made to Social Accountability Mechanisms

Within the health sector, the GON has remained officially committed to HFOMCs as an accountability structure and took steps to bolster their influence by reconstituting them with new membership in 2018. Ward Chairs became HFOMC chairpersons, giving the committees a clear channel to local officials. However, despite these positive steps, our research found that many of the structures remained inactive due to under-resourcing and committee members not understanding their roles and responsibilities.29

While social audits continue to be conducted within health facilities, questions persist about the commitment to this tool among municipal governments and the MOHP. The data support this – in 2017, the number of audits conducted increased by 386 from the year prior,30 but during the current fiscal year the MOHP did not earmark funds for social audits, shifting responsibility to municipal governments. Local councils have not authorised spending on social audits, calling the sustainability of MOHP’s flagship social accountability process into question. Since 2017, there have been isolated examples of elected municipal governments acting to establish legislation and policy around social accountability. For instance, Ramdhuni Municipality in Province 1 has prepared draft legislation focused on complaint handling, public hearings, social audits, and public audits, indicating the steps municipalities could take to establish a local framework for social and public accountability.31

**Elected municipal representatives see themselves as the accountability mechanism**

While elected municipal representatives state their commitment to accountable governance and service delivery, many leaders remain sceptical that their local areas need formal social accountability mechanisms. Rather than rely on structured processes for gathering community feedback, representatives view themselves as the primary source of accountability and elections as the ultimate accountability mechanism. This view is summarised by one official discussing the role of HFOMCs: “Why do you need the HFOMC? You now have local elected people! They should be playing this role rather than a committee.”32 This sentiment was strongest in the
initial days of the post-election period when local representatives had an especially nascent to non-existent familiarity with social accountability structures and process. Some local politicians have become proponents of local structures such as HFOMCS. For example, one health worker shared “it is useful to share the administrative and management related issues of health facilities in HFOMC meetings. The chair of this committee [i.e. the Ward Chairperson] is supportive of the decisions for actions.”33 However, others continue to question their relevance.

The sense among elected officials that they can embody accountable governance and service delivery reflects the way they gather constituent information. Across studies, local representatives made clear that they collect feedback and identify issues through informal channels, including constituent “walk ins” to their office, phone calls, and media reports. One Mayor in Surkhet district explained that their “office is located within the municipality, easily accessible six days a week for our constituents to come and talk to us.”34 Officials also described their established social and political networks (including opposition politicians) as important sources of feedback. Our recent research also suggests that social media is increasingly an important source of constituent information for local representatives.35 One Chief Administrative Officer noted, “nowadays if there is any indication of irregularity, it appears in social media. Media also plays a big role both in disseminating information about our good work and lapses.”36 While these informal channels may provide a means through which elected representatives can identify emergent needs, questions remain about who has equitable access to those networks (see Discussion).

Commitment to Gender Equality and Social Inclusion (GESI)-focused policies remains uncertain

As a response to Nepal’s history of marginalisation and inclusion, the GON established a set of GESI policies following the end of the civil war. Policymakers designed these provisions to ensure voice and resources for excluded groups such as women, Madhesi, Dalits, Janjatis, and Tharus communities. Prior to federalisation, the GON used CACs and reserved seats on WCFs and related structures to provide local representation of marginalised communities, with funding provisions governing local development budgets ensuring resources for excluded groups.

The constitution includes important provisions aimed at promoting political inclusion. For example, 33% of seats are reserved for women in parliament and women are represented either as mayor or, more often, deputy mayor (or Deputy Gaunpalika Chief) in all jurisdictions. Below the level of elected leadership, however, there has been a shift away from formal mechanisms for addressing social inclusion. By disbanding structures such as CACs and WCFs, the GON removed important avenues through which marginalised communities could aggregate and project their interests to local authorities. As discussed above, TLOs are still being established and have relatively weak inclusion requirements – one out of four leadership positions must be held by a woman. Within the health sector, previous requirements for representation of women and excluded groups on HFOMCs were jettisoned in favour of a smaller, more narrow membership structure.37

In addition, the Local Government Operation Act 2017 (LGOA) removed budget set-asides for marginalised and excluded communities. Previously, MOFALD guidelines for local development funds required that budgets include 10% for women, 10% for children, and 15% for socially excluded groups. Although VDCs and District Development Committees routinely watered down these provisions when allocating funds toward projects (particularly infrastructure projects) for
the general public, the guidelines ensured a baseline level of attention to GESI considerations during the budget planning process. While municipal governments are free to adopt similar guidelines formally or informally, local governments we profiled suggest that many do not privilege GESI considerations. Discussions with local stakeholders suggest that local governments continue to favour infrastructure development, with little-to-no consideration of their GESI impact. This may negatively affect the GON’s ability to meet health commitments articulated in the LGOA, Nepal Health Sector Strategy (2015-2020), and the Sustainable Development Goals, each of which embrace GESI as important vehicle to achieving equitable health outcomes for all populations.

In addition, many elected officials and other government stakeholders see formal GESI requirements as irrelevant in the federal system, like how many view structured social accountability mechanisms as less necessary in the federal era. This common sentiment is captured by one Health Facility In-Charge in explaining why reserved seats were not required on HFOMCs: “No more putting people in buckets. Elected people were elected by everyone! Now everyone has an equal role.”

*There are nascent reports of improvements in service delivery*

Our qualitative research suggests signs of improvements in health sector service delivery. One respondent from Beshishahar Municipality summarised the views of a diverse cross section of public-sector and community stakeholders thus, “there is a gradual improvement from before [local elections] in several aspects [of health service delivery] – from physical infrastructure to drug management.” Commonly cited areas of improvement included management of drug stocks, increases in health workers, establishment of new birthing centres, longer operating hours for health facilities, and improved support to FCHVs to carry out community-based activities.

Reports of initial improvements in health sector service delivery are perceptual and based on consultations with key stakeholders. They are not based on direct and rigorous assessment of service points, and the causes of any change in service quality are likely multiple. Respondents describe a more visible and available governance structure. In particular, they cite the ability to bring grievances to ward representatives, who are able to follow up at higher levels or with service units. This provides tentative evidence that there may indeed be information-sharing advantages to the evolving federal system and that at least some elected representatives are providing a social accountability-like function.

It is also possible that increased local budgets are positively impacting local service delivery. In a typical case, Naumule Municipality’s budget grew by 2450% from fiscal year 2015/16 to fiscal year 2019/20, primarily as the result of expanded sectoral responsibilities. Although municipal governments continue to prioritise infrastructure development over health and social sector expenditures, in fiscal year 2019/20 health sector allocations from discretionary budgets (i.e. “Equalisation” funds) increased approximately 3% in sampled municipalities and most sampled municipalities saw at least marginal increases in their health budgets, albeit from a low base. While modest, discretionary budgets represent an important funding source for basic health infrastructure, FCHVs, and mothers groups.
Discussion

Results from three years of qualitative research under SAHS indicate that the federalisation process, and its impact on accountability and service delivery in sectors like health, remains dynamic. The management of substantial financial resources has shifted to elected local leaders in a transformation away from Nepal’s history of centralised governance. Elected leaders at the municipal and ward levels are forging relationships with constituencies in ways that might alter the nature of state-society relations that are the basis for social accountability. At the same time, municipal governments and the broader GON continue to work through human resource and capacity constraints that affect the performance and responsiveness of local governments. However, commitment of local governments to pre-existing social accountability mechanisms designed to increase citizen feedback into the health sector remains questionable. As the federalisation process continues apace, there are manifold opportunities to build on this knowledge base in both research and application.

Evidence exists on how to build the capacity of municipal-level leaders and staff

The need to ensure adequate human resource capacity, both in terms of personnel and competencies, has been a critical constraint within the early stages of the federal era in Nepal. While important gaps remain, including inadequate technical staff within municipal health units, progress has been made over three years in establishing more robust capacity at the local level, including within wards where the government’s presence exceeds that of the former VDC structures. Municipal governments will continue to add staff, which therefore necessitates significant attention to capacity development for elected representatives and staff alike.

Findings across our research provide strong evidence that municipal governments have expanded their competencies through “learning by doing.” Respondents explained that formal trainings, workshops, and guidelines have been useful, but they have developed confidence through the practical work of governing. This is unsurprising, as it aligns with significant research related to the importance of hands-on learning, but further emphasises the need to intentionally structure practical learning and sharing opportunities for municipal leaders and staff. This should include significant investment in peer-to-peer exchange and mentorship, including focused in the health sector. It remains the case that most municipal governments have yet to pass health-focused legislation and proactive oversight of the health sector by political leaders is lacking. Practical capacity development approaches could focus on allowing leaders to learn from peers who are carrying out health sector legislation, oversight, and other activities and directly apply new competencies in these areas.

Further research could improve understanding how citizen perceptions impact federalism in sectors

The insights generated by SAHS are a useful barometer of public perceptions over the federalisation process, especially for the health sector. These results convey that a broad cross-section of stakeholders have been optimistic about federalisation fostering more accountable governance and services, although this positive outlook has been under strain and there exists potential divergence between the views of local level officials and demand-side actors.

Perception data provides a metric for understanding whether federalisation reforms are delivering on their promise for improved, accountable, and responsive governance. While based on large sets of respondents, our data is limited by not being drawn from statistically significant
public perception polls. Further research could provide more detailed information into how discrete categories of stakeholders, such as marginalised and excluded communities, view reforms and service improvements. Such research could further untangle perceptions over elected local governments, the reform process, and federalisation itself; issues that may be overlapping but remain distinct in how they are understood. Ultimately, additional research could provide insight into what factors drive changes in opinion and make it possible to understand the relationship between opinions over service delivery, for example, and confidence in the local governance system.

Public perception data could be useful for multiple sets of actors. Elected representatives could use the data to understand how specific subsects of citizens view the performance and degree of accountability in discrete sectors. Similarly, CSOs and donor-funded projects could use the data to understand where citizens perceive that federalisation reforms and efforts at service improvement are either falling short or gaining traction.

There is a need to understand who has access to local representative-oriented social networks

Our research suggests that local representatives are forging and maintaining meaningful relationships with their constituencies in ways that can spur responsive government action. Diverse stakeholders explain that the government is increasingly more accessible in important ways, particularly at the ward level. Local leaders also describe a reliance on informal channels for ongoing communication with their constituents.

It is evident that important constituencies have access to local level policymakers, which can be used to lodge complaints, including on health services. What is less clear is who has access to these information channels and how effective they are at eliciting response. The reality of social exclusion in Nepal is that marginalised groups remain less integrated into prevailing networks linking citizens to municipal leaders. The shift toward informal, personalised communication between citizens, political cadres, and elected representatives risks reinforcing patterns of exclusion and privilege, particularly if they are not supplemented by robust, structured processes for gathering feedback from those less inclined to approach local power holders.

Building on initial qualitative research showing the salience of informal communication patterns among local politicians, future research should map who has access to those feedback channels and who is on the periphery of existing networks. This research could examine how stakeholders use these channels, including the extent to which they are used for generating insights into service delivery processes and outcomes. Furthermore, it could also examine how informal communication tangibly contributes to decision-making. By mapping evolving communication patterns between citizens and local leaders, it may be possible to pinpoint where renewed and creative approaches are required to connect excluded voices to local authorities.

Health sector-focused social accountability mechanisms will be at risk and under-utilised without greater buy-in from local representatives

Politician-oriented communication flows are not a substitute for feedback mechanisms between health facilities and citizen-users. Mechanisms such as the social audit and HFOMCs have been primary tools for gathering grievances and concerns from citizen-users, bolstered by the community-level work of FCHVs and mother’s groups. However, local leaders have chosen to limit their engagement in these processes. Our research shows that many HFOMCs remain under-utilised or even inactive, despite Ward Chairs sitting on the committees. Furthermore,
there remains immediate uncertainty about whether there will be funding for health sector social audits.

In the federal system, social accountability mechanisms and processes will be most secure and utilised with explicit support from local representatives. Given this, champions of social accountability should proactively build support and awareness among local leaders on the importance of practices and structures like social audits and HFOMCs. This should involve supporting municipal officials to understand the potential for these mechanisms to generate insight from constituents, hold health facilities accountable, and ultimately improve service delivery. For example, there may be lessons learned from Ramdhuni Municipality in Sunsari District which has continued to proactively engage in social accountability through the development of local guidelines, allocate local budget to social audits, and fostered strong participation in the social audit process.

Conclusion

Federalisation ushered in a new era in Nepal, representing both a significant break from a centralised form of governance and a desire to create a form of government that unifies Nepalis across socioeconomic disparities. These aspirations, however, must be matched in practice for the hope that fuels them to be sustained. After three years of research into how social accountability mechanisms designed to capture and use citizen voice in the health sector were affected by federalisation, we have developed a multifaceted view of the opportunities and challenges to strengthen these efforts in Nepal. Although considerable capacity constraints remain at the local level, the optimism surrounding federalisation and elections also continues.

Further research opportunities exist for the GON, donor-funded projects, and CSOs to capitalise on progress made to date and overcome existing challenges. Investing in public perception data, mapping communication channels for inclusion, and tracing decision-making in service delivery sectors all offer important windows into the nascent citizen-state relationship. Additionally, exploring how to augment the knowledge and capacity of local government officials and identifying how to build durable support for social accountability mechanisms have the potential to improve government performance. Although the future of particular social accountability mechanisms in Nepal remains uncertain, the value of citizen voice in government decision-making has never been more evident.
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For More Information

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# Annex: Chronological Summary of SAHS Qualitative Research Studies and Works

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<th>Title</th>
<th>Description</th>
<th>Geography (Province (District))</th>
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| Situational Analysis on Social Accountability in the Health Sector (SA 1) | Baseline review of historic and existing social accountability practices in Nepal, including in the health sector | Bagmati Pradesh (Dolakha)  
Gandaki Pradesh (Lamjung)  
Karnali Pradesh (Surkhet)  
Sudurpashchim Pradesh (Kailali) | May 2017 |
| Baseline Applied Political Economy Analysis (APEA 1) | Baseline review of the political, economic, social, and other drivers of social accountability in the health sector, with emphasis on the influence of the federalisation process | Bagmati Pradesh (Dolakha, Kathmandu)  
Gandaki Pradesh (Lamjung)  
Lumbini Pradesh (Banke)  
Karnali Pradesh (Surkhet) | November 2017 |
| Case Studies:  
• Citizen Engagement in Health  
• Health Facility Operation and Management Committees and their role in citizen engagement  
• Social Accountability of the Public and Private Health Service Providers | Brief case studies exploring how local government officials view citizen engagement and opportunities to bolster citizen involvement in health services. Specific studies explored the functionality and evolving roles of HFOMC structures; the state of citizen engagement structures and the impact of federalisation on them; and how citizens and local government alike viewed private healthcare providers and how to ensure accountability. | Province No. 1 (Sunsari)  
Province No. 2 (Bara, Dhanusha)  
Bagmati Pradesh (Kathmandu, Nuwakot)  
Gandaki Pradesh (Lamjung)  
Lumbini Pradesh (Banke)  
Karnali Pradesh (Surkhet)  
Sudurpashchim Pradesh (Kailali, Kanchanpur) | January 2018 |
| Midterm Applied Political Economy Analysis (APEA 2) | Update of the baseline APEA report, with emphasis on examining progress on federalisation reform within the health sector | Province No. 1 (Sunsari)  
Province No. 2 (Bara, Dhanusha)  
Bagmati Pradesh (Makawanpur)  
Gandaki Pradesh (Lamjung) | November 2018 |
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<td>Midterm Situation Analysis (SA 2)</td>
<td>Update of baseline situation analysis</td>
<td>Province No. 1 (Sunsari, Morang) Province No. 2 (Bara, Dhanusha) Bagmati Pradesh (Bhaktapur) Gandaki Pradesh (Lamjung, Kaski) Lumbini Pradesh (Banke, Bardiya) Sudurpashchim Pradesh (Kailali, Dadeldhura)</td>
<td>April 2019</td>
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<td>Case Study: Impact of Federalism on Inclusion in the Health Sector</td>
<td>Brief case study examining how the adoption of GESI policies &amp; interventions impacted health outcomes among vulnerable and excluded populations.</td>
<td>Lumbini Pradesh (Banke, Bardiya)</td>
<td>November 2019</td>
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<td>Applied Political Economy Analysis (APEA 3)</td>
<td>Update of the APEA 1 and 2 reports</td>
<td>Province No. 1 (Sunsari) Province No. 2 (Dhanusha) Bagmati Pradesh (Bhaktapur) Gandaki Pradesh (Kaski, Lamjung) Lumbini Pradesh (Banke, Bardiya) Karnali Pradesh (Dailekh) Sudurpashchim Pradesh (Kailali)</td>
<td>November 2019</td>
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<tr>
<td>Situation Analysis 3 (SA 3)</td>
<td>Update on SA 1 and SA 1 reports</td>
<td>Province No. 1 (Morang) Province No. 2 (Bara, Dhanusha, Siraha) Bagmati Pradesh (Makwanpur, Ramechhap) Gandaki Pradesh (Lamjung) Lumbini Pradesh (Banke, Kapilvastu) Karnali Pradesh (Surkhet, Dailekh) Sudurpashchim Pradesh (Kailali, Kanchanpur)</td>
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