Decentralization and district health services in Nepal: understanding the views of service users and service providers

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ABSTRACT

Background Within the decentralization framework of Government, the Ministry of Health (MoH) Nepal initiated the decentralization of primary care services closer to citizens. This paper aims to examine and understand the effect of decentralization at the district health service from the perspectives of service users and providers.

Methods Using non-probability purposive sampling, we conducted a series of in-depth interviews and focus group discussions in four primary health care institutions with service users, providers and other stakeholders. QSR® NVivo7 software was used to analyse and categorize the data under emerging themes.

Results Decentralization was positively associated with increased service access and utilization and improved service delivery. The study also revealed areas of concern and possible improvement and identified the barriers to implementing these improvements. Problems described included three main areas: functions, functionaries and funding.

Conclusion Both service users and providers convey a generally positive message about the health sector decentralization. The active involvement of service users, providers, policy-makers in the process of decentralization and clear national and local policy agendas may bring positive changes in district health services.

Keywords decentralization, health services, nepal, qualitative study

Introduction

Decentralization is one of the most widely debated but controversial agendas among politicians, bureaucrats and donor communities in the world. It is a political reality worldwide with many forms and dimensions and varies greatly within and among countries.¹ Therefore, the interpretations of decentralization vary and it is often equated with the terms of democratic governance, government systems, human development and citizen participation.²–⁵

Decentralization can be described, in general terms, as the ‘socio-political process’ of ‘power-sharing arrangements’ between central government and local authorities in planning, management and decision-making.⁶–¹⁰ This process is often triggered by a desire to bring politicians and policy-makers closer to citizens¹¹–¹⁴ and also partly to make public services efficient and effective.¹⁵ To date, studies evaluating the impacts of decentralization on public services in developing countries provide mixed result.⁸,¹⁶–²⁰ Positive results are more rational and unified health services that cater for local needs and preferences, a reduction of health inequalities, community involvement and improved intersectoral coordination.²⁰ Negative results include capacity constraints (finances, functionaries and staff) at local levels, poor support or direction from the centre, a lack of clarity

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about the role and responsibility of managing local services in the new set-up, and poor coordination between central government and local authorities. Wolman strongly argues that the quality and accessibility of care may continue to be problematic due to over centralization and limited resource transfer from the centre. A recent report of the World Bank highlights, “too often, services fail poor people—in terms of access, quantity and quality. But there are strong examples where services do work, which means governments and citizens can do better. Putting people at the centre of service provision enables them to monitor and discipline service providers (SPs), amplifies their voice in policy-making, and strengthens the incentives for providers to serve the poor” (p. 25).

Decentralization has been acknowledged as a means of improving public services in both developed and developing world and has increased the potential to more effectively address poverty, gender inequality and overall improvement in health care systems. However, decentralization may also bring some disadvantages: lack of control over local bodies, a widening gap between and among regions whereby progressive regions could develop their economy, leading to regional imbalance, and intensifying regional sentiments at the expense of national unity.

Evidence shows that a number of impact studies focused on decentralization have been carried out, mostly on two-dimensional aspects: measuring decentralization on an economic scale or examining the structural implications. These studies therefore fail to capture the ‘human insights’ into the decentralization process. Very few studies have sought to explore the service impact issues from a user or provider perspective. Similarly, the impact of decentralization on health services management and on service delivery has rarely been assessed. Despite the widespread process of decentralization, little is known about the role that the health sector plays in this process or vice versa. This gap in the impact of decentralization on the local culture and circumstances needs to be addressed.

This paper aims to examine and understand the effect of decentralization on district health services: from the perspectives and perceptions of service users and SPs through the use of a qualitative study in Nepal.

**Study context**

During the past few decades, many countries have embarked on the decentralization of public services. Nepal has also tried to adopt decentralization as a key reform process. The 1990s people movement has been considered as a turning-point for the overall governance process and structure at all levels in Nepal. During the 1990s there was significant progress in the development of health systems under the framework of long-term (1997–2017) health plans and policies, guided by a vision of equitable access and the principles of community participation, decentralization, gender equality, effective services management, and a public–private partnership approach. Under the guidance of these plans and policies, Nepal has made visible progress in health sector reform despite the nature of difficult topography (hills, mountains). The main drivers for decentralization in Nepal include: socio-economic inequalities, multi-ethnicity and cultural heterogeneity, poverty, low efficiency of centralized delivery systems and the global phenomenon of decentralization. As in other countries, two important factors—technical or managerial, and political motives—were major contributing factors behind the decentralization process. In the governance system, decentralization and local self-governance have been made operational in Nepal since the 1960s. In 1999, Nepal enacted a Local Self-Government Act (LSGA) and this Act, whose monitoring committee was chaired by the Prime Minister, laid the foundation for establishing a local self-governance system adopting a broad-based and cross-sectoral approach. This Act recognized the role of local self governance and devolution of authority and responsibility to make local authorities more responsive and accountable to people. The rationale for this Act was both philosophical and practical and involved legislation, institutional provision, resources (both financial and human) mobilization and considerations, i.e. autonomy and equality.

To capture the spirit of LSGA, the following statement is noteworthy:

*Local authorities – districts and sub-distRICTS institutions are responsible and capable of managing health facilities in a participative, accountable and transparent way with effective support from the centre (MoH) and its sector partners*

One of the major reforms in Nepal’s health sector under decentralization was the restructuring of health services. In 1987, the centre (MoH) underwent change and as a result—Regional Health Directorates were established in five development regions in Nepal. Restructuring of the district health services (preventive and curative) was considered to be vital for meeting the health needs of local populations. A unique feature of the health sector in Nepal is that there is a strong community-based health workforce (more than 50,000 female community health workers in addition to 28,000 public health staff) across the country who are mainly responsible for preventive care. Since 2001/02, over 1435 primary health care facilities (100% in the study district)
devolve to the local community management. Government is now in the process of devolve other health care facilities i.e. district hospitals, zonal and regional hospitals to the management of local committees. This study seeks to provide a complementary ‘insider’ perspective on these for reaching changes to the health care system of Nepal.

Methods

Study approach

The research approach used in this study is qualitative and is based on social constructionism theory. According to Somekh et al. 32,38 a social constructivist approach aims to construct the meaning of social context and social reality. Guba and Lincoln44 believe that the human world is different from natural, physical science, therefore, it must be studied differently as individuals construct and assign meaning to the world through their interpretation and interactions with it.45 Shadish46 (p. 67) reminds us that social constructionism means ‘constructing knowledge about reality, not constructing reality itself’. The intention of this approach is to use multiple sources of data in order to investigate the same phenomenon from different perspectives because social reality is contextually embedded, interpersonally forged and necessarily limited.45,47

Setting

Four primary health care institutions (HIs) of Chitwan district (Nepal) were selected as the study area using the following criteria: (i) appropriate to the research topic as this district includes the feature of both hill and terai (plain) region and (ii) this district has been supported by different donor communities, civil societies and local and international organizations during the implementation of decentralization process.

Participants

Between June and October 2008, 20 in-depth interviews and four focus group discussions were conducted with service users (SUs) and health professionals or SPs who work in four HIs (of 36 HIs) operated under the district public health/development offices. The participants were selected using non-probability purposive sampling to achieve theoretical sampling.48 The final sample was inclusive of the population and represented the full range of demographic variables, e.g. age, sex, gender and caste. Patients’ attendance records and staff registers were the sampling frame. The size of the sample was not fixed at the initial stage so sample and data collection grew simultaneously, sample size was based on the results of the data analysis, and the recruitment (data collection) continued until saturation of emerging major themes or categories was evident.51 The participants included 20 SUs and 20 SPs (1 medical doctor, 9 paramedics (clinical staff), 8 nurses and 2 health administrators). The age of the participants ranged from 24 to 51 years.

Data collection

Prior to the data collection, participants were given a schedule of topics focused on three key questions: (i) understanding of decentralization and changes observed in the delivery of services, (ii) effects on the access and utilization of local health services, and (iii) the problems and challenges faced, if any, while accessing the essential health services. A topic guide was developed based on the literature review and the researchers’ reflection on their experience (Box 1). The topic guide was identical for both SUs and SPs and sufficiently flexible to allow any relevant issues to be discussed. The topic guide used in this study was piloted with five SUs and three SPs in one non-study health facility to establish face validity as well as to improve the intrinsic aspects of the questions.48,52 Based on the feedback received, the guide was slightly revised and finalized for use in the four study sites.

Box 1 Topic guide

- Tell me your understanding of decentralization?
- What have been the changes on the local service delivery (in planning process, resource allocation/mobilization and formation of new management committee with representative of poor, women and excluded people)?
- Do you think that (poor) people are getting benefit from the decentralized health services?
- Have you ever faced any problems or challenges while accessing and/or using local health services?
- Is there anything further you would like to discuss?

Data analysis

Focus group discussions and in-depth interviews were examined in relation to the perspectives and perceptions of SUs and SPs regarding access to, utilization and management of local health facilities. The interviews were audiotaped using a digital voice recorder after which they were transcribed verbatim including ‘pauses, emotional expressions and annotations’ into the computer using Microsoft® Word2003. The interviews were imported to QSR® NVivo7 software for qualitative data management and analysed to reveal coding structures: categories,
subcategories, themes and codes. NVivo7 enabled the exploration of each interview to identify words and phrases that formed the basis for the development of themes and sub-themes and it also enabled interviews to be linked. Transcribed versions were sent to those participants, who were requested to check if they agreed with what was written. Any inconsistencies were corrected accordingly. Nepali versions of transcripts were translated into English. Two independent bilingual translators (Nepalese and English) verified the translations for accuracy.

Ethical approval
Informed consent was obtained from individual participants before starting the study, after they had read the participant information sheet. Permission to conduct this study was granted by University of the West of England (UK) Ethics Committee in November 2008 and the Nepal Health Research Council (Nepal) in May 2008. Participants’ confidentiality and anonymity were maintained throughout by ensuring names were not reported in the findings. In addition, participants were free to participate, answer questions partially decline to answer or even terminate the interview at any stage should they wish to do so.

Results
Characteristics of the respondents
Twenty in-depth interviews were carried out with SUs (12 males and 8 females) and four focus group discussions with SPs (n = 20: 9 paramedics, 8 nurses, 1 doctor and 2 health administrators). Participants were categorized based on their demographic variables, e.g. age, sex, group, caste, social class, education/experience and marital status. Most of the participants were between the ages of 18 and 51 years and they were generally representative of the two-major groups based on their language and origin in Nepal: mainly Indo-Aryan (Brahmin, Chhetri, Newar) and Tibeto-Burman (Gurung, Tamang, Limbu). The demographic attributes are shown in Table 1.

Findings from the interviews and discussions
Decentralization has been a catchphrase in development discourse and has various meanings and interpretations depending on the socio-cultural and political boundaries. Therefore, it was felt necessary to explore the respondents’ understanding of the meaning of ‘decentralization’ of local services. For this purpose, we arranged discussion sessions with SUs and SPs. The majority of the respondents (61%) stated that they had heard and were aware of the decentralization of government services, for example, health, education and agriculture services. For those who were not aware or had not heard of the term decentralization (‘Bikendrikaran’, the Nepali equivalent term), we explained by highlighting its characteristics: (i) management of local health services by the community and (ii) local involvement in access to, utilization of, participation in, and decision-making regarding local health services.

The responses obtained from these groups are presented below. Since the interpretation of ‘decentralization’ by SUs is based on their reality and by SPs on their reality plus a

<table>
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<tr>
<th>Table 1 Frequency distributions showing the number of respondents by age, sex, education, ethnicity and marital status</th>
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<td><strong>Distribution</strong></td>
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Values in parenthesis are represented by percentages.

*aSLC or matriculation in Nepalese education system is equivalent to GCSE level in the UK system.*
conceptual theoretical basis, the findings are divided into two interlinked areas: (i) understanding decentralization and (ii) exploring the possible effects of decentralization on health services.

Understanding and perception of decentralization

Interpretation from SUs

The majority of participants viewed decentralization as a means to access health services:

“I am very poor . . . and have to work on others’ farms from morning until late evening to survive for my family as I have got four small children. Sometimes when I get ill, I visit this which I trust most, as it saved my husband’s life last year when he had got a serious illness and the doctor kept him for five days at the post with injections of water and ‘antibiotics’, but they didn’t charge us anything! I was so happy and thanks go to the doctors and this ‘Sarkar’ (central government) to make the health services free for people like us. They even come to visit to my poor house to get my feedback on ‘what kinds of services do me and my family like?’ (SU-P-015).

Making services available to the poor through health facilities (SU-P-04).

‘More power – including responsibilities – and authority to our health centres and they will provide 24/7 emergency care to the local people’ (SU-R-07).

‘Sakti Hastantaran’ (devolve power) to the hands of local people, to local leaders, and to us (laughing . . .). We, women, want to change services for the women’s needs but still the decision-making power is with men! I think, umm . . . making power balance between men and women is considered as decentralization (SU-R-07).

Power and money to the poor people’s hand and mobilized under their control. Good relation between people and health posts (SU-C-07).

Decentralization is . . . ‘gauwn farka aviyan’ (community self-reliance programme) (SU-S-015).

I don’t know . . . what it meant but I know services were much better, ‘chheto’ (quicker) and bishasilo (reliable) at the local level . . . we don’t have to go to district (district hospital) or private clinic to get the best services. In fact, for me, it was more about ‘cost saving (economic) health services (SU-C-07).

There were, however, concerns expressed by a number of respondents over decentralization:

One thing that made me very unhappy (I am a female community health volunteer (FCHV) and have served this community for nearly 10 years) was that I was never called for a health-related meeting. All were heads, ‘neta’ (political leaders), similar ‘Vrastachar’ (corruptions), and our problems are the same as before (SU-P-09).

Interpretation from SPs

The meaning of decentralization for SPs was straightforward. For them, decentralization is a robust process for local development, ushering in social, economic and political changes. Decentralization means having access to basic public services from the local level, where local institutions have a full range of community-focused services. According to SPs, decentralization is a process of transferring authorities and accountabilities, with resources (both manpower and finance) from the centre to local authorities and community health care facilities. This was viewed by some district respondents as a possible advantage of decentralization for the local government:

“It is now much easier to plan, develop and implement the community health programmes through development of ownership in the community (SP-P-09).

Running health services at the local level without any interference from the district or central authorities (SP-C-01).

Decentralization is about freedom of service planning and execution in the community. There was little difference in the attitudes towards decentralization, with most of the SPs being positive about it.

Putting power from centre (Ministry of Health) to local so that we can address the needs of local people (SP-C-01).

We have been working here for the past 7 years, and the only difference now from then was the programme ‘budget’ and ‘full-staff’ at the health centre (SP-R-01, 02, 04).

Village development committee (local authority) has now taken much more initiative for the health sector, but they didn’t bother before – they supported us for the construction of building, staff training and provided some extra funds (15,000 rupees) for the purchase of essential drugs . . . it is more ‘relaxed’ and a more flexible working process (SP-P-11).

To be honest, we are much ahead in terms of making services accessible to poor and excluded communities . . . political people often come to visit us to ask about the problems and our concerns. I had never met any political people during my 35 years work before that – maybe they are more responsible. I don’t know whether they were advocating for the benefits of local communities for the sake of their votes (SP-P-09).

Decentralisation is the opposite of centrally controlled processes (SP-P-06).

One thing I would like to raise very strongly . . . though we got some money from the centre (district), but we can’t plan for it as it is
still controlled by the centre. I think, maybe ... uhm ... free from any control from anywhere is called decentralisation (SP-P-06).

Effects of decentralization
One of the major reforms introduced in the health sector under decentralization was the restructuring of district health services. Most of the districts’ health service facilities (health institutions) were handed over to local committees and these committees were composed of local political and social leaders and representatives of the poor people, women and excluded and oppressed groups. The main purpose of restructuring was to involve community people and bring health services closer to the citizens. From the analysis of the transcripts, the core category that emerged from the analysis was that ‘decentralization is impacting positively on the district health services’. This core category was arrived at based on the following six themes identified from the data. The six themes or categories listed and described here are based on the validations of two bilingual and subject experts in their respective fields of study, and are as follows:

- Service quality, access and utilization
- Community participation and empowerment
- Service planning and management
- Policy provision
- Coordination
- Problems and challenges in service delivery.

These themes are not mutually exclusive, but overlap and contain contradictions, reflecting the complexity of the analysis within the wider socio-cultural and political context.

Service quality, access and utilization
Both SUs and providers felt that there were some improvements in service delivery:

Yes, service is very good ... all services now offered at the community level are absolutely free and easily accessible to the poor people. Women’s and children’s health services, for example, family planning, reproductive health, immunization and nutrition services are far better. The health facility is just a few minutes’ walking distance and health workers now feel more responsible for our health and well-being, not like before (SU-PC-12, 14, 17, 22, 25).

Nowadays, the flow of patients has increased, particularly women in general and women from excluded and oppressed communities. Since the decentralization, women’s, poor and underserved groups will get absolutely free-of-cost essential health services (SU-P-01).

I appreciate the government’s efforts in providing essential health services with provision of drugs and human health resources in remote areas (SU-R-11).

We tried to provide service in package — meaning that all essential services integrated into primary care. For example, if someone comes for family planning he also gets a comprehensive care package including education, advice and counselling and testing (if available) (SP-P-17, 18).

I think the services have improved because they are closer to the people and because most of the local health institutions are located within reach of the community — in fact in the middle of the village (SP-P-18).

I think we have provided the best health services to poor people free of cost, which was one of the demands of the community. If we want to start charging for the services again, I think we would be making them more vulnerable again (SP-P-01).

Some respondents had mixed reactions to the changes in district health services. Some believed that they were worse off while others were supportive of the changes.

Actually, health services were good during those times when we paid for the services. At least service providers used to pay attention and helped me whatever was needed. Since the health facilities were handed over, some members of the management board have misused their power — being more inclined towards their (political) party cadres, families and friends. I think that was really bad (SU-C-10).

Major health problems were related to women and children, and the ethnic minority communities were affected most. If you look at the diversity of people at the health facilities, there was a lack of qualified female health staff, a shortage of essential equipment, poor infrastructure ... no separate room for the women and poor quality medicine (SU-C-10).

Reflecting on the behaviour and the attitudes of SPs, one respondent argued that:

Though most of the health workers were very friendly and responsive, people from ethnic minorities reported that they were not responding well. We also reported this case to the management committee, but no further action was taken (SU-PC-10, 11).

Community participation and empowerment—every opportunity counts
Decentralization has emphasized community participation in the health sector at the district level. The community felt more ‘empowered’ and ‘included’ in service planning and delivery. The following narrations are helpful in understanding the concept of participation:

Participation, although time-consuming, has a sense of ownership. It makes people aware of what is going on ... best way to make people more sensitive as well as responsive towards the government’s activities (SU-P-12).

Community is more involved in health services. Initially, people were reluctant on the part of the community members and most of the members were hesitant about visiting health services. Since the hand-over of health facilities, we called a mass meeting and shared information about health plans and activities, and the roles of the community in health services. Now, community members are
encouraged to be involved with services through volunteering and representation of different community groups (SP-RC-02, 11, 18).

The same respondents expressed the notion of empowerment through informed decision-making:

When a mother has brought her child for vaccination, we don’t concentrate only on the child ... we also ask if there is anything that she would like us to attend to concerning her, and she goes out with the information she needed so that she would be able to make informed decisions and feel more empowered (SP-RC-02, 11, 18).

However, poor participation was noted in some HFs. According to one respondent:

This was due to the impact of former centralised governance, influenced by unnecessary party politics [leadership] in public services ... and also passivity in people’s attitude (SU-C-02).

This was also seen by one respondent as a potential problem:

It is completely useless ... they just come here and say, do this/do that ... but they don’t want to know what we want and how we want to do it. And most importantly, they will not pay for my time! Therefore, I don’t bother to participate in any government programme (SU-C-02).

Another respondent also supported the need for women’s participation in the decision-making process:

Women are the majority in this community but when it comes to representation we are still very poor ... there is always a problem of ‘heard women stories’ in the decision-making process. I think ... we need to distribute power equally among both men and women so that we can raise our voice (SP-C-02).

Service planning and management

The key potential advantage of decentralization is ‘planning with and for the community people.’ This was identified by a number of respondents. One respondent noted that:

We have prepared our annual plans in consultation with local communities, employing participatory approaches as and when necessary. But our priorities are often regulated by the centre (SP-R-01).

The government is committed to a bottom-up planning process so that the system can be more responsive and better meet the needs of local people:

The government is committed to bottom-up planning. It will approve only those projects which are identified and prioritized by the local authorities following the participatory planning methodology (SU-SP-P-C-R-01,03,05,09,11).

Three important points here are of particular relevance to the planning process: planning with political people, with local (district) authorities and with the donor communities.

I think we now need to liaise with political parties to make local people aware about the health and public services planning (SP-C-01, 03).

The District Health Office still controls and cuts some of our budgets, arguing that some items were not our immediate priority areas ... therefore, we have to bring them into our local planning process (workshop) so that they acknowledge why we need this and that ... (SP-C-01, 03).

Government of Nepal (GON) and UNDP reported that at least 14 bilateral and 15 multilateral donor communities are working in Nepal. While analysing their achievements, we observed that different donors have different priorities, sectoral focuses and target audiences, but one thing that they had in common was that they were starting to work through the model of decentralization (SP-R-11,17).

Reflecting on the concern of planning, one respondent pointed out that:

The criteria-based funding allocation plan needs to be expanded across the district (SP-R-13).

Policy provision

There was concern expressed by a number of respondents over policy issues:

To make our services better, we need to review the existing policy in the light of ‘size’ and ‘shape’ of the human resources, as the government is still employing the HR policy which was developed more than 10 years ago, and which is a very bureaucratic and feudal model. We also have to review the physical facilities (SP-P-01,04,07).

The centre needs to play a very proactive role in power-sharing and building capacity in local authorities – training, planning and management (SU-P-02).

Though the district health authorities have initiated some planning processes at the grassroots level, there are some constraints for its implementation, as the MoH, MoF and NPC still control the district budgets, which is the compilation of all health services across the district – that should be immediately cut off and the budget of each facility should be directly transferred to their account (SP-PCR-11, 03, 07, 011).

I think what the district or the responsible authority should have done is invest in the service providers and building capacity of the providers before taking the service out to the community (SU-S-02).

Other respondents argued that:

The present policy has given a very narrow space to local authorities in terms of exercising their power and authority over national policy ...
we have to do what the central government wants us to do! (SP-RCPP-02, 04, 11, 25, 14, 18, 19, 20).

Coordination
The majority of the respondents seemed satisfied and most expressed positive comments relating to the coordination between different stakeholders in the community. However, there were strong concerns expressed by some SUs. Two important points are of relevance to the coordination between local authorities, the central government and district authorities:

Firstly, the central government often argues that the development of the framework (decentralization) was the main role of the centre, which we already developed, but putting in essential ingredients for its implementation would be the role of local authorities. But the local HIs deny that local authorities are not playing their role as such, for example, the main coordination role at the district authorities (at district level) is held by the Local Development Officer (LDO), the permanent staff of the Ministry of Local Development, and also the head of the District Development Committee. That means :...whoever is in the post, they are solely accountable to the central government (SU-PPCR-01,02,16,19).

Despite these problems, one respondent pointed out a positive aspect:

We always work together with other line agencies at district and community levels, including non-government organizations, civil societies, women's forums and youth clubs, to make a collective response as well as raise collective demands of the community. Now the centre is more responsive and 'listens more' to the needs and concerns of the local authorities (SP-P-05).

Therefore, one respondent clearly pointed out that:

We need to develop the culture of 'agree to disagree' as that would help to develop conscious (culture). Given our (Nepalese) inheritance (laughing,...) and behavioural nature, we are still living in a hierarchical society and believing in supernatural forces (SP-R-04).

The same respondent continued by saying that:

Unless we keep our ideology on an equal footing, we can't work together – otherwise there would be a hierarchical and bureaucratic system, and therefore mind-setting is an important step (SP-R-04).

Problems and challenges in service delivery
The study reported a number of challenges from the perspective of SUs and providers. Problems arising from the relationship between the centre and local authorities, and within the local authorities, were also identified. Key challenges were identified at two levels—policy level and operational level. At the policy level, there was a problem of HR policy. For example, local staff are still under the control of central management. Second, there was no policy that focused on how to build institutional capacity within local bodies in terms of developing bottom-up approaches, including inclusive planning and its institutionalization. Third, coordination between and among different stakeholders both at central and local levels was problematic. At the operational level, staff career progression, lack of clarity on the role and accountability of new management committee structures, poor infrastructure, the influence of party politics, resource generation and mobilization, and central control over local priorities and budgeting were reported to be the major challenges.

These were seen by some respondents as potential problems following decentralization:

I can put it this way...after 1999, I observed some positive changes related to the way the patients or the users are treated at the local health facilities. All the health workers were very sensitive towards meeting the needs and interests of the community. The community people, who managed the health services, were also very proactive; they often visited the service sites and provided information about the policy debate at the national and local level. There is nothing that I can say, but the problem here is the lack of policy implementation at the local level. For example, in LGSA40 there was a clear protocol that district and local health facilities have the right to recruit the necessary staff, but still the central government is controlling staff recruitment and mobilization. I think...that's where most of the local people suffer and that's why we blame the central government (SP-R-02).

The central government has not been able to create an environment for self-governance. The prerequisite is that the central government has to be fully committed about decentralization. It is not that Kathmandu still wants to hold onto power and concentrate resources in their hands... Where decentralization has brought development, you do not see a Maoist movement in Nepal.

Another big challenge perceived among several services providers was the need for a:

Coordinating body for the decentralization in the centre – MLD or MoH? We think...there should be an independent authority who works as an apex body, like a National Planning Commission who sets up plans and policies of development across the country and should take the lead role, and this body should be free from the political parties (SU/SP-PPCR-04,13, 18).

Fig. 1 is a conceptual framework that summarizes the research findings and themes that emerged from the literature review. It highlights the decentralization of district health services and its possible effect on access to and utilization of health services.
Discussion

Main finding of this study
This study highlights a complex picture, revealing diverse relationships between the decentralization and health services in terms of service access to and utilization of services, and participation in the decision-making process. While examining the two important national indicators, access to health services has achieved over 85% and the availability of essential drugs achieved 95%. The study also reveals that the restructuring of the district health primary health care services was considered the most achievement for meeting health care needs of the local people, as HIs were within the reach of the community (distance wise) and most of the services are free for the women, children and disadvantage groups.

One of the main outcomes from this analysis is the conceptual framework (Fig. 1), which highlights the decentralization of district health services and its possible effect on service delivery, management and political aspects and overall linkage with the service utilization and performance which is often an ignored dimension in decentralization studies.14,35,63,64 (R. Dhakal, unpublished results) The case of Nepal also highlights that the transition from district health services requires a comprehensive approach—ensuring that there is no deterioration in the availability and accessibility of health services. The study has also noted some challenges or barriers related to the organizational and financial levels, for example, undue bureaucratic involvement and political interference in local planning and decision-making, poor reflection of local needs in health budgets, local health staff being under the control of central government and a limited financial resources base, which has ultimately affected the poor access to and utilization of district health services.

Despite these constraints, Nepal has opted for a model of decentralization at district and sub-district settings which aims to ensure that public services can be accessed free and utilize with ease. The process, however, has not been straightforward, and involved a series of amendments. This highlights the incremental nature of the reforms and the necessity to adjust them when problems in access, utilization and delivery arise. Of particular importance in Nepalese case was that women, poor and excluded groups are now in the centre of district planning and their representations on the decision-making, management committee and service planning is mandatory by law. This study was distinctive in its focus because, although there is information available about the decentralization and public services and possible barriers to community participation, service access, utilization and performance, there is little current considered intelligence on the nature of service delivery and achievements of decentralization from the perspective of ‘the core groups’—SUs and providers in health system and the impact on service performance.

What is already known on this topic
Decentralization is understood as part of a wider reform of the state and the health sector, which seeks to improve accessibility, efficiency, effectiveness, equity and quality of services.31,65 Effectiveness of decentralization on health services determines if local people, especially poor, women and marginalized groups, are involved in the planning and decision-making process then the system would be more
responsive and as a result they would be more likely to access to and utilize health services, leading to better outcomes.\textsuperscript{15,17,33,66–69}

\textbf{What this study adds}

Decentralization was positively associated with increased service access and utilization and improved service delivery. The findings indicate that those groups involved in the study were positive about the effect of decentralized health services in terms of services access to, utilization of and management of health services. There is a trend towards SUs and providers reporting that services are being developed and made more responsive in meeting the needs of poor people.

\textbf{Limitations of this study}

The study had a number of limitations. First, this study is limited to four primary HIs of Chitwan district in Nepal. Second, this study was limited to the specific district in Nepal and had a relatively small sample size (compared with quantitative). Third, all the data collection was completed before the analysis of data was undertaken. A more iterative process of data collection and analysis would have improved the topic guides and experience of the researchers. Fourth, quantitative study could have provided a more representative view, but not the depth of this approach. Finally, during the field research Nepal has faced many challenges related to political stability and good governance, due to the conflict between the government and Maoist rebels. The country has had more than nine governments. Conflict has also led to an increased number of internally displaced people. Therefore, continued access to and utilization of district health services have suffered additional challenges, mainly due to the strikes, travel restrictions and lack of guidelines clarifying the position of health professionals in dealing with victims during the insurgency.

\textbf{Conclusion}

This study suggests that among the study population, decentralization is associated with increased service access and utilization and improved service delivery. It reinforces evidence from previous studies regarding the likely impact of decentralization both at organizational and service level performance. We conclude that decentralization creates both opportunities as well as challenges for health service provision. Caution, however, needs to be taken when interpreting the findings and generalizing to a wider population because of the limited sample size and relatively under-representation of the respondents. However, we believe that this study is a valuable contribution to the policy debate of ‘better health services for poor people’ by focusing of an under researched (ethnic minority) group both in the Nepal and regional context. Evidence from this study noted that active involvement of SUs and services providers, and development of partnerships between government, civil society organizations and the private sector, with clear and effective policy and regulation, would bring changes in people’s health status.

An ongoing system of service delivery monitoring by local bodies, making the outcomes available to the public including service users, is suggested for promoting equity and quality and for improving efficiency. The study has also noted some discrepancies in service delivery, and lack of capacity building in local authorities—services management committees and intersectoral coordination among different authorities. Therefore, this study suggests that decentralization should be taken as a ‘mission’—ensuring that the public’s interest is at the centre of the planning and decision-making process, and that decentralization should be based on evidence-based principles of what works best where and in what context for improving the quality of, access to and utilization of district health services in meeting the needs of poor people.

\textbf{References}


18 Gilson L. Health care reform in developing countries. Lancet 1993;342:800.


67 Furuta M, Salway S. Women’s position within the household as a determinant of maternal health care use in Nepal. *Int Fam Plan Perspect* 2006;32:17–27.
