

Governance of Health Care Services: A Critical Understanding of Federal Experiences from Central Nepal

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Abstract

People in different locality interact, perceive, and experience the government and governance through the government's various service delivery mechanisms mainly, which affect them in their locale. Governance in the health sector can serve as an essential and critical window through which we can glance at the situation of governance in a given society. Multiple voices from the actors involved in delivering health care services and health service users portray the current emerging situation of health governance, especially, during the initial years of implementation of federal system in Nepal. In portraying the current health governance scenario in the study areas, this article shows how people's experience of forms of governance affects their uptake of health care services. It uses micro-level ethnographic information to look at the broader issue of health governance.

Keywords: Health Governance, Infrastructure, Ethnography, Federal System

Introduction

People in different locality interact, perceive and experience government and governance through various service delivery institutions and mechanisms of the government machinery mainly, which affect them. Understanding health sector governance at the local health facilities provides an opportunity to explore how it has been translated into practice. Good governance is one of the six constituent parts of a health system that can contribute to strengthening health services delivery (WHO, 2010). World Health Organization (WHO, 2017) emphasizes that good governance is essential to promote and maintain population health in a participatory and inclusive manner.

This paper sheds light on how actors involved in delivering health care services, the citizens supposed to utilize them, and the institutions through which they are provided understand, practice and, experience government from their respective

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locations. In doing so, this article focuses on examining how far the prevalence of inclusive governance, which promises to incorporate diverse voices, and to bring decision-making closer to citizens (Hinton, 2011), has been translated in the study area. Moving beyond the conventional model of measuring health care delivery only in terms of input and outcomes (Lewis and Pettersson, 2009), this paper has accommodated and paid attention to governance in the health service delivery system to know how well the system is operating and its effectiveness in terms of service delivery. In line with Lewis and Pettersson, this article deals only with some aspects of five general indicators to measure the performance of health care delivery: budget and resource management, individual providers, health facilities, informal payments, and corruption perceptions. Through the article, it is aimed to critically analyze how far federalization process has helped to strengthen the capacity of the Government of Nepal (GoN) to deliver health care services closer to its citizens.

Following the federal system, health facilities at the local level are running as part of and under the local level bodies. One of the main aims of this paper is to comprehend how the federal process has unfolded in the health sector and how far it had addressed the significant dimensions of governance, viz. the rule of law, representation, participation, transparency, and accountability. To get into that, the second objective of the paper is to grasp the experience, factors, perceptions, and meaning embedded with the unfolding process of federalization, from the perspectives of the actors and stakeholders involved in delivering health care service within this short period of federal governance.

Relating governance with performance, Lewis and Pettersson (2009) argue that good governance enhances performance in health care delivery whereas poor governance disproportionately affects the poor. For Dodgson, Lee and Drager (2002, p. 6), “health governance concerns the actions and means adopted by a society to organize itself in the promotion and protection of the health of its population”. Either formal (e.g., Public Health Act, International Health Regulations) or informal (e.g., Hippocratic Oath) rules may define such organizations and their functioning to advise or ban behavior. Health governance mechanisms can be located at the local, national or global level. They argue that historically the base of health governance has been at the national and subnational level, reflecting the primary responsibility of the government for the health of their people.

Some scholars and institutions have pointed out the potential hurdles on the way to realizing good governance. Analyzing how Indian bureaucracy works up to the community level, Gupta (2012) states that everyday bureaucratic practices systematically produce arbitrary consequences in its provision of care. The indifference to arbitrary outcomes has become the central feature of the state, emerging from the

workings of a supposedly highly rationalized, bureaucratic state. He regards such indifference through the production of arbitrariness as structural violence exerted by the state.

The Asia Foundation (TAF, 2015) has pointed out two prominent and interrelated challenges of governance at the local level in Nepal: politics matters a lot and informal matters more. For The Asia Foundation, the way politics is conducted in Nepal has degenerated governance practices and increased corruption at the local level. As the organizational basis of political parties, especially at the local level, is not ideology but political economy, they constantly use patronage networks and constituencies to maintain their size and influence. Informal ways have been the convenient paths for local bodies to plan, budget, and deliver services in a way that they will keep the local politics settled, while serving the interest of the political elites and the bureaucracy. Those who control the system find the informal as convenient and beneficial.

Health policies and plans have evolved through a long process in Nepal. Formulation of periodic development plans, which began in Nepal in 1956, has opened up the planned development in the health sector. The first fifteen-year long term health plan was developed in 1975. Sixteen years after the formulation of the first long-term health plan, National Health Policy (1991) has yet to emphasize to expand the availability of modern health facilities to the rural populace. By this time, health facilities have begun to display all the available health services on their signboards. It has also made the provision of free basic health services and drugs, whereas it could not pay attention to the unique needs of women, children, and poor and excluded groups. Second Long Term Health Plan (1997-2017) came with the promise of improving the health status of those whose needs had not met yet. It recognized poor and rural people, women and children, and marginalized and underprivileged people as vulnerable.

Engaging with existing literature on health governance, this introduction part of the article defines and highlights the health governance in Nepal. It also points out the research objectives and questions. The whole paper aims to bring out the answer for them. The second part of the article portrays the research methodology explaining how primary data were collated, which provided substance for this paper. Then, the article comes up with its main contents which comprise of discussions on the infrastructural base of the health facility, availability of services, provision and availability of human resources, and social audit and monitoring measures adopted in the locality. Finally, the conclusion part shows the form of health governance that has unfolded in the locality following the federalization in Nepal.

Research Methods

This article primarily bases on information generated from an ethnographic study conducted in 2018 (May-December) and 2019 (April-May) at select health facilities and community in Gorkha district and in Rautahat district to understand how the governance has unfolded in the health care realm. The researcher himself conducted a micro-level research in Gorkha district and information generation in Rautahat was also supported by field researchers. Though this article comprises of information from these two field districts, however, it is not the aim of this writing to make comparative presentations of the study findings. The information from both the districts has been employed as and when they are regarded relevant to substantiate arguments.

The fieldwork was conducted in two municipalities, and at a rural municipality in Rautahat district and in one rural municipality in Gorkha district. Considering the sensitivity of information and to protect the human subjects involved in the research study, “ethnographic masking” (Murphy and Jerolmack, 2016) has been done to anonymize name of the municipality, organization, and staff. In case of need, the names of the local bodies and people have been mentioned in the form of pseudonyms. The research team met health workers and visiting patients from three health facilities (one Primary Health Care Center and two Health Posts) from Rautahat district and one Health Post in Gorkha district.

This paper bases on the information acquired from personal conversations with 50 research participants from various segments of the society and five ward members of a rural municipality from Rautahat district have made their contributions in the form of group discussions. The conversations were held with 18 health seekers during their visits to the respective health facilities in these four different local municipalities. We also had conversations with 16 health workers in their respective health facilities, mainly about their experience of serving the people in a federal context. These health workers included the in-charge of each of these health facilities where we conducted a field study, medical officer, paramedical and nursing staff, lab technicians, and female community health volunteers (FCHVs). Our research was also enriched with the information from two Health Facility Operation and Management Committee (HFOMC) members, two non-governmental organization (NGO) workers, and two private pharmacy owners and dispensers. The interviews were also conducted with municipality/rural municipality officials from each of the four sites. Field notes (Emerson, Fretz, and Shaw, 1995) mainly in the form of “scratchnotes” (Clifford, 1990) were the part of information generation during observation and interactions process.

I have taken help of research guidelines and checklists to generate information staying closer to the ground and focusing on ‘small places’ that speak to ‘large issues’ (Eriksen, 2010). All the information were analyzed thematically ‘without

missing/ignoring the nitty-gritty of the research realm' (Uprety, 2009). In addition to priori themes, I also looked for the grounded themes across the primary datagenerated from the study.

Management and Operation of Health Facilities

In principle, Health Facility Operations and Management Committee (HFOMC) is supposed to govern all the affairs of the health facility for its smooth operations and to increase local people's access to available health care services. This paper highlights the very foundation of its formation, operation, how the HFOMC members understand their roles and responsibilities, and how far they assume them.

Aiming to encourage local communities to take greater responsibility in managing local health facilities and health programs, in 1999, the Government of Nepal (GoN) passed the Local Self-Governance Act, based on which the Ministry of Health and Population (MoHP) decided to decentralize health service management to local bodies. Only by 2002/2003, the MoHP began the formal hand-over process of health facilities. As per the request letter (2017) of the Federalism Implementation Unit of MoHP, written to the Ministry of Federal Affairs and Local Development (MoFALD), the MoHP advised the latter to inform the local bodies for the formation of HFOMC in the respective health post and PHCC at all local bodies. The content of the letter itself shows the complexity that the ministerial decision is made by MoHP, whereas it has to be implemented by MoFALD. This could be the reason that the message does not have mandatory provisions rather; it has a mild tone that the advice could be appropriate for the operation and management of the health facility.

Each HFOMC consists of nine to thirteen representatives from the municipality/rural municipality. As per the guideline, the Chairperson of the municipality will be the patron and there will be seven members in the committee, which comprises of four members by default of their position (ward chair, local headmaster, representative of the business community, and health facility in-charge). Additionally, there has to be three more nominated members, one by the municipality chair and two others, including a female, by the ward chair (MoHP, 2018). Ironically, some service providers do not know precisely how many members have to be there in the HFOMC and how many have to be nominated.

The composition of HFOMCs often does not reflect the constitutional thirst of inclusive democracy. A health facility I have observed in Gorkha district comprised a Dalit as a member of the committee, whereas, out of four health facilities that our team studied in Rautahat, none of them had any Dalit members in their HFOMC. One ward secretary had observed that even if there were a Dalit representative, that person would

be strategically selected as an illiterate (*aaunthachhap*), whose job simply would be to obey what the other members would propose.

Often, people are not informed about the formation of HFOMC. Local elites decide how to choose its members, without informing and consulting local people. As an administrative officer narrates, how to and whom to select in the HFOMC could represent a typical case of reality:

Ward chair became the chairperson of the HFOMC by being the ward chair of the concerned ward where the health facility is located. There was no consultation with the Dalits, scholars, and marginal segments of the society, instead, all the rest elected four members of the ward were nominated as members of HFOMC. Even a person who had donated 10 *Kaththa* land to the health facility was also not consulted, even though he was also interested in joining the committee.

Alma-Ata Declaration (1978) has accepted community participation as one of the crucial constituent parts for the successful implementation of primary health care strategies. HFOMCs can play critical role in enhancing community participation in the health sector. However, inclusive participation of local people in these HFOMCs has been limited to the rhetoric. Gurung and friends (2018) have found that there is only 77% representation of Dalits in such committees. They further claim that “the HF (O)MC member selection process and decision making within the committees were influenced by powerful elites”. This has ultimately curtailed their participation despite having their representation. Nonetheless, people are aware of the representation of various segments of the society that no monolithic approach can prevail there.

Physical Infrastructural Facilities

I conducted this study at a Primary Health Care Centre (PHCC), located in a rural municipality in Rautahat district. This PHCC is located in two-storey building, built only a couple of years ago. This building looks fine from the outside. I met an acting in-charge of the PHCC in 2019 April to talk about her experience and assessment of the operation of this health facility. Amidst our conversations, she pointed to the stains inside her office room where there was a flooding mark. It was from the 2017 flooding in which the building sank up to five feet. That flooding caused the damage of various documents, equipment, medicine, and medical supplies. Service providers had to drown themselves to visit the health facility. During those days, no patients and health seekers visited the health facility. Several stakeholders, inside and outside of the health facility, stated that the health facility is about five feet below the ground level, and that makes it bound to drown in the rainy season.

This health facility is spread into a sufficient amount of land. However, it still does not have a placenta pit on its premises. Each time, a birthing mother or her relative has to dig a hole for the placenta. For many service providers, this is a shameful act. A Community Medicine Assistant (CMA) who is from the same locality thinks “it is not related with the resources rather the matter of sensitivity of the municipality people who have to provide fund for the construction of the pit, it does not cost much”.

There is an alternative perception about the unavailability of the placenta pit. An accountant of the very rural municipality is states:

I could not get a request for an appropriate budget and technical estimation of placenta pit construction from the PHCC, and thus, I could not allocate funds for that. Without proper estimates, anytime I can be punished in the name of embezzlement. I do not want to be trapped in the problem (*phasnanachahane*).

Likewise, other health facilities have pointed out that their inability to run lab during the load shedding/power cut hours. Besides, running a health facility in insufficient space/rooms, which leads to the curtailing of the capacity to deliver quality service, has been reported by two health facilities. Ignoring their repeated requests has become a regular phenomenon in many municipalities in Rautahat district. A Health PostIn-charge says:

Our toilet collapsed on the rainy days of August 2017. We had requested the ward chairman for its construction immediately after this. We have to go to the open space even when we are in our office. Even now (November, 2018), we have not managed to rebuild.

Sometimes, when the municipality does not listen to them, health personnel/in-charge find coping mechanisms on their own, which is reflected in his statement:

Our toilet and hand pump had been non-functional for a year. Also, we had to confine ourselves only to three-room building. It should have had ten rooms to be well-equipped to serve the patients. The ward office did not provide any support. I did maintenance on my expenses. Besides, I also initiated gardening in the compound as I have to stay here for a long time.

In an instance, a supportive ward chairperson straightforwardly allocated a sufficient budget for the infrastructural improvement. In my field in Gorkha district, a Health Post in-charge told me that the Ward Office provided Rs. 50,000/- to build drainage around the health facility to protect it from the monsoon flooding. It also allocated Rs. 1, 50,000/-to buy essential medical equipment.

Inadequate physical infrastructural facilities ultimately affect health seeking of these women. Grown-up as bona fide women (Dahal, 2018a), upholding the existing gender norms and values, affects them not only at the household and community but also up to their journey to health facilities and their interactions with the service

providers. As shown in rural India (Bhandari and Dutta, 2007), most health workers, especially the ‘doctors’, hesitate to serve in the rural areas due to overall infrastructural inadequacy. Moreover, physical infrastructure is an essential factor influencing patient satisfaction in the healthcare delivery system (Hussain et al., 2019). Local people and health service providers have also realized that the availability of infrastructural facilities affects the viability of and quality of health care delivery.

Local Circumstances Constraining Availability of Services

In many health facilities, there are no proper and effective means of dissemination of information on available health care services. Sometimes, they have banners and flex boards on their walls. However, because of the medical and public health jargon and sometimes even literacy itself becomes a barrier for the people to understand what is written there. A medical officer from the PHCC states, “We do not have a proper channel to inform people about the available services. Though it is written there, I do not think that needy people understand this”.

The complexity also emerges when the health seekers do not know, rather, are not correctly informed, about how long a particular diagnosis takes up and whom they have to consult. Such confusion prevails not only in the local health facilities but also at the district hospital. In such an encounter, our field researcher follows an older man of about 60 years old from a rural part of the district. He could not manage to get his diagnosis reports before 3:00 p.m. and thus could not consult the physician on that day. When he approached the hospital on the following day a doctor told him “I have not checked up you earlier. So, you have to find the one who did that yesterday. Look for him in another room”. It is not easier for the patient, who cannot read and write, to find the doctor’s name and whether and where he is available. This kind of behavior is not limited only to the manner of health care delivery (Hahn, 1995, p. 263) rather is a constituent part of everyday bureaucratic practices that systematically produces arbitrary outcomes in its provision of care (Gupta, 2012). The bureaucratic procedures act as structural forces (Dahal, 2018b) in shaping the limits of health facilities to deliver care services.

Most of the time, in such hospitals, it is not the physician who deals with and diagnose these patients but the paramedics or administrative staff who come forward on behalf of these physicians. Often they ask the patients to collect the reports around 3:00 pm. And by 3:00 pm, when the patients go to collect them, they would be advised to come the next day, or, in case of hurry, they are advised to consult the doctors in their private clinics. This really becomes irritating for the patients who visit the hospital from distant places and need to return home in the evening. Eventually, these kinds of

behaviors, “the manners of its delivery” (Hahn, 1995, p. 263), discourage the patients to visit there again.

Sometimes, the availability of services is also affected by the inharmonious relationships among the service providers. A Health Coordinator from Madhav Narayan Municipality, Rautahat stated that one of their health posts had recently discontinued its birthing center because of a dispute between the in-charge and the ANM (Auxiliary Nurse Midwife). Because of that, the municipality is in the process of transferring the ANM to another health facility. However, her nexus with an influential political party has halted the transfer process. Some health facilities in the district had discontinued the twenty-four hours of emergency services for not getting paid for their overtime service. A PHCC in Rautahat had posted a notice on its wall which says that because of their inability to get money for the overtime job for the first half of 2017 they have closed the emergency services. Whereas the coordinator and sub-coordinator of health services at that municipality stated that they could not make the payment as the claimed overtime money was excessively high, much higher than their annual salary.

Unlike in hospitals providing tertiary care services in the Kathmandu and Chitawan, health seekers have not gone for confrontations with the service providers (Dahal, 2020). Constrained by the limited availability of health care services and the way they are delivered, people in the southern part of Nepal choose to go for cross-border medical travel to India. In such conditions, they go to neighboring towns and cities not only for the locally unavailable health care services but also for the ones which are available at the locality or the district headquarters. In these circumstances, people’s imagination of the health system includes the health care services available even beyond their national boundary (Dahal, 2019).

Provision of Human Resources and Absenteeism

Sita Devi Mahato, 45, got a ticket from Out Patient Department (OPD) around 2:00 p.m. at a PHCC in May 2018. The health personnel at the OPD informed her that there is no doctor. She became furious and asked the service providers, “Whether poor do not have any options” (to get health care services at the government health facility)? She was there for the treatment of her ear. Even though the medical doctor was not there at that time, other health personnel did not bother to check her. Upon her return, an ANM in her probation period stated that since the in-charge is not present there regularly, then why others should have to provide care to the patients? Altogether, there is thirteen staff in this PHCC. They have not received their salary and allowances for two months in mid May 2018. Their provident fund had not been deposited for ten months. It was mainly because of their dispute with the municipality regarding the emergency allowance.

Frequent absenteeism has been normalized in the health facilities. What makes people annoyed is not the absence of any of the staff but the lack of timely information of that. Lack of information before getting an OPD ticket or waiting for a long time irritates the service seekers. On May 30, 2018, when the doctor did not appear in a health facility by 12:30, patients and visitors became frustrated and questioned why the doctor has not turned up yet? After half an hour, the service providers turned up at the OPD and the patients waiting for the dressing approached him for that. However, as there was no medicine for the dressing, these patients got further irritated and scolded the staff for not informing them when they were waiting for the doctor. Later on, in my inquiry with other service providers, I learned that they do not prefer to tell the service seekers about the unavailability of the medicines they are looking for. They want to cover up the lack of medicines by the absenteeism thinking that the responsibility will not fall upon them. Then the visiting person will express their anger for the absentee and not blame the one for not providing medicine.

In our frequent visits to different health facilities, we have found that absenteeism of health personnel till 11:00 a.m. was not unusual. Although the health facility used to be opened by the peon/assistants, however, during this early hour presence of all the staff was not a common phenomenon. Ghimire and colleagues (2013) have shown that working lack of environment is the primary factor that leads to absenteeism of health work-force in Nepal. On the contrary, I would like to add that absenteeism of the health workers also contributes to creating the deteriorating working conditions.

The way the health facility in-charge treats other staff affects latter's motivation (not) to work. A lab assistant from a PHCC was not happy with the discriminatory behavior of the in-charge, who provides 2-3 weeks of absence without any leave to a few staff, and they can sign the attendance register upon their return to the office. Some other female staff even blamed that those who have affairs with the in-charge are the ones who get the chance to go to training. For them, there is no problem with attending the facility and they can easily do their attendance even after a month of absence. In contradiction to what these health personnel reported, a ward chairman thinks that these days the absenteeism of health personnel has declined significantly. Regardless of whether the ward chair is correct or the ANMs, at least either party is trying to construct the truth to support their intent of projecting it.

Another crucial implication of absenteeism of health personnel is that the staff, often the peon, without any medical/paramedical training, had to deliver the services and medicines. At the local level, along with other paramedics, they are also regarded as doctors. Based on their observation of how to diagnose, counsel, and dispense medicines, they provide medicine to the health seekers, even in the absence of

medics/paramedics. One peon from a health facility further told us that he had acquired such knowledge as he used to work at a pharmacy before joining this office. This situation does not seem to have been overcome from the time when Justice (1986) had already pointed out about such practice some thirty years ago. These peons are the ones who have to reach to open the health facility on time in the morning.

It is not always absenteeism, but also the unavailability of adequate health personnel in the health facility has sometimes curtailed the health delivery capacity in Nepal (Gurung and Tuladhar, 2013), even if these institutions are prepared with required medical equipment. X-ray and Electrocardiography (ECG) machine at a PHCC in Rautahat are reportedly have been lying idle because of unavailability of a radiographer. It is interesting to note that DHO and the municipality office is also aware of this situation, and none of them materialized their promise to resume these machines as functional.

Rit Puryaune: Social Audit, Monitoring, and Transparency

Social audit is a way of measuring, understanding, reporting, and ultimately improving an organization's social and ethical performance. Usage of this term can be traced as far back as the 1950s. It rests on the premise that democratic governance should be carried out, as far as possible, with the consent and understanding of all concerned stakeholders. Therefore, it is a process and not an event (Food and Agricultural Organization of the United Nations [FAO], 2019). Monitoring, on the other hand, can be understood as observation and checking the quality of something over a period through systematic review of the activities carried. Our research participants have pointed out some significant aspects of monitoring and social audit, which is supposed to be part of the operation of the health facilities.

While talking to an ex-chairman of the HFOMC, it is revealed that he does not know about the practice of social audit in the PHCC our research is based on. It is not only the patient and general populace of the community; rather, he was also not aware of such things prevailing in the health facility-“I was not aware of the activities carried out by the health facility even during my chairmanship”. It seems that there was and has been a tendency to view health facility as a medical domain and thus the commoners, regardless of whether they are in the HFOMC or not, do not have any say in the process of their operation and management.

Officially, it is the responsibility of the health coordinators and sub-coordinators of the municipality monitor health facilities operating under this health facility stated the in-charge of the PHCC. However, while talking to the in-charge other health facilities we got to know that rarely there is any monitoring by the coordinator and sub-coordinator. In-charges of these local health facilities have understood that “There is no

budget at the health post these days. Thus, there is no monitoring. We used to have monitoring only about the budgetary aspects, to inquire about whether the estimated budget was burnt or not”.

The research assistant had the opportunity to observe and participate in conduction of social audit on July 5th, 2018, at the end of the fiscal year. There was a social audit program conducted by an NGO called Forum for the Improvement of Society (Samaj Sudhar Manch). The program can be tentatively translated as ‘a ward level program conducted to public information acquired through the social audit of health facilities’.

At the beginning of the program, it is revealed from the conversation with the NGO representative about how the program was arranged. He had asked with the health facility in-charge, “as a local from a reputed family, can you please help me find some participants for this social audit program? It will be better if they will be around 25, for the logistic matter”. Though the in-charge had agreed to call for some participants for the meeting, however, it is clear from no presence of community members in the social audit program that he has not made a reasonable effort. Neither the PHCC has disseminated any information through its network and its official platform, nor does the NGO seem to have tried for that. There were only four FCHVs and few service providers from the same health facility. The in-charge repeatedly pointed and addressed an IT (Information and Technology) Officer of the municipality as a representative of the service user. That IT officer was smiling at the in-charge. This NGO got responsibility from the DHO to conduct a social audit. Ironically, when the health facility in-charge began to present the annual report, he felt sorry that there was no one commoner in the program. Later on, while talking to some other FCHVs in the community, we knew that they were not informed about this social audit programme.

Most of the research participants pointed out the prevailing situation of the lack of transparency in local level governing units like municipalities and rural municipalities, and health facilities. Some people stated that lack of appropriate and skilled human resources at the municipality office has mainly curtailed transparency in the activities carried out by the municipality. This is further aggravated by the practice of formation of user’s group to implement the developmental programs. Local people have understood that there is a clear provision of who can be a member of the user group. In an absence of such explicit provision, local level executives -municipality chair, vice-chair, and ward chair- select their *Aafno Manchhe* (one’s own people) (Bista, 1991) for the user’s group not from the project implementation area but from elsewhere. This effectively helps to cover up and curtail transparency.

Health personnel, who have a conflictual relationship with the municipality officials, especially regarding the overtime money, have observed that ‘corruption has

increased these days significantly, and now it has become open. Nowadays, municipality officials, mainly the chair and vice-chair have become corrupt and autocrat. They do not listen to anyone. They only do it as *Rit Puryaune*, ritual, in performing any developmental activities.

Sometimes people suspect, when the health personnel and the municipality officials are from the same caste group, same political party, or the kinship network, then the chances of forming an alliance for their own benefit i.e., *milimato*, and they can easily conceal the information and run the health facility without being transparent. *Milimato* etymologically comes from *milnu* i.e., to be in harmony with or not to have any gap and *mato* refers to an agreement. Collectively, it connotes that the people in power secretly act for the benefit of their circle.

Health facilities do not public their revenue and expenditure to the public. Amidst the situation of frequent lack of essential medicines in these health facilities, no practice of making them available raises the suspicion of the local people towards the health facility and the staff working there. Contrary to general people's blame to health facilities, sometimes, health personnel attempt to normalize the lack of transparency as common phenomena in the locality. They argue that it is not only the health facility that is not transparent but also the municipality is ahead of them which does not hold its assembly on time and does not make its activities, resources, and expenditures public. Since the ward chair is also a chairperson of the health facility, he can transcend what he learned from the municipality to the health facility management and operation. The empirical data from this program reveals that social audit has become a mere activity of *RitPuryaune*, only meeting and confirming the formal criteria. In practice, social audit is conducted simply to show following the law or legal criteria, it has been done whereas the actors, in essence, want to have, what can be regarded as the appropriate impact or consequences.

Conclusions

Often health facilities are projected as a dispassionate entity that delivers health care services, whereas, local stakeholders have divergent viewpoints to look at them based on their social positioning, location, affiliation with the political party, and the kind of relations with some health personnel. In this sense, health facility, as any other social institution in the society, provides space for construing the varieties of discourses. It is never left as a sacred entity considering its utilitarian value to promote health and well-being of the people, which is also embedded in broader social and cultural contexts (Dahal, 2007).

It is the primary responsibility of the government to promote the health of its people (Dodgson, Lee and Drager, 2002, p.7). The unfolding scenario in the Nepali

federal context shows that the government has not been able to meet this expectation in its fuller sense. On the other hand, people have realized the importance and the instrumental value of health in their everyday life. This has made people to look for better options in the health care services, and thus, often they tend to look for health care services in the private sector (Dahal, 2017) and even across the national boundary (Dahal, 2019), mainly because of the poor availability of health care services.

It is also apparent that there is no transparency in the operation and functioning of the local bodies and health facility not because of less attention towards this pillar of the governance but due to the deliberate attempt of the people in power to create a chaotic situation (Gupta, 2012). Lack of transparency helps them to take benefits of these public institutions and their resources for their personal or group advantages, which eventually hampers the collective good of the society at large and the marginal segment at most. This has weakened the health governance as a component of health care system and incapacitated local bodies to deliver the health care services.

Inadequate attention to the promotion of inclusive participation in health care delivery is reflected through the sphere of infrastructure as well. Sociality of particular kinds stems from the infrastructural condition of the health facility. The power rooted with the ‘social relations embodied in materials’ (Law and Mol, 1995) emanates as ‘social arrangement of infrastructures’, remarkably influence the sociality of the health service providers, health seekers, and the interactions between them. While observing the materials, a researcher may simultaneously witness the production of the social (p.274). The social reflected at the health facility is not purely “social” and the artifacts and infrastructures generating them have politics (pp.276-281).

One of the main thirsts of the federalization process in Nepal is the promotion of inclusion and democratic participation in the operation, management and benefit-sharing of the diverse categories of people, including women, Dalits, and marginalized segments of the society. Instead of paying attention to the promotion of inclusion and participation, authorities are found to have tended to nominate their people, *Aafno Manchhe* (Bista, 1991). The thinking of *Aafno Manchhe* also prevails in the selection of local staff and in providing opportunities to go for training and leave facilities to the staff of the health facilities. Same is the fate with any other kinds of user’s group. Local-level authorities till now seem to be fulfilling the formality as *Rit Puryaune* without paying adequate attention to real desired impact whether it is the case of formation of user’s group, conduction of social audit, or formation of HFOMC.

The mode of health service delivery affects the level of patient’s satisfaction. In case of isolated incidents of health personnel’s behavior, we can take that as a manner of individual. If it were a manner, it would have been limited to the individual; rather, it is the fact that it prevails in different health facilities means such kinds of behaviors are

exhibited by one or other service providers over the period. These behaviors are rooted in everyday bureaucratic practices (Gupta, 2012) and thus form a kind of pattern which discourages health seekers from revisiting the health facility. This makes them to consult a local pharmacist or go for cross-border medical travel to neighboring towns and cities in India.

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