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Making local health services accountable

Social auditing in Nepal's health sector

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German Health Practice Collection

Showcasing health and social protection for development

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Front cover photo: *A public meeting in the village of Guttu, Surkhet District, brings its 2014 social audit to a close.*

Table of contents

Executive Summary 4

Building up local democracy 6

Social audit: the right tool at the right time? 11

The social audit process 14

Results 23

Lessons learned 26

Looking ahead 29

Peer Review 30

Acknowledgements 31

References 32

Acronyms and abbreviations

BMZ	Federal Ministry for Economic Cooperation and Development, Germany
DFID	Department for International Development, United Kingdom
GDC	German Development Cooperation
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit GmbH
HFQI	Health Facility Quality Improvement
HSSP	Nepali-German Health Sector Support Programme
NGO	Non-governmental organisation

Making local health services accountable

Social auditing in Nepal's health sector

Executive Summary

Situation

During the past decade, Nepal has made measurable progress on a variety of health indicators. Nonetheless, at local level, public health facilities across the country face daunting problems, including insufficient supplies of drugs and lack of basic equipment, chronic understaffing and frequent staff absenteeism, poor provision of water and electricity, and low level of accountability to local people.

Social auditing has been introduced on an increasingly wide scale to enhance citizens' ability to participate in decision making about their health services at facility level. On behalf of Germany's Federal Ministry for Economic Cooperation and Development (BMZ), the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) has provided technical advice and funding for social audits in the Nepalese health sector since 2009.

Approach

The basic social audit is a five-day process, in which a comprehensive schedule of investigation, analysis and reporting is followed to audit the performance of a given health facility. A shorter two-day process is used in subsequent years to monitor progress in achieving the action plan agreed in the initial audit.

Independent organisations – usually a non-governmental organisation (NGO) – are hired through an open tender to facilitate the process for chosen health facilities within a given district. To be eligible, an NGO needs to be based in the district; must have existed for at least three years; and must have at least five years of experience in relevant fields such as social mobilisation, health system, women's rights, etc.

The tender is run by a Social Audit Committee at the district level, which is responsible for overall implementation within the district.

Once hired, the winning NGO works directly with individual Health Facility Management Committees, which are chaired by representatives of the Village Development Committee. Members include the health facility in-charge (director) and community representatives, including from marginalised ethnic groups and castes, and a Female Community Health Volunteer.

Social audits begin by examining the records that are kept by the facility. Voluntary 'exit interviews' are conducted with recently delivered mothers as they leave the facility. Female social auditors conduct the interviews in private, following a standardised questionnaire, taking between ten and 20 minutes. The social auditors also hold focus groups with local women and with representatives of disadvantaged ethnic or caste groups.

Results of the different information-gathering activities are presented at a public mass meeting where community members air concerns, ask questions of care providers and decision makers, and participate in forming an action plan. The auditor also prepares a final social audit report. The report and action plan provide a road map for the following year, identifying problems that need to be solved and ways to improve the quality of services. While the most immediate user of the results is the health facility itself, recommendations are also made to local and district levels of government.

Results

In 2013-14, a total of 602 facilities in 45 districts (i.e. the majority of the country's 75 districts) held social audits. At present, GIZ provides technical assistance in six districts, while other external development partners including UN system agencies, international NGOs, and bilateral agencies provide additional support. The targets set by the Ministry of Health for 30% of health facilities to have social audits by 2015 is on course to be met or surpassed a year early. Among other advances, social audits have promoted citizen participation, social inclusion and mutual accountability. They have also helped vacant positions to be filled through temporary contracts, improved the behaviour of health workers, made facilities more responsive to patients' needs, and helped to reform or re-energise Health Facility Management Committees.

A recent review in the Far Western Development Region allowed the results to be tracked over three years in two health facilities. Among other findings, social audits increased demand for services by informing people of (a) what is available and (b) what they are entitled to in their local area. In both facilities, staffing shortages identified by the social audits were fully or partially filled. The recurring challenge of drug stock-outs and infrastructure problems with buildings and equipment were effectively dealt with through the audit process. On a broader scale, beyond these two facilities, the social audit tool has added value in ways that were not originally envisaged, such as giving facility in-charges opportunities not just to respond to questions and concerns, but educate local community members.

Lessons learned

Social auditing in health facilities has now been carried out for five years, though the process has been one of fairly constant change over this period. A number of important lessons have been learned during that time. **Robust, experience-based guidelines** are indispensable to guide successful audits. The **quality of independent social auditors must be ensured**, particularly by setting minimum qualifications as hiring criteria and monitoring their performance in different parts of the audit. **Local health staff must be well oriented prior to a social audit** in order that they will assist rather than resist the process. **Social audits can reinforce other planning and quality management processes** such as quality improvement in other service areas. Finally, **better integration with other efforts to increase health service quality can help to access increased funding** for health facilities, notably from local government structures such as Village Development Committees.

Box 1. Key Messages

Situation. Public health facilities in Nepal face problems such as insufficient supplies of drugs and basic equipment, chronic understaffing and absenteeism, and poor infrastructure. A contributing factor is the lack of accountability to local people.

Approach. Social auditing has been introduced to increase citizens' participation in decision making about local health facilities. A five-day process of investigation, analysis and reporting is run by independent facilitators, with special provisions to include women and disadvantaged castes or ethnic groups. Results are presented at a public mass meeting where community members participate in forming an action plan.

Results. 602 facilities in 45 of Nepal's 75 districts held social audits in 2013-14. Social audits have promoted citizen participation, helped vacant positions to be filled through temporary contracts, improved the behaviour of health workers, and made facilities more responsive to patients' needs.

Lessons learned. Among other requirements, successful audits need robust guidelines and good-quality independent facilitators to carry them out. On a system level, social audits can reinforce planning and quality management processes in other service areas, and help access increased funding for health facilities from local government structures.

Building up local democracy

Social auditing in action

'It just isn't right to expect women to discuss their intimate health problems with us out in the open, under a tree!' the young woman says, to applause from the largely female audience. Dressed in the flowing blue-patterned shawl that marks her as a Female Community Health Volunteer, she nervously holds the microphone that has been passed to her.

'We need to have a proper building for the outreach clinic where I'm working, up in the hills,' she says. 'And it isn't just for the consultations. There needs to be a toilet too. Some of the women have walked a long way to get to the clinic, and we can't go on asking neighbours if they'd mind letting someone use their toilet.'

The final event of the Social Audit in the village of Guttu is well into its second hour. The area covered by the Village Development Committee (the local government) has a population of just over 8,000 people and 1,470 households. Around us are the rolling grasslands of western Nepal's Surkhet District, with the foothills of the Himalayas just visible to the north. A couple of hundred people have turned out for the mass meeting, where the results of the five-day audit have been presented and a work plan is being decided. Under a colourful canopy to keep the blazing sun off their heads, the largely female audience sits on a plastic sheet on the ground; a few dignitaries (mostly men, including representatives from all political parties and the members of the Health Facility Management Committee) have commandeered chairs.

The speaker isn't the only one with a serious complaint to bring up. After presenting his own report and fielding some questions from the crowd, the 'in-charge' (head) of the local health post has aired his own frustration with the long-delayed construction of a new building and repairs to the facility's water supply. 'I've even gone on local radio – but nothing seems to work. And I don't know what more to do!' An official from the District Health Office takes the microphone and offers an explanation: it seems the building contractor is being sued over another job, and has stopped work as a result. The District Health Office is trying to sort things out, he says, but it doesn't have control of the contract, which is the responsibility of another government department.

The meeting is facilitated by the leader of a local NGO. Over the two hours, the meeting covers everything from the bank balance of the health centre (225,000 rupees, about USD 2,300) to its supply of iron pills (there was a 'stock-out', which turned out to be a national one rather than just a local problem). Many of the public comments come from women who report problems in receiving the government stipends paid to encourage deliveries in health institutions rather than at home; the in-charge replies to each one, explaining the rules, and in several cases inviting the complainant to talk to him afterwards.

The meeting ends with the creation of an action plan, written in felt pen on a plastic flex print sheet. One of the agreed action points is to construct buildings for the outreach clinic. Although initially reluctant, the Health Facility Management Committee has agreed to this after the in-charge has spoken on the side of the Female Community Health Volunteers.

■ ***left:*** *A young woman takes the microphone at Guttu's mass meeting.*

■ ***right:*** *The in-charge (head) of the Guttu health post, Mr. Gagan Pandey, responds to questions from the audience.*

Guttu's social audit was held under a canopy near the health post.

When the animator asks who will take responsibility for monitoring whether this is accomplished or not by next year's follow-up social audit, a group of Female Health Care Volunteers chorus, 'We will!' The women look at each other, surprised and slightly embarrassed at having spoken out, then break into smiles.

A country of superlatives – and daunting challenges

Nepal packs many superlatives into one medium-sized country. It contains eight of the world's tallest mountains – including the tallest, Sagarmatha (Everest) – and is the birthplace of Gautama Buddha. Tucked between gargantuan neighbours China (the Tibetan Autonomous Region) and India, it boasts a richly varied geography, a stunning variety of ethnic cultures, and a remarkable degree of religious tolerance. At the same time, it is also one of the poorest places on earth, ranking 157th on the Human Development Index, and is still recovering from a bloody civil war.

Almost three-quarters of Nepalese work in agriculture, while about 7% of the country's 27 million population works outside Nepal at any given time. Average life expectancy is about 66 years (167th in world ranking), and health indicators are relatively poor despite strong efforts to improve the situation.

Malnutrition is a serious problem for many, and a variety of infectious diseases have a high prevalence, in large part due to a lack of infrastructure for clean water and sanitation facilities. Socially, the country retains a great deal of its traditional stratification, with a caste system that marginalises a number of ethnic groups or castes, and in which women have a very limited voice.

Yet Nepal is also making strong progress in a number of vital areas such as maternal health and immunisation, underpinned by a strong commitment to rebuilding and modernising the country.

Return to 'normality'

Nepal's return to peace began in June 2006, when its ten-year civil war was ended by a preliminary agreement between the Government of Nepal and the Communist Party of Nepal (Maoist). This was followed in November of the same year by a comprehensive agreement between the former antagonists. Further agreements guaranteed a political system based on international standards of human rights, multi-party elective politics, an independent judiciary, and other fundamentals of democratic governance.

Since then, the country has made many strides forward towards entrenching democratic institutions, but has also run into some setbacks along the way. National-level elections for the Constituent Assembly were successfully held in 2008 and 2013, but the Interim Constitution has still not been replaced with a permanent one. This has had knock-on effects by delaying the adoption of new and permanent government structures at all levels. At local level, elected administration has been absent since 2002, and village, district and municipal governments have been run by centrally appointed civil servants, though with informal all-party supervision. The resulting accountability 'vacuum' has been one important reason for low participation by local people in development activities (Ministry of Local Development, 2008).

A key initiative to address this vacuum has been the Local Governance and Community Development Programme, which began in 2008. Supported by a range of international donors, the programme has focused on helping communities to assume greater control over all aspects of development in their areas. This includes extending the processes of decentralisation, improving local government capacity to deliver services, and increasing the accountability and transparency of local government. The programme both reflects and encourages citizens' growing demand for government services to be more responsive and accountable.

Health system: progress slowed by centralised decision making

One of the institutional victims of the ten-year war was the health reform process that Nepal had begun in 1991. Since the end of war, however, efforts have been made to continue that process, building up a health system that languished during the war, and was both low-quality and under-resourced before that. The new government declared quality basic health services and maternity services to be fundamental rights for all citizens, and set about working to improve the situation.

A major initiative has been the Nepal Health Sector Programme, now in its second phase (2010 to 2015). Implemented with support from a variety of external development partners led by the UK's Department for International Development (DFID), the programme aims to improve the health status of all Nepalese, but especially that of disadvantaged groups including women, the poor, and excluded ethnic communities. The programme is inspired by the Primary Health Care approach, emphasising free basic health services, essential drug lists, and efforts to increase the access of remote and vulnerable population groups to good-quality care. As of January 2009, free essential health services became available at all public (Ministry of Health) health facilities, with no charges for registration, essential drugs, and emergency, inpatient and outpatient services.

In 2012, these facilities included 83 hospitals (from tertiary hospitals in the capital to district hospitals in all districts), 205 primary health centres, 822 health posts, and 2,987 sub-health posts (DoHS, 2014). The sub-health posts are the base of the health system's referral pyramid, serving as locations for community-based activities such as immunisation and primary health care outreach clinics, and are staffed on a part-time or periodic basis by Female Health Care Volunteers.

The country also has a large private health care sector, accounting for about 70% of total health expenditure in Nepal, much of it financed by out-of-pocket payments. The private sector is growing, with the number of private hospitals increasing from 69 to 147 between 1995 and 2008, compared to an increase in public hospitals from 78 to 96 in the same period (Karkee & Kadariya, 2013).

During the past decade, Nepal has made measurable progress on a variety of health indicators. It is currently on track to meet the Millennium Development goals for women's health and child mortality, as well as the sub-goal of achieving universal access to reproductive health (UNDP, 2013). Nonetheless, at local level, public health facilities across the country face a variety of daunting problems, including insufficient supplies of drugs and lack of basic equipment, chronic understaffing and frequent staff absenteeism, poor provision of water and electricity, and low levels of accountability to local people. In general, referral and curative health services are in poor condition despite improvements in primary and preventive health.

The issue of understaffing is particularly damaging to service quality. A survey of health facilities in 2012 found that only 64% of sanctioned (i.e. authorised and budgeted) positions at primary health care facilities were actually filled. In sub-health posts the problem was most severe, with 75% of sanctioned positions being vacant. About three-quarters of staff at health facilities reported that such staff shortages affected

service delivery, including safe motherhood activities, immunisation, primary health care outreach at small clinics, and surgery and nursing at hospitals (Mehat et al., 2013).

For some years, the government and its partners have recognised that continued over-centralisation of decision-making powers at national level has been a serious obstacle to progress. Such centralisation makes it difficult to adapt policies and budgets to local conditions, slows necessary change, and makes it near-impossible for service users and local governments to participate in efforts to improve health services.

Dr Susanne Grimm, who as GIZ's Programme Manager was closely involved with social audits for several years, describes the problem in concrete terms: 'When budgeting is "top-down" from the centre, the system can't be very flexible. For example, what happens if a local health-care facility needs to restock something as basic as paracetamol, or some equipment breaks down? The facility has to order what it needs from the Ministry, i.e. through the administration in Kathmandu. That means the drug simply isn't available for some weeks or months, or the facility has to make do without the equipment.'

For some years, the government and its partners have recognised that continued over-centralisation of decision-making powers at national level has been a serious obstacle to progress.

The Governance and Accountability Action Plan initiated by the Ministry of Health and Population in 2010, aims to make health services more accountable to patients. It includes the use of a number of 'social accountability tools' such as community score cards and public hearings to increase citizens' ability to participate in decision making about their health services. Social auditing is one of the most important of these tools, and one whose use has spread rapidly across the country since it was first introduced in Nepal in 2009.

German support for health and good governance

Germany has participated in development activities in Nepal since 1975. Current focus areas for cooperation are:

- sustainable economic development and trade;
- renewable energies and energy efficiency; and
- support for the health sector (GIZ, 2014).

In 2001, the Nepali-German Health Sector Support Programme (HSSP) was implemented to fund policy and technical cooperation, and to complement projects by other donors in the health field. Now in its third phase, the HSSP aims to increase access to good quality health services, especially for disadvantaged population groups. Specific objectives are to increase decentralisation and improve service quality, improve access to health care services, and promote sexual and reproductive health.

Germany is also highly involved in supporting local governance, notably in cooperation with the Ministry of Federal Affairs and Local Development and a wide range of international and bilateral partners. The second phase of the latter's Local Governance and Community Development Programme (2013-2017) is bringing reform to 75 districts, 58 municipalities and 3,915 villages. With an ultimate goal of reducing poverty through more efficient local governance, the programme aims for the following outcomes (MoFALD, 2013):

1. Citizens and communities hold their local governance actors accountable.
2. Local bodies are more responsive to citizen's demand.
3. All citizens are provided with efficient and effective local services

Box 2. 'Money or autonomy? I'd take more autonomy!'

■ *Lok Bahadur Shahi responds to questions at the Guttu mass meeting.*

On his way back to the District capital after attending the Guttu social audit meeting, Lok Bahadur Shahi smiles broadly at the interviewer's question: what would he do if the district health budget were magically doubled and he were free to spend the money any way he wanted?

Mr. Shahi, who is the district's Family Planning Officer, doesn't hesitate. 'First I'd fill all the vacant positions in the health facilities – there are just too many open at the moment. Second, I'd provide up-to-date training for all the staff. Third, I'd deal with the infrastructure problems.' Then the smile leaves his face and he sighs. 'But you know, I don't have the budget even to deal with a request like we heard at the meeting, for a toilet at an outreach health centre, although I strongly agree they should have one. Construction is not an issue I can deal with. Nor can I help them hire a doctor or nurse – that's a central decision.'

The smile returns when asked which he would take if offered a choice between a greater budget or more autonomy to make decisions. 'Definitely, I'd take autonomy!' he laughs.

Things should be easier when local elections finally return to village and district level, he feels. The constitution will provide greater decision-making power to elected governments than it gives to the civil servants who currently run local village and district development committees. 'So that means that many budget decisions that currently have to go 'up the line' in the Ministry will be taken locally. I look forward to that!'

Social audit: the right tool at the right time?

What is social audit?

In its narrowest sense, social audit is a means of independently monitoring or evaluating the performance of an organisation in attaining its social goals (Centre for Good Governance, 2005). More broadly, and in a way more tailored to the Nepalese context, it has been defined as

> a process where the beneficiaries/right holders and stakeholders analyse, review and provide feedback on the effectiveness, efficiency and relevancy of programmes, activities and resources of an institution. It is a way of understanding, measuring, reporting and ultimately improving an organization's social, ethical, environmental, financial and managerial performance through creating a conversation between an organization and its clients, partners and stakeholders (Association of International NGOs in Nepal, 2010).

Social audit is one of a range of so-called social responsibility tools such as community score cards and public hearings, which aim to improve the efficiency and effectiveness of services by making them more transparent and participatory. Social audits emphasise the active participation of community members, giving them access to service records (supported by independent verification) and involving them through various kinds of consultation exercises such as focus groups, site inspections, and public meetings. Properly carried out, social audits can help to raise awareness of service providers' responsibilities, expose corruption and waste, and empower citizens to demand accountability.

The concept has existed since the 1930s, though the actual term appears to have been coined in the 1950s (Ferguson, 2010). By the 1970s it had become popular in some European countries, where it provided an alternative to conventional accounting's narrow focus on companies' financial profitability; instead, its focus was on how business activities affect community conditions, jobs and the environment (Pearce & Kay, 2012). By the 1990s social audit was becoming widely used in developing countries such as India, where it came to mean participatory reviews of whether state agencies' reported expenditures actually reflected the funds 'spent on the ground.' In the Indian state of Andhra Pradesh, for example, social audits have been an integral part of major rural employment schemes (Aiyar & Samji, 2009). Lessons learned from the sources cited suggest that social audits work best if they are conducted regularly, give genuine access to service records, are supported by trained facilitators, and are held by governments committed to acting on audit findings.

Social audit in Nepal

Social audit has been used in Nepal since the 1990s, with early European Union-supported 'public audits' of rural development projects in Gulmi and Arghakhachi districts. The Ministry of Local Government has actively promoted public audit and social audit since 2007, making it mandatory for all local government development programmes, while the Department of Education has implemented social audits for the public school system since 2008 (Neupane, 2011).

Social audit for health services in Nepal initially proceeded along two separate tracks, both under the Department of Health Services. In 2009, the Family Health Division set up a social audit process for its Aama programme. Originally called the Safe Delivery Incentive Programme, the Aama programme provides incentives to encourage women to give birth in health facilities, including cash payments after delivery, and free delivery services at all public health facilities (Pradhan & Barnett, 2010). The programme created its own methodology and guidelines for social audits, and by 2010, these had been carried out in 42 health facilities across 14 districts.

Properly carried out, social audits can help to raise awareness of service providers' responsibilities, expose corruption and waste, and empower citizens to demand accountability.

At the same time, with technical and financial support from GIZ, the Management Division developed separate social audit guidelines. The focus of these social audits was broader than that of the Aama programme, aiming to assess the effectiveness of health care facilities in general, particularly in the context of free health care services. The Division developed guidelines and training materials, including a video for training social auditors. The methodology was centred on a one-day mass gathering facilitated by an appropriately skilled independent facilitator, and involving all relevant stakeholders. Initially, however, coverage was limited to the two districts participating in the Local Health Governance Strengthening Programme, which were also receiving support from GIZ and the Swiss Agency for Development and Cooperation.

In 2011, and with the support of both DFID and GIZ, the two approaches were harmonised by the Primary Health Care Revitalization Division, with a unified set of guidelines and manual that benefited from previous experience. The new guidelines and other tools were piloted in two districts and then implemented in 20. To support the process, GIZ assigned four programme officers to provide technical assistance in the field and one to provide advice at Division level (all are Nepalese nationals). This, along with funding for workshops and certain material support, has accounted for the majority of German investments in this area.

By late 2012, the stage was set for an ambitious increase in coverage to occur over the next three years.

Box 3. Early days in social auditing

■ *P.R. Shrestha, Regional Director, Far Western Region*

The formative days of the social audit are remembered fondly by P.R. Shrestha as a time of experimentation and discovery. Currently acting director of health in Nepal's Far Western Region, in 2007 he was working for the Ministry of Health's Management Division when far-reaching changes were being prepared. 'The Ministry budget was about to suddenly quadruple, free health services were about to begin, and there were huge expectations from the public,' he recalls. 'It was urgent to ensure that the money – which was coming from the national budget, not foreign funding – would be well spent. A few of us in the Ministry thought that social audit, done locally by the people themselves, would be a good tool for that, though we didn't yet know much about it. So we created a Task Team and started to see what could be done.'

With both technical and financial support from GIZ, and the participation of the Association of International NGOs in Nepal, the Task Team met several times to develop guidelines. The group realised that client satisfaction needed to be measured, even though this had not been a priority in Nepal, and included it among the information to be collected. By 2009, they were ready to carry out a pilot project in a small number of rural and urban districts, with further support from the Swiss Agency for Development and Cooperation.

Mr Shrestha participated in the pilot at a health post in Phasku, Dolakha, and found it a valuable experience. 'We went from house to house, inviting people to participate. That wasn't hard because people had lots of questions about the new services – was everything supposed to be free? What hours should services be open? And so on. But many of the health facility staff were frightened by the idea of the social audit – some even threatened to resign! We explained that it was just a pilot, and we were trying this out, and in the end, they participated in the social audit and it went smoothly.'

The task team arranged for videotaping of the final event, which proved a fortunate decision. 'The meeting went so well that we could use some of the footage for a training DVD. And that was important, because one of the things we've learned is that training and orientation are crucial to the success of social audits.'

Social audits now implemented in majority of districts

Since the integration of the two social audit streams in 2011-2012, there has been a rapid scale-up of coverage across the country. In that year, social audits were carried out in 20 of the country's 75 districts, covering a total of 128 facilities from sub-health posts to district hospitals.

The total number of audited facilities doubled to 256 in 2012-2013, though the number of districts remained the same. The 256 included 128 new audits, using the full five-day methodology, and 128 two-day follow-ups.

In 2013-14, additional funding from the Ministry of Health – a significant indicator of national 'ownership' of the process – contributed to a significant increase in both audited facilities and audited districts. Social audits using the integrated guidelines were conducted in 602 facilities (346 of them for the first time, using the five-day methodology) in 45 districts.

This meant that for the first time, social audits were carried out in a majority of the country's districts. At present, GIZ provides technical assistance in six districts across the Far Western and Mid-Western Regions. Examples of such assistance include working with districts on planning social audits, orienting social audit teams, and monitoring the quality of social audits. GIZ also provided support at central level to finalise a guideline and implementation plan.

Additional external development partners have also provided support recently, including UN system agencies (UNICEF, UNDP) and international NGOs (World Vision, Good Neighbours). USAID's Health for Life programme became a partner in 2013-14, funding social audits in 50 facilities across five districts; this will be increased to eight districts in the following year.

Social auditors Pabitra Poudel, KC Ghan Shyam, Hari Prasad Adhikari, and Muna Hamal at Dashrathpur Primary Health Care Centre

The social audit process

According to the operational guidelines published by Primary Health Care Revitalization Division in 2012, the social audit process is intended to make health facilities more responsive, sensitive and transparent, and to do so with the needs of women, the poor and excluded population groups firmly in mind. Among other objectives, it aims to increase public awareness of health issues and encourage the flow of information between service users and institutions that provide health services. It specifically mentions encouraging service users – meaning the general public – to demand information about the health system, while at the same time instilling among providers the practice of sharing such information (Neupane, 2011).

The scope of the social audit covers three main areas:

1. **Primary health care services** including safe motherhood (Aama) activities, free health services, free drugs, Community Based New-Born Care Programme (integrated child health), immunisation, nutrition, and disease control;
2. **Organisation and management** including the inclusiveness and effectiveness of the Health Facility Management Committee, decision-making processes, financial audit, service hours, health worker punctuality, patients' rights, presence and use of suggestion box;
3. **Quality of services** including human resource management, infrastructure, health worker/patient relationships, promotion of gender and social equality, implementation planning, and quality improvement.

Social auditor Hari Prasad Adhikari

The Ministry of Health has set two strategic objectives for the model of social audits defined in the guidelines, applying to all public health care facilities from sub-health posts to district hospitals with 25 beds or less:

- At least 30% of health facilities will be conducting social audits by 2015, in line with the Nepal Health Sector Plan (NHSP-2).
- All health facilities will be conducting social audits by 2020.

Lines of responsibility: who does what?

The basic social audit is a five-day process, in which a comprehensive schedule of investigation, analysis and reporting is followed. A shorter two-day process is used in subsequent years to monitor progress in achieving the action plan agreed in the initial audit.

District level

In operational terms, the process begins with the creation of a Social Audit Committee at the district level. Within Nepal's system of government, there are 75 District Development Committees and 3,754 Village Development Committees that constitute the local level government administration. As well as the District Health Office, the Social Audit Committee brings together representatives from other district level structures with an interest in the health system, notably the District Education Office, Women's Development Office, and District Development Committee. It is chaired by the Local Development Officer, representing the District Development Committee.

The Social Audit Committee is responsible for overall implementation and monitoring of the process within the district. One of its main functions is to hire and orient the independent organisation (see below) that will carry out the audit, using funds channelled from the Primary Health Care Revitalization Division to the District Health Office. Once this is done, the District Health Office liaises with the individual health facilities – district hospitals, primary health care centres, health posts and sub-health posts – in order to agree on the dates on which the social audit will take place.

Facility level

Each facility has a Health Facility Management Committee, which is chaired by the representative of the Village Development Committee. Its membership includes the health facility in-charge (director) and community representatives, including representatives of marginalised ethnic groups and castes, and a Female Community Health Volunteer (Morrison et al., 2011). The Health Facility Management Committee has a number of tasks in the social audit process. These include taking responsibility for the overall management of the process, helping to provide the auditors with all relevant information about the facility, and finding the financial resources needed to achieve commitments made in response to community concerns and demands.

Appointing independent social auditors

One of the key aspects of the social audit is the use of an independent entity – usually an non-governmental organisation (NGO) – to facilitate the process. Local NGOs have long been involved in delivering a variety of services in Nepal, and there is a relatively large pool of them to choose from.

The benefits of using independent local auditors include the following: they have local credibility, understand local conditions, and will be available over time and can thus build a base of expertise that will be available for future social audits.

To run social audits of health facilities on behalf of a district, an NGO needs to be based in the district; must have existed for at least three years; and must have personnel with at least five years' experience in relevant fields such as social mobilisation, health system, women's rights, etc. The social audit contract is based on an open tendering process, in which an announcement is published in local newspapers inviting eligible NGOs to compete for the job. Competition is based not only on price but on the quality and experience of team members proposed. Once chosen, the social auditor is hired for a period of one year and given a fixed budget based on the number of health care facilities where it will carry out audits. The social auditor will need to budget for approximately seven days of work per facility in the mountain and highland districts, and six days in the terai (lowlands) districts where transportation is generally easier.

A minimum of three bids must be received; few districts report having trouble meeting this quota, with one receiving bids from 37 different NGOs.

One innovation has been to use local Social Mobilisers to carry out the audit. Social Mobilisers are civil servants employed by Village Development Committees. Trained in encouraging community empowerment and raising awareness, they already have local knowledge and an orientation towards helping citizens engage with their local governments and hold them accountable. While unlikely to replace hired NGOs, their use may offer some savings since they are already on government salaries.

Box 4: Happy, but not satisfied

Health centre in-charge Krishna Gopal Chaudhary

Social audit action points are posted above Mr Gopal's desk.

Min Raj Pangeni and Rishi Raram Parajuli

I'll tell you what the social audit means in a facility like this,' Mr Rishiram Parajuli says. 'Back when it was just a health post, we were happy with it. It's better to have a health post than nothing. Then it got upgraded to a health centre, and we were happy with that too. Now that we have social audits, we're still happy – but we're not satisfied. Because we know what we need to make it better!'

This meeting of Saurahawa Primary Health Care Centre stakeholders has become animated. The social audit action plan, written on large orange sheets of paper, is posted above the desk of facility in-charge Mr Krishna Gopal Chaudhary. He points to issue number 5 on the plan. 'The ambulance issue was on the list from our first social audit three years ago, and it took a long time to solve,' he says.

'The request had to go up to the Village Development Committee, then to the District Council in Bardiya, then to the Ministry of Health, and then finally a member of the national assembly managed to get it funded through the Constitutional Assembly fund. The ambulance now brings many patients who previously would have gone to the district hospital. Mr Hari Bahadur Gharti, ex-member of the Health Facility Management Committee and a member of monitoring committee at present, added, 'We're happy about that, but we're not satisfied, because when they get here, they may find there's a power cut [he points to issue 7] or that we don't yet have a doctor on duty [point 3]. We've increased the centre's workload and raised expectations – but can we provide the services people expect?'

The health centre in-charge Krishna Gopal admits cheerfully that social audits increase the demands on his facility. A paramedic with a degree in management, he says that public discussion of weaknesses in a facility can be uncomfortable. 'But we take it positively, because we learn exactly what local people want from us. And certainly, it has made things much more transparent – our accounts are made public, so people know where our money comes from and what we spend it on.'

continued...

Mr Min Raj Pangeni, who heads the Health Facility Management Committee, comments, 'Different problems have to be addressed at different levels. We try to do as much as we can locally, with local resources. For example, improving our waiting room was a big issue for patients in the first audit, and the Health Facility Management Committee dealt with it by purchasing furniture and changing the layout. But the second audit came back with more complaints and suggestions, so we dealt with them. The third audit suggests it's okay now. But dealing with the electric supply, or hiring a doctor, those are different levels of problem entirely...'

Quietly listening in a corner is Mr Bishun Nath Tharu the *badghar* (headman) of the local Tharu community. The Tharu are tribal people indigenous to the area, who are now a minority; in this area, they have a separate village with its own health outreach clinic. Their social audit initially created dissension within the community, but eventually, the focus moved from seeking blame to searching for solutions. Typically of the independent-minded Tharu, the community decided to raise money and carry out the necessary improvements by itself.

Some of the benefits of the social audit come from the process rather than from action points. Mrs Mathura Regmi, one of the two Female Health Care Volunteers at the meeting, says that the focus groups give a structured, safe way to talk about problems. 'It used to be that patients would complain to us Volunteers because they had nowhere else to express their concerns, and we would talk amongst ourselves or maybe informally to staff. But the focus group gives us a chance to talk about issues openly – client satisfaction is specifically talked about – and the results go directly to the Health Facility Management Committee. And the information goes both ways, because we can tell people in the focus group what we know about how things work.'

■ *Bishun Nath Tharu,* Badhgar *of local Tharu Community*

■ *Female Community Health Volunteers Mathura Regmi and Jagrani Tharu*

The process step-by-step

Preparation and orientation

Following the selection of the social audit team, an orientation session is held to brief its members in more detail on the social audit guidelines and their responsibilities in the work to come. The district Social Audit Committee members also receive an orientation to help them properly supervise the process. Since some of the social auditors are likely to be from non-health backgrounds, the orientation may include visits to health facilities to familiarise them with health vocabulary, activities and administrative procedures. Orientation is currently provided by Primary Health Care Revitalization Division staff.

Once a list of facilities to be audited has been chosen, the Social Audit Committee sends an official letter via the District Health Office to each facility, containing preparatory information and a schedule to the facilities management. (The schedule is also announced in local media so that the wider community is alerted.) The social auditor then makes an orientation visit to each facility, often accompanied by a representative of the Social Audit Committee; this is usually an official from the District Health Office already familiar with the staff at the facility. The visit allows the social audit team to meet the facility staff and the Health Facility Management Committee, explain the objectives and procedures of the audit based on the guidelines, and answer any questions the staff and committee members may have. A local support group for the social audit is created at this time, which decides on logistical details and division of responsibilities, such as the choice of venue for the mass event.

According to Achyut Lamichhane, head of Bardiya's District Health Office, the preliminary visit is crucial. 'I make sure I visit half of the facilities that are doing social audits for the first time,' he says, 'and my social audit focal point visits the others. As well as making introductions, there is a lot of explaining that needs to be done, but it is worth it because it makes the process much smoother if everyone understands it. I am also careful to respond immediately if the social auditor tells me they are encountering resistance at any point. A phone call may suffice to clear things up, but again, a visit may be necessary.'

As the date of the social audit approaches, announcements are broadcast on local radio stations in order to publicise the process among the community, and particularly to invite people to the mass meeting at the end of the audit. Good relationships with local media are important. In Salkot district, for example, the USAID-funded Health for Life project funds a radio programme on health matters, which is broadcast each Friday at 7pm. Health For Life official Hem Raj Paudel comments, 'There are over 50 health care facilities in our broadcast area. We give social audits a high level of coverage, not only before the events but also afterwards, about the decisions they take.'

Gathering information

The first step of the social audit is to collect information about the facility's activities. Much of this is done by examining the records that are – or should be – kept by the facility. These include financial data and information about programme outputs (e.g. number of immunisations, free drugs dispensed, incentives paid for institutional births and maternal care consultations). The auditors also carry out observations of the physical state of the facility, including its buildings and equipment, and inspect drug stocks. Careful attention is paid to certain service indicators such as a staff attendance and scheduling. In addition, discussions are held with the facility in-charge, other facility staff, and with the Female Health Care Volunteers based in the facility.

A different type of information is collected by voluntary 'exit interviews' with recently delivered mothers as they leave the facility. Female social auditors conduct the interviews in private, following a standardised questionnaire, taking between ten and 20 minutes. Depending on how busy the facility is on the day of the visit, ten to 25 interviews may be conducted. The questions aim to find out what services the patient received, and how the patient feels about the experience. The guidelines recommend taking a day and a half for collecting information at the facility.

A further day is scheduled for collecting information within the community in order to gain a variety of perspectives on the performance of the facility. The social auditors hold at least two focus groups, one with local women – often chosen from a facility-based Mothers Group or local women's organisation – and the other with representatives of disadvantaged

ethnic or caste groups. The exit interviews and the focus groups serve not only to gather information, but to reassure disadvantaged groups that their concerns will be taken into account, and that they can speak safely and confidentially.

Once the different information-gathering activities have been completed, the social auditor and the local resource person analyse and then summarise the results for the public mass meeting. The summary information is grouped under standardised headings such as accessibility, quality and management, with indications of both positive aspects and those requiring improvement.

When a two-day follow-up social audit is being carried out, the focus of information gathering is on the facility itself, so exit interviews and focus groups are not carried out.

Reporting back to the community

The 'main event' of the social audit is the mass public gathering. This aims to bring a wide range of community members together to share the information gathered by the audit, to air any concerns they may have, to ask questions to care providers (particularly the facility 'in-charge') and decision-makers, and to participate in forming an action plan. Anecdotal evidence suggests that over 60% of participants in these events are women.

As well as the public and care providers, a range of local dignitaries are invited including the chairperson of the Village Development Committee or Municipal Development Committee, members of all political parties, representatives of the District Health Office, head of the local school, and officials from institutions and NGOs involved in development activities in the area.

The meeting follows a set schedule, which normally takes between two and four hours. After the facility in-charge welcomes all who have attended, the auditor explains the objectives of the meeting and the process that will be followed, including a Code of Conduct meant to ensure that everyone is treated with respect and has a chance to be heard.

The auditor or a member of the facility then presents the data gathered during the information-collection process. The basic data is presented on a large 'flex print' (plastic sheet for outdoor use), which was developed and printed with support from GIZ, and is standardised for all social audits. This data serves as a baseline by which progress can be judged in future audits.

Guttu health post's in-charge, Gagan Pandey, uses the flex print banner to report on the facility's performance during the year.

The presentation is followed by an open exchange between the community members, facility staff, and other stakeholders. Microphones are passed around the community members in order that their questions and comments can be heard by everyone, and the auditor helps to clarify questions as necessary and to direct them to the person best able to provide answers. The facility in-charge or head of the management committee often respond at some length to questions from the audience. Since some audience members are reluctant to speak in public, members of the audit team may circulate among the audience asking if they have questions they want answered. These are written down and passed to the auditor to read out publicly.

The final activity of the event is to create an action plan, which is written onto another flex print banner. The action plan contains not only the actions required to solve particular problems or improve specific facility activities, but also specifies who is responsible for the action and who will monitor whether it has been achieved by the time of the next audit. In general, the Health Facility Management Committee takes responsibility for finding the necessary technical and financial resources.

Box 5. 'You can see how the community learns over time'

'Namaste, everyone!' says Hari Prasad Adhikari, giving the traditional greeting to the crowd gathered in Dashrathpur Primary Health Care Centre. 'This is your health centre, and today is your opportunity to ask questions and say what you think about it.' Over the next three hours, he presides over the mass meeting that concludes the social audit, the first one ever carried out in this centre. That means ensuring both that the scheduled agenda is completed and that everyone gets their chance to speak.

His two young female colleagues Muna Hamal and Pabitra Poudel circulate through the crowd, taking attendance and writing down questions or comments for audience members who are too shy to speak in public. A third colleague, KC Ghan Shyam, passes the microphone around the audience during the discussion, then starts writing the action plan points on a large flex print form.

Later on Mr Adhikari talks about the process and his NGO's part in it. 'My NGO is called the Good Governance Club District Coordination Committee. We've existed for ten years, with clubs in a number of villages in the district. Our area of work is good governance and anti-corruption, so we've done over 100 public hearings as well as citizen report cards, social audits, and related activities. This is our third year doing social audits for health facilities. We did 15 in that first year; this year we are doing 31, with two teams.'

Mr Adhikari's background is in social science, with additional degrees in English and education. The tendering process requires that social auditors have Intermediate Diplomas as a minimum, and the Good Governance Club has no trouble meeting that. His younger colleagues have degrees in fields like population studies, journalism, and health education.

The contract is a good one he says, not profitable on a per-facility basis, but providing a lot of work for the NGO. 'You can see how the community learns over time. It is hard to get them to talk, particularly women, in their first mass meeting. But in the following years, they are much more open and we don't have to work so hard to encourage them.'

His colleague Pabitra Poudel explains that she and Muna Hamal are working for the NGO as interns. 'We earn a per diem and travel allowance, and it's a valuable experience.' She says that the hardest work for her at Dashrathpur was facilitating focus groups and conducting exit interviews with women at the maternity clinic. 'Rural women are really not used to formal questions like that,' she says. 'It helps that I'm from a village in the district myself.'

A social auditor fills in the Action Plan on a flex print sheet.

The auditor then prepares a final social audit report. In addition to summarising the information collected, the report describes the issues that surfaced during the process and the commitments made at the public meeting. The report is provided to the audited facility and the District Health Office. The auditor also has the responsibility for publicising the social audit further through the local press and radio. Following the completion of the audit, the auditor retains the raw information such as questionnaires and checklists.

From action plans to real action

The results of social audits are used in a variety of ways. The most immediate user of the results is the health facility itself and its facility management committee. The report and action plan provide a kind of road map for the following year, suggesting problems that need to be solved and ways to improve the quality of services. Some solutions may be purely local and community-based, e.g. when community members volunteer to help construct or repair buildings, or raise funds for a particular project. In other cases, where service quality issues visibly and directly affect large numbers of people in the community, and local solutions are available, the facility may use the report to negotiate with the Village Development Committee for funding or in-kind support.

Some problems require action or resources from the District Health Office or by other institutions of district government. It may be possible to encourage intersectoral action at this level (notably on infrastructure issues such as power or sanitation), or to obtain resources (e.g. funding for staff positions, or construction costs) that an individual facility might otherwise not have been able to access.

> The most immediate user of the results is the health facility itself and its facility management committee.

The District Health Office also has the task of creating a summary report from the audited facilities in the district. This is submitted to the Primary Health Care Revitalization Division in Kathmandu. The Division uses the summary reports in order to identify systemic problems affecting facilities across the country, and to propose policy changes at national level.

Box 6. A women's NGO takes on the social audit

■ ***top:*** *Achyut Lamichhane (left), head of Bardiya District Health Office, with district social audit focal point Sanat Sharma*

■ ***bottom:*** *Indira Subedi, chairperson of the NGO Sunaulo Mahila Bahuuddesya Sahakari Sanstha*

'Can social auditor Indira Subadi and the man who hired her – Bardiya District Health Office head Achyut Lamichhane – ever be friends? The question makes them both laugh.

Mrs Subedi has just completed her audit of the district hospital, which has documented some serious shortcomings ranging from staff absenteeism to the need for a reliable power supply. Responsibility for fixing many of these problems ultimately rests with Mr Lamichhane.

Over fragrant Nepali chiya (tea), the two discuss their professional relationship. She chairs a local NGO called Sunaulo Mahila Bahuuddesya Sahakari Sanstha (Golden Women's Multipurpose Cooperative Organisation), which for eleven years has carried out women-oriented activities such as human rights advocacy and income generation projects. This is the first year the NGO has bid on the social audit contract. 'We won the contract this year for several reasons,' says Mrs Subedi, 'particularly because we offered well-trained female members who understand maternal child health objectives, and have a lot of experience in social mobilisation. But we also hired three men from outside the NGO to provide some of the technical audit skills we lacked, particularly about facility management.' They created three teams to handle the 34 facilities being audited this year, with women being in the majority on each team.

Mr Lamichhane says that having a women's NGO in charge of the social audit was a good decision. 'Women are the majority of patients at the facilities,' he says, 'and as you'd expect, this NGO is very good at engaging with them at the exit interviews and focus groups. But we've observed they also handle the mass meetings very well – politely and correctly, but getting through the schedule. And of course, more women than men attend these meetings, so their participation is encouraged by having women in charge.'

This was the first year that the district hospital has been audited, which is a much higher-profile challenge than the other facilities. 'A lot of problems were brought to our attention during information collection phase,' Mrs Subedi says. 'To take just one, the hospital doesn't have its own generator, so if the municipal power goes off, so do the lights and X-ray machine – they may have to delay operations for several hours. Now, this is partly an issue for the district electric administration, so the hospital Facility Management Committee has made a request to them for 24-hour power supply. But ultimately this is a political decision because it involves resources. So we're making it more of a civil society issue, and mobilising public opinion and advocacy behind it.'

Mr Lamichhane admits that such advocacy isn't always comfortable, but adds that airing problems publically actually reinforces the District Health Office's position on some issues. He gives an example: 'The social audit documented a problem that has existed for some time. Many health workers were accustomed to arriving at 10:30 and leaving at 3pm. But the fact is that they are paid to work from 10 till 5. Similarly, the birth centre is supposed to be attended around the clock, but wasn't. The social audit highlighted this, and two things have happened. One is that patients are aware, and they demand that the hours be respected. And for me at the District Health Office, the information helps me to correct these practices. It will take some time to change the working culture, but ultimately everyone agrees this is what needs to be done.'

Full of ideas, Mrs Subedi makes some suggestions for improving social audits themselves: 'Several things should change. On the political level, social audits need to be scheduled to report before the Village Development Committees and District Development Committees start their planning and budgeting for the year. And on the technical level, social auditors need more accounting expertise if they are going to be really effective.'

That returns the conversation to how social auditors are selected. Mr Lamichhane notes that there were fewer NGOs competing in this district than previously, and that the previous year's winner had asked for more money this year – one of the reasons they lost the contract. Mrs Subedi isn't impressed: 'Well, we will certainly bid again next year!'

Results

The efforts of the Nepalese government and its partners to implement social audits in health facilities have been fruitful. Among other advances, social audits have promoted citizen participation, social inclusion and mutual accountability. They have also helped vacant positions to be filled through temporary contracts, improved the behaviour of health workers, made facilities more responsive to patients' needs, and helped to reform or re-energise Health Facility Management Committees (Aryal 2014; GIZ 2013a).

There has not yet been an overall evaluation of health facility social audits on a national level since the introduction of the integrated guidelines, but a recent review of experience in Doti district, Far Western Development Region, is instructive (GIZ, 2013a). The review covers three years of social audits at two facilities – Barpata sub-health post and Tikhatar health post – which have received support under the Nepali-German HSSP, allowing the results to be tracked over time.

Increased utilisation and demand

It is notable that the utilisation of both facilities increased during these years, particularly on such important indicators as institutional deliveries (from a total of 3 to 174) and immunisation coverage (up 24%). Qualitative research suggested that social audits actually increased demand for services by informing people of (a) what is available and (b) what they are entitled to in their local area. Thus, as well as greater numbers of patients who attend the facilities, the reviewers found increasing assertiveness and knowledge of patients regarding the specific services they want.

Increased staffing levels and attendance

One of the most frequently raised issues in the first year of social auditing at the two facilities was inadequate staffing levels or attendance at both facilities. In particular, the lack of a designated midwife was keenly felt, and frequent absences due to transfers, workshop attendance or extended leave were major complaints. Moreover, there were complaints about hygienic conditions at the sub-health post's birthing centre clean. After these concerns were flagged by the social audits, the problem at Barpata was solved by the secondment of an Auxiliary Health Worker by the regional health directorate; in addition, the Village Development Committee funded the hiring of a cleaner for the sub-health post birthing centre. At Tikhatar, the Village Development Committee agreed to pay the salary of an Auxiliary Nurse Midwife in order to ensure that 24-hour institutional delivery was available.

Drug stock-outs avoided

Drug availability was questioned in the first social audits at both facilities, with evidence that essential drugs were not always in stock. There was also a wider problem of unrealistic expectations, since community members did not understand the limited list of essential drugs that public health facilities are required to stock. The social audits provided an occasion for the limitations of the list to be explained, and the list is now displayed on bulletin boards at both facilities. In addition, the facilities made commitments to adhere to existing guidelines (notably authorised stock levels and emergency order procedures), with the result that in the third year no drug stock-outs were reported.

New or improved infrastructure

Problems with buildings and equipment are frequently brought up by social audits. Barpata's existing building in 2011 was damp, isolated, and too small for the services to be delivered. The social audit mass meeting resulted in an agreement that a new building should be constructed at a more convenient location. As of the 2013 social audit, the new building was nearly finished. Funding came from three sources: while the two-thirds came from the Village Development Committee, the facility was able to access significant funds from the District Development Committee and obtain a grant from the Local Health Governance Strengthening Programme. Local community members contributed free timber. However, a funding shortfall arose in the third year, causing the Health Facility Management Committee to undertake additional fundraising. The building was finally completed in 2014.

Increased local ownership

The review noted that the social audit had made the health sector an increasingly significant part of local development decisions. The review judged that, 'It is a fundamental indication that the local body is taking ownership and management of local health services.' Though not rigorously evaluated as yet, this development has been reported by many other facilities, including those visited for this publication.

More information for community members

On a broader scale, beyond these two facilities, the Nepalese experience has found that the social audit tool has added value in ways that were not originally envisaged, or were not in the original goals and objectives. One example of added value has been the opportunity that social audits give facility in-charges not just to respond to questions and concerns, but educate local community members. One in-charge interviewed for this publication noted that he now looked forward to the mass meeting as a chance to speak candidly to community members about the context in which his facility operates, and to move the discussion from technical or administrative details (though these are important and must be dealt with) to a discussion of wider health issues.

The Nepalese experience has found that the social audit tool has added value in ways that were not originally envisaged, or were not in the original goals and objectives.

Challenges

Despite undoubted successes and a great deal of promise, increasing the national coverage of social audits while increasing their quality poses a number of challenges.

Insufficient funding

Not surprisingly in a country with few easily exploitable natural resources and a low tax base, funding is a serious limitation. At the moment, the Primary Health Care Revitalization Division is budgeting approximately 400,000 rupees (just over €3,000) for each district to conduct social audits in a year. Since the average cost of running a five-day audit is approximately 42,000 rupees (€321), it is clear that the budget is insufficient to add many new facilities. Running the shortened two-day social audit reduces the costs considerably, but the fact remains that current funding levels do not permit all facilities to be covered (Aryal, 2014). If increased coverage is to be sustainable, local governments will need to be convinced that funding social audits from their own budgets is a good investment.

Need for greater inclusiveness

Progress towards the goal of inclusiveness, i.e. of increasing the meaningful participation of vulnerable and excluded groups, has not been formally assessed or evaluated – itself an indication of the challenge it poses. The review in Doti district observed that while the number and gender balance of participants in the mass meeting was satisfactory, most participants were from nearby wards and settlements, with little representation from more isolated places. In general, the experts interviewed for this publication agreed that social audits have contributed to increasing inclusiveness because of their formal requirement that women and marginalised ethnic or caste groups be consulted through focus group discussions and included in local and district social audit support committees.

Contracts awarded on the basis of price rather than quality

According to the existing rules of the Government of Nepal, social audit contracts have to be awarded to the lowest bidders. The Doti review found that this resulted in less experienced teams being employed than might have been the case if the quality of team members had been of higher priority. While the newly hired social auditors in Doti did successfully learn 'on the job', the review suggested that the benefits of this learning could easily be lost if they were not selected for the next contract (particularly if they found that their winning bid had been too low, and subsequently raised their proposed price). The review suggested that multi-year contracts be considered for this reason.

Lack of integration with other governance processes

Social audits are not formally integrated or harmonised with other activities and structures of local government. Social audits are not synchronised with Village Development Committee planning cycles, or with district Annual Work Plan and Budget exercises, with the result that issues raised in a social audit may have to wait till the following fiscal year to be addressed at these levels. Moreover, the Doti review and informed observers suggest that District Health Offices tend to treat social audits as 'one-off' exercises that are done once a year and otherwise ignored.

Broadening the issues addressed by social audits

A final challenge is a conceptual one, which was raised by several of the people interviewed for this publication, but none more eloquently than Mr P.R. Shrestha, acting director of Far-West Region and a long-time proponent of social audits: 'Health is multi-sectoral, and social audits need to take that into account. I'll give you an example: summer season diarrhoea isn't something the local care facility can fix – its role is to look after the patients who fall ill, and educate people about hygiene. That's important of course, but the root problem is poor sanitation! So the real solution is in the hands of the Department of Water Supply and Sewerage [Ministry of Urban Development], and its local offices.'

Social audits in health facilities can help flag up the problems, says Mr Shrestha, but then the connections have to be made with the other sectors on a formal and regular basis, followed by action. Continuing with the example of sanitation, he approvingly cites a recent initiative to make villages and municipalities Open Defecation Free: 'That is the type of multi-sectoral action that makes the entire Village Development Committee and citizens themselves responsible for progress. And it is the type of action that social audits can support.'

Lessons learned

Social auditing in health facilities has now been carried out for five years, though the process has been one of fairly constant change over this period. A number of important lessons have been learned during that time.

Robust, experience-based guidelines are indispensable

The current integrated social audit guidelines reflect earlier documents developed by two separate divisions of the Ministry of Health. The original guidelines were created with input from experienced civil servants with both a professional interest and a personal belief in social audits. In the case of the guidelines developed by the Management Division, funding from GIZ gave these individuals the time and space to work on the guidelines based on their own experience and research on best practice in other parts of the world. An independent review of social audits in Nepal found these guidelines to be clear and well thought out (Neupane, 2011). With the integration of social auditing under the Primary Health Care Revitalization Division in 2011, a new set of guidelines was devised, based on further experience. These have been well received and used by health facilities even in districts not directly supported by GIZ.

The quality of independent social auditors must be ensured

The basic strategy of employing independent contractors or institutions to carry out social audits has again been confirmed by experience in Nepal's public health facilities. Nepal's specific conditions, in which there are a relatively large number of reputable and experienced NGOs to choose from, is one of the factors that makes this strategy possible. Experience also indicates two lessons in this regard. First, careful attention has to be paid to the minimum criteria that NGOs or individuals must meet in order to bid for the social audit contract, and to how the winning bid is chosen. In many cases, the contract has gone to the lowest bidder, with the result that auditors have to 'learn on the job' or do not provide the best quality of service. Second, once the hiring process is complete, the district's Social Audit Committee must invest time in training the auditor team (particularly if it is their first time winning the contract) and reviewing the strengths and weaknesses of the previous audit. The Social Audit Committee also needs to monitor the quality of the contractor by sending representatives from the district government (not only the District Health Office) to attend different parts of the process such as initial visits to the health facilities and the mass meetings.

Local health staff must be well oriented prior to a social audit

It is frequently found that facility staff may react negatively to the news that a social audit will be conducted at their facility for the first time. They fear that the audit will focus attention on 'what they are doing wrong' and lead to public criticism and even punitive measures. The initial visit of the audit team can therefore be somewhat uncomfortable, and it is useful for a newly hired social audit team to be accompanied by a representative of the District Health Office to make introductions. Even with such an introduction, much depends on the team's interpersonal and communications skills, as well as on a systematic approach to orientation. Using the guidelines as a teaching tool, the team must clearly set out the social audit's goals and procedures, and the roles that staff will play in the process. In particular, the team needs to emphasise that the aim of the audit is not to embarrass or punish, but to improve service quality. The experience related by most of the people interviewed for this publication suggests that staff's attitudes tend to change quickly and become more positive, particularly when they learn that the audit will allow them to safely contribute their opinions and suggestions. This positive attitude tends to be reinforced when they experience the public meeting, and find that the social audits focus not on individuals but on systems, practices and resources.

Social audits can reinforce other planning and quality management processes

There is a great deal of evidence that social audits have strengthened individual health facilities' ability to access a wider range of funding, and thus their sustainability. This is supported more formally by the experience in Achham district (described earlier), which integrated social auditing with Health Facility Quality Improvement (HFQI) activities in 14 health-care facilities. The evidence suggests that combining social audit findings (notably the action plan) with the HFQI process allowed integrated work plans to be created which

were then submitted to the respective Village Development Committees. The result was that 11 of the health facilities were allocated increases in the budgets provided by Village Development Committees, with average increase amounting to 50% over the previous year. All of this indicates that further integration of social audits with other planning and quality management processes can reinforce the overall quality of local governance as well as the sustainability of the health sector.

Better integration can help to access increased funding

Social audits do not exist in a vacuum, and better integration with other efforts to improve service quality can be highly beneficial. This was strongly indicated by an experiment to coordinate social audits with the Ministry of Health and Population's Health Facility Quality Improvement guideline. Although the HFQI offers useful tools (QI plans, QI team, patient surveys) and has been mandated across the country, it has no specific funding and is not well known at district or health facility level.

With funding from the HSSP programme and technical expertise offered by GIZ, the District Health Office at Achham district decided to bring HFQI and social auditing processes together. Trainings in Quality Improvement were held for 14 health care facilities prior to their social audits, and the facilities followed the HFQI guidelines to create work plans which were then presented and discussed with Village Development Committees. The integration proved successful, with the 11 out of 14 health facilities having their budgets increased by their Village Development Committees (the average increase was 50% over the previous year). There was also an efficiency saving in having the two processes done simultaneously in a coordinated way, rather than separately (GIZ, 2013b).

Box 7. 'Social audits should be compulsory for VDC officials.'

Mr Tilak Adhikari, head of the Village Development Committee and chair of the Health Facility Management Committee at Salkot Primary Health Care Centre

Mr Dilli Sapkota, in-charge of Salkot Primary Health Care Centre (right), at the reception area of the facility

Women carry a patient from a nearby village for emergency care using a stretcher supplied by the Salkot Primary Health Care Centre.

Compared to public hearings, which are used widely in Nepal, social audits are much more effective,' says Tilak Adhikari. Accountability is an important issue for him, for as well as chairing the Health Facility Management Committee at Salkot Primary Health Centre, Mr Adhikari is head of the local Village Development Committee.

'Public hearings tend to be pretty non-specific, even though they are facilitated,' he says. 'The social audit has at least two major advantages: it collects information systematically, and it results in an action plan.'

The health centre at Salkot is a busy facility, seeing 100-150 patients per day. Its well-lit, spotless birthing centre was built a few years ago with support from German Cooperation. A new building is about to open, and there are plans to upgrade the centre to hospital status if resources can be found.

The centre's in-charge, Mr Dilli Sapkota, remembers that the first social audit here, held three years ago. 'Attendance was pretty low – only 15 or 20 people showed up. But the issues raised then and in the following years have been quite consistent, and some are pretty intractable. Each year, for instance, the social audit demands that the centre hire a doctor and some other medical staff. So far, it hasn't happened. But other things, yes there is progress.'

Mr Adhikari provides an example that touches on a central objective of the national health strategy: providing better services to people in all parts of the country. 'Some wards in the hills are quite isolated, as much as six hours walk from here, with 500 or more households. An early action point was to upgrade an existing outreach clinic – a small building used only a few times a month – to become a sub-health post. Making it an action point helped a lot by showing it was taken seriously, and that something needed to be done. It sparked a mass meeting of 200 people in the hills, and they sent a delegation here to show how determined they were. That then pushed the Health Facility Management Committee to work out a detailed plan and budget, and as a result the District Health Office has already approved the upgrade and the medicines. That has helped me to lobby the District Development Committee about the construction costs, which is the last big obstacle, and I am confident that they will commit the resources this year.'

Looking forward to the long-awaited local elections, Mr Adhikari says he will be happy to return to his former role as secretary of the Village Development Committee – its top civil servant – rather than acting as the central government's representative. He intends to remain on the health centre's management committee, and will continue to attend social audits. 'I'm experienced enough to know most of the issues, but hearing it from people's mouths is important. If I have one piece of advice for improving the process, it is this: participation in social audits should be compulsory for officials of the Village Development Committee. At the moment it is a guideline, but they don't always come.'

Looking ahead

The future of social audits in Nepalese health facilities appears to be bright. The targets set by the Ministry of Health for 30% of health facilities to have social audits by 2015 is on course to be met or surpassed a year early. The longer range of goal of 100% coverage by the end of the decade will depend primarily on budget considerations that are not yet in play. It seems clear that the current model of social audits, worked out by careful planning and learning from experience, is a successful one, supported by well-considered guidelines that the Ministry of Health is willing to adapt as necessary. The past five years also indicate that the country contains the necessary technical expertise to support the wider rollout of social audits if the government continues to support this activity.

There appear to be many reasons for the government to do so. First, a wide and expanding range of external development partners now support social auditing in health facilities, from funding to expanding coverage (in the case of USAID) to technical or material support by international NGOs in specific local areas or individual facilities. Second, the experience at village and district level suggests that social audits have enabled facilities to access financial resources that might otherwise have gone unspent or been used less productively. Local governments have indeed responded to concerns and demands raised by social audits, and incorporated them in planning and budgeting processes. Third, social audit is a vivid example of the type of governance that Nepal is committed to achieving: open, inclusive and accountable.

The current GIZ Programme Manager, Paul Rückert, stresses that social audits are not the solution to all of Nepal's health system problems, but simply one of many social responsibility tools that will be needed to enhance accountability and promote governance in health. 'Right now,' he comments, 'Nepal is in a transitory phase waiting for its new constitution which, it is hoped, will result in establishing decentralised decision-making and planning. In such a context, social audits have a better chance to produce results that will actually be used at local level.'

With the prospect of a new constitution finally being instituted and the holding of local elections, social audits appear to support the goal – clearly expressed back in the 1990s – of moving decision-making to the local level wherever possible. In this sense, social audits will help Nepal to conclude some important 'unfinished business.'

Peer review

The German Health Practice Collection has established criteria that programmes and projects must meet to qualify for publication as part of this series (see Box 8). The two expert reviewers of this report concluded that the approach had a positive balance on all eight criteria, though to varying degrees.

The reviewers concurred that the social audit activity described in this publication, particularly in the past three years, has become an effective approach. One reviewer specified finding it effective 'in terms of communicating and monitoring of real action of health system' and for putting concrete information 'in front of community people in a transparent way.' Both felt it was transferable to other countries, so long as local specificities were taken into account; one noted that it could also be usefully adapted to other sectors than health (e.g. local government in general). Both agreed that it was participatory (by definition) but also empowering to excluded communities. A reviewer pointed out that as well as empowering different population groups, the approach provides an additional means for community leaders and facility managers to be heard by policy makers.

The reviewers both said that the Nepalese approach to social auditing was innovative (particularly in the use of third-party facilitators) and cost-effective, although one said that more financial data over time would be needed to definitively judge the latter. Both said that good gender awareness had been demonstrated, mentioning in particular the auditing guidelines' mechanism for ensuring women's voices are heard. However, one suggested that this aspect of the approach could be improved if more data could be collected (i.e. as part of monitoring and evaluation) in order to track the impact of social audits specifically on gender. As regarding monitoring and evaluation specifically, one reviewer suggested that the social audit would be more effective if it could be incorporated into other monitoring and financial audit exercises currently carried out by the government. Doing so would make it, the reviewer said, 'a strong monitoring mechanism to do the comprehensive analyses of targets, inputs and achievements.'

Finally both reviewers found the approach sustainable, though one noted that ultimately its sustainability was dependent on the government's willingness to budget for it once external development partners no longer provide funding.

Box 8. Publication process of the German Health Practice Collection

In response to annual calls for proposals, experts working in GDC-supported initiatives propose projects that they regard as good or promising practice to the Managing Editor of the GHPC at ghpc@giz.de. All proposals are then posted on the Collection's website to allow GDC experts and the interested public to compare, assess and rate them. The proposals are also discussed in various technical fora in which German experts participate.

Informed by this initial peer assessment, an editorial board of GDC experts and BMZ officers select those they deem most worthy of publication. Professional writers then make on-site visits to collect information, working closely with the local partners and GDC personnel who jointly implement the selected projects.

Each report is submitted in draft form to independent peer reviewers who are acknowledged internationally as scholars or practitioners. The reviewers assess whether the documented project represents 'good or promising practice,' based on eight criteria:

- Effectiveness
- Transferability
- Participatory and empowering approach
- Gender awareness
- Quality of monitoring and evaluation
- Innovation
- Comparative cost-effectiveness
- Sustainability.

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References

Aiyar, Y. & Samji, S., 2009. *Transparency and accountability in NREGA: a case study of Andhra Pradesh.* Available at: http://knowledge.nrega.net/193/ [Accessed July 17, 2014].

Aryal, A., 2014. *Social Audit in Nepal's Health Sector*. Kathmandu: Deutsche Gesellschaft für Internationale Zusammenarbeit.

Association of International NGOs in Nepal, 2010. *Guideline for Social Audits.* Available at: http://www.ain.org.np/publications_files/Social%20Studies_English_cover.pdf [Accessed July 18, 2014].

Centre for Good Governance, 2005. *Social Audit: A Toolkit. A Guide for Performance Improvement and Outcome Measurement.* Hyderabad: Centre for Good Governance

DoHS, 2014. *Annual Report: Department of Health Services* 2069/70 (2012/2013), Kathmandu: Ministry of Health, Government of Nepal. Available at: http://umeshg.com.np/wp-content/uploads/2014/06/Annual_report_2069_70.pdf [Accessed September 16, 2014].

Ferguson, J., 2010. *Social audit and stakeholder thinking: the radical ideas of George Goyder.* Available at: http://strathprints.strath.ac.uk/45998/ [Accessed July 31, 2014].

GIZ, 2013a. *Effects of social audits at community level.* Eschborn: Deutsche Gesellschaft für Internationale Zusammenarbeit.

GIZ, 2013b. *Knitting local health governance tools together: Quality Improvement, Social Audit and Local Planning.* Kathmandu: Deutsche Gesellschaft für Internationale Zusammenarbeit.

GIZ, 2014. Nepal. Eschborn: Deutsche Gesellschaft für Internationale Zusammenarbeit. Available at: http://www.giz.de/en/worldwide/378.html [Accessed May 5, 2014].

Karkee, R. & Kadariya, J., 2013. *Choice of health-care facility after introduction of free essential health services in Nepal.* WHO South-East Asia Journal of Public Health, 2(2), p.96.

Mehat, S. et al., 2013. *Service Tracking Survey 2012.* Kathmandu: Ministry of Health and Population, Government of Nepal. Available at: http://www.nhssp.org.np/monitoring/Service%20Tracking%20Survey%202012.pdf [Accessed July 22, 2014].

Ministry of Local Development, 2008. *Local Government and Community Development Programme (LGCDP).* Kathmandu: Ministry of Health, Government of Nepal.

MoFALD, 2013. *Local Governance And Community Development Programme (LGCDP-II).*
Available at: http://www.lgcdp.gov.np/home/publication/LGCDP%20P-II_new.pdf [Accessed July 15, 2014].

Morrison, J. et al., 2011. *Community mobilisation and health management committee strengthening to increase birth attendance by trained health workers in rural Makwanpur, Nepal: study protocol for a cluster randomised controlled trial.* Trials, 12, p.128.

Neupane, B.D., 2011. *A Review of Social Audit Practices and Guidelines in Nepal.*
Available at: http://www.nhssp.org.np/gesi/Social%20Audit%20Review%20-%20Final%20Draft%20Report%20-%2010%20Oct%202011.pdf [Accessed July 22, 2014].

Pearce, J. & Kay, A., 2012. *Brief History of Social Accounting and Audit* (updated 2012). Liverpool: Social Audit Network.
Available at: http://www.socialauditnetwork.org.uk/getting-started/brief-history-social-accounting-and-audit/ [Accessed May 5, 2014].

Pradhan, A. & Barnett, S., 2010. *An Assessment of the Impact of the Aama Programme: Changes in the Utilisation of Emergency Obstetric Care (EOC) Services.* New York: UNFPA.

UNDP, 2013. *Nepal Millennium Development Goals Progress Report 2013*, Kathmandu: UNDP Nepal.
Available at: http://www.np.undp.org/content/nepal/en/home/library/mdg/mdg-progress-report-2013/ [Accessed July 15, 2014].

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