

1 Introduction

This article will describe the activities of the Baudha Bahuniapati Family Welfare Project (BBP). The BBP was set up by the national level NGO Family Planning Association of Nepal (FPAN) in 1973, initially to distribute contraceptives and provide a basic medical service. In the districts in which it operates, it has set in motion a process of initiating bottom-up planning, handing over responsibility to locally-formed NGOs, and creating a sustainable programme of local activities. Several NGOs have resulted from this process. This article describes in detail the experiences of one of them: the Mahankal Health Service Management Committee (MHSMC), and how it became financially self-supporting through charging for medicines and services.

2 Background

The BBP was started with two Village Development Committees (VDCs), the smallest geographical division for administrative purposes, in Sindhupalchowk District and Baudha (a village in Kathmandu District) to distribute condoms and pills for family planning and also provide a basic health service. The BBP wanted to support and work together with these communities to solve their health problems. However, the community told the VDC field staff that, in addition to family planning and basic health, they needed to increase the productivity of their land. The project therefore added an agriculture component and other new activities, such as nutritious fodder and grass for improved goat, sheep, and buffalo production; coffee and orange growing; construction of drinking water and irrigation schemes; formal and non-formal education, etc. User groups were formed in many of these activities in order to raise funds for repair and maintenance, and these evolved into a credit system programme. By 1978 the project had expanded from two to 48 VDCs.

Up until 1982 the project had been 'top-down'; in other words it was central management that planned, implemented and monitored all the activities, rather than the community members. This meant that information and ideas emanated from the educated and qualified personnel in the BBP, making it extremely likely that many appropriate local alternatives for solving problems would be

Local People Assume Responsibility for their Health Service

*The Experience of
the Mahankal
Health Service
Management
Committee, Nepal*

Gopal K. Nakarmi

IDS Bulletin Vol 31 No 1 2000

overlooked. It is said that a doctor can only imagine the degree of pain a sick person is feeling, she/he can never feel it him/herself; the project management might have been able to collect information about people's problems, but might not know what it is to experience them.

With this in mind, in 1983 planning was shifted from central management to supervisors in four regional 'blocks' (Chautara, Bahunipati, Helambu, Indrawati). That year the programme's achievements improved dramatically. Supervisors were able to make the programmes for their block more relevant, set their own targets, and take responsibility for achieving those targets. They also experienced greater recognition and encouragement in their work.

Even though planning at block level made projects more relevant, community participation was still very limited. In 1984 the planning process took a further step downwards to include the communities. Community level planning for some activities was possible through working with the existing user groups, organising meetings to discuss their needs and the process of implementing their own project ideas. In addition, focus groups were formed where a relevant user group did not already exist, in order to plan and implement a range of development activities under the support of the BBP. These included health activities.

3 The Health Challenge

In 1988 World Neighbours, an international NGO whose aim is to strengthen people's abilities to meet their basic needs, raised the issue of how many years BBP would need to depend on outside support for medicines. At the same time the FPAN was forcing them to face this question by ruling that all branches and projects must raise at least 30% of total medicines' cost. The project had been distributing medicines to patients free of charge from the beginning of 1973, and was afraid to implement the new charges.

BBP tried to think of a way to solve the problem of introducing the user charges in a participatory manner. They decided to hold mass meetings in two of the blocks (Helambu and Bahunipati), inviting two

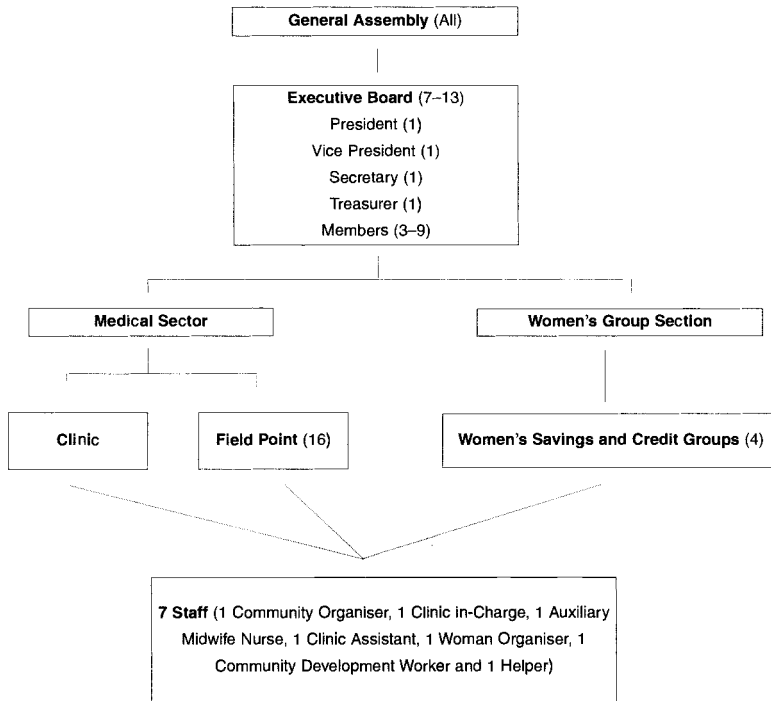
representatives of each user group managing community activities in those areas. The first meeting about the charging for medicines was held at Mahankal (Helambu), and was attended by about 58 participants. After a long discussion local people and representatives of the user groups actually suggested charging 40% of the cost for the medicines, but with the request that they would like to form autonomous organisations to manage the medicines and the income. A seven-member *ad hoc* committee was formed on the same day. A similar process took place in Bahunipati and they in turn also formed an *ad hoc* committee and later an NGO. In the following sections, the process, development and activities of the *ad hoc* committee in Helambu, the Mahankal Health Service Management Committee (MHSMC), will be described.

3.1 Mahankal Health Service Management Committee

From its very conception at the user group meeting in 1988, the MHSMC wanted to be registered as an NGO; however, due to the political system in Nepal at that time, this could not be realised. Therefore, for two years it operated as an *ad hoc* committee under the guidance of BBP. After democratisation in Nepal in 1990 the committee was registered as an NGO. It is a non-profit making, non-racial, autonomous organisation formed by local people. It has been registered with the Social Welfare Council (SWC), the NGO's supporting body in Nepal, and has also been affiliated with other NGO federations.

There are 45 general members, who pay a membership fee of Rs. 30/- per year. From the general members, an Executive Board of 7–13 members is elected every three years. There are four ex-officio members (Chairman, Vice-Chairman, Secretary and Treasurer) on the Executive Board. The main rights and duties of the Executive Board are: to coordinate with other governmental and non-governmental agencies; to develop policies and enforce them; to approve the annual programmes and budget; to hire and fire staff; and to evaluate the impact of the organisation. None of the general members, including Executive Board members, are paid for their services. The NGO's assets have increased every year, and on the last day of the fiscal year 1998/99, it had assets of Rs. 662,245. The Executive Board members meet a minimum of four times a year.

Figure 1: The organisational chart of Mahankal Health Service Management Committee



The MHSMC organises a general meeting at least once a year, when they discuss the progress and expenditure of the past year; the programme and budget for the coming year; the appointment of an auditor; the amendment of the constitution if necessary; the election of the Executive Board once every three years, etc. The General Assembly is the highest body within the NGO. The organisational chart of the MHSMC is given above.

According to the law in Nepal, NGOs must be registered every year with the Home Affairs Ministry along with their annual progress reports and statement of audited accounts. The MHSMC submits these reports and the statement of accounts to the SWC and all concerned agencies. It maintains transparency to the general assembly in conducting programmes and financial procedures. In addition, community members are not excluded from General Assembly or Executive Board meetings if they wish to express concerns or complaints.

3.2 Achieving sustainability for the health programme

The charge for medicines decided by the original *ad hoc* committee of MHSMC was 40% of cost price. Surprisingly, several major improvements in the effectiveness and efficiency of medical provision resulted from this change:

1. When drugs were free, people used to request medicines (sometimes expensive ones) from the clinic even when they were not needed. Therefore charging for medicines was successful in reducing this wastefulness and misuse.
2. Long official procedures for purchasing medicines, involving around four transactions and taking at least one month, were eliminated. The committee decided from the beginning to purchase their own medicines in a more efficient way and to keep their own records.
3. Despite the introduction of payments, the number of patients using the health service increased, turnover of medicines increased, and

expiry of medicines whilst in stock was reduced to almost nil. During this time the confidence of the community members in the efficiency and effectiveness of the service increased, since medicines were always available, there was more transparency with respect to the purchasing and selling of the medicines, and there was improved accountability to the service users.

Although at the outset some local people were unhappy with the decision of the committee members with regard to the 40% charge, when they realised that they could not depend on the support of the BBP forever, people came to understand the concept of self-reliance and the need to contribute for the medicines and services. In addition, in cases of the 'very poor', exemptions were permitted (these cases are always put before the committee for approval). Therefore, to increase their self-reliance further, MHSMC decided after only six months to increase the payment rate to 50% of cost price, and in June 1990 they increased the charge to 100% of cost.

3.3 Programmes of the MHSMC

Initially the MHSMC was only responsible for managing the curative health and family planning aspects of BBP's activities. However, from July 1994 all other development activities were also managed by them within the same district: drinking water; agroforestry; livestock; horticulture; women's savings and credit group; immunisation; and reproductive health. The reproductive health programme is given the topmost priority, and BBP still supports the NGO by providing contraceptives, training, networking, exchange of experiences and ideas, assistance in writing proposals for funding, and coordination among NGOs.

The MHSMC has several approaches to its health activities. It provides curative health through its clinic, treating more than 4,000 patients per year. Patients are charged Rs. 5/- per year, and now medicines are sold at 30% more than cost price in order to cover salaries and clinic overheads. There are sixteen field camps that operate every two months to provide simple treatments, contraception and prenatal services. Health issues are also addressed through the women's groups. This is a forum for discussing their problems and for providing services to them.

3.4 Participatory approach of MHSMC

MHSMC uses a number of participatory methods when working with community members in the field. These include seasonal calendars, social mapping, matrix etc. In order to identify priority reproductive health activities in each community, the BBP, in cooperation with World Neighbours, developed a series of sixteen pictures depicting reproductive health problems that community members could then discuss and rank. The sixteen issues were decided on after an extensive survey of reproductive health problems identified by community members in three districts. Of the sixteen issues, nine are medical, and seven are social. After training by BBP/ World Neighbours, the MHSMC has been using these pictures to stimulate discussion with community groups and, after ranking the issues, a programme of priority activities is decided with them.

Once the needs of the community are identified, an action plan is developed stating the activities and months by which they should have been undertaken. These then act as indicators for monitoring the achievement of programme goals. MHSMC field staff are responsible for monitoring the field activities using participatory methods. The activities of the field staff and other aspects of the programme (e.g. clinic, field camps, etc.) are in turn monitored by the Executive Board members during their quarterly meetings.

3.5 Cooperation with government and other agencies

In the areas where it has women's savings and credit groups, the MHSMC has assumed responsibility for 100% immunisation of eligible children using vaccines provided by the Government Immunisation Programme. The government also provides contraceptives free of charge to the NGO, and pays Rs. 300/- to the NGO for each client given a vasectomy. MHSMC has a very good relationship with the local government health branch, and the NGO reports to them once every three months on its immunisation and family planning activities. District level government offices such as drinking water, forestry, agriculture, etc. are also supportive to MHSMC in achieving its long term goal of improving the livelihood of community people. The Social Welfare Council also supports the NGO by providing training and information about the activities of other NGOs and INGOs in Nepal and abroad.

MHSMC has a good relationship with other NGOs working in the area, sometimes providing training to their staff (e.g. in traditional birth attendance), and sometimes collaborating with them in certain activities (e.g. in conducting appraisals to identify problems in the area).

The MHSMC receives funds from local government; national level NGOs (such as Nepal Agroforestry Foundation); INGOs (such as World Neighbours and Action Aid); and from the World Bank Programme in Nepal (i.e. Fund Board). Local people, including the general and executive board members and user group members, voluntarily contribute their time, skills, knowledge, space and materials without expecting anything in return.

3.6 Limitations of MHSMC

- Although membership of the Executive Board is prestigious in the villages, many of the general members are not always happy with this obligation (although voluntary) because they have to spare time and effort for the NGO work.
- It seems that the MHSMC has merely replaced the BBP in the continuation of its activities. It has never brought in any innovative ideas of its own, and has not expanded its working areas and range of activities.
- The MHSMC still seems to lack 100% confidence, and still seeks some support from outside, for example, in writing and submitting proposals and approaching new donors for new programme funding.

4 Lessons Learnt by the BBP

The BBP has been working for over 25 years in Sindhupalchowk and Kavre Districts and, as well as

supporting the formation of the MHSMC in Mahankal, it also handed over management of activities to another seven NGOs in these two districts, and maintains a partnership relationship with them. From the strategies and approaches used by BBP over the years, it has learnt a number of important lessons.

It has become evident that local people are more aware of the local problems than outside people, and that they are able to run their own programmes. The project has found that programmes run and managed by local people through such an NGO as MHSMC can be easily replicated in other parts of the country. Experience has shown that the level of sustainability of programmes (culturally and financially) is much higher when it is run and managed by local volunteers. This is because the feeling of ownership is strong; the programmes are socially and culturally more appropriate; the administrative costs are less; and the organisation is not overly sophisticated. Local volunteers (teachers, businessmen, women, leaders, farmers, etc.) are able to undertake the responsibility of running the organisation effectively up to a certain level, if they are properly supported, i.e. given training.

Perhaps the most important lesson of all is that development is not a short-term process. The processes of identifying community needs and problems, as well as designing programmes to solve them, are also time-consuming. Delivering the actual services often does not take such a long time, but delivering responsibility certainly does. Creating a vision for the future takes time and supporting the processes that can enable this vision to shape reality demands a longer term perspective.