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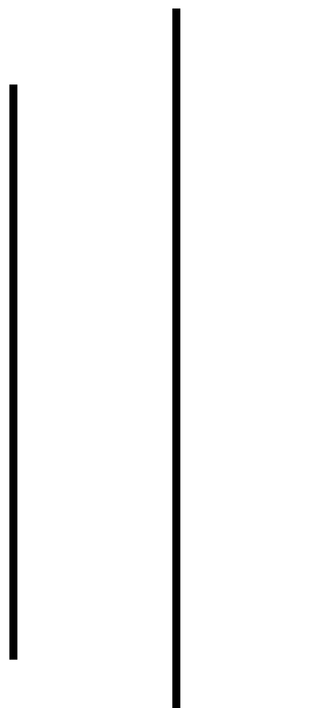
Government of Nepal
Ministry of Health & Population

Health Sector Social Audit
Operational Guidelines - 2068 [2012]



Government of Nepal
Ministry of Health and Population
Department of Health Services
Primary Health Care Revitalization Division

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LIST OF ACRONYMS

ANC	Antenatal Care
DoHS	Department of Health Services
DP/HO	District Public/Health Office
FCHV	Female Community Health Volunteer
FDG	Focus Group Discussion
HFMC	Health Facility Management Committee
HP	Health Post
I/NGO	International Non-Governmental Organisation
JAR	Joint Annual Review
MoHP	Ministry of Health and Population
NGO	Non-Governmental Organisation
PHCC	Primary Health Care Centre
PHCRD	Primary Health Care Revitalization Division
RHD	Regional Health Directorates
SHP	Sub-Health Post
VDC	Village Development Committee

CHAPTER – 1
BACKGROUND

1.1 INTRODUCTION

Following the restoration of democratic practices in Nepal political awareness among citizens has significantly increased, contributing to raised expectations for improved public services. This has increased the requirement to deliver quality public services to meet the needs and expectations of common citizens. Due to the increased capacity to press for improved governance in the delivery of public services, people are seeking meaningful participation, particularly in monitoring public services including health services.

The provision of people's meaningful participation in public service delivery and monitoring are clearly recognized in the following laws: the Governance and Management Act 2063 [2007] (procedure 2064 [2008]), the Right to Information Act 2063 [2007], the Public Service Act 2049 [1993] (and procedure 2050 [1994]), and the Health Service Act 2053 [1997] and procedure. Against this background, Government has realized the need to introduce Health Sector Social Audit Operational Guidelines - 2068 [2012] to facilitate increased participation of the general public in health service management and to achieve increased utilisation of services.

The Social Audit Operational Guidelines – 2068 [2012] are being introduced to facilitate the effective utilisation of resources allocated to the health sector in order to increase people's access to health care services. This will enhance the fundamental right of the people of Nepal to basic health care services as established in the Interim Constitution 2007 [2063].

1.2 BRIEF NAME AND COMMENCEMENT

1.2.1 The Guidelines shall be called 'Health Sector Social Audit Operational Guidelines - 2068'.

1.2.2 The Guidelines shall come into force from the date of approval by the Government of Nepal.

1.3 DEFINITIONS

Unless the subject or context otherwise requires, in these Guidelines:

1.3.1 *Health Sector Social Audit* means an analytical assessment made on the basis of opinions of service recipients, service providers and stakeholders on the policy, rules, process, conduct/behaviour, programme implementation and service providers. It also assesses the regularity, transparency, effectiveness and relevance of the resource mobilization. In this process, the achievements and changes noted in providing health services shall be transparently assessed and presented in an objective manner. The social audit also contributes to gradually institutionalizing health service delivery by making public the types of minimum services and benefits to be provided by health facilities and their quality and impact. The social audit is a process that provides an authentic and open discussion or interaction among the community, service users and service providers.

The social audit shall give utmost importance to the opinions, perceptions and feelings of the poor, women and excluded groups, who are on other occasions normally paid little

attention. The process shall contribute to maintaining good governance by making health facilities more accountable and transparent.

1.3.2 *Institutional Arrangement* means the provisions of the Primary Health Care Revitalization Division (PHCRD) at the central level and the Regional Health Directorates (RHD) at the regional level for effective coordination and monitoring of the social audit process. Furthermore, the institutional actors at the district level and health facility level responsible for the effective implementation of the health sector social audit process will be District Public/Health Offices (DP/HOs), the Health Sector Social Audit District Committees and the Social Audit Local Support Groups respectively.

1.3.3 *Health Facility* means district hospital, primary health care centre (PHCC), health post (HP) and sub-health post (SHP).

1.3.4 *Health Facility Management Committee* means the committee formally created to manage the health facility in accordance with approved government guidelines.

1.3.5 *Social Audit Organisation* means the non-governmental organisation of the concerned district selected by the Health Sector Social Audit District Committee to facilitate the social audit process in line with the designated roles and responsibilities.

1.3.6 *Social Auditor* means the person appointed by the Social Audit Organisation in accordance with the Social Audit Operational Guidelines, and with the approval of the Health Service Social Audit District Committee, from among those with the stipulated qualifications to discharge the required duties and responsibilities. The Social Auditor shall facilitate the social audit process at the health institution level under the leadership of the Social Audit Organisation.

1.3.7 *Local Resource Person* means the person the Social Audit Organisation appoints as an assistant for a definite period to support the social audit process with a view to developing competent human resources at the local health facility level.

1.3.8 *Poor* means the disadvantaged or those marginalised from a social, economic, geographic or empowerment point of view.

1.3.9 *Excluded Group* means a socially excluded group which has traditionally faced discrimination due to its economic status, ethnicity, gender, disability, religion or geographic region. The health sector’s Gender Equality and Social Inclusion Strategy has defined women, Dalits, Janajatis, Madhesis, OBC (Other Backward Communities), Muslims, people with disabilities and citizens residing in remote areas which have not been included in the mainstream of the national development process, as excluded groups.

1.4 FUNDAMENTAL GUIDING PRINCIPLES OF THE HEALTH SECTOR SOCIAL AUDIT

All processes and methods of the social audit shall be premised on the assumption that health services should be provided to the general public with consideration to good governance and practices. The following guiding principles shall be applied during the overall social audit process.

1.4.1 *Multi Perspective/Inclusive and Comprehensive:* The social audit process should comprehensively incorporate the perceptions, recommendations, positive feelings and grievances of all the service recipients, users and concerned stakeholders in an orderly fashion. The process and methods of the social audit should be prepared in such a way

that all concerned stakeholders (especially women, the poor and socially excluded), can express their views, perceptions and opinions on the health services with no hesitation or fear. Likewise, all the achievements, strengths and weaknesses of the health facilities and health services should be acknowledged within the social audit process.

1.4.2 Participatory: The engagement and participation of all the concerned stakeholders including women, the poor and excluded groups, health service recipients and users, and health service providers at different levels should be ensured in the process. The social audit process greatly contributes to community empowerment as a democratic exercise is promoted by facilitating the local community and general public in a participatory development approach.

1.4.3 A Continuing Process: The social audit process regularly addresses current social and organisational issues concerning health service provision. Once the social audit is undertaken in a given health facility, it should be continued at regular intervals. Continuity in the social audit process is expected to contribute to the institutionalization of social concerns in the society in general and in health facilities in particular.

1.4.4 Transparency, Accountability and Responsibility: All health facilities are expected to ensure transparency in all activities and accountability in delivering service by openly describing all of the health services available, the process for accessing these services, the achievements made and any grievances from the public with a strong commitment for timely improvements.

1.5 OBJECTIVES OF THE SOCIAL AUDIT IN THE HEALTH SECTOR

The main objective of adopting the social audit process in the health sector is to make health facilities more responsive, sensitive and transparent in the eyes of the general public especially including women, the poor and excluded. The specific objectives of the process are as follows:

- To make the various services provided by the health sector and community health related activities transparent;
- To increase the level of general public awareness (especially among women, the poor and excluded) on their rights, responsibilities and sense of ownership of health service related programmes based on their direct involvement;
- To contribute to achieving the expected results from health services by making health service providers more accountable toward the general public especially women, the poor and excluded;
- To develop a mechanism for openly exchanging information, holding regular discussion and dialogue on various health issues between the general public (especially women, the poor and excluded) and health service providing organisations;
- To establish the practice among the public of demanding information related to health and among health service providers of imparting such information.

CHAPTER 2

IMPLEMENTATION STRATEGY

2.1. COVERAGE AND SCOPE OF THE SOCIAL AUDIT

Generally social audits will be undertaken from the level of sub-health post to district hospital and urban health clinic by following the process stipulated in the Health Sector Social Audit Operational Guidelines - 2068. The District Public/Health Offices are responsible to develop a five-year district action plan and to accordingly inform the Department of Health Services (DoHS) on approval by the Health Service Social Audit District Committee.

The action plan will be formulated so that the social audit, once begun in any health facility, will be conducted every year in a regular manner. In the initial phase of the first five years, it is expected that the social audit will be conducted regularly in order to enhance the capacity of the Health Facility Management Committee (HFMC) and increase meaningful participation of the local community.

2.2 PARTICIPANTS IN THE SOCIAL AUDIT PROCESS

The participants in the social audit process vary during the different stages. The Health Facility Management Committee and health workers should actively participate in the preparatory stage under the guidance of the District Public/Health Office and Health Sector Social Audit District Committee. The health service providers and recipients should actively participate in the information and data collection stage that is led by the Social Audit Local Support Group and facilitated by the Social Audit Organization.

Likewise, the Social Auditor and the Social Audit Local Support Group should participate in the analysis of data and information. The mass meeting is the most important event of the social audit process, where the preliminary findings of the social audit are presented and participants are provided with an opportunity to flag concerns and raise issues in order to develop a common understanding and consensus. Hence all health services stakeholders, including service recipients, all citizens, representatives of government line agencies, mothers' groups, female community health volunteers, health workers, political leaders and social workers should participate in this event.

The mass media should participate actively in disseminating the results of the social audit process (highlighting positive aspects and/or aspects to be improved) to the community and up to policy makers at all levels. The mass media can also help to bring the needs of health service delivery to the attention of policy planners and political leaders. A comprehensive list of participants to be included in the overall social audit process is given in Annex - 1.

2.3. SUBJECT AREAS OF THE SOCIAL AUDIT

The social audit should be carried out for priority government health services and programmes by applying the process and methods set forth in these operational guidelines. The social audit should cover the following areas, plus management and other social aspects related to the delivery of health services.

2.3.1 Areas Related to Health Services:

a) Aama Surakshya Programme: Details of recipients of incentives and their distribution – to include recipients' names and receipt dates. Details of the Antenatal Care (ANC) incentive amount – recipients' names and receipt dates.

b) Free Health Care Services: The number of recipients including the total number of women, and members of poor and excluded communities. The regularity of services and the presence of health workers at health facilities.

c) Free Distribution of Medicines: The medicines distributed free of cost. The regular availability of very essential medicines including antibiotics (see table in Annex - 2).

d) Integrated Child Health Management: The number of service recipients and the types of service provided.

e) Community-based New-born Treatment: The number of service recipients and types of services provided (treatment of diarrhoea, dysentery, nutritional and respiratory problems).

f) Family Planning, Immunisation and Nutrition Programme: Targets for providing services, achievements and comparative status with regard to previous fiscal year. For immunisation, the number of children who dropped out categorised by sex, caste/ethnicity and location.

g) The social audit process should also cover any new programme introduced or any change made in existing programmes, in addition to all the prioritized programs described above.

2.3.2 Areas Related to Institutional Management:

a) The status of representation by gender and the representation of various caste and ethnic groups in the Health Facility Management Committee.

b) Meetings of the HFMC: The number of meetings held during the year, the regularity of the meetings according to the guidelines, attendance in the meetings, especially the presence of women and members of excluded groups.

c) Important decisions: Decisions made in favour of the poor, women and excluded groups, decisions regarding coordination with other government and non-governmental organisations working at Village Development Committee (VDC) or local levels, resource mobilization, resource consumption and implementation. What decisions were reached to make health service gender sensitive and inclusive? What is the implementation status of the decisions made?

d) Issues relating to the mobilization of financial resources (the amount equivalent to the unit cost) including what the government provides for free delivery and free health care services rendered by the local health facility. The amount provided by the government and the date, the utilisation of the funds and how they are used, decisions made to utilize the funds and initiatives undertaken for the effective enforcement of decisions.

e) Health Facility Office Hours: Information shown by the health facility attendance register, remarks by health workers and perceptions and experiences of service users and recipients and the community.

f) The mechanism to address public grievances: Existing provision or mechanism to address public grievances, the number and types of public grievances received and addressed within the year, examples of the ways in which the service has been improved.

2.3.3 *Areas Related to Quality of Health Services*: This relates to the perceptions of health care providers and users on the provision of the minimum quality of health services. The focus areas are:

a) Human resource management: Postings at the health facility, availability of health workers in line with posts, the adequacy of postings in proportion to service recipients, punctuality of health workers at the health facility, the community's perceptions and the facts shown by records maintained at the health facility.

b) Behaviour of health workers: Direct observation, the perceptions of health workers, service recipients and the community.

c) Sterilisation: Provision made for the sterilisation of equipment and instruments.

d) Cleanliness: Cleanliness and sanitary condition of the facility (inside and outside) including the availability of toilets, water etc.

e) Gender Sensitivity: Perceptions and feelings of the health service recipients should also be gathered, including in relation to confidentiality and service delivery according to the needs and wishes of the service recipients.

2.4 INSTITUTIONAL ARRANGEMENTS

The Primary Health Care Revitalization Division will take overall responsibility for providing leadership and coordination to carry out all the activities of the social audit process. The specific provisions, formation process, roles, responsibilities and duties of the bodies directly involved in the social audit process will be as follows.

2.4.1 Primary Health Care Revitalisation Division: This division will fulfil the following roles and responsibilities to complete the social audit process:

a) Take up various policy and institutional responsibilities, especially those required in connection with the social audit;

b) Prepare the annual budget, release the budget on time (to ensure that financial resources are available to conduct the social audit within the first four months of each Nepali fiscal year);

c) Coordinate and initiate joint actions with external development partners and I/NGOs at the central level;

d) Assure that the social audit is carried out as per the plan;

e) Ensure that a strong mechanism is in place to receive reports in time from every district, and

f) Prepare and submit a report to the Joint Annual Review (JAR) held in January (Poush) each year.

2.4.2 Regional Health Directorate: The RHD offices will fulfil the following roles and responsibilities to complete the social audit process:

a) Develop/maintain regional level coordination and monitor district level activities;

b) Coordinate and initiate joint actions with external development partners and I/NGOs at the regional level;

c) The Regional Health Directorate will also take the responsibility to include the social audit in the run up to the formulation of national policies by presenting its results/benefits in district, regional and national review meetings.

2.4.3 <u>District Public/Health Office</u>: The DP/HO will fulfil the following roles and responsibilities to complete the social audit process:

a) Prepare the social audit work plan for the district and monitor its implementation;

b) Hold overall responsibility for implementation of the social audit in the district;

c) Arrange third parties for the social audit by mobilizing the available budget and local resources;

d) Create a favourable/enabling environment for smooth facilitation of the social audit process at the health facility;

e) Coordinate and initiate joint actions with external development partners and I/NGOs at the district level;

f) Submit social audit reports to the PHCRD in November (Mangsir) every year, and

g) Enforce and monitor the plan of action prepared (in each health facility and district) following the conclusion of the social audit.

2.4.4 <u>Health Sector Social Audit District Committee</u>: In order to take full responsibility for the overall coordination and leadership of the social audit process, a district level social audit committee will be formed. Generally, the committee will take the overall leadership for social audit implementation and will develop strategic relationships with the District Development Committee (DDC), Village Development Committees (VDCs) and other governmental and non-governmental agencies/stakeholders as needed. For this purpose, the DP/HO will serve as the secretariat in the district.

The **Composition** of the Health Sector Social Audit District Committee will be as follows:

a) Local Development Officer – Coordinator

b) Social Development Officer, DDC – Member

c) District Education Officer – Member

d) Women Development Officer – Member

e) District Public/Health Officer – Member Secretary

Note: The DP/HO focal person for the social audit will provide necessary support for effectively arranging the work of the Social Audit District Committee.

The **Roles** of the Health Sector Social Audit District Committee will be the following:

a) Approve the district action plan for the social audit and the social audit progress report;

b) Select the district level Social Audit Organisation in accordance with the process and criteria specified in the operational guidelines;

c) Develop a mechanism of social audit implementation and monitoring and, based on the established mechanism, conduct an effective monitoring and follow-up of the social audit implementation in the district hospital and peripheral health facilities;

d) Prepare and organize a district level public gathering at the district hospital after completing the social audit process at peripheral health facilities in the district;

e) Review the reports submitted by the social audit organization based on the social audit process completed at the district and health facility level, and address the issues or implement the recommendations, raised in the report; prepare and submit a comprehensive social audit report to the PHCRD that includes its own commitments and recommendations; and

f) Engage a district level Social Audit Organisation for necessary facilitation and preparation of a district level report.

2.4.5 Social Audit Local Support Group: The Health Facility Management Committee will be placed at the centre of the social audit process at the local level. The HFMC will form an inclusive Social Audit Local Support Group that includes individuals interested in promoting social accountability at the local level, and functions under the leadership of one designated HFMC member. The support group will be formed every year at the beginning of the social audit process and will automatically be dissolved (if the HFMC does not see the need for it to continue) at the end of the fiscal year after successful implementation of the action plan developed by the social audit process. The local health facility will serve as the secretariat for this group.

The **Composition** of the Social Audit Local Support Group will be as follows:

a) One designated member of the HFMC – Coordinator;

b) One person from among the headmasters of local schools (who is not already a member of the HFMC) – Member;

c) One person from among the chairpersons of the mothers' group network at the VDC level or the chairperson of the mothers' group where the health facility is located – Member;

d) One female community health volunteer nominated on the basis of consensus – Member;

e) The chair of the Ward Citizens' Forum where the health facility is located – Member;

Note:

- *The Social Auditor will act as a facilitator of the local support group. The local support group will include a total of five members if there is Dalit representation in the group. However, if there is no Dalit representation, one Dalit member should be nominated and the total number of group members will be six.*
- *Social mobilisers working for government or non-governmental organisations in the respective VDCs may be invited to the local support group as required.*

The **Roles** of the Social Audit Local Support Group will be the following:

a) Actively participate in the orientation to the social audit;

b) Assist the Social Auditor as required in preparation for the social audit;

c) Assist the Social Auditor in collecting various information and data from the health facilities;

d) Support the Social Auditor in collecting information from community and service recipients, prepare an analysis of findings in a participatory way, and support preparation of the primary results;

e) Present the findings and results at a public gathering attended by all the stakeholders and receive any positive feedback and grievances from the general public;

f) Assist in facilitating the public gathering; and

g) Develop an action plan to implement or address the areas suggested (the issues raised) by the social audit and monitor its implementation.

2.4.6 Social Audit Organisation: The Health Sector Social Audit District Committee should appoint local NGOs that fulfil the following criteria and have the following qualifications as Social Audit Organisations after completing the following process. The number of Social Audit Organisations in one district may be one or two as required.

The **Selection and contract process** of the Social Audit Organisations will be as follows:

The Social Audit Organisations should be selected and contracted in accordance with the Public Procurement Act and Guideline of the Government of Nepal.

a) Issue a public notice transparently calling for applications along with letters of interest to be submitted within 15 days, and clearly mentioning the required qualifications, provisions of perks and benefits, the job description, framework of the application and necessary credentials.

b) Make a primary list of organisations meeting the criteria by screening the applications received.

c) Call the short-listed organisations to prepare and submit comprehensive proposals (technical and financial) within seven days. The organisations should enclose a brief curriculum vitae of the possible Social Auditor in the proposal.

d) Select the best organisation(s) by reviewing and analysing the applications in the presence of members of the Health Sector Social Audit District Committee, including a representative from the RHD and one independent external consultant.

e) A multi-year contract that can be renewed every year after completing an annual performance evaluation should be made with the selected organisation(s). New Social Audit Organisation(s) may be selected by following the standard selection process if the performance of the existing Social Audit Organisation(s) is found to be unsatisfactory.

The **Qualifications** of the Social Audit Organisation will be the following:

a) At least three years of active functioning after having registered in the concerned district;

b) At least five years of working experience with social auditing or social mobilization;

c) Working experience in the public health service delivery process and with public health and social justice concerns; and

d) Regularity in annual audits and renewal of registration of the organisation.

e) Priority should be given to experienced organisations that are practising social auditing and/or public auditing in their own organisations.

The **Roles** of the Social Audit Organisation(s) will be the following:

a) Prepare for the social audit by applying the specified methods and processes contained in the Social Audit Operational Guidelines.
b) With the support of the DP/HO, inform the concerned VDC(s) and local health facilities about the social audit and its procedures.
c) Facilitate the formation of the Social Audit Local Support Group in coordination with the Health Facility Management Committee at the local level.
d) Conduct an orientation programme for the representatives of the HFMC, the Social Audit Local Support Group and health workers of concerned institutions.
e) Provide the necessary information and requests for participation after determining the venue, the sources of information and respondents for collecting information according to the demands of the method and process.
f) With support from the Social Audit Local Support Group, collect and analyse necessary information/data both from the health facility and the community.
g) Coordinate with local government and NGOs at the district and local levels as needed.
h) Prepare the primary and final results of the social audit.
i) Motivate local people, particularly women, the poor and excluded, to become actively involved in the social audit process, and mobilize all stakeholders.
j) Prepare, organize and facilitate a public gathering at district and health facility levels.
k) Facilitate the action planning process in a mass gathering in the presence, and with the participation of, service users, the HFMC, service providers and other local stakeholders.
l) In order to complete the above task, work together with the Social Audit Local Support Group at the local institution level.
m) Prepare and submit a final report of the social audit to the DP/HO and other specified bodies within the stipulated time.
n) Provide support to the Health Sector Social Audit District Committee as needed and carry out all the work in line with the Committee's guidance.

2.5 SOCIAL AUDITORS

The Social Audit Organisation should include the curriculum vitae of its potential competent Social Auditors in the comprehensive proposal submitted for the selection process. Before signing the contract between the Social Audit Organisation and the DP/HO, at least two Social Auditors from among those proposed will be selected in coordination with the DP/HO. One of the two contracted Social Auditors will be female.

The **Qualifications** of the Social Auditors will be the following:

a) Resident of the concerned district;

b) Minimum educational qualification – Certificate level or equivalent;
c) Knowledge of health service delivery;
d) At least five years working experience in facilitating social mobilization, training and workshops;
e) Knowledge and experience regarding social justice;
f) Knowledge and skills in information gathering, analysis and report writing;
g) Coordination and collaboration building skills; and
h) Capability in facilitating meetings, orientations and workshops at the local level.

The **Roles** of the Social Auditors will be the following*:*

a) Coordinate with the Health Service Social Audit District Committee, DP/HO, health facilities and other stakeholders.
b) Prepare to start the social audit process.
c) Facilitate training and orientation related to the social audit process.
d) Facilitate the social audit process after establishing a congenial atmosphere.
e) Motivate all local people including women, the poor and excluded communities to participate actively in the social audit process and mobilize all stakeholders at all levels.
f) Gather information and data from health facilities and the community level in cooperation with the Social Audit Local Support Group.
g) Analyse the data and information gathered, in cooperation with the Social Audit Local Support Group.
h) Present the results and conclusions of the social audit in a mass gathering and prepare the report accordingly.
i) Execute all necessary activities with guidance from the Social Audit Organization and in cooperation with the local HFMC.

2.6 SELECTION AND MOBILIZATION OF LOCAL RESOURCE PERSONS

During the social audit period the Social Audit Organisation will select local resource persons, one in each health facility holding a social audit, in order to develop competent human resources for Social Audits at the local level. The local resource persons will be selected in consultation with the Social Audit Local Support Group. In the selection process preference will be given to local teachers or experienced and mature community level facilitators working in the respective VDCs in governmental or non-governmental organisations. The major duties of the local resource persons will be to mobilize the local community in the social audit process, to determine the venue, participants and time for focused group discussions, to take notes of the discussions and interactions, and to carry out other necessary work in coordination with the Social Auditor.

2.7 CAPACITY BUILDING

Special attention has to be given to capacity building on related areas of the social audit process in order to bring tangible changes in service delivery (which the general public can easily see)

through successful implementation of the social audit process. Building the capacity to implement and institutionalise social audits in the health sector is a priority for the first five years of the programme. The capacity building programme shall mainly cover central and regional level office-bearers, representatives of Health Sector Social Audit District Committees, DP/HOs, Social Audit Local Support Groups, HFMCs, health workers at the health facility level, Social Audit Organisations and Social Auditors. Different types of capacity building programmes shall be tailored and delivered to people at various levels in order to develop competent human resources at the local level.

- Initially, basic orientation will be imparted by PHCRD to concerned office-bearers at the central and regional levels on the basic concept, process and steps of the social audit prescribed by the operational guidelines.
- Orientation will be conducted for the Social Audit District Committee, the concerned employees of the DP/HO - especially supervisors and health facility in-charges -, members of the HFMC and Social Audit Local Support Group, on the basic concept, monitoring and their role in the entire process of the social audit.
    a. Orientation training will be provided to in-charges and health workers at the health facilities on the concept and necessary preparation for the social audit.
    b. A comprehensive training will be imparted to Social Auditors focusing on the basic concept of the social audit, skills, processes, facilitation skills, information/data collection processes, methods of participatory analysis of information/data and mass mobilization skills in information/data collection and analysis.
- All the orientation and training related to the social audit implementation will be organized by the DP/HO. However, the DP/HO may obtain necessary support from any organisation or individual as per the need.
- To raise public awareness and disseminate information about social auditing, linkages will be made with existing community initiatives and organisations, such as Female Community Health Volunteers (FCHVs), mothers' groups, forestry user groups etc.

2.8. MOBILIZATION OF MASS MEDIA

Making necessary arrangements to disseminate the results and findings of the social audit to the community, policy makers and stakeholders through local and national media is important. It helps fulfil people's right to information by presenting the information required and the results to be implemented, and offers the opportunity to learn from the strengths and weaknesses of the social audit implementation. For this purpose, journalists should be involved from the beginning of the social audit process preparations. They should be made aware of the advantages of disclosing the social audit findings and the subsequent benefits to the public. A dissemination plan should be formulated by the DP/HO and the Social Audit Organisation in coordination with journalists and their networks at the local level prior to the social audit process.

CHAPTER 3
PROCESS, METHODS AND TOOLS OF THE SOCIAL AUDIT

3.1 TIME FRAME

Sub-health posts, health posts, primary health care centres and district hospitals should each complete all the processes involved in social audit planning and orientation at the health facility level, preparation for data collection, information/data collection, analysis of information, holding the public mass gatherings and report writing within a maximum of six days in the Tarai, and seven to eight days (including travel time) in hill and mountain areas. The following steps and methods will be completed to accomplish the entire social audit process. The timeframe for implementing the social audit is presented below.

Table 1: Stipulated timeframe for implementation of the social audit

SN	Proposed Activities	Stipulated Time	Special considerations
1	Travel day.	1 to 2 days	Only for hill and mountain areas.
2	Orientation, preparation and interaction with health facility staff and health facility management committee.	1 day	Delegation of work among local resource person, social auditor, and social audit local support group.
3	On-site observation, information gathering at health facility, exit interviews.	1.5 days	Delegation of work among local resource person, social auditor, social audit local support group.
4	Information gathering in the community (focus-group discussions and tracking of Aama beneficiaries).	1 day	Conduct two focus group discussions (FDG): one of a women's group and one of a Dalit community; if not possible, a mixed group. FGDs should be held in different wards.
5	Analysis of information.	1 day	Ensure the presence of the social audit local support group and local resource person.
6	Public mass gathering, community score card and action plan.	1 day	Complete the public mass gathering within a maximum of three hours
7	Prepare the social audit report.	0.5 day	Submit to the DP/HO.
	Total	7 days	6 days in Tarai and 7/8 days in hill and mountain areas.

3.2 FIRST STEP – PREPARATION AND IMPLEMENTATION OF THE SOCIAL AUDIT ACTION PLAN

3.2.1 District Public/Health Office:

- In consultation with stakeholders, prepare and gradually implement a five-year social audit action plan to cover all health facilities in the district. The Health Sector Social Audit

District Committee will approve the plan. Make necessary arrangements to submit the five-year social audit plan to PHCRD.

- Create a facilitating environment by imparting information about the action plan among concerned health facilities and all other stakeholders.
- Conduct designated orientation and training programmes for capacity building.
- Select and make agreements with the Social Audit Organisation.
- Carry out necessary coordination and collaboration with all the stakeholders according to the need and importance.

3.2.2 Social Audit Organisation:

- Select necessary human resources (social auditors) and make contracts with them.
- After making a contract with the District Public/Health Office, select local level facilitators and make other necessary preparations.

3.3 SECOND STEP – CAPACITY BUILDING

3.3.1 Central and Regional Orientation: Orientation will be organized by PHCRD to concerned central and regional level office-bearers in order to increase their understanding of the importance of the social audit and its results. The potential participants in the central level orientation programme will be the representatives of various divisions and sections of the Ministry of Health and Population (MoHP), representatives of concerned divisions of the DoHS, and representatives of external development partners working in the health sector. Likewise, office-bearers of the RHD, office-bearers of the Regional Health Training Centre and representatives of external development partners working at the regional level should participate in the regional level orientation.

Topics for Orientation

- Concepts and the importance of the social audit
- Implementation process of the social audit guidelines
- Steps, methods and process of the social audit
- Potential challenges in implementation and potential roles of different agencies

3.3.2 District Level Orientation: The district level orientation will be conducted by facilitators trained at the central level in coordination with PHCRD. The participants will be members of the Health Sector Social Audit District Committee, the social audit focal person of the DP/HO, other concerned health workers and other participants deemed appropriate by the district committee.

3.3.3 Local Health Facility Level Orientation: The orientation at the health facility level will be conducted by facilitators of the Social Audit Organisation trained at the district level in coordination with the Health Sector Social Audit District Committee. The participants will

be members of the Social Audit Local Support Group, members of the HFMC, health workers at the health facility and other participants deemed appropriate by the local support group.

Topics for District and Local Level Orientation

- Concepts of the social audit
- Objectives and strategies of the social audit
- Steps, method and process of the social audit
- Roles of the Social Audit District Committee, District Public/Health Office, Social Audit Organisation, Social Auditor, Health Facility Management Committee and Social Audit Local Support Group in the social audit process

3.3.4 District Public/Health Office Orientation: The DP/HO should formally introduce the Social Audit Organisation in its monthly regular meeting and orient participants by covering the topics described in 3.3.3 above. The district supervisors should also be invited to participate in the orientation. This mechanism is expected to ensure a relationship between health workers and the Social Audit Organisation that will ultimately help the Social Audit Organisation to implement the social audit process effectively.

3.3.5 Training to Social Auditors to implement the *social audit:* A district-level three-day orientation training programme will be jointly conducted by trained facilitators of the Social Audit Organisation. The facilitators will receive training from the Regional Health Directorate and PHCRD. Social auditors from throughout the district shall be potential participants in this programme. Training for two or three districts could be conducted at one time, keeping in mind the need and resources.

Table 2: Training Outline for Social Auditors

Day/ Session	Session I	Session II	Session III	Session IV
Day I	• Objective and topics to be Covered • Concepts of Social Audit	• Presentation on health services being delivered by health facilities	• Data/Information collection methods: Interview, FGD	• Exit Poll, Citizen Charter • Information and data collection from health facilities
Day II	• Preparation for field work • Field practice of key social audit methods in nearby health facility	• Field practice continues	• Field practice continues	• Analysis of information and data
Day III	• Presentation of field learning and discussion	• Preparation of mass meeting and facilitation	• Preparation of mass meeting and facilitation continues	• Monitoring of social audit process • Report preparation of social audit.

3.4 THIRD STEP – PREPARATION OF THE SOCIAL AUDIT

The preparatory steps have been divided into those for the district and local levels.

3.4.1 District Level

- The DP/HO will inform the various health facilities and stakeholders about the district level social audit action plan.
- The Social Audit Organisation will be formally introduced at the monthly meeting of health in-charges. District supervisors will also be present at this time. This process will help build harmonious relations between the Social Audit Organisation and local health workers and facilitate implementation of the social audit process.
- The DP/HO and the Social Audit Organisation will jointly set the date for the social audit in coordination with the concerned health facilities.
- The necessary logistics, tools and techniques for the social audit process will be organized.

3.4.2 Local Level:

- The Social Audit Local Support Group will coordinate the HFMC, the health facility and health workers, local level stakeholders and the general public.
- A sequential timetable for the social audit will be prepared. (Set the day and time to collect and analyse information and data, and to present the results and findings.)
- The venue for the public mass gathering will be set and the primary results of the social audit will be presented in the gathering.
- Necessary pre-information will be given to all concerned about the mass gathering and other necessary topics.

3.5 FOURTH STEP – IMPLEMENTATION OF THE SOCIAL AUDIT PROCESS

3.5.1 Orientation: After arrival at the health facility, the Social Auditor will orient the HFMC, health staff, and the Social Audit Local Support Group based on the format given under section 3.3.3 above. Participants for the orientation will also be selected based on the instructions given above.

3.5.2 Information and Data Collection: It is important to take into account the following three aspects at the beginning of implementing the social audit in line with its principles and underlying spirit:

- First, observe the various efforts and activities undertaken to provide health services to the general public, or investigate what kind of health services the public is receiving, and from where and how the health services are received.
- Second, gain a clear understanding of the perceptions of the general public on how health services available at the local level are provided (such as whether health check-ups are provided free of cost, whether medicines are available free of cost, or whether patients are told to purchase medicines from the market), the conduct and behaviour of the health workers, and the quality of the services. The Social Auditor should discuss this with people gathered at tea shops and other places and prepare notes of the discussion.

- Third, create a congenial environment by developing informal relations with health workers. Focus should be given to enhancing cordial and friendly relations from the beginning, keeping in mind that receiving the necessary information will be practically difficult if the relationship is merely formal, as the health workers are the key informants.
- Considering the three suggestions mentioned above, the following tools and methods have been prepared to collect information at both the health facility and community levels.

A. **Observations at the Health Facility:** In the social audit process comprehensive information on attempts made by the health facility to improve the quality of health services being delivered should be recorded from the perspective of good governance. Attention should be given to the following factors in the observation process:

   - Legal provision has made it mandatory for health facilities to have a visible citizens' charter reflecting available services in the facility and their responsibilities. The citizens' charter should categorically state the available health services, the process of accessing these services, the required time to access each service, the provision of any fee wherever applicable, the health worker responsible to deliver the service, and the responsible authority to record and respond to public grievances, in cases of dissatisfaction with the service. First, observe and take note of whether the citizens' charter is properly placed at the health facility in accordance with the stipulated standard. Observe whether the information about free health care services, the maternity incentive and four ANC visits incentive, the free distribution of medicines and free delivery service under the Aama programme are displayed on the notice board and take notes accordingly.
   - Observe and take notes on the number of information boards displaying different kinds of information on services and good governance, and whether they are clearly and systematically presented.
   - Observe and take note of whether the name list of women who received free delivery service and the maternity incentive is displayed in the notice board. This is a mandatory provision.
   - Observe and take note of whether the health facility environment is clean, whether waste management is properly practiced, and whether proper security is provided etc.

B. **Information Gathering from the Health Facility:** Collect information and data from the health facility. The information is generally obtained from various registers, records and documents maintained at health institutions.

   I. **Information on mothers receiving free delivery services:**

   A disaggregated list of mothers receiving free delivery services and the maternity incentive during the fiscal year should be recorded in the table below:

Table 3: Description of Mothers Receiving Free Delivery Services

Fiscal Year………….. Information Collected on ……………

Four-monthly	First	Second	Third	Remarks
Number of mothers receiving free delivery services and incentives				
Among the number above, the number of pregnant women attending four ANC check-ups regularly				
Number of mothers receiving free delivery care and incentive (disaggregated)				
Brahmin, Chhetri and Sanyasi				
Poor Janajatis				
Religious Minorities				
Well off Janajatis				
Dalits				
Other poor groups				

Note: All the above information could be gathered from the maternity register with the help of the health facility in-charge and nursing staff.

II. Home visits to mothers who received free delivery care:

In the table below, prepare an inclusive list of randomly selected mothers who received the maternity incentive under the free delivery care services based on the list above, with a balanced representation of ethnicity and geographical areas. The number of mothers is prescribed as below:

- Randomlyselect the names of 5 women from a health facility that has fewer than 50 delivery cases per year;
- Randomly select the names of 10 women from a health facility that has 50 to 200 delivery cases per year;
- Randomly select the names of 15 women from a health facility that has more than 200 delivery cases per year.

Table 4: List of Mothers Receiving Free Delivery Service under the Aama Programme

Fiscal Year………….. Information Collected on ……………

SN	Name of Mother	Address	Age	Delivery Date	Date incentive received	Date discharged from health facility	Ensure 4 ANC (4th 6th 8th and 9th month of pregnancy)

Information should be collected on the form prescribed above from selected women visited at their own homes for the interaction. Information should also be gathered on whether the women interviewed made four ANC visits and, if yes, whether they received incentives; whether women who delivered at the facility received incentives; whether they paid any fee in the health facility during delivery; and on the behaviour of the health workers and nursing staff. Any other interesting information or cases may be recorded separately.

Note: It will be easy to find the homes of the women selected for the detailed interaction during the focused group discussion. Local FCHVs can also be helpful in locating the homes of the selected women.

III. Store Entry and Stock Outs of Medicines:

It is important to ensure the availability throughout the year of the medicines that the government is providing for free distribution through health facilities. The availability of medicines at the health facility throughout the year can be assessed by filling out the form attached in Annex - 2**.** Record the number of entries of antibiotics and other essential medicines, and also find out the number and duration of stock-outs of these medicines in a year. This information may be recorded from the store register. If the time is not sufficient during the social audit process, do not forget to at least record the stock-outs. Also record any excessive stocks of these medicines.

IV. Income and Expenditure of the Health Facility:

All types of income and expenditure made by the health facility including money supplied by the government for providing free delivery care and free health care (unit cost for free delivery care and a fixed amount of money for providing free health care services) should be carefully recorded for transparency purposes. The table below has been prepared for recording all related financial information.

Table 5: Details of Income and Expenditure of the Health Facility

Fiscal Year…………..   Information Collected on ……………

Income			**Expenditure**	
Description	Number	Amount received	Descriptions	Amount
Carried forward from previous year (cash in hand and bank balance): Total			Salary of new employees recruited by local health facility management committee. Salary and allowances	
Unit cost for normal delivery service			Medicines, medical supplies, equipment	

Unit cost for complicated delivery service			Expenses made for quality improvements	
Unit cost for caesarean delivery			Infrastructure development	
Money received against Registration			Employee incentives	
Unit cost for free health care services			Bank balance	
Others			Cash in hand	
Total			Total	

V. Attendance of Health Workers at the Health Facility:

The attendance record of health workers designated by the health facilities to ensure the delivery of quality health services should be reviewed to assess their regular presence in the health facility. The attendance record should be collected in the table below from the staff attendance book, with the help of the health facility in-charge.

Table 6: Attendance of Health Workers at the Health Facility

Fiscal Year………….. Information Collected on ……………

SN	Name/position of health worker	Annual attendance at the health facility (days)	Kaj/Deputation during the year	Public holidays	Leave days	Absent days	Total

VI. Utilisation Records of Immunisation, Family Planning and Safe Motherhood Programmes:

As the progress made against targets in health services delivery shows the effectiveness and efficiency of the health facility, it is essential to (publicly) disclose the targets and achievements of the health facility's major programmes. The targets and achievements made in utilisation of immunisation, family planning and the safe motherhood programme should be categorically recorded in the format provided in Annex - 3, with the help of the health facility in-charge.

VII. Utilisation Records of Miscellaneous Services from the Health Facility:

In addition to all the above, and in order to assess the workload/coverage of the health facility, identify the current situation of mobilization and utilisation of medicines and other resources and the service utilisation ratio by men/women and record them using the following format. This information will help to assess the workload and popularity of the health facility.

Table 7: Utilisation Records of Miscellaneous Services from the Health Facility

Fiscal Year…………. Information Collected on ……………………………………..

Total No. of patients treated last year:…………… Total No. of patients treated previous year:…………..

Type of Service	No of patients receiving health services from health facilities												Reasons behind the difference between the current and last fiscal years
	First Quarter				Second Quarter				Third Quarter				
	F		M		F		M		F		M		
	Last Year	This Year	Last Year	This Year	Last Year	This Year	Last Year	This Year	Last Year	This Year	Last Year	This Year	

VIII. Interaction with Health Workers:

The provision for interaction with health workers has been made to assess the effectiveness of the institutional management, attempts to improve the quality of services in the health facility, and initiatives taken to ensure accountability and good governance. The interaction should be facilitated considering the indicative check list attached in Annex - 4. The issues in the check list could be modified to meet local context and need.

IX. Interaction with the Health Facility Management Committee:

Interaction with the HFMC is an important and integral part of the social audit. The interaction with HFMC must be facilitated by using the check list attached in Annex - 5.

Consider the following factors while facilitating interactions with health workers and the HFMC:

- Two persons, including a member of the Social Audit Local Support Group and a Social Auditor, should jointly conduct a focus group discussion. One person should facilitate the discussion and the other should take notes of the issues raised during the discussion session. Notes should be taken literally, without analysis of the participants' answers. The interaction should be facilitated neutrally, without giving preference to any side. *(The member of the Social Audit Local Support Group is often local and could be seen as taking the side of one group or other.*

Hence the person should be sufficiently careful so that the participants do not feel that preference is being given to one group or another.)

- Create an environment favourable for all participants to articulate their opinions and offer an equal opportunity to everyone to speak. Do not hesitate to stop participants from talking too much at an appropriate time, but without hurting their feelings.
- Do not make any suggestions or provide answers under any circumstances, but rather remain neutral during the discussion.
- Conduct the discussion according to the pre-determined check list of contents in a sequential manner.
- Present a summary of the discussions and seek participants' consent after the conclusion of the discussion. This can be done as follows: 'Our discussion has almost ended. What I understand from what you said is ……Please do not hesitate to correct me if I am wrong.'
- Conclude the discussion by amending the report as needed and thanking the participants.

X. Exit Interviews:

The exit interview poll is proposed as an important tool to capture the perceptions and reactions among service recipients to the health services provided by the health facility and the behaviour of service providers. It is conducted immediately after users exit the facility. Client exit interviews should be taken from at least 5 patients in each sub-health post, 10 in each health post, 15 in each primary health care centre and 25 in each district hospital. The questionnaire for the client exit poll is presented in Annex - 6. Participants for the exit poll should be selected by ensuring the representation of different geographical locations covered by the health facility, women and people from excluded groups.

Consider the following factors during exit interviews:

- Assure the patients of confidentiality such that their opinions and comments will remain secret and not be quoted anywhere.
- Make the interviewees feel comfortable and encourage them to articulate their opinions confidently, without hiding anything.
- Ask interviewees to reveal frankly if there are constraints to them articulating their opinions and offer assistance if required. Facilitate the situation by sharing relevant experiences with them so they feel free to speak out.
- Be attentive to whether patients are tired, not recovered well, or are feeling inconvenienced.
- Service recipients feel uncomfortable making critical remarks if the interview site is close to the health facility where they received services. Therefore, choose an appropriate venue.
- Patients are comfortable responding in their mother tongue, so emphasize the local vernacular for discussion. This may be possible with help from the local resource person. If not, arrange for translation with the help of any member of the local support group.

C. *Information and Data Collection at the Community Level*

Capturing the level of understanding, experiences and reaction of service users on the health services being provided by the health facility is key to the social audit process. In order to facilitate effective and efficient discussion, follow the discussion process explained in Annex - 7 and the focus group discussion indicators explained in Annex - 8. The person facilitating the discussion should internalise these process and indicators before conducting the focus group discussion. The discussion should be led openly and without referring to a note book or check lists. Follow the methods described below to capture the community reaction:

Focus Group Discussion: Focus group discussions should be organised with excluded groups (Dalits, marginalized Janajatis, economically poor people and geographically remote communities) from the catchment area of the health facility. At least 2-3 focus group discussions (one for Dalit and another for non-Dalit mothers' groups) should be arranged in each health facility with 12-16 participants invited for each discussion. One focus group discussion should be organized in a distant village of the health facility catchment area. If there is not a large Dalit community in the VDC, organize a focus group discussion in a mixed community.

Focus group discussions should be held at the SHP, HP and PHCC levels based on the above, but for the social audit process at hospitals, one focus group will be enough as a sample and further discussions should be conducted with the nearest excluded community.

- The Social Auditor should lead the focus group discussions in cooperation with the Social Audit Local Support Group and local resource person. A woman facilitator should facilitate the women's focus group discussion whereas mixed focus group discussions may be facilitated by either a man or a woman.
- Hold brief discussions with FCHVs in the ward where the health facility is located to capture their perceptions on the following: the general public's views on the local health facility and its services; local willingness to use, and trust in, the public health facility; the barriers existing for pregnant women, children, senior citizens or other villagers to receive health services; the availability of free medicines in the health facility; the regularity of health workers at the health facility; the behaviour and conduct of health workers; the awareness of all villagers on the types of services and facilities provided by the health facility; the sanitary condition including the provision of toilets, water and other facilities in the health facility.

Consider the following factors while facilitating the focus group discussions:

- Let participants know that the focus group discussion will centre on exploring citizens' perceptions of the effectiveness of the services provided by the health facility, the behaviour of the health workers and the overall standard of the health service. Stress that issues raised during the discussion will help make the health service more effective.

- Request all participants to present their opinions in a confident manner and assure them of confidentiality i.e. that comments made during the discussions will not be quoted anywhere under the speaker's name.
- Encourage all participants to express their opinions equally, on a turn-by-turn basis, and adopt measures to control talkative participants so as to let all participants express themselves in a systematic manner.
- Discuss all the topics included in Annex - 8 one after another. Properly understand the community's perceptions of each of the indicators during the discussion and note them down accordingly. At the end of the discussion, summarize the key points and obtain the participants' agreement and consent.
- Separately record the main summary points from each of the focus group discussions. Integrate and correlate all the results and take notes about the differences and similarities coming from the various groups.

3.5.3 *Integrating the Results of the Community Scorecard Exercise*: Some health facilities will have used the community score card prepared by the Ministry of Health and Population. If so, the results of the community score card should also be considered and used in analysing the results of the social audit process. The results should be presented during the mass gathering and also be included in the final report of the social audit.

3.5.4 Information/Data Analysis: At this stage, the task of gathering all the information and data from different sources has been completed. The next step is to analyse it and reach a conclusion. The analytical job is primarily that of the Social Audit Organisation and the Social Auditor. However, ensuring the involvement of the Health Facility Management Committee, the Social Audit Local Support Group and health workers at the health facility in the data analysis process adds to the validity of the conclusions and results, and enhances the sense of ownership in the overall social audit process among all the stakeholders. Emphasis should be laid on adopting a neutral position while drawing conclusions.

Consider the following steps while analysing the information and data:

1. First, organize all the information and data gathered from different sources and methods.
2. Fill in all the forms provided. Analyse every aspect of the information to identify the positive comments and issues requiring further action.
3. Analyse the commonalities, differences and the diversity of information provided by the community, the health facility and the health workers, and make notes of positive aspects as well as issues needing improvement. If some issues are raised by all different types of respondents, prioritize these issues.
4. If some information and data is doubtful or unclear, immediately meet the concerned individual or body for the necessary verification.
5. Record the concerns raised by the majority of the respondents as priority issues. However, the reason that any particular concern is categorized as an issue should be

mentioned (e.g. it is a legal provision but is not complied with, or it is a concern of the majority of people consulted).

6. Next, identify the key positive aspects and areas for improvement in the future under the specific areas, e.g. access to and utilisation of available health services, management of the health facility and participation.
7. Prepare a comprehensive presentation for the mass gathering by incorporating all positive aspects and areas for improvement from the overall social audit process. The presentation should be shared with the Health Facility Management Committee and health workers in advance. The outline of the presentation is explained in Annex - 9.

3.5.5 Mass Gathering at the VDC Level: A mass gathering of the general public and local stakeholders should be organized as the final step of the social audit process at the health facility level. The mass gathering is a very important programme where a work plan will be developed to address the issues discussed and summarised after disclosure of the results derived from the different social audit tools.

A. At the outset of the mass gathering, the objectives, rationale, definition and importance of the social audit exercise should be presented in a comprehensive manner. This enables the participants to understand the seriousness of the issues, so it will be easier in the future to effectively address them.

Objectives of the mass gathering:

- To disclose the primary results and findings from the social audit.
- To collect participants' suggestions and comments about people's access to the available health services, their quality and effectiveness, and the health facility's degree of accountability.
- To formulate an action plan including a monitoring provision to address the issues raised to ensure service quality, ready access and overall effectiveness.
- Ensure the commitment of all concerned stakeholders for the effective implementation of the action plan and its monitoring.

B. For various reasons the general public may not be aware of the different health services provided by the Government of Nepal. Therefore, it is important to impart brief information about these services when people's comments, opinions and recommendations are being solicited. Either a health facility in-charge and/or a district public/health officer should provide information on the available health services. The presentation should focus on the following:

- The services provided at each facility and in the community;
- The provision of priority programmes in the health sector;
- The service delivery process; and
- Examples of best practices.

C. Collection of Community Perceptions: This is a rapid process for assessing participants' perceptions on the available health services. Distribute one of the checklists attached in Annex - 10 to groups of 2 to 4 participants from different geographical areas**.** This will help in gathering citizens' perceptions about the overall management and performance of government health services. The results of the community perception checklist should be quickly analysed and presented in the same mass gathering.

D. The mass meeting should be organized at the time and venue determined earlier according to the detailed programme available in Annex - 11**.** Considering the sensitivity of the mass gathering, the following fundamental factors should be followed in facilitating the meeting.

- **Venue:** The mass gathering must be organized at the health facility compound. Likewise the district level mass gathering must be organized in the district hospital.
- **Participants:** The mass gathering is the most important and final event of the social audit process. Hence, the representation of all classes, genders, ages, ethnic groups, geographical areas and all other stakeholders is required for the process. The following participants should be invited to the mass gathering but the presence of the general public must include at least the minimum number mentioned below.
    - *At least 20 from among all the service recipients, including male and female, ethnic groups, Dalits, Madhesis, Muslims, and backward groups covered by the district hospital and all health facilities on the basis of geographical area and representation.*
    - *Nine Female Community Health Volunteers from all wards of the VDC. In some VDCs the number could be higher. In the district level mass gathering, female health volunteers of the municipality and village where the hospital is located should be included as participants.*
    - *At least 15 teachers, School Management Committee members, students and guardians representing all the schools at the local level. For the district gathering, teachers, guardians, Management Committee members and students of 2-4 schools near the district hospital should be invited.*
    - *At least 20 participants representing the Aama programme, pregnant women, children, youth, and senior citizens from among the service recipients.*
    - *Six participants from the ward where the two focus group discussions were held earlier. At the district level there will only be three participants as only one focus group discussion is organized in such cases.*
    - *Representatives of the political parties.*
    - *Head/Chairperson of the municipality/VDC of the geographical areas covered by the health facility, Chairperson or office-bearers of community based organisations, members of mothers' groups, users committees (forest, drinking*

water, irrigation etc), representatives of working NGOs, and representatives of religious institutions (temples, churches, and mosques) of the area.

  - *At the district level mass gathering, also invite representatives of the concerned government offices in the district since the results of the social audit of the district hospital and the overall district health facilities are presented at the gathering.*

- **Invitation:** In a timely manner, dispatch formal invitations to all invitees. Include the venue and time for the mass gathering, the tentative time of the programme's completion, and the list of agenda items to be discussed. It is best not to rely only on formal invitations. The Social Audit Local Support Group and the Social Auditor should call on invitees in an informal manner and request their presence.
- **Time:** Facilitate the mass gathering in such a way so that it can be completed within three hours. In the case of district meetings, up to four hours may be required as the objective is to present the social audit results of the entire district at the district level event.
- **Facilitation:** The Social Auditor should facilitate the programme and inform the presenters in advance about the stipulated time and the importance of stopping their presentation when their time is up. Allow all the participants to speak and express their views while informing them that the programme should be completed within the stipulated time. Encourage service recipients of the health facility to express and share their views openly.
- **Commitment:** Create an atmosphere that will make it easy for all concerned stakeholders (especially the DP/HO, local health facility and VDC) to make public commitments and agree to a monitoring mechanism to effectively track implementation of the recommendations made by the social audit.
- **Action Planning:** At the end of the mass gathering an action plan with monitoring provisions will be formulated based on the issues raised (focusing on people's access, utilisation and management of the available health services and their participation). Mobilisation of local resources for the effective implementation of the action plan through effective coordination with other agencies is very important. This action plan should also be presented in the VDC council so that they will assume some ownership and provide leadership - for example by incorporating the action plan within their annual VDC work plan.

3.5.6 Action Plan Framework: As stated above, a practical action plan should be formulated to address major issues identified from the analysis of information and data gathered during the social audit process in order to improve the delivery of quality services at health facilities. Effective implementation of an action plan through the provision of an accountable and responsive health service is expected to resolve issues and concerns gradually over time. The action plan should be formulated on the basis of the matrix given below:

Table 8: Action Plan Framework

Fiscal Year…………..   Information Collected on ……………

Issues raised during the social audit	Proposed actions to address the issues	Completion period	Responsible body or person	Responsible body or person for monitoring	Possible Support Organisation
		from …..to ……..			

3.6 FIFTH STEP - MASS GATHERING AT THE DISTRICT LEVEL

- Upon completion of the social audit in the planned health facilities in the first quarter of each fiscal year effective from 2069/70, the social audit for the district hospital should be conducted. A comprehensive district report should then be presented in the district level mass gathering by integrating the findings of the district hospital social audit and the consolidated results of all the social audits in other health facilities conducted during the fiscal year. A consolidated action plan and monitoring plan should also be formulated to address the issues and concerns flagged in the district level report.

- Officials from the District Development Committee and government line agencies, political party leaders, representatives of non-governmental organisations, human right activists, journalists and local intellectuals should be invited to participate in the district level mass gathering. At the end of the mass meeting the issues identified for further improvement should be prioritized for action planning with the commitment of key stakeholders.

- The social audit reports from all health facilities should be compiled to prepare a single district level report. The District Public/Health Office should design the process taking into account the local context and availability of funds. The report may be prepared by organizing a one-day workshop attended by everyone involved in the social audit process at the health facility level.

  Note: The detailed programme for the mass gathering is highlighted in Annex - 11.

3.7 IMPORTANT ASPECTS TO CONSIDER WHEN CONDUCTING THE SOCIAL AUDIT

1. Pregnant women, recently delivered mothers, other health service recipients, health workers, local political leaders, media professionals, and other stakeholders should be meaningfully engaged at appropriate stages of the social audit process.

2. Since the health facility is responsible for implementing all health programmes and the delivery of health services, the mass gathering – which is the most important part of the social audit process – should be organized in the health facility itself.
3. The social audit process should emphasise assessing the health facility's income and expenditure (especially the money that government is providing for different types of free health care service based on unit costs) and should also assess the targets and achievements made by the health facility in delivering health services. Regarding management of the health facility, an assessment of participation in regular decision making processes should be made, and the contributions of individuals and/or organisations towards various activities of the health facility should be explored.
4. The comprehensive report of the social audit, prepared on the basis of the information gathered from different sources, should be either distributed or posted at the programme venue on the day when the mass gathering is organized.
5. The issues identified during the social audit process should be duly addressed through formulation of a practical action plan. The commitment and role of local level stakeholders in implementing the action plan should be highlighted in the plan itself.
6. Participants in the mass gathering, which is the most significant event of the social audit process, should be facilitated for meaningful discussion and allocated sufficient time. The poor, women and excluded communities should be especially encouraged to express their perceptions and opinions at the meeting. Careful attention should be given to the issues raised by the poor, women and excluded groups during the in-depth discussion and sufficient time for this should be allocated.
7. The issues and concerns identified during the social audit process should be brought to the attention of the community, policy planners at various levels, and stakeholders through mobilising local and national media.
8. It should be noted that the social audit process aims to improve the health service delivery mechanism to make services more effective, efficient and transparent but not to identify the weaknesses and limitations of any individuals.

CHAPTER 4
MONITORING AND REPORTING

4.1 MONITORING OF THE SOCIAL AUDIT

Monitoring is an essential element of the entire social audit process and central to assuring the effective implementation of the five-year social audit action plan formulated by the District Public/Health Office. Monitoring should assess whether the social audit process is following the steps outlined in the guidelines (following appointment of the Social Audit Organisation) and should help make the process more effective and timely. Monitoring is also expected to help correct any deviations from the agreed process on the basis of experience. Process monitoring shall be carried out by the centre to the district, and by the District Public/Health Office and Social Audit District Committee to the health facility level.

4.2 MONITORING PROCESS

Central level institutions should be responsible for process monitoring of district level activities and the DP/HO along with the Social Audit District Committee should monitor the process at the health facility level.

It is essential to effectively monitor implementation of the action plan developed on the basis of issues raised and suggestions made during the social audit process. For this reason, arrangements should be made to actively engage the HFMC, Social Audit Local Support Group, DP/HO and I/NGOs active at the local level in the monitoring process. A system should be established to incorporate monitoring of the action plan developed during the social audit process within regular integrated supervision being carried out by the DP/HO. This is expected to monitor fulfilment of commitments made and the availability of necessary resources for effective implementation of the action plan. The social audit and its monitoring should be made an important agenda item for meaningful discussion in all regular meetings and periodic reviews. The progress and achievements made in the social audit process should be presented with due emphasis in the annual report prepared by the DP/HO.

Accordingly, the integrated action plan (to implement the social audit outcome) being prepared at the district level will be monitored by the Social Audit District Committee, the Reproductive Health District Committee, the RHD, the DoHS, and the PHCRD.

4.3 MONITORING FRAMEWORK

The following step-wise monitoring process has been designed for effective implementation of the social audit recommendations:

A. Based on the comprehensive report of every stage of monitoring, the concerned agency will be responsible to gradually implement the actions recommended. Monitoring of the overall social audit process will be carried out as follows:

- The monitoring process will ensure involvement of all agencies including central level divisions and departments, the RHD and the DP/HO. Monitoring should include the entire social audit process in general and should also review the effective implementation of recommendations made (including the action plan) on the basis of the social audit results.
- The results of the social audit and progress made in implementing the recommendations should be embedded in the district level quarterly review meetings. District level progress should be incorporated in the regional and national reviews respectively.
- In preparing the progress report emphasis should be given to the analytical presentation of tangible changes that citizens have observed and/or experienced after implementation of the action plan developed at the end of the social audit process.

B. Despite its overall role in monitoring the entire social audit process, the PHCRD should have an independent agency or individual monitor a few selected districts as a sample every year. Similarly, the Social Audit District Committee should have an independent agency or individual review the social audit of some selected sample health facilities. Regular integrated supervision by the DP/HO should monitor the implementation status of the social audit action plan.

C. External development partners and non-governmental organisations working at the district level should be encouraged to monitor implementation of the social audit action plan formulated to address the issues and concerns raised in the social audit.

D. The Social Audit Organization is primarily responsible to submit the final report of the social audit process to the DP/HO. Subsequently, the DP/HO should send the report to the PHCRD and RHD after receiving approval from the Social Audit District Committee. The monitoring format is given in Annex - 12.

E. The local level health facility and DP/HO should include the status of progress made against implementation of the social audit action plan developed at the end of the social audit process in their quarterly reports.

F. The DP/HO should submit the final report of the social audit process to the PHCRD not later than December 15 (Mangsir) since resources will be made available to carry out the social audit in the first quarter of the fiscal year. The PHCRD should integrate all reports from districts and monitoring reports by independent agencies or individuals and include them in the annual report of the DoHS. A summary of the social audit report should also be presented in the Joint Annual Review jointly organized by MoHP and external development partners.

G. The issues raised in the social audit process should be presented in the VDC council so that these issues can be addressed at the local level.

Table 9: Social Audit Monitoring Framework

Level	Responsibility	Process Indicators	Outputs Indicators
District Level	Primary Health Care Revitalization Division Regional Health Directorate (designated regional focal person)	• Formulation of social audit district level plan by DP/HO and subsequent approval by social audit district committee • Implementation of various capacity development programmes • Monitoring of the social audit process at the health facility level by DP/HO • Organisation of the joint mass gathering at the district level to present the consolidated results of the social audit at the local level and district hospital level • Preparation of the consolidated district social audit report • Formulation of the action plan and its effective implementation to address the issues and concerns raised during the social audit	Overall District • Availability increased and improved health services • Increased access of general public to health services • Gradual quality improvements in the delivery of health services • Improvement in the behaviour of the service providing organisation and health workers
Health Facility Level	Health Sector Social Audit District Committee District Public/Health Office	• Formation of the Social Audit Local Support Group with appropriate composition • Organising capacity development programmes • Preparation of the social audit process • Information provided to the social audit committee • Authentic and quality information gathering at the community level	Health Facility Level • Availability increased and improvement in health services • Increased access of general public to health services • Gradual quality improvements in the delivery of health services • Improvement in the behaviour of the service providing organisation and health workers

Community Level	Health Facility Management Committee Social Audit Local Support Group	• Social mobilization for the participation of people from remote villages and clusters, women and excluded groups • Participation in the social audit process: focus on number, quality, diversity incl. poor and excluded • Social audit action plan to address issues and effective monitoring	Catchment Area of Health Facility • Positive attitude of general public towards health services • Availability increased and improvement in health services • Increased access of general public to health services • Gradual quality improvements in the delivery of health services • Improvement in the behaviour of the service providing organisations and health workers

4.4 **REPORTING**

On completion of the social audit in compliance with all the suggested processes, tools and methods, including the mass gathering, the Social Audit Organisation should prepare a consolidated district level social audit report and submit it to the DP/HO and local health facilities. The DP/HO should then present the report to the Social Audit District Committee for discussion and approval.

After approval by the Social Audit District Committee, the report should be forwarded to the PHCRD. The report should generally include the entire process, the results, issues, concerns, best practices, areas for improvement and findings of the monitoring process. The report should also contribute to comparing the goal and targets, achievements and progress of the health services and programmes. Issues and concerns raised during the mass gathering by participants along with their recommendations should be included. The report is expected to be useful for health programme implementers, external development partners and other stakeholders. The report should be prepared following the outline format in Annex - 12, so that all important aspects are covered.

4.4.1 Information and Data Related to Health Services: A brief description of the health services provided along with the goal, objectives and progress made should be prepared on the basis of the information and data gathered during the social audit process and should be included in this section of the report.

4.4.2 Community Perception on Health Services: The general perceptions of citizens captured during the focus group discussion, observations and issues raised during the mass gathering should be an integral part of this section of the report.

4.4.3 <u>Future Action Plan</u>: A practical action plan prepared on the basis of suggestions from the mass gathering, its implementation strategy and monitoring plan should be included in this section.

4.4.4. *<u>Comparison with the Past</u>***:** The issues raised by the social audit of the previous fiscal year, implementation of the action plan, achievements and issues not addressed along with the valid causes should constitute this section.

4.4.5 <u>Remarks by the Social Auditors</u>: The Social Auditors should express their feelings and observations on any matters that are not reflected in other sections of the report in this section.

4.4.6 <u>Photographs of the social audit process</u>: Some good photographs of the social audit process should be included to complete the report. Generally, photographs of different processes and aspects of the programmes should be included.

CHAPTER 5
MISCELLANEOUS

5.1 EXPLANATIONS

The Ministry of Health and Population can make timely and necessary explanations, additions and deletions on any element of these Guidelines in order to resolve any confusion and overcome various obstructions and barriers to facilitating their effective implementation.

5.2 AMENDMENT

The MoHP can make any necessary amendments on the basis of its experience in implementing these Guidelines.

5.3 ABROGATION

The "Safe Motherhood Programme, Social Audit Operational Hand Book, 2066" and "Health Sector Social Audit Operational Guideline, 2066" shall be automatically abrogated once these Guidelines come into effect.

5.4 IMPLEMENTATION

These Guidelines should be implemented in all districts of the country gradually over a period of time.

Annex 1

Participants of the Social Audit process at Different Levels and Stages

Stage	Participants		Responsibility for leadership		Responsibility for facilitation	
	District Level	Local Level	District level	Local level	District level	Local level
Capacity building	Health Sector Social Audit District Committee, District Public/Health Office, health workers and other related stakeholders	Health Facility Management Committee, Social Audit Local Support Group, health workers, Social Auditor, local resource person and local pharmacists	District Public/ Health Office	Social Audit Local Support Group	Social Audit Organisation	Social Auditor
Preparation	District Public/ Health Office, Health Sector Social Audit District Committee, health workers	Health Facility Management Committee, Social Audit Local Support Group, health workers	Social Audit Organisation	Social Auditor, health workers and Social Audit Local Support Group	Social Auditor	Social Auditor and local resource person
Information gathering	Hospital, service users, stakeholders	Social Auditor, health workers, community and local resource person	Social Audit Organisation	Social Auditor, Social Audit Local Support Group	Social Audit Organisation	Social Auditor
Information analysis	Social Audit Organisation, Social Auditor	Social Audit Local Support Group, Social Auditor, Local Resource Person, Health Facility Management Committee and health workers	Social Audit Organisation	Social Audit Local Support Group	Social Audit Organisation	Local resource person, Social Auditor
Public gathering	Health workers, community/ stakeholders, service users, mothers group representatives, social and political activists, general public, media people	Social Auditor, health workers, community, health service users, mothers' group representatives, mass media and local pharmacists	Health Sector Social Audit District Committee	Social Audit Local Support Group	Social Audit Organisation	Social Auditor, local resource person

Annex 2

Record of the Entry Date and Stocks of Medicines

Fiscal Year…………… Information Collected on ………………………….

SN	Name of medicine	Annual entry	Entry date (trimester)				Periods when no medicines were in stock (state how many days)								Remarks (note "stock out" or "in dispensary")
		Quantity	1st	2nd	3rd	4th	1st		2nd		3rd		4th		
							No	Day	No	Day	No	Day	No	Day	
1	Iron capsules														
2	Cotrim (Child)														
3	Cotrim (Adult)														
4	Cotrim (P)														
5	Amoxycillin														
6	Paracetamol														
7	Family Planning Contraceptives														
7.1	Condom														
7.2	Pills														
7.3	Dipo														
8	IUCD														
9	Vitamin (A)														
10	ORS (Jeevan Jal)														
11	Zinc Tablets														

Annex 3

Details of Utilisation of Immunisation, Family Planning and Safe Motherhood Services

Fiscal Year………….   Information Collected on ……………………….

	Targets	Achievement (Number)	Achievement %	Last year's progress	Difference compared to this year
Immunisation					
BCG					
DPT/Polio					
Measles					
TT 2 and TT 2+					
Nutrition					
Number of undernourished children, if any					
CDD and ARI					
No. of patients treated for severe pneumonia					
No. of patients treated for severe diarrhoea					
Safe motherhood					
No. of women with four ANC visits					
No of deliveries by a skilled birth attendant?					
No of institutional deliveries					
No of women receiving PNC within 24 hours of delivery					
Family planning					
No. of persons using family planning methods					
Pills					
Dipo					
IUCD					
Implant					
Miscellaneous					
Number of EPI Clinics					
Number of outreach Clinics					
Number of mothers' groups formed					
Number of mothers' group meetings					

Annex 4

Check List for Interactions with Health Workers

(These issues merely provide an agenda for discussion; questions can be added on any issue as needed.)

- How do service recipients lodge grievances when they desire? What grievances were received last year? How have these grievances been addressed so far? What differences were noted after addressing the grievances in this way?
- What are the good aspects and weaker aspects of the health facility management? What support and barriers have you experienced with the health facility management? What is the innovative/exemplary work of the heath facility?
- Formation of the management committee (is it inclusive and does it contain the appropriate number?), meetings (regularity, attendance?), decision making process (in favour of the poor, women and excluded groups?), coordination with other bodies and resource mobilization etc.
- Discuss the adequacy of the physical infrastructure and its proper use. If there are gaps, what type of infrastructure is insufficient? Discuss the possibility of improving insufficient infrastructure in an alternative way rather than from the government.
- Investigate the presence of health workers in the health facility. What is the quota? How many are present at the moment? Are the stipulated quotas sufficient? How many and what types of health workers are lacking? Discover why individuals are absent, whether they are on deputation or on leave or for other reasons.
- From which geographical regions do people come to receive health services? What is the flow of patients receiving health services from particular groups or regions? Why is there a high or low flow from particular groups or regions? Does the health facility have any initiatives to address the situation?
- In the opinion of health workers is the general public cooperative in the operation of the health facility?
- What initiatives are taken by the health facility to make it more inclusive and gender-sensitive? Or are such initiatives not needed? Are current initiatives sufficient? If not what measures should be taken and who should initiate this?
- If any weaknesses were found in observing the Citizens' Charter, ask for the reason and facilitate commitments for improvements, if needed.
- Discuss attitudes concerning the use of the Citizens' Charter and changes the Charter has brought about among service recipients.
- What are health workers' perceptions on the adequacy of financial and other resources to provide quality health services?
- What are the perceptions of service providers about the health services provided by the facility and what do health workers think about the perceptions of service recipients on the available services?
- Number of maternal and new-born deaths in the catchment area of the health facility (if any).
- Take notes of any suggestions.

Annex 5

Check list for Iteraction with the Health Facility Management Committee

a. Meetings – Number of meetings conducted in a year, regularity of meetings, meeting attendance, especially the presence of women, the poor and members of excluded groups.
b. Important decisions made – Decisions made and implemented in favour of the poor, women and excluded groups, coordination with the VDC and other government and non-governmental organisations working at local levels, decisions made and implemented in relation to resource mobilisation and its utilisation. What decisions were taken to make the health service gender-sensitive and inclusive?
c. Issues concerning the mobilization of incentive amounts provided by the government to local health facilities for free delivery service and other health services – the date that the government provided the amount, decisions made regarding use of the amount and initiatives taken for the effective implementation of decisions.
d. Health facility office hours – Facts shown by the health facility records, remarks made by health workers and the opinions of service users.
e. Mechanisms to redress grievances of the general public – Arrangements made in this regard, types of grievances received during the year, ways to address grievances and the effect on the community.
f. Attendance of health workers at the health facility – Are health workers present at the health facility throughout the year? If not, why? Does the management committee take any initiative to ensure the presence of all health workers throughout the year? If yes, what are they?
g. Number of maternal and new-born deaths in the catchment area of the health facility (if any).
h. Take notes of any suggestions or responses.

Annex 6

Questionnaire for Exit Interviews

Fiscal Year………….   Information Collected on ………………………

Age: …………………..   Sex - Male/Female: ………………   Caste/Ethnicity:…………………………

(Tick appropriate answer and give reasons to support your answers.

1. Why did you choose this particular health facility for health services?
   a. Convenient location......................................   b. Good quality service...................................
   c. Good behaviour of health workers.................   d. No alternative...

Comment/Reason………………………………………………………………

2. How did the health workers behave while delivering the health service?
   a. Decent/Cooperative.........................   b. Fair.................................
   c. Rude..   d. Offensive………………………

Comment/Reason……………………………………………………………….

3. Did you lodge a grievance anywhere if a health worker's behaviour was not decent?
   a. To Chief/In-charge.............................   b. To other health workers...................
   c No grievances....................................   d. No awareness of grievance procedure.........
4. Was there a toilet at the health facility?
   a. Yes..............   b. No................
   If yes,
   a. Was it clean?   a. Yes...................   b. No.....................
   b. Was water available?   a. Yes...................   b. No.....................
5. Living arrangement for attendants/caregivers? a. Yes........... b. No............ Comments............................
6. Free medicine
   a. Received as required.............   b. Some only.............   c. All purchased from market..............
   If all purchased how much did you spend? …………………………………….
   Comments ....
7. Free service
   a. No charge at all....................
   b. No service charge but costs for lab and other services...............................
   c. Charges paid for all services....................................
   How much was spent……………
   Any comments ....
8. Time required to receive service
   a. Received service upon arrival....................................
   b. Waited almost two hours...................................
   c. Waited more than two hours………………………Why?...
9. How long did it take you to reach the health facility from your home?................................

How did you come and how much did the travel cost? ....

10. Was confidentiality maintained during the health check-up? a. Yes .... b. No................

11. How did you know about the available health services at this health facility?

    a. Through neighbours...........................
    b. Through health volunteers........................
    c. Through Radio/TV...............................
    d. Other (Specify)...

12. Arrangement for health facility cleanliness and sanitation?...........................

    Comments.......................................

13. Do you have any suggestions for improvements to services at this health facility?

    -
    -
    -

    Comments.......................................

14. Only for female patients

    - Did you receive the delivery incentive amount?...
    - Did you receive the incentive for ANC visits?...
    - Did you spend any amount for any reason?..
    - As a female did you have any difficulty receiving service? (e.g. was there adequate privacy?)

    Comments.......................................

    (ii) did you have any difficulty receiving service from a health worker of the opposite sex?

    Comments.......................................

    - Did you receive service as you anticipated?................ Comments..
    - Are you satisfied with the service you received?........... Comments..

Annex 7

Check list for Information Gathering at the Community Level

Access to Health Facility:

a. What is the distance between community and health facility, and the availability of various means of transportation?

b. Do all patients of different castes and ethnicities, genders and age groups receive equal treatment?

c. Are facilities arranged according to the requirements of children, the elderly, women and people living with disabilities? Are separate rooms available for check-ups for women? Are any living arrangements made for attendants to stay with and care for the elderly? Is there any place for children to play? Are ramps and wheel chairs available for people living with disabilities?

Conduct of Health Workers:

a. Do the health workers behave respectfully with all patients from indigenous nationalities, women, the elderly and people living with disabilities?

- Do they pay attention to the elderly, give affection to children, show respect to women and recognize the different capabilities of people living with disabilities?

Quality of Health Service:

What is the community's opinion regarding the quality of health services provided by the health facility?

Accountability of Health Workers:

Does the health facility in general, and health workers more specifically, take responsibility for problems occurring with patients after they receive treatment at the health facility?

Transparency of Health Facility:

a. Can the community easily obtain information about health facility activities, such as how many women receive free delivery services, how many receive the maternity incentive, how many receive the ANC visit incentive? Among other services, how to access them and how much they cost?

b. What are the means of access to this information? What media are used, local radio or newspaper or notice board of health facility?

Awareness and Information about Health Services:

Are the community people aware and informed about free health care, the free distribution of medicines, the Aama Programme (free delivery service, the amount of the maternity incentive), incentive amount for ANC visits and other health care services?

Presence of Health Workers in the Health Facility:

a. Are the required numbers of health workers available in the health facility throughout the year?

b. If not, what may be the reason? Is it because of lack of proper facilities in the community?

c. Are the health workers sufficiently respectful and trustworthy?

d. Other comments?

Duration of health services provided by health facility:

Does the health facility remain open as stated?

Other suggestions?

Do you have any suggestions for the gradual development of the health facility?

Annex 8

Tips for Facilitating Focus Group Discussions

Focus group discussions with two groups in the community have been proposed during the social audit. The following processes are recommended for facilitating the discussions:

- **Participation:** The engagement of participants is crucial to meeting the objectives of focus group discussions. Hence, the active and meaningful involvement of all participants should be guaranteed.
    - At the outset, ensure the presence and meaningful participation of the stipulated participants. The Health Facility Management Committee and Social Audit Committee should officially inform the designated participants at the appropriate time prior to the discussion date considering the local context. The participants could forget the programme if informed too early or could be engaged in other affairs if informed too late.
    - Not only relying on formal channels, the Social Audit Local Support Group members should personally visit the formally invited participants to request their compulsory attendance.
- **Seating arrangements:** The seating arrangements of the participants should create a feeling of equal treatment and make the discussion useful. For this purpose, a circular or semi-circular seating arrangement is appropriate.
- **Turn-wise speaking:** All participants should be offered an equal opportunity to express their opinions during the discussion. By nature, some may speak too much while others do not want to say anything. Good facilitation is to stop those who are speaking a lot and encourage those who do not tend to speak.
- **Note taking on discussion:** All the opinions of each participant should be thoroughly recorded without any analysis, synthesis and additions. Mapping the seating arrangement of the participants makes it easier to analyse the information and data obtained from an issue-based discussion while taking notes on who says what and who responds with what remarks.
- **Conclusion of discussion:** The discussion should be concluded by briefly presenting the opinions of each participant and obtaining their consent. Changes can be made if any participant does not agree with the conclusion.
- **Role of facilitator**: Facilitators should not make any counter arguments on any issue, should not correct the opinions expressed by participants, and should not reply to the queries and concerns raised by participants since they are not authorized members of the health service.

Annex 9

Presentation Outline for the Mass Gathering

Objective of Social Audit :

Process of Social Audit :

Duration of Social Audit :

Major Areas Covered by Social Audit:

1. Information Gathering

- **Health Facility Observation**

  (Purpose, Areas of Observation, Result, Positive or Reformative Issues Identified)

- **Details of Mothers Receiving Free Delivery Care under the Aama Programme**

  (Information and its source, Majority of Recipients – who received more, or less, and the causes)

  Total Number of Mothers ……………

  Dalit…………… Poor Janajati…………. Well Off Janajati……………

  Religious Minority…………… Brahmin, Chhetri, Sanyasi………………

  Number of Pregnant Women Attending 4 ANC visits

- **Home Visit for Interaction with Mothers who Received Free Delivery Care**

  Total Mothers Met …………

  Dalit…………….., Poor Janajati…………….. Well Off Janajati………….

  Religious Minority…………. Brahmin, Chhetri, Sanyasi….………

  Places Visited……………(VDC, Ward, Tole).

  Number of Mothers who Received Incentive………… and Number Who Did Not Receive…….......

  Comments and Reactions of Mothers (Write comments and reactions of the majority of mothers)

- **Availability of Medicines for Free Distribution**

  Information and its source…………………………………………………………

  Types and number of medicines distributed freely for the entire year……………………………………………

  …….

  Stock out (which medicines were stocked out and for how long)

SN	Name of the Medicines that were stocked out in a given time of the year	I Trimester		II Trimester		III Trimester		IV Trimester		Total in a Year	
		No (frequency)	Day	No	Day	No	Day	No	Day	No	Day

- **Income and Expenditure of Health Facility**

  Explain information and its source. Present the income and expenditure of the health facility as per the form in Annex………………………

- **Availability of Health Workers to Deliver Health Services**

  Source of this information and present using the form in Annex………….

  Total No of Health Workers………… Male………. Female…………

  Sanctioned but Vacant Positions

  1.

  2.

- **Details of Utilisation in Immunisation, Family Planning and Safe Motherhood Program**

  Source of information, and present the formats available in Annex - 3

- **Details of Miscellaneous Health Service Recipients**

  Source of information:

  Presentation formats are attached in Table 6.

- **Interaction with Health Workers**

  Place…………………………… ………. No of Times ………… Date………… Time: From……... To …………

  Number of participants: Total: …………………… M:………………………… F:…………………..

  Topics of Discussion …….

  Key Issues Identified…….

- **Interaction with Health Facility Management Committee**

  Place……………………………………… No of Times ………… Date………… Time: From………. To ………

  Topics of Discussion ………

  Key Issues Identified………

- **Client Exit Poll**

  No of service recipients interviewed for Exit Poll…………….. Female………. Male…………….

  Key reflections from majority of respondents ……………………………………………………………………………

  Key issues identified ……….

- **Focus Group Discussion with Women**

  Place of FGD:………………………………………… Date:…………. …. Time: From …………. To……………

  Total no of participants…………………….

  Dalit…………… Poor Janajati…………… Well Off Janajati……………….

  Religious Minority…………. Other Poor Groups ……………..

  Topics covered in FGD……………………………………………………………………………………………………….

Key issues identified………

- **Focus Group Discussion with Dalits**

  Place of FGD:…………………………………………. Date:………………… Time: From ……….. To…………

  Total no of participants………….. Female………… Male…………….

  Dalit………………….. Poor Janajati……………. Well Off Janajati………………

  Religious Minority………………. Other Poor Groups …………………

  Topics covered in FGD…….

  Key issues identified…….

- **Focus Group Discussion with Mixed Group**

  Place of FGD:…………………………………………. Date:……………… Time: From ……….. To………..

  Total no of participants…………………

  Dalit…………………… Poor Janajati……………….. Well Off Janajati……….

  Religious Minority………………… Other Poor Groups ……..

  Topics covered in FGD……..

  Key issues identified……

2. Analysis of Information

- The Social Auditor will analyse all information jointly with the Social Audit Local Support Group and local resource person. Identify positive aspects and areas needing improvement from information and data gathered from using all methods and tools. All the information gathered from health facilities and the community should also be triangulated and confirmed and key positive aspects and areas needing improvement identified. Do not ignore any issues gathered from the community. If key issues identified in the social audit could not be included in the priority list note them down under the miscellaneous section.

Key Areas	Positive aspect	Areas needing improvement
Access to Health Services		
Management of Health Facility and Accountability (Institutional Area)		
Quality Dimension of Health Care Services		

➢ Miscellaneous Area

Present the exact reflections of health service recipients during the social audit process.

➢ Key Issues Related to Health Facility

SN=	Issue	How this was classified as issue? (Legal provision or concern of majority of people)	Remarks

Annex 10

Programme for the mass gathering

Fiscal Year………………….. Date of mass gathering ……………………

SN	Programme Details	Responsible Person
1	• Objective of the gathering	
2	• Information about the social audit	
3	• Brief information about available health services of the Nepal government	
4	• Distribute the questionnaire specified in Annex 11 to the participants (in groups of 2-4 people) and collect general public perceptions on the health facility overall	
5	• Presentation of primary results of the social audit • Collection of queries/concerns from participants	
6	• Presentation of overall conclusions based on the forms filled in by participants (This will not be done at the district level). If it is a district level mass meeting present summary of the findings of the social audit conducted in all health facilities.	
7	• Responsible health sector officials (health facility in-charge, Management Committee chairperson, representative of District Public/Health Office) address queries and concerns.	
8	• Presentation of progress review of recommendations and issues raised by the social audit conducted during the last fiscal year.	
9	• Make a public commitment to the recommendations received and the corrective measures suggested by the social audit. Write them on a large piece of paper and have all participants sign the paper, if possible. • Chart out a viable action plan and formulate a monitoring plan for effective implementation of the social audit findings and the recommendations made at the public gathering as per Table 7.	
10	• Conclude the mass gathering after a vote of thanks.	

Annex 11

Checklist for Collecting Community Perceptions about Health Facilities

Fiscal Year…………………………… Information Collected on ……………………..……..

Indicator	Perceptions of the community			
1. Is the village clinic operated in the VDC (family planning service, delivery test etc) convenient for all?	Convenient	All right	Not convenient	Don't Know
2. Is the immunisation clinic run in the VDC convenient for all?	Convenient	All right	Not convenient	Don't Know
3. How do you perceive the behaviour (dealing with, listening to, informing) of the health workers?	Decent	Fair	Rude	Don't Know
4. Cleanliness inside health facility (painting , management of materials, park, compound, drainage, waste management etc)	Clean	Clean only sometimes	Often dirty	Don't Know
5. Arrangement of waiting area (waiting for turn, sitting space etc)	Convenient	All right	Not convenient	Don't Know
6. Toilet facility	Clean, separate for male and female	Clean but only one for all	Dirty	Don't Know
7. Are the health services like delivery and other emergency services provided by health workers in a timely manner?	Timely	Delays in service	Give words but no actions	Don't Know
8. Water facility	Available for drinking and toilet use	Only available for drinking	No water available	Don't Know
9. Does everyone know about available health services and the opening hours of the health facility?	All are aware	Some are aware	Most are unaware	Don't Know
10. What is the attendance pattern of health workers at health facility?	Mostly present	Almost half	Only present sometimes	Don't Know

11. Does the facility remain opened (according to schedule) when you are at the facility?	Always open	Shuts down sometimes	Closes before the scheduled time	Don't Know
12. Are the listed medicines made available free of cost?	All medicines are available	All medicines are available sometimes	Often we have to buy medicine from outside	Don't Know

Annex 12

Social Audit Reporting Format

1. Background
2. Brief introduction of health facility
3. Major objective of social audit
4. Duration of social audit
5. Methods, tools and process of social audit
6. Key areas (topics) covered by social audit
7. Major activities undertaken in social audit process
8. Comprehensive results of social audit *(include overall key results of social audits by crosschecking the results from different tools and techniques applied during social audit process)*
    a. Positive aspects
    b. Aspects needing improvement
9. Organisation of mass gathering
10. Key concerns raised in the mass gathering and issues identified to be properly addressed
11. Key issues identified by the social audit and commitment from responsible stakeholders
12. Action plan developed to address the issues raised by social audit
13. Remarks by the social auditor
14. Annexes