Exploring health facilities’ experiences in implementing the free health-care policy (FHCP) in Nepal: how did organizational factors influence the implementation of the user-fee abolition policy?

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Accepted 1 December 2014

Background This article presents an Asian experience of abolishing health-care user fees: Nepal’s universal free health-care policy, implemented in 2008. Based on doctoral fieldwork between August 2008 and April 2009, the paper analyses primary-care facilities’ and central and district health systems’ experiences with the policy. It makes a unique contribution to existing evidence because it explicitly applies organizational theory within a carefully designed, rigorous, multiple case-study analysis to deepen our understanding of the organizational and ‘people’ factors in the successful removal of user fees.

Methods The cases were two pairs of primary-care facilities in one district, paired for comparison of the facilities’ experiences with the policy in relation to its effects on health care utilization. Data collection methods included document reviews; key informant interviews at district and central levels; in-depth, semi-structured interviews and group interviews at case facilities. (Data on indicators of utilization and quality changes over time were also collected and will be published separately). Using key elements of Nadler and Tushman’s ‘Organizational Congruence’ model, a degree-of-fit analysis tested the study’s initial propositions and yielded generalizations for contexts in and outside Nepal.

Results The study found that Nepal’s key implementation challenges were similar to Africa’s: insufficient or delayed inputs of drugs and compensation; insufficient workforce and the resulting reduced quality of services that hampered facilities’ relationships with their clients and health providers’ attitudes. However, the Nepalese case facilities with (1) good intra- and inter-facility relationships, (2) adequate staffing, (3) well-oriented providers and (4) previously trained, better-informed and skilled health management committees experienced higher utilization and better-quality indicators over time.

Conclusions Through its detailed analysis of Nepal’s experience in removing user fees, the study highlights the importance of addressing the ‘people’ and ‘organizational’ factors in health-policy development and implementation.

Keywords Nepal, organizational factors, policy analysis, user-fee removal
KEY MESSAGES

- Nepal’s early experiences and key implementation challenges were similar to Africa’s. The sudden increase in demand in already weak health system exacerbated its policy implementation.
- The study highlights the importance of anticipating and addressing the ‘people’ factors (views, attitudes, motivations including non-financial, behaviours and relationships) in health-policy development and implementation.
- The study identified community governance and support groups such as Health Management Committees (HMCs) as important actors outside the facilities that exercise agency and that could support or hinder the implementation of centrally driven reform.

Introduction

The removal of user fees in developing countries has been the subject of much debate in the past decade (Hutton 2004; Pearson 2004; Gilson and McIntyre 2005; Witter 2005; James et al. 2006; Yates 2009). Reviews of studies examining the effects of fee abolition in Africa (Lagarde and Palmer 2008; Lagarde et al. 2012) have found that utilization of services increased abruptly after user-fee elimination, but the increases were not sustained over time. Other effects of user-fee removal include changes in the quality of services, especially drug shortages (McCoy 1996; Riddle and Morestin 2011), longer waiting hours (Kajula et al. 2004), reduced privacy (Walker and Gilson 2004) and reduced cleanliness (Burnham et al. 2004). The policy also resulted in increased workloads and poor working conditions, which had negative effects on health workers’ attitudes and staff morale and motivation (Walker and Gilson 2004; Gilson and McIntyre 2005; Riddle and Morestin 2011). Wider evidence suggests that the process of policy implementation (including organizational factors such as staff perceptions, attitudes and behaviour and the relationships between health managers and workers) influences the effects of user-fee removal (Gilson and McIntyre 2005; Hercot et al. 2011). Although a better understanding of how these factors affect policy implementation would help health-policy decision makers considering reforms (Franco et al. 2002; Weiner et al. 2008), there has been limited investigation of these issues in any area of policy implementation (Gilson and Raphaely 2008).

This article addresses the question ‘How did organizational factors influence Nepalese primary health-care facilities’ implementation of user-fee abolition?’ It presents research findings about the implementation of the universal Free Health-Care Policy (FHCP), which removed user fees and was one of a series of FHCP introduced between 2006 and 2009 in Nepal.

Nepal is one of the poorest countries in the world, with diverse geographical, religious, linguistic, cultural and ethnic characteristics. Despite Nepal’s good progress in reducing poverty and improving education and health sector indicators, health disparities and inequalities still remain across the country’s regions, genders and socio-economic classes (Government of Nepal, 2010; MoHP et al. 2012). Responding to the 2006 people’s movement that called for democracy, the government made its first-ever political commitment to the population’s health by declaring ‘Basic Health a Human Right’ in the Interim Constitution of Nepal 2007 and introducing the FHCP (MoHP 2010). In practice, the FHCP was introduced in phases (Figure 1). First, in 2006, targeted free care was introduced at referral facilities [District Hospitals (DHoS) and Primary Health Care Centres (PHCCs)] in selected districts, followed by universal, free essential services (i.e. all preventative services and a limited package of maternal health and curative services) provided at the lowest health-care facilities [Sub-Health Posts (SHPs) and Health Posts (HPs)] nationwide in January 2008. These free essential services were gradually expanded to DHs and PHCCs nationwide (MOHP 2009), including free delivery care provided at DHs in 2009, although the latter was not the focus of this study.

Both the national data and the data from the case facilities’ district showed similar utilization trends after the FHCP’s implementation (Sato 2013). Utilization levels increased for all population groups after implementation (RTI 20091), although in the study district, the overall outpatient care utilization, which had reached its highest levels 9 months after inception, had decreased by January 2009, ~1 year after the policy’s inception. The national and district data also showed that the increases in outpatient utilization especially benefited the Dalit (the poorest and the most disadvantaged group), while other disadvantaged groups2 had similar or lower utilization in the first year after user-fee removal than their proportion within the population. Meanwhile, utilization by the higher caste groups (Brahmins/Chhetris, Newar) increased throughout the first year, reaching a level slightly higher than their proportion within the population. A similar trend among higher caste groups was also observed in the case facilities’ district (RTI 2009). These utilization patterns point to the importance of further investigating the facility-level experience of FHCP implementation.

Regarding changes in the quality of services after FHCP, the national data showed that an increasing number of HPs and SHPs had stock-outs of essential drugs lasting more than a week, from 66.7% in the first data-collection interval (mid-March to mid-July 2008) to 71.9% in the second (mid-July to mid-November 2008) and 85.4% in the third (mid-November 2008 to mid-March 2009) [an increase of 19% between the second and third interval (RTI 2009)]. The increase in shortages was attributed to the FHCP’s introduction and its associated changes to the drug policy [e.g. the termination of the Community Drug Revolving Programme (CDP)]. The CDP was started in 2002 and had expanded to 56 districts by 2007 (Aryal 2008); many more types of drugs were available through the CDP than through the FHCP’s list of essential drugs. Despite increases in the national drug budget between 2007/2008 and 2008/2009, existing problems in the central and district drug-procurement processes further exacerbated the problem, and
the sudden termination of the CDP hampered facilities, which ran short of medicines.

Methods
In line with wider calls for the greater use of theory in policy analysis (Walt et al. 2008), the study was guided by Nadler and Tushman’s ‘Organizational Congruence Model’.Originating from the Open Systems Theory (Burke 2011), the model consists of four basic elements: (1) ‘the input’; (2) ‘the strategy’; (3) ‘the output’ and (4) the critical ‘transformation process’ (Figure 2). Considering an organization to be an open system, the model assumes that an organization’s performance is determined by the fit or the possible interactions or conflict between the organizational dimensions influencing the transformation of inputs (environment, history, resources) into outputs [performance; Nadler and Tushman in Hackman et al. (1983)].

This model was selected for this study because it examines both formal and informal organizational elements and specifically considers the influence of people on organizational performance. These are all factors that have influenced implementations of user-fee removal elsewhere but that have been under-investigated in past research. As part of the study’s preparation, existing research on experiences with user-fee abolition was also reviewed through the lens of the Nadler and Tushman model, generating three core propositions to test in subsequent analysis (see Table 4 later in this section).

Using a case study design, this article examined the experience of four primary-care facilities (all in one district) with user-fee abolition. Table 1 shows that, in terms of a range of national socio-economic indicators, the district was fairly ‘typical’ for the country as a whole (Yin 2003, p. 40). Reflecting the national political instability of the time (between 2008 and 2009), the district was affected by political strikes, conflict among ethnic minorities and everyday criminal violence. Between 2005 and 2006, the local Health Management Committees (HMCs) for all 50 SHPs in the focus district were given authority over key SHP operation and management functions (e.g. identification of needs, prioritization, development and implementation of action plans, mobilization of funds).

The four case facilities included two SHPs and two HPs, covering both levels of primary care where the universal FHCP was first introduced. The paired facilities from each level were selected because they were similar in demographic, geographic and socio-economic terms but had experienced different post-implementation utilization patterns. One of each pair was judged as having been more successful than the other after implementing user-fee abolition, with more successful implementation judged as a greater overall increase in utilization and an increase in utilization by the lower caste groups relative to other groups, who were the target of the FHCP (Table 2). This approach to case study selection allowed comparison of experiences within and across each pair, and so allowed propositions about the factors explaining those differences (derived from theory and wider experience) to be tested.

The differences between the highest utilization rates (all groups) after the FHCP compared with 1 month before the policy’s inception (in January 2008) varied across facilities. In SHP-A, the highest rate was eight times higher than before the FHCP; in SHP-B, 4.8 times; HP-A, 7.6 times; HP-B, 6.2 times. The lower caste groups in SHP-A substantially increased their utilization relative to all groups (the proportion of the total visits by these groups was 7% greater after the policy), whereas in SHP-B and HP-B the utilization of these groups decreased relative to all groups, and in HP-A there was only a quite small change in utilization by lower caste groups relative to all groups (Table 2). The upper caste groups also increased their utilization in SHP-B, HP-A and quite substantially in HP-B, relative to all groups, suggesting that higher caste groups contributed more than the lower castes to those facilities’ overall increases in utilization (Table 2).

The research took a bottom-up perspective on implementation by considering the perspectives of four sets of actors: (1) managers at district offices; (2) facility managers or senior-level
staff; (3) health workers and (4) members of the HMCs who had been involved in the FHCP implementation. In total, 30 people were interviewed at the district level and 21 people at the case facility level (Table 3).

Data collected at the district level provided insights into the context of the case facilities' experiences and identified issues for further investigation at the facility level, ultimately allowing a triangulation of aspects of the facilities' experiences. Eighteen in-depth, individual, semi-structured, face-to-face interviews and five group interviews were conducted using an interview guide developed from the research questions and the original theoretical framework. The interviews comprised all managers and technical and administrative officials involved in FHCP implementation in the case district’s District Public Health Office (DPHO)/District Health Office (DHO), as well as managers of PHCCs and the DH. Open interview questions

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Table 1 Characteristics of the case district

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Case district</th>
<th>National average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Human development index*</td>
<td>0.482</td>
<td>0.471</td>
</tr>
<tr>
<td>Gross domestic product per capita (purchasing power parity), USSa</td>
<td>1310</td>
<td>1310</td>
</tr>
<tr>
<td>Adult literacy rate (aged 15 and above), %a</td>
<td>53.1</td>
<td>51.4</td>
</tr>
<tr>
<td>Infant mortality rate (per 1000 live births)b</td>
<td>56</td>
<td>48*</td>
</tr>
<tr>
<td>Household possessions, %b</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radio</td>
<td>67.3</td>
<td>61.0</td>
</tr>
<tr>
<td>TV</td>
<td>32.0</td>
<td>27.9</td>
</tr>
<tr>
<td>Bicycle</td>
<td>33.1</td>
<td>32.7</td>
</tr>
<tr>
<td>Land</td>
<td>66.8</td>
<td>68.1</td>
</tr>
<tr>
<td>Livestock</td>
<td>71.9</td>
<td>76.9</td>
</tr>
</tbody>
</table>

*aUNDP (2008).  
*bMoHP et al. 2007 sub-regional estimate for the western region was used, since no district data were available.  
*Middle quintile average is 70/1000 live births (2006 DHS further analysis report).  
**National averages on household possession were derived from household estimates, not population estimates.
allowed the exploration of issues and challenges faced by providers and managers. Other district-level data and documentation (e.g. staff absenteeism; drug stock-outs; policy and programme reports such as the DHO’s annual report, UNICEF programme reports and the district FHCP monitoring report) were used to supplement and verify facility-level findings.

Each case facility’s FHCP implementation experience was examined using multiple sources: In-depth interviews and group discussions with health workers and HMC members; document reviews (e.g. HMC performance charts; facility records such as meeting notes and visitor records); brief periods of direct observation and field notes. In each case facility, the research team (author and two research assistants) spent on average 4-7 days (half a day to observe; 3-4 days to conduct interviews with the In-Charge and key health workers involved in FHCP implementation and 1-2 days to collect facility information), although there were some variations due to political instability. Interviews were conducted in Nepali, audio-taped, and then transcribed and translated into English; the quality of the translation was checked by two Nepali research assistants. Semi-structured interviews were conducted in Nepali and were guided by the study’s conceptual framework (Figure 2) and related propositions (Table 4), and the issues identified from the district level. Although the total number of interviews at each facility may seem small, each facility’s total staff size was also quite small (Table 3, first column), and in most of the case facilities, the majority of the health workers (excluding non-technical staff) was interviewed. The exception was HP-B, where the absence of critical health workers (due to leave and training) limited data collection (Table 3, footnote c).

Coding of the district and the first case facility data were done independently by the author and the research assistant using the coding template (initial coding generated over 100 codes, which were later reduced to 82). The evidence for the final coding was discussed and agreed on to avoid bias and increase reliability.

### Table 2 The case facilities’ characteristics

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Pair 1 SHP-A</th>
<th>SHP-B</th>
<th>Pair 2 HP-A (oversaw 4 SHPs)</th>
<th>HP-B (oversaw 4 SHPs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total catchment population</td>
<td>12 268</td>
<td>14 246</td>
<td>51 072 (included 4 SHPs)</td>
<td>47 726 (included 4 SHPs)</td>
</tr>
<tr>
<td>VDC&lt;sup&gt;a&lt;/sup&gt; population</td>
<td>10 137</td>
<td>14 396</td>
<td>7790</td>
<td>9519</td>
</tr>
<tr>
<td>Geography&lt;sup&gt;b&lt;/sup&gt;</td>
<td>Inner terai/mid-hill</td>
<td>Inner terai/mid-hill</td>
<td>Inner terai/mid-hill</td>
<td>Inner terai/mid-hill</td>
</tr>
<tr>
<td>Distance from highway &lt; 30 min</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>by car?</td>
<td>3A</td>
<td>3A</td>
<td>3A</td>
<td>3A</td>
</tr>
<tr>
<td>Socio-economic status: poverty (DAG&lt;sup&gt;c&lt;/sup&gt;) mapping category</td>
<td>Yes in 2005/2006</td>
<td>Yes in 2005/2006</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Decentralization</td>
<td>Well-off/higher caste (Brahman, Chhetri), disadvantaged Janajatis (indigenous group Tharu and Magar)</td>
<td>Hill-Janajatis (Magar) and Brahman, Chhetri</td>
<td>Tharu (Janajatis), and Brahman, Chhetri</td>
<td>Hill-mountain Janajatis (Magar, Gurung) and Dalit, and well-off Brahman, Chhetri</td>
</tr>
<tr>
<td>Overall facility visit (utilization). Before FHCP/After FHCP&lt;sup&gt;d&lt;/sup&gt;</td>
<td>132/1045</td>
<td>72/347</td>
<td>131/991</td>
<td>104/649</td>
</tr>
<tr>
<td>Overall increase in total outpatient utilization after FHCP&lt;sup&gt;e&lt;/sup&gt;</td>
<td>7.9 times</td>
<td>4.8 times</td>
<td>7.6 times</td>
<td>6.2 times</td>
</tr>
<tr>
<td>Utilization by the lower caste groups as a proportion of the total visits. Before and after the policy&lt;sup&gt;f&lt;/sup&gt; (male/female)</td>
<td>−7.1/+.78</td>
<td>−18.4/+.5.2</td>
<td>−2.8/+.0.6</td>
<td>−17.0/−9.0</td>
</tr>
<tr>
<td>Utilization by the higher caste groups as a proportion of the total visits. Before and after the policy&lt;sup&gt;f&lt;/sup&gt; (male/female)</td>
<td>−5.4/−3</td>
<td>+12.5/+1.2</td>
<td>+6.1/+3.0</td>
<td>+47.0/+22.2</td>
</tr>
</tbody>
</table>

Source: Most data were obtained through interviews with facility respondents; utilization data were from facility HMIS (disaggregated by caste and gender). Data with an asterisk (*) are from ISRSC (2002) and ISRC (2008; Sato 2013).

<sup>a</sup>A VDC is the lowest administrative section of the ministry of local development. An average VDC has nine wards and is guided by the district development committee (DDC) headquarters; the DDC chief is a local development officer (LDO).

<sup>b</sup>Terai is an area near the Indian border.

<sup>c</sup>Discriminated group mapping (DAG), % of district VDCs falling under the categories: category 1 (wealthiest), 0%; 2 (upper middle class), 4%; 3A (middle class), 33%; 3B (poorer), 36%; 4 (poorest), 27%. (Shrestha 2006).

<sup>d</sup>District records compiling monthly FHCP monitoring data from facilities.

<sup>e</sup>Difference between the highest utilization rate after the FHCP’s inception compared with 1 month before it.

<sup>f</sup>Changes in utilization by the lower caste groups as a proportion of the total visits by all groups between July-November 2007 and July-November 2008.

<sup>g</sup>Changes in utilization by the upper caste groups as a proportion of the total visits by all groups between July-November 2007 and July-November 2008.
(Green and Thorogood 2004). ATLAS.ti 6.2 software was used for coding and for producing quotations and the case reports at the national, district and facility levels. The ‘framework analysis’ approach (Green and Thorogood 2004; Pope et al. 2007), which helps organize data within a thematic framework, was used to summarize and classify coded data (charting) in each facility, and to identify overall patterns of experiences and relationships between the codes (organizational factors). Data from each facility were analysed separately, first by respondent and data source (i.e., observation, field notes, individual interviews, group interviews), and then by facility. Triangulation across the data from different sources was facilitated at this stage by summarizing data within a Microsoft Excel spread sheet (‘data extraction initial template’). Four framework analyses (one Excel spread sheet for each facility) were merged into one common spread sheet, while four separate narrative case reports were produced.

For each facility, a ‘degree-of-fit analysis’ was then conducted, using the analysis results mentioned earlier, to assess the facility’s experience against key elements of the conceptual framework (Supplementary Box S1). This involved analysing interrelationships between organizational factors and variables, and making judgments about the degree of fit or unfit for 10 questions (Supplementary Box S1, Table 6). The assignment of a ‘(++) strong fit,’ ‘(+ +) fit,’ ‘(−) unfit’ or ‘(−−) poor fit’ between an organizational factor and the facility’s experience was determined by considering the strength and frequency of interviewees’ responses. For example, if more than one respondent (or one who was the only authority to answer the question) viewed the organizational factor as strongly and positively influencing the facility’s implementation experience, then the factor was a (++) strong fit. The degrees of fit for each facility’s set of organizational factors were then compared within and across paired facilities, to identify explanations for the differences in the facilities’ implementation experiences and subsequent changes in utilization.

Finally, the author used this degree-of-fit analysis to test the study’s three propositions (Table 4), in order to consider whether (1) existing empirical evidence was consistent with or discounted the propositions and (2) theoretical replication [i.e. the replication of contrasting results for predictable reasons to support, refine and test the initial set of propositions (Yin 2003, p. 47)] could be made. The three core propositions were then refined.

### Results

After an overview of the key elements of the district-level experience of FHCP implementation, this section will present the analysis of the factors explaining the case facilities’ implementation experiences. (Summaries of the case facilities’ experiences are available as extra material on the journal website).

After the focus district’s personnel first learned of the FHCP through a sudden announcement in the Nepal media (rather than through the official government’s communication channels), they developed an initially negative view of the FHCP.
itself. This perception was confirmed by this study’s findings of the implementation’s initial effects at the district level:

(1) An increased flow of ‘false’ and ‘pill’ patients (i.e. anticipating possible illnesses, their inability to pay and chronic shortages of medicines due to a dysfunctional health system, these patients often demanded medicines that might not be of any use) and increased conflicts between clients and health workers.

(2) Acute shortages of drugs during the first 7 months after FHCP’s implementation and delays in district-level local procurement.

(3) Personnel shortages and increased concerns about the decline in health workers’ ability to provide quality care (due to their decreased morale, the shortening of consultations and the longer waits from their increased patient loads during the shortage).

(4) Delayed and insufficient resource inputs (drugs, funds).

(5) Weak monitoring and supervision.

(6) Poor communication and information-sharing practices.

These district-level experiences affected facilities’ experiences and produced the unsatisfactory attitudes and low morale among health workers that were also reported in Africa after user-fee removal (Gilson et al. 2003; Gilson and McIntyre 2005; Nimpagaritse and Bertone 2011; Meessen et al. 2011).

The district-level and facility-level experiences with external factors

Despite the central government’s strong political backing of the FHCP, several external factors explain some of the district and case facilities’ implementation challenges (Table 5). For example, the FHCP was introduced to the district and all facilities (January 2008) with very short notice; the district learned of it first through the media and then by a government letter, with just a 1-day orientation at the zonal annual review meeting for only the DPHO director and focal point, and with simple guidelines distributed only a few days before the policy’s inception. The case facilities thus had no time to prepare to meet the sudden increase in demand for health services. The lack of clarity in the FHCP guidelines and the inadequate orientation produced differing interpretations and feelings of exclusion among district-level managers, along with tension among district managers. Due to delayed receipt of funds from the central level and because the district accountant was not clear about how funds should be allocated, the district reimbursed the facilities only once (instead of three times) during the first year and then less than what was anticipated.

In turn, these insufficient and delayed inputs to an already weak health system triggered stock-outs and delays in distributing medicines in the district; the number of stock-out drugs and drugs with ≤1 month’s stock at the facility level peaked in the first 6 months after the FHCP, reflecting the national experience. Because they did not receive the requested amounts and types of medicines promptly, the facilities faced occasional drug shortages. The total number of drug quantities (all types) replenished as a percentage of the total quantities requested, once before and once after the policy, shows that the drug replenishment rate improved from 53.7 to 89.8% in SHP-A, remained the same in HP-A (72.1-70.1%) and worsened in SSB-P (84.8-70.3%); data from Logistics Management Information System and facility records; data for HP-B were incomplete). Specifically, the drug shortages were due to (1) increased demand, (2) the delayed procurement and distribution of drugs from the central and district levels, (3) the delay in transferring funds from the central level to the district and to the facilities and (4) insufficient budget allocations for travel allowances for facilities to collect drugs. The central level’s pre-existing problems had been triggered by district-level factors, such as an inefficient procurement and commodity distribution system and the absence of the director in charge of the tendering process; these factors in turn hampered the overall FHCP implementation and the case facilities’ experiences. The clients’ mistrust in the quality of the FHCP’s free medicine and an insufficient selection of free drugs were perceived to have also affected provider-client relationships at the district level and in all case facilities. Other key external factors influencing the FHCP’s implementation included the lack of general engagement, monitoring and DPHO supportive supervision, and the district informants’ perceptions of a lack of useful support from local and political groups, although some facilities (SHP-A and HP-A) received such support.

Key organizational factors and their degree of fit

Degree-of-fit analysis and comparisons within and across the paired case facilities allowed the identification of selected organizational factors’ specific influence on the FHCP’s implementation. Overall, the study identified strong fits between the various organizational transformation factors (People, Task and Formal and Informal Organizations) in facilities with higher utilization increases over time (SHP-A and HP-A), while more
Table 5 The district-level and facility-level experiences with external factors influencing the FHCP’s implementation

<table>
<thead>
<tr>
<th>External factor</th>
<th>District-level views on experiences (source of data)</th>
<th>Case facilities’ experiences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information and orientation on FHCP received from external (outside facility) sources.</td>
<td>All facilities started services on time. District officials received policy information from media first, then only did the DPHO director and a focal point receive orientation at zonal annual review meeting. Lack of clarity in the guidelines and poor understanding by district-level managers, especially the accountant and the storekeeper. No training held for the above key staff involved in managing and implementing the FHCP. (accountant, DPHO director, FHCP focal point).</td>
<td>Implementation on time with very short notice (by media, then letter, brief orientation); additional debriefing organized by PHCC.</td>
</tr>
<tr>
<td>(Inputs) delayed release of reimbursement funds.</td>
<td>The case district health office only reimbursed health facilities once in the first year of policy implementation (instead of three times), because funds were received late from the central level and because the accountant was not clear about how funds should be allocated. The case district used its own method to calculate fees. (accountant, DPHO director, FHCP focal point).</td>
<td>Was paid once (after 4 mos.) at 64%, but used its own resources to deal with the problem.</td>
</tr>
<tr>
<td>(Inputs) drug shortage due to delayed distribution from central/district levels.</td>
<td>Drug shortages (caused by delay in receiving drugs and funds from central level and delay in procurement process itself) at DPHO triggered stock-outs and delays in distribution to the facilities, which in turn hampered their service provision. The district storekeeper now had to deal with many emergency requests and paperwork, and his workload increased substantially. Many workers came to collect drugs without being given travel allowances, as they did not have budget for it. (DH director, storekeeper, accountant)</td>
<td>Drug replenishment rate, April–July 2007 to April–July 2008⁹.</td>
</tr>
</tbody>
</table>

(continued)
Table 5 Continued

<table>
<thead>
<tr>
<th>External factor</th>
<th>District-level views on experiences (source of data)</th>
<th>Case facilities’ experiences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clients’ reduced trust in drug quality and health workers.</td>
<td>Concerned about deteriorating client-provider relationship due to drug stock-outs, changes in clients’ views on quality of free drugs, and insufficient type of drugs provided free. (storekeeper, FHCP focal point) The FHCP created high expectations among clients, but misunderstanding about policy coupled with unavailability of drugs caused conflicts between providers and patients; the patients became more violent towards providers. (DPHO former director).</td>
<td>Health workers perceived negative changes in client–health worker and facility relationships. Clients perceived decline in quality of free drugs.</td>
</tr>
<tr>
<td>General lack of engagement and monitoring, and lack of DPHO supervision.</td>
<td>FHCP monitoring is integrated into other programme monitoring and thus had no separate budget, but since FHCP there had been no increase in this line item’s budget. The district-level FHCP monitoring committee was not functioning. There was lack of monitoring by the higher authorities (DPHO managers mainly), specifically assessing the FHCP implementation. (DPHO former director).</td>
<td>No monitoring visit by DPHO FHCP monitoring committee not active.</td>
</tr>
<tr>
<td>Support received from local and political groups and civil society.</td>
<td>Although support was received from political parties, community groups, and civil societies for raising awareness about the FHCP, the district respondents did not perceive it as major, useful support for implementing the FHCP.</td>
<td>Received support from international NGO.</td>
</tr>
</tbody>
</table>

\[ \text{Formula} = \frac{\text{Total quantities of all types of drugs received}}{\text{Total quantities of all types of drugs requested}} \times 100\% \]

The data compared two periods (any one-time request April–July 2007 vs any one-time request April–July 2008). Data were from Logistics Management Information System and facility records; data for HP-B were incomplete.
negative fits on these factors were found in the other facilities (SHP-B and HP-B). This suggests that, despite facing challenges similar to their paired facilities’, the better-performing facilities demonstrated a stronger combination of organizational characteristics: better-oriented, better-skilled, and a larger number of qualified staff, stronger facility management systems, better information sharing, better staff relationships and coordination, and the existence of previously trained, better-informed, and skilled HMCs.

Four main ‘themes’ or combinations of organizational factors emerged to explain higher post-implementation utilization and its possible positive effects on utilization equity, particularly in the SHP-A. These were (1) a stronger fit between a facility’s formal structural and management system and its informal organization (i.e. its structure and arrangements); (2) motivated health workers whose needs and expectations were met by tasks and/or formal organizational arrangements; (3) skilled staffing, good information/communication and good intra-facility relationships and (4) a higher level of engagement and influence by the HMC. Table 6 presents the details of each case facility’s experience against each study proposition, noting the degrees of fit between the facility’s organizational factors that have been judged to explain the facility’s utilization.

First, the health facilities with strong support networks and relationships with local government and community groups were better able to adopt new changes to their management systems to implement the FHCP and provide a higher quality of services. Differences were much stronger in the HP pair than the SHP pair. For example, HP-A had supportive informal relationships with the local HMC and political groups; the HMC could use its power and resources (HP-A had its own fund-raising mechanisms) to change official operating hours, request and obtain additional skilled staff and influence workers’ prescribing patterns. HP-A’s HMC members had previously received management training from an international NGO and were more committed. On the other hand, HP-B staff had no close ties with local community or political groups and had a weak HMC (its meetings rarely took place; it received no support from International NGOs like HP-A, and it had a weak governance structure). There was no established system of monitoring and taking actions between the HMC and HP-B to solve the implementation problems that hampered service quality, leading to a lack of trust between HP-B and the community after fees were removed. The fact that HP-B was built by an international aid agency without any community involvement could explain this lack of strong community governance and a facility management system. Conversely, SHP-A had an established system for monitoring performance, an intra-facility communication system, community governance with an active and skilled HMC trained by International NGO, and good intra-facility relationships among the health workers (who were locals); all of these assets facilitated SHP-A’s ability to cope with implementation problems and seek informal community support for infrastructure development after the FHCP.

These findings supported the study’s original Proposition 1:

“Health facilities with functioning and supportive informal structures that are either consistent with formal structures or are able to influence and transform formal structures to adopt new changes are more likely to deliver a higher quality of services.”

Second, none of the case facilities had made any arrangements and mechanisms for provider incentives that would replace the previous additions to their salary from user-fee revenue. Thus, case studies did not allow the initial Proposition 2 to be considered. In practice, the study found that in all facilities, health workers’ needs and expectations for rewards increased after the FHCP, since their physical workload doubled or tripled, yet their needs were not met by any of the formal organizational arrangements. Compensation for overtime and weekends and a night-time allowance was an issue in all facilities, and facilities expected other forms of motivation, such as training opportunities (an issue particularly in SHP-A), a staffing increase (all facilities), ensuring workers’ security during night services (HP-B), recognition and encouragement (SHP-A, HP-A) and supportive supervision (SHP-A). For example, in HP-A, the staff member in charge and the health workers perceived that workers’ motivation had decreased by receiving constant criticism instead of encouragement and appreciation from the HMC. However, staff in HP-A made official (formal) arrangements to change its operating hours to meet community demands, and its motivated staff took actions consistent with the FHCP’s task demands. On the other hand, HP-B providers did not welcome and did not follow through on the new decision by its HMC to extend operating hours. A possible explanation is that HP-B’s providers and HMC lost their source of staff incentive from the additional charges they used to make before the policy.

Based on the earlier findings, the original Proposition 2 was revised to address (1) the fit between the different kinds of people factors (e.g. needs, preferences, perceptions) and other organizational elements (not only formal arrangements and systems, but also tasks and task design) and (2) how the congruence between these factors influence providers’ motivations, behaviour and overall performance:

“Health facilities that understand health workers’ different types of needs, perceptions, and motivations and that can provide formal arrangements and/or mechanisms to promote and motivate providers’ positive behaviour (with not only monetary but also other forms of rewards) and the encouragement and acknowledgement of good performance through supportive supervision, are likely to produce a better quality of service outputs/outcomes (i.e., less provider absenteeism).”

Third, the facilities with better ‘people’ (capacity and skills) factors had teams that performed better than those in their paired facility. The difference was more apparent and notable in the HP pair than the SHP pair; however, both HP-A and SHP-A had better staffing situations than the paired facility, and both had better health workers oriented in the FHCP (through training, debriefing and regular meetings).

For example, in the HP pair, HP-A (1) was better staffed (with the exception of a junior clerk post that was a ghost position, all positions were filled), (2) had better-oriented and skilled workers with good relationships with the community (the majority was locals who spoke local languages), (3) had a
Table 6 The degrees of fit between organizational factors that explain the case facilities’ FHCP experiences and their effects

<table>
<thead>
<tr>
<th>Main theme</th>
<th>Relevant degree-of-fit questions</th>
<th>SHP-A (higher utilization) explanation</th>
<th>SHP-B (lower utilization) explanation</th>
<th>HP-A (higher utilization) explanation</th>
<th>HP-B (lower utilization) explanation</th>
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<tbody>
<tr>
<td>ORIGINAL PROPOSITION No. 3</td>
<td>The organizational fit between formal structure (management system) and informal organization (structure and arrangements) facilitate or hinder task performance.</td>
<td>CD1: formal (job design, structure, relationship, support system)–informal (goal, rewards, structure, relationship) fit (are the goals, rewards, and structures of the informal organization consistent with those of the formal organization?).</td>
<td>Various informal arrangements the SHP-A developed (selling medicines, the Peon providing services) complemented the functioning of formal organization. Although the In-Charge’s informal behaviour was not consistent with formal organization, it may have helped solve implementation problem (CD1).</td>
<td>The informal arrangement of non-technical staff providing health services created a lack of trust in the community and was not in line with health workers’ formal functions and job design. Thus patients and even the HMC complained about the arrangement and the provider’s (i.e. Peon) poor attitude (CD1).</td>
<td>Despite HP-A’s poor relationship with its HMC chair, the HMC as a whole helped HP-A’s performance. The HMC’s financial and technical support from VDC was consistent with formal structure; the HMC influenced HP-A through its monitoring and management decisions (CD1).</td>
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<td>ORIGINAL PROPOSITION No. 2</td>
<td>Motivated health workers whose needs and expectations for rewards are met by tasks and/or formal organizational arrangements.</td>
<td>ABI: people (needs)-task fit (to what extent are individuals’ needs met by the tasks?) AC1: people (needs)–formal fit (to what extent are individuals’ needs met by organizational arrangements?) BC1/2: task–formal (are the formal arrangements adequate and do they motivate behaviour consistent with task demands?).</td>
<td>Health workers’ motivation declined due to increased workload, lack of compensation for weekends/ overtime, and decreased field allowances (ABI and AC1).</td>
<td>Health workers did expect rewards and encouragement, but were told not to (AC1). Facility made no formal or informal arrangements to compensate for additional operating hours; thus there was no official change in formal operating hours (although workers provided services on weekends and after hours on Ad hoc basis) (BC2).</td>
<td>In-Charge and health workers perceived a decline in workers’ motivation from HMC’s constant criticism instead of encouragement and appreciation (ABI, AC1). The facility made official (formal) changes to operating hours to meet community demands, and the health workers viewed it positively (BC1).</td>
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<td>ORIGINAL PROPOSITION No. 3</td>
<td>Skilled staffing, a good communication/information-sharing system, and good intra-facility</td>
<td>BC1: formal (manpower structure/job design)–task fit BC1: formal (communication/information</td>
<td>All sanctioned positions were filled (BC1) before and after the policy, and all main health workers.</td>
<td>One technical position had not been filled since before FHCP (BC1), and health workers were not satisfied.</td>
<td>Except for one junior clerk post (never filled), all positions were filled (BC1), and HP-A had at least 3 staffs (2 AHWs and 1 VHW)</td>
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Table 6 Continued

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<tr>
<th>Main theme</th>
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<th>SHP-A (higher utilization) explanation</th>
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<tr>
<td><strong>ORIGINAL PROPOSITION</strong></td>
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<td>STRONG FIT</td>
<td>POOR FIT</td>
<td>STRONG FIT</td>
<td>POOR FIT</td>
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<td>No. 3</td>
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<td>relationships among the staff help them cope with increased patient load.</td>
<td>sharing system-task fit AB2: people (skills)–task fit BD1&amp;2: informal (intra-group)-task fit (does the informal organization structure facilitate or hinder task performance?).</td>
<td>(MCHW) had FHCP orientation by DPHO and PHCC (AB2). Despite increased physical workload and morale decline from lack of training opportunities, health workers were all locals and had good communication system (BC1) and intra-facility relationships to support (BD1&amp;2) the In-Charge and each others' tasks. Although Peon checked patients and prescribed medicine, she was trained for MCHW (AB2).</td>
<td>fully aware of FHCP (AB2); thus it became more difficult to manage patient load. The situation lead to Peon (non-qualiﬁed) and ANM providing most of services (in absence of In-Charge); observation also conﬁrmed Peon screening patients and giving injection to a patient (BD1&amp;2). However, health workers were all locals and had good intra-facility relationships to support In-Charge and each other's tasks (BD1&amp;2).</td>
<td>[one local, the other long-serving], 1 ANM borrowed from other facility with good capacity and relationship with community (BD1&amp;2). One of them received FHCP orientation and briefed all health workers and HMC (AB2). Leadership delegated by sick In-Charge to capable health workers; having a good intra-facility communication system (BC1) and relationship with the local community facilitated good performance. (BD1&amp;2).</td>
<td>increased workload of remaining staff, who were not briefed well about the FHCP by the In-Charge (AB2). This affected workers’ morale (concern about quality of service, overwhelmed by heavy workload), and there was no system to share these concerns and review performance (BC1). Poor intra-facility relationship between non-local In-Charge and the two locals (one senior AHW, junior AHW) (BD1&amp;2), the In-Charge's absence, and poor information-sharing (BC1) caused poor coordination in the facility, hindering a supportive work environment.</td>
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**ADDITIONAL PROPOSITION PROPOSED**

The HMC members with skills, capacity, and understanding of their roles are more likely to exercise their power to positively influence their facilities.

| BC1: formal (arrangements)-task fit (are the organizational arrangements adequate to meet the demands of the task?) AB2: people (skills)-task fit (to what extent do individuals have the skills and abilities to meet task demands?). | HMC Previously trained by an NGO and played key role in establishing SHP-A (AB2). Although HMC members never read the guidelines, they understood their responsibilities, became more engaged after FHCP, raised awareness in the community, held regular meetings to review performance, and helped the facility solve problems (drugs, human resources) (BC1), all of which suggests the HMC's association with higher utilization. | HMC Tenure was over before FHCP started, and it became less engaged after CDP was terminated and regular meetings had not taken place (BC1). HMC members were not briefed by In-Charge who attended the training, never saw the implementation guidelines, and thus did not understand their roles clearly (AB2). Since the HMC's financial decision-making authority remained unchanged, their inactivity delayed decision making (BC1). | HMC had been previously trained by NGO and had received orientation on FHCP (AB2); it had strong political inﬂuence over the facility before and after the policy. Its clear understanding and exercise of political power let health workers adopt local strategies (BC1) (i.e. let DPHO sign a letter to change operating time; introduce new financial rules). This enabled the facility to achieve higher utilization. | | Although the HMC was briefed by the In-Charge about FHCP, it lacked clear understanding of its rights and responsibilities even before the policy (AB2), and it remained less engaged in FHCP and in solving implementation problems (BC1). |

Note: The 'AB1', 'BC1' etc. designate a specific degree-of-fit relationship between two organizational factors as outlined in Nadler and Tushman (1983) in Hackman et al. (1983).
better coordination and communication system and (4) had better intra-facility relationships. Furthermore, HP-A’s leadership had been delegated by the ill staff member (the In-Charge) to capable health workers. On the other hand, HP-B faced a reduction in manpower (two vacant positions after FHCP), and its staff had not been briefed about the policy by the In-Charge, which lowered staff morale. Additionally, HP-B’s poor intra-facility relationships, the poor communication and information-sharing between its non-local In-Charge and its local staff, and the In-Charge’s absence hindered a supportive environment for the workers and the facility’s performance.

In the SHP pair, SHP-A had (1) all sanctioned positions filled before and after the policy implementation, (2) better provider characteristics such as capacity [i.e. both the In-Charge and the technical maternal and child health worker (MCHW) had received FHCP training from the DPHO and PHCC; the non-technical Peon was trained as an MCHW], (3) a better allocation of providers fitted to their job design, (4) a better intra-facility communication and information-sharing system and (5) the resulting smoother intra-facility relationships among workers, who were all locals. Although SHP-B’s workers were also all local, it had one less technical position filled than SHP-A, and its providers were not fully oriented with the FHCP, which led to non-qualified staff [the Peon and auxiliary nurse midwife (ANM)] screening patients and giving injections to a patient (Observation, SHP-B).

Thus, Proposition 3 could be modified to the following:

“Health facilities in which motivated, skilled, and sufficient manpower exists, and the intra-facility relationships and in-house communication system support them to perform tasks as a team, are likely to meet the policy objectives despite implementation challenges.”

Fourth, in both pairs, the better-performing facilities (SHP-A and HP-A) shared characteristics. They showed stronger congruence (fit) among organizational elements than the lesser-performing facilities, in having stronger support from local groups [i.e. HMCs, FHCP monitoring committees, village development committees (VDCs)] that had better capacity (both received intensive training and support for capacity building from an international NGO), were more knowledgeable about the FHCP, and played essential roles in making decisions and performing tasks in implementing the policy.

For example, in the SHP pair, although both facilities were built with support from the HMC and local groups and were decentralized, SHP-A’s HMC became more engaged after the FHCP, while SHP-B’s HMC became less engaged, due partly to the members’ reduced motivation after the termination of their tenure. Although both HMCs were not formally trained in the FHCP, SHP-A’s HMC understood its role, held regular meetings to review performance, and helped the facility solve problems (e.g. drug shortages, human resources issues). On the other hand, SHP-B’s HMC members were not briefed on FHCP by the In-Charge, had never seen the implementation guidelines, and did not understand their roles clearly.

In the HP comparison, HP-A’s HMC was debriefed on the FHCP by the health worker who attended the district’s FHCP orientation. The HMC’s members became much more engaged after the FHCP, clearly understood their role, and actively monitored HP-A. They exercised their political power (with the FHCP monitoring committee) to influence the district authority to lengthen HP-A’s operating hours and introduced new financial management rules to cope with the changes. HP-B’s HMC had never been very engaged, and this did not change after the FHCP. No regular meetings were held due to the members’ lack of initiative and interest; their lack of understanding about their rights and responsibilities were major reasons for their lower degree of engagement.

The findings above generated an additional proposition to this study:

“Health facilities that have had the community’s involvement in their establishment and that have had support for strengthening the community governance system are likely to have a motivated, skilled, responsible, and active health management committee, which will provide better support and strong influence to the facility in providing quality services and achieving policy goals (BC1: Formal arrangements adequate to meet demands of the task and AB2: HMCs are equipped with knowledge and skills to perform their tasks for better governance at the community level).”

Discussion

This investigation of Nepal’s early experiences with user-fee removal at the lowest-level facilities supports the recommendation for deeper analysis made in a review of similar policies in sub-Saharan Africa (Meessen et al. 2009, 2011). Moreover, this study’s analysis generated five policy recommendations that can be added to the international literature on user-fee abolition and the general literature on policy implementation.

First, despite the inability of the study’s framework to fully address contextual factors, the analysis suggests that contextual and historical factors interact with organizational factors: e.g. the better-performing facilities (SHP-A, HP-A) had historically active HMCs with some influence over providers and service management. We were constantly reminded in this study that researchers of policy analysis need to carefully assess, understand and anticipate contextual and organizational factors and their interactions in policy analysis (Walt et al. 2008).

Second, the findings contribute to the policy implementation literature by confirming the important effects of ‘people’ factors [front-line facility managers, health workers and ‘street-level bureaucrats’ (Lipsky 1980; Gilson and McIntyre 2005)]. Future policies need to understand health providers’ views, expectations and motivations. To address workers’ motivating and demotivating factors (Blauw et al. 2006, p. 18) that may or may not be financial (Franco et al. 2002; Walker and Gilson 2004), policies need to build in mechanisms that encourage motivation.

Third, the study’s finding that active health facility committees were linked to the two better-performing facilities runs counter to Ugandan experience, e.g. although, as in Uganda, in one worse performing facility, an initially active committee became inactive after user-fee abolition (Burnham et al. 2004; Ridde and Mosterlin 2011)."
all case study facilities anyway shows that the committees' functioning is influenced by history, the relationship with community groups, their functions, decision authority, availability of resources at local level and from national level, motivation for involvement and relationships among staff, as also identified in two recent systematic reviews on health facility committees (Molynieux et al. 2012; McCoy et al. 2012). As shown in the two better-performing facilities, community governance and support groups such as HMCs can be important actors outside the facilities that exercise agency and that can support or hinder the implementation of centrally driven reform. HMCs in the better-performing facilities in Nepal became more engaged and actively solved problems after the FHCP; they felt ‘ownership’ of the facilities due to their history of involvement; and they had received training and technical support to strengthen their management skills. Additional assessments are needed in Nepal to understand the roles and influence of HMCs and other governance groups in health-policy reform, with the results incorporated into the design of future health policies.

Fourth, the better-performing case facilities displayed the characteristics of stronger facility management systems, such as better and more routine intra-facility coordination and staff relationships and better information sharing, performance monitoring and communication systems. The overall management capacity and leadership of each facility’s In-Charge need strengthening to facilitate change and better-systems management (e.g. of finance, HR, logistics, information and communication, staff relationships, monitoring and evaluation), which will in turn help the implementation of new policies and programmes. These findings support the recommendation of a study of African user-fee removal, which called for overall health-systems strengthening when governments are planning for such a policy (Gilson and McIntyre 2005).

Fifth, Nepal’s unclear FHCP guidelines, its lack of communication strategies to inform the main actors (i.e. the intended beneficiaries and front-line implementers), and the media’s sudden announcement of the FHCP led to a lack of understanding about the policy’s content and implementation by all actors at the district and facility levels, as experienced elsewhere (Gilson et al. 1998; Bitran and Giedion 2003). For example, the lack of clear guidance on the calculation and disbursement modalities was one of the reasons the district substantially delayed disbursement to the facilities, which in turn hampered facilities’ FHCP implementation. Ghana had a similar experience when funds were reimbursed without clear guidance for the managers on the funds’ calculation and replenishment (Witter et al. 2007b). According to an existing study on Nepal’s user-fee abolition (Witter et al. 2011) that assessed the first-year experience and effects of the national free delivery policy (the ‘Aama’ programme), the central government transferred compensation to the facilities within Aama’s first month, and it even permitted the flexible use of funds for staff rewards and hiring. To avoid inefficiency and a lack of transparency, policy makers should allow sufficient time to align new policies with existing management systems and practices. It is also important to pilot test a new policy’s operational guidelines with front-line workers, to improve the guidelines’ clarity and ensure they reflect the workers’ experiences. Nepal would benefit from an in-depth assessment of governance and accountability in these two equity-related policies.

Besides the organizational factors mentioned earlier, simple demand-side factors [such as improved knowledge of the FHCP; the community’s care-seeking behaviours; reduced financial barriers to access and other socio-economic factors such as changes in women’s status (McPake et al. 2011)] and economic growth may have contributed to the higher utilization, in spite of the organizational and people factors negatively affecting the FHCP’s implementation.

This study’s research method (a multiple-case study design to test propositions derived from wider empirical work and organizational theory) allowed multiple layers of comparative analysis of case facilities (within, between and across the pairs), underpinning the rigor of analysis. The detailed analysis and the study’s in-depth focus on organizational factors using theory-driven degree-of-fit questions have provided a rich understanding of the case facilities’ experiences with FHCP implementation. The method has also yielded plausible, in-depth explanations about how the interactions of organizational and people factors explained differences in the facilities’ experiences, supporting ‘analytic generalization’ (Yin 2003). The study’s internal validity was achieved through various methods, such as inclusion of all cases of data (including those that did not quite fit with the original propositions or the theoretical framework [‘deviant case analysis’ (Mays and Pope 2000, p. 89)]) and comparing experiences across cases to identify patterns [‘pattern-matching’ technique (Yin 2003, p. 36)]. Case study reliability and overall rigor were established through well-documented accountability procedures (Yin 2003), such as maintaining the chain of evidence by making sufficient citations from specific data and quotes in the case study database throughout analysis and writing.

One limitation of the study’s data collection process was the small number of interviews at each facility, due to the small number of staff positions at these lowest-level primary-care facilities (Table 3), and, in HP-B, to the absence of health providers for training and leave. Logistical factors such as time and security also posed challenges: e.g. political strikes restricted movements and limited the days available for interviews in HP-B. To address these limitations, multiple sources of data were collected to increase their validity and to triangulate and comprehensively understand the case facilities’ experiences.

Another limitation of the study is that whilst it shows all four propositions are plausible, this is weakly proven due to the small number of case comparisons (only two pairs of health facilities). In order to overcome this limitation, authors present detailed case study narratives which carefully document the experiences and actions of people in each case (Supplementary data, available at HEAPOL online).

The study also demonstrated the limitations of the study’s framework in the analysis of policy implementation. Specifically, the framework does not fully consider the implementation’s context, power, actors’ agency or networks, yet all are central elements of policy change experiences (Walt et al. 2008) and remain relatively under-researched in the health systems literature (Gilson and Raphae 2008). Future work on policy implementation would be strengthened by combining the
Conclusions

This study makes an important contribution to the existing evidence because it uses a carefully designed and rigorous multiple case-study analysis to test the theory-based framework of Nadler and Tushman. Their degree-of-fit questions allowed the author to conduct a detailed analysis of organizational and people factors in Nepal’s implementation of the FHCP, and to test propositions derived from empirical evidence and theory. The study’s findings yield four lessons for the future implementation of equity-oriented policies such as user-fee abolition:

1. Anticipate and address contextual and organizational factors and their interactions when designing and implementing user-fee abolition policies for various levels of a health system.
2. Understand the influence of local governance groups on a policy’s implementation. This study’s findings can help inform future policy implementation studies in similar decentralized situations, because local groups (a) play critical roles in community-based governance and in the accountability of decentralized reforms, and (b) can support or hinder any on-the-ground implementation of centrally driven reform.
3. Build the management capacity and leadership skills of the district managers and the facilities’ In-Charge personnel.
4. Pilot test the operational guidelines with front-line workers to improve the guidelines’ clarity and ensure they reflect the workers’ experiences’ and experiences.

In sum, policy makers need to acknowledge the skills, experiences, and characteristics of the ‘people’ in the organizations where policy changes are implemented.

Acknowledgements

This research would not have been completed without research participants who shared their experiences and those who supported my fieldwork. The authors gratefully acknowledges the contribution of Ms Jyotsna Tamang, Ms Achala Shrestha, Dr Robert Timmons, Dr Devi Prasai, Dr Damodar Adhikari and Dr Amin Acharya. Fieldwork in Nepal was supported by the Research Triangle Institute International (RTI) Health Sector Reform Support Programme (HSRSP) Nepal, UNICEF Nepal Central Region Field Office and their teams.

Supplementary data

Supplementary data are available at HEAPOL online.

Funding

This study was funded by the International Federation of University Women, the Gordon Smith Travelling Scholarship of the Wellcome Trust and travelling and institutional support from Research Triangle Institute (RTI) International-Nepal as well as the Joint Japan World Bank Scholarship. Findings and analysis presented are the authors and do not necessarily reflect those of any of the funders or current affiliation.

Ethical approval

This study received ethical approval from both LSHTM and the Nepal Health Research Council. Conflict of interest statement: None declared.

Endnotes

2. The Dalit, Janajati, Madhesi and Muslim groups have been discriminated against, and their socially excluded status is becoming clearer in various social and development indicators (Bennett et al. 2008).
3. The DPHO/DHO is the focal organisation of each district’s health system; it regulates all the activities related to health services (public health and clinical) at the district level.
4. A judgment of positive fit and negative fit was made by the strengths and frequency of responses. If more than one respondent viewed the combination of factors as strongly influencing the experience either positively or negatively, then there was a (+++) strong fit or (−−−) poor fit. If only one respondent stated the factor was influential then it was judged (+) fit or (−) unfit. However, if that one respondent was the only one who was in a position to explain the situation, then his or her response carried more weight, and the factor was, thus, considered as strongly influencing the experience positively or negatively.
5. For example, Nepali Rupees (NRs) 10-20 [US$0.10-0.20] for dressing; NRs 100 [US$1.20] for stitching; NRs 300 [US$3.60] for delivery.

References


