Mid-Term Review of the 2013-2017 WHO Country Cooperation Strategy: Nepal

December 2015

Mid-Term Review

WHO 2013-2017 Country Cooperation Strategy

Nepal

December 2015

Table of Contents

Executive Summary

A mid-term review was conducted from October 25th 2015 to November 7th 2015 of the WHO Country Collaboration Strategy (CCS) 2013-2017 for Nepal. The main objectives of the review were to assess the *relevance* of WHO CCS in terms of responsiveness to the needs and national health priorities, to determine the *effectiveness* of WHO cooperation of its program implementation and analyze the *sustainability* of WHO-supported results and strategies. The MTR was asked to focus on the WHO response to the national health objectives, coherent and results oriented strategies supported by biennial programs and partnerships. A specific question on WHO's response during and following the earthquake of April 2015 was included.

The methodology applied was to review and analyze relevant documentation and conduct semi-structured interviews and focus group discussions with key informants. A protocol including questions to guide the interviews was used. The preliminary findings, conclusions and recommendations were discussed with senior officials in Ministry of Health and Population and the Country Office to verify findings, observations and test the validity of the conclusions and recommendations. A rapid survey was conducted among the interviewees on their assessment of WHO's performance in Nepal according the organization's core functions

The strategic priorities of the Country Cooperation Strategy 2013-2017 are still valid and relevant, but need to be more focused to avoid that WHO is overstretched in too many areas, and to adapt to the changes in the country, in particular the new Constitution, National Health Policy 2014 and the National Health Strategy 2015-2020. MTR recommends a shift with an increased priority to health system strengthening and non-communicable diseases.

WHO should strengthen its capacity to support and monitor universal health coverage and to address inequity in access to health services. The new Constitution implies restructuring of the state through federal form of governance with special emphasis on decentralization and strengthening local health governance. It calls to restructure central and local authorities to make them more responsive to health needs and provides an opportunity for addressing weaknesses in the current health care system and improve service delivery. WHO should be prepared to assist the Government at this important juncture and play a leading role in advising and coordination of the technical support from the external development partners. Health system strengthening should consequently become a core area for WHO support to Nepal. The health system support up to now has been too fragmented and requires a more holistic approach and enhanced technical capacity within the country office.

The development and finalization of the National Multisectoral Action Plan for Prevention and Control of Non-communicable diseases 2014-2020 has been completed. To operationalize the Multisectoral Action Plan will require an effective follow-up, continued advocacy and technical support. WHO therefore needs to work with Ministry of Health and Population (MoHP), Department of Health Services (DoHS,) other government agencies, civil society, academic and teaching institutions to move forward the NCD agenda. MTR recommends that NCD prevention and control should be a key strategic priority for WHO in Nepal.

The post-earthquake situation and a prolonged fuel crisis may also require reprioritization in the work plan 2016-2017, in particular for monitoring of the health situation and service delivery.

Nepal UNDAF 2013-2017 Outcomes have been articulated in WHO CCS Strategic priorities and are linked to the strategic approaches and the main focus areas. SEARO's flagship priorities are well aligned with the Country Cooperation Strategy.

The six strategic priorities of the Country Cooperation Strategy are to a large extent reflected in the biennial work plans. However, the majority of financial resources for activities have gone to achieve communicable disease control targets, while the other strategic priorities have received limited funding.

Weaknesses in the organizational and administrative structure of the country office has reduced the effectiveness of WHO's work in Nepal. The administrative services have been decentralized to program teams resulting in an increased workload and difficulties in the management of administrative procedures. Many national staff are on continuous short-term contracts, and this is not providing the ideal environment for optimal work performance and pursuing technical excellence. The new leadership in the country office has already taken some steps to address these challenges. However, there is a need to relook at the organizational structure of the office to increase the effectiveness of technical support, program planning & management and administrative services. The organizational structure should reflect the key strategic priorities, an optimal mix of international and national staff with predictable time-limited posts to ensure best work performance.

The Technical Assistance Matrix developed with technical support from WHO used by all external development partners is perceived as a positive step. Although national counterparts perceive most technical assistance provided by the organization as satisfactory, WHO and the country office need to focus and strive towards technical excellence. Staff can spend more time on technical support and building of national capacity. Furthermore, to pay more attention that the technical assistance is fully adapted to the national context and that the recommendations are doable in Nepal. The MTR team has not been able to obtain a list of WHO technical missions for the current biennium,

suggesting that the management and the follow up of technical assistance are not sufficient.

The large field operation with SMOs for the surveillance of AFP and vaccine preventable diseases is providing an important national function, but needs to be handed over in a phased manner to the MoHP & Regional Health Authorities, and expanded to address integrated disease surveillance. This is important to ensure the sustainability of the WHO support in this area.

The continuous and sustained significant support to communicable disease control by WHO in the current work plan may suggest that not enough efforts have been done to institutionalize and hand-over some of these programs to the Government. MTR proposes that this may be assessed as part of reviewing the organizational structure of the country office.

WHO is considered by all stakeholders as a trusted partner working closely with MoHP. The good and close collaboration with MoHP/DoHS is one of the main WHO comparative strengths in Nepal, but the organization is perceived by partners as having difficulties in challenging the Government when needed. Many stakeholders, both within the Government, UN and other stakeholders, suggest that WHO could play a more significant role in providing leadership on matters critical to health, coordination and partnerships. The new management in the country office appears to recognize this and is taking a more active approach on health leadership and coordination.

WHO is participating in and hosting the EDP meeting, but the partners suggest that WHO could play a more active coordinating and advising role. WHO also needs to be more engaged in Joint Annual Review (JAR). MoHP and development partners have concern that WHO has not been able to unwind and mediate to solve the problems related to the GF grants. WHO has had limited engagement with professional societies, academic institutions and civil society.

The WHO's response to the earthquake in April 2015 working with the Government and other partners was considered very satisfactory by all stakeholders. Efficient deployment of experienced WHO staff from the country office, SEARO and other offices shortly after the earthquake and effective coordination with MoHP and other partners are the main reasons for this achievement. WHO as an organization and EHA staff had taken on board the lessons learned from previous disasters effectively serving as lead for the Health Cluster and carrying out disease surveillance and other tasks as expected. Sustained disaster preparedness activities over several years had created a strong commitment from the key decision makers in MoHP and a platform for collaboration with the health partners. The recent establishment of the Health Emergency Operation Centre (HEOC) at the MoHP was shown to be effective and operational because of the preparatory work done.

Recommendations

1. WHO should strengthen its capacity to technically support and monitor universal health coverage and to address inequity in access to health services.
2. Health system strengthening should become a core area for WHO support to Nepal with special attention to:
    a. Supporting MoHP in the devolution process as a consequence of the new Constitution
    b. Health financing and health insurance
    c. Human resources
    d. Quality of care
    e. Quality assurance of pharmaceuticals and National Regulatory Authorities (International TA requested)
3. More focus and resources are needed to prevention and control of non-communicable diseases
    a. Through multisectoral policies and broader engagement with academic, professional and civil societies.
    b. Primary and secondary prevention of NCDs
    c. Mental health and suicide prevention
    d. Tobacco control
    e. Traffic accidents
4. Continue building national capacity for Nepal to be fully IHR compliant.
5. Develop a plan for building up the capacity of integrated disease surveillance and a phased hand-over of the field operations of the SMOs in cooperation with MoHP, USAID and WHO.
6. Increase focus and support for building national capacity in health related research, in particular operational research linked to health system development. This could also imply a closer collaboration with academic, research and teaching institutions.
7. Work with academic and teaching institutions in updating curriculum for pre-service training in key public health areas.
8. Reorganize the country office to address the shortcomings in the program planning & management, the increased focus on health system support, the effectiveness of technical support and administrative services.
9. Establish a coordination mechanism between MoHP and WHO for the planning and implementation of collaborative work plan.
10. Consider reducing the number of task and activities, and identify areas where the main support will come from the Regional office and HQ.
11. Clarify the specific role and responsibilities of UNICEF, UNFPA and WHO related to reproductive, maternal and child health in the country.
12. The country office in cooperation with SEARO could consider how to incorporate the MTR recommendations in the 2016-2017 work plan. It is suggested to revisit the follow-up of the recommendations after a period of 6 and 12months.

Acronyms

AIDS	Acquired Immunodeficiency Syndrome
AFP	Acute Flaccid Paralysis
BCP	Business continuity plan
CCM	Country Coordinating Mechanism
CCS	Country Cooperation Strategy
DDA	Department of Drug Administration
DFID	Department for International Development
DoHS	Department of Health Services
EDP	External Development Partners
EHA	Emergency Preparedness and Humanitarian Action
EPR	Emergencies preparedness, response
GAVI	Global Alliance for Vaccines and Immunization
GF	The Global Fund to Fight AIDS, Tuberculosis and Malaria
GPW	Global Programme of Work
GS	General Service
HEOC	Health Emergency Operation Centre, Ministry of Health and Population
HIV	Human immunodeficiency virus
HSD	Health Systems Development
HQ	WHO Headquarters
HR	Human Resources
IHR	International Health Regulations
IPD	Immunization and Vaccine Development
JAR	Joint Annual Review
JPO	Junior Professional Officer
LDC	Least developed countries
LMIC	Lower middle income countries
MDG	Millenium Development Goals
MNCAH	Maternal, Newborn, Child and Adolescent Health
MoHP	Ministry of Health and Population
MTR	Mid-term review
NCD	Noncommunicable Diseases
NPO	National Professional Officer
NGO	Nongovernment Organization
NHSP	National Health Sector Programme
NHSS	Nepal Health Sector Strategy
NPC	National Planning Commission
PB	Programme Budget
PEN	Package of Essential Noncommunicable Diseases
RO	Regional Office
SEARO	Regional Office for South-East Asia
SMO	Surveillance Medical Officer
SSA	Special Services Agreements
SWAp	Sector-wide Approach
TB	Tuberculosis
UN	United Nations
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Plan
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VDC	Village Development Committee
WB	World Bank

WCO	Country Office
WHO	World Health Organization
WR	World Health Organization Representative

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Introduction

WHO currently implements its Country Collaboration Strategy (CCS) in Nepal for the period 2013-2017.

The strategic priorities of the Country Collaboration Strategy 2013-2017 are:

(1) Achieving communicable diseases control targets.
(2) Controlling and reversing the growing burden of non-communicable diseases.
(3) Promoting health over the life-cycle, focusing on interventions for under privileged and vulnerable populations.
(4) Strengthening health systems within the revitalized primary health care approach and support policy dialogue on health policies, strategies and plans for universal coverage.
(5) Reducing the health consequences of disasters.
(6) Addressing environmental determinants of health.

The Guide for the formulation of the WHO Country Cooperation Strategy (2014) recommends that the CCS be reviewed midway on its implementation and should be linked with the Biannual Work Plan monitoring and assessment of the UNDAF. Furthermore, it suggests that the midterm review should be process-oriented and be used to correct the implementation process of the CCS, including adjustments to changes that may have occurred in the country. The recent political changes with a new Constitution in the country made this MTR also relevant in time.

Due to the earthquake, timing of this Mid-term Review had been modified and postponed. However, it was still considered a timely activity, due to several factors. The year 2015 is the last year of the National Health Sector Programme (NHSP) 2010-2015. The next National Health Sector Strategy 2015-2020 of the Government of Nepal has just been approved. The biennium 2014-2015 is ending and the biennial 2016-2017 WHO Collaborative Programme Budget for Nepal had just been finalized. A new management of WHO Country Office to Nepal has very recently been appointed. The prioritization of WHO managerial and technical focuses' exercise in the WCO has started in September 2015.

The WHO Country Office, in cooperation with SEARO and HQ, therefore initiated this Mid-Term Review (MTR) of the CCS in the Nepal.

Methodology

The MTR had three general objectives:

1. *Relevance* of WHO CCS in terms of responsiveness to the needs and national health priorities of Nepal and the WHO reform context[1];
2. *Effectiveness* of WHO cooperation in terms of progress of its programme implementation (PB2-12-13 and 2014-15) and factors affecting implementation. Recommend specific programmatic and policy-related actions that could further steer programme implementation;
3. Analyze the *sustainability* of WHO supported results and strategies that have a higher probability of benefits to continue over time as a contribution to national health development.

Specific Objectives:

- Review the CCS strategies and their relevance to articulated health priorities in the current context of the country's political and socio-economic development.
- Assess overall progress made against the programmatic commitments, targets and how this progress contributes to the CCS strategies.
- Identify *best practices and lessons learned* from CCS and PB implementation to inform future collaboration.
- Assess strengths and weaknesses of existing partnerships including state partners and civil society with a view to identify relevant partnerships. Assess the effectiveness of partnership mechanisms and collaboration with UN through UNDAF cycles[2].
- Based on the current development landscape, national health priorities, policies, strategies and plans (in particular, Nepal Health Sector Strategy – 3), provide substantive and practical recommendations for steering of the CCS and PB2016-2017.
- Specific question should address WHO's response during and following the earthquake of April 2015.

MTR aims at responding the following critical questions:

1. *Responsiveness*

What are the capabilities of WHO to respond to: (i) changes and/or additional requests from national counterparts, and (ii) shifts caused by external factors in an evolving country context? To what extent has the Country Office been able to respond to changes in national needs and priorities or to shifts caused by crises or major political changes?

[1] Including WHO's Strategic Vision for South-East Asia "1 by 4" Available at http://www.searo.who.int/mediacentre/features/2014/flyer_1by4.pdf?ua=1 accessed on 30 November 2015

[2] Nepal's current UNDAF covers the period from 2013-2017.

2. *Added value/results*

To what extent does WHO-country collaboration add value in addressing global, regional and national health priorities? What are the main WHO comparative strengths in the country – particularly, in comparison to other partners, UN agencies? To what extent would the observed results in the health sector have been achieved without WHO support?

The methodology used included to review and analyze relevant documentation, identify the major stakeholders and interested parties and interview key informants using semi-structured face-to-face interviews and focus group discussions. Based on the objectives and the scope of the MTR, a protocol including questions and prompts to guide the interviews was developed. The Country Office, in cooperation with the MTR Team, identified the major stakeholders and interested parties prior to arrival in the country and this list was adjusted during the course of the review.

The Review Team, consisting of Dr. Eigil Sorensen and Dr. Anton Fric, visited Nepal from October 25th 2015 to November 7th 2015. They met with officials and technical staff in the Ministry of Health and Population, other relevant Government Ministries and agencies, academic and research institutions, UN agencies and civil society organizations. The team had extensive discussions with the WR and WHO Country Office staff. All interviews were recorded.

The preliminary findings, conclusions and recommendations were presented and discussed with the MoHP senior officials and with the Country Office staff towards the end of the mission. This was also done to verify findings, observations and test the validity of the preliminary conclusions and recommendations. Teleconferences were also conducted with CSU and HSD in SEARO and Department of Country Cooperation & Collaboration with UN System, HQ.

Country Context

Nepal is going through a complex transition phase after a decade-long internal armed conflict. Since the signing of the Comprehensive Peace Agreement in November 2006, there have been a number of historic achievements. These include maintenance of the ceasefire, Constituent Assembly elections in 2008, the peaceful declaration of Nepal as a federal democratic republic, and finalization of the New Constitution.[3]

Restructuring of the state through federal form of governance is a prominent current political agenda of the Government. The National Health Policy of 1991 captured the contemporary democratic essence of bringing government services closer to the people, calling for community participation, and seeking increased private sector engagement. The

[3] United Nations Development Assistance Framework for Nepal, 2013-2017

New Constitution indicates a guarantee in access to basic health as a fundamental right of every citizen. National Health Policy 2014 sets out a forward looking agenda for improving the health and well-being of all citizens of Nepal, including the elders, disabled, single women, poor, marginalized and vulnerable communities. It articulates nation's commitment towards achieving Universal Health Coverage. It seeks to place health as a central component of overall development, building partnerships and establishing multi-sectoral collaborations.

National Health Sector Strategy 2015-2020 outcomes are aligned with these policy elements. [4] It puts special emphasis on decentralization and strengthening local health governance and calls to restructure central and local authorities to make them more responsive to current health needs. It also recognizes the necessity of restructuring the health sector to ensure improvements in the health and well-being of the nation in the current socio-political context.

Nepal is governed according to the Constitution of Nepal, which came into effect on 20 September 2015.[5] The dynamic transitional period in Nepal has been felt during the Mid-Term Review of the WHO CCS, when a new President has been selected and the new ministers appointed, with other appointments at the secretaries' and DGs' levels expected soon.

According to a United Nations system, Nepal belongs to the group of the least developed countries (LDCs)[6]. Gross National Product (GDP) per capita has increased from 326.5 USD in 2005 to 654.0 USD (2013)[7]. Annual GDP growth rate in 2013 was 3.7 percent. The catastrophic 7.8 magnitude earthquake on 25 April 2015 and its aftershocks are estimated to have slashed Nepal's Gross Domestic Product growth in financial year 2015 (ended 15 July 2015) by over 1.5 percentage points from the 4.6 % Asian Development Outlook 2015 projection a month before.[8] According to Asian Development Outlook 2015 Update, inflation is estimated to be at 7.2 % in 2015 with 9.0 % expected in 2016. It also indicated

[4] National Health Sector Strategy 2015-2020, Nepal

[5] Constitution of Nepal 2015 (unofficial English translation by International IDEA, UNDP, Nepal Law Society. Available at https://www.google.com/search?q=The+Constitution+of+nepal&num=30&tbm=isch&imgil=P36TuK2yZBRkYM%253A%253BQkZTItEQ0SAQVM%253Bhttp%25253A%25252F%25252Fglocalkhabar.com%25252Fnews%25252Fdeliberations-on-bill-relating-to-the-constitution-of-nepal-2072-begins%25252F&source=iu&pf=m&fir=P36TuK2yZBRkYM%253A%252CQkZTItEQ0SAQVM%252C_&biw=800&bih=471&usg=__ZBSAelP0_5jlV-ZabCehxAf3N-U%3D&ved=0CCgQyjdqFQoTCK3liZ_DgMkCFQkcjgod5z8OWg&ei=eBc_Vq3JHom4uATn_7jQBQ#imgrc=fX74xJgtk2OP9M%3A&usg=__ZBSAelP0_5jlV-ZabCehxAf3N-U%3D accessed on 8 November 2015

[6] http://unctad.org/en/docs/ldc2011_en.pdfm accessed on 8 November 2015

[7] United Nations Statistics Division. World Statistics Pocketbook 2014. Available at http://data.un.org/CountryProfile.aspx?crName=Nepal, accessed on 8 November 2015.

[8] Asian Development Bank: Nepal Economy. Available at http://www.adb.org/countries/nepal/economy accessed on 9 November 2015

that the total cost of recovery from the earthquake is estimated at about $7.1 billion (a third of GDP), about $5.2 billion to repair damage to buildings and infrastructure and the balance to cover economic losses from forgone income. The earthquake caused tremendous loss of lives and properties, slowed process in achieving some of the MDGs, pushed about a million people below the poverty line, and sapped investors' and consumers' confidence.[9]

As in other countries in WHO South-East Asia Region, Nepal is facing an epidemiological transition and double burden of diseases, with the increasing burden of noncommunicable diseases. Out of top 10 causes of deaths, 7 were from noncommunicable diseases - including chronic obstructive pulmonary disease, ischaemic heart diseases, stroke, diabetes mellitus and road injuries (in 2012).[10] Major risk factors for noncommunicable diseases are prevalent in the country. At the same time, diseases from maternal and neonatal conditions, acute respiratory infections, HIV, TB and malaria, in addition to major noncommunicable diseases including neuro-psychiatric conditions, posed still the major burden.

At the national level, the country has achieved Millennium Development Goals (MDGs) 4. and 5. The maternal mortality ratio and under 5 mortality rate have been reduced to 190 and 38 respectively. It means that, between the period of 1990-2014, under five mortality has reduced by 73 percent; and, between 1996-2013, maternal mortality has reduced by 76%. Efforts to tackle tuberculosis, HIV/AIDS and malaria have shown progress in halting and reversing the trend of these diseases.[11] Nepal is on track to meet MDG 1C, to halve the proportion of people suffering from hunger. The nutritional status of children has improved and Nepal is now close to achieving its 2015 MDG target for reducing the percentage of underweighted children. However, stunting still persists at a rate of 41 %.[12] Vaccine Preventable Diseases programme with its central structure and WHO's field officers has achieved 85% full immunization coverage in infants against key childhood diseases.[13] IPV (injectable polio vaccine) has been introduced as part of the completion of

[9] Asian Development Bank. Macroeconomic Update, Nepal, August 2015. Available at http://www.adb.org/documents/macroeconomic-update-nepal-august-2015 accessed on 9 November 2015
[10] WHO Global Health Observatory. Available at http://www.who.int/gho/countries/npl.pdf?ua=1 accessed on 11 November 2015.
[11] Government of Nepal: Nepal Health Sector Strategy 2015-2020.
[12] Ministry of Health and Population, Nepal; WHO, The World Bank; The Partnership for Maternal, Newborn and Child Health; Alliance for Health Policy and Systems Research: Success Factors for Women's and Children's Health. World Health Organization, 2015. Available at http://www.who.int/pmnch/knowledge/publications/nepal_country_report.pdf, accessed on 12 November 2015
[13] Nepal Multiple Indicators Cluster Survey (NMICS) 2014 Key Findings

polio eradication. Measles elimination and rubella control have been targeted for the year 2019.[14]

Some other key findings from the 2014 Nepal Multiple Indicators Cluster Survey 2014 (UNICEF) included skilled birth attendance during delivery (56 percent) and at least one antenatal care visit (68 percent). Nearly half (49 percent) of women of reproductive age are marrying before the age of 18, of them 16 percent were married before the age of 15. Neonatal mortality rate was 23 per 1000 live births, which accounts for 61 percent of under-five deaths. Though access to improved water has increased (to 93 percent), about 71 percent of the water sources were contaminated with fecal coliform.

In the area of other communicable diseases prevention and control, Nepal has achieved leprosy elimination in 2010 at national level. At present, only 10 out of 75 districts have leprosy prevalence rate above the target. 60 district were endemic for lymphatic filariasis; all geographical areas have now been covered with Mass Drug Administration (MDA) and 20 districts have completed its 6 rounds. Remarkable reduction of Kala-Azar cases has been achieved and a new drug introduced. At a National Public Health Laboratory, BSL3 laboratory[15] has been established. A work-plan for the national compliance with International Health Regulations (IHR 2005) has been drafted.[16]

In prevention and control of noncommunicable diseases, the National Multisectoral Plan for Prevention and Control of Noncommunicable Diseases 2014-2020 was finalized, approved by the Cabinet and a road map plan was developed. STEPs Survey for NCD risk factors was conducted in 2013. NCDs' prevention and control has received high level political commitment in Nepal.[17] Adoption of WHO PEN guideline and protocol is being developed for implementation of package for diagnosis and treatment of hypertension, chronic respiratory diseases and diabetes mellitus Type 2 in country context under the coordination of Primary Health Care Revitalization Division, Department of Health Services (DOHS) and will be piloted in two districts in 2016. Except for a recent initiative for road safety, there are limited multisectoral approach to address NCDs and its risk factors.

In spite of the national level data showing that poverty has been falling over the last two decades and there has been a remarkable progress in maternal and child health and some other national level health indicators, there are still signs of large geographical variation, inequality and vulnerability and much higher levels of poverty in rural and mountainous

[14] WHO Nepal. Work of the World Health Organization in Nepal (2014). Annual Report of the WHO Representative. WHO Country Office, Nepal, March 2015.
[15] Biosafety level 3. This level is applicable to clinical, diagnostic, teaching, research, or production facilities in which work is done with indigenous or exotic agents which may cause serious or potentially lethal disease after inhalation.
[16] Source: WHO's key informants interview
[17] Source: WHO's key informants interview

areas, especially the Mid-West and Far-West regions. People living in these regions are mainly self-employed in subsistence agriculture with little cultivable land and hence low productivity. Food shortage is a chronic problem and there is high prevalence of under-nutrition, both under-weight and stunting in children, as well as anaemia. These regions, being remote, also lack access to basic services and amenities.[18] In addition to a high risk of earthquakes (11th on the Global Earthquake Safety Initiative scale), Nepal is also facing floods, drought, heat and cold waves, and forest fires. The country's vulnerability has been felt during the Mid-Term Review, particularly the fuel crisis and a consequent problem with supplies of basic amenities; its impact on health services would require further study, particularly in the less developed Regions.

The sub-national differences and inequities in morbidities and in access to health services are a challenge[19]. For instance, inequities in access and use of maternal health services were reflected in the differences in maternal mortality ratios in different ethnic groups and regional identity. There were also social disparities in nutritional status of mothers and children. The inequities and their detrimental effect on health in the communities have increasingly been recognized.[20] Addressing the equity gaps between poor and rich, between urban and rural populations, and between educated and less-educated populations is the most pressing challenge of the health system in Nepal.[21]

Regarding gender disparities, Nepal's progress towards achieving MDG 3 is fair.[22] However, some disparities in the ratio of girls to boys in primary education by social and geographic locations continue, as well as at the higher secondary level. Furthermore, literacy rate in youths shows a notable gap between urban and rural youths, particularly among females. Economic status is correlated with educational status such that the lower the economic status the lower educational attainment. Women often work for no monetary remuneration, a fact suggesting that a large number of economically active women have no access to economic resources. It is important that WHO should promote gender sensitivity in all areas of its work in Nepal.

[18] Department for International Development; UKaid. Regional Dimensions of Poverty and Vulnerability in Nepal. Available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/209483/Regional-dimension-poverty-nepal-background.pdf accessed on 9 November 2015

[19] Ibid.11

[20] Ministry of Health and Population, Nepal; USAID; UKaid; UNFPA; New Era: Maternal and Child Health in Nepal: The Effects of Caste, Ethnicity, and Regional Identity. March 2013. Available at http://www.dhsprogram.com/pubs/pdf/FA73/FA73.pdf accessed on 11 November 2015.

[21] Ministry of Health and Population: Key informants' consensus

[22] Government of Nepal; UNDP Nepal: Nepal Millennium Development Goals, Progress Report. September 2013. Available at http://www.np.undp.org/content/dam/nepal/docs/reports/millennium%20development%20goals/UNDP_NP_MDG_Report_2013.pdf , accessed on 12 November 2015

The 1978 Alma Ata declaration has influenced the health system development in Nepal, as was evident by the establishment of a network of primary health care facilities and deployment of community health workers to provide essential health services at the community level. [23] There are major challenges in the Nepal health systems which should be addressed. There are, between others, unequal distribution of health care services, inadequate infrastructure and supply of essential drugs, limited regulation of private providers, inadequate budget allocation for health, and poor retention of human resources in rural areas. There are 0.17 doctors per 1000 population, and 0.50 nurses per 1000 population. This represents 0.67 doctors and nurses per 1000 population, which is significantly less than the WHO recommendation of 2.3 doctors, nurses and midwives per 1000 population.[24] There is an unequal distribution of health workers, with their majority working in urban areas. Determining and achieving the "right mix" of health workers, who are productively efficient is a challenge. Only 43 percent of hospitals and 18 percent of PHC facilities had an appropriate skill mix i.e. at least one health worker from each HRH cadre (Medical Doctor, Nurse, Health Assistant, Assistant Health Worker, Laboratory Assistant/Technician, Radiographer). Furthermore, the in-service curriculum does not take into consideration the epidemiological shifts in the population. Only 17.4 percent of Health Workers have received orientation training on NCDs from government.[25]

As far as total health expenditure is concerned, the private sector accounts for 70% of which 81% comes from out-of-pocket payment.[26] The free public health care service covers basic health services with 40 essential drugs; for other services, people have to pay out of their pockets. Out-of-pocket payments have been the main way of financing health care in Nepal.[27] Private health institutions in Nepal make a significant contribution in the health sector. There is a long tradition of collaboration between public and private health care providers. A number of partnerships are operational in the country, with non-for-profit NGOs, private hospitals and medical colleges. However, in the absence of standards in

[23] Shiva Raj Mishra, Pratik Khanal, Deepak Kumar Karki, Per Kallestrup, Ulrika Enemark: National health insurance policy in Nepal: challenges for implementation. Global Health Action, Vol 8 (2015). Nepal Development Society; University of Western Australia, School of Population Health Nepal; Institute of Medicine, Maharajgunj Medical Campus, Kathmandu, Nepal; Nepal Health Economics Association (NHEA), Kathmandu, Nepal; Center for Global Health, Aarhus University, Denmark. Available at http://www.globalhealthaction.net/index.php/gha/article/view/28763, accessed on 12 November 2015.

[24] Ministry of Health and Population. Human Resources for Health, Nepal Country Profile. August 2013. Available at http://www.nhssp.org.np/human_resources/HRH%20profile%20%28QA%29.pdf, accessed on 12 November 2015.

[25] Society for Local Integrated Development Nepal (SOLID Nepal) and Merlin Nepal. Barriers to Effective Policy Implementation and Management of Human Resources for Health in Nepal: The Distribution and Skill Mix of Human Resources for Health in Nepal. Lalitpur, Nepal, 2012. Available at http://www.merlin.org.uk/sites/default/files/Report%201.pdf accessed on 12 November 2015.

[26] Available at http://data.worldbank.org/indicator/SH.XPD.OOPC.ZS/countries, accessed on 12 November 2015

[27] Ministry of Health and Population, Nepal. Nepal Health Sector Programme – Implementation Plan 2010-2015.

partnership structures or its effective supervision and monitoring, these partnerships may lack long-term strategic commitments and sustainability. Particularly, when decentralization occurs, the public sector would have to take a stronger role in providing stewardship and regulatory functions. Pharmaceutical industry in the country is booming; about 40 percent of the essential medicines list in Nepal is produced domestically, by 50 manufacturing sides[28] out of which a half have currently been certified. An improvement of National Medicine Laboratory technical capacity, assessment of the quality of medicines and their monitoring, and regulatory capabilities would be the essential focused activities for WHO's technical assistance in the near future.

The contribution of external development partners during NHSP I and II has remained almost one third of the total MoHP expenditure, highest being 42 percent in 2009-2010 and lowest being 25 percent in 2013-2014.[29] As Nepal plans to graduate to LMIC by 2022, it is likely that in future EDP's investment in health may decrease. This gap is then expected to be filled through increased government investment in health. There is an anticipated fiscal deficit in the years to come because the earthquake that could threaten the social gains made during the last decade. Over the period of NHSP I and II, MoHP has introduced different interventions to increase the utilization of priority interventions (e.g. free care, safe delivery) and provide financial protection to the poor and selected target groups. Consequently, per capita expenditure in the health sector has witnessed an increasing trend (USD 39 in 2013) and a decreasing trend of out-of-pocket spending.[30] However, out-of-pocket expenditure still constitutes the largest (49 percent) source of funding in Nepal. In the absence of comprehensive regulatory fee structure, citizens face unfair prices and/or inadequate, inappropriate or unnecessary services when seeking care. [27]

The New Constitution indicates that every citizen should get the basic health services free of cost. Currently, 61.8% of the Nepalese households have access to health facilities within 30 minutes, with differences between urban (85.9%) and rural (59.0%).[31] In February 2015, a Social Health Security Development Committee was set-up, to implement a social health security scheme. This scheme should ensure universal health coverage, mainly increasing access to, and utilization of, quality health services.[32] The recently endorsed National Health Insurance Policy foresees the integration of all social protection schemes, demanding a clear roadmap towards this end. There is a need to formulate a comprehensive health financing strategy to garner adequate resources in the health sector, ensure efficient and effective utilization of available resources, and to streamline different social health protection schemes.

[28] Director General Drug Administration, Ministry of Health and Population, interviewed on 29 October 2015
[29] Government of Nepal. National Health Sector Strategy 2015-2020
[30] World Health Organization. Global Health Expenditure Database, 2013
[31] Central Bureau of Statistics, Government of Nepal. Nepal Living Standard Survey 2010-2011.
[32] Government of Nepal. National health insurance policy. 2013.

The strategic document – the Nepal Health Sector Strategy 2015-2020 – addresses the above-mentioned issues of the health system. As the government moves to progressively realize Universal Health Coverage, it remains committed to expand health services, increase the population coverage and reduce financial burden for the citizens. Technical support from developing partners, under a WHO's leadership, in tackling the health system development challenges in a federal system of the Government would be required. Reducing disparities in health, stronger management and multi-sectoral collaboration in recognition of the importance of sectors beyond health, building effective and well-regulated partnerships with the private sector, building capacities in decentralized planning, and establishing a sound health financing strategy in a partnership with external development partners are some of the key areas for a concerted efforts of all stakeholders in health in Nepal.[33]

Findings

Relevance

There are six strategic priorities in the CCS 2013-2017 with a total of 21 main focus areas. The CCS Guide 2014 recommends maximum of 3-5 strategic priorities and 1-3 focus areas under each strategic priority[34]. This suggests that the current CCS is maybe too expansive with too many strategic priorities and focus areas. For example, the specific role and responsibilities of UNICEF, UNFPA and WHO related to reproductive, maternal and child health in the country could be better defined to avoid overlap. The risk is therefore that the Organization spreads its technical and financial resources too thinly with the chance of less long-term impact. WHO's programmatic reform involves explicit priority setting to avoid an overcommitted and overstretched Organization. The MTR therefore recommends that the country office consider reducing the number of focus areas, tasks and activities in the work plan, and identify areas where the main support will come from the Regional office and HQ.

The strategic priorities of the Country Cooperation Strategy 2013-2017 are still valid and relevant, but need to be more focused to avoid that WHO is overstretched in too many areas, and to adapt to the changes in the country, in particular the new Constitution, National Health Policy 2014 and the National Health Strategy 2015-2020. WHO in Nepal is currently spending more than 50% of its financial allocation for activities and technical staff on communicable diseases control. MTR recommends a shift with an increased priority to health system strengthening and non-communicable diseases.

[33] HEART (Health & Education Advice and Resource Team): NHSP II Mid Term Review Report, 2013.
[34] World Health Organization. Guide for the formulation of the WHO Country Cooperation Strategy. 2015.

Health system

Nepal Health Sector Strategy (NHSS) 2015-2020 has four strategic pillars:

1. Quality health services
2. Equitable access to health services
3. Health system reforms
4. Multisectoral approach

The NHSS therefore centers on health system strengthening. MTR recommends that WHO should strengthen its capacity to support and monitor universal health coverage and that health system strengthening should become a core area for WHO support to Nepal. This is in line with WHO's global priority in the area of health systems for moving towards universal health coverage. Health system support has in the past been too fragmented and need a more holistic approach.

The country office in Nepal unlike most other countries in the region does not have a full-time person working on health systems. The Government is looking to WHO to provide further assistance, in particular for the decentralization and strengthening local health governance. The country office should therefore consider establishing a P-5 post on health systems. The country should continue to draw on technical support in health systems from SEARO and HQ when required, particular for decentralization, health sector financing, quality of health care, public private partnership and oversight of non-State actors. Management of human resources for health also still remains a challenge.

Ministry of Health and Population and Department of Drug Administration (DDA) in Nepal expressed the need for technical assistance to strengthen the regulatory system and quality control of pharmaceuticals. An increasing number of domestic pharmaceuticals companies highlights the need for strengthening of the regulatory system, quality control towards compliance with international standards and oversight by the Department of Drug Administration. This is an area where MoHP and DDA to a large extent rely on WHO for technical support as no other agency is involved.

Noncommunicable diseases

The development and finalization of the National Multisectoral Action Plan for Prevention and Control of Non-communicable diseases 2014-2020 has been completed. In June 2014, the draft action plan was submitted for cabinet approval. Nepal has a coordination committee in place with the highest-level national coordination committee chaired by Chief Secretary, Prime Minister's office and member secretary is the Secretary of Ministry of Health. However, NCDs is not yet positioned and prioritized in the national development agenda. NCD activities are mostly integrated within the health system focusing on traditional disease management model. To operationalize the Multisectoral Action Plan will require an effective follow-up, continued advocacy and technical support. WHO therefore needs to work with MoHP, DOHS, other government agencies, civil society, academic and

teaching institutions to move forward the NCD agenda. MTR recommends that NCD prevention and control should be a key strategic priority by WHO in Nepal.

The post-earthquake situation and a prolonged fuel crisis may also require reprioritization in the work plan 2016-2017, in particular for monitoring of the health situation and service delivery.

Effectiveness

Weaknesses in the organizational and administrative structure of the country office has reduced the effectiveness of WHO's work in Nepal. The administrative services have been decentralized to program teams resulting in an increased workload and difficulties in the management of administrative procedures. Many national staff are on continuous short-term contracts, and this is not providing the ideal environment for optimal work performance and pursuing technical excellence. There are few international staff and several vacancies have not been filled. The new leadership in the country office has already taken some steps to address these challenges. However, there is a need to relook at the organizational structure of the office to increase the effectiveness of technical support, program planning & management and administrative services. The organizational structure should reflect the key strategic priorities, an optimal mix of international and national staff with predictable time-limited posts to ensure best work performance.

Program implementation

For the first year of the biennium 2014-2015, implementation rate was 43.6 percent (against USD 20,514,109 planned cost) and 74.2 percent (against USD 12,039,933 awarded budget). Out of the total awarded budget, 64.1 percent was awarded for the activity work plan. As of 11 November 2015 (less than 2 months before the end of the biennium), the implementation rate was 80.5 percent (against the planned cost) and 87.0 percent (against the awarded budget). Taking into consideration the April 2015 earthquake, and its consequences in focusing the WHO's assistance, the financial implementation rate as of November 2015 may be considered satisfactory; however, in the biennium 2016-2017,more efforts could be made to increase financial implementation during the first year of the biennium.

There has not been a full-time person on program planning, monitoring and evaluation. This may be one of the reasons that program planning and implementation has been sub-optimal resulting in slow program implementation, in particular prior to the earthquake. It has also been highlighted by MoHP that the dialogue with MoHP on the development of the collaborative work plan 2016-2017 was limited. Regular reviews of the program activities with the technical units of the MoHP and improved coordination between WCO technical staff and their counterparts could enhance financial implementation of the collaborative activities and maintain the quality of the outcomes.

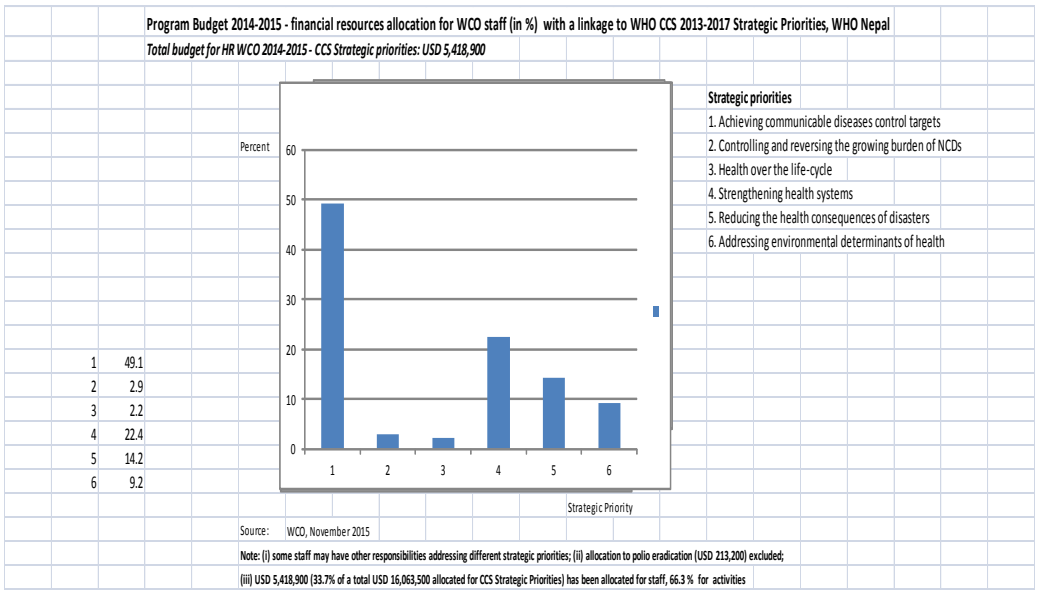
Progress made against programmatic commitments and targets

The MTR Team looked at a linkage of WHO CCS Strategic Priorities to Programme Budget allocations – for technical staff and for activities – for both 2014-2015 and 2016-2017 biennia. The following are the main features of the findings:

(i) For 2014-2015, 33.7% of a total budget (USD 16,063,500) was allocated for technical staff, 66.3% for activities. For the biennium 2016-2017, 31.2% of a total budget (USD 16,649,840) was allocated for staff, and 68.8% for activities. No remarkable difference between two biennia.

(ii)*Financial allocation for technical staff*. For *2014-2015*, 49.1% of a total allocation for technical staff (of USD 5,418,900)went for communicable diseases, 22.4% for the staff in health systems, 14.2% for disaster preparedness / response, 9.2% for environmental health and between 2-3 % for noncommunicable diseases and life-cycle programs. Taking into account WHO CCS 2013-2017 Strategic Priorities, it is a misbalance in distribution of resources for the technical staff, with a huge preference of communicable diseases programs. For a biennium *2016-2017*, however, there is a shift and more balanced distribution of financial resources for the technical staff: 31.8% of a total for staff (of USD 5,188,200) would go for communicable diseases, 26.1% for health systems, 17.8% for disaster preparedness, between 10-11% for NCDs and Life-cycle areas, and 9.6% for environmental health.

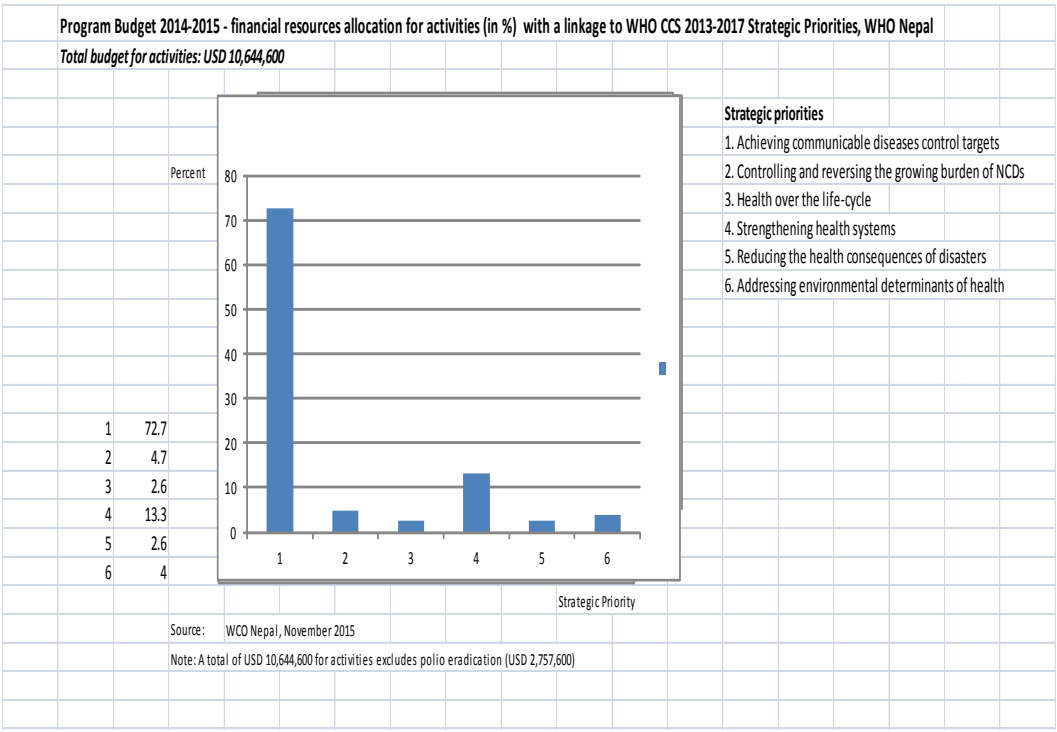
Fig.1



(iii)*Financial allocation for activities*. For *2014-2015*, 72.7% of a total budget for activities (of USD 10,644,600) went to communicable diseases, 13.3% to health systems, and between 3-5% to remaining CCS priorities. Again a remarkable misbalance, taking into consideration WHO CCS Strategic Priorities. For *2016-2017*, a more balanced distribution of resources for activities was observed (of a total USD 11,461,640 for activities) – 43.6 % for

communicable diseases, 21.1% for health systems, 13.9% for disaster preparedness and between 3-7% for remaining three CCS strategic priorities.

Fig.2



The MTR Team studied *the coherence between the CCS strategic priorities and the biennial work plans*. One main focus area was randomly selected from each CCS strategic priority and linkages between strategic approaches of CCS and top tasks and activities of the work plans 2014-2015 and 2016-2017 were assessed. For *2014-2015*, 18 strategic approaches from the randomly selected main focus areas guided 23 top tasks and activities, and for *2016-2017*, 28 top tasks and activities.

In Strategic Priority 1. – Communicable Diseases, in 2016-2017 work plan, there seems to be a repetition of the 2014-2015 activity – Malaria Strategy Revision, for USD 220,000.

In Strategic Priority 2 – NCDs, the funds planned for ”Support integration of mental health within a revitalized PHC system” have been shifted to three not-related tasks – for Multi-sectoral NCD Plan (USD 245,000 for 2014-2015) and one not-related task for USD 62,800.

Other top tasks and activities for 2014-2015 and those planned for 2016-2017 were found in coherence with the main focuses and their strategic approaches of CCS 2013-2017.

For 2014-2015, WHO has been able to provide technical and policy support in the Regional Flagship Priorities linked to the strategic focus in the CCS and outputs of the work plan[35]. For the biennium 2016-2017, all regional flagships have been addressed in top tasks, particularly measles elimination and control of rubella/CRS target, prevention / control / monitoring framework for NCDs, development of RNMCAH plans based on National Strategy, UHC (essential drugs/quality/regulatory, HRH, preparedness and response to emergencies / IHR, Antimicrobial resistance as a national priority/awareness/surveillance systems and Neglected Tropical Diseases control and elimination.

Technical assistance

The Technical Assistance Matrix developed with WHO's technical support and used by all external development partners is perceived as a positive step. The mid-term review of the NHSP II highlighted that technical assistance is most often seen by the EDPs as very well aligned with the government and providing well-targeted support, but government managers cited that they have little input on decisions on technical assistance and that the purpose of building capacity of the government is not met[36]. Although the most technical assistance provided by WHO is perceived as satisfactory by national counterparts, WHO and the country office need to focus and strive towards technical excellence and that technical staff can spend more time on technical support and building of national capacity. Furthermore, to pay more attention that the technical assistance is fully adapted to the national context and that the recommendations are doable in Nepal.

The MTR team has not been able to obtain a list of WHO technical missions for the current biennium, suggesting that the management and the follow up of technical assistance are not sufficient.

Sustainability

Sustainability in this MTR is considered as the likelihood that the impact of WHO interventions will be maintained over time.

WHO in Nepal has contributed to national strategies, policies and plans in several important areas in such as NCD multisectoral plans, Leprosy Elimination Strategy, Reproductive Health Strategy, National Guidelines for Vector Borne Diseases Prevention and Control. The sustainability will only be effective if the policies and plans supported by WHO are implemented. The earthquake response (See section below) is an example where WHO together with other partners worked consistently with the Government over several years in building national capacity and preparedness that proved to be effective at the time of the earthquake.

[35] http://www.searo.who.int/mediacentre/features/2014/flyer_1by4.pdf?ua=1
[36] Ibid. 32

The recent report on the success factors for women's and children's health in Nepal also provide some important lessons learned in terms of sustainability [37]. Concerted action led by the Government with support of the WHO and other EDPs through the SWAp, NGOs and civil society contributed to the significant reduction observed in maternal and child mortality. A multi-faceted approach recognizing the inequalities and topographical challenges of Nepal in terms of access, improve quality of care, family planning and filling the human resource gap are some of the contributory factors. Despite rapid turnover in leadership, the MoHP has led in policy formulation and advocacy, promoted good coordination with health sector EDPs. Sustained support by WHO over several years closely coordinated and in partnership with other EDPs and under the Government leadership is likely to have the greatest impact.

The large field operation with SMOs for the surveillance of AFP and vaccine preventable diseases is providing an important national function and has been in place since 1999. This has undoubtedly contributed to the success of the immunization program in Nepal and reduced child mortality. This is also an example of a successful partnership between MoHP, WHO and USAID. However, there is a question about the sustainability as this has been run by WHO over many years and has not been embedded into the MoHP/DoHS and regional structure. At the moment, this is mostly substitution of work that normally will be carried out by the Government. Recognizing the significance of the work done by the SMOs and the need expanded into integrated disease surveillance, MTR recommends that handover to the MoHP & Regional Health Authorities will be done in a phased manner.

The continuous and sustained significant support to communicable disease control by WHO in the current work plan may suggest that not enough efforts have been done to institutionalize and hand-over some of these programs to MoHP/DoHS. MTR proposes that this may be assessed as part of reviewing the organizational structure of the country office.

Partnerships

WHO is considered by all stakeholders as a trusted partner working closely with MoHP. However, many partners both within the Government, UN and other stakeholders consider that the country office could play a more significant role in providing leadership on matters critical to health, coordination and partnerships. Except for the earthquake response, WHO has often been perceived as not being active enough, in particular by the UN and the development partners. MoHP and development partners expressed concern and disappointment that WHO has not engaged to unwind and mediate to solve the current problems related to the CCM and the GF grants.

One of the main WHO comparative strengths in Nepal in comparison to other partners and UN agencies is its good and close collaboration with MoHP/DoHS. However, WHO is

[37] World Health Organization. Success factors for women's and children's health: Nepal. 2015.

perceived by partners as having difficulties in challenging the Government when needed. Government staff also complained that WHO was to lenient accepting any nominations for internationals meetings although they were not the appropriate participants. While WHO is working closely with governments and national health authorities, the ability to challenge governments when necessary is an important part of WHO's role working in and with countries.

WHO is participating in and hosting the EDP meeting, but the partners suggest again that WHO could play a more active role. WHO chaired the EDPs in the past, but this is now on rotation with UNICEF being current chair. A co-chair role of WHO as done in some other countries and as expressed by some of the development partners could be considered if the EDPs and MoHP considered this useful.

WHO also needs to be more engaged in Joint Annual Review (JAR). The MTR of the NHSP II recommended that while the National Annual Review and the JAR should remain separate, format for the review should be revised to incorporate more space for analytical discussion of the findings.

WHO has in recent years had limited engagement with professional societies, academic institutions and civil society. MTR believes that there is considerable scope for working with non-State actors in pursuing WHO's mandate and its Core Functions in line with the 12th GPW[38].

The new management in the country office appears to recognize the issues related to partnerships and is taking a more active approach on health leadership and coordination.

UNDAF

Nepal UNDAF 2013-2017 Outcomes, particularly of its Component I. (Advancing equality through equity) and of the Component II. (Protecting development gains), have been articulated in WHO CCS Strategic priorities and are linked to main focuses and strategic approaches. In its Component I. the UNDAF lists the key challenges for Nepal, which include "universal access to primary health care while responding to changing morbidity and mortality pattern due to social, demographic and climate changes", maternal and neonatal health care, child health, water / sanitation, rapid urbanization and its consequences". CCS Strategic priorities 1., 3., 4. and 6. address all those issues and the top tasks and activities are being implemented. UNDAF expected results in attainment of the health-related MDGs with respect to maternal and child health, adolescent and neonatal care, reduction of burden of communicable diseases (TB, HIV/AIDS, malaria), reproductive health and population interventions addressing non-communicable diseases through a multi-sectoral approach have been in the coherence with the main focuses and strategic

[38] World Health Organization. Twelth General program of Work. Not merely the absence of disease.2014.

approaches of the CCS. A partnership support of UN agencies in "enhancing the evidence base for social sector policies" are explicitly indicated in the CCS Strategic Priority 4., main focus 4.5. Outcomes 5. and 6. of the UNDAF Component I. captures the effectiveness and accountability of governance, as well as the more specific governance needs related to transitioning to a federal republic. The Main Focus 4.1 of the CCS Strategic Priority 4. and its strategic approaches are linked to these UNDAF outcomes, and, at the same time, prioritization of the work-plan in top tasks and activities are being streamlined taking into consideration the current dynamics of the new Constitution and the National Health Sector Strategy 3. 2015-2020.

Outcome 7. of the UNDAF Component II. focuses on protecting development gains by strengthening national and local government capacity to reduce risk and adapt to climate change as well as addressing the needs of people vulnerable to climate change and disasters. WHO CCS for Nepal, in its Strategic Priority 5. (main focuses on strengthening national capacity and coordination in health sector emergency risk management and promoting and supporting a coherent inter-sectoral approach to health emergency preparedness and response including recovery), and in the Strategic Priority 6. which supports efforts to identify and mitigate the public health impact of climate change, indicates WHO's focus in relation to the UNDAF Component II., Outcome 7.

Earthquake response

The WHO's response to the earthquake on April 2015 working with the Government and other partners was considered very satisfactory by all stakeholders. Efficient deployment of experienced WHO staff from the country office, SEARO and other offices shortly after the earthquake and effective coordination with MoHP and other partners are the main reasons for this achievement. WHO as an organization and EHA staff had taken on board the lessons learned from previous disasters effectively serving as lead for the Health Cluster and carrying out disease surveillance and other tasks expected by the organization. Furthermore, sustained disaster preparedness activities over several years had created a strong commitment from the key decision makers in MoHP and a platform for collaboration with the health partners.

WR had emergency experience and mobilized the whole country office shortly after the earthquake, and highlight the need for head of WHO country office to have practical experience in managing emergencies. The country office staff had technical skills and knowledge from previous emergencies and the country office had finalized Emergency SOPs 2013, and business continuity plan (BCP) in 2014, and SEARO had developed benchmarks on emergencies preparedness, response (EPR) in 2011.

WHO provided support to the central level coordination team especially on deployments, information management, and the logistics. The recent establishment of the Health Emergency Operation Centre (HEOC) at the MoHP was have shown to be effective and

operational because of the preparatory work done. WHO mobilized Emergency District Support Team (WEDST) to 14 highly affected districts for supporting DHO/DPHO for assessment, surveillance and coordination using the existing surveillance medical officers (SMOs). Prepositioning of medical kits and medical supplies in strategic locations was also important. WHO response included the use for the first time of the newly developed medical camp kit (MCK). While release of emergency funds from SEARO and HQ was done efficiently for the initial response, procurement still remains a bottleneck for WHO in the post-disaster situation.

Success factors

The MTR team heard unanimous praise and recognition of WHO's effective response to the earthquake. It is therefore important to analyze the factors that contributed to this achievement and generate some lessons learned that maybe be applicable for the work of WHO in Nepal in general:

- *Need for strong leadership*
- *Good technical skills and knowledge within the county office*
- *Effective use of technical resources across the organization*
- *Sustained support over several years giving opportunity to institutionalize technical support into national policies and guidelines*
- *Building a joint platform for collaboration with MoHP and development partners*

Best practices

- Show leadership when health matters
- Use human resources within all of WHO
- Mobilize the whole country office when needed

Lessons learned

- Working closely with MoHP but maintain integrity
- Consistent technical and policy support over a longer period provide greatest impact
- Focus on technical excellence
- Be better organized within the office

Conclusion

The strategic priorities of the Country Cooperation Strategy 2013-2017 are still valid and relevant, but need to be more focused to avoid that WHO is overstretched in too many areas, and to adapt to the changes in the country, in particular the new Constitution, National Health Policy 2014 and the National Health Strategy 2015-2020. The majority of financial resources in the work plan have is currently going to achieve communicable disease control targets, while the other strategic priorities have received limited funding. MTR recommends a shift with an increased priority to health system strengthening and non-communicable diseases.

The new Constitution implies restructuring of the state through federal form of governance with special emphasis on decentralization and strengthening local health governance. WHO should be prepared to assist the Government at this important juncture and play a leading role in advising and coordination of the technical support from the external development partners. Health system strengthening should consequently become a core area for WHO support to Nepal. The health system support up to now has been too fragmented and requires a more holistic approach and enhanced technical capacity within the country office.

To operationalize the Multisectoral Action Plan will require an effective follow-up, continued advocacy and technical support. WHO therefore needs to work with Ministry of Health and Population (MoHP), government agencies, civil society, academic and teaching institutions to move forward the NCD agenda. MTR recommends that NCD prevention and control should be a key strategic priority for WHO in Nepal.

SEARO's flagship priorities are well aligned with the Country Cooperation Strategy.

Nepal UNDAF 2013-2017 Outcomes, particularly of its Component I. (Advancing equality through equity) and of the Component II. (Protecting development gains), have been articulated in WHO CCS Strategic priorities and are linked to main focuses and strategic approaches

The post-earthquake situation and a prolonged fuel crisis may require reprioritization in the work plan 2016-2017, in particular for monitoring of the health situation and service delivery.

Weaknesses in the organizational and administrative structure of the country office has reduced the effectiveness of WHO's work in Nepal. There is a need to relook at the organizational of the office to increase the effectiveness of technical support, program planning & management and administrative services. The organizational structure should reflect the key strategic priorities, an optimal mix of international and national staff with predictable time-limited posts to ensure best work performance.

The country office program planning and implementation has not been optimal with limited dialogue with MoHP on the new work plan. The country office was lagging behind in the program implementation, especially for the first year of this biennium and prior to the earthquake.

The Technical Assistance Matrix developed with technical support from WHO used by all external development partners is perceived as a positive step. Although national counterparts perceive most technical assistance provided by the organization as satisfactory, WHO and the country office need to focus and strive towards technical excellence. The MTR team has not been able to obtain a list of WHO technical missions for the current biennium, suggesting that the management and the follow up of technical assistance are not sufficient.

The large field operation with SMOs for the surveillance of AFP and vaccine preventable diseases is providing an important national function, but needs to be handed over in a phased manner to the MoHP & Regional Health Authorities, and expanded to address integrated disease surveillance. This is important to ensure the sustainability of the WHO support in this area.

The continuous and sustained significant support to communicable disease control by WHO in the current work plan may suggest that not enough efforts have been done to institutionalize and hand-over some of these programs to the Government. MTR proposes that this may be assessed as part of reviewing the organizational structure of the country office.

WHO is considered by all stakeholders as a trusted partner working closely with MoHP. The good and close collaboration with MoHP/DoHS is one of the main WHO comparative strengths in Nepal, but the organization is perceived by partners as having difficulties in challenging the Government when needed. Many stakeholders, both within the Government, UN and other stakeholders, suggest that WHO could play a more significant role in providing leadership on matters critical to health, coordination and partnerships. The new management in the country office appears to recognize this and is taking a more active approach on health leadership and coordination.

WHO is participating in and hosting the EDP meeting, but the partners suggest that WHO could play a more active coordinating and advising role. WHO also needs to be more engaged in Joint Annual Review (JAR). MoHP and development partners have concern that WHO has not been able to unwind and mediate to solve the problems related to the GF grants.

WHO has had limited engagement with professional societies, academic institutions and civil society.

The WHO's response to the earthquake on April 2015 working with the Government and other partners was considered very satisfactory by all stakeholders. Efficient deployment of experienced WHO staff from the country office, SEARO and other offices shortly after the earthquake and effective coordination with MoHP and other partners are the main reasons for this achievement. WHO as an organization and EHA staff had taken on board the lessons learned from previous disasters effectively serving as lead for the Health Cluster and carrying out disease surveillance and other tasks expected by the organization. Sustained disaster preparedness activities over several years had created a strong commitment from the key decision makers in MoHP and a platform for collaboration with the health partners.

Recommendations

1. WHO should strengthen its capacity to technically support and monitor universal health coverage and to address inequity in access to health services.
2. Health system strengthening should become a core area for WHO support to Nepal with special attention to:
    a. Supporting MoHP in the devolution process as a consequence of the new Constitution
    b. Health financing and health insurance
    c. Human resources
    d. Quality of care
    e. Quality assurance of pharmaceuticals and National Regulatory Authorities (International technical assistance requested)
3. More focus and resources are needed to prevention and control of non-communicable diseases
    a. Through multisectoral policies and broader engagement with academic, professional and civil societies.
    b. Primary and secondary prevention of NCDs
    c. Mental health and suicide prevention
    d. Tobacco control
    e. Traffic accidents
4. Continue building national capacity for Nepal to be fully IHR compliant.
5. Develop a plan for building up the capacity of integrated disease surveillance and a phased hand-over of the field operations of the SMOs in cooperation with MoHP, USAID and WHO.
6. Increase focus and support for building national capacity in health related research, in particular operational research linked to health system development. This could also imply a closer collaboration with academic, research and teaching institutions.
7. Work with academic and teaching institutions in updating curriculum for pre-service training in key public health areas.
8. Reorganize the country office to address the shortcomings in the program planning & management, the increased focus on health system support, the effectiveness of technical support and administrative services.

9. Establish a coordination mechanism between MoHP and WHO for the planning and implementation of collaborative work plan.
10. Consider reducing the number of task and activities, and identify areas where the main support will come from the Regional office and HQ.
11. Clarify the specific role and responsibilities of UNICEF, UNFPA and WHO related to reproductive, maternal and child health in the country.
12. The country office in cooperation with SEARO could consider how to incorporate the MTR recommendations in the 2016-2017 work plan. It is suggested to revisit the follow-up of the recommendations after a period of 6 and 12months.

Annex 1: List of persons interviewed

S.N.	Name	Title	Organization
1	Dr Jos Vandelaer	WHO Representative to Nepal	WHO
2	Dr Akjemal Magtymova	Public Health Administrator	WHO
3	Mr Shanta Bahadur Shrestha	Secretary	MoHP
4	Mr Mahendra Shrestha	Chief, Planning Policy International Cooperation Division (PPICD)	MoHP
5	Dr G.D Thakur	Public Health Administration Monitoring and Evaluation Division (PHAMED)	MoHP
6	Dr Kiran Regmi	PHAMED	MoHP
7	Dr Guna Raj Lohani	Chief, Curative Service Division, Health Emergency Operation Centre (HEOC)	MoHP
8	Dr Senendra Raj UpretI	Director General, Department of Health Services (DoHS)	DoHS
9	Mr. Achyut Lamicchane	Director, National Health Training Center	DoHS
10	Dr Dipendra Raman Singh	Director, National Centre for AIDS/HIV and STD Control	DoHS
11	Dr Krishna Paudyal,	Director Child Health Division	DoHS
12	Dr Baburam Marasini	Director, Epidemiological Disease Control Division (EDCD)	DoHS
13	Dr Ramesh Kharel	Director, Primary Health Care Division	DoHS
14	Dr Narayan Dhakal,		Ministry of Finance
15	Mr. Bal Krishna Khakurel,	Director General, Department of Drug Administration	Department of Drug Administration
16	Mr. Rene Bernard Michel TOMASZEK,	Consultant – logistics Emergency Health Preparedness	WHO

17	Mr Shankar Nepal	Under Secretary, Department of Civil Registration	Ministry of Local Development and Federal Affairs
18	Mr Bishnu Nepal	Under secretary, National Planning Commission	National Planning Commission
19	Ms Linda Kentro	Environmental Health Team Leader	USAID
20	Dr Andrew Castle	Consultant (previous WHO staff)	GH Associates
21	Paul/Franciscka	Health Advisor	GIZ
22	Dr. Hendrikus Raaijmakers	Chief of Health Section Chair, EDPs	UNICEF
23	Dr Edwin Salvadore	EHA	WHO
24	Dr Nihal Singh	CDC	WHO
25	Dr Prakash Ghimire	CDC	WHO
26	Dr Zainab Naimy	JPO,RMNCAH/GER	WHO
27	Dr Keshav Yogi	NTD, NPO	WHO
28	Dr Damodar Pokhrel	NPO EHA	WHO
29	Dr Jagannath Giri	NPO IPD	WHO
30	Dr Ganga Ram Chaudhary	NPO IPD	WHO
31	Dr Lonim Prasai Dixit	NPO NCD	WHO
32	Prof. Dr Arjun Karki		PAHS (former VC)
33	Prof. Dr Bhagwan Koirala	Professor	Manmohan Cardiovascular Institute, Institute of Medicine
34	Dr Suniti Acharya	Former WHO staff	CSO
35	Dr Rita Thapa	Former WHO staff Chairperson	Bhaskar Memorial Foundation (CSO)

36	Dr B.D Chathaut	Managing Director	Central Institute of Science and Technology (CSO)
37	Dr Lata Bajracharya,	President	NESOG
38	Dr Yasho Vardhan Pradhan,	President	SoPHEN
39	Dr Pradeep Vaidya		Institute of Medicine
40	Prof. Dr. Ganesh Bahadur Gurung,	VC, NAMS	National Academy of Medical Sciences
41	Dr. Sushil Baral	Executive Chair	HERD
42	Mr. Amit Aryal	Freelance, Health System	
43	Dr Khem Karki,	Member Secretary	Nepal Health Research Council
44	Dr Dharmakanta Baskota	Chairperson	Nepal Medical Council
45	Mr. Shravan Kumar Mishra	Chairperson	Nepal Health Professional Council
46	Ms Chandrakala Sharma	President	Nepal Nursing Council
47	Dr Rui Paulo de Jesus	Country Support and Coordination	SEARO
48	Dr Phyllida Travis	Director, DHS	SEARO
49	Dr Funke Bolujoko	Dept of Country Cooperation & Collaboration with UN System	WHO HQ
50	Ms Preeti Kudesia	Senior Health Specialist	World Bank
51	Ms. Nicholas Cadge.	Health Advisor	DFID
52	Mr Deepak Paudel	Health Advisor	DFID
53	Dr Ruben Del Prado	Country Coordinator	UNAIDS
54	Ms Giulia Vallese	Representative	UNFPA
55	Mr. Tomoo Hozumi	Representative	UNICEF

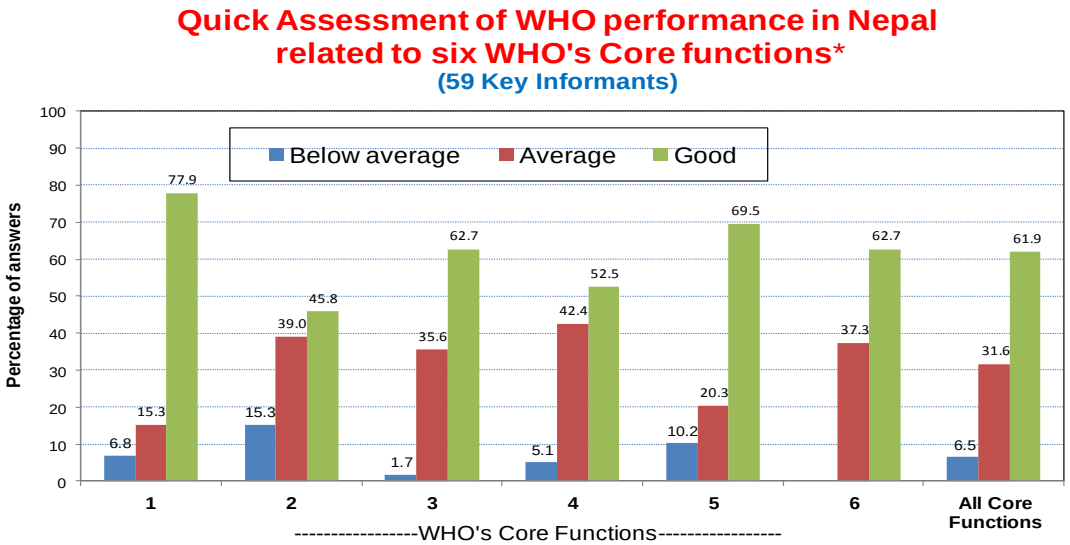
Annex 2: A quick assessment of WHO's performance in Nepal according to the Core Functions of the Organization

WHO's Core Functions are set out in the Twelfth General Programme of Work[39], which provides the framework for organization-wide programme of work, budget, resources and results. Entitled "Not merely the absence of disease", it covers the 6-year period from 2014 to 2019. During the Mid-Term Review, a quick assessment of key informants' perception about WHO's performance in Nepal related to six WHO's Core Functions was conducted. This was also done to prime the interviewees on WHO's core function. 59 respondents participated in the assessment (19 key informants from the Government of Nepal, 9 from development partners, 13 from Civil society/Academia/medical and nursing associations, and 18 informants from WHO Country Office), filling in an individual questionnaire

In spite of all the limitations of the quick assessment (with the small sample size, small difference between the key interview groups), the analysis of the questionnaires may suggest some conclusions, as follows:

- 61.9 percent of all respondents assessed WHO's performance related to its Core Functions as "good", whereas 38.1 percent as "average" or "below average");

Fig. 3



Source: WHO CCS Nepal Mid-Term Review, 26 October - 6 November 2015, key informants, anonymous questionnaire

Note: total number of respondents: 59. (Government of Nepal - 19 respondents, WHO Country Office - 18 respondents, Development partners - 9 respondents, Civil Society - 13 respondents

[39] Ibid.36

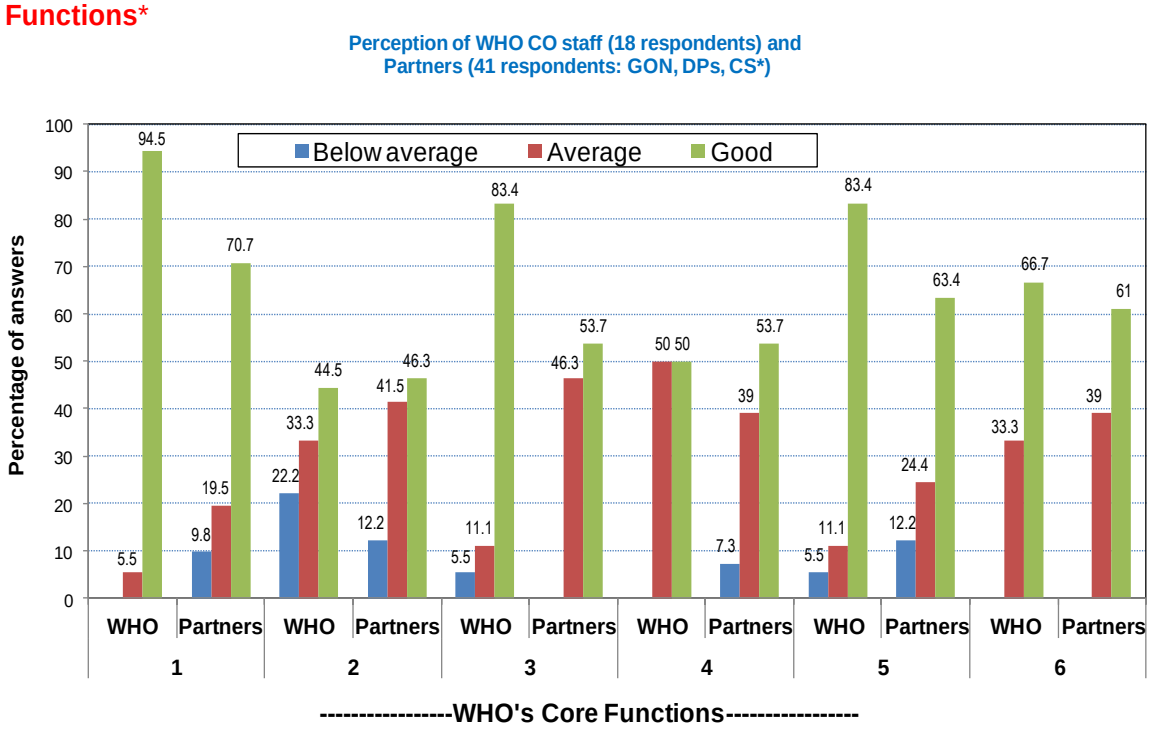
- In some of the Core Functions, the perception of partners in health differs significantly compared to the perception of WHO's Country Office staff (Fig.…Annex…); i.e. in the Core Function 1. – *leadership and engaging in partnership*, where 71 percent of partners answers were "good", compared to 95 percent of WHO staff answers. However, in the same Core Function, 1., almost 1/3 of the partners answer was "average or below average".

- The partners were more critical in their perception of WHO's performance in all other Core Functions, particularly in higher percentage of their answers "average" and "below average".

- Both the partners and WHO staff considered the Core Function 2. – *shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge,* as a weakest performance out of all six Core Functions (more than a half of the answers were either "average" or "below average"

Fig.4

Quick Assessment of WHO performance in Nepal related to six WHO's Core Functions*



Source: WHO CCS Nepal Mid-Term Review, 26 October - 6 November 2015, key informants, anonymous questionnaire

Note: total number of respondents: 59. (Government of Nepal - 19 respondents, WHO Country Office - 18 respondents, Development partners - 9 respondents, Civil Society - 13 respondents