HEART

HEALTH & EDUCATION ADVICE AND RESOURCE TEAM

Nepal Health Sector Programme II (NHSP II)

Mid-Term Review

15 February 2013
Final Report

Disclaimer

The mid term review of Nepal Health Sector Programme II (2010-2015) was carried out by HEART for the Government of Nepal/Ministry of Health and Population (GoN/MoHP), managed by Oxford Policy Management (OPM) and funded by UK's Department for International Development (DFID). The views expressed in this report are those of the review team and do not necessarily reflect those of the GoN/MoHP and DFID.

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The following supplements are available as separate documents:

Supplement 1: GESI Supplement
Supplement 2: Service Delivery
Supplement 3: Health Financing
Supplement 4: Monitoring and Evaluation
Supplement 5: Improved Physical Assets and Logistics Management

(These supplements were working documents of the MTR team and are provided for background information only. For any variation in content between this final report and the supplements, the final report should be taken as the MTR team's opinion.)

Acronyms

AWPB	Annual Work Plan and Budget
CSO	Civil Society Organisations
DFID	Department for International Development
DDA	Department of Drug Administration
DDC	District Development Committee
DHO	District Health Office
DoHS	Department of Health Services
DPHO	District Public Health Office
DUDBC	Department Urban Development and Building Construction
EDPs	External Development Partners
EHCS	Essential Health Care Services
FCHV	Female Community Health Volunteer
FMIP	Financial Management Improvement Plan
JAR	Joint Annual Review
JCM	Joint Consultative Meeting
JFA	Joint Financing Arrangement
JTAA	Joint Technical Assistance Agreement
GAAP	Governance and Accountability Action Plan
GAVI	Global Alliance for Vaccines and Immunisation
GESI	Gender, Equality and Social Inclusion
GSC	GESI Steering Committee
GoN	Government of Nepal
HEO	Health Education Officer
HET	Health Education Technician
HMIS	Health Management Information System
HP	Health Post
HRH	Human Resources for Health
HSISS	Health Sector Information System Strategy
IHP	International Health Partnerships
I/NGOs	International Non-Governmental Organisations
LHDSP	Local Health Development Support Programme
LMIS	Logistics Management Information System
MCHW	Maternal and Child Health Worker
M&E	Monitoring and Evaluation
MIS	Management information systems
MoF	Ministry of Finance
MoHP	Ministry of Health and Population
MTR	Mid-term Review
NCD	Non Communicable Disease
NDHS	Nepal Demographic and Health Survey
NHA	National Health Accounts
NHIC	National Health Information Centre
NHSP	Nepal Health Sector Programme
NHSSP	Nepal Health Sector Support Programme
NLSS	Nepal Living Standards Survey

NPC	National Planning Commission
OCMC	One stop Crisis Management Centre
OOP	Out-of-Pocket
PHAMED	Public Health Administration, Monitoring and Evaluation Division
PHCC	Primary Health Care Centre
PPICD	Planning, Policy and International Cooperation Division
PSC	Public Service Commission
QM	Quality Management
SHP	Sub Health Post
SSU	Social Service Unit
STS	Service Tracking Survey
SWAp	Sector Wide Approach
SWC	Social Welfare Council
TA	Technical Assistance
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VDC	Village Development Committee
VHW	Village Health Worker
WHO	World Health Organisation

EXECUTIVE SUMMARY

The NHSP-II is the second sector programme covering the period from 2010 to 2015 and aims to improve the health and nutritional status of the Nepali population, especially the poor and excluded. At the onset it was envisaged that the successful implementation of NHSP-II, assuming a middle scenario of government and EDP expenditure of around NRs 115 billion, would avert 45,000 deaths and save around 1.5 million DALYs at a cost of US$147 per DALY saved. This MTR's purpose[1] is to assess progress of the NHSP-II against its objectives and revised M&E framework, provide recommendations for accelerating progress, and provide insights for the design of the next five-year programme.

METHODOLOGY

This mid-term review assesses progress on delivering NHSP-II's objectives, focussing on the nine output areas outlined in the results framework:

1. Improved service delivery
2. Improved sector management
3. Improved health governance and financial management
4. Reduced cultural and economic barriers to accessing health care services
5. Strengthened human resources for health
6. Increased health knowledge and awareness
7. Improved M&E and health information systems
8. Improved physical assets and logistics management
9. Improved sustainable health financing

A brief inception phase[2] included participation in the Eastern Region Health Review Meeting in Biratnagar and was followed by the main consultation phase of 15 days in September and October 2012 when all team members undertook a series of in-depth consultations with a broad range of health sector stakeholders to inform quantitative and qualitative measurement of progress. A number of key documents have provided important insights into current context and historical development of M&E in the Nepal Health Sector. A full list of these documents as well as a list of consultations carried out is provided in Annexes 3 and 6. A second phase of the MTR took place for 6 days in December 2012 when some further consultation and analysis took place. Oversight and guidance was provided to the MTR team by a Technical Working Group established by the MoHP. Findings from the MTR were presented at the MoHP and at the Joint Annual Review in January 2013.

The MTR team consulted most senior managers across the public health system, attended two of the Annual Regional Health Review Meetings, and met representatives from most External Development partners (EDPs) working in health. Consultations and focus group discussions were also held with District health officials, community representatives, facility health workers, representatives of Non-State actors. The views expressed in this report are attributable to the MTR team.

[1] NHSP-II MTR Terms of Reference (see annex 2)

[2] NHSP-II MTR Inception Report

REPORT ORGANISATION

The report is organised based on the MTR Terms of Reference (Annex 2) and the structure of the NHSP II Monitoring and Evaluation (M&E) framework document. Section 1 provides some context and background to NHSP II and the Mid-Term Review; Section 2 presents the analysis of progress against indicators and a summary of the main findings of the MTR team in each of the output areas and identifies priority issues; Section 3 presents a set of recommendations based on the analysis in the previous section. The structure stays predominantly linked to the different outputs with appropriate cross-linkages mentioned. The ordering of the findings and recommendations is in line with the order of outputs as in M&E framework and is presented in such a way that the reader can select areas of interest and read in the order preferred. A set of supplements to the final report has also been provided for background information only.

PROGRESS ON NHSP-II

The MTR Terms of Reference (Annex 2) were broad-based and included quantitative and qualitative review of progress against all nine outputs of NHSP II. In Section 2 of this report the MTR team has provided its main findings and identified a set of priorities for action linked to these. In Section 3 the MTR team has provided its recommendations for MoHP, government Departments and Centres, as well as EDPs and other stakeholders across the sector. Progress against the NHSP II M&E Framework has been updated during the review with the assistance of the MoHP and DoHS, NHSSP and many other contributors. This was a considerable task and included new and in some cases draft data that was made available for 2012 through the hard work of many individuals. The updated M&E framework is provided in Annex 1 with a note that some data is still to be verified or included. The MTR has by its nature and scale identified many issues and challenges and for some areas[3] these are presented in more comprehensive background working documents that can be found in the NHSP II MTR Supplement.

The MTR team recognises that in such a process and report the key messages risk being lost in the detail and as such have decided to adopt the progress indicator system of the ICAI[4] to provide a rapid visual indication of the MTR opinion on progress. It is hoped that this alerts the reader to areas of progress in more general terms and assists in providing a more rounded view.

Table 1 provides a summary of the MTR team's assessment of progress against NHSP II commitments for each output area.

[3] Supplement includes sections on: GESI, Service Delivery, Health financing, M&E, Logistics and Supplies Management.

[4] ICAI – Independent Commission on Aid Impact – a UK body set up to scrutinize the UK governments aid programme. This uses a simple traffic light system.

Table 1: Summary of MTR view on progress in key elements of each NHSP II output

Key  Poor Progress  Limited Progress  Progress  Good Progress	
NHSP II Output	**Summary opinion on progress**
1. Reduced cultural and economic barriers to accessing health care services	 PROGRESS The MTR identified growing commitment to GESI in policy and intention. Early signs of implementation are evident but now this needs to be better integrated into service delivery results, expansion of GESI targeted interventions and diversifying skilled human resources for health.
2. Improved Sector Management	 PROGRESS The MTR concludes that there has been continued effort in sector management and coordination (e.g. planned JCMs taking place, coordination between TA mechanisms) but there are still considerable challenges for GoN and EDPs. Leadership, regulation, planning, management and harmonisation are all areas that need attention.
3. Strengthened Human Resources for Health	 LIMITED PROGRESS The MTR concludes that little progress has been made on establishing an effective HRH system. While the policy has been developed and strategy recently approved there are systemic problems that are a major cause of limiting progress in service delivery. Solutions need to be worked on as a matter of urgency.
4. Improved Service Delivery	 PROGRESS The MTR found that there has been progress in service delivery and improvements in health indicators, although evidence of plateauing in progress is emerging. However disaggregated data shows considerable inequities. Access has been the focus and this needs to continue. Now more attention on quality of care is needed as a matter of priority.

5. Increased health Knowledge and Awareness	 PROGRESS Progress has continued through existing programmes although renewed efforts are needed especially with regard to increasing uptake of family planning, Non-Communicable Diseases and other issues such as road safety. Greater citizen's engagement may be a key element in achieving more progress on key health outcomes.
6. Improved M&E and health information systems	 PROGRESS Progress continues and considerable data is produced through MISs as well as studies and surveys. Better integration of systems is now needed with improved data quality and data use. More disaggregated analysis is starting to emerge and now needs to be used in decision-making.
7. Improved physical assets and logistics management	 PROGRESS The MTR identified progress towards establishing systems and controls for procurement of pharmaceutical supplies, but limited progress in distribution and stock management. No evidence is recorded of increased budget allocation for maintenance and the completion of the on-going 527 infrastructure projects.
8. Improved health governance and financial management.	 LIMITED PROGRESS Progress is judged to be limited in the area of financial management. Greater engagement of senior management is required as well as cross-government (MoF, NPC, MoHP) changes to ensure human resources continuity and improved performance.
9. Improved sustainable health financing.	 LIMITED PROGRESS A complex set of financing initiatives does not add up to a health financing strategy. A clearly articulated health financing strategy is now needed especially given the wide range of pilot initiatives, free health policy and interest in health insurance.

SECTOR MANAGEMENT AND EFFECTIVENESS

The SWAp introduced in 2004 aimed at a step change in effectiveness across the sector focusing on improved coordination of government and EDPs linked to the Paris principles that all have signed up to. As repeated reports on progress have shown the health sector has made substantial strides and now has a mature SWAp and well defined associated agreements. Reflecting on each of the main Paris principles shows that progress is being made, that international assessment shows good performance. The challenge now is not to be restricted by or complacent with the progress but to look for ways to maintain the momentum and seek further improvements that should translate ultimately into health gains for all the people. The NHSP II was reportedly drafted in a short timeframe and this appears to have affected ownership of the programme by government and integration with on-going government sector plans and processes. There is also a need to review technical assistance supported by external partners to ensure this is fully integrated and supportive of a government led agenda.

BETTER PLANNING AND BUDGETING

The MTR comments in several areas on the need for better planning and budgeting. This includes functional review from the central level down to the service delivery points. Restructuring of MoHP, strengthening capacity, refocusing from centrally-driven to needs-based planning and budgeting are all discussed in this report. The MTR concludes with a set of recommendations that strives for more needs-based planning, better integration of programmes, more multi-sectoral collaboration and more accountability through local governance arrangements.

ORGANISATIONAL AND MANAGEMENT ISSUES

There are three big organisational and management issues that have been a key element of all past reviews and strategic discussions. This report is no exception. The MTR restates and re-emphasises the need for improvements in PFM, procurement and human resources for health. Some of the recommendations are repeats from past reviews and some aim to provide new ideas for improvement. All of these recognise the need to work beyond the health sector boundaries and include joint working with NPC, MOF, PSC and several other key government institutions to effect change.

REACHING OUT TO THE UNDERSERVED

This report emphasises the importance of GESI and the progress in putting the foundations in place. The health system must be fair and equitable to all the citizens. It must provide safety nets for the poor and marginalised. And it must ensure that access is accompanied by quality. Progress is being made but disaggregated data shows a clear picture on inequality, including in urban areas. Progress has also been made on most health indicators but not uniformly across ethnic groups and ecological zones. The further analysis of NDHS (2011) data exposes the disparities in health and health provision and provides compelling evidence for urgent attention to those sections of the population that are being missed.

There are considerable challenges ahead to scaling up and improving the situation with regard to gender, equality and social inclusion. As well as consolidating the incorporation of GESI into all policies, strategies and guidelines and ensuring training of all key health cadres, there now needs to be further implementation of key activities and services. One Stop Crisis Management Centres (OCMC) are considered a major contribution to the National Action Plan in the Prevention of Gender Based Violence

and their phased introduction at district level needs to continue. Social Audits are now an integral part of the health system programming at the facility level. Social Service Unit (SSU) and Social Audit guidelines have also been finalized. Better data on the disparities now needs to be used for establishing services for those currently underserved.

THE PRIVATE SECTOR

NHSP II mentions the private sector and it is recognised that the private sector is expanding rapidly across the country. The coming years will see the need for a substantial increase in the partnership between government and all non-State actors if those currently underserved or receiving poor quality services are to be reached. The draft policy in this area needs to be owned by government and all stakeholders and a programme of work established to ensure improved services are provided including through better regulation and contracting of the non-State sector (not-for-profit and for-profit service providers). Where access to primary and secondary health services is limited or absent government should work with non-State actors to find cost-effective solutions that deliver quality services. This should also ensure recognition of different systems of medicine such as Ayurvedic Medicine that are widely used by the population. Through effective partnerships between the public and non-State sector it should be possible to extend service provision across all geographic and technical areas.

FINANCING THE HEALTH SECTOR AND LEGAL PROVISIONS FOR HEALTH

A question the MTR has kept in mind is whether the country can really afford the provisions in the Constitution to provide free health services and put these into Law. Given the current fiscal situation, recent budget statement (December 2012) and the constraints on international development budgets the prospects for an increasing budget for health from government and EDP sources is unlikely in the remaining period of the NHSP-II and for the foreseeable future (2016-2020). There is an urgent need to look at what the government promotes as policy in terms of citizens' rights and entitlements to health and the approach to financing these.

The MTR team highlights a number of issues that impact on government's ability to provide equitable and affordable services. Firstly the national budget allocation to health is unlikely to increase to the target 10% as required, this is made more unlikely by the recent budget statement and the on-going differential between budget allocation and achieved expenditure. Secondly, the lack of a coherent health financing strategy and slow progress on stated priorities such as the introduction of social health insurance. The current range of initiatives each with related strategy documents, pilot activities and, in some cases, intended national roll-out is not sufficient. Thirdly, there is an important difference between resources committed by EDPs and actual resources provided which exacerbates predictability issues. Fourthly, there is a lack of good quality analysis on how the available resources are spent and what outcomes are being achieved for the various investments. The MTR supports previous views expressed that there is considerable room for improvement in both efficiency and effectiveness in use of resources. In an increasingly constrained fiscal environment the importance of better use of existing resources is high. Where resources are available and not being used the MTR considers there to be a need for new thinking on ways to make sure these are in fact used.

BETTER USE OF INFORMATION IN DECISION-MAKING

Good information provided in a timely manner is key to good planning and decision-making. There has been good progress in establishing an M&E Framework under NHSP II and the efforts to put this in place are commendable. Similarly the health sector has many initiatives for collection of data and as described in the report much data is being generated through routine systems and studies and surveys. The priority now is to ensure a better integration of the different systems and the proposal is made for modifications to create a unified coding system linking all nine MISs. This process should include broad stakeholder engagement to ensure buy-in from managers and users of all nine systems. The MTR also reflects on the need for better use of data and, as part of this, calls for a Data Use Plan to be developed. At the same time efforts are needed to build the capacity in the MOHP, and especially PPICD, in data analysis and its use in planning, budgeting and decision-making.

The MTR also discusses the merits of establishing a semi-autonomous National Health Information Centre with a mandate to coordinate all information systems, oversee all routine data collection, strengthen data validation mechanisms and ensure dissemination of up-to-date information management policies and protocols. This Centre, it is proposed, should be located under the Ministry of Health and Population as a semi-autonomous centre.

Future progress in this area will be tracked through the Country Accountability Framework, a WHO initiative that aims to accelerate efforts to improve country accountability systems with a focus on women's and children's health. This initiative provides an overview of the current status of accountability mechanisms, lays out specific activities that form the foundation of a roadmap, and serves as a general monitoring tool for tracking progress in this area. The focal areas include: advocacy and outreach; review processes; monitoring of resources; innovation and eHealth; maternal death surveillance and response; monitoring of results; and civil registration and vital statistics systems. The roadmap document also details required resources and highlights unfunded amounts. WHO has already committed catalytic funds towards the initiative.

AN INITIATIVE FOR DISTRICT LEVEL SCALE UP OF EQUITABLE HEALTH CARE PROVISION AND IMPROVED NUTRITION

The MTR has made a set of recommendations that aim to go beyond organisational and institutional systems change alone. The combination of MTR recommendations, if undertaken, is intended to provide the opportunity to both build stronger leadership and ownership, strengthen systems, build on pilots of innovative ideas and create a sound basis for better delivery of equitable and good quality health care. The final recommendation of the MTR sets out an agenda for scale up of district level service delivery built on the lessons learned through programmes and pilots of local governance and service delivery. The MTR considers it time for a programme that tests out the models at scale, moves to start the process of decentralised planning, budgeting and uses the resources available locally for local governance and accountability. The MTR suggests that for a time-bound scale up initiative a basket arrangement could be established that utilised under-spending on pooled funding. This would ensure a mechanism that allows disbursement from the start of the fiscal year and ensures that available external funds are more fully utilised. An initiative of this kind started within the NHSP II timetable and at the scale suggested will provide valuable experience and lessons in preparation for future political moves to Federalism and greater decentralisation.

BEYOND NHSP-II

This report also aims to provide some guidance on the key issues that need to be considered in the early planning stage of the NHSP III period. The updated data shows a continued improvement in most health indicators but it also shows a plateauing of progress and a considerable disparity between people across the country. If progress is to be maintained the government and EDPs must guard against complacency which such data may invoke.

Several of the recommendations have a longer-term perspective that will have an impact, if adopted, beyond the NHSP II period. Some of the key areas are linked to establishing more equitable and quality health services to the communities that are underserved whether due to geography, sex, ethnicity or economic status. The remainder of NHSP II and its successor must focus on reducing the disparities in health.

NHSP III should focus on continuing the improvements for stronger management of the sector, better integration of support and uptake of opportunities for multi-sectoral collaboration in recognition of the importance of sectors beyond health in improvements. The planning should include a strong focus on building capacities to establish and support decentralised planning, improvements in quality as well as access and building effective and well-regulated partnerships with the private sector. The government will continue to face several challenges as it strives to reach its MDG targets. Concentrated work is needed to improve the provision of family planning services, improve maternal health outcomes and ensure unmet needs are indeed met. More focus is needed on reducing neonatal mortality through better education and post-natal services as well as tackling the emerging challenges linked to increasing mortality and morbidity due to non-communicable diseases and other issues such as road traffic accidents.

The start of designing NHSP III presents a real opportunity to build on recent experiences and lessons, establish a sound financing strategy and increase the partnerships with EDPs and with it the predictability of that support. NHSP III should look to establish a programme that goes beyond the public sector but encompasses all stakeholders, State and non-State, to maximise progress and make the best use of all resources available.

Table 2: Summary of MTR recommendations indicating responsibility and timing

Key / Timetable	Start	End
Short term	04.13	08.13
Medium term	08.13	08.14
Long term	08.14	04.16

Ref.	Description (abbreviated)	Responsible	Timetable
Reduced cultural and economic barriers to accessing health care services (output 1)			
R1.1	Agreement to disaggregate data and strengthening of indicators	MoHP	Short
R1.2	Development of a GESI sub-strategy for district/facility level	Pop Div	Short

Ref.	Description (abbreviated)	Responsible	Timetable
R1.3	Strengthening and expansion of GESI targeted interventions	Pop Div	Medium
R1.4	Strengthen GESI leadership	MoHP	Medium
R1.5	Integration of GESI into key training programmes	GSC / NHTC	Medium
R1.6	Development of GESI relevant communication	Pop Div	Medium
R1.6	Consideration of the phased integrated governance for GESI institutional mainstreaming	Pop Div/ GSC	Long
Improved Sector Management (output 2)			
R2.1	An Organisational and Management Review that covers MoHP, Departments and Centres and the way EDP support and structures are organised	Sec Health; Chair EDP	Short
R2.2	A comprehensive management capacity needs assessment is conducted that covers governance, leadership and management (strategic and financial) as well as management systems and tools currently in place.	Sec Health; Chair EDP	Short
R2.3	Following R2.2 government and EDPs convene a high level roundtable to agree a programme of work tailored to identified management needs.	Sec Health; Chair EDP	Short
R2.4	The MTR recommends that the PPICD should be substantively strengthened to improve effective use of the health information generated by the various management information systems as this is key to evidence-based planning.	Sec health	Medium
R2.5	The Annual Health Review and the JAR processes should be more integrated. Develop more action oriented aide memoire from JAR 2013 with timetable and responsibility included.	Sec Health; EDP Chair	Short
R2.6	AWPB is developed to include more results focus and this should be aligned with the NHSP-II M&E framework.	PPICD	Short
R2.7	A move to more needs-based planning and budgeting utilising local and district level planning. A revised planning framework to be developed and a workplan and timetable for change developed.	PPICD	Medium
R2.8	Greater government leadership of all key committees at the appropriate level, rationalisation of the functions and overall structure. An official map of committees to be adopted by MoHP.	Sec Health	Medium
R2.9	TWG established and preparation of a new Technical Assistance Harmonisation Agreement and Plan.	Sec Health; Chair EDP	Short
R2.10	MoHP takes the lead in development and drafting NHSP III, establishing TWG and chairing all meetings.	Sec Health/ PPICD	Medium
Strengthened Human Resources for Health (output 3)			
R3.1	Senior management team of the Ministry and Departments meet to consider and decide upon the HR priorities and timetable that should be pursued.	Sec Health	Short
R3.2	The Ministry recruits health workers to a specific job in a particular location, rather than to a cadre.	Sec Health	Medium
R3.3	Ministry to conduct survey on incentives. Expand staff in	Sec Health	Medium

Ref.	Description (abbreviated)	Responsible	Timetable
	remote areas and encourage training institutes to adopt remote areas.		
R3.4	The Ministry moves quickly to adopting multi-year contracts, which are permitted under the GoN's financial regulations.	Sec Health	Short
R3.5	Service contracts are piloted in some of the most remote areas where it is difficult for GoN to attract and retain staff.	Sec Health	Short
R3.6	The Ministry embraces the PIS as its core HR database and takes immediate steps to put in place robust processes to make sure all personnel transactions are accurately captured through the PIS.	Joint Sec HR	Short
R3.7	The appointment of a permanent human resource management adviser	Joint Sec HR	Short
R3.8	The Ministry establishes a single HR division and that all HR activities are assigned to this division (see 2.1)	Sec Health	Medium
Improved Service Delivery (output 4)			
R4.1	Attention is now focused on greater targeting to priority technical and geographic areas of inequality as demonstrated by quantitative results.	DG DoHS	Short
R4.2	More functional authority devolved so that demand based planning, budgeting and HR management can be carried out to the district level (see R10.1).	Sec Health/ DG DoHS	Medium
R4.3	Mechanisms to ensure State non-State partnership be further developed and implemented, such as contracting in and contracting out of service delivery.	PPICD	Medium
R4.4	A disease prevalence survey needs to be undertaken to provide primary data to provide reliable evidence for planning strategies	PPICD	Medium
R4.5	Service delivery is a major focus of NHSP III and includes attention to quality and equity, looking beyond EHCS, and includes tackling areas such as NCD, CPR and NNM.	PPICD	Long
Increased Health Knowledge and Awareness (output 5)			
R5.1	A comprehensive Community Public Health Awareness Strategy is developed and adopted.	DoHS	Short
R5.2	The reinstatement of the focal health promotion position at district level and provision of additional TA for advancement and better integration of community based IEC/BCC delivery	MoHP	Medium
R5.3	An increased allocation for health promotion and link this to more ambitious targets and be more GESI focused	MoHP	Medium
Improved M&E and Health Information Systems (output 6)			
R6.1	A number of revisions to information management, including: linking M&E and Planning (see R2.1); new National Health Information Centre; a National M&E Plan; Revised HIS strategy; E-Health policy	MoHP	Short
R6.2	While the National Annual Review and the JAR should remain separate, format of the reviews should be revised to incorporate more space for analytical discussion of the	MoHP/ EDP	Medium

Ref.	Description (abbreviated)	Responsible	Timetable
	findings		
R6.3	Considerable new attention is given to data quality by the MoHP (this includes a set of proposed measures)	PPICD/ M&E	Short
R6.4	A Data Use Plan be developed and accompany it by a number of measures to ensure its proper implementation	PPICD/ M&E	Short
R6.5	The better integration of existing management information systems that will allow better analysis of existing data sets	PPICD/ M&E	Medium
Improved physical assets and logistics management (output 7)			
R7.1	Senior Management should enforce provisions for preparation of procurement plan together with e-AWPB.	Sec Health	Short
R7.2	Alternative solutions for Centralised Bidding Local Purchasing should be adopted such as prequalification of suppliers and setting of maximum pricing by commodity by DDA and link this with local purchasing.	Sec Health	Short
R7.3	Deadlines need to be set for the preparation and implementation of the Consolidated Procurement Plan.	DoHS	Short
R7.4	A set of actions to improve current physical asset and logistics management.	Sec Health	Short
Improved health governance and financial management (output 8)			
R8.1	The establishment of a strong mechanism in the MoHP for the oversight of FMIP implementation and monitoring of budget execution, chaired by the Secretary of MoHP, with the representation of EDPs.	Sec Health	Short
R8.2	The MoHP advocates for the inclusion of the sector financial management agenda in the PEFA indicators and that this is incorporated in the NPPR	Sec Health	Short
R8.3	Improve linkages of MoHP senior management with the financial management team in planning, monitoring and information including information linkage with the FCGO	Sec Health	Short
R8.4	Support is provided to the FCGO to incorporate curricula on 'Financial Management in SWAp' in its Gazetted II Financial Management Training	Sec Health	Short
R8.5	Setting targets for all the cost centres for limiting their current audit irregularities and monthly targets for the settlement and clearance of irregularities of the past years, complimented by a system of constant reporting and monitoring of progress.	Sec Health	Short
Improved Sustainable Financing (output 9)			
R9.1	Studies are carried out in order to better understand the efficiency of the current budget allocations (see detail)	Sec Health	Short
R9.2	The MoHP investigates the issues that underpin the low rate of expenditure (79%) against budget and address the absorption capacity issues.	Sec Health	Short
R9.3	The MOHP explores the introduction of a need-based resource allocation formula.	PPICD	Medium
R9.4	A comprehensive and integrated health financing strategy is	PPICD	Medium

Ref.	Description (abbreviated)	Responsible	Timetable
	elaborated and agreed upon. This should take into consideration critical assessment of several aspects of current health financing landscape.		
Scale–up initiatives at district level			
R.10.1	A substantive and integrated scaling up of pilots that builds on the lessons learned and experiences gained to date. A scaled-up district decentralisation initiative should now be established that encompasses a number of actions to increase service coverage and quality utilising the range of resources available more effectively.	Sec Health/ EDP Chair/ Pool Fund partners	Short-Medium

SECTION 1 - BACKGROUND

1.1 PERSPECTIVE ON THE SOCIAL AND POLITICAL CONTEXT IN NEPAL

The natural diversity of Nepal's terrain, remotely located communities, a long feudal history and complex social fabric with deep rooted traditions and culture have contributed to inequality and exclusion in all spheres of life[5]. Nepal's low Human Development Index (HDI 2011) of 0.48, whilst improving over time, still places the country 157 out of 187 countries which is lower than the South Asian average of 0.55.[6]-[7]

Nepal is one of the 189 countries committed to the Millennium Development Goals (MDGs) as reflected and renewed in the country's Three Year Plan (2010-2013).[8] In order to fulfill the goals of this Plan, the impetus created by the Nepal Health Sector Programme I and II (NHSP 2004-10 and 2010-2015) and its Gender Equality and Social Inclusion (GESI) Strategy in creating an enabling environment for revitalizing services and mobilizing resources in health to women especially the poor and marginalized and the removal of cultural and economic barriers is undisputed.

In Nepal, 25 percent of the people live below the poverty line and the majority of the poor are women, Dalit, disadvantaged Janajati (indigenous groups) and households living in less-developed communities[9]. The worst off are households from the Karnali zone, the Far Western region and other remote hills and mountains and the Terai Adibasi (indigenous community) in the plains. Whether due to gender, poverty, being socially excluded or geographically isolated, these groups have limited access to quality health services even where public health services exist. From a gender perspective, women as a group are the largest excluded population in Nepal and remain marginalized economically, socially and politically, all of which affect access, demand and utilization of health services[10]. With an overall Gender-related Development Index (GDI) and Overall Gender Empowerment Measure (GEM) of 0.49, the status of Nepali women and girls, irrespective of caste, ethnicity and geographic location have remained lower compared to men and boys[11].

1.2 THE HEALTH SYSTEM IN STATE RESTRUCTURING

The dissolved Constitution Assembly has not made public the proposed health system within the State restructuring agenda. It is anticipated[12] that during the future State restructuring, the health sector will be divided into three tiers of government: national, State and local bodies to replace the present centrally controlled system. The sharing of resources and organisations of government depends upon

[5] Supplement 1 – GESI (annex 1)

[6] UNDP, Human Development Report 2011

[7] In 2012, South Asia has one of the highest and lowest Gender Gap Index (GGI) in Asia with Sri Lanka at 0.71 and Pakistan at 0.54. The GGI for Maldives and Bangladesh is 0.66, India 0.64 and Nepal 0.60

[8] UNDP, The MDG Needs Assessment Report for Nepal, 2010

[9] Nepal Central Bureau of Statistics, Nepal Living Standards Survey III, 2011

[10] By gender, this analysis means social relations between women and men where women are more discriminated (without forgetting or being unfair to the men). For this reason it is believed that women have a bigger stake given the reality in any process that is trying to redress imbalances.

[11] UNDP, Nepal Poverty Mapping Project : Human Development Report based on 2009-10 data

[12] Based on personal communications with key health sector informants

how the responsibility of health facilities will be divided among these tiers of governments. Resources from the centre will likely be provided to the States through block grants, conditional grants and equalization funds according to their strength and responsibility and health needs. Similarly, the State will also provide resources to the local bodies accordingly.

Structure, functions and responsibility: The major issue here is the question of establishing the relationship between the facility level and the referral level hospitals.

MoHP will be responsible for the formulation of national health policy, running of national level programmes and monitoring of State performances against national objectives and targets. Coordination with EDP and other national level agencies will be another function of the central government. The centre will also be responsible for basic and essential health services across the country. Local bodies will be responsible for functions delegated by the centre especially for the delivery of basic and free health care services. The LHFMCs will function as the frontline community health service providers. The relationship between the centre and local bodies will be established through the State government.

Resources: The centre will provide resources to the States in the form of block grant, conditional grant, loan and equalization fund on the basis of expenditure level together with the financial strength and level of provision of health services. The centre will also invest from its own internal resources for the obligation of health service assigned to it. Local bodies also contribute in meeting the cost of health services assigned to this level of government.

Organisation: As a result of reduction in the functions and responsibilities relating to the health services currently performed by the centre, the existing organisational structure of MoHP and DoHS will undergo change and become lighter. The future of regional offices is uncertain but these might not exist. The roles and responsibility of DHOs are likely to be revised based on the perception of the State governments regarding the provision of health services on their part. The VDCs will be restructured to a lower number considering their financial viability and the intention of States regarding the delivery of health services from their part.

Human Resources: The HRM Strategy of MoHP acknowledges that there will not be any problem if delivery of health services currently being performed by the centre is assigned to the State or local level. In the event of restructuring of the States, issues like the sharing of the services of existing permanent human resources on the basis of functions and jobs assigned needs to be resolved. The policy of giving opportunity to the existing employees to choose among the three levels of government could be one option. Offering voluntary retirement schemes to currently serving staff could be another scheme.

The health and other personnel of the State and local bodies could be hired by the centre, provided that there is an agreement among these three parties for this purpose. Every State will have its own Public Service Commission for the recruitment of employees required at the respective level of governance by entrusting the task of formulation and refinement of policies regarding the recruitment of personnel to the Union Public Service Commission. At the request of State restructuring commission, MoHP has already submitted its restructuring proposal. It is, however, too early to predict what type of arrangements there will eventually be at the three levels.

SECTION 2: NHSP II - MID-TERM REVIEW FINDINGS & RECOMMENDATIONS

SUMMARY OF PROGRESS TOWARDS MDGS AND TARGETS IN THE NHSP II M&E FRAMEWORK

Progress in the health sector over the last decade has been impressive with most key health (and nutrition) indicators showing improvements. Life expectancy at birth in Nepal is rising and is now higher than most other neighbouring countries at 67 (Asia-Pacific HDR, 2012), infant mortality has declined to 46 infant deaths per 1,000 live births and maternal mortality now stands at 229 maternal deaths per 100,000 live births (MMR Study 2009). However these data also mask considerable gender, ethnic and ecological zone differentials across the country. This is now one of the major challenges facing government. The MOHP recognises the progress but also highlights the need to ensure more equitable, good quality and sustainable health services and the need for greater linkage with other sectors if further gains are to be made during the remainder of NHSP II and beyond[13]. Review of data also shows a slowing of progress for some key indicators (e.g. CPR, IMR, NMR) and there appears to be a plateauing effect.

NHSP II builds on the Health Sector Reform Strategy and Sector Wide Approach (SWAp) established almost a decade ago, strengthening partnerships across the sector, building government leadership and ensuring effective use of available resources. The MTR has reviewed progress at the mid-point of this programme and commends the progress made to date in many areas of sector management and programme implementation, as well as in areas such as government/EDP relations. Improvements in health outcomes continue, indicators of aid effectiveness show progress and slow but discernible improvements in the introduction and management of core systems are apparent. The MTR has aimed to identify the foundations for further improvements and suggest ways to use the platforms that have been or are being built to strengthen national leadership, improve sector management, exploit inter-sectoral links, utilise local governance opportunities and resources, to build a more equitable and financially sustainable health system.

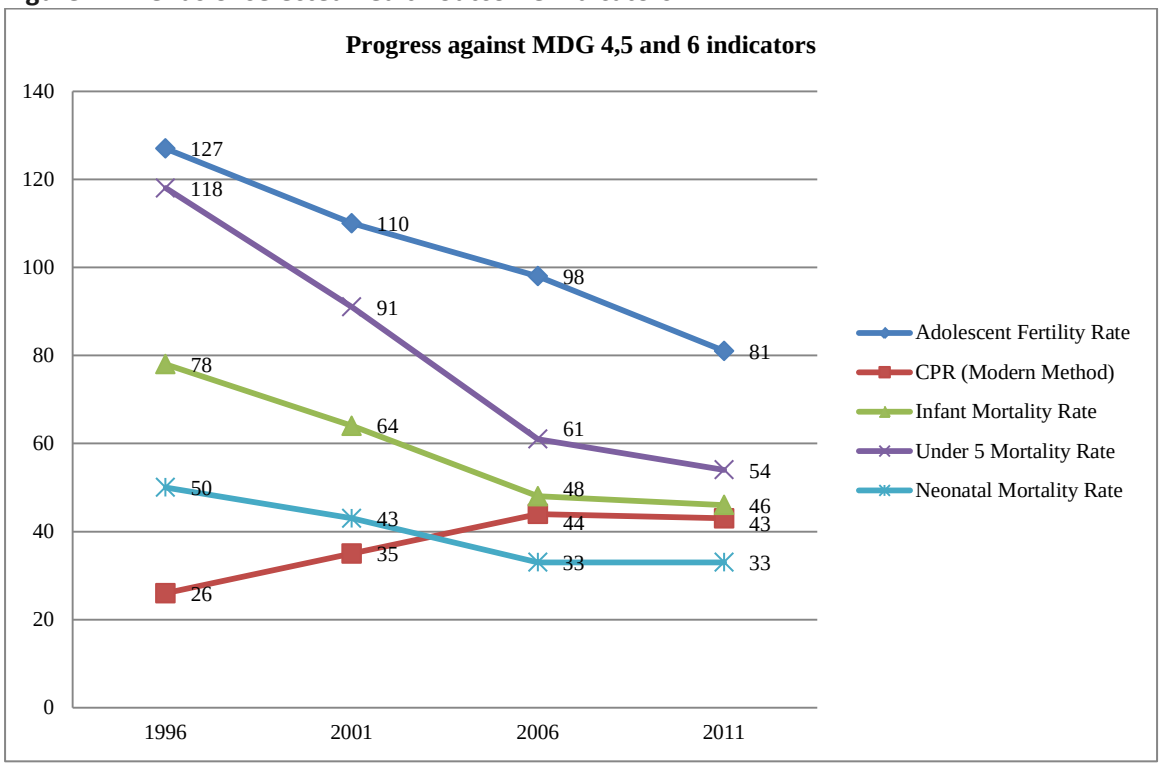
The MTR report has investigated progress across all the main output areas of the NHSP II. While the main recommendations that have emerged are presented by output the MTR team has considered each with a view to its link with other output recommendations. As such we have attempted to provide a package of synergistic recommendations aimed at sector progress. With this in mind we have included a recommended course of action that brings these specific recommendations together in the form of a District level scale-up initiative.

[13] Personal communication – Secretary of Health

Table 3: Progress against MDG 4, 5 and 6 indicators

MDG Indicators	Achievements				MDG Revised Targets
	1996	2001	2006	2011	2015
Maternal Mortality Ratio	539	415	281	229	134
Total Fertility Rate	4.6	4.1	3.1	2.6	2.5
Adolescent Fertility Rate	127	110	98	81	70
CPR (Modern Method)	26	35	44	43	67
Infant Mortality Rate	78	64	48	46	32
Under 5 Mortality Rate	118	91	61	54	38
Neonatal Mortality Rate	50	43	33	33	16

Figure 1: Trends of selected health outcome indicators



The importance of looking at disaggregated data is recognised and these are now being included in the NHSP II M&E framework. Newly presented draft disaggregated data (December 2012[14]) also show important disparities between people from different ethnic groups, by gender, wealth, and by ecological zone. These new data analyses highlight the importance of developing strategies for reaching the poorest and underserved communities where at the same time the burden of mortality and morbidity is most pronounced. This is a recurrent theme of the NHSP II MTR findings and recommendations.

Updated M&E Framework – 2012

The MTR worked with colleagues in the MoHP, DoHS, WHO, NHSSP and others to update the data in the M&E framework. The previous update as presented in the Logical Framework Achievements in 2011

[14] Presentation by MoHP to MTR

against Targets document[15] has been used as the basis and new data used to assess progress in 2012. The MTR has used new data and further analysis of existing data made available from the NDHS, latest Household Survey, STS and HMIS.

Summary comment on quantitative analysis of progress

The revised M&E framework is a very useful tool for tracking progress against key indicators. The work undertaken to establish this framework and to collect data for measuring progress against the targets is a big step forward. One concern is that the combined set of frameworks and indicators including the Results framework, GAAP and Strategy Table/Strategic Framework is considerable and time consuming to monitor. For NHSP III some rationalisation of the different frameworks would be worthwhile to ensure key indicators remain the focus and that the data produced is relevant and timely for decision-making.

While the overall quantitative assessment of progress is positive there is no room for complacency and this message was made clear at the 2013 meeting. High-level indicators are continuing to fall and progress to the 2015 targets is in general going well. However the data indicates areas of concern both in terms of the plateauing of progress and in terms of inequities between different parts of society and geographic region. These trends are continued into output indicators across the board. Discussions with senior government officials and representatives from EDPs have also highlighted this concern as well as the recognition that many of the gains are attributable to actions beyond health (e.g. Water, sanitation, housing, nutrition). This in turn raises policy issues in the next phase of sector management about more inter-sectoral thinking and working.

While the data analysed shows progress in many areas of access to services there is little in the way of indications on comparable progress in quality of care. This is increasingly a topic of discussion amongst policy-makers, implementers and monitoring and evaluation specialists. The planning for NHSP III must address these issues.

PROGRESS ON IMPLEMENTATION OF NHSP II

The aim of the Mid-Term Review (MTR) of the Nepal Health Sector Programme II (NHSP II) is to provide an update on the progress with implementation of the Strategy and offer recommendations for the remainder of the programme period 2013 to 2015. The MTR also provides insights for the forthcoming design of the programme's successor whether NHSP-III or another programme.

PROGRESS AGAINST JOINT ANNUAL REVIEW 2012 AGREED ACTIONS

A key mechanism used in Nepal for reviewing progress of NHSP II and the wider sector performance is the Joint Annual Review (JAR) that is held in January each year and is attended by GoN, EDP and other State and non-State actors. At the Second JAR, January 2012, a set of priority actions was agreed and documented in an Aide-Mémoire[16]. Progress was reviewed during this MTR against these agreed actions and progress found to be varied.

[15] GoN / NHSSP (2012) NHSPII Logical Framework; Achievements in 2011 against Targets

[16] NHSP II. The Second Joint Annual Review (JAR), January 16-18, 2012. Aide-Mémoire.

Table 4: Summary of progress on agreed priority actions of JAR (2012)[17]

Key  Poor Progress  Limited Progress  Progress  Good Progress	
Agreed Action	**Progress**
i) Strategic direction and expenditure priorities: It was agreed that the Ministry and EDPs will elaborate on the priorities and associated expenditures outlined in the first Annual Work Plan and Budget (AWPB) by March 2012 during the first Joint Consultative Meeting (JCM) so that adequate attention is given to improving the performance of lagging indicators.	 **Good Progress** The AWPB 2012/13 (also the "Business Plan") shows a share of 75% for EHCS. The JCM meetings took place in March and June 2012 at which MoHP and EDPs presented priorities and associated expenditures. Discussions included TA needs and financial issues.
ii) Monitoring and evaluation: The Ministry will lead the work to finalize the M&E framework with the support of EDPs and produce a guideline and an implementation plan by the end of the current FY. Furthermore the M&E division will take the lead in producing the interim progress reports for each trimester on the performance of NHSP II. MoHP and EDPs will collaborate to finalize the revised RF for NHSP II by the end of February 2012.	 **Progress** The M&E Framework was revised and published in May 2012. This is a comprehensive document including the logical framework, a breakdown of activities under each output, an indicator matrix, and details on disaggregation of indicators. MOHP and NHSSP have since then published an update of the Logical Framework with 2011 achievements, a 2012 update of which forms part of this MTR report. The M&E Plan is yet to be completed, an action this MTR highlights as a priority.
iii) Technical Assistance: It was agreed that such an assessment (review TA requirements) will be done this year together with the mid-term review of NHSP II. Furthermore, in order to make sure that TA is provided based on the demand from MoHP and DoHS, it was agreed that the Ministry will present its need for TA during the AWPB consultations so that the total financial as well as TA requirements for the implementation of AWPB will be discussed in order to have a	 **Progress** The MTR has looked at TA across the sector rather than performance of specific TA mechanisms (see main report) that JCM meetings have highlighted as TA needs of MoHP. Technical Assistance is currently extensive and contributing to the health sector but not well owned by MoHP and government and not seen as building capacity. It is in general not well integrated and no systematic TA plan has been developed linked to the AWPB. This is a lost

[17] Traffic light scoring system used reflects colour coding in NHSP II M&E Framework and also system adopted by UK's Independent Commission on Aid Impact.

financial and TA support package agreed upon by the time the AWPB is finalized. This practice will begin starting from the current AWPB preparation and will be subject to the bilateral and multilateral agreements for Technical Assistance and Technical Cooperation between MoHP and the various development partners.	opportunity and should be remedied in the next planning cycle. The JTAA has not been signed and needs to be replaced by a new more pragmatic agreement. TA is not well harmonised. A proposal for one Steering Committee is supported by the MTR. A harmonisation plan should be developed linked to the next AWPB. The TA matrix is useful and should be kept up to date. The Matrix should be extended to include TA sourced directly by the MoHP.
iv) Fiduciary: It was agreed that the Ministry will give high priority to completing the overdue trimester reports and submit by the end of January 2012. As per the letter of December 15, 2011, the pooled partners will consider the audit of FY 2009/10 complete with qualification. Furthermore, it was agreed that the procurement plan is included in the AWPB document of next FY. MOHP will establish an audit committee to prevent recurrence of audit observations, put in place measures to limit the number of future audit observations, and address future audit observations in a timely manner. The EDPs will support the work of this committee through Technical Assistance and Technical Cooperation.	 **Limited Progress** Trimester report submitted by January 2012 as agreed upon in the JAR. Audit report for 2009/10 has been completed. All procurement plans are not included in AWPB 2012/13. It has been prepared later. The plan needs to be revisited because of reduced budget for the year 2012/13. Audit committee established. MoHP has not requested for TA support to the audit committee.
v) Drug stock-outs: Alternative ways of distributing drugs and supplies from district stores to health facilities, including partnering with private agencies, will be explored by GoN with support from EDPs. This action will be incorporated in the coming AWPB.	 **Poor Progress** In 2012, compared to 2011, there has been a 5.1% decline to 75.1% of public health facilities with no stock out of the listed free essential drugs. The MTR noted a lack of adherence to agreed minimum stock levels and good storage practices at facilities visited. In addition the MTR understands that surveys (in draft) that are measuring stock-outs on a continual basis, are showing significantly worse stock-outs of drugs.
vi) Participation of NGOs and private sector in national programs: It was agreed that the Ministry will start a performance based payment system with hospitals, including NGO and private sector	 **Limited Progress** The meeting decided to elaborate performance indicators to start a performance based payment by

facilities, during the next Fiscal year. Performance indicators and the modalities will be elaborated by end of April 2012.	April 2012. The progress could not be identified during MTR. However, the MoHP has started preparation of the State /Non-State Partnership Policy for Health Sector, draft for circulation that highlights contract management provisions.
Vii) Physical asset management: All stakeholders involved in the preparation of the AWPB for FY12/13 will collaborate to ensure an increased budget allocation for maintenance and the completion of the on-going 527 infrastructure projects.	 **Limited Progress** The AWPB 2012/13 does not show evidence of increased budget allocation for maintenance and the completion of the on-going 527 infrastructure projects.
Viii) Medical waste management: The MoHP will print the Environment Health Impact Assessment (EHIA) plan and Environmental Management Framework plan and organise a workshop in order to disseminate and distribute them to the health facilities. The compliance of the health facilities with the plans will be presented in the next JAR. The MoHP will assess the situation of health care waste management at different health facilities including the functioning of placenta pits and come up with a strategy for medical waste management considering geographical locations and the volume of waste generated at different facilities by mid-March 2012.	 **Poor Progress** World Bank Environment Mission August 2012 reported that: Nepal does not have a focused regulatory framework for Healthcare Waste Management (HCWM) but the DOHS has prepared HCWM Guidelines and an Orientation Manual. The MOHP and DOHS agreed that this activity has been extremely delayed and assured the World Bank mission that a detailed Action Plan will be ready by end August, in time for discussions during the MTR. The MTR was not made aware of any Action Plan.
ix) Urban health MoHP will approach the National Planning Commission in order to initiate a multi-sectoral approach to urban health under the coordination by the National Planning Commission by June 2012.	 **Poor Progress** The MTR was informed in December 2012 that no multi-sectoral urban health initiative has been presented to the NPC. A draft urban health policy originated by PHCRD is now under review by PPICD. This draft policy looks at the poor state of EHCS services through municipalities.

x) Gender Equality and Social Inclusion (GESI): All departments, divisions and centres will be encouraged to take into consideration the issue of reaching the under-served and include specific actions and budgets in their workplan and budgets for the next fiscal year as a way of demonstrating commitment to GESI priorities.	 **Progress** In order to put into operation and mainstream the GESI Strategy, the MoHP approved the GESI Institutional Modalities (henceforth referred to as the GESI Guidelines) in September 2012 which unequivocally states that the process of health systems strengthening will define exclusion primarily from four dimensions: i) gender-based, ii) caste and ethnicity, religious minority based, iii) poverty-based, and iv) geographical based (ecological, regional with disaggregation by residence such as rural and remote, hills and plains). Further disaggregation by age and disability are also given due consideration. All the main divisions, departments and centres have responsibilities in taking the GESI Strategy forward
xi) Harmonisation and alignment All stakeholders look forward to agreement with the GoN on finalizing the Joint Assistance Arrangement (JTAA) within FY 2011/12	 **Limited Progress** The JTAA has not been finalised during FY11/12. While GoN and EDPs express interest in making progress the JTAA is unlikely to be signed and a revised approach is needed. Other progress is however noted such as the work on the TA Matrix and coordination through the EDP Group is seen as useful for sharing TORs and experiences, avoiding duplication, etc.

The MTR considers the JAR Aide-Mémoire a useful way of summarising discussions and tracking follow up of decisions made. Given the mixed progress presented above the GoN and EDPs need to reflect on the JAR process and in particular the setting of priority actions. This progress report suggests that a mechanism for follow up on agreed actions in the Aide-Mémoire is not sufficiently in place. Actions should be more clearly stated with definite timelines and allocation of responsibility. This is not unique to the Nepal JAR and similar issues have been documented from other countries with similar processes[18].

[18] IHP+ (2012). Joint Annual Health Sector Reviews: A review of Experience (December 2012)

PROGRESS AGAINST THE NHSP II RESULTS FRAMEWORK

The results framework has been updated with available 2012 data from a variety of sources (see Annex 1). The MTR team has considered progress and provided a judgement on likelihood of achieving the 2013 targets at Goal, Outcome and Output levels. Comments have been included for certain indicators where for instance targets have been achieved and new targets are suggested. In general the update shows good progress on many key indicators such as the percentage of children under-5 years of age who are stunted and the Under-5 Mortality Rate. However the MTR also highlights that there is also evidence of plateauing of progress and the need to avoid complacency. The reasons behind this slowing of progress needs to be carefully analysed. Some key indicators, such as that for neonatal mortality, indicate the need for more focused attention. There is a general lack of any quality indicators in the matrix and this should be addressed.

2.1 NHSP II Output 1: Reduced Cultural and Economic Barriers to accessing health care services

2.1.1 Output 1 Findings

Progress against targets set for two of the three output 1 indicators of the NHSP Logical Framework has been slow. Reporting from 2012 indicates that it is not likely that 2013 targets for OP1.1 and OP1.3 will be achieved:

- OP 1.1: % of women utilizing FCHV fund. The target for 2013 is 8% and 2012 reporting indicates only 0.5% women of reproductive age are utilising the FCHV Fund. In comparison to 2011 (5%), this represents a 90% decrease since 2011.
- OP 1.3: % of HFMOC/HDMC with at least 3 female members and at least 2 Janajati and Dalit members. 2012 reporting on this indicator shows minimal movement; the achievement of 41% representing a small decline from the 2012 achievement of 42%. The 2013 target of 70% remains far off.

Conversely OP1.2 indicates positive progress:

- OP 1.2: Number of health facilities providing adolescent-friendly health services. Considerable progress has been made on this indicator, with reporting showing an increase from 78 in 2011 to 455 in 2012, an increase of 483%.

The unique geography and social diversity of Nepal have contributed to inequality and multiple levels of exclusion. Women as a group are the most excluded in Nepal[19]. A quarter of the Nepalese population live below the poverty line, the majority of whom are women, Dalit and disadvantaged Janajati (indigenous groups). The worst off are groups from the Karnali zone, the Far Western region and other remote hill and mountain regions and the Terai Dalits and Terai Adibasi (tribal community).

The GESI Strategic Framework is a key part of NHSP II and in order to put this into practice and mainstream the strategy, the MoHP also approved the GESI Institutional Modalities (or GESI Guidelines) in September 2012. This states that the process of health systems strengthening will define exclusion primarily from four dimensions: i) gender-based; ii) caste and ethnicity, religious minority based; iii) poverty-based; and iv) geographical based (ecological, regional with disaggregation by residence such as rural and remote, hills and plains). Further disaggregation by age and disability are also given due consideration. The full findings of the GESI assessment by the MTR team can be found in the MTR GESI Supplement.

GESI within NHSP II

The NHSP II and GESI Strategy jointly are considered significant breakthroughs for Nepal and both GESI institutional mainstreaming and targeted interventions by the health sector are viewed as a best practice. The term GESI was generally familiar to all. But the concept of GESI is less understood and mainstreamed in the periphery. For example, the interconnectedness between GESI institutional mainstreaming and targeted interventions that also supported the revitalising of health services was progressively less understood as one moved away from the centre, and was seen as two separate processes especially at lower levels of the health hierarchy. The GESI concept and terminology was still a

[19] With a Gender-related Development Index and Overall Gender Empowerment Measure of 0.49, the status of Nepali women and girls irrespective of caste, ethnicity and geographic location have remained lower compared to men and boys

novelty to most District Public Health Officers (DPHO) and District Health Officers (DHO), even the ones who had received orientation. They however, understood the term 'social barriers to health' better than GESI.

Improved health and increased utilisation of services by the poor and excluded is the goal and purpose of NHSP II with three outcomes related to equitable access (Outcome 1), universal coverage of Essential Health Care Services EHCS (Outcome 2) and increased adoption of health practices (Outcome 3). The NHSP II updated Monitoring and Evaluation (M&E) Framework (May 2012) includes eighteen GESI related activities under four different outputs out of a total of nine output areas in the Logical Framework.

This review has calculated the implementation rate of planned activities between July 2011 to September 2012 against the working policy of the NHSP II, ANNEX 3 (Strategy Table/Strategic Framework) as:

- Objective 1 or GESI institutional mainstreaming: 78%
- Objective 2 or Capacity building, ensuring equitable access and utilisation: 65%
- Objective 3 or Improving health seeking behaviour: 43%

The M&E Framework document for the first time presents levels of inequality in 2006 and 2011 as reported by the Nepal Demographic Health Survey 2011[20]. This data is disaggregated by sex, caste and ethnicity and wealth quintile but not rural and remote area. There are national targets for each output but no targets set for each of the disaggregation.

Selected important developments, 2011-2012 for GESI institutional mainstreaming and targeted interventions in health

- GESI institutional mainstreaming modality was fully established in MoHP, Department of Health Services (DoHS), five Regional Health Directorates (RHD) and in 41 District (Public) Health Offices
- The Population Division was approved in 2011 as the overall GESI Secretariat for the MoHP and a GESI Steering Committee was established with the Secretary of Health and Population as Chair
- GESI related provisions were added in the approved Human Resource for Health Strategy Plan (2011-15)
- One Stop Crisis Management Centres (OCMC) were established in a phased manner at the district level. These are considered a major contribution by MoHP to the National Acton Plan in the Prevention of Gender Based Violence
- Social Audits – especially those using the updated comprehensive guidelines – are now an integral part of the health system programming at the facility level
- The Annual Work Plan and Budget (AWPB) of MoHP now have budget provision for GESI issues and the Business Plan for 2012/13 has incorporated GESI related activities

[20] This covers all of the fourteen Goal indicators (14), eleven (out of 12) Purpose indicators, two (out of 8) Outcome 1 indicators, all six of Outcome 2 indicators and two (out of 4) Output 5 indicators.

- The Health Policy of 1991 was reviewed in 2012; the revised policy will include a number of new issues from a GESI perspective
- The Health Sector Strategy for addressing Maternal Under-nutrition and the Health Communication Policy incorporated GESI issues; there will be GESI integration in the new Urban Health Strategy, to be developed in 2013
- Five service-related curriculums have been reviewed by National Health Training Centre (NHTC) from a GESI perspective; plans for technical teams to develop GESI modules and materials for integration in the curriculums are in process
- The implementation of the GESI Strategy is included as an integral aspect of Regional Health Systems Strengthening
- Social Service Unit (SSU) and Social Audit guidelines were finalised
- A consolidated GESI Operational Guideline will be available for launch in February 2013

Review of NHSP II, Annex 2 (GAAP) objectives, in relation to GESI

Objective 7 (Social/Equity Access and Inclusion) implementation rate against annual planned activities, 2011-12 showed:

- The establishment of One stop Crisis Management Centres – 50%
- The conduct of social audits according to updated operation guidelines – 81%
- The number of HFOMC with at least 3 numbers of female members and at least 2 members from Janajati and Dalit. – 42%

There are other GESI targeted interventions which meet the GAAP criteria of being client-oriented activities which focus on women especially those in rural and remote areas, the poor and excluded; but are not included in the GAAP although they should be in order to increase downward accountability by the system. These GESI targeted interventions are: Equity and Access (EAP), Social Service Units (SSU) and Free Health Care (FHC), AAMA Samuha (Mother's Group), Female Community Health Volunteer programme (FCHV) and Health Camps in rural and remote areas.

The Business Plan (2012-13) is committed to strengthening the GAAP. The document indicates that there are twenty four activities that were defined as GESI. Of these, sixty two percent (62%) were supply side activities related to monitoring, standard operating procedures and training as well as capacity building in GESI mainstreaming and thirty eight percent (38 %) could be referred to as creating demand as they provide support to the current GESI targeted interventions.

Gender Responsive Budgeting

Gender Responsive Budgeting (GRB)[21] in MoHP started well in 2007-8 with sixty two percent (62%) of the budget directly responsive. This reduced over time, and by 2010-11 it was 37% although the total in

[21] The MoF has developed a system called Budget MIS. All line ministries have to respond to the LMBMIS which is classified into 3 discrete categories: Directly Gender Responsive, Indirectly Gender Responsive and Neutral. These categories are then divided into 5 classifications with equal point system (20 each out of a total of 100) for: Women's participation in formulation of programme, women's capacity development, women's share in benefit,

gross amount in rupees had almost doubled. The impression given in the course of this appraisal was that the GRB process in the MoHP is highly mechanistic and was being done to fulfil a Ministry of Finance requirement rather than to promote an ethos in support of GRB among programmers. However, in mid-2012, an initiative was undertaken jointly by the DoHS and the NHSSP on Financial Allocation Review from a GESI perspective as an input for the AWPB of 2012-13 across seven divisions/centres of the MoHP. This analysis combines GRB (although with slightly different categories) with allocations disaggregated by women, children, poor and marginalised and elderly/disability. There is also further categorisation of the financial allocations by Domains for Change (access to services and voice or the level of participation by the community and changes in informal and formal policies). This initiative remains ad hoc and waiting further approval.

GESI governance

The process of GESI institutional mainstreaming such as GESI Committees and technical working groups in DoHS, in the Regional Health Directorate (RHD) and District Health Offices was seen by some interviewees as creating parallel modalities and the process as mechanistic. GESI institutionalisation has not reached the districts and health facilities fast enough and this was a major shortcoming.

Given the critical importance of the GESI Strategy some interviewees thought it should have remained with Policy, Planning and International Co-operation Division (PPICD). However it was agreed that Population Division had proven itself as the new GESI Secretariat and that outputs under their tutelage have been reasonable.

GESI integration

There was a close linkage between GESI issues and the implementation of the Human Resource for Health Strategy (HRH). This entailed strengthening human resources for GESI institutional mainstreaming and intensification of GESI principles within the HRH Strategy. Half of those interviewed for the MTR thought that the recently approved HRH Strategy was GESI compliant.

GESI integration is prominent in high-level policy and strategic documents, but decreases in operational tools, frameworks and in implementation. There is a reasonable tally between information received from strategic documents and MTR interviews with both remaining hopeful about the implications of GESI Strategy on the health system. GESI-focused technical assistance is recent (just over a year old). GESI institutional mainstreaming where integration of issues becomes a daily practice across the board is acknowledged to take time.

Currently, the importance of GESI a) increases as the approved GESI Guideline transitioned from documents to implementation at central and regional level; b) decreases as one moves away from policy and strategic documents of NHSP II which is strong on GESI, into the realm of the updated Monitoring and Evaluation Framework, the Logical Framework and HMIS which is weak on GESI disaggregation of outputs and c) remains neutral on the achievement of the GAAP which has tried to integrate a few targeted interventions but left out some critical ones (see MTR GESI supplement for more detail).

Support in employment and income generating for women and Quality reform in women's time – use and minimization of their work load. Within each classification there are coding and points.

Disaggregation of data with regards to GESI

Most MTR interviewees believed that the NHSP II demands GESI disaggregation and that there was sufficient disaggregation within the health system, especially if all the nine information systems are combined with surveys also including disaggregated data[22]. The problems are: these are parallel systems; they are not well maintained; and they exclude reporting on caste, ethnicity and religion. Hence there is a consistent call for further GESI disaggregation in the regular HMIS.

Participants of the Joint Annual Review (JAR) have not taken any decisions on the necessity for GESI analyses of the various presentations or HMIS disaggregation. It was noted that there was not sufficient demand for, or utilisation of, disaggregated data by policy planners and this was the main reason why GESI disaggregation has been delayed.

GESI at the district and facility level

Given the progress of GESI mainstreaming and targeted programming thus far, there is a need to update the GESI Strategy as well as further expanding the mandate for working directly with district health offices and health facilities. The Equity and Access Programme (EAP), SSUs and Social Audit needs acceleration as the numbers are too few to make a big difference in a short time. The plans to scale up these activities next year with a quality assurance component are vital. The OCMCs are an important initiative to provide services to GBV survivors, at this point there are too few of them on one hand but their management and follow-up services is open to many questions. Furthermore, information, education and communication that will address GESI issues e.g. structural causes of women's discrimination, effect of caste based discrimination and of language on access of health services by Dalits, by Madhesis and Adibasi Janajati's respectively, are not adequately developed or aired.

There is a need to align social audits, SSU and free health, district health profile and VDC mapping with EAP and more harmonisation of the Logframe indicators with relevant GAAP indicators that were related to GESI targeted interventions. There is a call to review and update the AAMA Samuha especially by bringing in young adults (20-30 years) and to link such changes to M&E Framework indicators and STS. However, with the incentives package, in many communities the FCHV programme is now quite highly developed and is competitive, hence there is an imperative to practice affirmative action. District Health Offices and EAP as well as vertical programmes like Safe Motherhood and Immunisation are struggling with not having multiyear contracts for NGOs working in the field. Social mobilisation for health can be a complex, time-consuming process and requires expertise.

2.1.2 OUTPUT 1 RECOMMENDATIONS

During the NHSP II period there has been good progress in turning the commitment of the GESI Strategic Framework into actions such as approving and integrating the GESI institutional modalities, developing operational guidelines and widening the implementation of GESI targeted programmes across main departments, divisions and centres of the sector. The following recommendations are aimed at supporting the work of MoHP and the GESI Steering Committee (GSC) and other stakeholders in implementing GESI at operational levels.

[22] HMIS, HIV-IS, Logistics MIS, Financial MIS, THIS (health training), EWARS (epidemic), Immunisation + polio and other vertical programmes, TB-IS and HuRIS. Surveys include Population census and maternal mortality data (every 10 years), NDHS (every 5 years), NLLS (every 3 years), HHS (every 2 years) and STS every year starting from 2011.

Overall recommendations are provided specifically for the MoHP as the national steward of NHSP II and the GESI Steering Committee (GSC) as the custodian of GESI in Health; the DoHS and Population Divisions not just as the implementing agencies but as two GESI movers, the pool donors as critical stakeholders and the NHSSP as the lead technical facility on GESI with the contractual obligations.

Disaggregation of data and strengthening of indicators

R1.1: The MTR recommends the following set of actions to be agreed at the JAR 2013:

- Improving the harmonisation of the NHSP II Strategic Framework with the Logical Framework and GAAP;
- Disaggregation by 2015 of selected logical framework outcome and output indicators and annual reporting by HMIS
- Making the relevant heads of all concerned departments, divisions/centres of MoHP responsible for ensuring the achievement of related disaggregation outcome and output indicators under the leadership of the Population Division of MoHP, who in turn will report to the Chair of GSC biannually;
- Formulating a small set of process indicators reflecting both GESI institutional mainstreaming and targeted interventions and integrating them into the M&E and Logical Framework;
- Sharing the results of the 17 district pilot on disaggregation and implications for integration and quality provided to the GSC;
- GESI technical support, skilled human resources and non-cash incentive package for disaggregation reporting from district to HMIS.

Development of a GESI sub-strategy for district/facility level

R1.2: The MTR recommends that the formulation and funding of a three year GESI sub-strategy for health for mainstreaming at the district and facility level. This must be done in consultation, and there must be a specific focus on local needs and issues relevant to key indicators that have stagnated. The sub-strategy must also include:

- Clarification of all GESI terminologies, definitions and responsibilities regarding mainstreaming and linkages to targeted programming
- Identification of working modalities, community based entry points and skilful local champions
- Development of self-assessment tools and Oversight Plan under the tutelage of the GSC for monitoring technical assistance, advocacy and resource mobilisation
- Promotion of using evidence on GESI for programming at district level.

Strengthening and expansion of GESI targeted interventions

R1.3 The GESI Unit within Population Division could facilitate the relevant MoHP agencies to:

- Work with the five concerned Ministries to develop comprehensive and agreed guidelines for establishing OCMCs at district level;
- Invest more in making EAP a flagship programme within DoHS and ensure the provision of multiyear contracting of EAP through implementing NGOs;
- Strengthen Social Service Units by making them more functionally efficient, and expand to new areas ensuring expedited certification and ensuring proper recording of clients and disaggregated reporting of free service utilisation;
- Develop specific targeted interventions within national programmes to address the barriers of specific social groups through FCHV programme fund, Village Development Committee (VDC) mapping and local planning.

Strengthening GESI leadership

R1.4: The MTR recommends that the GESI Steering Committee is active in convening its own meetings on a regular timely basis with appropriate administrative documentation. The GSC is supportive with resources of the regional monitoring and evaluation role which ensures: a) functional and well co-ordinated reviews of GESI at all levels; b) technical assistance for strengthening a GESI unit within Population Division as the overall Secretariat of the MoHP; and c) that the health system utilises its own expertise as much as possible in the push to mainstream GESI in districts and facilities, backstopped by the NHSSP and other such support.

The GSC should ensure that:

- The GESI Guidelines definition of exclusion is standardised across all major policy and programme documents in the health sector;
- Analysis of financial allocation from a GESI perspective is widened and made into a regular practice to inform the AWPB and Business Plan preparations and the exercise cascaded to the region and districts;
- The roll out of the GESI operational guidelines is timely;
- At the end of 2013, review technical assistance from the perspective of the recipients;
- Al EDPs and TA including NHSSP report on progress on GESI issues as an integral part of TA and a practice is also established within each TA program to report on progress on GESI issues at clearly defined intervals.

Integration of GESI into key training programmes

R1.5: The MTR recommends adding value to the National Health Training Centre's GESI review by:

- Funding as soon as possible the roll out of GESI modules/materials in its five critical training programmes targeting Health Facility Operations Management Committee (HFOMC), Female Community Health Volunteer (FCHV), Behaviour Change Communication (BCC), Skilled Birth Attendant (SBA) and upgrading Auxiliary Health Worker (AHW).
- Establishing a GESI sensitized pool of master trainers
- Strengthening a GESI sensitive Human Resource for Health approach and making provisions for appropriate support.

Development of GESI-relevant health communication

R1.6: The MTR recommends a number of measures to add value and make effective the new operational guidelines of NHEICC by:

- Utilising local skills to develop materials and advocating for increased number and type of media outlets to offer these materials to its audiences;
- Ensure broadcasting is not constrained to only technical issues but that it addresses structural issues of caste/gender/ethnicity based discriminatory social practices which impact negatively on availability, affordability and utilisation of health services.

Consideration of a phased integrated governance for GESI institutional mainstreaming

R1.7 The MTR recommends considering integrating GESI responsibilities into existing committees and structures. Since GESI is cross-cutting, a better fit might have been for GSC to be a sub-committee of the NHSP II Steering Committee (if functional). It is advised to retain the status quo at the centre and regions remains until further work is done on GESI issues. Experimentation in integration is possible in the districts as suggested in recommendation 2. The end assessment of NHSP II could consider whether GESI is routine at all levels, where the greatest need is and then recommend the future institutional modality.

2.2 NHSP II Output 2: Improved Sector Management

2.2.1 Output 2 Findings

Update the 2012 achievements for this output in the NHSP II Logical Framework has not been possible. All indicators for this output have been reported 'Not Available' for 2011 & 2012. While some of information is available, such as for progress on JAR actions, it is difficult to use precisely in these indicators, i.e. % JAR actions completed. As can be seen from the analysis above, the actions and responses lack precision.

The management of the health sector has evolved over the last decade since the advent of the sector wide approach back in 2004. There has been a process of maturing of systems and agreements that has led to steady progress in sector and aid effectiveness. The MTR recognises this progress and the management systems currently in place. Progress since the 2004 "Statement of Intent"[23] has been well documented[24] and demonstrates considerable progress in aid effectiveness in the health sector. The MTR has identified a number of areas where the management of the sector could be improved and suggests a set of recommendations that are in most cases mutually supportive and as such should be considered as a package rather than stand alone.

Organisational review

An area of considerable discussion during the MTR was the degree to which the current organisational arrangements within the MoHP, DoHS and other Departments and Centres were functioning optimally. Recognising that there has been considerable restructuring of the central level in the recent past this is an area that needs careful consideration. Having said this, the MTR team has concluded that there are several areas where roles and responsibilities for important aspects of sector management are either unclear, duplicated or poorly linked. Until some of these management functions are clarified, strengthened and organised in a way that facilitates decision-making, strategic planning and oversight of implementation, inefficiencies will continue and systems improvement proceed slowly. The issue of organisational review was highlighted in interviews with senior managers and the need for further attention generally agreed (see R2.1 & R2.4 below).

Government leadership and effective coordination

The health sector is complex with numerous stakeholders both within the public sector and beyond. The non-State sector is a major provider of services and one that is growing rapidly. The number of external partners is considerable as is the number of different programmes and projects under implementation. While the SWAp is a major achievement in the health sector there is considerable influence on the sector from off-budget health funding and health related activities led by other sectors such as water, education etc.

Building the capacity of people across the different levels of the health sector was a major topic of discussion between the MTR team and senior managers from GoN. Recognising the need to build

[23] MoHP (2004). Statement of Intent to guide the partnership for health sector development in Nepal. Cosigned by MoH and EDP representatives. February 2004.

[24] IHP+. 2012. Aid effectiveness in Nepal's Health Sector: Accomplishments to date and measurement Challenges. Vaillancourt, D. and Pokhrel, S. February 2012.

capacity is an important step and allows discussion on the need to assess skills and competencies, identify gaps and put in place programmes to address the findings. Leadership, strategic planning and management and associated systems and tools were clearly identified as areas for more focus (see R2.2 & R2.3).

Useful studies have been undertaken to look critically at the current coordination across the sector. This has identified the need to rationalise the current system of committees, technical working groups and other mechanisms. The issues identified include the need for better definition of terms of reference, level of participation and reporting and communication between committees. Improving the efficiency and effectiveness across the current committee structure is a pressing need (see R2.8)

Sector Planning and budgeting

Current MoHP and DoHS division of labour means that evidence based planning and monitoring of progress is not optimal. This is a constraint as functions are often disassociated, coordination intermittent or dysfunctional. Review of core functions, roles and responsibilities of departments and divisions should be undertaken and adjustments made to improve the efficiency and effectiveness of government stewardship of the sector (see R2.4).

There are two key review processes taking place in the sector. The first being the government's annual health sector review process involving district reviews and reports, regional summaries and regional health review meetings and a national review meeting (December 2012). The final product being a substantial Annual Report that documents progress in implementation of the AWPB and 3 year plan across the country. The second is the Joint Annual Review process (January 2013) that focuses more on the NHSP and progress against outputs and outcomes as specified in the Results Framework. Currently these review processes are too distinct and opportunities for cross-learning not sufficiently taken (see R2.5).

Progress on the AWPB planning process is commendable especially the reduction in line items and move to eAWPB system. The AWPB process needs to continue to evolve from mainly input focus to include more linkage to sector outputs and outcomes. The eAWPB does now link line items to logframe indicators. This is a move towards output based budgeting that, while notional is a useful step towards output based funding This is a big challenge that has been previously recognised but still exists (see R2.6).

Health sector planning needs to be more needs-based, driven by district analysis and plans rather than by centrally funded programmes. This will involve considerable change in the way business is conducted in the sector and is linked to the proposed review of functions and structure above. It will also require a revised planning and budgeting approach and related capacity development. A year on year programme of change should be developed so that by the start of NHSP-III the planning and budgeting is driven by local needs rather than central programmes and globally funded agendas (see R2.7).

Technical Assistance

The MTR team looked at technical assistance across the NHSP II outputs. The main discussions have revolved around the efficiency, effectiveness and added value of this support. The first challenge has been to identify the scale and scope of technical assistance, the second has been to look at how technical assistance is or is not aligned with the government's agenda for the health sector. The TA

Matrix has been a useful addition to the documentation and has highlighted the considerable range of support being provided by EDPs. The document is useful and the challenge now is to develop this further to make it more user-friendly and to keep it up to date on a regular enough basis.

A number of issues have arisen in discussion with government and EDP representatives that merit further work. The current JTAA draft is seen as a useful document and contains a range of issues that make a lot of sense. However its current form and indeed history make it unlikely to be signed. This is unfortunate and requires action by government and EDPs (see R2.9).
Technical assistance is often, but not always, seen by EDPs as very well aligned with government and providing well targeted support. However government managers frequently cited that they have little input on decisions for technical assistance assignments, knowledge of assignments in progress and that the purpose of building capacity of the government is not met. Given the considerable resources involved this issue needs to be resolved (see R2.9).

Moving from pilots to scale up

Government and EDPs alike mentioned the need to move beyond the piloting of numerous initiatives. The discussions and documents show that there are a very large number of pilots either completed, in-progress or in a rather indeterminate situation. Evaluation of findings and lessons from pilots are not so evident and the need for evaluation studies was highlighted on several occasions. These evaluations should focus both on effectiveness of interventions under ordinary field conditions. All assessments should include costing information, so that the financial implications of scaling up are clear. The need to move to more coordinated scale up of piloted work, based on a comprehensive mapping of pilots/evaluations, especially linked to district governance, organisational change and service delivery is evident (see R10.1). Although the future structure of the health system is uncertain due to on-going discussions on federalism and decentralisation more integrated and comprehensive pilots at district level are likely to be very useful for the future agreed situation.

2.2.2 OUTPUT 2 RECOMMENDATIONS

Based on the findings of the MTR in the area of sector management a set of related recommendations are proposed. These aim to support further strengthening of government leadership and ownership, more efficient and effective ways of working that require considerations for organisational change and capacity building in key areas linked to governance, stewardship and management systems.

Organisation and management

R2.1: The MTR recommends an Organisational and Management Review that covers MoHP, Departments and Centres and the way EDP support and coordination structures are organised. This study should identify key functions and responsibilities with a view to revising the current organisational arrangements and in turn support a restructuring exercise to improve efficiency and effectiveness of government.

There are two key review processes taking place in the sector. The first being the government's annual health sector review process involving district reviews and reports, regional summaries and regional health review meetings and a national review meeting (December 2012). The final product being a substantial Annual Report that documents progress in implementation of the AWPB and 3 year plan across the country. The second is the Joint Annual Review process (January 2013) that focuses more on

the NHSP and progress against outputs and outcomes as specified in the Logical Framework. Currently these review processes are too distinct and opportunities for cross-learning not sufficiently taken.

Management Capacity

Linked to the above the skills and competencies of those responsible for leading and managing the government role and the existing management systems need to be developed.

R2.2: The MTR recommends that a comprehensive management capacity needs assessment both in terms of governance, leadership and management (strategic and financial) as well as management systems and tools currently in place. This assessment would identify current capacity and system gaps and put in place a programme of work to strengthen National, Regional and District capacity in line with the functions required.

Tailored capacity building for different levels of the sector management structure should be developed and supported preferably by a pooled funding or, if not possible, by clearly aligned allocations by EDPs.

R2.3: The MTR recommends that, once the assessment (R2.2) has been completed, government and EDPs convene a high level roundtable to address the issue of capacity in leadership and management and in systems and tools and agree a programme of work tailored to identified management needs. Support outside this programme or ad hoc additions based on opportunistic trainings should be discouraged.

This will also look at clarifying the relationship between government departments, the leadership role of government in the context of NHSP-II's remaining period and the future NHSP-III (or successor), providing the necessary competencies and depth of management within government to translate EDP commitments to aid effectiveness principle into practice; establish one comprehensive and harmonised support programme to build government governance, leadership and management to implement NHSP-II and then NHSP-III.

Sector Planning and budgeting

Current MOHP and DOHS division of labour means that evidence based planning and monitoring of progress is not optimal. This is a constraint as functions are often disassociated (e.g. planning and information – see R2.1 above), coordination intermittent or dysfunctional. Review of core functions, roles and responsibilities of departments and divisions should be undertaken and adjustments made to improve the efficiency and effectiveness of government stewardship of the sector.

R2.4: The MTR recommends that the PPICD should be substantively strengthened to improve effective use of the health information generated by the various management information systems as this is key to evidence-based planning.

Harmonisation of review processes

R2.5: The MTR recommends that the Annual Health Review and the JAR processes should be more integrated and as a starting point ways of linking the two final meetings should be explored. One option is to have back-to-back meetings in early December. The JAR would benefit from the high level of engagement of districts and whole-sector issues while the Annual Review would benefit from more focus on outputs and outcomes. As part of this revision the format and terms of reference of the annual review process should be revisited to be more action-oriented and aimed at being a major contribution to district driven needs based planning. This harmonisation of the review processes should be closely linked with improvements in the availability of quality data and streamlining of information systems (R6.1 and R6.3).

Increasing the focus on results and needs-based planning

Progress on the AWPB is commendable especially the reduction in line items and move to eAWPB system. The AWPB process needs to continue to evolve from mainly input focus to include more linkage to sector outputs and outcomes. This is a big challenge that has been previously recognised but still exists.

Health sector planning needs to be more needs-based, driven by district analysis and plans rather than by centrally funded programmes. This will involve considerable change in the way business is conducted in the sector and is linked to the proposed review of functions and structure above. It will also require a revised planning and budgeting approach and related capacity development. Local planning in health should be closely linked to local government planning to ensure alignment and optimal use of available resources. A year on year programme of change should be developed so that by the start of NHSP-III the planning and budgeting is driven by need rather than central funds and globally funded agendas.

R2.6: MTR recommends that AWPB is developed to include more results focus and this should be aligned with the NHSP-II M&E framework.

R2.7: The MTR recommends that there is a move to more needs-based planning and budgeting utilising local and district level planning as basis for resource allocation and annual work-planning. A revised planning framework will need to be developed and a workplan and timetable for change developed. While work can be started with immediate effect downstream introduction should be considered for the start of the NHSP-III period.

Sector Coordination

Previous reviews on health committees have highlighted a number of areas for improvement of how the sector is coordinated. These findings should now be acted on as some of the constraints in coordination are a constraint to progress.

R2.8: The MTR encourages the adoption of greater government leadership of all key committees at the appropriate level, rationalisation of the functions and overall structure of committees and TWGs and greater participation by civil society and private for profit groups. An official map of sector committees should be adopted by the MoHP as soon as possible and included as an annex to the NHSP-III.

A “master document” should be prepared and adopted by government based on the existing review findings, with support from stakeholders that identifies the key committees and TWG, their function, TOR, the post that should chair the meeting, membership, and relationship with other committees. This should cover all areas of the health sector including MoHP, Departments and Centres.

Technical Assistance

The JTAA contains very useful directions for improvement of harmonisation, coordination, alignment and relevance of technical assistance. However as a guiding document it has failed because it has not been signed and the requirements it involves mean that it is very unlikely to be adopted in its current form. The MTR considers it is time to develop a new document.

R2.9: MTR recommends that a time-bound TWG is established to prepare a new Technical Assistance Harmonisation Agreement and Plan to replace the JTAA, and that this is signed by MoHP and all health sector EDP before the end of NHSP-II.

- The Technical Assistance Harmonisation Plan should include the requirement for an annual technical needs assessment and annual technical assistance workplan (with TA Matrix for previous year as annex) that links to the NHSP-II objectives and compliments the AWPB.
- TA should be more integrated within specific divisions and departments of MoHP, Departments and Centres.
- The Technical Assistance Steering Committee should be expanded and mandated to develop a harmonised annual work-planning process co-chaired by the Head of PPICD and a representative of the EDPs. The annual TA workplan will to be signed off by the Secretary Health and agreed representation of the Pooled and Non-Pooled Funders

2.3 NHSP II Output 3: Strengthened Human Resources for Health

2.3.1 Output 3 Findings

Two of the seven Output 3 indicators, OP3.1.4 (% of sanctioned posts that are filled - nurses at district hospitals) and OP3.7 (Number of Female Community Health Volunteers) are on track to achieve at least 90% of the 2013 target, however the majority of indicators for this output are unlikely to achieve 2013 targets. Of note, the following indicators have shown negative progress in 2012:

- OP3.1.1: % of sanctioned posts that are filled - doctors at PHCC. 2012 reporting on this indicator represents a 62% decline on the 2011 achievement (19% down from 50% in 2011) that is particularly worrying given the target of 88% for 2013.
- OP3.1.2 % of sanctioned posts that are filled - doctors at district hospitals. This indicator has seen a 19% decline in progress from 2011 and is unlikely to achieve its 2013 target.
- OP3.1.3: % of sanctioned posts that are filled - nurses at PHCC. Reporting for 2012 shows a decline of 20%, from 74% in 2011 to 59% in 2012. Again, this indicator is unlikely to reach the 2013 target of 88%.
- OP 3.2: % of district hospitals that have at least 1 MDGP or Obstetrician/ Gynaecologist; 5 nurses (SBA); and 1 Anaesthetist or Anaesthetist Assistant. 2012 reporting on this indicator was at 0%, representing a worrying decline in progress from 2011, when the achievement was 13%. It is unlikely that the 60% target for 2013 will be achieved.

OP3.3 is disaggregated by 14 cadres of health professional, only one of which 2012 data is available: skilled birth attendants. This indicator has seen a 42% increase over 2012, rising from 2,562 in 2011 to 3,637 in 2012. If this trend continues in 2013, it is likely that 90% of the 2013 will be achieved.

HR strategies and polices

The HRH strategic plan is comprehensive in its coverage of the critical issues affecting the delivery of health services and it elaborates a range of concrete measures to address these issues, and further analysis and research where necessary.[25] Although the plan was developed using a consultative process involving a range of stakeholders, it is unclear whether the ownership of the final plan has been widened beyond the HR function. The HRFM Division submitted an annual work plan based on the HRH strategic plan, but it has not proved possible to include any new activities in the GoN budget because of the limitations imposed by the two-thirds budget. The implementation of activities in the strategic plan which require financial resources is therefore frozen.

The MTR team recognises that the HRH strategic plan is an ambitious document given the present levels of HR capacity within the Ministry and the frequent turnover of senior personnel. Many of the activities identified in the HRH strategic plan are work streams in their own right. There would appear to be a pressing need for the senior management team of the Ministry and the Department to consider and decide upon the HR priorities which should be pursued. This will help to build ownership among line managers. The priorities can be gradually extended as capacity is built.

The MTR team re-examined the policies and strategies contained in the HRH strategic plan for addressing the mal-distribution of health workers in Nepal. The situation analysis of the HRH Strategic Plan presents the available (albeit deficient) data on the supply and stock of health professionals. It

[25] The only neglected area is the recent emergence of informal employee power through the affiliation of health workers to political parties who are prepared to defend their rights.

concludes that for most cadres there are enough qualified health professionals to meet the needs of the country. The majority of health workers are not working in the public sector. For instance, of a national stock of 8,335 medical doctors, only 1,112 are working in government facilities. According to NHSP-2, one-third of sanctioned posts for doctors and nurses are vacant and only 82 per cent of posts in Primary Health Care Centres and district hospitals are filled.[26] Government has been unable to entice public sector health professionals to work in remote and rural facilities. Two-thirds of medical doctors in the public sector are working in the Kathmandu valley and urban areas. This has been a longstanding problem in Nepal.

The distribution of health workers is governed by three core HR processes: (a) the recruitment of permanent staffs; (b) the employment on temporary staffs on local contracts and most critically, (c) the postings and transfers processes.

The recruitment of permanent health workers is the mandate of the Public Service Commission, which has the duty to ensure that all new recruits are hired on the basis of merit through open competition. The PSC has not recruited any gazetted health workers for around three years because of the absence of any inclusivity provision in the Health Services Act. This problem has now been addressed, but it seems unlikely that the Act will be passed by the President as an Ordinance (it cannot be passed as an Act because there is no sitting Parliament) because of the lack of consensus between the political parties. In the interim, the PSC has recently given authority to the Ministry to recruit gazetted staffs on one year contracts to vacant sanctioned posts. It is understood that authority to recruit non-gazetted staffs was given some time ago.

There is a considerable volume of temporary hiring (mainly nurses, ANMs, AHWs) which is being undertaken by DPHOs/DHOs on one year service contracts. The costs are met with project resource provided in the GON's "Red Book".

In addition, the MTR team was told that VDCs also engage ANMs and staff nurses on contract using their own resources. Recruitment is generally carried out by advertising and interviews (no written examinations) though we were told some headhunting takes place. Salaries (more precisely fees for service) vary considerably from district to district; at best they are equivalent to the appropriate civil service salary without the benefits. The exception is for specialist surgical teams where doctors have commanded salaries of five to 10 times the relevant government salary. It has proved possible to attract and retain nursing and paramedical staff on these relatively unfavourable contracts in all parts of the country, even in the most remote areas. The biggest problem is how to finance the contracts when they are renewed between the start of the financial year and when the resources are released, a gap of around three months.

Generally, the contract staffs are providing excellent services, often superior to the performance of permanent staffs. In practice therefore and with some exceptions, local contracting is making a valuable contribution to improvements in service delivery. Local contracting can allow recruitment of service providers from a more diverse social background reflecting the local community they serve.

Postings are decided by senior officials depending upon the grade level following recruitment. Postings are necessary because recruitment is made to a cadre rather than a specific job in a particular location.

[26] Ministry of Health and Population, National Health Sector Programme – 2, 2010-2015

In principle, staff transfers can be used to deploy health workers based on the needs of the service and to tackle inequitable distribution. In practice, however, transfers are often used as tools of patronage and punishment. Individual health workers must therefore lobby senior officials and perhaps politicians to secure desirable postings in urban areas, the Kathmandu valley or their home district. The result is a high volume of movement of health workers away from remote areas (where they are often first appointed) towards urban centres (especially Kathmandu), the terai and their home districts.

According to the official transfer policy in the Health Services Act, health workers need only to spend one year in a very remote area and two years in a remote area. These minimum periods are usually interpreted as a maximum requirement, effectively establishing a "right" to be transferred after the minimum period has expired. The consequence of the actual practice of transfers, therefore, is that mal-distribution is frequently exacerbated. This is a common problem in countries that adopt a centralized postings regime.

There is no magic bullet that will solve the inequitable distribution of health workers. As acknowledged in the HRH strategic plan, a package of complementary measures will be required. In principle, a centralized system involving postings and transfers should be able to tackle mal-distribution. However in practice, this is not the case in Nepal where patronage and personal interest prevents the centralized system from working as it should.

The MTR concludes that individuals would be given the opportunity to choose which jobs they apply for and to work in their home districts. "Decentralized" recruitment would obviate the need for transfers and the distortions that the current practice creates. It will also allow recruitment of people from local areas and with appropriate language skills for the communities they serve. An appropriate incentives package would need to be provided to ensure sufficient recruits are attracted to remote areas.

A number of priority issues emerged from consultations such as the need to determine the mix of financial and non-financial incentives that are likely to be most effective. In order to expand the number of qualified applicants in remote areas, the Ministry should continue to develop its work with training institutions to "adopt" remote districts by providing them with scholarships to residents of these districts. These scholarships must of course have criteria to ensure women and people of excluded social groups also receive opportunities. Another is that the Ministry move quickly towards adopting multi-year (renewable) contracts.

Information on Human Resources

Addressing the mal-distribution of human resources requires that the gaps (and surpluses) are correctly identified in the first instance. Accurate data on the current stock and distribution is essential.

Several years ago the Ministry established its own HR database, HURIS, which contains personal details on every permanent employee in the Ministry (though not on health workers in the police, army and civil service hospitals.) The system is capable of producing standard reports on workforce stocks and flows by location and institution. Unfortunately, it does not appear that the database is systematically updated so the reports are inaccurate. As of 7 December 2012, there were 24,983 permanent employees on the data base, compared with an estimated actual number of around 29,000. MoGA has a whole civil service database (the Personnel Information System - PIS) that was designed to support HR operations. The system has recently been upgraded and a major validation exercise was completed to verify the information on every personal file. As of 6 December 2012, however, there were only 22,571 permanent

employees on PIS, less than on HURIS. Neither of these databases captures temporary employees that have recently expanded in number.

A recent assessment concluded that the HURIS is not accurate because it was not designed to be used by HR personnel for operational purposes.[27] There are no incentives to maintain it accurately since employees can be paid on one of the 270 local payrolls even if they do not have a personal record on HURIS. The PIS was designed to serve as an operational database which would address such problems; yet it is seemingly more inaccurate than HURIS. The PIS does not control entry to the payroll, though it must be used in order for pensions, gratuities and terminal benefits to be paid.

Even though neither HR database is used for operational purposes, it appears that the various personnel administration sections in the Ministry, Department and Regions are raising the necessary paperwork whenever a transaction occurs and sending this to both HURIS and the Department of Personnel Records of MoGA. It is unclear therefore where the problem lies; it may originate at the regional level that relies on the official postal service to deliver the letters to Kathmandu. Clearly, the use of remote entry using designated users at the point where the transaction occurs would help to solve this problem.

There does not seem to be a justification for maintaining two HR databases. Though both databases have their weaknesses, the MTR view is that the PIS offers the better medium-term solution for the Ministry both for maintaining its personnel records and producing accurate workforce reports for HR planning purposes. The Ministry would benefit from the technical support available for the PIS at MoGA (e.g. server maintenance) and the existence of permanent staffs for programming and data entry. The Ministry currently relies upon two temporary computer operators hired on three-month renewable contracts.

Capacity and Organization of Human Resource Management

In the Nepali civil service human resource management is regarded as an administrative function which can be handled by generalist administrators who simply apply a centralized set of personnel regulations, rather than a profession in its own right. The HRFMD and the PAD are both headed by Joint Secretaries belonging to the administrative service whose careers are managed by the Ministry of General Administration. They may be transferred between government ministries based on the needs of the administration rather than the needs of any particular Ministry. Postings are typically of one to two years duration, though exceptionally the former JS, HRFMD stayed in the Ministry for four years. None of the section officers have received training in human resource management. The two divisions therefore lack even the most basic skills and experience required to direct and manage human resources for a large organization with a nationwide geographical spread.

HR activities are split between three divisions. The Joint Secretary, HRFMD, is responsible for human resource planning and development and training needs analysis, though currently it carries out neither of these activities. HURIS is housed within this division. The Joint Secretary, PAD, is responsible for administering HR transactions (e.g. postings, transfers, leave, performance appraisal, promotions), conducting O&M studies and handling grievances from civil servants. PPICD, which performs the

[27] Blair G, Human Resource Information Assessment, LATH, 2011.

planning function of the Ministry, has an international section that awards training scholarships funded by donors.[28]

No other Ministry has more than one division for human resource management, and no one could tell the MTR why separate divisions from human resource management and personnel administration had been created. The consequence is that there is no single senior manager with overall responsibility for managing the HRM function. One key advantage of having one human resource (or personnel division) is that it would enable related HR tasks to be better coordinated. For example, the staffs responsible for HR transactions would be closer to those responsible for data entry. Another advantage is that that the limited HR capacity could be pooled for better effect.

2.3.2 OUTPUT 3 RECOMMENDATIONS

As highlighted in many previous reviews human resources remains a major concern and bottleneck to progress in both access and quality of public health services. As such the recommendations made mirror many that have been made before and while encouraging MoHP to take actions as recommended the MTR also recognises that aspects of human resources management go beyond the health sector. The MTR team also notes the GESI improved sensitivity of the HRH Strategic Plan.

R3.1 The MTR recommends that the senior management team of the Ministry and the Departments meet to consider and decide upon the HR priorities which should be pursued. This will help to build ownership among line managers. The priorities can be gradually extended as capacity is built.

Distribution of health workers

R3.2: The MTR recommends that the Ministry recruits health workers to a specific job in a particular location, rather than to a cadre and that this recruitment process promotes diversity of the workforce.

R3.3: The MTR recommends that the Ministry conducts the necessary surveys to determine the mix of financial and non-financial incentives which are likely to be most effective. In addition, to expand the number of qualified applicants in remote areas, the MTR team recommends that the Ministry encourages training institutions to "adopt" remote districts by providing them with scholarships to residents of these districts keeping in mind GESI principles.

R3.4: The MTR recommends that in the short-term (while permanent appointments by the PSC are not possible) the Ministry moves quickly towards adopting multi-year (renewable) contracts, which are permitted under the GoN's financial regulations. This device can be applied to temporary appointments to vacant sanctioned posts as well as to "project" appointments. In addition, the MTR team encourages the Ministry to request the participation of the PSC's regional and zonal offices in the employee selection process to strengthen transparency and to minimise nepotism and patronage.

R 3.5: The MTR recommends that service contracts be piloted in some of the most remote areas where it is extremely difficult for the GoN to attract and retain professional staff.

[28] HRH Strategic Plan, February 2012

Information systems

R 3.6 The MTR recommends that the Ministry embraces the PIS as its core HR database and takes immediate steps to put in place robust processes to make sure all personnel transactions are accurately captured through the PIS. The Ministry should nominate staffs who are authorised to access the database in order to make the necessary changes.

Organisation and capacity

R3.7: The MTR team recommends that in order to address capacity problems the appointment of a permanent human resource management adviser within the HR function reporting to the Joint Secretary.

R3.8: The MTR recommends therefore that the Ministry establishes a single HR division and that all HR activities are assigned to this division.

2.4 NHSP II Output 4: Improved Service Delivery

2.4.1 Output 4 Findings

Of the Output 4 indicators for which 2012 data was available, achievements against six indicators show positive progress and are likely to achieve 100% of the 2013 target. These indicators include:

- OP4.1: Number of one stop crisis centres to support victims of gender based
- OP4.2: Number of HPs per 5,000 population
- OP4.4: Number of district hospital beds per 5,000 population
- OP4.5: % of districts with at least one public facility providing all CEONC signal functions
- OP4.8: % of safe abortion (surgical and medical) sites with post abortion long acting family planning services
- OP4.12: % of PHCC with functional laboratory facilities. It is worth highlighting that this indicator requires further work to improve the definition of 'functional' and ensure this is what is being measured in the progress reporting.
- OP4.13: % of public hospitals, PHCCs, and HPs that have infrastructure as per GoN standard.
    - Hospitals: on track to achieve the 2013 target of 65% with 63% in 2012
    - PHCCs: the 2013 target of 65% has already been reached, in 2012 69% was achieved.
    - HPs: off track and unlikely to achieve the 2013 target of 65%, with 37% reported in 2012.

The above represents good progress; however the MTR Team would like to highlight two service delivery indicators which are off-track and unlikely to achieve at least 90% of the 2013 target:

- OP4.3: Number of PHCCs per 50,000 population. 2012 reporting on this indicator represents a decline from 2011 reporting, with the 2012 achievement of 0.37 remaining well below the 0.7 target for 2013.
- OP4.9: % of health posts with at least five family planning methods. 8% of health posts report having at least 5 FP methods in 2012, representing a 39% decrease on the 2011 figure. This indicator is far off achieving the 35% target for 2013.

Progress on one of the indicators (OP4.7) has shown negative progress in 2012; however it is still likely that at least 90% of the 2013 target will be reached:

- OP4.7: % of health posts with birthing centre. A decline of 22% has been reported over 2012, from 93% in 2011 and 72% in 2012. If efforts are made during 2013 to reverse this trend, the 2013 target of ≥ 80% will likely be reached.

Health is a high priority of the Government of Nepal and basic health care has been enshrined in the interim constitution as a fundamental right. The measure of how well this fundamental right is translated into action lies in the successful delivery of health services to the people. It follows that service delivery therefore forms the core of NHSP II. In this section, the MTR aims to provide an analysis of progress and identify any shortcomings that may be affecting quality of the services delivered. This has involved a very broad range of issues but the MTR has focused on areas which can have a bearing on the remaining period of the plan and inform the priorities of NHSP III.

Policy level - Ambiguity regarding 'basic health'

While the Interim Constitution guarantees basic health as a fundamental human right of the citizens of Nepal, to date there is no legislation that supports this right. This leads to an ambiguity between basic health as enshrined in the constitution and the EHCS package being provided by the government. EHCS

in effect has no legal cover and also does not provide the possible range of services that might fall under the ambit of 'basic health' as stated in the constitution. It is important that this ambiguity be clarified.

Planning level - Lack of functional empowerment at the district level

A top down approach seems to be favoured in planning and budgeting. Matters of procurement, resource allocation, transfers and leave issues are dealt with at the central level, going against the concept of decentralization. However, at the district level, a bottom up process is also functioning. The health committees and staff at the sub-health post and health post level, reflect the local community needs and draw up plans which are transmitted to the district level. The two processes resulting in different priorities, needs and demands have to be compromised at the district level, where there is variable capacity for such planning and coordination. Some districts have demonstrated this ability through the development of district strategic plans and a regional periodic plan which are not only costed but have disaggregated indicators and logframes. Other districts lack such capacity, but the issue more than capacity is one of functional authority. Even if the district were to demonstrate the capacity, the planning process and resources back the top down agenda resulting in pre-determined budgets and plans being given to the district which therefore do not reflect the specific local needs.

Implementation level - HRH issues (see above)

The HRH Strategic Plan 2011-2015 identified five key HRH problems and issues that limit the effectiveness of service delivery at facility level:

- Shortage of HRH as a result of imbalances between supply and demand
- Mal-distribution of staff, especially in remote and rural areas
- Poor staff performance, including productivity, quality and availability
- Fragmented approaches to human resource planning, management and development
- HRH Financing

Document reviews, interviews and field visits indicate that these continue to be the key issues. Specifically, a ban on recruitment and ad hoc transfers has been cited as a major obstacle to proper HR management.

Access and Equity

There are wide variations in health services availability, utilisation and health status across different social- economic and geographical population groups in the country, indicating the *challenge of access and equity*. More than 60% of the people across the country have indicated problems in accessing basic health care. In mountain region more than 70% of people reported the problem of access compared to hill (62%) and Terai region (57%) [29]; 35% of households in rural areas (in mid and far western hill areas) reported less than adequate availability of health care facilities in their area[30]. The indicators for urban health are better than rural areas but in absence of disaggregated data for urban poor, the information about the health status of the poor could mask the plight of urban poor.

[29] Central Bureau of Statistics and National Planning Commission, Nepal Living Standard Survey 2010/11 Volume 1. 2011, CBS: Thapathali, Kathamndu.

[30] Central Bureau of Statistics and National Planning Commission, Nepal Living Standards Survey, 2010/11, Volume 2. 2011, CBS: Thapathali, Kathamndu.

Poor people report greater incidents of illness, and utilize less health services, due to social, economic and geographical barriers[31]. Low utilization of health services was reported to be highest among Dalits, ethnic and religious minorities and people in remote areas, as cost of care, transport, and non-availability of staff and drugs in public health facilities acted as barriers[32].

Referral services

A key challenge to address is to ensure effective linkages between the various components of the health system. Since district health offices in Nepal generally oversee hospitals and primary health care facilities (PHCC, HP and SHP), this provides a natural starting point for developing and monitoring effective referral. Interviews with key informants suggest that currently this system is not well structured. Referral services are poor and institutional linkages have not been developed.

A report on the Quality and Accessibility of RH services 2010[33], found that all the surveyed health facilities contain the standard referral form (HMIS 8) provided by Department of Health Services. However, the use was very limited. Theoretically referral mechanism has been accepted by the health system of Nepal but it lacks appropriate arrangement and linkages to make it really functional. According to the report, 19% of outpatients from hospitals, 32% from PHCCs, and 38% from health posts were referred to other facilities. From hospitals it took a maximum of six hours to reach the nearest referral facility, while for PHCCs and health posts it took a maximum of two days. These long transfers can prove fatal and costly for clients.

Standards and quality of health care

The NHSP II lays emphasis on improving the quality of care. The recently developed guidelines for Health Facility Quality Management (QM), Performance Based Management System and Integrated Supervision are quality standards approved by the MoHP and can be seen as a general District QM system[34]. A 2009 Quality Assurance Policy is also available, which also lays down several levels of indicators, however in practice quality assurance mechanisms are weak. The policy aims to ensure quality of services provided by public, private and NGOs according to set standards. In doing so, the policy intends to establish an autonomous body, a quality assurance mechanism through establishment of quality assurance (QA) committees at various levels, developing quality and safety guidelines. There is however, no resource backup for the intended mechanisms.[35]

A report on Committee mapping shows there is no Quality Assurance Steering Committee which is meant to be functional under the Management Division[36]. Interviews with key individuals also point to a lack of quality management.

[31] RTI International, Health System Performance. May 2010: Research Triangle Park, NC, USA.

[32] Ministry of Health, Strategic plan for human resource for health 2003 to 2017, MoH, Editor. 2003: Kathmandu, Nepal

[33] Quality and Accessibility of RH services in Nepal 2010. Published by South Asian Institute of Policy, Analysis and Leadership (SAIPAL) Anamnagar and Family Health Division, Department of Health Services Kathmandu, Nepal

[34] NHSSP Essential Health Care Capacity Assessment 2010

[35] NHSSP State Non State Partnership in Health Sector in Nepal: A Diagnostic Report. MOHP September 2012

[36] NHSSP Health Committee Mapping 2010

Lack of regulation of private sector

The non-State especially the private sector in Nepal has grown in an unorganized manner. Most recent data from the National Health Accounts (NHA) suggests that the government sector contributes less than a quarter of total health spending (23.7 %), 20.8 % from external development partners (EDPs) and 55.6 % from the private sector. However, there is little empirical information available on the size, composition, distribution and characteristics of the private health sector in Nepal. Lack of data on non-State especially private-for-profit sector is primarily due to the fact that hospital and clinic registration can be made in various government institutions: the Office of Company Registrar of the Ministry of Industry under the Company Registration Act; District Administrative Office and Social Welfare Council for an NGO working in health; and under the Department of Co-operatives in the Ministry of Agriculture and Development for a cooperative hospital. Since hospital establishments are licensed and registered under various authorities, the non-State health care providers have grown without adequate physical/ clinical standards, accreditation, quality norms or protocols. This is compounded by the fact that there is lack of legal framework or institutional structure or resources to supervise, monitor or regulate the non-State especially for-profit private sector. The private pharmacy sector is another area where regulation is lacking and outlets proliferating.

Moreover, there is no evidence to suggest that the quality of care at the private sector is based on any clinical norms or standard protocols. Quality of care from individual providers is questionable. As stated earlier, MoHP does not have sufficient infrastructure to monitor quality in the non-State especially for-profit private sector.

Strategic Gaps and Future Priorities

EHCS and universal coverage: Implementation of EHCS has increased utilization of services by the poor and excluded, but the majority of services in the free package are preventive services, which are low cost anyway, whereas the life threatening or curative care services are not subsidized or not so to the same extent. Moreover even the services in the EHCS package do not have universal coverage. There is a degree of ambiguity in what is provided for free and for what there is a charge. All groups including the poor are still required to pay for laboratory and diagnostic services, safe abortion services and drugs not on the list of essential drugs. Many Government health staff have private pharmacies and have a potential conflict of interest to prescribe drugs that must be bought from them rather than supplied free[37]. Where they are targeted, there have been problems in identifying and benefiting the deserving. The approach of identifying patients qualifying for exemption at facility level leaves patients facing uncertain risks regarding the costs and is a barrier to seeking care. The definition of EHCS and universal coverage needs to be re-considered, as does the mechanism for targeting free services to the poor and the option of health insurance.

Lack of curative services: Beyond EHCS

As Stated above the provision of EHCS has increased utilization of preventive primary care, diagnostic services and access to drugs by the poor[38], however curative care services are limited and the poor need to make out of pocket expenditures to receive such care, which they can often not afford. Because of inadequate availability of services in public health facilities in remote areas a large proportion of people

[37] Ministry of Health and Population, G.o.N., *Nepal Health Sector Programme-II 2010-2015*. 2010: Kathmandu

[38] NHSSP Essential Health Care Capacity Assessment Report 2010

(63%) seek services from the non-State sector, including pharmacists, and non-professional care providers[39]. More people in the Terai region use private facilities, while people in the Mountain region rely on public facilities due to fewer private facilities[40]. The private-for-profit sector is mainly located in the urban areas, providing high cost curative services that are not easily accessible for either the rural or urban poor.

Currently the out-of-pocket expenditure (OOP) by household at the time of service is estimated to account for more than 55% of the total expenditure on health[41]. Due to such high costs an estimated 43% of the poorest do not seek care for their last illness[42]. Thus, whereas evidence shows greater incidence of illness amongst the poor, it also shows their utilization rates of health services remain lower than for the richer groups[43]. Various studies show the lowest utilization rate of health services by Dalits, ethnic, religious minorities and people in remote areas[44]. This points to the need to re-think the current health finance mechanisms, State / non-State partnership modalities and a re-evaluation of the EHCS package.

Changing disease profile and mortality patterns

With changing demographics and epidemiology, the disease pattern in Nepal is also changing. There is now a triple burden of disease. While communicable diseases still continue to be an important cause of preventable deaths in the country, non- communicable diseases (NCDs) are emerging as a major health problem accounting for more than 44% of deaths, 80% of outpatient contacts, and 39% of DALYs lost [45]. The third category contributing to burden of diseases is constituted by injuries, disasters, road accidents and other public health conditions caused due to changes in the environment. Tackling these rapidly growing health demands, especially those related to NCDs, is a challenge as there are only a few tertiary care hospitals in the public sector.

Planning to deal with this challenge requires a national disease burden study. Currently morbidity utilization patterns are used which may not reflect the real situation. Moreover acknowledging resource constraints, alternate health financing schemes will need to be considered to address the needs.

Urban health

In recent years there has been rapid urbanization in Nepal and there has been an influx of large numbers of labourers, internally displaced people, and people looking for better opportunities. This high level of migration to the towns and cities has led to crowded and unregulated settlements. There is an increase

[39] National Planning Commission and Central Bureau Statistics, Preliminary Findings: National Census 2068. 2011: Kathmandu, Nepal.

[40] National Planning Commission and Central Bureau Statistics, Preliminary Findings: National Census 2068. 2011: Kathmandu, Nepal.

[41] Shrestha BR, et al 2006, Nepal National Health Accounts 2003/04- 2005/06, GON, MOHP, Kathmandu

[42] Central Bureau of Statistics and National Planning Commission, Nepal Living Standard Survey 2003/04 Volume 1. 2011, CBS: Thapathali, Kathamndu.

[43] Ministry of Health and Population, G.o.N., *Nepal Health Sector Programme-II 2010-2015*. 2010: Kathmandu

[44] WHO, UNICEF, UNFPA, and The World Bank, *Trends in maternal mortality 1990 to 2010*. 2012.

[45] Ministry of Health and Population, Memorandum of Understanding Among Key Implementing Partners of the Local Health Governance Strengthening Programme, MoHP, Editor. 2010: Kathmandu, Nepal.

in unauthorized colonies, resettlement colonies, and slum areas. This urban population growth largely comprises the urban poor who are mostly living in unsanitary living conditions and poor and overcrowded housing. The municipal poor living in slums face greater health risks, especially the mothers and children. There is a draft National Urban Health Policy, Strategy and Action Plan on Primary Health Service Delivery System in the Municipalities of Nepal (2010 – 2014), according to which there is research to show that the health of the municipal slum dwellers is worse than the rural poor in some areas. Health care facilities for primary health care services in town and cities are also inaccessible due to inaccessible locations, overcrowding of patients, the lack of effective outreach and referral systems, and a lack of information. These factors combined with lack of economic resources has led to a increasingly high number of socially excluded urban people.

The FCHVs, who have been so successful in rural areas are not as effective in urban areas because of more ethnically diverse and shifting populations, weaker community cohesion and different social dynamics. In urban areas, municipality appointed ward level health workers are meant to provide community based services but their effectiveness is questionable. While tertiary care services are available in urban areas, they are out of reach to the urban poor.

Emergency Preparedness services

Nepal is in the high risk region for natural disasters. As such emergency preparedness should be a priority concern. It was observed that while WHO is leading several interventions like hospital and school safety, health facility mapping, rapid response training etc., on the ground the progress is slow. According to the STS 2011, about half of hospitals and PHCCs and a lower proportion of health posts and SHPs had emergency contingency plans. For health facilities overall this figure is about 35%. Of facilities with plans, only a quarter of hospitals and fewer lower level facilities reported that a budget had been allocated to implement the plans.

Participation of NGOs and the Private Sector in the National Programmes

The NPC has committed to PPP in its' three Year Plan Approach Paper (2010/11-2012/13)[46]. GoN has reiterated that a "State non-State partnership project will be implemented where it is appropriate and offers better value for money". Several models are deemed appropriate in the context of Nepal. However, partnership models or proposal will need to demonstrate innovative design, better efficiency, value for money, and achievement of stated outcomes. The GoN further states that "a partnership option shall not be exercised if the cost of pursuing the model far exceeds the value or estimated benefits of the project".

A functional partnership between State and non-State requires a strong institutional system with necessary technical and management capacity to design, implement, and monitor the partnership projects on a long-term basis instead of specific projects or transactions. The MoHP recognises that in order to implement the partnership policy in a comprehensive manner it would require three distinct systems to be in place. These are (i) a State /non-State partnership unit; (ii) a licensing, registration and regulatory body for all clinical establishments and clinical care providers; (iii) a National Quality Assurance and Accreditation agency. A working guideline will be developed with clearly defined roles and responsibilities, as the mandate for each of the institutional setup would be different.

[46] National Planning Commission (2011) White Paper on Public Private Partnership (PPP). GoN (March, 2011)

The MoHP has started preparation of the State Non-state Partnership Policy for the Health Sector. A draft for circulation highlights contract management provisions for (i) managing underperforming or non-functional government facilities; (ii) increasing the access to essential health care services, including to poor, underserved and socially vulnerable groups:

- Contracting: Management contract (government hospitals/ health centres)
- Co-location of specialty wards/ units in regional or central hospitals
- Contracting of medical diagnostic equipment manufacturers to operate advanced diagnostic facilities in regional and central hospitals
- Contracting private laboratories for pathological services
- Contracting clinical support services (blood bank, dialysis units, etc)
- Government accredited, franchised private clinics in rural areas with funding from the government.
- Contracting of emergency transport/ ambulance in Rural/ Hilly areas
- Grants to hospitals on population norm or capitation norm
- Contracting of mobile health clinics with basic diagnostic facilities in mountainous/ hilly region
- Tele-medicine and tele-health link between government and non-State health facilities

One example of contracting is between government and leading national training institutions. Work is on-going to establish contracts for training institutions to support selected districts through placements of staff and medical students at district hospital level. This should provide increased service quality, consistent supply of medical students that benefits both the hospital and the student. Supervision and support from the institutes will also improve planning and management of services within the district.

There are a number of other examples in the health sector where PPP is already being used to some success such as for eye care and uterine prolapse services. Lessons need to be learned from these experiences.

Role of CSOs and Private Sector

- NHSP II has defined the role of the private sector and civil society organisations (CSOs) in the health sector. During design of NHSP II the thematic area on engagement of non-State actors was chaired by an NGO representative with participation from other members from the NGO and private sector. The participation of private organisations and NGOs has increased in the course of NHSP II design, joint annual planning and monitoring.
- Representatives from the private sector and CSOs are invited and attend meetings by MoHP and DoHS. However the structure for collaboration and consultation remains weak and non-State actors are often not informed about meetings in advance or outcome of meetings.
- Mostly participation/consultation is initiated by government rather than more demand side consultation from users and community groups. Because of this inadequate consultation process, ownership of health sector programmes by civil society is weak.
- Some health services have also been contracted through the private sector i.e. the safe delivery incentive scheme, integrated management of childhood illness, safe motherhood, and family planning services are available in all registered private facilities.
- Civil society has traditionally been involved in service provision and a more active voice and accountability function is only slowly emerging. The private sector remains relatively disconnected from health sector policy. Efforts have been made to broaden the base of policy engagement but progress is slow.

2.4.2 OUTPUT 4 RECOMMENDATIONS

Targeted interventions

While acknowledging that many of the health indicators in the Results and Logical Framework have shown a positive trend, it is necessary to note that the averages are masking multiple levels of inequalities. These inequalities now need to be the focus of attention.

R 4.1: The MTR recommends that:

- **GESI disaggregated data, using the MoHP approved definition of exclusion, should be made available for annual reporting and correspondingly disaggregated targets should be set.**
- **Using micro planning tools, those groups that are underserved and marginalized be targeted for services, and**
- **Areas where progress has been slow or where there is cause for concern, should be focused as priorities, e.g. malnutrition, neonatal mortality, maternal health, urban health etc.**

Devolving authority to the district level

The current situation runs contrary to the spirit of decentralization as the majority of decision making, including budgeting and planning, is happening at the central level.

R 4.2: The MTR recommends that more functional authority be devolved so that demand based planning, budgeting and HR management can be carried out at the district level. While capacity for such responsibility may vary at present, evidence suggests that districts are capable of developing district health strategies and periodic plans and that these can be integrated at Regional level (Integrated Regional Health Sector Strategy and Periodic Plan 2010/11 to 2012/13 in the Mid-Western Region) and this model could be used as a foundation to develop capacities further. A useful tool in this regard could be a 'district assessment indicator'. The transition of building capacity, delegating responsibility and demanding accountability should be carried out in a phased manner.

State/Non-State Partnership

It is important to ensure that people not only get access to free primary care through the EHCS but that they are also able to access curative and particularly life saving services, especially in areas which are remote or under-served. While the NHSP II identifies PPP as important, progress to date has been limited.

R 4.3: The MTR recommends that mechanisms to ensure State / non-State partnership be developed, such as contracting in and contracting out of service delivery. A pre-requisite for this is a State / Non-State Partnership policy to be adopted and owned by government. This process should build on the White Paper on Public Private Partnership (PPP) of the National Planning Commission (March 2011) that emphasises its importance for infrastructure and service delivery and includes health and education as priority sectors.

Disease Prevalence Survey

With changing epidemiological and demographic trends in Nepal, the burden of disease attributable to non-communicable diseases has grown rapidly and is now responsible for 44% of deaths, 80% of outpatient contacts and 39% of Disability Adjusted Life Years (DALYs) lost. However, accurate information is not available on which to plan the most effective and targeted response.

R 4.4: The MTR recommends that a disease prevalence survey needs to be undertaken to provide primary data in order to provide reliable evidence for planning strategies in the coming years. This should be one of the focus areas for NHSP III.

Priorities for NHSP III

R4.5: The MTR recommends that service delivery is a major focus of NHSP III and includes attention to quality and equity, looking beyond EHCS, and includes tackling non-communicable diseases:

1. Quality and Equity

The focus in the Nepal health sector has been on providing primary health care services to the people. This has shown dividends with many of the health indicators showing remarkable improvements and Nepal being on course to meet some of the MDGS, therefore that focus should be continued. However to make it more robust in the coming years, attention is needed on issues of quality and accessing the under-served, which includes those living in remote areas, the poor and marginalized, and residents of urban areas utilising GESI definition of exclusion as prescribed by MoHP. This will require better quality assurance processes and collection of disaggregated data with disaggregated targets.

2. Beyond EHCS

To ensure that the progress in health indicators remains on track and does not plateau, there needs to be planning to improve the whole range of health services. This will need more attention to curative care services, a functioning referral system to link the levels of service and a mechanism to ensure that the services are affordable to the people. In this context, considering resource constraints and consequently low probability of expansion of EHCS package to include tertiary care services, functioning models of state / non-state partnership or alternative health financing schemes are essential to provide a degree of social protection to those facing catastrophic health expenditure. More emphasis on health promotion s also needed to ensure that citizens have better knowledge and understanding of choices and entitlements available to them.

3. Non-communicable diseases

Based on the findings of a national disease prevalence survey, the next plan will need to include prevention and management of Non Communicable Diseases and tackle issues like road traffic accidents, environmental health, high suicide rates among women of reproductive age, etc. With a state /non-state partnership strategy in place, the public sector could undertake the preventive aspects for risk factor reduction, while the private sector could be co-opted for case management.

2.5 NHSP II Output 5: Increased Health Knowledge and Awareness (NHSP II – Output 5)

2.5.1 Output 5 Findings

Progress for achieving the 2013 targets for Output 5 is on track. Of the four indicators, three are likely to achieve 100% of the 2013 target, and at least 90% of OP5.4 (% of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS (by sex) will likely be achieved.
Of note, although OP 5.1 (% of women of reproductive age (15 – 49) aware of safe abortion sites) is likely to achieve the 35% 2013 target, the 2012 achievement of 34% represents a decrease of 42% on the 2011 achievement.
The MTR Team recommends raising the targets for OP5.2 and OP5.3 as the 2012 reporting already exceeds 2013 targets.

There is currently no IEC policy in health. There is also reportedly a reduction in district level capacity and coordinated action over the last few years. The importance of ensuring well-informed citizen's and their understanding of health determinants and their health entitlements is clear both for improved healthy lifestyles and seeking behaviour as well as a foundation for local accountability and governance.

According to NHSP II, health education and communication is crosscutting to all health programs, aiming to increase knowledge and improve behaviors of all castes, ethnic groups, disadvantaged, and hard-to-reach population regarding key health issues. It also aims to create demand for quality essential health services, thereby improving access and creating public trust in health services and ultimately encouraging people to utilize existing health services.

Performance review

NDHS 2011 data shows improvement in several key health indicators and this should in part be attributable to health promotion work given the focus that this has been given across different programmes. However more specific indicators measuring increased health knowledge and awareness show limited impact. The percentage of population with knowledge of HIV seems to have gone down, while other data has not been collected. Moreover the targets set are low and do not seem to be coordinated with those set for utilization.

The Quality and Accessibility of RH 2010 report also shows limited impact of BCC and IEC activities. According to the Annual Report 2011, the progress in terms of activities and funding of the regular IEC programme carried out by NHEICC in the first two fiscal years was increasing but in FY 2010/11 the activity and financial progress decreased by 6 percent and 2 percent respectively. This was mainly attributed to the fact that the recommendations of the formative research done in 2006 were not implemented. Reportedly, the delay in approval from the MoHP for cost estimation was one of the reasons for not completing IEC/BCC programme activities.

Issues identified

A number of issues were identified during the MTR:

- Less priority is being given to health education and education, information and communication and the budget allocated for IEC/BCC is inadequate (0.7% of total health budget).
- The focus is on free medicine distribution rather than on IEC/BCC activities

- There is a lack of messages addressing structural issues of discrimination (e.g. untouchability, gender biased practices) and also the approaches/mediums used are not effective for these social groups to internalize the messages.
- There is a lack of integrated IEC/BCC messaging such as can be done for TB and Leprosy. Each division carries out its own separate activities
- There is inadequate trained human resource for HIEC training to IEC/BCC program focal persons
- The Health Education Technician (HET) post has been abolished in all DPHO/DHOs thus there is now no focal person to provide integrated health education at the district level
- Out of 20 positions of Health Education Officer (HEO) at centre, regional and district level, 13 are vacant and the Public Service Commission has yet to fill the vacant posts

Emerging Priorities

While reinforcing the current agenda, it is also important to take note of the changing disease pattern of Nepal, the increasing incidence of non-communicable diseases, factors such as road traffic accidents and risk of natural disasters. Increased resources may be needed to address behavior patterns, risk factors (results from NCD risk factor study conducted in Nepal revealed that more than one third (37.1%) of the population in the country smoke tobacco and nearly 28.5% drink alcohol - two important risk factors for NCDs) and raise knowledge and awareness levels to effectively tackle these emerging issues.

2.5.2 OUTPUT 5 RECOMMENDATIONS

The importance of ensuring well-informed citizens and their understanding of health determinants and their health entitlements is clear both for improved healthy lifestyles and health seeking behaviour as well as a foundation for local accountability and governance. There is currently no IEC policy in health. There has also been a reduction in district level capacity and coordinated action over the last few years. There is little attention to IEC/BCC on NCDs or other emerging priorities such as road traffic accidents.

R 5.1: MTR recommends that a comprehensive Community Public Health Awareness Strategy and action plan is developed and adopted

R 5.2: MTR recommends the reinstatement of the focal health promotion position at district level and provision of additional technical assistance for advancement and better integration of IEC/BCC delivery.

R 5.3: MTR recommends that there is an increased allocation for health promotion and that this should be linked to more ambitious targets and be more GESI focused.

2.6 NHSP II Output 6: Improved M&E and Health Information Systems

2.6.1 Output 6 Findings

Of the four Output 6 indicators, two indicate positive progress in respect of reporting on public facilities but a lack of available data for private facilities, highlighting the need for increased efforts to obtain private facility data:

- OP6.3: % of tertiary and secondary hospitals (public and private) implementing ICD 10 and reporting coded information to health information system. Reporting on public facilities indicates that the 2013 target has been reached, as has the 100% target for 2015.
- OP6.4: % of health facilities (public and private) reporting to national health information system (by type or level). As above, the 100% target for 2015 has nearly been achieved (2012 shows 99% of public facilities reporting).

Indicator 6.2 related to uniform coding of MIS remains at 0%. Discussions around uniform coding are underway, and a concept paper has been developed, however there remains a significant amount to do to achieve the 100% target for 2013. It is therefore recommended that the target for 2013 is reviewed downwards from 100% to 50%. The 2015 target of 100% should remain as it is.

Comprehensive Monitoring and Evaluation supported by well-functioning information systems is required in order to evidence the reported gains resulting from the investments to the health sector made by GoN, EDPs and other stakeholders. The need to demonstrate results is part of a broader global movement to increase accountability and coordination amongst governments, donors, and civil society so as to streamline efforts and improve performance. Over the course of NHSP-I recognition of the importance of developing a coherent approach to M&E grew considerably. NHSP-II has built on this momentum and the resulting systems operating across the health sector generate a considerable volume of data.

The NHSP-II includes two important tools for monitoring progress and increasing accountability, the Results Framework and the Governance and Accountability Action Plan (GAAP). In response to the need to operationalize the original NHSP-II Results Framework to adequately track progress, the MoHP, WHO and NHSSP developed a comprehensive M&E Framework outlining the NHSP-II vision, goal, purpose, outcomes and outputs, as well as indicating baselines and targets for 2011, 2013 and 2015. Subsequently a document detailing achievements in 2011 against targets of the NHSP-II Logical Framework has been published, an update of which is included as part of this MTR.

The MTR team were specifically asked to investigate a number of issues related to Output 6, including: the current institutional set-up, review mechanisms, data quality, data use, linkages between the various management information systems (MIS), and value added of TA.

NHSP-II has already seen considerable progress in establishing systems to monitor and report on progress to targets. There is a wealth of data from a range of sources available to decision makers in the health sector and the NHSP-II M&E Framework provides a comprehensive tracking tool for measuring progress. However, a number of barriers inhibit the use of these data to the full extent. The MTR identifies nine priority areas upon which efforts to improve M&E and information management should be focussed:

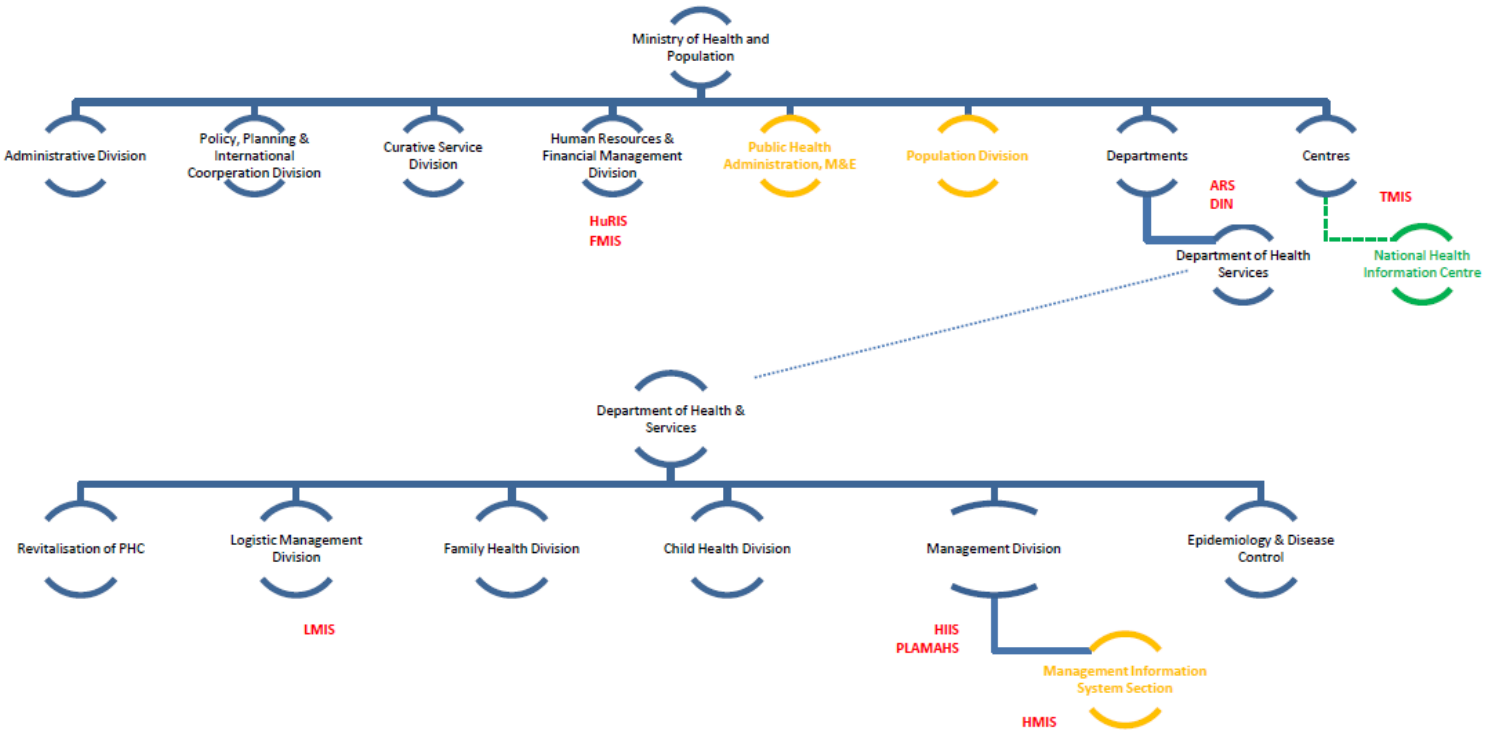
Institutional Set-up

Structural barriers impact on coordination, alignment and dissemination of the various data sets, thereby limiting the extent to which it is fed into decision-making processes.

- A priority for consideration is whether to create a semi-autonomous National Health Information Centre with a mandate to coordinate all information systems (including all nine MISs), oversee all routine data collection, strengthen data validation mechanisms and ensure dissemination of up-to-date information management policies and protocols. It is proposed that this centre is located under the Ministry of Health and Population (see diagram below).

At present the Monitoring and Evaluation Section is located within the Public Health Administration, Monitoring & Evaluation Division of the MoHP. The Population Division leads on key population-based surveys (such as the NDHS), use of population data, and GESI mainstreaming. Nine independent management information systems are distributed across different divisions/departments throughout MoHP and DoHS. The Management Information System (MIS) Section, mandated to coordinate these nine systems, occupies a relatively low lying position within the Management Division of the DoHS. The issue of establishment of a National Health Information Centre (NHIC) has been central to discussion. The establishment of the NHIC was one of the core elements of the 2005 HSIS National Strategy yet there has been little concrete progress in this area. Figure 2 illustrates the proposed location for the NHIC.

Figure 2: Structure of the Ministry of Health and Population showing key M&E-related departments, locations of the various Information Systems and suggested location for National Health Information Centre



The need for an NHIC was highlighted in the NHSSP Capacity Assessment undertaken in 2010 and echoed in the IHP+ Nepal Situation Analysis and M&E Roadmap for 2011/12. The NHSSP Capacity Assessment proposed a structure composed of three distinct sections covering[47]:

1. Management Information System (MIS) and Geographical Information System (GIS) headed by a Medical Officer. This MTR recommends this section takes the lead on coordination and harmonisation of the nine information systems.
2. Research and Demography headed by a Research Methodology Specialist, housing demographers from the Population Division and the DoHS.
3. Epidemiology and Biostatistics with strong links to the Disease Control Division.

It is recommended that the centre's structure and functions are formalised and detailed terms of reference for the key positions are developed as a matter of priority. Cross-sectoral learning from similar initiatives in other sectors should be incorporated into this process (e.g. learning from experiences from the education sector in establishing the Education Review Office).

Data Quality

Top-level validation between population survey data and HMIS indicate a generally acceptable level of consistency, but closer inspection has revealed a range of systemic issues affecting timely accurate submission of HMIS data. A lack of guidance and protocols on data verification has resulted in patchy coverage and poor capacity at lower levels. The lack of private sector reporting remains an important issue impacting on data quality. These issues are also highlighted in the Country Accountability Framework, with a number of proposed activities detailed around developing the capacity of the private sector and implementing data quality and validation mechanisms. This MTR has identified a number of priority areas:

- Dissemination of comprehensive HMIS guidelines which include data verification protocols and stipulate the need for regular data quality audit reports.
- Greater stewardship of the private sector, including review of regulatory mechanisms to ensure compliance with government reporting requirements. The relatively high reporting rate for private sector and NGOs[48] is misleading as some of the largest private health providers do not report and there is not a comprehensive list of private sector facilities for use in estimating reporting coverage.
- Address human resource issues around recruitment and retention of key staff including Regional Statistical Officers and Hospital Medical Recorders. Capacity building for District and Ilaka level staff involved in data verification is required.

Data Use

Although mechanisms for bottom-up planning and review exist and are to some extent functional, the scope for localised evidence-based planning is limited by the heavily centralised systems of planning, budgeting and target-setting. Data use at central level for planning and budgeting purposes is not comprehensive as reported by senior managers. The centralised system has also led to a poor data-use culture at sub-national level. This said, effective data use to guide implementation strategies was visible at the local level. The MTR team observed feedback mechanisms in operation at the VDC level that made good use of monitoring data. However, the interventions implemented at this level are responding to top-down target and strategy setting which effectively limits the scope of data utilisation to implementation planning.

[47] GoN / NHSSP (2010). Monitoring &Evaluation: Capacity Assessment for Health Systems Strengthening

[48] 67% in the 2010/11 Annual Report Department of Health Services. 2010/11 Annual Report.

- Planning, budgeting and M&E should be decentralised to enable reporting against district-level M&E plans with locally relevant targets and budgets. This should be complemented by a programme of capacity building at district level in planning, budgeting and M&E. The role of Regional Health Directorates could be enhanced in ensuring better data use.

Gender, Equality and Social Inclusion (GESI) related M&E

Despite progress in disaggregation of population survey data, the process has been less straightforward with HMIS data. A process of HMIS revision is underway, including review of indicators, recording and reporting tools, HMIS procedures, validation mechanisms, data analysis, and data use. These indicator revisions will hopefully go some way to providing data to better monitor GESI-related access issues, but the poor use of GESI data at central level provides little incentive to drive the process forward.

- Scale-up of the revised HMIS from fiscal year 2013/14. The current revision process will enable NHSP-2 to be effectively monitored for the last two years of NHSP-II; and the availability of disaggregated data will help with the planning of NHSP III. The process of HMIS revision has been informed by the GESI team to maximise the potential for measurement of progress in overcoming barriers to access.
- Mechanisms are needed for integrating GESI-focussed analysis into planning and decision making, particularly at central level.

Management Information Systems

The nine MIS vary significantly in their ability to provide useful data for decision-making. The data that is available is not currently coded so as to facilitate cross-system analysis. Functionality varies greatly across the different MIS, as does the extent to which they interlink with one another.

- Modifications are needed to create a unified coding system linking all nine MIS. This process should include broad stakeholder engagement to ensure buy-in from users of all nine systems and dispel fears around potential damage to well-functioning systems. The Country Accountability Roadmap provides catalytic funds to develop the schematics of the unified coding system and to roll it out to all institutions housing health information systems.

Policy Environment

Lack of clear policies and protocols to guide M&E and Information Management activities has resulted in a fragmented system with patchy accountability. A number of important issues have been highlighted:

- National M&E Plan for Health: The Aide Memoire of the 2012 JAR included the development of an M&E implementation plan as a priority action to be undertaken by the Ministry. This is yet to be completed. The M&E Roadmap 2011/12 gives a summary of the required areas of focus for this plan. In order to further harmonise research efforts, the set of health research priorities being developed by The National Health Council should be aligned with the M&E Plan once developed. Both of these initiatives are also highlighted as required actions in the Country Accountability Framework, with resources being available for the finalisation of the M&E Plan as part of the catalytic funding.
- Revision of the Health Sector Information Systems Strategy: this was written in 2005. Since this time, both the technological and the M&E landscape have changed significantly. The HSIS approach has been piloted for a number of years and the learning from these pilots needs to be incorporated into a revision of the 2005 document.

- e-Health Policy: the development of an e-Health Policy covering aspects of service provision as well as information management would provide an opportunity for producing clear guidance on issues around data confidentiality as well as on the legal validity of digital data, both issues central to the development of effective Health Information Systems.

The Annual Health Review Process

The annual health review process is inclusive of a broad range of stakeholders. It is structured so as to facilitate a bottom-up process of feedback. Monitoring data is used to assess progress and highlight implementation challenges. However, the format of the reviews could be altered to allow more space for analytical discussion, and for holding actors to account for previous commitments. This is also an important arena for GESI related issues to be presented and discussed, including disaggregated progress, issues and challenges in reaching the unreached, lessons learned and good practices related to GESI. District and Ilaka Reviews are also an important, and often neglected, opportunity to strengthen data quality review mechanisms.

- Currently, the government's annual review and the JAR are two distinct processes with limited connectivity. It is advised that the format of the reviews should be revised to: Integrate and provide linkages between the government's annual review process and the JAR, thereby providing opportunities for sharing of lessons learnt (see R2.5 under Sector Management).
- Incorporate more space for analytical discussion of findings. Mechanisms should be developed for reviewing commitments and holding actors to account for commitments not achieved.
- Ensure adequate time and space is given to investigation of data irregularities at District and Ilaka review meetings resulting in agreed actions for follow-up.

Human Resources

Systemic issues with recruitment and retention of key positions, particularly at the sub-national level, impact on capacity and knowledge levels, supervision and data verification mechanisms. There is a lack of recognition of the importance of M&E leading to a high attrition rate of senior staff.

- Mechanisms are needed to build and retain skills in M&E, information management and data analysis amongst existing staff, encouraging the development of 'experts' in their field and the recognition of the importance of the role they play.
- Strategies should be reviewed for improving staff retention both for senior staff at central level as well as at regional level, particularly regarding Regional Statistical Officers.

Cross-sector Partnerships

Coordination of M&E activities between the MoHP and external development partners has improved with the creation of an M&E Technical Working Group. There have been valuable contributions from TA partners in driving forwards improvements in M&E however more could be done to ensure transfer of skills to government counterparts. Issues around the lack of regulation and inclusion of private sector impact on completeness of data:

- TA functions continue to support government implementation through embedding long-term positions within government departments, ensuring clear identification of government counterparts.
- Greater stewardship of the private sector, including review of regulatory mechanisms to ensure compliance with government reporting requirements.

2.6.2 OUTPUT 6 RECOMMENDATIONS

There have been several developments and improvements in the overall collection, quality assurance and use of information during NHSP II. However there are also several areas where improvement can be made in data quality, systems integration and data use.

Institutional Setup

There are a number of institutional issues that needs to be addressed to improve overall information system within MoHP.

R6.1: The MTR recommends a number of revisions to information management:

- The linkages between M&E and Planning need to be strengthened and this includes rethinking the MoHP set up.
- Progress needs to be accelerated in establishing a semi-autonomous National Health Information Centre housing the MIS Section (and HMIS) with a mandate to coordinate all information systems and data collection.
- A National M&E Plan for Health needs to be developed and costed, ensuring alignment with Health Research Priorities identified by National Health Research Council
- Revise 2005 Health Sector Information Systems Strategy
- Develop E-Health Policy

Review Process

R6.2: The MTR recommends that while the National Annual Review and the Joint Annual Review should remain separate, the format of the reviews should be revised to incorporate more space for analytical discussion of the findings (including issues related to access and use of services by women, poor and the excluded) and to improve accountability. This should be linked to the recommendation that planning, budgeting and M&E are decentralised to enable reporting against district-level M&E plans with locally relevant targets.

Data Quality

R6.3: The MTR recommends that considerable new attention is given to data quality by the MoHP and that this includes a set of measures as listed:

- HMIS Guidelines should be developed revised and disseminated, to include a comprehensive section on data validation protocols.
- Regular data quality audits should be instigated at all levels of the HMIS reporting path
- Human Resource issues around recruitment and retention of Regional Statistical Officers and Hospital Medical Recorders needs to be addressed.
- Capacity building of key staff involved in data verification at district and Ikaka levels, ensuring provision of guidance to DPHOs on the effective use of the data verification budget.
- Revised format of district and Ilaka review meetings to ensure adequate time and space is given to investigation of data irregularities.
- Improved mechanisms for ensuring VHWs receive their training and receive capacity building in data collection with an emphasis on the importance of knowledge transfer to FCHVs.
- Greater stewardship of the private sector, including review of regulatory mechanisms to ensure compliance with government reporting requirements.
- Explore the potential to strengthened linkages with the Social Welfare Council to access NGO reporting on service statistics

Data Use

Date use is key to systems and service improvement. This is an area that the MoHP should pay more attention to.

R6.4: The MTR recommends that a Data Use Plan be developed and that this plan is accompanied by a number of measures to ensure its proper implementation:

- The establishment of a National Health Information Centre will go a long way to facilitating better data use. Until this is established, the MTR Team recommends that the capacity of PPICD is built in effective data analysis and use for evidence-based planning.
- Planning, budgeting and M&E functions are more decentralised to district level, ensuring locally relevant targets and more effective targeted resource use.
- Capacity building at district level in planning, budgeting and target-setting
- Functional linkages between the nine information systems are established to facilitate easier analysis of data for decision making

Management Information Systems

R6.5: The MTR recommends the better integration of existing management information systems that will allow better analysis of existing data sets for planning and review purposes.

- Prioritise proposed modifications to create a unified coding system linking all nine MIS. This process should include broad stakeholder engagement to ensure buy-in from users of all nine systems and dispel fears around potential damage to well-functioning systems.
- Disaggregation of HMIS indicators should be prioritised, ensuring adequate consultation with GESI specialists on selection of indicators to disaggregate.
- Training on the use of new HMIS tools which will form part of the on-going revisions should emphasise to staff involved in HMIS reporting, the importance of the data they collect and the reason for disaggregation.

2.7 NHSP II Output 7: Improved Physical Assets and Logistics Management

2.7.1 Output 7 Findings

Reporting for OP7.1 (% of public health facilities with no stock out of the listed free essential drugs in all four quarters) indicates that at least 90% of the 2013 target is likely to be achieved for this indicator. The 2012 achievement of 75% is not far off the 80% target for 2013, however it is worth highlighting that this does represent a decrease compared to the 2012 achievement of 79.2%. Increased efforts will be required to ensure this downward trend does not continue.
Conversely, OP7.2 (% of the budget allocated for operation and maintenance of the physical facilities and medical equipment) shows poor progress, with reporting indicating <1% allocated in 2012, below the 2013 target of at least 2% allocated.

Procurement, health facility construction and logistics management are a focus of NHSP II. The MTR found that since 2010, procurement of essential health supplies has seen several improvements at the central level through introduction of new systems, tools and technical assistance. Availability of essential medicines continued to improve with 75% no stock-out in 2011/12 compared to 79% in 2010/11. A reduction of 4.4% expiry/losses in 2011-12 compared to 5% in 2007-08 at health facilities indicates losses still need further attention[49]. Progress has been made towards establishing standards and specifications for medical equipment, for acceptance of goods and, health facility design standards. The paper-based Logistics Management Information System (LMIS) is widely used with high reporting rates, while technical issues have limited reporting rates through the web-based LMIS. The Department of Urban Development & Building Construction (DUDBC) completed 48.9% of all health facility projects.

Procurement

Progress in establishing a procurement system which functions efficiently and effectively remains a challenge however the MTR identified a number of areas of progress that should be noted.

- The institutional capacity has been increased, with support from EDP. Skills on procurement and logistics staff have been built in the preparation of bidding documents, bid evaluation, contract award and inspection on receipt and acceptance of goods.
- New tools and systems have been introduced such as multi-year contracts, a complaint and dispute resolution process, a procurement code of ethics, templates for services, bid opening, bid security calculation, award of contracts, acceptance of medical equipment, and job descriptions for procurement officers.
- A consolidated procurement plan for FY 2012/2013, has been prepared for the first time consolidating the demand of all programme divisions.
- The procurement technical working group chaired by LMD, with participation of the pooled partners, has started work to provide regular updates on procurement progress to EDP's.

At the same time the MTR recognizes that there are a number of outstanding issues that require further work to resolve.

- Procurement has been a continual cause for concern since NHSP I despite attention of the MoHP and EDPs to find solutions. Respondents during the MTR observed that the situation is perceived to be improving after preparation of the consolidate procurement plan for 2012/13.

[49] Final Progress Report Basic Health Services Programme III (2004/05 to 2007/08, May 2009 KFW

- There is still insufficient specialised, skilled human resources in procurement units. There is a continued need to strengthen the procurement process with more professional staff that have IT expertise and a technical background in the field of procurement of medicines, medical supplies and equipment.
- Preparation of the annual consolidated procurement plan in time remains a challenge. The plan is not made available before the end of the fiscal year. For FY 2011/12 the procurement plan wasn't consolidated and in FY 2012/13 the consolidated procurement plan was only endorsed in October (3 months late). Nevertheless, this is an improvement on previous years.
- E-Bidding or E-Procurement is not yet in operation. Delayed implementation poses a risk to increased efficiency, transparency, procurement performance, competition and value for money.
- Developing new Standard Operating Procedures to fill gaps in the Public Procurement Act is not completely done and therefore poses a risk to the quality of procured pharmaceuticals and equipment. The PPA & PPR lack specifications for procurement of pharmaceutical supplies, which poses a risk of procuring lower quality medical supplies.
- Former lack of public disclosure of procurement documents and complaint mechanisms were a risk to LMD's procurement efficiency. Public disclosure on LMD's website is now the norm although the Complaints Procedures have yet to be implemented.
- A paper on strategic use of framework contracts was developed but framework contracts have not yet been implemented.
- Publication of the consolidated procurement plan 6 months in advance of the fiscal year. Programme divisions do not start preparation of the procurement plan before the budget is announced. The programme Divisions should be encouraged to plan well ahead (January) to avoid a repeat of delay in the publication of the consolidated procurement plan.
- The systems of Centralized-Bidding-Local-Purchasing (CBLP) has been tried but reportedly has not succeeded. Alternative solutions to current implementation constraints have not been explored to current implementation constraints in order to achieve economies of scale, ensure adequate quality assurance and increased transparency of local procurement.
- District level procurement is directed by the budget and plan provided by the Revitalisation Division, with little input and feedback from the Districts. This means that although district procurement is decentralized the planning and forecasting is still centralized and not adjusted to changes in need at the district level.
- The stakeholders observed weaknesses in procurement because of the absence of timely procurement planning, collusion, intimidation, extortion and insecurity; corrupt practices further increased due to rare prosecutions and convictions.

Procurement is an area in which transparency and corruption are frequently mentioned issues and Nepal is no exception. Nepal is ranked 139 out of 176 countries scoring 27 in the Corruption Perception Index 2012 of the Transparency International and falls under the corrupt countries category. During MTR, the respondents interviewed felt that despite the various measures to strengthen PFM and increase transparency the level of corruption has increased. Bureaucracy is seen to be politicised and there is a perception of increased corruption. There is concern expressed about increased political influence and involvement in staff transfer and procurement which is a high profile area in terms of corruption. A number of interviewees also commented on the environment of impunity that has arisen during the period of current political transition.

Physical assets and logistics management

The MTR highlighted a number of more specific issues on physical assets and logistics management:
Forecasting

- The forecast of Programme Divisions for the AWPB is not clearly linked to the results of the annual forecast workshop and based on up-to-date stock, consumption and pipeline data, which creates a risk of stock out and expiry.
- District forecasts made by the Revitalisation Division are made with little input from Districts, posing a risk to forecasting accuracy.
- Procurement is based on forecast and LMIS pipeline data that can be up to 16 months old when procurement is initiated.

Storage and Distribution

- Stores at all levels in the system do not adhere to agreed minimum stock levels. This poses a risk to stock outs at the health facility level
- Insufficient storage space at central, regional and district stores is a risk to good storage practices, damage and pilferage.
- Frequent rotation of store managers is a risk to good storage practices, damage, wastage and expiry.
- Lack of integration of the regional warehouses increases the risk of expired drugs due to low stock turnover rates.

Equipment maintenance

- The lack of Standard technical specifications for medical equipment is a risk to quality and service delivery. By the end of 2012, 403 such standard technical specifications were in place and up-loaded to LMD's website. A further 450+ will follow before end of February 2013.
- No maintenance agreements for equipment exist, except in 22 districts of the KfW project. This is a risk to uninterrupted service delivery

Information Systems

- A duplication of function of web- and paper-based LMIS, is a risk to efficiency/value-for-money
- Limited IT capacity at DHO's and internet problems pose a risk to sustainable use and devolution of the web-based LMIS
- Many LMIS reports contain drugs listed as 0-balance. Low data quality has a risk that stock-outs go undetected.
- Over-stock and low stock on LMIS reports are not regularly followed up, which is a risk to stock-out and expiry of supplies.
- Little evidence of meaningful analysis of LMIS reports, posing a risk to accurate stock levels.

Quality Assurance

- Infrequent use of pre- and post-shipment inspections is a risk to commodity quality.
- DHO's lack routine systems and training for quality control of medicines, which poses a risk to product quality in districts.

Infrastructure works

- Indicator OP 7.2 (% of the budget allocated for operation and maintenance of the physical facilities and medical equipment) has not yet been reported and does not accurately reflect budget spent on maintenance of buildings and medical equipment.
- Low bidding on infrastructure works is a risk to timely project execution and works interruption.
- Selection of in-adequate sites is a risk to increased costs and project delays due to additional development required.

- Weak contract management and enforcement of controls/fines are a risk to project delays.
- Insufficient capacity of DUDBC divisional offices and the PAM unit to monitor project progress are a risk to project delays.
- Late approval and dissemination of standard building designs are a risk to standardization and quality of health facilities
- Insufficient control of the private health sector by MoHP poses a risk to duplication of services and loss of value-for-money.
- Lack of local responsibility & local budget for building maintenance poses a risk that maintenance is neglected.

Healthcare waste management

- Lack of institutional integration of healthcare waste management in health offices and enforcement of rules are a risk to effective waste management.
- Incinerators at Healthcare facilities are not present or not adequately managed, creating a risk for staff and environment.
- Improper Healthcare waste disposal creates an immediate risk for population and environment near health facilities.

2.7.2 OUTPUT 7 RECOMMENDATIONS

Progress has been made towards establishing standards and specifications for medical equipment, for acceptance of goods and, health facility design standards. The paper-based Logistics Management Information System (LMIS) is widely used with high reporting rates, while technical issues have limited reporting rates through the web-based LMIS. The Department of Urban Development & Building Construction (DUDBC) completed 48.9% of all health facility projects.

Procurement

As highlighted some improvements were observed but concerns remain about transparency and corruption on the one hand and efficiency and technical capacity in procurement on the other.

R7.1: Senior Management should enforce provisions for preparation of the consolidated procurement plan together with the e-AWPB. This will require arranging for adequate human resources for procurement at all levels under MoHP payroll. Specifically further development of staff capacity is needed in areas such as annual forecasts and procurement planning based on an updated inventory and the consumption plan. In addition support should be provided to the Public Procurement Monitoring Office to execute e-bidding and standard bidding documents for the health sector.

R7.2: Alternative solutions for Centralised Bidding Local Purchasing should be adopted such as prequalification of suppliers and setting of maximum pricing by commodity by DDA and link this with local purchasing.

R7.3: Deadlines need to be set for the preparation and implementation of the Consolidated Procurement Plan. If not practised or if this does not result in substantive improvement in performance then procurement functions should be outsourced through formation of an autonomous procurement agency under MoHP.

R7.4: The MTR recommends a set of actions to improve current physical asset and logistics management:

- Forecasting: Programme Division's forecast for the AWPB should clearly be linked to the results of the annual forecast workshop and justify any deviations. The Revitalisation Division should train districts to prepare annual forecasts, procurement plans and distribution plans, based on updated inventory and consumption data.

- Storage and Distribution: LMD to discuss and agree with EDP's objectives to increase and improve storage space and effectively monitor good storage practices, to be included in a consolidated development plan. LMD to seek a solution to integrate regional stores into the regular supply chain to reduce the risk of expiry.

- Equipment maintenance: MoHP to review, plan and expand the KfW maintenance project.

- Information systems: LMD to establish one integrated LMIS system for essential medicines. Consideration should be given to including all medical supplies (instruments, equipment and furniture) into LMIS. LMD to follow up 0-balance, over-stock and low stock and share reports and recommendations quarterly with districts

- Quality assurance: MoHP to establish minimum criteria for use of pre and post shipment inspections, and contract inspection services

- Infrastructure works: Expand DUDBC and PAM unit capacity and improve contract management by DUDBC and division offices and enforce fines in case of delays. Approve and disseminate new standard building designs. Provide budget & autonomy to HFMC for building maintenance, up to a certain threshold. Scale up installation of renewable energy technologies and water catchment systems.

- Healthcare waste management: Include objectives, targets and budget in AWPB's to improve health care waste management at health facilities at all levels. In the short term, agree on budget and minimum criteria to contract out health care waste disposal to private sector.

2.8 NHSP II OUTPUT 8: IMPROVED HEALTH GOVERNANCE AND FINANCIAL MANAGEMENT

2.8.1 OUTPUT 8 FINDINGS

Progress towards achieving the 2013 targets set for the five Output 8 indicators is positive. OP8.1 (% of health facilities that have undertaken social audits as per MoHP guidelines in last fiscal year) is likely to achieve the 2013 target, and remaining three indicators with reliable data are likely to achieve at least 90% of the 2013 target.

Indicator 8.5 (% of district health offices receiving budgeted amount within one month of budget disbursement from MoHP/DoHS with clear-cut guidance for expenditure) is reported as 100% in 2012 however this figure relates to data 'sent' to DHOs rather than data 'received' by DHOs and as such needs clarification.

Public Financial Management

On the basis of document review and interviews the MTR concludes that some improvement have been made in PFM in the formulation of the annual work plan and budgeting by introducing e-AWPB and more timely submission of Financial Management Report (FMR). The Financial Management Improvement Plan (FMIP) is finalized and some activities that are included in the FMIP have been implemented from the beginning of NHSP II. TABUCS has been developed which is near to piloting stage that should bring about significant changes in the generation of financial reports and budgeting. Authorization letters for DHOs are being delivered within 30 days of issuing of the letters that will help to release the funds with less delay.

On more specific points the MTR found the following:

- The budget absorption capacity is improving gradually and the volume of audit irregularities has decreased to a level of 5.77% of audited expenditure. A constant and continuous monitoring of the clearance and settlement process of irregularities by higher-level officers could help to improve the situation.
- The expenditure warrants have reached the cost centres within a reasonable time from the date of issue of the warrant letter. In most of the cases, the issue of expenditure warrant is itself getting delayed due to late submission of the programme for approval to NPC. This appears to be caused mainly by the need to reformulate the annual plan in line with the approved annual budget by the Ministry of Finance.
- The direct funding of technical assistance has also contributed significantly in increasing the volume of the budget which is outside the FMIS system, unless these partners report to MoHP on the expenditure.
- Accounts staff are mobilized by FCGO every two years on a regular basis. The current approach to One-time capacity enhancement of finance people at MoHP is not sufficient to support strengthening of the overall capacity. Greater involvement of FCGO is needed.
- The perceived weaknesses in the health sector financial management systems and the gaps that have opened up in procurement processes have raised additional concerns related to fiduciary risk.
- There remains a lack of confidence among the DPs on the financial management system of the health sector and unless there is sufficient confidence in that system the concern over fiduciary risk may present grounds for bypassing or avoiding it.

- Confidence in health sector financial management systems can ultimately only be built by those who implement those systems. The accountants, managers and administrators have to accept the challenge and ensure that the systems are operated as designed.

2.8.2 OUTPUT 8 RECOMMENDATIONS

The perceived weaknesses in the health sector financial management systems and the gaps that have opened up in procurement processes have raised concerns related to fiduciary risk. During the MTR respondents felt that despite the various measures to strengthen PFM and increase transparency the level of corruption has increased. While strong PFM systems crowd-out opportunities for fiduciary risk, which is good, but doesn't in itself tackle all forms of corruption. There is clearly inadequate confidence among the EDPs in the financial management system of the health sector and unless there is measured improvement in that system the concern over fiduciary risk will present grounds for bypassing or avoiding it. With this said, confidence in health sector procurement and other fiduciary systems can ultimately only be built by those who implement the systems. The accountants, managers and administrators have to accept the challenge and ensure that the systems are operated as designed.

R8.1: The MTR recommends the establishment of a strong mechanism in the MoHP for the oversight of FMIP implementation and monitoring of budget execution, chaired by the Secretary of MoHP, with the representation of external development partners. The recently established Financial Management Committee can play an effective role in reviewing the financial position, identifying bottlenecks and actions needed and ensuring reporting timetables are met.

This should include improving the linkage between the financial management team and the FCGO (Financial Comptroller General Office) in planning, monitoring and information sharing. Specific responsibilities should be assigned to the financial management team to report back to the JAR on financial management perspectives beyond the current information on financial flow and internal financial management.

Recognising that some of the constraints identified in public financial management are beyond the control of the sector, the MOHP with support from EDPs should advocate for change.

R8.2: The MTR recommends that the MoHP advocates for the inclusion of the sector financial management agenda in the PEFA indicators and that this is incorporated in the NPPR, so that it will be reviewed by EDPs and GoN jointly. This is aimed at making the MoHP and FCGO more responsible for the internal financial management control system.

R8.3: The MTR recommends improved linkages of MoHP senior management with the financial management team in planning, monitoring and information including information linkage with the FCGO (Financial Comptroller General Office). Furthermore specific responsibilities should be assigned to the Finance Section of the MoHP to report the overall financial management scenarios in the JAR (currently reporting is limited to financial flow and internal financial management).

One of the problem issues identified by many respondents was that of regular transfer of financial staff with limited hand-over possibilities and periods familiarisation with SWAP approaches.

R8.4: The MTR recommends that support is provided to the FCGO to incorporate curricula on 'Financial Management in SWAp' in its Gazetted II Financial Management Training so that transfer of an individual would not affect operations due to inadequate understanding of the successor on the SWAp financial management processes.

One of the repeated concerns of respondents was the lack of resolution of audit irregularities.

R8.5: The MTR recommends setting targets for all the expenditure centres for limiting their current audit irregularities and monthly targets for the settlement and clearance of irregularities of the past years, complimented by a system of constant reporting and monitoring of progress.

2.9 NHSP II OUTPUT 9: IMPROVED SUSTAINABLE FINANCING

2.9.1 OUTPUT 9 FINDINGS

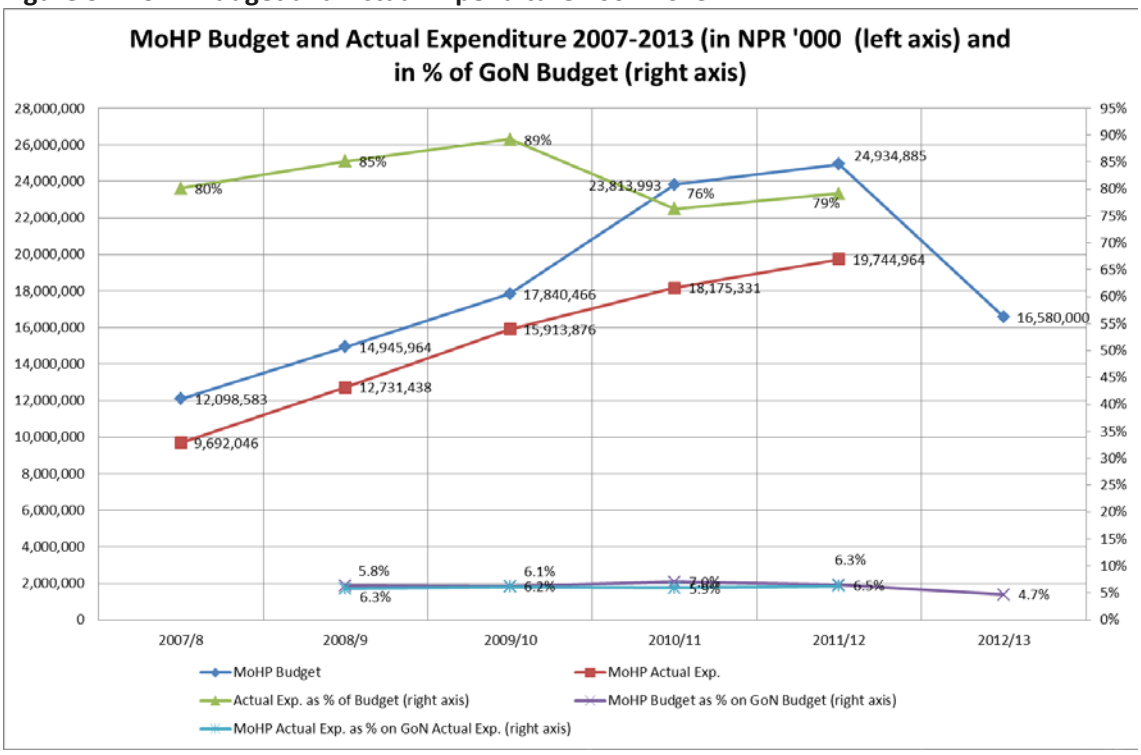
Of the three Output 9 indicators, two show good progress. OP9.1 (% of MoHP budget allocated to EHCS) has already achieved the 75% target for 2013, and OP9.3 (% of government allocation (share) in total MoHP budget) is likely to achieve the 2013 target.
Progress is not so positive for OP9.2 (% of health sector budget as % of total national budget) that has dropped from 7.1% in 2011 to 6.1% in 2012. It is therefore unlikely that the 8.5% 2013 target will be met.

MoHP Budget and Actual Expenditure

The MoHP budget as a share of GDP grew from around 1.5% in 2007/8 to reach a peak of 1.74% in 2011/12 (1.33% in terms of actual expenditure). The MoHP budget as a share of national budget oscillated around 7% between 2010/11 and 2011/12 (6% in terms of actual expenditure and 4% if the foreign aid (pool fund and other on-budget aid) is not included) and dropped to 4.7% in 2012/13 (see below).

The MoHP budget has more than doubled in nominal terms between 2007/8 and 2011/12, and the absorption capacity (budget execution rate) improved substantially between 2007/8 and 2009/10 (80% to 89%) before declining to 76% and 79% respectively in 2010/11 and 2011/12. The MoHP budget 2012/13 has been reduced to NPR 16.5 billion (not including non-pooled EDPs) while the MoHP AWPB/Business Plan 2012/13 was based on a planned allocation of NPR 27 billion. The issue of under-funding is now added to the absorption capacity issues. Based on this background it is going to be a challenge to maintain the free health care system unless non-pooled EDPs increase substantially their support and redirect it towards EHCS. Moreover, some Pool-Fund EDPs might be inclined to redirect part of their budget out of the Pool-Fund and into another mechanism such as a basket fund that will allow spending from the start of the financial year.

Figure 3: MoHP Budget and Actual Expenditure 2007-2013



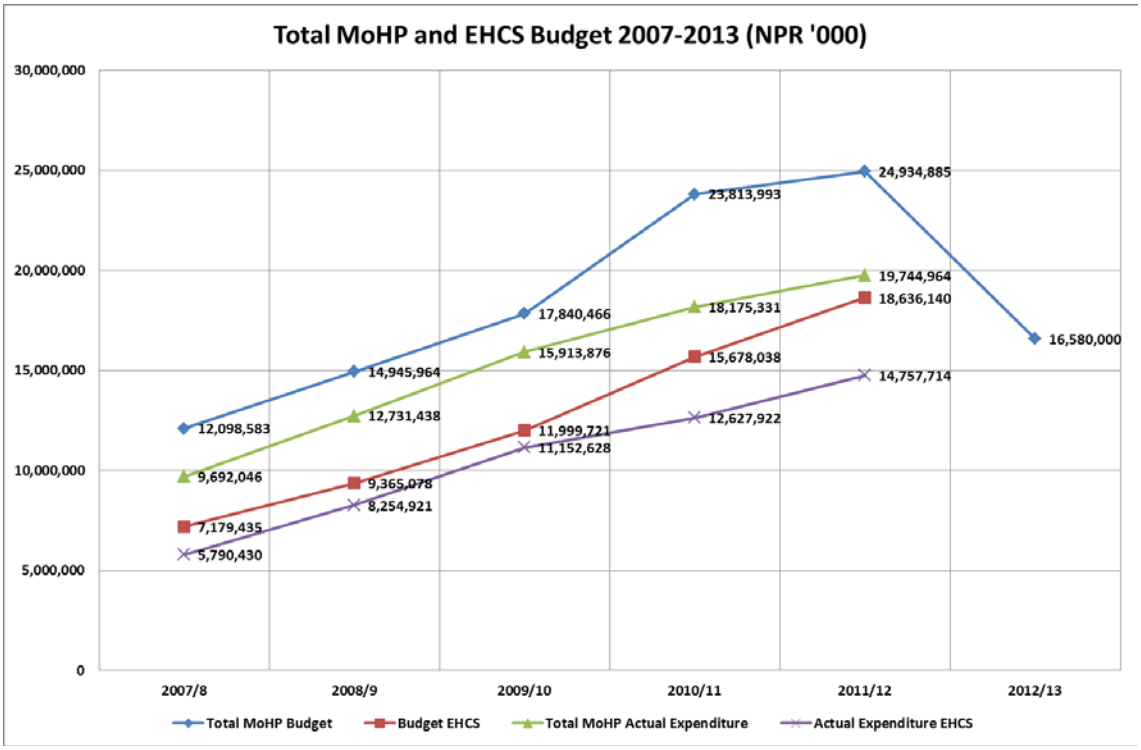
The MoHP budget per capita increased from NPR 474 to NPR 924 (respectively USD 6.3 and USD 12.6) from NPR 380 to NPR 683 (respectively USD 5.1 and USD 9.2 in terms of actual expenditure) between 2007/8 and 2011/12. This increase represented 20% in real terms (constant prices 2007/8).

EHCS

The GoN share of the MoHP budget increased from 49% (2007/8) to 61% (2011/12), (79% in 2011/12 in terms of actual expenditure). This is a consequence of both the increase in the domestic budget allocated to MoHP and the rather low execution of some development programmes (see below) mainly funded through foreign aid (pooled and not pooled on-budget aid). It is not easy to precisely quantify the off-budget foreign aid. Anecdotal evidence suggests that the off-budget aid (including INGOs, OECD and non-OECD countries like China and India) might be equivalent to the on-budget (pooled and not-pooled) aid.

Four "Programmes" represented more than 50% of total MoHP budget and actual expenditure in 2011/12: PHC (DHO, HC, HP, and SHP), Integrated Women Health & Reproductive Health Programme, Integrated Child Health & Nutrition Programme, and Integrated District Health Programme. The EHCS share of the health budget (and actual expenditure) increased from 59% to 75% from 2007/8 to 2011/12, showing the clear MoHP commitment to MDGs and EHCS (allocative efficiency). The budget execution rate is slightly better for the EHCS share than for the entire MoHP budget.

Figure 4: Total MoHP and EHCS Budget 2007-2012 (NPR '000)



In terms of the budget, overseas aid (on-budget) is very heavily allocated to EHCS: 83% of total pool-fund and 89% of non-pooled aid, while the share of GoN/MoHP resources for EHCS is limited to 68%.
The substantial decrease of the MoHP Budget 2012/13 that was notified in December is a matter of concern. Actual expenditure on EHCS represented almost NPR 15 billion in 2011/12 and the total MoHP budget 2012/13 is NPR 16.5 billion. What will be the impact on free care (EHCS, demand side financing schemes, etc.) considering that an additional 25,000 patients (among which 10,000 are women) will attend health facilities this year to get free EHCS?

NHSP II Scenarios versus Actual Expenditure

Three possible scenarios for the future growth in the resources available for health were set out in the NHSP II initial document, based on different assumptions relating to GDP growth, to the share of GDP used to finance public expenditure, to the share of domestic resources allocated to the health sector, to the MoHP budget execution and to the real ODA support to the health sector. All scenarios predict an increase of between US$1 and US$4 per head from domestic sources, but the uncertainty was higher with respect to external financing ranging between a small decline and an increase of nearly US$ 9 per capita.

The reality (till 2011/12) was beyond the high case scenario in terms of budget, and below the low case scenario in terms of actual expenditure (except for 2011/12). However what is significant is the growth of domestic source (especially in terms of budget) compared to the initial scenarios and the sharp decrease of the external resources in terms of actual expenditure: the three scenarios were quite optimistic in terms of amounts of overseas aid and pessimistic in terms of domestic resources. This might be one of the reasons why the EHCS could not be expanded in coverage as foreseen. However, it is

difficult at this stage to assess whether the limited expansion of EHCS is due to underfunding or to efficiency issues (delivery and administrative efficiency) or to absorption capacity, or even to underestimation of EHCS cost in the NHSP II costing exercise. The MoHP budget 2012/13 (NPR 16.5 billion) will likely be a breakpoint in the extension/expansion of the EHCS and other financial protection schemes. This limited budget will also hide the lack of absorption capacity and will bring to the forefront allocative efficiency issues, potentially at the expense of other highly needed improvements and reforms (e.g. decentralisation, integration of programmes at district level, PPP).

The 2012-2015 Framework

Macroeconomic and macrofiscal frameworks[50] (2012-2015) expect (1) a real GDP growth of 3.8%, (2) GoN (primary) expenditures averaging 21% of GDP, and (3) inflation stabilising around 8%. This scenario is very similar to what happened during the last decade. In this context, and considering that the MoHP budget has already reached 7% of the National Budget in 2011/12 (but dropped to 4.7% in 2012/13), the prospects of substantial additional public resources for health are relatively low. Having said this an allocation of 7% is comparatively low internationally (but not necessarily regionally) suggesting there is still scope for the MOHP to advocate for a higher allocation.

Health financing strategy – Health financing system

The NHA 2003-2009 shows that household out-of-pocket spending (OOP) is the dominant source of health financing in Nepal accounting for more than half of the total health spending in the country. Foreign remittances play a major role in private (household) spending on health (WB 2011). Remittances are expected to decrease from 19% to 15% of GDP, but still representing more than US$5 billion (the share of households receiving remittances increased from 30% in 2003/4 to 55% in 2010/11, enabling welcome improvements in living standard).

Several national initiatives are already in place to enhance access to health care in Nepal: EHCS is free for all at sub-health and health posts as well as primary health care centres; about 25 different medicines are free at peripheral facilities and 40 medicines are free at PHCs and district hospitals; services at district hospitals are free for the poor and the disadvantaged; institutional deliveries (normal, complicated and caesarean sections) are free at all public health care institutions and at certain selected autonomous government-aided and private institutions.

Demand side measures targeting financial risk protection are in place, including cash transfers in favour of some targeted essential services: safe delivery with the Safe Motherhood Programme (with a provider payment mechanism that links budget allocations to the actual delivery of services) and the 4ANC Programme; targeted free services for communicable diseases like Kala-Azar, TB and HIV/AIDS; safety net against catastrophic illnesses such as Alzheimer's disease, cancer, heart ailments, Parkinson's disease, paraplegia due to spinal injury and renal failure; free treatment of Uterine Prolapse; and special grants to community-based health insurance to include the poor. In addition to this free care policy, there are some experiences of Community Based Health Insurance, but with rather limited population coverage (sustainability issue).

[50] Macroeconomic Survey 2011/12, IMF Report and Budget Speech 2012/13

However, this free care policy faces many challenges (WHO 2012 and GIZ 2011) These include: the lack of appropriate mechanisms to identify the poor; lack of contracting policy; efficiency concerns with respect to both government and household resources; lack of appropriate provider payment mechanisms; out of pocket payment for free care services.

A draft National Health Insurance (NHI) Policy has been recently issued by the MoHP. The objectives are (1) to ensure additional financial protection through the implementation of national health insurance in an inclusive manner; (2) to improve access and utilization of quality health services by reducing financial barriers; (3) to generate financial resources for health service delivery; and (4) to promote efficiency, effectiveness and accountability in health service delivery. The National Health Insurance Fund would be established as an autonomous entity being in charge of pooling and allocating funds, listing and accrediting providers, managing contractual agreements with providers, monitoring and paying the providers, and settling the complaints. The household will be the unit for enrolment. Arrangements will be made for the accreditation of all types of health facilities (government, non-government, community and private) based on certain qualifying criteria. The Benefit Package (BP) will include health services that are currently provided for free and other services will be defined to be included in the BP.

It is not known to what extend the NHI system will be able to raise substantial additional resources for the health sector. International evidence suggests that if enrolment is voluntary, coverage will be low. Therefore, the main questions are (1) how will this new health financing system facilitate efficiency gains in the health sector (in complementarity to other reforms such as decentralisation, PPP, etc.), and (2) how to avoid the risk that its implementation jeopardises the relatively good results achieved through the social health protection interventions put in place so far by the MoHP with the support of EDPs.

The matrix below assesses sustainability, equity and efficiency for each element of the health financing approaches currently being used and also includes the new NHI draft policy.

	Efficiency	**Equity**	**Sustainability**
Line Item Budget (Input Based Financing System)	+/- -Fragmented resource allocation -Passive purchasing -Challenge to move towards PPP -Challenge to incentivise the providers	+/- -Limited ability to address inequities -Depends on allocation formulas	+ -Depends on the share of foreign aid on total budget
Decentralised Budget (Integration at District level and beyond; Autonomy) and Block Grants	+ -Integration at District level -Depends on District Capacity (procurement, financial management, etc.) -Challenge to move towards PPP	+ + -Better capacity at District level to identify needs -Better capacity at decentralised level to address equity issues	+ -Depends on the share of foreign aid on total budget -Depends on District (and beyond) management capacity

	Efficiency	Equity	Sustainability
Demand Side Financing (Aama, etc.)	+ -Enables the introduction of output based budgeting and financing -Prepares the third party payer system -Better managed at District level -Impact on quality of services?	+ + -Seems to have a real impact on access -Issues relating to awareness -Issues relating to persisting payments	+ + -Depends on health facility management capacity
CBHI	+/- -prepares the third party payer system -can pave the way to specific provider payment mechanisms -Impact on quality of services? Current pilots inefficient	+ -Risk pooling -Tendency to target richer households	- -No example of CBHI being financially sustainable (needs subsidies) -Limited coverage -Challenge to scale up -Management capacity?
NHI	Will depend on the way it is implemented	Will depend on the way it will be funded	Will depend on the way it will be managed

2.9.2 OUTPUT 9 RECOMMENDATIONS

Macroeconomic and macro-fiscal frameworks 2012-2015 do not show any major improvements compared to what happened during the last decade. In this context, and considering that the MoHP budget has already reached 7% of the national budget (although the 2012/13 drop is a matter of serious concern), "*the prospects of availability of additional domestic public resources for health are relatively low, unless additional earmarked taxes and/or some form of social health insurance are introduced*" (WB 2011). Moreover, the MoHP budget execution rate for the last 2 years has not exceeded 79%, showing an absorption capacity issue, mainly due to under-spending on the capital budget. Therefore it seems that the priority for the MoHP, in order to secure the extension of the EHCS under such budgetary constraints, should consist of (1) identifying areas for efficiency gains[51] and (2) advocating for more alignment of the off-budget foreign aid (from OECD and non-OECD countries).

Budget Allocation

[51] A recent study showed that the cost of building new health facilities could be substantially reduced (between 40% and 80% depending on the type of infrastructure) following the introduction of an e-bidding system and integrated designs for new health facilities. (NHSSP, Assessing the Value for Money of Technical Assistance provided by NHSSP to the Nepal Health Sector - Three Case Studies-, October 2012, Rachel Phillipson & Sumanta Neupane).

R9.1: The MTR recommends that studies are carried out in order to better understand the efficiency of the current budget allocations: allocative efficiency (e.g. share of domestic budget allocated to EHCS and extension of EHCS to underserved areas, including urban areas); delivery efficiency (e.g. comparison of budget/outputs between districts, between health facilities, between state and non-state health providers, costing studies); administration and management efficiency (e.g. procurement, financial management, bottom-up vs. top-down approach for planning and budgeting process, integrated vs. fragmented health plan and budget at district level). This will allow managers a better understanding of how the budget is spent and to take measures for efficiency gains. It will be important to ensure full ownership of this analysis as it will be the foundation of developing a health sector financing strategy (see R9.3 below).

R9.2: The MTR recommends that the MoHP investigates the issues that underpin the low rate of expenditure (79%) against budget and address the absorption capacity issues. Until this is done and expenditure rates increased the argument for increased budget is undermined and available resources underutilised.

Elsewhere in this document we alluded to the need to make the resource allocation process more health needs based. While some progress can be made by improving the current planning and budgeting processes, this can also be achieved by the introduction of a resource allocation formula. Most references on health resource allocation formulae recognise three main elements: demography, non-demographic health related led and cost of services. The extent to which these are introduced into a formula tends to evolve over time. Once large scale data sets at an individual level are available complex methods permit the construction of sophisticated formulae that take account of needs. Until they are available and also in order to facilitate transparency it is usually better to keep formulae simple; complexity can be incorporated over time.

R9.3: The MTR recommends that the MOHP explores the introduction of a need-based resource allocation formula.

A health financing strategy

The MoHP has introduced several social health protection interventions to increase citizens' access to health care services (e.g. EHCS; free public hospital services for the poor, free deliveries at all public health care institutions and at certain select non-state institutions, demand side measures (cash transfers) with a provider payment mechanism that links budget allocations to the actual delivery of services, targeted free services for some communicable diseases, safety net against some catastrophic illnesses, free treatment of Uterine Prolapse). However, these interventions do not add up to an integrated health financing strategy and several challenges remain (e.g. lack of appropriate mechanisms to identify the poor, lack of contracting policy, lack of separation of purchasing from provision that makes difficult to find appropriate provider payment mechanisms for public health institutions, fragmented financing leading to inefficiencies).

R9.4: The MTR recommends that a comprehensive and integrated health financing strategy is elaborated and agreed upon. This should take into consideration critical assessment of:
(1) the preservation (and extension in terms of coverage) of the benefits of social health protection interventions already put in place;
(2) the new PPP policy (e.g. inclusion of non-state health providers through outsourcing, contracting-in and contracting-out processes) and its concrete implications;
(3) the decentralisation/devolution process and its implications on the (public and private) health system
(4) the necessary adaptation of the MoHP structure relating to the paradigm shift that these reforms will imply (see R2.1).

The Health Financing Strategy (and its related medium term implementation plan) should primarily encompass (1) the future Basic Benefits Package (EHCS +) consistent with the evolution of the burden of disease (equity issues), and (2) the Provider Payment Mechanisms differentiated by type of provider (State vs. Non-State Health Providers; Hospitals vs. PHC Facilities; Capital vs. Recurrent Cost; Administrative vs. Operational Cost) that will enable efficiency gains (see R9.1 above). This will require more effective TA coordination in the areas of health financing, PPP, decentralisation and institutional management (see R2.9).

2.10 SCALE-UP OF DECENTRALISED DISTRICT HEALTH CARE

The NHSP I and NHSP II have included a comprehensive range of pilot initiatives some being more coordinated than others. The MTR has been informed and noted that many of these pilots have taken place over extended periods and have provided useful insights and experience in areas of local governance, service delivery, contracting in and out of elements of service delivery. At the same time there appears to have been a degree of duplication and often pilots have not been well evaluated or if they have the results not extensively used. Having said this there have been some very useful results and lessons learned as well as plans in place for further impact evaluations. On the basis of these experiences it is proposed that the thinking of MoHP and EDPs moves from continuing with numerous small scale piloting initiatives to scaling up in a way that combines the evidence and seeks substantive change. As a precursor to this a comprehensive stock-take of existing pilots should be undertaken.

Rather than ad hoc measures to address issues as they arise, a systems approach is recommended. The motivation is to build on available evidence to create synergies so that the whole is more than the sum of individual interventions. Such an all-encompassing model will need to:

- Address identified concerns, such as over-centralized planning, resource allocation, procurement, HRH shortage and mal-distribution, inequities in service deliveries, standards of quality, state/non-state partnerships and community accountability, not through multiple vertical interventions but in a single viable model which will allow horizontal linkages and multiply advantages;
- Be evidence based so that it can effectively use evaluations from various disparate initiatives undertaken over an extended period of time;
- Be grounded in the administrative, political, legal and constitutional framework of Nepal thus ensuring sustainability and buy-in with policy makers;
- Be financially sustainable.

The pilot work on health sector local governance and decentralised service delivery focusing on the district level has indicated the potential and real benefits of strengthening local structures and providing

them with resources to manage. The Local Health Governance Support Programme (LHGSP) in districts of Far West Region has provides good experience in decentralisation of management of health services to local control. This programme included support to HFMCs, scale up of social audits as well as more local control over human resources decisions. Similar pilots have been conducted by NHFP and a new pilot is in the early stages with support from NHSSP. Small grants to facilities under LHGP have been used with management oversight from the HFMC and a degree of topping up by the VDC and these have proved to be very useful flexible funds. Small-scale infrastructure development with matching funds from communities has proven popular with higher levels of matching funds than anticipated. The LHGP impact study currently in preparation should be fast tracked and will no doubt provide more detailed insights and lessons from this pilot work.

Another important programme is the nationwide Local Governance Community Development programme (LGCDP), led by the Ministry of Local Development with support from EDPs, which is now moving to a second phase. LGCDP is reported to have provided positive improvements in both 'demand side' and 'supply side' governance including some progress in public financial management. It has provided funds to local bodies across several sectors such as health, education, children, roads. While support specifically to the health sector appears to have been rather underutilised this programme provides both useful lessons and a good foundation for progress in the sector. Citizen Awareness Centres and Ward Citizen Forums have high levels of representation from women and disadvantaged groups and are generating active engagement in local governance and ownership of local initiatives. The programme is "pushing civil society to engage with and respect the role of local government, supporting and helping to improve the work of local government through activities such as public and social audits, monitoring budget allocations, and similar" activities[52]. Early results demonstrate acceptance by local officials and politicians of the Performance Based Grant System as well as the use of an agreed formula for allocating national grants to local bodies. Another advance is the expanding role of local User Committees in project management and monitoring, supporting the work of Ward Citizen Forums in securing better implementation[53]. The programme provides a positive foundation for progress in health sector local governance and improved local health services while also highlighting on-going challenges in areas such as local financial management and accountability and ensuring inclusive representation on local bodies.

The experiences in local governance and progress being made are very much in line with senior government thinking and concerns to ensure more equitable and better quality health care across the country and reaching out to those currently excluded from services in an affordable and sustainable way. As highlighted in this MTR report progress has been made in a number of areas, the introduction of GESI and practical tools for local governance such as social audits, the outreach work of FCHW and their links with SHP and HPs, the introduction of a range of social health protection measures, progress on a range of health interventions including those linked with improvements in water and sanitation and improved multi-sectoral working particularly linked to nutrition. The evidence for wider application of these experiences is now growing and the last period of NHSP II and the focus of NHSP III should now be wider application and scale up.

R10.1 - The MTR recommends a substantive and integrated scaling up of pilots that builds on the lessons learned and experiences gained to date. A scaled-up district decentralisation initiative should now be established that encompasses a number of actions to increase service coverage and quality utilising the range of resources available more effectively. This would allow successful pilots to be taken to scale and combined with emerging policy and strategy directions for more decentralised sector management and planning. The scale up should be focused on establishing equitable quality health services across all districts of one region as a precursor to nationwide coverage. A basket fund should be considered to fund the district scale up initiative.

The provisions within the Interim Constitution of Nepal (2007) provide the enabling framework for an initiative of this kind. The Interim Constitution proposes the future restructuring of the state to promote and institutionalise an inclusive, democratic and progressive local governance system, maximising people's participation based on decentralisation, devolution of power and the equitable distribution of resources to local bodies.

A number of core components to such an initiative are suggested all of which the MTR has assessed as within the existing legal and policy framework for the sector. Substantial preparation work combined with emerging results from evaluation of pilots is needed. The Regional programme proposed could include the following:

- Comprehensive district workforce mapping and workforce plans;
- Comprehensive stock-take on lessons from existing and past pilots and programmes;
- Mapping of all local service providers: public, private for profit, NGO and CSO this to include clinical services, diagnostic and pharmacy services. Ayurvedic services should be included.
- Undertake a review to ensure compliance with government policies on health entitlements and service standards, based around the EHCS;
- Contracting of health services - Where primary and secondary care district services are identified as sub-standard or absent especially in remote or hard to reach areas options for contracting to non-state actors (NGO, CSO and private providers) should be introduced based on open tendering; proposed basket fund conditions (see below); Agreed procurement guidelines for the basket fund; addendum to JFA to be considered (see below)]
- Contracts with medical colleges in the districts included should be facilitated and further extended. This should include placements into health facilities and allocation of scholarships to people from remote/ underserved districts with appropriate post-training bonds and opportunities for advanced training;
- Technical assistance to the District DHO/DPHO offices and Regional Health Directorate should be intensified. MoHP/DoHS and EDPs should agree reallocation of some existing TA resources to this initiative including capacity building in leadership and management, planning and budgeting, commissioning, quality assurance, NHSP-II, to name a few areas [Amendment to TORs of existing TA; adoption of TA Harmonisation Plan (see R2.9)].
- Provision of earmarked grants to DDC (District Development Fund) for district primary health facilities for flexible local procurement, related to primary health care facilities' services and short falls in EHCS essential drugs, based on needs assessments and procurement plans. Services including water and electricity supplies and other services, and limited procurement related to renewable energy sources, improved waste management and facility maintenance. Drug procurement only through pre-selected suppliers (DDA certified) and adherence to standards on pricing and quality determined centrally (DDA) with quality assurance by PAC. Grant allocation and management should learn from the lessons of the LHGP and LGCDP and ensure local matching funds, accountability and inclusive representation of disadvantaged groups on local bodies (FHOMC, VDC etc). Local procurement plans submitted to DHO/DPHO via HFOMCs and consolidated for submission to DDC.
- Establishing a comprehensive service quality assurance programme under the DHO or DPHO including monitoring of contracted services, private clinics and suppliers such as independent pharmacies. [Delegated authority to DHO for monitoring of private health facilities].

- Contracting arrangements to include human resource management linked to contracting out and contracting in models. This to include provisions for secondment/transfer [provisions within new PPP policy; Contract Act 2000].
- Increased attention to developing multi-sectoral linkages. This includes linkage with the Multisectoral Nutrition Plan and phase 2 of the LGCDP, water supply initiatives, school education programmes etc.
- To ensure good tracking of progress the initiative should include a comprehensive monitoring and evaluation plan. This will include existing systems such as HMIS. One option to be considered is the establishment of a Demographic Surveillance System covering one or two sites across the Region. This will give longitudinal data and allow more specific intervention studies to be undertaken.

A supportive legal and policy framework

The legal and policy frameworks in place are compatible with this approach (see Annex 4).

Funding the scale up pilot – A Basket Fund

Funding for the decentralised service delivery scale up initiative could be provided through an earmarked basket fund established by MoHP and interested partners. EDP allocations and under-spending from existing EDP commitments to pooled fund can be channelled into this regional basket fund and allocations agreed by a basket funding committee against an Initiative scale up strategy and costed Periodic Plan. Specific areas under the Periodic Plan will be supported by the Basket Fund and management contracts tendered. This approach will require an addendum to the Joint Financing Agreement (JFA).

Under the new basket it will be necessary to establish procurement guidelines endorsed by the Basket Management Committee.

Selection of scale-up initiative region

The area could cover one region or take in districts from a number of regions. This will need to be decided as part of the initial design phase but should be both manageable logistically and include a representative cross section of the existing ethic, economic and geographic variation that exists.

Annex 1 - Updated NHSP II Results Logical Framework (2012)

The updated (2012) Logical Framework presented here is the result of collaborative work between the MTR Team, WHO consultants and several departments within the MoHP and DoHS as well as consultants from the NHSSP. The data presented here has been revised since the JAR, based on some revisions and updates received.

The MTR has presented the data in a way that includes the 2011 achievements as well as the original targets set for 2013 and 2015. The updated data, where available, has been presented in a 2012 achieved column. As there is no 2012 target the MTR decided that the most useful indication of progress is to show percentage change since 2011 data and give a measured opinion on the likelihood of the 2013 target being achieved based on 2012 data where available.

MTR Indicator Updates

Key for shading	Colour
Likely to Achieve 100% of 2013 target	
Likely to Achieve at least 90% of 2013 target	
Not likely to achieve at least 90% of 2013 target	
No target for 2013	
No Data for 2011/2012	

GOAL: IMPROVED HEALTH AND NUTRITIONAL STATUS OF PEOPLE, ESPECIALLY THE POOR AND EXCLUDED

Code	Indicator	Baseline			Achieved		% change in 2012 compared to 2011	Target			Data source 2012	Notes	Comments
		Data	Year	Source	2011	2012		2011	2013	2015			
G1	Total Fertility Rate (per woman)	3.1	2006	NDHS	2.6	NA		3.0	2.8 (2.5)	2.5 (2.3)			2017 target is 2.1
G2	Adolescent Fertility Rate (women aged 15-19 years, per 1,000 women in that age group)	98	2006	NDHS	81	NA		-	85 (80)	70			Reset 2013 target
G3	Under-five Mortality Rate (per 1,000 live births)	61	2006	NDHS	54	NA		55	47	38			On track for revised MDG target
G4	Infant Mortality Rate (per 1,000 live births)	48	2006	NDHS	46	NA		44	38	32			Ambitious target that need progress on GESI
G5	Neonatal Mortality Rate (per 1,000 live births)	33	2006	NDHS	33	NA		30	23 (28)	16 (20)			Revise targets and disaggregate
G6	Maternal Mortality Ratio (per 100,000 live births)	281	2006	NDHS	NA	NA		250	192	134			2010 MDG progress report status 229
G7	HIV prevalence among men and women aged 15-24 years (per 100,000 population)	All= 0.12 M=0.20 F=0.05	2010	EPP/ Spectrum modelling	NA	NA		0.1	0.08	0.06			
G8	Malaria annual parasite incidence per 1,000 (per 1000 population in a year)	0.15	2009/10	HMIS	0.16	0.11	31.3%↓	0.15	halt & reverse	halt & reverse	HMIS		This target needs to be revised
G9	% of children under five years of age, who are stunted	49.3	2006	NDHS	40.5	NA		40	35	28			Consider disaggregation by zone rather than ethnicity
G10	% of children under five years of age, who are underweight	39	2006	NDHS	28.8	NA		39	34 (26)	29 (24)			Revise target based on 1.1% reduction per year

Code	Indicator	Baseline			Achieved		% change in 2012 compared to 2011	Target			Data source 2012	Notes	Comments
		Data	Year	Source	2011	2012		2011	2013	2015			
G11	% of children under five years of age, who are wasted	13	2006	NDHS	10.9	NA		10	7	5			Consider disaggregation by zone
G12	% of low birth weight babies	14.3	2006	NDHS	12.4	NA		-	13	12			

PURPOSE: INCREASED UTILISATION OF HEALTH SERVICES, AND IMPROVED HEALTH AND NUTRITIONAL BEHAVIOUR OF THE PEOPLE, ESPECIALLY BY THE POOR AND EXCLUDED

Code	Indicator	Baseline			Achieved		% change in 2012 compared to 2011	Target			Data source 2012	Notes	Comments
		Data	Year	Source	2011	2012		2011	2013	2015			
P1	% of neonates breast fed within one hour of birth	35.4	2006	NDHS	44.5	50.9	14.4↑	-	55	60			
P2	% of infants, exclusively breast fed for 0 – 5 months	53.0	2006	NDHS	69.6	68.7	1.3↓	35	48 (70)	60 (75)	HHS		Targets could be revised upwards
P3	% of one-year-old children immunised against measles	85.0	2006	NDHS	88.0	NA		85.0	85.0 (89)	85.0 (90)	HMIS		2012 HMIS data indicates 86. Revise target upwards
P4	% of children aged 6-59 months that have received vitamin A supplements	87.5	2006	NDHS	90.4	90.2	0.22↓	≥ 90	≥ 90	≥ 90	HHS		
P5	% of children aged 6 -59 months suffering from anaemia	48.4	2006	NDHS	46.2	NA	-	45	44	43			Rate of decline low (UNICEF) Keep targets pending results of anaemia study of progress
P6	% of households using adequately iodised salt	NA	NA	NA	80	NA	-	80	84	88			While no new data available progress expected to continue.
P7	Contraceptive Prevalence Rate - modern methods (%)	44.2	2006	NDHS	43.2	43.1	0.23↓	48	52	67	HHS		This indicator relates to married women of reproductive age. MTR recommends looking also at all women of reproductive age Eg: 2011 = 33.2: 2012 = 38.7
P8	% of pregnant women attending at least four ANC visits	29.4	2006	NDHS	50.1	48.1	3.9↓	45	65	80	HHS		4th ANC visit is low and is unrealistic target. Consider 4th ANC in-house visits
P9	% of pregnant women receiving IFA tablets or syrup during their last pregnancy	59.2	2006	NDHS	79.5	91.1	14.6↑	82	86	90	HHS		Revise 2013 and 2015 target upwards
P10	% of deliveries conducted by a skilled birth attendant	18.7	2006	NDHS	36.0	46.3	28.6↑	-	40 (50)	60	HHS		Revise 2013 target
P11	% of women who had three postnatal check-ups as per protocol (1st within 24 hours of delivery, 2nd within 72 hours of	NA	NA	NA	35.8	31.4	12.3↓	-	43	50	HMIS	2011 was first year this data was collected 2012 data does	Ensure 2013 data is per protocol

Code	Indicator	Baseline			Achieved		% change in 2012 compared to 2011	Target			Data source 2012	Notes	Comments
		Data	Year	Source	2011	2012		2011	2013	2015			
	delivery and 3rd within 7 days of delivery, as % of expected live births)											not reflect PNC visit as per protocol	
P12	% of women of reproductive age (15-49) with complications from safe abortions (surgical and medical)	58.4	2006	NDHS	49[1]	1.2	-	<2	<2	<2	HMIS	NDHS reports on complications after any abortion	Not colour coded as redefinition of indicator required.
P13	Prevalence rate of leprosy (%)	0.77	2009/10	HMIS	0.79	0.85	7.6↑	halt & reverse	halt & reverse (0.75)	halt & reverse (0.7)	HMIS		
P14	Obstetric direct case fatality rate (%)	0.4	2009/10	EOC monitoring	0.17	-	-	< 1	< 1	< 1			

[1]The abortion complications are for all abortions (miscarriage and induced abortion) as complication from safe abortion in not available for NDHS 2011.

OUTCOME 1: INCREASED AND EQUITABLE ACCESS TO QUALITY ESSENTIAL HEALTH CARE SERVICES

Code	Indicator	Baseline			Achieved		% change in 2012 compared to 2011	Target			Data source 2012	Notes	Comments
		Data	Year	Source	2011	2012		2011	2013	2015			
OC1.1	% of population living within 30-minutes travel time to a health or sub-health post	NA	2003/04	NLSS	61.8	47.2	23.6↓	60	70	80	HHS	NLSS 2003/4 did not collect data	Should use population based data from Household Survey. Revise target downwards
OC1.2	% population utilising outpatient services at SHP, HP, PHCC and district hospitals	76.0	2009/10	HMIS	70.4	76.1	8.1↑	-	-	-	HMIS		Clearer definition of the indicator and targets is needed
OC1.3	% population utilising inpatient services at district hospitals (all level of hospitals)	9.2	2009/10	HMIS	9.1	9.5	4.4↑	-	-	-	HMIS		Clearer definition of the indicator and targets is needed
OC1.4	% population utilising emergency services at district hospitals (all level of hospitals)	2.4	2009/10	HMIS	2.4	2.7	12.5 ↑	-	-	-	HMIS		Clearer definition of the indicator and targets is needed
OC1.5	Met need for emergency obstetric care (%)	29	2009/10	EOC monitoring	23	15.9	30.9↓	-	43	49	HMIS	2012 data calculated from HMIS	Need explanation of how it is calculated
OC1.6	% of deliveries by caesarean section	3.3	2009/10	EOC monitoring	4.6	4.9	6.5↑	4	4.3 (5)	4.5 (5.2)	HHS		Revise target upwards Disaggregate by ethnicity, urban/rural and quintile
OC1.7	Tuberculosis treatment success rates (%)	89	2009/10	HMIS	90	90	0	89	90	90	HMIS		

Code	Indicator	Baseline			Achieved		% change in 2012 compared to 2011	Target			Data source 2012	Notes	Comments
		Data	Year	Source	2011	2012		2011	2013	2015			
OC1.8	% of eligible adults and children currently receiving antiretroviral therapy	NA	NA	EPP/ Spectrum modelling & routine ART monitoring report	NA	NA	-	24	55	80			No data. Consider removing or replacing

OUTCOME 2: IMPROVED HEALTH SYSTEMS TO ACHIEVE UNIVERSAL COVERAGE OF ESSENTIAL HEALTH CARE SERVICES

Code	Indicator	Baseline			Achieved		% change in 2012 compared to 2011	Target			Data source 2012	Notes	Comments
		Data	Year	Source	2011	2012		2011	2013	2015			
OC2.1	% of children under 5 with diarrhoea treated with Zinc and ORS	0.4	2006	NDHS	5.2	-	-	7	25	40	HHS	NDHS 2006 provides data for zinc but not ORS and zinc together	Target maintained based on HHS 2012 estimates of 21.9 (HHS 2012 provided data for zinc and ORS) together
OC2.2	% of children, under 5 with pneumonia, who received antibiotics	25.1	2006	NDHS	35.1	36	2.6↑	30	40	50	HHS		
OC2.3	Unmet need for family planning (%)	24.6	2006	NDHS	27	NA	-	-	20	18			Need to disaggregate by women living or living without husband
OC2.4	% of institutional deliveries	18	2006	NDHS	35.3	43.5	23↑	27	35	40	HHS		Consider raising targets based on HHS target
OC2.5	% of women who received contraceptives after safe abortion (surgical and medical)	50.8	2009/10	HMIS	41	33	19.5↓	55	60	60	HMIS		Well off track but target should be raised
OC2.6	% of clients satisfied with their health care provider at public facilities	94*	2009	Examining the Impact of Nepal's Free Health Care Policy, 2009	96	91	5.2↓	68	74	80	STS	* Re-calculated 2009 figure as incorrect denominator used	Consider definition of client satisfaction
OC2.7	Tuberculosis case detection rate (%)	75	2009/10	HMIS	73	73	0	75	80	85	HMIS		

OUTCOME 3: INCREASED ADOPTION OF HEALTHY PRACTICES

Code	Indicator	Baseline			Achieved		% change in 2012 compared to 2011	Target			Data source 2012	Notes	Comments
		Data	Year	Source	2011	2012		2011	2013	2015			
OC3.1	% of children under 5 years who slept under a long lasting insecticide treated bed net the previous night in high-risk areas	94.2	2010	PSI-TRaC study	67.8	NA		70	80	80		Study in 13 high-risk districts	
OC3.2	% of key populations at higher risk (sex workers, men who have sex with men, people who inject drugs, male labour migrants) reporting the use of condom at last sex												No new data for 2012 available from IBBS
	Female sex workers (FSWs)	NA	NA	IBBS survey on Ktm valley FSW cluster	82.6	-		82.6	-	85	IBBS		
	Male sex workers (MSWs)	37.8	2009	IBBS Survey	NA	-		-	-	80		IBBS did not collect data on MSW in 2011	
	Men who have sex with men (MSM)	75.3	2009	IBBS survey on Ktm valley MSM cluster	NA	-		-	75	80		IBBS did not collect data in 2011 on MSM	
	People who inject drugs (PWIDs)	NA	NA	IBBS survey on Ktm valley PWID cluster	46.5	-		46.5	60	80			
	Male labour migrants (MLM) to India	53	2010	IBBS survey on mid and far-western Nepal MLM cluster	NA	-		-	65	80		IBBS did not collect data in 2011 on MLM	
OC3.3	% of people who inject drugs reporting the use of sterile injecting equipments the last time they injected	95.3	2010	IBBS	NA	-	-	≥ 95	≥ 95	≥ 95		IBBS did not collect data in 2011 on drug injectors	

Code	Indicator	Baseline			Achieved		% change in 2012 compared to 2011	Target			Data source 2012	Notes	Comments
		Data	Year	Source	2011	2012		2011	2013	2015			
OC3.4	% of households with hand washing facilities with soap and water nearby the latrine	64.1	2006	NDHS 2006 asked women aged 15-49 who washed hands with soap	47.8	19.7	58.7↓	-	65	85	HHS		NDHS 2011 reflects households having a hand-washing station with soap and water, but it does not include proximity to a latrine HHS 2012 reflects households having hand washing station near a latrine with soap and water Revise target downwards

OUTPUT1: REDUCED CULTURAL AND ECONOMIC BARRIERS TO ACCESSING HEALTH CARE SERVICES

Code	Indicator	Baseline			Achieved		% change in 2012 compared to 2011	Target			Data source 2012	Notes	Comments
		Data	Year	Source	2011	2012		2011	2013	2015			
OP1.1	% of women utilizing FCHV fund (among women of reproductive age)	NA	NA	HMIS	5	0.5	90↓	-	8	10	HMIS		
OP1.2	Number of health facilities providing adolescent-friendly health services	0	2010	FHD	78	455	483.3↑	-	500	1,000	FHD		
OP1.3	% of HFMOC/HDMC with at least 3 number of female members and at least 2 members from Janajati and Dalit	NA	NA	NA	42	41	2.4↓	-	70	100	STS		

OUTPUT2: IMPROVED SECTOR MANAGEMENT

Code	Indicator	Baseline			Achieved		% change in 2012 compared to 2011	Target			Data source 2012	Notes	Comments
		Data	Year	Source	2011	2012		2011	2013	2015			
OP2.1	% EDPs providing Official Development Assistance (ODA) on rolling 3-year period basis				NA	NA		-	50	90			
OP2.2	% of health sector aid reported by the EDPs on national health sector budgets	NA	-	-	NA	NA		-	50	85			
OP2.3	% of actions documented in the	NA	-	-	NA	NA		-	100	100			

	action plan of aid-memoire completed by next year												
OP2.4	% of EDPs reporting to JAR their contribution to the health sector (including expenditure) aligned to the agreed annual reporting format for EDPs as developed by MoHP	NA	-	-	NA	NA		-	100	100			

OUTPUT3: STRENGTHENED HUMAN RESOURCES FOR HEALTH

Code	Indicator	Baseline			Achieved		% change in 2012 compared to 2011	Target			Data source 2012	Notes	Comments
		Data	Year	Source	2011	2012		2011	2013	2015			
OP3.1.1	% of sanctioned posts that are filled - doctors at PHCC	50	2011	STS	50	19	62↓	85	88	90	STS		
OP3.1.2	% of sanctioned posts that are filled - doctors at district hospitals				69	56	19↓	85	88	90	STS		
OP3.1.3	% of sanctioned posts that are filled - nurses at PHCC				74	59	20.3↓	85	88	90	STS		
OP3.1.4	% of sanctioned posts that are filled - nurses at district hospitals				83	83	0	85	88	90	STS		
OP3.2	% of district hospitals that have at least 1 MDGP or Obstetrician/ Gynaecologist; 5 nurses (SBA); and 1 Anaesthetist or Anaesthetist Assistant				13	0	100↓	-	60	80	STS		
OP3.3	Number of production and deployment of:												
	Skilled birth attendants (SBA)				2,562	3,637	42.0↑	4,000	6,000	7,000	NHTC		
	Medical doctors general practice (MDGPs)				NA			-	28	56			
	Anaesthetists								22	44			
	Psychiatrists								28	56			
	Radiologists								27	55			
	Physiotherapists								10	20			
	Physiotherapy assistants								35	70			
	Radiographers								50	100			
	Assistant anaesthetists								31	62			
	Procurement specialists								3	7			
	Health legislation experts								1	3			
	Epidemiologists								3	7			
	Health economists								3	7			

Code	Indicator	Baseline			Achieved		% change in 2012 compared to 2011	Target			Data source 2012	Notes	Comments
		Data	Year	Source	2011	2012		2011	2013	2015			
	Health governance experts								1	3			
OP3.4	Number of Female Community Health Volunteers (FCHVs)	48,489	2009/10	FHD	48,680	48,897	0.45↑	50,000	52,000	53,514	HMIS		

OUTPUT4: IMPROVED SERVICE DELIVERY

Code	Indicator	Baseline			Achieved		% change in 2012 compared to 2011	Target			Data source 2012	Notes	Comments
		Data	Year	Source	2011	2012		2011	2013	2015			
OP4.1	Number of one stop crisis centres to support victims of gender based violence	0	2010	Population Division	6	8	33.3↑	5	10	20	Population Division		
OP4.2	Number of HPs per 5,000 population	0.13	2010	HMIS	0.12	0.8	567↑	-	0.5	1	HMIS		
OP4.3	Number of PHCCs per 50,000 population	0.38	2010	HMIS	0.37	0.35	5.4↓	-	0.7	1	HMIS		
OP4.4	Number of district hospital beds per 5,000 population	NA	NA	NA	1.06	0.8	24.5↓	-	0.6	1	HMIS	HMIS did not record data prior to 2011	
OP4.5	% of districts with at least one public facility providing all CEONC signal functions 24/7	44.0	2009/10	AR	39	-	-	-	68	76	STS		Based on 2012 STS data = 62
OP4.6	% of PHCCs providing all BEONC signal functions 24/7	27.9	2009/10	AR	14	-	-	-	50	70	STS		Based on 2012 STS data = 39
OP4.7	% of health posts with birthing centre 24/7	60.1	2009/10	AR	93	72	22.6↓	≥ 80	≥ 80	≥ 80	HMIS		
OP4.8	% of safe abortion (surgical and medical) sites with post abortion long acting family planning services	NA	NA	NA	91	90	1.1↓	≥ 90	≥ 90	≥ 90	STS		
OP4.9	% of health posts with at least five family planning methods	NA	NA	NA	13	8	38.5↓	-	35	60	STS		
OP4.10	% of households with at least 1 long lasting insecticide treated bed net per 2 residents in all high-risk areas	99.9	2010	PSI, TRaC study	NA	NA		≥ 90	-	-		Study in 13 high-risk districts	Consider deleting the indicator
OP4.11	% of key populations at higher risk (people who inject drugs, sex workers, men who have sex with men, male labour migrants) reached with HIV					-							No new data for 2012 available from IBBS

Code	Indicator	Baseline			Achieved		% change in 2012 compared to 2011	Target			Data source 2012	Notes	Comments
		Data	Year	Source	2011	2012		2011	2013	2015			
	prevention programmes												
	People who inject drugs (PWIDs)	71.4	2011	IBBS survey	71.4	-		71.4	75	80	IBBS Survey	IBBS survey conducted only on PWIDs and FSWs from Kathmandu valley cluster	
	Female sex workers (FSWs)	60	2011	IBBS survey	60	-		60	-	80			
	Male sex workers (MSWs)	93.3	2009	IBBS survey	NA	-		-	≥93	≥95		IBBS survey did not include MSWs, MSM and MLM in 2011	
	Men who have sex with men (MSM)	77.3	2009	IBBS survey of Ktm valley cluster		-			80	≥80			
	Male labour migrants (to India, MLM)	22.9	2010	IBBS survey of mid and far-western Nepal cluster		-			50	80			
OP4.12	% of PHCC with functional laboratory facilities	87.2	2010	HMIS	97.6	97.6	0	90	95	100	HMIS	Data does not specify whether 'functional' or not	Need criteria for functional
OP4.13	% of public hospitals, PHCCs, and HPs that have infrastructure as per GoN standard	NA	-	-	NA	Hosp:63 PHCC: 69 HP: 37		50	Hosp: 65 PHCC: 65 HP:65	80	HIIS		

OUTPUT 5: INCREASED HEALTH KNOWLEDGE AND AWARENESS

Code	Indicator	Baseline			Achieved		% change in 2012 compared to 2011	Target			Data source 2012	Notes	Comments
		Data	Year	Source	2011	2012		2011	2013	2015			
OP5.1	% of women of reproductive age (15 – 49) aware of safe abortion sites	50	2006	NDHS: (based on knowledge of a place where abortion is carried out	58.8	34.3	42↓	-	35	50	HHS		Based on 2012 HHS Data

Code	Indicator	Baseline			Achieved		% change in 2012 compared to 2011	Target			Data source 2012	Notes	Comments
		Data	Year	Source	2011	2012		2011	2013	2015			
				not — necessarily a safe site)									
OP5.2	% of women of reproductive age (15 – 49) who know at least three pregnancy related danger signs	NA	-	-	NA	56.9		-	40 (60)	50 (70)	HHS		Revise targets
OP5.3	% of women of reproductive age (15 – 49) giving birth in the last two years aware of at least three danger signs of newborn	NA	-	-	NA	48.3		-	40 (60)	50 (70)	HHS		Raise targets
OP5.4	% of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS by sex	M=44 F=28	NDHS	2006	M=33.9 F=25.8	NA		M=33.9 F=25.8	M=40 F=40	M=50 F=40		Data recorded on 'comprehensive knowledge' not on 'comprehensive correct knowledge'	

OUTPUT6: IMPROVED M&E AND HEALTH INFORMATION SYSTEMS

Code	Indicator	Baseline			Achieved		% change in 2012 compared to 2011	Target			Data source 2012	Notes	Comments
		Data	Year	Source	2011	2012		2011	2013	2015			
OP6.1	% timely and complete data on annually reportable M&E framework indicators reported within end of December of the following year	NA	-	-		NA	-	-	100	100			
OP6.2	% of health information systems implementing (using) uniform standard codes	0	2010	HMIS	0	0	-	-	100	100		Uniform coding system yet to be developed	
OP6.3	% of tertiary and secondary hospitals (public and private) implementing ICD 10 and reporting coded information to health information system				Public: 65 Private: NA	Public: 100 Private: NA	Public: 53.8 ↑	-	Public: 75 Private: 75	100	HMIS		Raise target for public facilities
OP6.4	% of health facilities (public and private) reporting to national health information system (by type or level)	NA	-	-		Public: 99 Private: 66	-	-	Public: 80 Private: 80	100	HMIS		Raise target for public facilities

OUTPUT 7: IMPROVED PHYSICAL ASSETS AND LOGISTICS MANAGEMENT

Code	Indicator	Baseline			Achieved		% change in 2012 compared to 2011	Target			Data source 2012	Notes	Comments
		Data	Year	Source	2011	2012		2011	2013	2015			
OP7.1	% of public health facilities with no stock out of the listed free essential drugs in all four quarters	75.6	2010	LMIS unit/ LMD	79.2	75.1	5.2↓	70	80	90	LMIS	LMIS records = for just 9 essential drugs	
OP7.2	% of the budget allocated for operation and maintenance of the physical facilities and medical equipment	NA	-	-	NA	<1		at least 2	-	-	AWPB		

OUTPUT8: IMPROVED HEALTH GOVERNANCE AND FINANCIAL MANAGEMENT

Code	Indicator	Baseline			Achieved		% change in 2012 compared to 2011	Target			Data source 2012	Notes	Comments
		Data	Year	Source	2011	2012		2011	2013	2015			
OP8.1	% of health facilities that have undertaken social audits as per MoHP guidelines in last fiscal year	0	2010	PHC-RD	31	-	-	5	15	25	STS		Based on 2012 STS data = 21
OP8.2	% of MoHP budget spent annually	81.4	2007	e-AWPB	76.3	79.7	4.5↑	83	84.5	86	AWPB		
OP8.3	% of budget allocated to district and below facilities (including flexible health grant)	57.6	2009	e-AWPB	59.5	59.44	0.1↓	60	65	70	AWPB		
OP8.4	% of irregularities (*Beruju*) among the total public expenditures				6.2	NA		6	5	4			
OP8.5	% of district health offices receiving budgeted amount within one month of budget disbursement from MoHP/DoHS with clear-cut guidance for expenditure	NA	-	-	100	100	0	-	100	100	AWPB	Data is for 'sent' not received	

OUTPUT 9: IMPROVED SUSTAINABLE HEALTH FINANCING

Code	Indicator	Baseline	Achieved	% change in	Target	Data	Notes	Comments

		Data	Year	Source	2011	2012	2012 compared to 2011	2011	2013	2015	source 2012		
OP9.1	% of MoHP budget allocated to EHCS	75.4	2009	e-AWPB	76.8	75.01	2.3↓	75	75	75	AWPB		
OP9.2	% of health sector budget as % of total national budget	7	2009	MoF	7.1	6.05	14.8↓	7.5	8.5	10	AWPB		
OP9.3	% of government allocation (share) in total MoHP budget	52.2	2009	e-AWPB	39.2	60.3	53.8↑	60	65	70	MoF (Red Book)		

Annex 2 – NHSP II MTR - Terms of Reference

Mid-term Review of the Nepal Health Sector Programme (NHSP II)

TERMS OF REFERENCE FOR THE CONSULTANTS

July 2012

Background

The Government of Nepal (GoN) in collaboration with External Development Partners (EDPs) and other health sector stakeholders, including civil society, finalised the five-year Nepal Health Sector Programme 2 (NHSP II) design in 2010 and implementation began in July 2010. The programme has been running for almost two years.

Nepal has experienced two decades of steady improvement in health outcomes. Progress accelerated and was accompanied by significant improvements in equality of access during the first NHSP (2004-10). Nepal met or exceeded nearly all of the outcome and service output targets that were set for 2004-10, and is on track to meet the child and maternal mortality MDGs. It is estimated that NHSP1 saved 96,000 deaths and nearly 3.2 million disability-adjusted life years (DALYs) at a cost of $144 per DALY saved. The current plan (NHSP II) represents a continuation and refinement of earlier policies and plans based on implementation of cost-effective, evidence-based health interventions, some free of charge.

The endorsement of the Health Sector Reform Strategy and subsequent advent of Sector Wide Approach (SWAp) in 2004 marked the beginning of improved partnership in the health sector between the government and the EDPs. Despite challenges, partnership, harmonisation and alignment have been improving in the health sector. Various instruments and initiatives such as Joint Annual Review (JAR), Joint Financing Arrangement (JFA), Governance and Accountability Action Plan (GAAP), and International Health Partnership (IHP+) National Country Compact have been developed which have contributed in strengthening the overall aid effectiveness in the health sector.

Both NHSP I and NHSP II were developed with joint participation of development partners and civil society indicating greater focus on partnership in the health sector. Development partners have largely aligned their programmes and resources in national health sector policies and strategies. This has, among other things, reduced aid fragmentation and led to better budget absorption capacity of Ministry of Health and Population (MoHP).

NHSP II aims to widen and strengthen partnerships in the health sector, espousing core values that reflect the current socio-political and socio-economic paradigm of the country.

NHSP II's vision is to improve the health and nutritional status of the Nepali population, especially the poor and excluded. Government will contribute to poverty reduction by providing equal opportunity for all to receive high-quality and affordable health care services. Three main objectives in the NHSP II results framework are:

- Increase access to and utilisation of a package of quality essential health care services;
- Reduce cultural and economic barriers to accessing health care services and harmful cultural practices in partnership with non-state actors. Fundamental to this objective is the implementation of the *Gender Equality and Social Inclusion Strategy*;
- Improve the health system to achieve universal coverage of essential health services. Fundamental to this objective is the implementation of the *Governance and Accountability Action Plan.*

The results framework (within NHSP II Implementation Plan in Annex 1) summarises how the vision will be achieved. The full objectives of NHSP II are set out in the NHSP II Implementation Plan.

NHSP II is funded principally by six main sources of revenue:

- Annual sector budget provided by Ministry of Finanace to Ministry of Health and Population (MoHP);
- Sector Budget Support provided by 'pool funding' development partners;
- Earmarked off-budget funding and service delivery provided by 'non-pooling' development partners;
- Technical assistance provided by both 'pool' and 'non-pool' development partners;
- Resources provided by the local bodies (DDCs, VDCs, and Municipalities) at the sub-national level and;
- User fees paid by the recipients of health services.

In addition, some health services providers (including the non-state sector) also provide services that contribute to the objectives of NHSP II.

The agreement to finance and support the programme of work in NHSP II was formalised in a Joint Financing Arrangement (JFA – Annex 2) using a Sector Wide Approach (SWAp). Individual development partners may be 'pool' or 'non-pool' signatories to the JFA, depending on whether they provide fully flexible budget support or not. It provides a common framework for the health sector planning and budgeting cycle, financing obligations of each party, financial management and reporting procedures, and monitoring and evaluation as well as agreement on both yearly and midterm review mechanisms.

In line with this provision, a Mid Term Review (MTR) is proposed. This review will assess progress on delivering NHSP II's objectives, drawing on primary research by the review team, and key health sector[54] and other relevant reports from other sectors from the financial years preceding 2012/13 (which is the third year of NHSP II). The MTR will be the primary focus of the Joint Annual Review meeting in January 2013. It will consider the contributions made by the main sector stakeholders (including EDPs, GoN and other non-state actors). Some health services providers (including the non-state sector) also provide services that will contribute to the objectives of NHSP II, and it will be important to disaggregate the contributions made by these providers if possible.

Aim of the Mid Term Review

The overall aim of the review is to assess the progress made in reaching the objectives of the NHSP II:

- Increase access to and utilisation of a package of quality essential health care services;
- Reduce cultural and economic barriers to accessing health care services and harmful cultural practices in partnership with non-state actors. Fundamental to this objective is the implementation of the *Gender Equality and Social Inclusion Strategy*;
- Improve the health system to achieve universal coverage of essential health services. Fundamental to this objective is the implementation of the *Governance and Accountability Action Plan.*

Specifically, the MTR is expected to:

- Assess quantitatively (against the indicators/targets of NHSP II) and qualitatively the progress in meeting NHSP II output targets and trends towards meeting health outcomes as stipulated in the results framework of NHSP II and recently developed M&E Framework[55] (given in Annex 3). The M&E framework has defined the following nine outputs for NHSP II:
    - Improved service delivery
    - Improved sector management

[54] Including the Demographic and Health Survey and follow-up analysis; the Department of Health Service's Health Management Information System; the Service Tracking and Household Surveys

[55] M&E Framework is an operationalized version of results framework of NHSP II to facilitate effective monitoring of the NHSP II. This Framework is developed as per the Results Based Monitoring and Evaluation Guideline 2010 issued by the National Planning Commission and is endorsed by the Secretary (MoHP) in April 2012.

- Improved health governance and financial management
- Reduced cultural and economic barriers to accessing health care services
- Strengthened human resources for health
- Increased health knowledge and awareness
- Improved M&E and health information systems
- Improved physical assests and logistics management
- Improved sustainable health financing

- Identify resource and capacity needs as well as constraints in implementing NHSP II and analyse how efficiency gains and technical assistance can address them;
- Assess the contribution of technical assistance to progress in each area;
- Identify, prioritize and propose relevant and evidenced-based programme and system interventions that would accelerate achievement of NHSP II goals and objectives.

Key areas for the review against the outputs of NHSP II

1. Improved service delivery

a. Quantitatively assess the progress on this output against the M&E Framework indicators
b. Assess the quality of Essential Health Care Services including identifying priority shortcomings at facility level significantly limiting the quality of services
c. Appraise performance at national and district levels in delivering EHCS including quality of care. At nationl level focus should be on performance of technical programmes in carrying out their core functions; and harmonization and inter-linkages of plans of individual Divisions and Centres. At district level focus should be inputs, processes and outputs
d. Assess whether different levels of entitlement to basic health care are clear: are they implemented as guaranteed by the Interim Constitution and espoused by NHSP-II? Are citizens, as right-holders, aware of their entitlements? Is Government, as duty-bearer, doing enough to make citizens aware?
e. Assess the progress on EHCS not directly related to MDG 4, 5, and 6 (e.g. mental health, NCDs, etc., that are not captured well in the Results and M&E frameworks) and health emergency preparedness and response
f. Assess the progress made on integration of services (e.g CB-IMCI, PMTCT)

2. Improved Sector Management (and Partnership)

a. Quantitatively assess the progress on this output against the M&E Framework indicators
b. Assess contribution of technical assistance in achieving NHSP II outputs, and identify ways to improve EDPs' provision of TA and Government's use of TA
c. Assess overall contribution of EDPs in achieving NHSP II outputs, identifying ways in which they could work better to deliver NHSP II

d. Appraise effectiveness of and challenges associated with multi-sectoral collaboration (both at national and sub-national levels) to deliver public health objectives, with particular reference to environmental health, food security and nutrition, HIV and AIDS, local health governance, and training of human resources for health

e. Assess capacity of MoHP to implement NHSP II taking into account any ongoing work

f. Assess JFA signatories' performance in adhering to JFA provisions, including effectiveness of financial modalities of each JFA signatory to the health budget

g. Assess the effectiveness of different aid / partnership instruments (e.g. Paris Principles, Accra Agenda, Busan, IHP+, JFA, draft JTAA etc.) within the SWAp framework and asses the extent to which EDPs, MoHP and other signatories/major parties adhere to the principles and spirit of these instruments.

h. Assess contribution of Public Private[56] Partnerships (PPP) in achieving NHSP II outputs, including reviewing progress, challenges and constraints

3. Improved health governance and financial management

a. Quantitatively assess the progress on this output against the M&E Framework indicators

b. Review progress in implementing the Govenance and Accountability Action Plan (GAAP) – including the financial management aspects of the Plan

c. Assess progress towards setting up systems and structures necessary for implementing the NHSP II, including government's regulatory capacity of private service providers

d. Review financial management systems at central (including early review of Financial Management Improvement Plan), regional, district and hospital levels. At sub-district level assess the need for financial management by examining the pattern on revenue and expenditure

e. Assess the planning capacity and practices (focusing on improving efficiency and effectiveness of the existing procedures) for delivering health services at central (especially DoHS and its divisions), regional and district levels and horizontal and vertical inter-linkages

f. Appraise the effectiveness of Health Facility Management Committees in improving facility level health governance and quality of service , taking into account the contribution of piloted initiatives like Local Health Governance Strengthening Programme

g. Appraise the readiness of the health system administration (including implications on financing, organization and management of health services, rols and responsibilities of different tiers of health governance) in adapting to the forthcoming state restructuring process

h. Assess the progress on addressing Office of the Auditor's General (OAG) recommendations

4. Reduced cultural and economic barriers to accessing healthcare services

a. Quantitatively assess the progress on this output against the M&E Framework indicators

b. Asess the mainstreaming of Gender Equality and Social Inclusion (GESI) in health sector policies, major strategies, plans and budget including institutional mechanisms

c. Assess the progress made, especially at the sub-national/facility level, on mitigating cultural and economic barriers to accessing healthcare services including through community-driven approaches, and to ensure equitable delivery of EHCS, for marginalised, disadvantaged and focused groups like adolescents

[56] NHSP II defines 'Private Sector' as for-profit and not-for-profit non state actors

d. Briefly review the NHSP II indicators and existing data sources (household surveys, Service Tracking Survey, Demographic and Health Survey, Nepal Living Standard Survey, routine health information systems like HMIS, Adolescent survey, etc.) to assess the scope of capturing and reporting disaggregated data by gender, ethnicity, and socio-economic status

5. Strengthened human resources for health

a. Quantitatively assess the progress on this output against the M&E Framework indicators

b. Appraise policy/strategic gaps in HRM (including brief review of existing HR strategies/plans) especially with reference to overcoming inequitable distribution of HR

c. Review the institutional and administrative arrangements for Human Resource Management (including Human Resource Information System) focusing on ensuring availability of sufficient numbers and the right mix of health work force

d. Appraise the effectiveness of training institutions and mechanisms, taking into account the recently completed capacity assessment of NHTC, in line with health sector requirements

e. Review the contribution of non-formal health work force, including Female Community Health Volunteer (FCHV), approach in achieving NHSP II outputs and towards long-term public health outcomes

f. Assess the progress and key challenges on short-term local contracting and their effect on continuity of service delivery

6. Increased health knowledge and awareness

a. Quantitatively assess the progress on this output against the M&E Framework indicators

b. Assess whether Behaviour Change Communication (BCC)/Information Education Communication (IEC) is being implemented well and having an impact on service utilisation and health behaviours especially amongst poor and marginalized people and if not, what structural factors are inhibiting it

c. Appraise the extent to which BCC/IEC interventions are focused on increasing awareness on health rights and entitlements and promoting equitable health outcomes

d. Review the focus and intensity of BCC/IEC interventions on encouraging healthier lifestyles to prevent non communicable diseases (NCDs)

7. Improved M&E and health information systems

a. Quantitatively assess the progress on this output against the M&E Framework indicators

b. Assess the appropriateness of current institutional setup to govern M&E and information management in the health sector including linkages between planning, M&E, and information management functions

c. Assess different review mechanisms in the health sector (e.g. Annual Review, Joint Annual Review), scrutinizing their efficacy and format, with an aim to better streamline the review processes

d. Review the mechanisms/protocols that are currently in place for ensuring the quality of data and give an assessment of data quality levels

e. Review the use of data produced by different health information systems (HMIS, LMIS, HuRIC, etc.) for decision making and for improving the overall performance of the health system – both at national and sub national levels. At sub-national level also look at the capacity for utilizing data

f. Briefly Review the functional linkages between different information sytems

8. Improved physical assets and logistics management (including drugs, medical equipment and supplies)

a. Quantitatively assess the progress on this output against the M&E Framework indicators

b. Review the appropriateness of existing standards for medical equipment by level of facility, the efficiency of procurement procedures and of the maintenance of equipment including reviewing the effectiveness of current service arrangements

c. Review progress in forecasting (including validaty of quantification methods used), procurement and distribution and supply of medicines and commodities (including integration of supply chains)

d. Assess the current physical infrastructure investement in effectively delivering EHCS, including the number and distribution of health facilities

e. Appraise any guidelines related to infrastructure development (including those pertaining to maintenance) and assess to which extent these are being adhered to

f. Review the progress in the implementation of physical works and planning processes, including rational budgeting, timely completion of infrastructure projects, and promoting community ownership

g. Briefly review the degree of integration of physical-works planning with planning of other inputs needed to implement health services such as water and electricity supply and other basic requirements such as waiting rooms, toilets etc

h. Review implementation of procurement improvement steps and progress on procurement and logistics objectives within the GAAP

i. Review current structure of procurement entitities in health sector and explore possibilities that could improve the availability of essential medicines in health facilities, value for money and timeliness and address the risk of corruption

j. Review the progress in implementing Logistics Management Information System (LMIS) and recommend how it can be further leveraged to improve the overall logistics function

9. Improved sustainable health financing

a. Quantitatively assess the progress on this output against the M&E Framework indicators

b. Assess the clarity of national health financing objectives and strategy to achieve those objectives. Assess sustainability, equity and efficiency (including in pooling risk) of current and proposed health financing

c. Review initial finance scenarios of NHSP II including costs and resources available, in the light of current disease burden, type and volume of intervention and macro economy

d. Project costs and resources available from all sources for the remaining phase of NHSP II and recommend strategies to close the gap

e. Critically assess the effectiveness and efficiency of the existing centralized budget allocation process and the authority (or lack of) of Health Facility Management Commities over matters concering the finances

f. Assess whether financing patterns correspond with delivery of EHCS package

Structure of the Review

The MTR of NHSP II is the responsibility of MoHP with support from all partners supporting the NHSP II implementation. It should be seen as an integral part of the health sector SWAp process. The overall responsibility of the process will lie jointly with the Secretary for Health and the chair of the EDP group.
MoHP's Policy Planning and International Cooperation Division (PPICD) shall coordinate the MTR process supported by the technical working group on NHSP II MTR[57], who will report to the PPICD Chief and the chair of

[57] The working group was formed by MoHP in June 2012 with members comprising from both the GoN and EDPs

the EDP group. The review shall be carried out by external consultants, supported by relevant GoN personnel and EDPs as needed.
The final MTR Report will be presented for discussion at the 2013 Joint Annual Review.

Proposed Methodology for the Review

The MTR consultants' team will:

1. Review appropriate documents & reports (including, but not limited to, ones listed in Annex 4)
2. Consult all major stakeholders at different levels of the health sector including the following:
   - Head of Departments, Units within the MoHP and other relevant GoN Ministries, and Health Professionals Regulatory bodies
   - Other NHSP II partners including EDPs, civil society organization, academia, and other relevantnon-state actors
   - Chairpersons of relevant steering committees and Technical Working Groups; attend ongoing/ specially convened TWG meetings
3. Visit selected Zonal Hospitals, District Health Offices, and a sample of health facilities as necessary; also interact with local communtities
4. Attend selected Regional Health Reviews and the National Health Reviews (takes place in September/October
5. Operate focus groups as necessary

Deliverables

1. An inception report with plan of action (within 15 days of contract).
2. The main output of the review shall be:
   a. an executive summary of not more than 10 pages;
   b. a main report with evidence-based recommendations not more than 50 pages (excluding annexes).
3. PowerPoint Presentation on the Key findings and recommendations of the MTR to be presented by MoHP in the 2013 JAR

The Team Leader shall submit the draft report to the PPICD Chief and the MTR TWG by 15th December 2012 and a final report within two weeks after the 2013 JAR.

Team Composition

A core team of consultants with both Nepali and international credentials will be required with the following capacity (these are not necessarily separate individuals).

1. Team Leader – expert in Public Health Policy, Health governance and Planning, and SWAps with experience of conducting MTRs of health sector strategies
2. Public health specialists (particularly EHCS, MDG 4, 5 and 6, Emergency health)
3. HR / institutional development expert

4. Physical assests and logistics management specialist
5. Procurement Management specialist
6. Financial management specialist
7. Health economist / health financing expert
8. M&E expert with experience on health information management
9. GESI, community involvement and empowerment expert

Reporting

It is expected that all experts will be accountable to the Team Leader who will ultimately be accountable to the MoHP for delivery of the review. The Team Leader will take overall responsibility for the fulfilment of the Terms of Reference by the MTR Consultants. All team members will report to the Team Leader. The Team Leader will ensure that specific tasks of all other team members are clarified and that team members perform their expected roles in accordance with the ToRs. The Team Leader will propose the layout of the MTR final report, propose a programme of work to accomplish the task (inception report and plan of action), and will produce the MTR final report in accordance with the TOR. The Team Leader will ensure that all the Consultants work as a team and interface with each other to produce the consolidated draft report by 15th December 2012.
Team Leader is expected to be in the country at least twice during the assignment – once for observation, interviews, field visit, data collection and the other during JAR in the last week of January 2013. One of the Nepali consultant in the team will be designated Deputy Team Leader for the assignment, with a responsibility to maintain regular (day to day) liaison with the PPICD and the MTR TWG throughout the assignment (particularly when the Team Leader is not in country).

Duration of the assignment

The review team will be expected to carry out the review between September and December 2012, and have a draft report ready for presentation by the Team Leader to the MTR TWG by 15th December 2012. Team Leader and the Deputy Team Leader will have to be present during the 2013 JAR and may have to make final revisions to the MTR report within two weeks of the completion of the JAR.

Annex 3 - People Met

No.	Meeting with	Designation	Organisation
1	Mr. Basanta Thapa	MNCH Specialist	NHSSP, RHD Eastern Region
2	Mr. Bhanu Yanden	District Health Officer	DHO, Dhankuta
3	Mr. Ghana Shyam Pokharel		DHO, Illam
4	Ms Bimba Bhattarai	GESI Specialist	NHSSP, RHD Eastern Region
5	Mr. Kusmakar Dhakal	Under Secretary	Population Division, MoHP
6	Ms Januka Subedi	Section Officer	Population Division, MoHP
7	Dr. Ananda Shrestha	Director	PHC RD, DoHS
8	Mr. Rupnarayan Khatiwada	Section Officer	PHC RD, DoHS
9	Mr. Kabiraj Khanal	Under Secretary	Policy, Planning & International Cooperation Division (PPICD), MoHP
10	Mr. David Hepburn & Dr. Astrid Thygesen	Sr. Procurement Advisors	NHSSP
11	Dr. Suresh Tiwari	Sr. Health Consultant	NHSSP
12	Dr. Sushil Baral, Exe. Director, HERD	Executive Director	Health Research & Social Development Forum (HERD)
13	Mr. Ajit Pradhan	M&E Advisor	NHSSP
14	Mr. Ramchandra Khanal	Sr. Public Health Administrator	MoHP
15	Mr. Sunil Khadka	Maintenance & Infrastructure Advisor	NHSSP
16	Dr. Baburam Marasini, Chief, HeSRU	Chief	Health Sector Reform Unit, MoHP
17	External Development Partners		
18	Mr. Surya Prasad Acharya	Joint Secretary	HR&FM Division, MoHP
19	Mr. Shiva Pd. Simkhada, Under Secretary, Finance Section	Under Secretary	Finance Section, MoHP
20	Dr. Naresh Pratap KC	Director	Logistics Management Division (LMD)
21	Mr. Suresh Mehata	Research Associate	NHSSP
22	Dr. Amit Bhandari	Health Advisor	DFID
23	Mr. Hom Nath Subedi, Ms Chhaya Jha and Mr. Sitaram Prasai	GESI Team	NHSSP
24	Mr. Sudip Pokharel	WHO Consultant	
25	Ms Franziska Fuerst, Team Leader	Team Leader	GIZ
26	Mr. Heem Shakya, Director, USAID JSI-Deliver	Director	USAID JSI-Deliver
27	Mr Ramesh Prasad Singh	Dpty. Director	Department of Urban Development & Building Construction (DUDBC)
28	Dr. Mahendra Subba	Director General	DUDBC

29	Mr. Prem Adhikari & Mr. Sarad Raj Shrestha	Programe Officers	LMIS, LMD (USAID Deliver Project)
30	Mr. Netra Bhatt	Coordinator	Association of International NGOs (AIN)
31	Mr. Tek Bahadur Khatri	Under Secretary	Ministry of Finance
32	Dr. Arun Malik	Technical Officer	Emergency Preparedness, WHO
33	Mr. Ramchandra Man Singh	Health System & Governance Advisor	NHSSP
34	Dr. Nancy Gerein	International Lead	NHSSP
35	Dr. Manav Bhattarai, Health Specialist, World Bank	Health Specialist	
36	Mr. Padam Raj Bhatta, Under Secy, Min of Women	Under Secretary	Ministry of Women, Children & Social Welfare (Former Population Div. Chief at MoHP)
37	Ms. Natasha Mesko	Health Advisor	DFID
38	Dr. B K Subedi (immediate past PPICD Chief)		
39	Dr. Bhola Rizal	President	Association of Private Hospitals & Nursing Homes
40	Mr. Susheel Lekhak	WHO Consultant facilitating the development of M&E Framework	
41	Mr. Dinesh Kumar Chapagain	Sr. Public Health Administrator	Management Division, DoHS
42	Dr. George Ionita	Project Manager	GFATM Rd 7 HIV and DFID HIV/AIDS Programme Management Unit – UNDP NEPAL
43	Mr. Paban Ghimire	HMIS Chief	Management Division, DoHS
44	Dr. Praveen Mishra	Secretary	MoHP
45	Dr. Laxmi Raj Pathak, Health Policy & Planning, NHSSP	Health Policy and Planning Advisor	NHSSP
46	Dr. Lin Aung	WHO Representative to Nepal	WHO
47	Mr. Deepak Paudel	Program Specialist	USAID
48	Ms Sudha Pant	Gender Advisor	UNFPA
49	Mr. Todd Pertersen, Managing Director, Options	Managing Director	Options UK
50	Dr. Saroj Prasad Rajendra	Director	Management Divison, DoHS
51	Mr Mohan Thapa	Accounts Officer	Finance Section, MoHP
52	Mr Leela Paudel	PHA Section Officer	MoHP
53	Mr. Sabin Sharm	Computer Programmer	Health Sector HR Information Center (HuRIC) MoHP
54	Mr. Khagendra Rizal	Section Chief	HuRIC
55	Mr. Pradeep Paudel	M&E Implementation Advisor	NHSSP

56	Mr. Rabin Regmi	Consultant	LMIS, LMD
57	Dr. Maureen Dar Iang	Essential Health Care Services (EHCS) Advisor	NHSSP
58	Mr. Atma Ram Paudel	Joint Secretary	National Planning Commission
59	Ms. Latika Maskey	Programme Manager	AusAID
60	Dr. Padam Bahadur Chand	Chief	PPICD, MoHP
61	Dr. Basu Dev Pandey		DHO, Ramechhap
62	Mr Sachitanand Deo	Public Health Administrator	Rautahat
63	Mr Janardan Neupane		DHO Kavre
64	Ms Sushila Pandey	GESI Specialist	NHSSP, RHD Central Region
65	Mr. Sharad Shrestha	Programme Officer	USAID Deliver Project
66	Mr. Shree Krishna Bhatt	Chief Public Health Administrator	MoHP
67	Mr. Janardan R. Lamichhan		NFHP II
68	Mr. Bigyan Pradhan	Senior Financial Management Specialist	World Bank
69	Shambhu Pd Uprety	Procurement Specialist	World Bank
70	Mr. Matt Gordon	Service Delivery Team Leader	DFID Nepal
71	Mr. Ramu Sharma	Director	National Health Training Center (NHTC), MoHP
72	Mr. Shiva Pd Pandit	Public Financial Management Advisor	NHSSP
73	Mr. Han Kang	Dpty Director for Health & FP	USAID
74	Ms Jessica Healey USAID	Consultant	Health4Life, USAID
75	Mr. Durga Khatiwada	PO, Gender Responsive Budget	UNWomen
76	Ms Srijana Shrestha	Public Health Administrator	Management Division
77	Dr. Yesho Vardan Pradhan		Immediate Past Director, DoHS
78	Dr. Frank Paulin	Public Health Administrator	WHO Nepal
79	Mr. Satya Raj Acharya	Under Secretary	Health Economics and Finance Unit, MoHP
80	Mr. Gagan Gurung	Sr. Programme Coordinator	Save the Children
81	Mr. Baburam Gautam	Under Secretary	Population Division, MoHP
82	Mr. Tekabe Belay	Sr. Health Economist	World Bank
83	Mr. Krishna Kumar Rai	Director	National Centre for AIDs and STD Control (NCASC) DoHS
84	Mr. Shanker Raj Pandey	Local Expert	KfW
85	Mr. Badri Bahadur Khatri	Director	National Health Education Information, Communication Centre (NHEICC), DoHS

86	Mr. Dhurba Pd. Dahal	Joint Secretary	MoHP
87	Mr. Pushpa Raj Katuwal	Under Secretary	HuRIC, MoHP
88	Dr. Radha Raman Prasad	Director General	Department of Drug Administration
89	Dr. Ram Narayan Shah	Director General	Department of Ayurveda
90	Mr. Nathu Prasad Chaudhari	Secretary	Public Service Commission
91	NHSSP HRH Strategic Plan Working Group (Krishna Sharma, Dr. Maureen Dariang, Dr. Ganga Shakya, Hom Nath Subedi, Bal Govinda Bista, Kamal Bikram Khadka)		
92	Dr. Taranath Pokharel	Director	Child Health Division, DoHS
93	Dr. Shilu Aryal	Sr. Consultant, gynaecologist obgyn	Family Health Division, DoHS
94	Dr. Markus Behrend	Programme Manager	GIZ
95	Department of Record, MoGA (PIS)		
96	Dr. Senendra Upreti	Director	Family Health Division, DoHS
97	Dr. Susanne Grimm	Deputy Programme Manager	GIZ
98	Technical Working Group Meeting, National Health Training Centre		
99	Dr. Mark Zimmerman	Executive Director	Nick Simons Institute (NSI)
100	Mr. Chandraman Shrestha	Joint Secretary	Personnel Administration, MoHP
101	Prof.Dr. Shiva Rai	Member	National Planning Commission
102	Mr. Gyanendra Poudel	Chief Financial Controller	DoHS
103	Mr. Ghan Shyam Gautam		GIZ, HSSP
104	Dr. Hendrikus Raaijmakers	Chief of Health	UNICEF
105	Dr. Saba Mebrahtu	Chief	Nutrition Section, UNICEF
106	Dr. Kishori Mahat	Health Specialist	UNICEF

Annex 4 - Summary of legal and policy framework

Political - Framework Conditions

- For over last 239 years, Nepal was an independent state under a royal family regime.
- In 1990 Nepal became a parliamentary democracy with a constitutional monarchy.
- The Communist Party of Nepal - CPN (Maoist) waged a "people's war" from 1996 to 2006. From 2001 onwards the armed conflict intensified, with peace negotiations failing twice, once in 2001 and again in 2003.
- In 2005, the then King took absolute power in his hands.
- In April 2006, seven main political parties and the CPN (Maoist) agreed to launch a "people's movement", in which civil society was at the forefront.
- The peace process started in June 2006, with the signing of the eight-point agreement between the Seven Party Alliance (SPA) and the Communist Party of Nepal (CPN) Maoist.
- The comprehensive peace agreement, concluded between the GON and the CPN (Maoist) in November 2006 guaranteed a political system based on universally accepted fundamental human rights, a competitive multiparty democratic system, constitutional checks and balances, independent judiciary, periodic elections, monitoring by civil society, press freedom, people's right to information, transparency and accountability in the activities of political parties, peoples' participation and the concepts of impartial, competent, and fair administration.
- The Interim Constitution of Nepal (2007) reflects the commitments made by the SPA and the CPN (Maoist) and sets the future direction for the social, political and economic transformation of Nepal. The Interim Constitution also proposes the future restructuring of the state to promote and institutionalise an inclusive, democratic and progressive local governance system, maximising people's participation based on decentralisation, devolution of power and the equitable distribution of resources to local bodies.
- In April 2008, Constituent Assembly (CA) elections took place, with the CPN (Maoists) emerging as a single largest party.
- In May 28, 2008 CA declared Nepal a democratic federal republic; abolished the monarchy and formed a coalition government under the CPN (Maoist).
- The Prime Minister CPN (Maoist) resigned in April 2009 and a coalition government under the CPN UML has been formed.
- The CPN UML resigned in 2011 and the current CPN (Maoist) led government has been formed in Aug 2011.
- With the CA's term expired on May 27, 2012 and further extensions barred by a Supreme Court ruling, the most contentious issues of federalism such as the number of states, their boundaries and—emotionally charged—their names have not been sorted out.
- The process of constitution-making, which began in 2008, had produced important agreements on almost all aspects of a new constitution except State restructuring (federalism).

Federalism and Health

Interim Constitution 2007 –

1. Decentralisation and Federalism

- The 2007 Interim Constitution specifies that decentralization will be the cornerstone of national development. It also says that a conducive environment will be created to promote people's participation at the grassroots level. The enabling legislation is in place with the Local Body (Financial Administration) Regulations, 2007, and the Governance (Management and Operation) Act, 2008, which focuses on good governance principles and norms (including fiscal discipline), aligns civic rights to good governance, and delineates the functions and responsibilities of officials at different levels of government.

2. Fundamental Rights

Rights to Equality: The State shall not discriminate against any citizen in the application of general laws on grounds of religion, colour, caste, tribe, gender, sexual orientation, biological condition, disability, health condition, marital

condition, pregnancy, economic condition, origin, language or region, ideological conviction or other similar grounds. (...)

Rights Regarding Health:

- Every citizen shall have the right to free basic health services and no person shall be deprived of emergency health services.
- Every person shall have the right to reproductive health.
- Every person shall have the right to informed health services.
- Every citizen shall have the right to equal access to health services.
- Every citizen shall have the right to an access to clean (pure) drinking water and sanitation (cleanliness).

3. Policies Regarding Basic Needs of Citizen
   - To expand the opportunities and standard of education, health, accommodation, food and employment in order to enhance the living standard of general people.
   - To increase necessary investment of the State in the field of public health in order to keep the citizens healthy.
   - To ascertain easy, simple and equal access of all to quality health services while keeping in mind the basic health as a human right.
   - To discourage commercialization of health sector by regulating and managing the private investment in this sector while enhancing the state investment in this field.
   - To increase the number of health institutions and health workers while stressing on health research in order to make health services accessible to all and qualitative.
4. MoHP's perspectives in managing transition
   - Ensuring that health services will not be interrupted during the transitional phase
   - Preparation of transitional plan: 5 years, integrated with Nepal Health Sector Programme II – Implementation Plan (2010-2015)
   - All health services related to fundamental health rights need to made available at possible lowest level to ensure easy access and coverage
   - Address gaps occurred during the transition and use this gap as an opportunity to improve the health system
   - MoHP has institutional network up to the community level and it has good linkages with the community groups through FCHVs, such experiences and learning will be scaled up
   - MoHP is initiating restructuring process, reviewing related policies together with delineation of functions to be carried out at different level of governance
   - Communities are taking initiatives to establish hospitals at community level which needs to be facilitated by the policy framework

Federal	Provincial	Local
National/Advance health services	Current regional and zonal hospital	Current district hospital, PHC, HP and SHP services
Communicable disease control	Communicable disease control	
	Approval and regulation of medical colleges and private hospital	
	Human resource production and management	

Source: Report, Interaction Programme on 'Federalism and Health' February 01, 2010, Ministry of Health and Population

Annex 5 - Note on Methodology

The methodology of the MTR was outlined in the Inception Report:
Organisation and Management:

The MTR Team included nine specialists from a wide range of technical and management disciplines sourced nationally and internationally (see team composition and disciplines below). The Team was managed by the Team Leader and the Deputy Team Leader against a detailed workplan and scope of work for each individual team member. Regular team meetings were held during the course of the review and close relations maintained with the Ministry of Health and Population (MoHP) and External Development Partners (EDPs). Support was provided through an MTR Secretariat. The main point of contact for the MTR team was with the MTR-TWG.

The MTR Team ensured full engagement and coordination with the MoHP's Population Planning and International Cooperation Division (PPICD) and the NHSP II MTR TWG. Broad based consultations with all stakeholders in the sector were emphasised for collecting opinions from different client groups including those from more vulnerable or disadvantaged situations. Consultations were held with Civil Society organisations. A series of Focus Group Discussions were held.

Quantitative and qualitative assessment of progress
The MTR reviewed progress against the three main NHSP II objectives as stated in the NHSP-IP II (2010-2015) and the MTR Terms of reference.

Progress against M&E Framework:
The review WAS organised to address progress in all strategic priority areas of the NHSP-II as articulated in the nine outputs of the M&E Framework. This looked at quantitative and qualitative data sources. Monitoring against the M&E Framework was the key quantitative assessment at output levels using the specified indicators, targets, and data sources.

The Review also assessed progress against outcome indicators for the three specific objectives as outlined in the M&E and Results Frameworks and again assessed against the stated milestones for 2013 while recognising that some of the 2012 data for indicators was available only in early December.

Quantitative analysis was dependent on data from a range of sources including NDHS, HMIS, STS and several other important annual surveys as well as other more specific sources of data available.

The TOR highlighted the importance of quantitative and qualitative assessment of progress and this was a priority focus for the MTR Team. All available sources of data were requested from the MoHP and Partners to provide the best possible data sets. This included HMIS, surveys and other research undertaken of relevance to the review. The Team reviewed data sets, assessed quality of data and its analysis and use and undertook additional analysis as useful and feasible.
The Review team also reviewed as appropriate progress against the key objectives as set out in the 7 areas of the GAAP.

Where data was found to be inadequate the team sought alternate sources of information or verification. While some limited primary data collection was undertaken this was more through interview of key informants, focus group work where appropriate and observation through field visits. The use of field visits was seen as an important means of verification of the data provided through routine and survey based data collections. The review team looked for on the ground evidence of progress reported through data.

Other key focus areas for the review

The MTR concentrated on:

- Identification of resource and capacity needs and constraints;
- Assessed the contribution of technical assistance;
- Identifying, prioritizing and proposing relevant and evidence-based programme and system interventions to accelerate progress.

These key areas of the review process were undertaken across all the output areas of the NHSP II and were part of the individual terms of reference for each of the team members. These important issues were assessed through critical appraisal of progress reports, interviews with key stakeholders and service providers and reference to the national and international literature on experiences and best practice.

Each team member acted as a lead expert in at least one of the nine output areas and was in a position to contribute to discussions at the outcome level and on specific issues identified as important. As an example all the team looked at how technical assistance has been provided, its effectiveness and value added and the extent to which technical assistance has been harmonised and aligned behind the NHSP II.

Review Analytical Framework

The analytical framework used for the review was based on the nine output areas and key questions in the MTR Terms of Reference.

The framework used included:

- Identifying progress against higher level indicators of progress and team members were asked to contribute to analysing those data related to their technical area.
- Key indicators linked to each output area were assessed as well as indicators in other relevant strategies and plans.
- An analysis of progress, relevance and comprehensiveness of intervention activities under each output as stated in the logical framework were also assessed.
- Recommendations relating to indicators and targets within the logical framework and M&E Framework.

Team Composition

Name	Responsibility
Mr David Daniels	Team Leader – Improved Sector Management and Partnership; Improved M&E and health information systems (HRH Working Group)
Mr Kapil Ghimire	Deputy Team Leader – Sector Management and Partnership; Improved health governance and financial management (Procurement WG)
Mr Deb Raj Pathak	Improved Health Governance and Financial Management (Procurement WG)
Mr Marc Reveillon	Improved sustainable health financing; (Improved health governance and financial management)
Dr Narmeen Hamid	Improved service delivery; (Increased health knowledge and awareness); (HRH WG)
Dr Kedar Baral	Improved service delivery (HRH WG)
Dr Poonam Thapa	Reduced cultural and economic barriers to accessing healthcare services; (Increased health knowledge and awareness)
Mr Kevin Brown	Strengthened human resources for health

Clea Knight (+ support from Mr Sanjaya Thapa)	Improved M&E and health information systems
Mr Jurgen Hulst	Improved physical assets and logistic management (including drugs, medical equipment and supplies); (procurement WG)
Mr Mike Naylor	Quality Assurer

MTR Secretariat: Mr Sanjaya Thapa (WHO); Ms Bhavana Shakya (USAID), Ms Bhuvanari Jha. (NHSSP)

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