Nepal Health Sector Programme - 2
Joint Annual Review (JAR) 2012

Government of Nepal
Ministry of Health and Population

Report of the
Joint Annual Review Meeting 2012

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The Joint Annual Review meeting was co-hosted by
The Nepal Health Sector Support Programme (NHSSP)
and
The World Health Organisation (WHO)

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Acknowledgement

Government of Nepal adopted a Sector Wide Approach in the health sector, coordinating the efforts of the Government and External Development Partners (EDPs) in support of effective implementation of Nepal Health Sector Programme (NHSP) towards achieving the health related Millennium Development Goals. Joint Annual Review (JAR) meetings are an important annual event of the Ministry of Health and Population (MoHP), organised with an aim to review the progress against the indicators set in the health sector programme, the challenges and major areas to be improved; and to set priorities for the next year. Besides these, the JAR also discusses issues related to governance, coordination, policies and other important issues. The JAR is led by the MoHP and widely participated by MoHP officials; Department of Health Services (DoHS) and its Divisions and Centres; Ministry of Finance; National Planning Commission; EDPs and international delegates; Civil Society; I/NGOs and Academia.

This is the second JAR of NHSP-2. According to the delegates, who have attended the JAR every year since FY 2004-05 have observed a remarkable improvement in the quality of JAR – its processes, presentations, interactions and actions taken. This became possible due to efforts of all stakeholders engaged in the health sector and consistently builds on lessons learnt, consultations and experience in organizing the consecutive JARs.

Making this JAR a success was only possible due to greater engagement and support from various partners/stakeholders – EDPs, I/NGOs, Civil Society and DoHS and its Divisions. In particular, the MoHP likes to thank Nepal Health Sector Support Programme (NHSSP) and World Health Organization (WHO) for their support provided in organizing the JAR. The MoHP is also thankful to all participants and the facilitator of the JAR.

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ACRONYMS

AIN	Association of International NGOs
AM	Aide-Memoire
ASRH	Adolescent Sexual and Reproductive Health
AWPB	Annual Work Plan and Budget
BEOC	Basic Emergency Obstetric Care
CB-IMCI	Community Based Integrated Management of Childhood Illness
CB-NCP	Community Based New-born Care Programme
CCF	Country Coordination Forum
CEONC	Comprehensive Emergency and Neonatal Care
CPR	Contraceptive Prevalence Rate
CSOs	Community Service Organisations
DFID	Department for International Development
DG	Director General
DoHS	Department of Health Services
DUDBC	Department of Urban Development and Building Construction
EAP	Equity and Access Programme
EDP	External Development Partner
EHCS	Essential Health Care Services
EOC	Emergency Obstetric Care
FAP	Foreign Aid Policy
FMIP	Financial Management Improvement Plan
FMR	Financial Monitoring Report
GAAP	Governance and Accountability Action Plan
GAVI	Global Alliance for Vaccine and Immunisation
GBV	Gender Based Violence
GESI	Gender Equality and Social Inclusion
GoN	Government of Nepal
HMIS	Health Management Information System
HR	Human Resources
HRH	Human Resources for Health
HSD	Health System Delivery
HSS	Health System Strengthening
IEC	Information Education and Communication
IHP	International Health Partnership
IYCF	Infant and Young Child Feeding
JAR	Joint Annual Review
JCM	Joint Consultative Meeting
JE	Japanese Encephalitis
JFA	Joint Financing Agreement
LMD	Logistics Management Division
LMIS	Logistics Management Information System
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MDGP	Medical Doctor General Practice
MoF	Ministry of Finance
MoHP	Ministry of Health and Population
NCD	Non-communicable Disease
NDHS	Nepal Demographic Health Survey
NHA	National Health Account
NHRC	Nepal Health Research Council
NHSP	Nepal Health Sector Programme

NPC	National Planning Commission
NPPR	Nepal Portfolio Performance Review
NSI	Nick Simons Institute
OPE	Out-of Pocket Expenditure
PHC-RD	Primary Health Care Revitalisation Division
PMTCT	Prevention of Mother to Child Transmission
PPICD	Policy Planning and International Cooperation Division
PPP	Public Private Partnership
RHCT	Regional Health Coordination Team
RHD	Regional Health Directorate
SBA	Skilled Birth Attendants
SOI	Statement of Intent
STS	Services Tracking Survey
SWAp	Sector Wide Approach
TABUCS	Transactional Accounting and Budget Control System
TA/TC	Technical Assistance/Technical Cooperation
TFR	Total Fertility Rate
THE	Total Health Expenditure
WASH	Water and Sanitation Hygiene
WB	The World Bank
WHO	World Health Organization

1. BACKGROUND

In 2004, the Government of Nepal (GoN) introduced its "Health Sector Strategy: An Agenda for Reform" and the first "Nepal Health Sector Programme (NHSP-1) 2004 -2009". The Government adopted a Sector Wide Approach (SWAp) in the health sector, coordinating the efforts of the Government and External Development Partners (EDPs) in support of effective implementation of NHSP-1 towards achieving the health related Millennium Development Goals (MDGs). The successful implementation of NHSP-1 led to the development of NHSP-2 (2010-2015), which has its goal improving the health and nutritional status of the Nepali population, especially the poor and excluded. The following three key objectives are set out in the Results Framework:

- to increase access to and utilisation of quality essential health care services;
- to reduce cultural and economic barriers to accessing health care services and harmful cultural practices in partnership with non-state actors;
- to improve the health system to achieve universal coverage of essential health services.

Joint Annual Reviews (JARs) participated in by the Ministry of Health and Population (MoHP), the Department of Health Services (DoHS) and their divisions and centres, EDPs, Civil Society, I/NGOs and academia, have been a platform to review the progress against the indicators set in the health sector programme, the challenges and major areas to be improved; and to set priorities for the next year. During the period of NHSP-1 the JAR was organised bi-annually, and during NHSP-2 it is organised annually. This is the second JAR of NHSP-2.

2. JAR OBJECTIVES

The main objectives of the JAR were:

- to review the overall progress against the indicators in NHSP-2 Results Framework for the last fiscal year,
- to review the progress in the achievement of NHSP-2 including the Governance and Accountability Action Plan (GAAP) and the Gender Equality and Social Inclusion (GESI) Strategy,
- to review the progress against the agreed actions of the last Aide Memoire (AM).

3. EXPECTED OUTPUTS

The JAR meeting was designed to achieve the following outputs and thus help to maximise NHSP-2 performance:

- Review and analyse the overall programme performance of NHSP-2 during the last fiscal year as a basis to plan the priorities for next year.
- Both MoHP and EDPs will discuss the indicators that are lagging behind (gaps) and give special consideration to the gaps in the coming year.
- Agreed priorities for the coming year will be based on the mutual understanding of MoHP and EDPs, which will be reflected in the Aide Memoire.

4. METHODS AND MODALITY

The following methods were adopted in the meeting to ensure active participation of the participants in order to achieve the meeting's objectives.

- *Presentations:* Presentations were made concerning the NHSP-2 Results Framework and the Annual Work Plan and Budget (AWPB) of the last year, including new initiatives.
- *Question and answer sessions:* The presentations made in the JAR were followed by discussions where participants had the opportunity to raise and clarify relevant issues.
- *Panel Discussion:* A panel discussion was conducted on the priority areas that need to be considered in the coming fiscal year. The panel was comprised of the Secretary MoHP, the Director General DoHS, EDP's chair and vice-chair, and representatives of Civil Society and Academia. During the discussion participants from the floor also interacted with the panel members.
- *Moderation:* A moderator was identified to facilitate the meeting and ensure meaningful discussions on areas/issues identified by the participants and the presenters.

The meeting was divided into two types of sessions: *inaugural* and *technical* sessions. Day 1 began with the inaugural event followed by technical sessions, while the second and third days began with the facilitator reviewing the previous day, focusing on major issues and actions discussed and potential opportunities to address the issues.

5. INAUGURAL SESSION

DAY-1: The inaugural session was chaired by Dr. Praveen Mishra, Secretary MoHP, and attended by Honourable Minister for MoHP Mr. Rajendra Mahato as Chief Guest, Honourable Member of the National Planning Commission Prof. Dr. Shiva Kumar Rai, Secretary for the Ministry of Finance (MoF) Mr. Krishna Hari Banskota, Director General for DoHS Dr. Y.V. Pradhan and EDP Chair Dr. Albertus (Bert) Voetberg. The facilitator shared a brief history of JARs in the health SWAp up to the current date followed by inaugural remarks from key personalities.

Inaugural remarks: *Dr. BK Suvedi*, Chief of the Policy Planning and International Cooperation Division (PPICD) of MoHP, welcomed all the participants of the JAR on behalf of MoHP and stated the objectives of the meeting. *Dr. Bert*, EDP chair, reminded all of the successful progress in health outcomes towards meeting the MDG goals. He also noted the lack of progress in some key Health System Strengthening areas and urged a need for better alignment and communication of Technical Assistance/Technical Cooperation (TA/TC) to address gaps in the health system. This should be a joint priority of EDPs and MoHP. In addition, he clarified the need for further advancing the joint funding arrangement mechanism with a clear direction.

Mr. Krishna Hari Baskota, Secretary MoF, acknowledged the progress in the health sector along with the initiation of the SWAp, resulting in an increase in the health budget each year. He expressed MoF commitments to any initiatives taken by the MoHP towards attaining MDG goals. He also urged EDPs to put more resources into national budgets in order to deliver the MDGs. He said he expected the MoHP to work on health system and service strengthening in the following areas: Human Resource (HR) retention, basic health service delivery in rural areas, procurement management, output-based financial management, and general improvement of financial management, and highlighted a need for effective utilisation of allocated resources.

Honourable Minister for MoHP, *Mr. Rajendra Mahato*, acknowledged the progress in the health sector despite difficult circumstances. However, he noted a greater need to focus on health service strengthening in rural areas. He highlighted disparities in health outcomes due to the basic nature of the services in remote areas combined with referral failure, and recommended that basic medical services are needed in rural areas alongside upgrading of district hospitals into specialist hospitals.

Dr. Praveen Mishra, Secretary MoHP, highlighted that the JAR is a platform for evaluating ourselves – both the MoHP and EDPs – our challenges, successes and areas to be improved in the health sector. He reminded the participants that NHSP-1 was successfully implemented with the joint effort of all the partners but strongly urged that *"health is beyond health"*, and requires a comprehensive and coordinated multi-sectoral approach. He noted that the health sector budget has tripled over the years and that notable improvements have been made in the absorption capacity of the MoHP and its divisions. However, further advancement is always needed. He noted key challenges in the health sector: reaching the unreached regardless of where they reside; changes to the disease pattern, care and treatment; tripling of the population; and multi-sectoral coordination. To be able to attain the targets set by NHSP-2 he urged a focus on sustainable health financing, quality of care, the referral system, HR management – deployment and retention, financial management, Public Private Partnership (PPP) for quality and increased access to care, understanding patient satisfaction by undertaking social audits, Monitoring and Evaluation (M&E), scaling up cost-effective interventions, inter-ministerial coordination especially on Water, Sanitation and Hygiene (WASH), pollution and nutrition; increased budget contributions by EDPs matching MoF increases in allocation to the MoHP budget, and multi-

year procurement and contracting. He also said that MoHP would soon prepare a new HR plan and stated that governance and accountability was a major challenge for MoHP, especially financial management.

Honourable Member of the National Planning Commission *Prof. Shiva Kumar Rai* identified poverty as the root cause of all problems, including health. Thus, he pointed to poverty alleviation as the main measure that had to succeed in all fronts. He discussed the challenges and opportunities of working multi-sectorally, especially for reaching the unreached with the best use of limited resources and making the best use of health spending from other ministries' budgets.

Dr. YV Pradhan, Director General, DoHS, encouraged looking at the performance of the health sector before and after the SWAp to assess how much MoHP capacity has been developed by the TA programmes (citing procurement and disease surveillance as examples where capacity development did not seem to be working).

All speakers commented upon the success in health outcomes and the progress made towards meeting the MDG goals, with acknowledgement of the SWAp in health. All renewed their commitment to universal access to Essential Health Care Services (EHCS), reaching the unreached, good governance, and keeping health a national priority.

6. TECHNICAL SESSIONS

6.1 PROGRESS AGAINST NHSP-2 RESULTS FRAMEWORK

Dr. BK Suvedi, Chief, PPICD, MoHP presented the progress update on the NHSP-2 Results Framework, as shown in Table 1.

Table 1: Summary of progress update – 2011

S.No	Indicators	Target 2011	Ach. 2011	Performance lights*	Source
1	TFR	3	2.6	0.4	NDHS 2011
2	CPR	48	43.2	4.8	NDHS 2011
3	Under 5 Mortality Rate	55	54	1	NDHS 2011
4	Infant Mortality Rate	44	46	2	NDHS 2011
5	Neonatal Mortality Rate	30	33	3	NDHS 2011
6	% of Underweight children	34%	28.80%	0.052	NDHS 2011
7	TB- Case detection rate	75%	76.30%	1.3%	HMIS, DoHS
8	TB- Cure rate	89%	90%	1%	
9	Annual parasitic incidence per 1000 population	0.15	0.15	0	EDCD, DoHS
10	% of children who received all basic vaccines	85%	86.60%	2%	NDHS 2011
11	% of births assisted by SBAs	18.70%	36%	17%	NDHS 2011
12	% of births in health facilities	27%	28.10%	1.1%	NDHS 2011
13	Met need for EOC	31%	42.20%	11%	FHD
14	Met need for C-section	2.50%	2.30%	0.002	FHD
15	Comprehensive knowledge of HIV/AIDS	24%	71%	47%	NDHS 2011
16	% of children with ARI receiving antibiotics	30%	41%	11%	HMIS, DoHS
17	% of children with diarrhoea treated with Zinc	7%	6.20%	0.8%	NDHS 2011
18	One stop crisis centre piloting (#)	3	5	2	MoHP (admin)
19	% of PHCC providing BEOC signal functions	23%	21%	2%	MoHP, STS, 2011
20	% of HP providing selected FP and 24/7 delivery services	45%	11%	34%	MoHP, STS, 2011
21	% of sanctioned Doctors' and Nurses' positions filled	85%	61.30%	24%	MoHP, STS, 2011
22	HP per 5,000 population	1	0.13	0.87	HMIS & CBS
23	PHCC per 50,000 population	1	0.39	0.61	HMIS & CBS
24	Health facilities with no stock-outs of essential drugs in the last year	70%	15%	55%	MoHP, STS, 2011
25	Number of FCHVs	50,000	52,161	2161	FHD
26	% of GAAP actions implemented	90%	75%	15%	HSRU, MoHP
27	Number of SBAs trained	1134	909	225	NHTC, MoHP
28	Use of community based emergency funds	All: 19%	All: 2.8%	16.20%	MoHP, STS 2011

***Performance light index**

Achieved	13 indicators
Not achieved	15 indicators

Indicators: achieved

1. Total Fertility Rate
2. Under-five Mortality Rate
3. % of children under five years of age who are underweight
4. Tuberculosis case detection rate (%)
5. Tuberculosis case success rates (%)
6. Malaria annual parasite incidence per 1,000
7. % of children who have received all basic vaccines by 12 months of age
8. % of births delivered in a health facility
9. % of women aged 15-49 with comprehensive knowledge about AIDS
10. % of children under age five with symptoms of ARI who received antibiotics
11. % of clients satisfied with their health care at district facilities
12. % of health facilities subjected to social audits
13. Number of Skilled Birth Attendants trained

Indicators: not achieved

1. Contraceptive Prevalence Rate (modern methods) for women of reproductive age
2. Infant Mortality Rate
3. Neonatal Mortality Rate
4. % of community based emergency funds granted
5. % of children under-5 with diarrhoea that have been treated with zinc
6. % of PHCCs that provide all BEOC signal functions
7. % of health posts that provide delivery services 24/7 and short term hormonal, non-hormonal, IUCD and implants
8. C-section rate
9. % of sanctioned doctors & nurses posts at PHCCs and hospitals that are filled
10. Number of HPs per 5,000 population
11. Number of PHCCs per 50,000 populations
12. % of health facilities with no stock-outs of 'essential drugs' in last one year
13. % of GAAP actions implemented
14. Number of SBAs trained
15. Use of community based emergency funds

6.1.1 Issues and discussion

All together 28 indicators were assessed using the original Results Framework. Overall achievements are impressive, although there are also areas for concern as 15 indicators are noted as "under performance" against the target set in 2011. Although the indicators of the NHSP-2 Results Framework were discussed in a workshop in 2011, they have not yet been revised, and a suggestion was made to discuss this in the business meeting.

Questions were raised on exaggerated reporting in the Health Management Information System (HMIS), and on comparison of data – Nepal Demographic Health Study (NDHS) 2011, Services Tracking Survey (STS) 2011 and HMIS – since triangulation of data is vital for informing decision-making. Also discussed was whether MoHP has a plan to review and address the health indicators that were lagging behind, especially the MDG related indicators. The issue of how the MoHP could use results from routine M&E to guide resources to respond to needs was raised as well.

6.2 DOHS ANNUAL PERFORMANCE 2010/2011

Dr.YV Pradhan, Director General, DoHS, presented the annual performance of DoHS derived from the National Annual Performance Meeting. This was held few months before the JAR and was the 15th in its series. Key achievements noted in 2067/2068 (2010/2011) were:

- The Maternal and Neonatal Tetanus elimination status was maintained, with a movement towards measles elimination and a significant reduction in Japanese Encephalitis (JE) cases in endemic districts. Diphtheria and Pertussis are no longer public health problems.
- CB-IMCI throughout the country provides good quality case management for diarrhoea and pneumonia, but zinc coverage is very low.
- The expansion of CB-NCP contributed to increases in institutional deliveries.
- Nutrition received a major emphasis with a multi-sectoral plan in progress.
- The Total Fertility Rate (TFR) has declined from 3.1 to 2.6 in the last 5 years (Urban: 1.6; Rural: 2.8).
- Women having at least one ANC for their last pregnancy during the past five years has increased from 44% to 58%.
- Approximately 2600 SBAs have been trained, CEONC sites expanded from 76 to 93, and birthing centres increased from 532 to 695.
- No diarrhoeal outbreaks have been reported this year.

6.2.1 Issues and discussion

- Although investment in maternal health has increased (a 36% increment from last year), the uptake of ANC 4 visits (48.8%) and institutional delivery (33.2%) is still low. About 67% home deliveries were recorded. ANC 4+ rates are stagnating, and 15.2% of the women who completed the 4th ANC visit did not have an institutional delivery.
- DPT3 >85% is challenging at the district level for some districts (although good nationwide).
- Diarrhoea treatment with zinc is still low. Progress on anaemia is stagnant.
- The wastage of Pentavalent vaccine is equivalent to NPR 26 million; half of this is unacceptable.
- CPR: in 2010/2011, four districts had higher than 60%; 27 districts had 40%-59%; 43 districts had 20-40%; and 1 district (Achham) was below 20%. The contribution of social marketing in CPR was raised.
- PHC-RD: 23% districts (17 of 75) reported more than 100% OPD attendance compared with the total population of the districts (i.e. Dadeldhura

Table 2: OPD visits against district population (%)

District	2066-67	2067-68	% change
Okhaldhunga	107	125	18
Achham	105	117	12
Parbat	106	114	8
Bajura	117	112	-5
Dailekh	99	111	12
Surkhet	105	110	5
Jajarkot	87	101	14
Salyan	98	100	2
Sankhuwasawa	97	98	1
Siraha	77	91	14
Bardiya	79	90	11
Kavre	74	82	8
Syangja	76	81	5
Saptari	86	78	-8
Rolpa	95	78	-17

239% and Humla 194%). This needs to be investigated. As an example, Table 2 above highlights the % change in OPD visits against the total population of the districts in the last two years.

- A budget of approximately NPR 6.5 million was allocated to free drugs and the unit cost of free drug expenditure per population is around NPR 23. However, the unit cost should be NPR 78 per capita.
- A careful review of OPD attendance and budget allocation is highly recommended, to be addressed in the next AWPB.
- Financial Management**:** Around 46% of NRS 3 million in financial irregularities was cleared in 2010/11 – a good achievement. Overall expenditure of allocated budget has been declining by 1% over the last three years, indicating reduced absorptive capacity of the DoHS.
- A NPC Member proposed the introduction of pro-poor health insurance.
- A participant asked whether the government has disaggregated data for institutional deliveries and ANC4+ by rural / urban localities and whether we should consider a reward system for health facilities that perform well, without any prior additional assistance.
- A participant asked why teaching hospitals, large NGOs or private-for-profit hospitals have not joined the Aama programme. It was suggested that implementing the Aama programme should be a precondition for registration and grant disbursement to hospitals. Ensuring timely fund flow to these hospitals is equally important to prevent damages that could occur if the Aama programme were implemented poorly.
- The question of WHO carrying out accreditation of health facilities and training institutions in line with action from the last JAR was also raised. MoHP explained that guidelines were finalised but not approved yet. The question was asked whether pre-service and in-service training on family planning could be introduced.
- A comment was made on the high demand for postings, especially in newly created posts in upgraded health institutes, with high demand for "deputations".
- There is an immediate need to fill the vacant positions, both for officers and non-officers, at various levels.

The Director General, DoHS presented a case study of Sunnikot sub health post of Bajhang, a district in Far Western Nepal, regarding local leadership for community mobilisation. A remarkable achievement was made by the sub health post in-charge Mr Keshav Bhattarai in delivering health services through greater community participation. The participants praised this case study highly and suggested that the MoHP scale up such best practices by rewarding the "local heroes," i.e. the frontline health workers.

It was *suggested* that MoHP do the following: review the MDG indicators that are lagging behind; review and scale-up the most cost effective interventions; finalise the HR strategy and begin its effective implementation with a focus on deployment and retention of health workforce in rural areas. All the agreed points will be considered in the AWPB.

NPC Member *Prof. Dr Shiva Kumar Rai* acknowledged the progress made in the last year but raised a few areas of concern. First, the quality of HMIS data and its verification: in the absence of a robust M&E system, this could easily lead to incorrect decisions and resource allocation. Thus it is extremely important that MoHP focus on strengthening the M&E system. Second, the delivery of quality service in the absence of trained human resources, especially in remote areas, requires better coordination with academic

institutions, such as medical schools, and the Centre for Vocational Education and Vocational Training. Third, he urged exploring better means of health financing such as community health insurance for those who cannot afford to pay the health service costs. He concluded by saying that we should learn from our mistakes to inform the future.

6.3 PROGRESS ON AGREED ACTION FROM THE PREVIOUS JAR

Dr. BR Marasini, MoHP, presented the actions undertaken following the first Aide Memoire (AM) for NHSP-2. This AM had combined ownership as it was jointly signed by the secretary of MoHP and the EDP chair (July 2011). However, the delay in finalisation of the AM was unfortunate, and this should be noted in the current JAR as a lesson learned. One AM will be finalised each year. Dr Marasini briefly presented the progress on 24 agreed actions as outlined in the AM, including the sub-activities. He observed that progress on the agreed actions was partially completed.

6.3.1 Issues and discussion:

- The 2011 Aide Memoire was not signed until six months after the JAR, resulting in MoHP having little time to respond to the action points.
- Across the board, many actions were begun, but few had been completed and there was little discussion of the impact of results.
- Of particular concern to EDPs was the lack of progress on finalising the revisions to the GAAP.
- Even though Nepal is one of the signatories of the International Health Partnership (IHP), this was not well articulated and discussed in the AM.
- A time bound action plan for Safe Motherhood and Family Planning scale-up with an indicative cost will be presented in next the Joint Consultative Meeting.
- Expediting actions to finalise the HIV bill and articulate the types of support required for final approval was recommended.
- A detailed workout on environmental health and hygiene, a multi-sectoral technical committee and water quality surveillance team, and mainstreaming of WASH all require accelerated efforts in the next year.
- The GAAP is to be revised based on the suggestions and feedback received.
- Delayed progress on the financial management improvement action plan will be considered seriously. Hence it is a priority for next year.
- Accreditation guidelines for health facilities and health training institutions will be finalised and implemented.
- Further discussions are needed on how to address actions requiring multi-sectoral efforts.

6.4 PROGRESS ON NEPAL HEALTH DEVELOPMENT PARTNERSHIP

Dr. Albert Voetberg, EPD chair, presented findings of the EDPs' assessment with regard to commitments and accountability under NHSP-2. The assessment compiled all the commitments that EDPs agreed to from the Statement of Intent (SOI), IHP and Joint Financing Agreement (JFA), and a scored matrix was used to assess the progress made against the objectives.

Of the total EDP contribution to NHSP-2, 54% was in the form of financial resources and 46% was technical resources.

Box 1: Key observations from the assessment

- *Joint planning*: Progress has been made in receiving an early indication of tentative contributions from the EDPs. Similar improvements are necessary in the AWPB consultation process, and the process for subscribing to the AWPB. More realism is needed regarding EDP internal processes to commit resources.
- *Coordination and joint consultation:* Good progress was noted in JAR/JCM schedule and in coordination of TA/TC. Improvements are necessary in the schedule of meetings of the Health Sector Development Partners Forum and the development of a rolling three-year procurement plan.
- *Harmonisation:* Good progress was made in the use of common reporting formats and avoiding additional reports and in alignment with NHSP-2, but there are still too many EDP-specific monitoring activities. A common programme for country systems strengthening needs to be agreed upon in order for EDPs to use those systems more.
- *Transparency:* MoHP is well informed about EDPs contributions, both in the red book and outside. However, accounting for expenditures by NGOs is to a large extent not reported; the inclusion of civil society in consultations is still a major issue; and the MoHP website is not updated.
- *M&E and reporting requirements:* No changes are made in requirements without consultation. Clarifications are needed for some of the commitments (eg. technical review, output-based progress reporting).
- *Fiduciary:* Resources are channeled to the end user on a timely basis. However, major problems persist with regards to delays in IPR/FMR and complete audit report submission, audit observation follow-up and in updating the Financial Management Improvement Plan.

6.4.1 Issues and discussion

- The difficulty of entering into multi-year contracts due to the short-term predictability in funding was raised. However, discussion revealed that the majority of pooled funding was highly predictable over the life of NHSP-2.
- The performance and structure of TA within NHSP-2 needs to be more systematically assessed. Examples were cited of continued delays in Financial Monitoring Reports (FMR), Implementation Progress Reports (IPR) and procurement plans. There was some discussion of a proposed assessment of TA alongside pooled finance as part of the mid-term review of NHSP-2.
- A suggestion was made that EDPs should present progress of directly executed projects.
- Discussion noted that experience from other countries showed that peer review mechanisms where governments, donors and Community Service Organisations (CSOs) reviewed proposals for new TA worked to enhance the responsiveness of TA to local needs.

6.5 UPDATES ON FINANCIAL MANAGEMENT

Mr. S.P. Simkhada, Under Secretary (Finance), MoHP, presented the status of the health sector budget. He explained that the health sector budget is experiencing an increasing trend (Table 3). Utilisation of the health budget declined by 12.88% in 2010/2011 compared with FY 2009/2010, indicating reduced absorptive capacity (Table 4). Some progress was noted in financial management: a concept note on a Transactional Accounting and Budget Control System (TABUCS) has been developed; workshop/training was conducted on Output Based Budgeting (OBB) and procurement; a web-based Electronic Annual Work Plan and Budget (eAWPB) is under development; the Service Tracking Survey (STS) was done; and greater efforts have been made to clear irregularities.

The presentation also noted key challenges in financial management: direct budget execution by some EDPs; weak budget forecasting of external assistance and requirement for separate reports and audits from EDPs; inadequate discussion with EDPs during the budget preparation process; poor execution and a declining trend of budget utilisation weakening the argument for an increased health budget; challenges in accounting and the audit mechanism, as well as timely reporting.

Table 3: Trend of Health Budget against National Budget (NPR '000')

FY	National Budget	Health Budget	Health Budget (%)	Health Budget Growth	Growth %
2006/07	143,912,000	9,230,000	6.41	1,675,000	22.17
2007/08	168,996,000	12,098,583	7.16	2,868,583	31.08
2008/09	236,015,897	14,945,964	6.33	2,847,381	23.53
2009/10	285,930,000	17,840,466	6.24	2,894,502	19.37
2010/11	337,900,000	23,813,993	7.05	5,973,527	33.48

Table 4: Utilisation of Health Budget (NPR '000')

Particulars	NHSP I (2004/05-2009/10)	2009/10	2010/11
Allocated Budget	68,310,643	17,840,466	23,813,993
Expenditure	56,250,699	15,913,860	18,175,831
Expenditure %	82.35	89.2	76.32

6.5.1 Issues and discussion

- The presentation of the utilisation of funds by sources (MoHP/pooled/non-pooled) was agreed to be misleading.
- Many unresolved challenges relate to financial management and a plan for how to resolve them is urgent.
- There have been inadequate responses from MoHP on financial management, with a focus on financial "reporting" not financial "management". Discussion noted that better FM will reverse the decline in fund utilisation and reduce the risk of EDPs withholding pooled fund disbursement.
- Key issues noted were: delayed financial reporting and the quality of reports; responses to audits; and the AWPB consultation process.

6.5.2 Suggested decisions

- Convene a proper forum for discussion of technical PFM reforms to define how EDPs can support public FM and what more can be done by MoHP.
- Develop a Financial Management Improvement Plan (FMIP) and review progress quarterly.
- Agree how and when key activities (for example, such as TABUCS) will lead to improvements.
- MoHP should treat audits as a management information tool to improve FM in future.
- Ensure timely and wider consultation on AWPB before finalisation.

6.6 UPDATES ON INFRASTRUCTURE

Mr. Shyam Kishor Singh, Chief, Health Building Unit, DUDBC, presented the status of health related construction projects: completed, on-going, completed but not handed over, sick and dead projects. Over the last seven years a total of 973 projects were undertaken by DUDBC, of which 38% (367) projects were completed and handed over to MoHP, 54% (527) are on-going, and 8% (79) were completed but not handed over (Table 5). About 81 projects are considered "sick" or "bad" projects. Budget utilisation averaged 78% over that period. This year, NPR 2.7 billion has been allocated.

Table 5: Status of construction projects undertaken by DUDBC

Base Year	Undertaken	Completed/Not Handed Over	Continued	Handed Over
2061/062	74	-	2	72
2062/063	40	-	1	39
2063/064	101	3	7	91
2064/065	166	31	26	109
2065/066	113	20	55	38
2066/067	299	25	256	18
2067/068	180	-	180	-
Total	973	79	527	367
Status %		**8%**	**54%**	**38%**

6.6.1 Issues and discussion

- Key issues raised: The handover process, the increased number of sick and bad projects, the capacity of DUDBC to complete assigned projects on time with proven quality, time over-runs and cost over-runs, poor monitoring of construction sites and weak involvement of local level health authorities in planning and monitoring.
- Increased resources to DUDBC seem difficult to absorb while maintaining good quality.
- Delays caused by weak capacity of contractors and issues over land to be used for building sites.
- Districts are now responsible for monitoring projects and DUDBC will cancel contracts for projects not started.
- MoHP ownership and leadership is essential to minimise delays and over-expenditure.
- Suggested decisions: Since increases in resources to DUDBC seem to have been difficult to absorb while maintaining good quality, the involvement of a lower level health management committee in project approval could alleviate the difficulties in monitoring and signing off. Forming a Joint

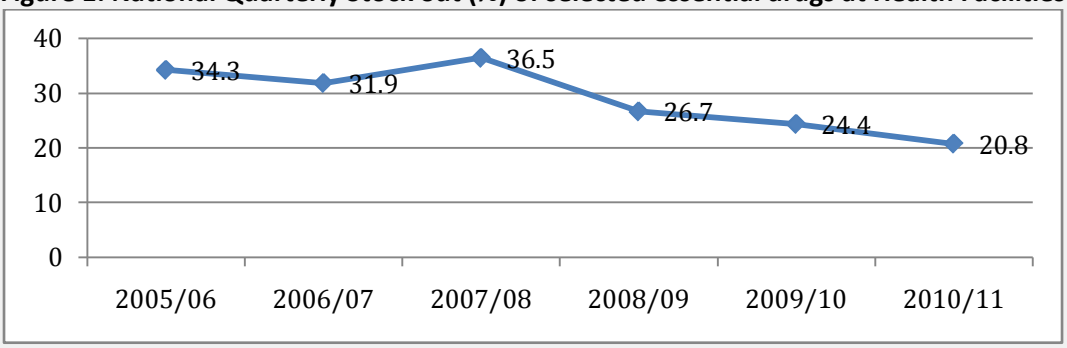
Central Coordination Committee (NPC, MoHP, DoHS, DUDBC, EDPs) with MoHP taking a lead role in planning and monitoring progress and quality of construction was also suggested.

6.7 UPDATES ON PROCUREMENT OF HEALTH COMMODITIES

Dr. Mingmar G. Sherpa, Director, LMD, presented the overall procurement procedure, the role of LMD in maintaining the flow of health commodities, progress made to the present, and challenges. The following key progress has been made:

- A consolidated procurement plan was developed this year, including service and NGO contracts. It is essential that the plan accompany all budget requests.
- E-bidding was introduced but may not be applicable in all situations.
- Multi-year procurement for contraceptives, essential drugs and equipment began last year.
- Pre and post shipment tests for drugs and equipment are conducted "where possible".
- Software has been developed to conduct an inventory of assets and update annually. Guidelines on asset disposal developed by MoHP have been adopted for all sectors.
- Biomedical engineers have been hired in two regions for equipment maintenance.
- Concerning the Logistics Management Information System (LMIS), all commodities are now included in the forecasting tool. A pull system has been introduced along with web based LMIS.
- Training in procurement at centre and district levels was conducted.
- A master plan for central and regional stores was developed and initiatives taken for clean/solar energy promotion.

Figure 1: National Quarterly Stock out (%) of selected essential drugs at Health Facilities



6.7.1 Issues and discussion

- The volume of procurement has increased four-fold, yet the capacity of LMD has remained the same. TA has helped, but is sometimes insufficient and unresponsive.
- Stock-outs of health commodities, including essential drugs, continue to be significant (see figure 1) as a consequence of the inability to deliver drugs from districts to periphery level health facilities and delayed procurement of FP commodities. Contracting the private sector to distribute commodities from districts to periphery level health facilities is an option to consider – an option that has been under consideration for three years. A distribution budget has been provided to district health offices.

- Additional stores must be built and a number of new posts created that are related to maintenance at central, regional and district levels.
- Inconsistent information – from LMIS and service tracking surveys – on drug stock outs lead to difficulties discovering the true situation.

6.7.2 Suggested decisions

- A clear understanding of solutions for the "last mile" (moving drugs to the lowest level health facilities) needs to be developed and implemented.
- Work needs to be done to understand trends in stock availability at the facility level.
- Next year, procurement planning and budgeting processes need to be linked; the AWPB should have a procurement plan attached (procurement plans should accompany all budget requests by cost centres).
- EDPs, DG and LMD should meet to discuss how to improve capacity building of TA and understand why it may not have worked in past, using procurement planning as a case study.

6.8 KEY ISSUES DISCUSSED ON DAY 1

- Results Framework: 28 indicators were assessed using the Results framework of NHSP-2; 13 indicators were noted as under performance against the target set in 2011. Data disaggregation and a careful review of indicators that are lagging behind is a must.
- Although investment in maternal health has increased, progress remains low, especially on institutional delivery uptake (33.2%), and disparities in health outcomes remain a concern.
- Human Resources management: Making progress on health outcomes is unthinkable in the absence of skilled HRH at the point of service delivery.
- Financial Management: FM improvement has been discussed for many years but many unresolved challenges continue to hinder progress, e.g. timeliness of reporting, quality of reports, and inadequate response to issues raised. Hence, a proper discussion forum is urgently needed along with development and implementation of an FM improvement plan.
- Procurement: Stock outs of essential health commodities remain an issue. A multi-year costed procurement plan should be strengthened further with a clear link to AWPB. A service contract for commodities distribution is to be considered.
- M&E: A national M&E framework is not in place. Although HMIS has been implemented, consistency and comparability of data using various sources remain an issue. Thus, standardisation of HMIS/HSIS towards a robust M&E system is a priority.
- Infrastructure: Quality service delivery is unachievable in the absence of basic infrastructure. Resources to DUDBC have increased over the years but are difficult to absorb while maintaining good quality. Hence, a review of the current modality by formation of a Joint Central Coordination Committee should not be further delayed.
- TA/TC: A proper review of TA/TC taking into account the Results Framework of NHSP-2 and advancing aid transparency with better alignment and harmonisation is needed.
- A quality assurance system and accreditation of hospitals and related courses is to be taken forward.

6.9 GLOBAL STRATEGY FOR MATERNAL AND CHILD HEALTH

Day 2: *Dr. BR Marasini* presented the progress on Nepal's commitments to the UN Secretary General's Strategy on Maternal and Child Health. The strategy consists of 11 commitments. Dr Marasini highlighted Nepal's progress on the major indicators such as nutrition, CB-IMCI, expansion of BEOC, CEOC, birthing centres, infant and young child feeding, community based management of acute malnutrition (CMAM), Nutritional Rehabilitation Homes (NRH), Nutrition Emergency Cluster, integration of CB-NCP into CB-IMCI, CPR, the unmet need for family planning, total fertility rate, the "Aama programme", training of SBAs, and distribution of Vitamin A and de-worming tablets. He also highlighted the new initiatives taken by MoHP such as the National Adolescent Sexual and Reproductive Health (ASRH) programme initiated in 2011.

- Ensure that at least 70% of PHCs offer EOC.
- Improve child nutrition.
- Integration and expansion of CB-IMCI and CB-NCP.
- Reduce unmet need for family planning by 18%.
- Maintain de-worming and micronutrient supplementation coverage at over 90%.
- Fund free maternal health services among hard-to-reach populations.
- Recruit, train and deploy 10,000 additional SBAs.
- Use of cash transfers to pregnant and lactating mothers.
- Make family planning services more adolescent friendly.
- Encourage PPP to raise awareness and increase access and utilisation.

6.10 M&E FRAMEWORK FOR NHSP-IP 2

Dr. Padam Bahadur Chand, Chief of Public Health Administration Monitoring and Evaluation (PHAM&E) Division, MoHP, presented the M&E framework for NHSP-2. The presentation was a true reflection of the M&E context including how and whether the existing health information management system is robust enough to monitor and evaluate health interventions, gaps and challenges. He highlighted some of the issues needing immediate attention: lack of a national M&E framework, inadequate guidelines and plans regarding M&E, inadequate capacity, lack of use of information in the decision making process, data quality and mismatch etc.

Current progress in M&E to support NHSP-2

- NDHS survey 2011
- Nepal Living Standards Survey (NLSS III) and Census (CBS)
- Service Tracking Survey (MoHP/NHSSP)
- MDG Need Assessment (NPC)
- National Health Account Budget Analysis (MoHP/NHSSP)
- Other activities are undergoing and planned, e.g. household survey of free care uptake (NHSSP/DFID)
- Survey, assessments, research are ongoing
- Youth and Adolescent Survey (MoHP) etc.
- M&E Matrix for NHSP-2 – 1st draft (WHO)

Key highlights of M&E focus in NHSP-2:

- As equity is a major concern, data on national level impact and outcome indicators must be disaggregated by caste/ethnicity, and income quintile.
- The NHSP-2 broadened the scope of M&E by considering research, surveys and assessment as an integral part of M&E.
- By providing a Results Framework and GAAP (Governance and Accountability Action Plan), the programme tries to facilitate M&E, although it not adequate or standardised.

6.10.1 Issues and discussion

- A national M&E framework is not in place.
- The proposed Results Framework in NHSP-2 is complex, i.e. not easily understandable and with no apparent link to programme specific monitoring mechanisms.
- Though there are many efforts and mechanisms for M&E, most are fragmented. While all programmes have strategic and M&E plans, the link between the programme specific monitoring and NHSP-2 is less clear.
- M&E and HMIS are used interchangeably although they are different. A careful interpretation is required.
- The systems are overambitious, with too much being asked in terms of information and methods.
- There is no coordinated sector-wide support in M&E. Currently, NHSSP is providing TA but the real challenge is to improve the institutional capacity of MoHP for the long run.
- Capacity: The MoHP and DoHS has units responsible for monitoring and evaluation but they lack adequate capacity, including the number, knowledge and skills of the HR, along with poor institutional support.
- The utilisation or translation of information into decision making is quite limited.
- There is no M&E plan covering human resources, finance, information infrastructure, logistics, or organisational issues. Nor is there a master M&E guideline to facilitate M&E activities, processes and mechanisms at programme and sub-national levels.
- Limited financial resources are available for M&E. Programme driven financing limits the budget for M&E, MIS, surveillance, research and surveys.

6.10.2 Suggested actions

- Finalise the draft M&E framework for NHSP-2. MoHP should take the lead on this.
- Develop a national M&E framework which is simple and easy to implement, properly costed, guided by the country's needs, and linked with other programme specific M&E strategies. It should serve the purpose of MoHP, its divisions and other stakeholders i.e. EDPs, and be accessible to all stakeholders.
- Develop a linkage between existing information sources, the planning process and M&E.
- Allocate a rational proportion of the development budget for M&E.

6.11 AID EFFECTIVENESS, BY MINISTRY OF FINANCE

Mr. Bhuwan Karki, Under secretary MoF, presented the principles regarding aid effectiveness and the MoF initiatives. He highlighted the definition and importance of aid effectiveness, the principles of the Paris Declaration, the Accra Agenda for Action, and the Fourth High Level Forum on Aid Effectiveness, Busan, Korea, along with the MoF initiatives on aid effectiveness. He also noted that the MoF is undertaking a project on capacity development for effective aid management with the following objectives: design and implement a Nepal aid management platform; implement a revised foreign policy and national action plan for aid effectiveness; and develop greater ownership and capacity of the NPC and key line ministries to engage aid effectiveness reform.

MoF Initiatives

- 2008 Monitoring Survey
- Joint Evaluation of the Implications of the Paris Declaration, Phase II (2010)
- 2011 Monitoring Survey II
- Local Donors Meeting (bi-monthly)
- Nepal Development Forum
- Nepal Portfolio Performance Review (NPPR)
- Participated in Paris, Accra and Busan High Level Forum

6.11.1 Issues and discussion

- Nepal Portfolio Performance Review (NPPR) was better planned after the JAR meeting.
- The Aid Management platform is better positioned at the sector level than at MoF.
- Can the mutually agreed conditions be implemented?
- Is there adequate capacity at the sector level for the Aid Management platform?
- The friendliness of the Aid Management project.
- Budget capping by MoF, especially for additional HR.
- Partnership with Donor Agencies and Line Ministries, especially on the Aid Management platform, is a challenge.

6.12 HUMAN RESOURCES FOR HEALTH (HRH) – DRAFT STRATEGY

Mr. KR Khanal, Under Secretary, MoHP, presented the processes involved in developing the HRH Strategic Plan. A draft HRH plan has been developed and presented to the Country Coordination Forum (CCF). The plan has four outputs with various strategies (Table 6) and covers a 4-year period from 2011 to 2015, aligned with the timeframe of the NHSP-2. Key problem areas identified during the development process were: a shortage of HRH and imbalance between supply and demand; maldistribution of staff, especially in remote and rural areas; poor staff performance (productivity, quality, and availability) and fragmented approaches to HRH planning, management and development. Likewise some contextual issues were identified that will impact on HRH strategy.

Table 6: Outputs and strategies of the HRH plan

Output 1: Appropriate supply of health workers for labour market needs *Strategies* 1.1: Improve HR planning for the health sector 1.2: Improve recruitment and deployment processes and ensure they are effective and timely 1.3: Improve attractiveness of jobs for increased recruitment and retention 1.4 Ensure that the basic and pre-service education and training is in line with the requirements of the health sector
Output 2: Equitable distribution of health workers *Strategies* 2.1: Review current distribution trends and processes and ensure that deployment systems result in equitable distribution of health workers 2.2: Make jobs/postings in rural and remote areas more attractive in order to retain health workers 2.3: Prepare and support staff better for working and living in remote areas 2.4: Improve workers' living and social conditions in remote locations 2.5: Impose compulsory service to improve the provision of service in rural areas 2.6: Continue to identify new areas for task shifting and alternative staffing in clinical areas 2.7: Use NGOs and private health providers for service delivery in the most difficult areas
Output 3: Improved performance of health workers *Strategies* 3.1: Provide staff with leadership and clear direction 3.2: Strengthen skills/capacity of health workers to do their jobs 3.3: Ensure that an effective rewards and sanctions systems is in place 3.4: Reduce staff absence from assigned posts
Output 4: Effective and coordinated HRH management and development across the health sector *Strategies* 4.1: Appropriate HRH policies are put in place 4.2: Appropriate organisational structures, systems and capacity are developed to support HRH functions 4.3: Effective coordination mechanisms are put in place at all levels within the health sector

6.12.1 Issues and discussion

- Management of HRH functions and service delivery in the context of federalism.
- Linking HRH development with population growth and its dynamics, the changing patterns of disease, care and treatment, and the role of state and non-state partners.
- Security of staff, especially those working in remote or hard to access areas, has been a concern but no adequate measures have been taken yet.
- New recruitment of 14,230 over the next four years is an ambitious plan.
- Did the workforce projection consider new and emerging areas such as nutrition, non-communicable diseases (NCD), GESI, public health professionals?
- Will the projected cost of the HRH strategy be secured, as it appears to be high?

6.12.2 Suggested actions

Before finalisation of the HRH plan:

- A proper needs assessment of the health workforce (state and non-state providers) is needed.

- Consider the specific HRH specialties required for MDG indicators, i.e. MDG 5, nutrition, NCD, GESI, cardiovascular disease.
- Revisit projected HRH costs and ensure wider consultation on the plan.
- Ensure the provision of continuing education to maintain knowledge and skills.

6.13 GESI AND POPULATION IN THE HEALTH SECTOR

Mr Padam Raj Bhatta, Joint Secretary, Population division, MoHP, highlighted the population prospective plan and progress on GESI. Key areas of progress made are:

- Nepal Adolescent and Youth Survey has been completed and disseminated.
- A GESI Steering Committee has been formed under the Secretary MoHP and a Technical Working Group has been formed under the DG DoHS.
- Institutional modalities (in MoHP, DoHS, RHDs, DHOs and Health Facilities) have been approved and are being established.
- GESI Orientation and capacity building processes are underway.
- Guidelines for Hospital based One Stop Crisis Management Centres were approved and are being piloted.
- Social audit operational guidelines were prepared and are being piloted in two districts.
- EAP is now the responsibility of PHC-RD, with implementation planned for 21 districts through contracting NGOs.

6.13.1 Issues and discussion

- How will the changing population ratio and the changing pattern of diseases be aligned with HRH and other health priorities?
- The rapid growth of the urban population and thus the urban poor, and the absence of an adequate PHC network to deliver basic health care services in urban areas is a concern.
- Is there any plan to evaluate the EAP and reflect upon the AWPB?
- Progress with regard to GESI initiatives, i.e. remote area strategy, EAP, GBV is not clear.
- Less clarity and reflection on GESI related activities is found in the AWPB.

6.13.2 Suggested actions

- The GESI strategy framework requires mainstreaming and institutionalisation.
- A clear GESI implementation plan is to be developed that is better aligned with the AWPB.
- Better dissemination is needed of surveys and evaluations related to GESI.
- A detailed assessment is required of Social Service Units at service delivery sites.
- Provision of well trained counsellors (GESI and GBV) in Social Service Units is vital.

6.14 JOINT FIELD VISITS – SHARING AND OBSERVATION

Joint field visits were planned before the JAR meeting. Two teams were formed, and visits were made to Dhading, Arghakhanchi and Kapilvastu, as well as urban health centres in Kathmandu, Bhaktapur and Lalitpur. Key observations were the following:

Urban health service delivery - Kathmandu Valley: A two-day visit was conducted in the Kathmandu Valley, visiting urban health clinics conducted by municipalities and NGOs.

Table 7: Key observations on urban health - issues and opportunities

Issues	Opportunities
No policy for EHCS	Urban Health Policy under development
Inadequate resources	PHC-RD providing funds through DHO
Lack of clarity in roles and responsibilities	Address in the urban health policy Reactivation of coordination committee
Health is a low priority in municipalities	Community involvement in planning (use health networks), decentralised planning process
HR is under-emphasised in municipalities	HR development plan, recruitment of long-term staff
Poor infrastructure	Refurbishment plan
Poor access to EHCS	Service expansion and community involvement
Quality assurance	Develop and implement QA process
No/poor referral system	Define urban health service delivery model with referral services
Documentation and reporting	HMIS, data audit and financial accounting
Irregular and inadequate supply	Implement free EHCS policy, revisit supply management
Accountability	Activation of health management committee Use of community health network

Observations from Dhading:

- Access to services was generally good but is still challenging for many from remote rural areas.
- Supplies of drugs were good, except for iron and ORS in some locations.
- Institutional delivery was progressing well but is still challenging in remote areas.
- The large number of vacant HRH positions is hindering service delivery.
- Good local leadership and an active health management committee are the driving forces.
- Health Care Waste Management is an issue in almost all facilities.

Observations from Arghakhanchi and Kapilvastu Districts:

- Low performing districts continue to perform poorly, with HR being an issue (hiring, retention and security).
- The quality of services is questionable in the absence of basic standards.
- Leadership is important. Some but not all health facilities were performing well, when the person in charge is committed and community involvement is high.
- Lack of HR and basic infrastructure is limiting service delivery. Retention and capacity enhancement of health workers is needed.

- High prevalence of HIV was found among spouses of migrants in Kapilvastu.
- None of the people from Arghakhanchi or Kapilvastu were aware of adolescent sexual and reproductive health, which thus needs greater attention.
- Poor waste management systems were found in both districts.

6.14.1 Issues and discussion

- MoHP has begun providing funds to municipalities for urban health but utilisation is poor.
- Cost of EHCS delivery in urban and rural areas needs to be evaluated. Unreached populations should be reached by the health system regardless of where they reside.
- Proper mapping of the health service delivery network in urban areas is essential.
- Earmarking of financial resources may be an option for programmes that are performing poorly.
- Tailoring resources to consider the burden of diseases in rural and urban areas is essential.
- Partnership with NGOs and the private sector to deliver priority programmes in urban areas is to be considered as an option.
- HR capacity development and deployment through partnership with academic institutions is to be explored further.
- Districts performing poorly require additional attention. A blanket policy is not feasible for such districts.

6.15 MULTI-SECTORAL NUTRITION PLAN

Mr. Atma Ram Pandey, NPC, presented the draft multi-sectoral Nutrition Plan of Action (2011-2012), pending approval from the cabinet of ministers. The plan has eight major outputs.

Major outputs of the Plan:

Outcome 1: ***2 Outputs*** 1.1: Policies and plans updated/reviewed to incorporate nutrition specific indicators at national and local government levels 1.2: Multi-sectoral coordination mechanisms functional at national and local government levels
Outcome 2: ***4 Outputs*** 2.1: Maternal and child care service utilisation pattern changed 2.2 : Adolescent girls' education, life skills and nutritional status improved 2.3 : Reduced episodes of diarrheal diseases and ARI among mothers, adolescents, infants and young children 2.4 : Feeding behaviours improved with increased availability and access to appropriate food (in quality, quantity, frequency and safety)
Outcome 3: ***2 Outputs*** 3.1 : Capacity of national and local government enhanced to provide appropriate support to improve maternal and child nutrition 3.2 : Multi-sectoral nutrition information updated and linked both at national and local government level

Key characteristics of the plan

- Clear leadership of the NPC while actively involving health and other sectors.
- Focuses on the first 1,000 days of life and reducing stunting.
- Addresses immediate, underlying and basic factors such as women and children's access to education, health and nutrition, safe water and sanitation, as well as the existing inequities.
- Emphasis is on decentralised implementation by working initially in selected districts.
- The vision is of gradually scaling up to all districts by 2016, with an approach of learning by doing.

6.15.1 Issues and discussion

- NPC needs to play a coordinating role rather acting as an implementing agency.
- How can all agencies (GoN, I/NGOs, local CS organisations) be brought on board?
- The plan is ambitious, aiming for coverage of 75 districts in five years.
- HR for nutrition is to be ensured in the HRH strategy.

6.15.2 Suggested actions

- A detailed implementation plan is needed with due consideration of the HRH requirements at all levels.
- The plan needs to reflect the findings and lessons learned in the past and the on-going programmes under various agencies including MoHP.

6.16 COMPREHENSIVE EMERGENCY OBSTETRIC AND NEONATAL CARE

Dr. Naresh KC, Director, FHD, presented findings of a study on the readiness of Comprehensive Emergency and Neonatal Care (CEONC). He highlighted the importance of readiness of CEONC, which is vital for saving the lives of pregnant women and new-born babies. The study focused on the experience with CEOC funds, major bottlenecks and lessons learned in CEONC sites. Key findings were:

- CEOC funds provided flexibility to hire HR locally.
- Advanced SBA training for personnel with MBBS seems to be working well.
- Inadequate numbers of trained personnel for C-section was an issue.
- MDGP is an unpopular career choice, with no commitment to stay in the post.
- Basic infrastructure for service delivery and waste management is not adequate in many districts.
- Leadership is important. The commitment of some district managers and health professionals makes a difference but not all districts and facilities have the same commitment among their leaders.
- Partnership with Nick Simons Institute on HR deployment and management is a road to success.

6.16.1 Suggested actions

- The CEOC fund is to be continued as a transitional strategy as long as the OBGYN/MDGP post is not created or filled in the districts.
- A well-planned skill matched transfer mechanism is needed to ensure the success of a CEONC team.
- Establish an earmarked budget for regular repair and maintenance.
- Install a robust waste management system and monitor its functionality.
- Develop simplified user friendly guidelines for the CEOC fund and procurement of HR. Implement multi-year procurement budgets for CEONC services.

6.17 SEISMIC VULNERABILITY AND HOSPITALS IN KATHMANDU

Dr. SR Upreti, Chief of Curative Division, MoHP, presented Seismic Vulnerability and Hospitals. A 2004 study (UNDP/BCPR,) ranked Nepal as the 11th most at risk country for earthquakes and the 30th with respect to floods. Similarly, Nepal is believed to rank in the 6th position among countries most at risk due to climate change. Kathmandu is one of the few cities in the world on a very high alert due to potential earthquake disaster. Although the results of various assessments show the immense need to take action for mitigation, disaster preparedness has always been a low priority in Nepal. Therefore, among other measures, making hospitals safer is a very high priority in order to respond to situations of disaster when most needed. He urged the need for a comprehensive disaster preparedness plan in coordination with other ministries, and for the structural and non-structural retrofitting of hospitals in the Kathmandu valley.

6.18 INGO CONTRIBUTIONS TO THE HEALTH SECTOR IN NEPAL

Dr. Ashish KC, on behalf of INGOs working in Nepal, presented the mission of the Association of International NGOs (AIN) working in Health and Nutrition and their contribution to the health sector in 2011. An assessment carried out to map the INGOs' contribution in health noted the following priority areas: Maternal Health and Family Planning; Adolescent Health; Child Health (Nutrition, IMCI, New-borns and Immunisation); School Health and nutrition; Malaria Control and prevention; Physical Rehabilitation centres for disability; Leprosy and TB; Health System Strengthening/Human Resources for Health; Health Promotion and Advocacy; Water and Sanitation; and Mental Health. The focus is on MDGs 1, 4, 5 and 6. He mentioned that strengthening NGOs through partnership and knowledge sharing is the major role of AIN. The major contributions of AIN include providing approximately US$ 62 million to the health sector, a three-fold increment in the last three years; running programmes in all 75 districts although not all VDCs are covered; and working in both rural and urban sectors, with more focus in the Mid-western and Far-western Regions. Many activities serve to strengthen NGOs since INGOs work in partnership with NGOs, including knowledge sharing and replicating international best practices.

A question from the floor asked what innovations and successes AIN has demonstrated over the years that the government has successfully scaled-up.

6.19 KEY REFORMS IN THE REGIONAL HEALTH SECTOR

Mr. Mahendra Shrestha, Director of the Far-western Regional Health Directorate (RHD) presented the regional initiative for cooperation through the formation of a Regional Health Coordination Team (RHCT) in Dec 2007 under the leadership of the RHD. The major objectives of the RHTC are to bring government and non-state actors together to coordinate programme planning, implementation and resources to maximise service coverage and thus to increase access to quality health care services with improved health governance. He emphasised that RHTC was formed to harmonise and align health activities, including the mobility of HRH. He presented the following additional suggestions: provision of AWPB at the regional level; a joint monitoring framework; flexible financial management to address local issues; accountability and good governance. The floor acknowledged the initiative taken at the regional level and suggested replication in other regions and districts for better harmonisation of resources among various actors.

Issues affecting the health sector at the regional and district levels

- Central decision making results in a less transparent system.
- Weak local ownership.
- Weak links are need identification, planning and resource allocation among the district, RHD and central levels.
- Poor coordination is found between state and non-state actors.
- The spirit of SWAp is lacking at regional and district levels.

6.20 PROGRAMMES AND PRIORITIES FOR NEXT FY 2012/13

Dr. BK Suvedi, Chief of PPICD, MoHP presented the new health programmes and priorities for FY 2012/13. The presentation was made under seven key themes (Table 8).

Table 8: Key programmes and priorities FY 2012/13

1. *Scaling up Community Based and Institutional Interventions*
• Community Based New-born Care Programme (CB-NCP) • Nutrition care and rehabilitation programmes • Emergency obstetric care and delivery care • HIV/AIDS care and support • Disease control programmes
2. Maintaining the Quality of Existing Programmes
• Maternal health (CEONCs, BEOCs, Birthing Centres) • IMCI programme • Free Health Care services • Immunisation • Family planning • Tuberculosis control • Care and support for HIV/AIDs • Malaria control

3. Integrating Programmes
• Incentive for ANC visits with the Aama programme • CB-IMCI and CB-NCP • PMTCT with ANC • Nutrition programmes • Training programmes • Revitalising the family planning programme • Strengthening the local health governance system • Strengthening supply side interventions • Mainstreaming GESI • Expanding the benefits package and population coverage of free care
4. Partnerships
• Inter-Governmental – example: Urban health programme, where MoHP provides 50% of the funds and the municipality 50% • Government and EDP and I/NGO – example: child health, maternal health and disease control (demand creation by I/NGOs and service provision by government) • Government and private sector – example: Aama programme, uterine prolapse surgery • Government and NGO and community – example: establishing birthing centres
5. Multi -sectoral collaboration and cooperation
• Local health governance • Management of uterine prolapse • Nutrition care and support • HIV/AIDS control • WASH • Hospital service delivery (MoHA, MoGA, MoLD, MoD, MoE) • Health insurance
6. Institutional development
• Health Sector Information System (HSIS) • National centre for nutrition • National health training academy
7. New Strategies for Health System Development
• Implementation of the Human Resource Strategy • Development of a Health Financing Strategy

Likewise, the top priorities were divided into two categories: health service delivery and health system strengthening (Tables 9 and 10).

Table 9: Top priorities for Health Service Delivery

Health Services	Component
Child health	• Scaling up CB-NCP and sustaining quality IMCI • Community and institution based nutrition • Measles Rubella Campaign and routine immunisation • Maintenance of existing programmes
Maternal health	• Scaling up CEONC sites and birthing centres • FCHV programme • Family planning • Scaling up management of uterine prolapse • Quality maintenance of existing programmes • Control and management of gender based violence
Disease control	• Elimination of kala-azar and lymphatic filariasis • Pre-elimination of malaria • Control of dengue fever • Outbreak response
TB, HIV/AIDS	• Scaling up care and support programme • Quality maintenance of national tuberculosis control programme
Free health care	• Universal free care (HP/SHP/PHCC levels) • Free care at district hospitals for targeted groups • Health Insurance • Community Drug Programme
New elements of EHCS	• Piloting of community based mental health programme • Piloting of basic oral health programme

Table 10: Top priorities for Health System Development

Health System	Component
Human Resources	• Implementation of new HRH strategy • Production of critical human resources • Retention of medical doctors and nurses • Training of SBAs, anaesthetic assistants, and biomedical technicians
Finance	• Health financing strategy development • Output based budgeting system • Web-based TABUCS
Construction	• Completion of existing construction projects • Priority construction as required by service expansion plan • Construction/expansion of CEONC at referral and central hospitals
Procurements	• E-submission of bids • Multi-year contracting: construction, drugs, commodities, services • Monitoring supply of drugs and medical supplies • Quality purchasing
Drugs and Equipment	• Revision of listed essential drugs for free care • Inventory of equipment
Information and Evidence	• Quality improvement of HMIS • Operational research

Observation: NPC member *Prof. Dr Shiva Kumar Rai* noted that securing high health gains with the limited resources available is a real challenge for us. Thus, we must pay careful attention in reviewing the progress and make sure our discussions and consultations are wide enough before redefining our priorities. He emphasised that the focus should be on strengthening the health system; then only can quality service delivery be ensured. While our programmes and policies sound pro-poor and people friendly, we need to understand how they have been implemented and whether or not services have reached the unreached and the poor as we envisaged. He suggested that MoHP carefully consider what has been achieved so far and what remains to be achieved, and also to reflect the budget ceiling when defining priority areas for future investment. He favoured an increment to the health budget equivalent to 10% of the national total, but requested that everyone understand the limitations and resource availability.

The detailed discussion on priority areas is summarised in the panel discussion. See section 7.

6.21 NATIONAL HEALTH ACCOUNTS 2008/09

Mrs. Parbha Baral, Health Economics and Finance Unit (HEFU) of MoHP, presented the preliminary findings of the National Health Account (NHA) 2008/09, which was the third round effort of MoHP to analyse the NHA. She explained that the estimation is based on the concepts and accounting framework of the Organisation for Economic Cooperation Development – System Health Account (OECD-SHA 1st). Over the last nine years (2000/01 to 2008/09), a 139% increase has been observed in Total Health Expenditure (THE), which rose from NPR 21953 million to NPR 52526 million. Similarly, per capita THE increased from US$ 13.2 in 2002/03 to US$ 24.8 in 2008/09. In that year, the private health sector was the major contributor (60.5%) to THE followed by the government (21%) and other sources (18.5%) (Figure 2). Despite the introduction of free health care, the share of out-of-pocket expenditure (OPE) is still high (54.8%) (Figure 3). A careful consideration of free health service implementation and its impact in OPE is highly recommended. It was noted that the THE is high for medical goods for outpatient care.

Figure 2: Total Health Expenditure by source (%)

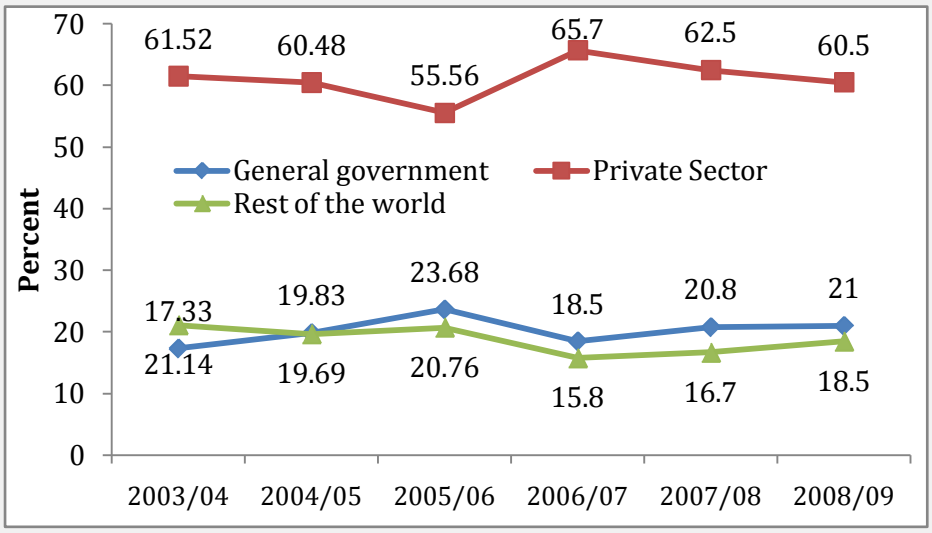
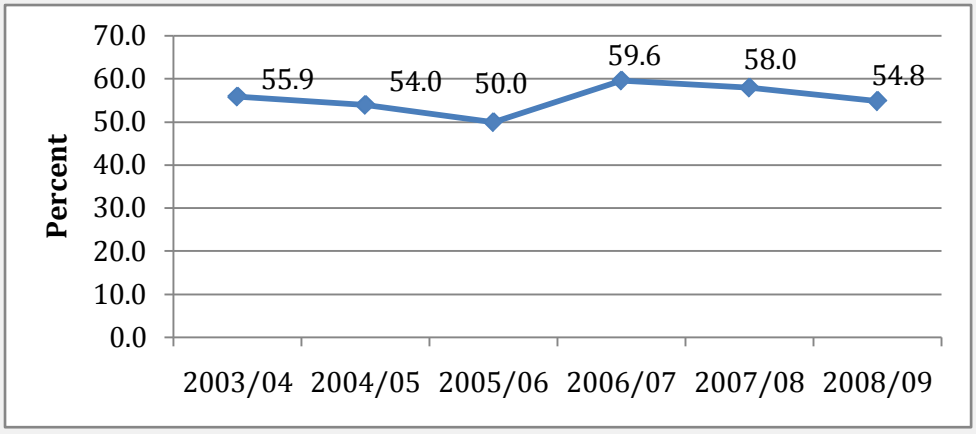


Figure 3: Share of OPE spending in THE



7. PANEL DISCUSSION ON PRIORITIES FOR NEXT YEAR

A panel comprised of representatives from MoHP, DoHS, EDPs, academia and civil society (see box) discussed the health programmes and priorities for FY 2012/2013. The results were presented by Dr. BK Suvedi in section 6.20 of this report. The discussion was divided into two sections: priorities in *health system strengthening* (HSS) and *health service delivery* (HSD).

The Panel members
Chairperson: Dr P Mishra, Secretary, MoHP
Members
- Dr. YV Pradhan, DG, DoHS
- Dr. Lin Aung, WR, WHO, Nepal
- Dr. Bert, Chair EDP Health Group
- Dr. Arjun Karki, Patan Academy
- Dr. Sunidhi Acharya, Civil Society

Facilitator: Dr. SC Baral

7.1 Panel discussion on Health Service Delivery (HSS):

Dr. Bert insisted that the NHSP-2 *Results Framework* and *Progress to the Present* should be considered as the basic standard when re/defining priorities for the future, indicating that the MoHP should focus on results based planning – a substantial move from the traditional practice of setting priorities and resource allocation. With regard to health system strengthening he urged that improvements in the financial management system of MoHP should receive greater attention in the coming years. He also suggested setting targets based on the audit observations, and ensured that EDPs will engage with the MoHP in doing so. He highlighted the need for a realistic procurement plan that is linked to the AWPB and developed with active participation of all divisions and centres. Another important priority area he emphasised was the development of a health care financing strategy with wider consultation among stakeholders. He suggested exploring strategic partnerships by purchasing EHCS, especially from hospitals, i.e. in the form of block grants. Moreover, he queried whether the MoHP should consider a multi-sectoral approach to address urban health issues.

Dr. Lin Aung highlighted the need to advance the M&E system for health, and suggested a critical review of performance indicators using a robust M&E framework at each level. He also urged a greater focus on programme-based operational research linked with Nepal Health Research Council and other academic institutions to inform evidence-based policies. He reemphasised WHO's commitment to providing strategic technical assistance in developing M&E and programme based operational research.

Dr. YV Pradhan questioned whether health system strengthening is still a priority of EDPs, and whether the EDPs' priorities are different than those of MoHP. He noted that the EDPs' focus has changed over the years, which he thought could create confusion. If HSS is still a priority, there is a greater need to focus on HRH – the mainstay of the health system. During the discussion it was concluded that under the SWAp the EDPs and MoHP collectively own the health sector priorities. The evidence is NHSP-2, since the EDPs appraised it and aligned their support accordingly. Dr. Pradhan also highlighted that a considerable delay experienced in procurement of health commodities over the years has hindered quality service delivery – an issue requiring urgent attention.

Dr. Pradhan discussed the AWPB and its link to the various approaches and frameworks of the last few years: result based, need based, output based, resource based etc. These have not changed the budget allocation and implementation modalities, however, as should be noted with caution. He shared the example of FHD failing to procure basic equipment in the last three years, and said we should learn a lesson from this and not act in the same way again. He suggested agreeing upon one framework and aligning budget allocation and implementation modalities to the framework.

Dr. Arjun Karki highlighted the double burden of diseases, as non-communicable diseases, largely associated with life style and high-risk individual behaviours, are increasing. In such cases, there is a greater need to focus on preventive actions rather than only on curative aspects. Hence, he suggested developing public health specialists, nutritionists and health counsellors in the existing health workforce. He noted certain issues related to pre-service training where initiatives have been started and need strong monitoring. He discussed the issue of urban health, saying we cannot afford to ignore it any longer, and that the meaningful involvement of medical schools in delivering EHCS in urban areas could be an option for MoHP.

Dr. Suniti Acharya focused on recruiting local HR by adopting a local recruitment process, which will help achieve maximum retention and sustainability of human resources. She said emphasis should be given to reducing the time for procurement of health commodities. She also highlighted the need for conducting operational research and translating the results into policy and planning. She mentioned that urban health needs to be one of MoHP's priority issues since the population is growing quickly and rapid urbanisation is taking place.

7.1.1 Issues raised from the floor:

- Strengthening HSIS should receive a greater focus and clear alignment between inputs and outputs is a must.
- All health programmes should focus more on addressing the needs of marginalised communities, not only on paper but also in practice.
- Although increasing the number of doctors and nurses supports the degree of specialisation, it is equally essential to focus on service access to marginalised people. Hence, a careful look at our service delivery modality is recommended.
- DFID clarified that HSS has been a priority of EDPs and suggested paying specific attention to HRH and financial management in the next year.
- New drugs have been added to the EHCS list but the evidence is rather unclear. It was suggested that MoHP consider a systematic review of the evidence, taking into account cost implications, benefits, demands and the burden of diseases, especially among the poor and marginalised, before adding new drugs to the EHCS list.
- Pay careful attention to improving logistics management, including for drugs and equipment, so that the current gaps are minimised if not eliminated.
- A simple linear approach cannot be taken to HR issues, such as deployment, retention and capacity development. Strategies should be piloted first before being made into blanket approaches across the country. HR deployment and retention in rural areas must be taken into consideration. We should reflect on the lessons learned and best practices to inform the HRH strategy.
- Many top level positions are vacant. If this situation continues, there will be considerable gaps in MoHP and DoHS. This area needs to be reviewed carefully and addressed accordingly.
- Many barriers are found to HR reform in the health sector. The entry point should be revision of policy and legislation, for which further exercises are recommended.
- Regarding health financing, the MoHP has allocated budget for insurance for the past three years but the results are unclear. Such interventions must be reviewed, using a standard set of indicators.

- HSS and HSD should go hand in hand, as a joint priority of EDPs and MoHP.
- We need to do things differently; business should not continue as usual if we are really serious about achieving results. Hence the priorities should be linked with the Results Framework.
- Focus more on neonatal and adolescent health.
- If the priority is quality service delivery, focus on HRH. If the priority is to get more EDPs into pool funding, focus on Financial Management and Health Financing.

7.2 Major issues discussed on Health Service Delivery (HSD)

- Expansion of EHCS should be a priority. However, a wider discussion on impact, scope and resources is recommended.
- Free health care: We should define what basic health care is and review the current provision of free health care.
- Nutrition: Further clarity on a multi-sectoral plan, provision of HR and monitoring using HSIS should be a priority for next year.
- For scaling up of successful community based health interventions a proper evaluation of pilot interventions is recommended.
- Prevention of non-communicable diseases should be a priority considering the increasing burden in the country. We should act before it is too late.
- The achievements of last year should be carefully reviewed when setting priorities for HSD. Output based budgeting should be used, not only changing the words but as a means to increase health sector funding.
- Infrastructure development is a must for quality service delivery.
- Since a sound M&E system is needed to focus on results-based programming, the M&E framework requires improvement.
- Disease control is an area requiring further investment.
- PPP with profit and non-profit organisations in delivering EHCS and other services should be a priority.
- Changing patterns of disease, care and treatment should be considered in planning health system strengthening, and more emphasis placed on prevention.
- HRH is not only an issue at the service delivery level but also at higher levels. This must be addressed urgently to avoid the gaps.
- Articulate a strategy to coordinate between MoHP and the academic sector for HRH development, including pre-service training, curriculum planning, and service delivery. Form a coordination body in MoHP.
- Finalisation of the urban health policy and strategy should be prioritised. The implementation of urban health with a focus on EHCS delivery to the urban poor requires a multi-sectoral approach between MoHP, MoLD and WASH, including waste management and involving medical schools and NGOs.

- Global Alliance for Vaccine and Immunisation (GAVI) support has been aligned to NHSP's priorities. A greater focus is needed on reaching the unreached, especially in rural areas. Evidence should be used to inform plans and policies with a focus on equity.
- Acknowledging civil society's contribution, CSOs could be further instrumental in advancing service delivery at the district level and below. A partnership modality needs to be well defined that is applicable to all.
- Regarding HIV, we must articulate what support is needed to finalise the HIV bill. We should consider including prevention of HIV as a priority, so the strategy becomes HIV prevention, treatment, care and support. We should articulate a strategy/approach of engaging other sectors on HIV prevention, as well as integration of MCH and HIV (PMTCT), and HIV with the child health programme.
- Timely clearance of the procurement plan is needed, with a review of current processes and barriers and ways to address them with clear deliverables.
- Further advancement of demand side programmes with a focus on equity is needed.
- MoHP is working on a new health policy but the status and plan is unclear.
- Health cooperatives should be considered in defining the health care financing strategy.
- Multi-sectoral collaboration is required in mainstreaming GESI, but what is included in the AWPB is yet to be clear.
- Shape inter-sectoral collaboration by focusing on results, e.g. WASH, nutrition, HIV.
- Procurement should be reviewed before and after pool funding, reviewing e-bidding, developing a multi-year plan, and speeding up the approval process from WB.
- Medical schools should be mobilised. A few clusters can be adopted to improve coverage and service delivery as well as HRH.

Comments and observations: Dr P Mishra, Secretary for MoHP and chair of the panel discussion, highlighted the following key areas for consideration:

- We (MoHP and its stakeholders including EDPs) now require a holistic approach for HSS, so a further discussion on the HSS framework is vital.
- We should understand peoples' perception of our ways of working and the services they receive. Are we meeting their expectations for minimum care without compromising quality? We should now develop a tool to measure their perceptions, and the findings should guide us to further improve health care delivery.
- The causes of neonatal deaths should be carefully reviewed and plans identified to address the causes.
- The AWBP should be realistic and linked to our agreed Results Framework. We should consider wider consultations while developing the AWPB and incorporate suggestions to make it implementable and cost effective.
- Nutrition is an important area to be taken up further, and MoHP is committed to make this happen.
- HRH has been an issue for many years but no substantial progress has been made. We must resolve this issue as it is fundamental to achieve results. Thus, we require the best locally feasible practical

solutions. Collaboration with academic institutions and professional councils is important. MoHP will finalise the HRH strategy without further delay.

- EDP support is crucial to increase the health budget to 10% of the national budget. Let's join hands to make this happen.
- Why is procurement so difficult since we are buying the same things over the years? Why are we so late in finalising the process? We should agree with EDPs on how to resolve this issue and develop a realistic plan jointly.
- Regarding Financial Monitoring Reports (FMRs), it is embarrassing to all of us why they are not submitted on time. MoHP lacks the adequate capacity and HR, and there is a lack of cooperation among us. Now that we know the issue, we should identify the solution as it is our shared responsibility. We should not blame each other but start addressing the issues.
- We need to finalise the urban health policy and then develop the strategy. PHC-RD will collaborate with municipalities and other stakeholders to speed up this process.

8. CLOSING SESSION

Dr. P Mishra, secretary for MoHP, chaired the closing session.

Jill Bell, AusAID Asia Health Specialist, presented her observations of the last three days. She noted that it was a well organised JAR with healthy discussions on key issues. She was glad to see the relationship and ownership between MoHP and EDPs towards key areas of reform maturing and being implemented in a mutual fashion. The EDPs are committed to further advancing health service delivery focused on the poor and marginalised. Nepal could be an example of a successful SWAp and provide learning for other countries elsewhere.

Dr. Bert highlighted the major areas and suggested actions from the JAR. He presented key points from the draft Aide Memoire and suggested having an in-depth discussion in the business meeting. Acknowledging MoHP's commitment and participation throughout, he said it was a successful JAR and has set a high standard for the future. Health discussion on key areas has led to some agreed actions and has highlighted a greater focus on HR, financial management, procurement, M&E, coordinated and need based TA/TC, setting the future priorities considering the Results Framework, and seeking modalities to address certain issues, especially nutrition and urban health.

Dr. BR Marasini, Chief HRSU, offered a vote of thanks to all stakeholders.

Finally, Dr. P Mishra, Secretary for MoHP, closed the JAR meeting with the chairperson's remarks.

The proposed date for the next JAR is the third week of January 2013.

Annex 1: Agenda

Government of Nepal
Ministry of Health and Population (MoHP)
Joint Annual Review of NHSP-2
16th-18th January, 2012-Hotel Soaltee, Kathmandu

Time	Agenda	Responsibility
Monday, 16th January		
8:30-9:30 am	Registration	PPICD/NHSSP/WHO
9:30-10:30 am	Inaugural Session	Dr. BR Marasini/SC Baral
10:30-10:50 am	Progress against NHSP-2 RF	Dr. BK Suvedi
10:50-11:15	DoHS progress of last year	Dr. YV Pradhan
11:15-11:45	Progress on agreed actions from the previous JAR	Dr. BR Marasini
11:45-12:30	Q&A/Discussion	Dr. SC Baral
12:30-13:30	**Lunch**	
13:30-13:50	Progress on Nepal Health Development Partnership (including Mutual Accountability)	Dr. Albertus (Bert), EDP Chair
13:50-14:10	Q&A/discussion	Dr. SC Baral
14:10-14:30	**Tea break**	
14:30-14:50	Updates on financial management	Mr. Shiva Simkhada
14:50-15:20	Updates on procurement	Dr. Mingmar Sherpa
15:20-15:40	Updates on infrastructure	Dr. Ashok Nath Upreti
15:40-17:00	Q&A/discussion	Dr. SC Baral
17:00-17:50	Remarks/wrap-up	Dr. SC Baral
Tuesday, 17th January		
8:30-9:15	Registration and tea	PPICD/NHSSP/WHO
9:15-9:40	Sharing of progress on Global Strategy for Women's and Children's Health (Sec. Gen. Ban Ki-moon initiative)	Dr. BR Marasini
9:40-10:00	Presentation on M&E Framework for NHSP-2	Dr. PB Chand
10:00-10:40	Q&A/discussion	Dr. SC Baral
10:40-10:55	**Tea break**	
10:55-11:15	Presentation on Aid Effectiveness	Mr. B Karki, MoF
11:15-11:30	Q&A/discussion	Dr. SC Baral
11:30-11:50	Presentation on draft strategy for Human Resources for Health	Mr. T Sharma/KR. Khanal
11:50-12:15	Q&A/discussion	Dr. SC Baral
12:15-12:30	Presentation on GESI and Population in the health sector	Mr. PR Bhatta
12:30-12:45	Q&A/discussion	Dr. SC Baral
12:45-13:45	**Lunch**	
13:45-14:15	Sharing of field observations	Field visit team
14:15-14:35	Multi-sectoral Nutrition Plan	Mr. AR Pandey, NPC
14:35-14:50	Presentation on CEONC site readiness progress	Dr. Naresh KC
14:50-15:20	Q&A/discussion	Dr. SC Baral
15:20-15:35	**Tea break**	
15:35-15:50	Seismic Vulnerability and Hospitals	Dr. SR Upreti

15:50-16:05	Contribution from AIN in Health	Dr. A KC
16:05-16:20	Regional Health Coordination team-RHD, Far west	Mr. Mahendra Shrestha
16:20-16:40	National Health Accounts 2008/09	Dr. BK Suvedi Ms. Prabha Baral
16:40-17:15	Q&A/discussion	Dr. SC Baral
17:15-17:30	Remarks/Wrap up	Dr. SC Baral
Wednesday, 18th January		
8:30-9:15	**Tea**	
9:15-9:40	New Health Programmes and Priorities for next FY 2012/13	Dr. BK Suvedi
9:40-11:00	Panel discussion on Priorities for next FY 2012/13	Dr. SC Baral
11:00-11:15	**Tea Break**	
11:15-11:30	Sharing of draft Aide Memoire	Dr. Bert
11:30-12:00	Discussion on draft Aide Memoire	Dr. SC Baral
12:00-13:00	**Closing Ceremony**	Dr. SC Baral
13:00-14:00	**Lunch**	

Other features of the JAR

1. Business meeting of Joint Financial Arrangement (JFA) signatories and MoHP; held on the 2nd half of Jan 18th

2. Information marketplace with poster/report presentations on:

   i. EDP Technical Assistance Matrix

   ii. Service Tracking Survey

Annex 2: List of presentations made in the JAR

1. Progress against NHSP-2 Results Framework
2. DoHS Annual Progress including MDGs
3. Progress on agreed actions from the previous JAR
4. Progress on Nepal Health Development Partnership (including Mutual Accountability) by EDPs
5. Updates on Financial Management (progress/challenges/way forward)
6. Updates on Procurement (progress/issues/challenges)
7. Updates on Infrastructure (progress/issues/challenges)
8. Sharing of progress on Global Strategy for Women's and Children Health (Sec. Gen. Ban Ki-moon initiative)
9. M&E framework for NHSP-2
10. Aid Effectiveness by Ministry of Finance
11. Draft Strategy for Human Resources for Health
12. GESI and Population in the health sector
13. Sharing of observations from EDPs/MoHP joint field visits
14. Multi-sectoral Nutrition plan by National Planning Commission
15. CEONC site readiness progress
16. Seismic Vulnerability and Hospitals
17. Contribution from AIN on Health
18. Regional Health Coordination Team - RHD, Far West
19. National Health Accounts 2008/09
20. New Health Programmes and priorities for next FY 2012/13

Presentations can be downloaded from the MoHP website.

Annex 2

JAR Presentations

Presentations

- Progress against NHSP-2 Results Framework
- DoHS Annual Progress including MDGs
- Progress on Agreed Actions from the previous JAR
- Progress on Nepal Health Development Partnership (including Mutual Accountability) by EDPs
- Updates on Financial Management (progress/challenges/way forward)
- Updates on Procurement (progress/issues/challenges)
- Updates on Infrastructure (progress/issues/challenges)
- Sharing of progress on Global Strategy for Women's and Children Health (Sec. Gen. Ban Ki Moon Initiative)
- M&E Framework for NHSP-2
- Aid Effectiveness by Ministry of Finance
- Draft Strategy for Human Resources for Health
- Sharing of Observations from EDPs/MoHP Joint Field Visits
    i). Field Visit Observation- Dhading
    ii). Field Visit Observation-Urban Health
    iii). Field Visit Observation-Kapilvastu-Arghakhanchi-Nawal Parasi
- Multi-sectoral Nutrition Plan by National Planning Commission
- CEONC Site Readiness Progress
- Seismic Vulnerability and Hospitals
- Contribution from AIN on Health
- Regional Health Coordination Team - RHD, Far West
- National Health Accounts 2008/09
- New Health Programmes and Priorities for next FY 2012/13

Progress Update on NHSP-2 Results Framework Indicators

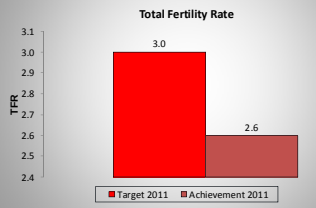
Presented at
Joint Annual Review
January 2012

Dr Bal Krishna Suvedi
Chief
Policy, Planning and International Cooperation Division
Ministry of Health and Population

Data Sources

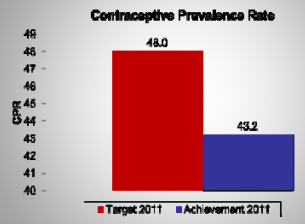
- Health Management Information System.
- Administrative Records of Divisions and Centers of DoHS, MoHP.
- Service Tracking Survey 2011.
- Nepal Demographic and Health Survey 2011 (Preliminary Findings).
- IBBS (HIV/AIDS).
- EOC Monitoring System and Aama Programme Monitoring.
- Census

Im2: The TFR target for 2011 have been met.



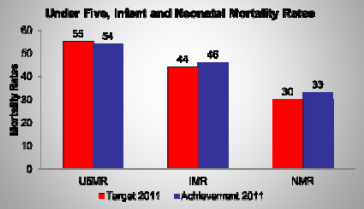
Source: NDHS 2011 (Prelim Report)

Im4: There was shortfall in achieving CPR Target for 2011.



Source: NDHS 2011 (Prelim Report)

Im5,6,7: The U5MR has declined but IMR & NMR need attention.

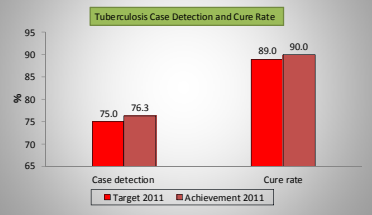


Source: NDHS 2011 (Prelim Report)

Im8: The targeted reduction in % Underweight Children has been achieved

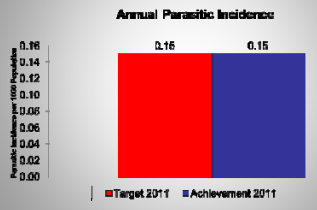
Source: NDHS 2011 (Prelim Report)

Im10,11: The TB target was achieved.



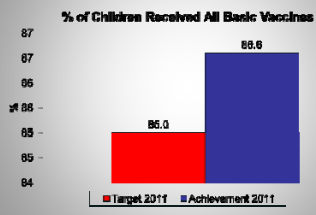
Source: HMIS, DoHS

Im12: The Malaria Programme achieved the API level.



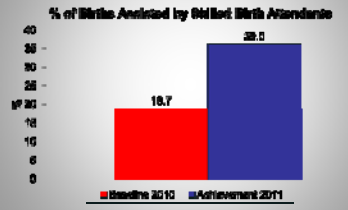
Source: EDCD, DoHS

OI1.1: The target for coverage of Basic Vaccines to Children has been achieved



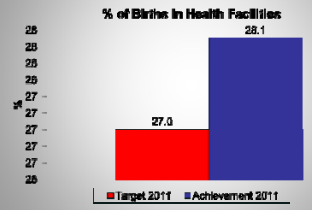
Source: NDHS 2011 (Prelim Report)

OI1.3: The birth assisted by Skilled Birth Attendants almost doubled from the baseline 2010. (Target not specified for 2011.)



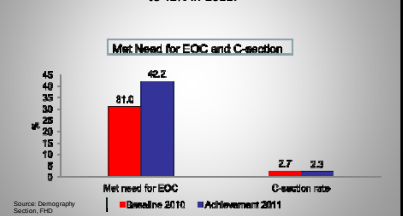
Source: NDHS 2011 (Prelim Report)

OI1.4: The Delivery in Health Facilities target was met



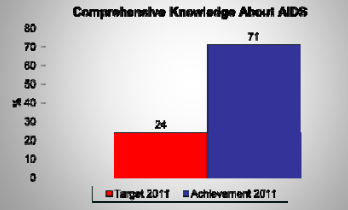
Source: NDHS 2011 (Prelim Report)

OI1.5, 1.6: Met Need for EOC has increased from 31% in 2010 to 42% in 2011.



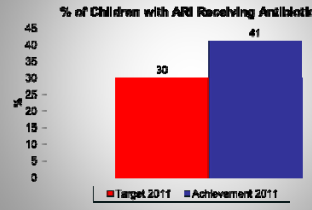
Source: Demography Section, FHD

OI1.11: The achievement of comprehensive knowledge about AIDS among WRA far exceeded target.



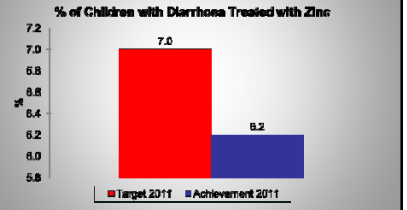
Source: NDHS 2011 (Prelim Report)

OI1.12: The target for ARI treatment have been met.



Source: HMIS, DoHS

OI1.19: The target of treating children with Zinc for diarrhoea was lees than expected

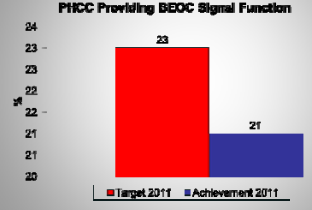


Source: NDHS 2011 (Prelim Report)

OI2.7: Piloting of one Stop Crisis Centre for GBV Victims in 5 selected hospitals piloting initiated in 2011

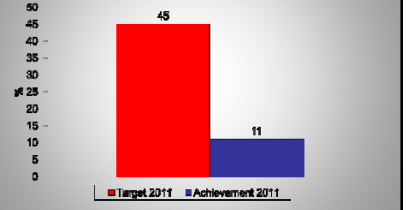
Source; Population Division, MoHP (Admin Records)

OI3.3: The achievement of PHCC (%) providing BEOC signal function was less than target



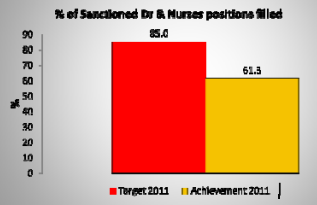
Source: STS 2011, MoHP (Prelim Findings)

OI3.4: The achievement of HP (%) providing selected FP and 24/7 Delivery services was very low compared to target



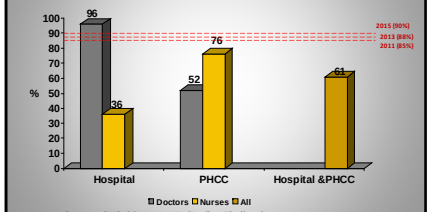
Source: STS 2011, MoHP (Prelim Findings)

OI3.10: Of a total 85% targeted only 61% of the Dr/ Nurses positions in PHCCs and Hospitals was filled



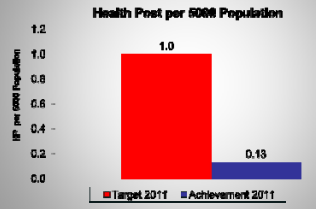
Source: STS 2011, MoHP (Prelim Findings)

OI3.10: HR target is a challenge to fill all vacancies for nurses in hospitals and doctors in PHCCs



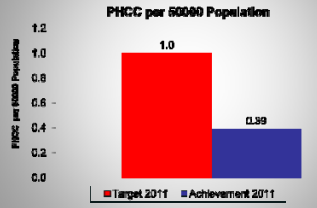
Source: STS 2011, MoHP (Prelim Findings)

OI3.11: The target of one Health Post per 5000 population is still to take off.



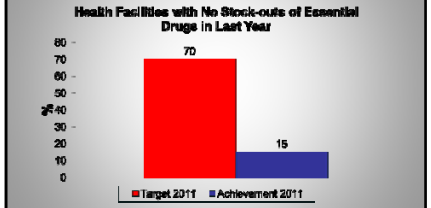
Source: HMIS, DoHS (for # of HP), CBS (for Population)

OI3.12: The target of one PHCC per 50000 population is still to be achieved



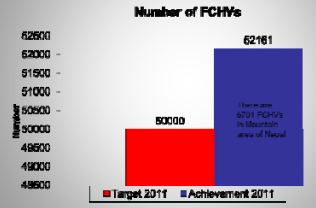
Source: HMIS, DoHS (for # of PHCC), CBS (for Population)

OI3.15: The Essential Drugs Stock-out situation needs improvement.



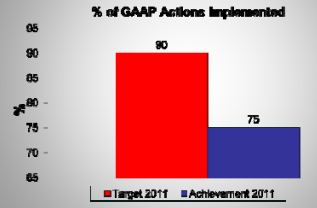
Source: STS 2011, MoHP (Prelim Findings)

OI3.16: More FCHV have joined the health system of Nepal.



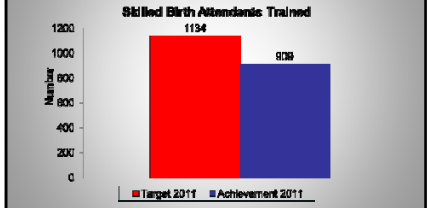
Source: FCHV Unit, FHD (Admin Records)

OI3.17: The GAAP Action achievement was not met as targeted



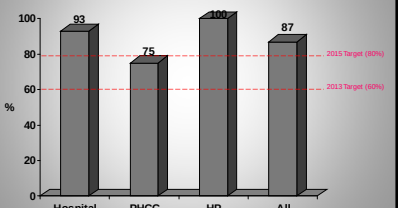
Source: HSRU, MoHP

OI3.20: Only 80% of SBA training target was met



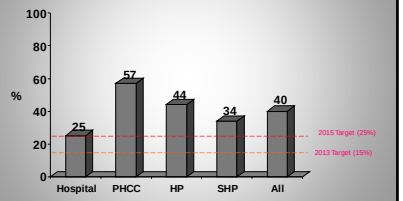
Source: NHTC, MoHP (Training records)

OI3.1: Most facilities offering abortion care are providing post-abortion family planning.



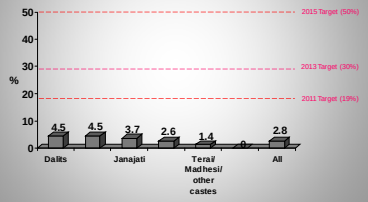
Source: STS 2011, MoHP (Prelim Findings)

OI3.18: All facility types have reached the social audit target



Source: STS 2011, MoHP (Prelim Findings)

OI2.6: Use of community-based emergency funds.



Source: STS 2011, MoHP (Prelim Findings)

Achievement meeting the target

- Total Fertility Rate,
- Under-five Mortality Rate,
- % of children under five years of age who are underweight,
- Tuberculosis case detection rate (%),
- Tuberculosis case success rates (%),
- Malaria annual parasite incidence per 1,000,
- % of children that have received all basic vaccines by 12 months of age,
- % of births delivered in a health facility,
- % of women aged 15-49 with comprehensive knowledge about AIDS,
- % of children under age five with symptoms of ARI received antibiotics,
- % of clients satisfied with their health care at district facilities,
- % of health facilities subjected to social audits,
- Number of Skilled Birth Attendants trained.

Achievement not meeting the target

- Contraceptive Prevalence Rate (modern methods) for WRA,
- Infant Mortality Rate,
- Neonatal Mortality Rate,
- % of community based emergency funds granted,
- % of children under-5 with diarrhoea that have been treated with zinc,
- % of PHCCs that provide all BEOC signal functions,
- % of health posts that provide delivery services 24/7 and short term hormonal, non-hormonal, IUCD and implants,
- C-section rate,
- % of sanctioned doctors & nurses posts at PHCCs & hospitals that are filled,
- Number of HPs per 5,000 populations,
- Number of PHCCs per 50,000 populations,
- % of health facilities with no stock-outs of 'essential drugs' in last 1 year

Thank You

Joint Annual Review Meeting 16-18 Jan, 2012

Dr Y V Pradhan
Director General
Department of Health Services

Outline

1. National Annual Review Meeting : Historical perspective
2. Bird's eye-view of some health programmes
3. General Observations of Regional Review Meeting FY 2067/68

1. Annual Review Meetings : Historical Perspective

Annual Reviews- Highlights (1)

- National Annual Performance Review Meeting started from 2051/52 (1994/95), gradually expanded up to district level;
- This review meeting is **15th** in its series
- Duration of Annual Performance review gradually condensed to 3 days from 7 days;
- Progress, Issues /Problems are shared at all levels of health facilities (up to Ilaka) & Institutions and brought to District, Regional and National forum

Annual Reviews- Highlights (2)

- Large and highest forum to share among stakeholders, review the performances and find the ways to improve the effectiveness and efficiency of Health Programs.
- The workshop reviews target vs. achievement with respect to budget, service coverage, continuity and its trend;
- Review the Implementation status of recommendations made during previous national workshops and regional workshops
- Comprehensive DoHS Annual Report published on the basis of national review;
- Contribute to revise policies, strategies and to support MDG goals.

Expected Outcomes

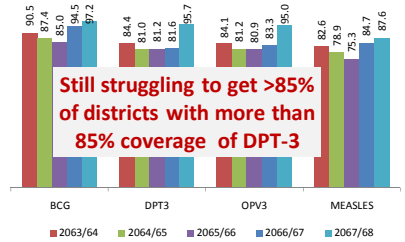
- All the Health Programs are reviewed
- Identified Strength, Weakness, Opportunity and Threat in program implementations
- Bring out recommendations for the overall improvement

2. Bird's Eye View of some key health programmes

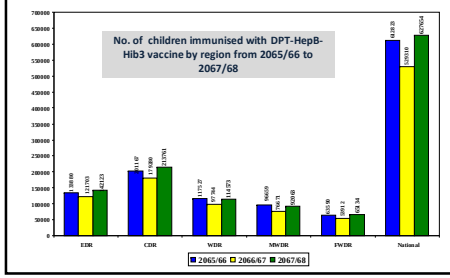
Key Success in Routine Immunisation

- Maternal and Neonatal Tetanus Elimination (MNTE) status maintained
- Significant reduction in the number of JE cases in endemic districts
- Moving towards measles elimination
- Close to Polio eradication- last case in August 2010
- Diphtheria, Pertussis no more a public health problem

Routine Immunisation- Coverage



Number of Immunized Child with DPT-HepB-Hib



Vaccine Wastage- Pentavalent Vaccine

Area	Vaccine Wastage Rate	Vaccine wastage in doses	Cost in Rs
EDR			7,392,893
CDR			5,357,205
WDR			4,148,865
MWDR			5,962,950
FWDR			3,425,310
National			26,287,223

This is equivalent to 2.6 cores on one single vaccine due to wastage, half of this is only acceptable

Expenses of Vaccine per child per District

- Does not Include shared cost (~24%) of the system as well as other local budgets

	Budget	# children immunized by penta	Budget per child (Nrs)
Bhaktapur	2,216,000	5,110	434.00
Kaski	3,634,000	9,958	365.00
Surkhet	6,862,000	9,064	757.00
Mugu	2,267,000	1,060	2,138.00
Rautahat	5,753,000	18,751	307.00

Child Health Programming

- CB-IMCI through out the country
  - Quality of case management fro diarrhoea and pneumonia improving
  - BUT ZINC !!!!– no stock out but coverage very low
- CB-NCP- Rapid expansion
  - Good results
  - Priliminary data showing reversal in the ration of Institutional and Home delivery. Institutional delivery rapidly increasing
- Nutrition
  - Major programmatic emphasis given
  - Multisectoral plan in progress
  - Sustained the achievement in micronutrent deficiency: VitA, IDD are no more a public health problem-

Family Health

Achievements

•Total Fertility Rate downed from 3.1 to 2.6 in last 5 years

Urban : 1.6

Rural : 2.8

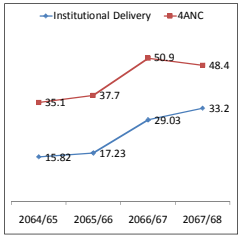
•Current Use of Contraceptive Modern Method downed from 44.2 to 43.2 in last 5 years

•At least one ANC for last pregnancy during last five years increased from 44 percent to 58 percent

Achievements

- Increasing trend of institutional deliveries
- CEOC sites expanded from 76 to 93 in 2067/68
- Total birthing centers increased from 532 to 695 in 2067/68
- Around 2600 SBAs trained till last fiscal year.

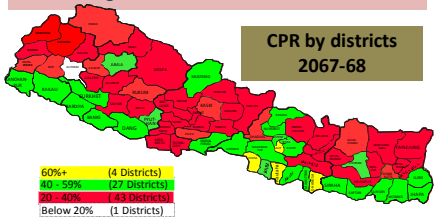
Picking a Point: 4 ANC vs Instituitional Delivery



- Rupees **129** Cores allocated for Safe motherhood programs this year in compared to Rupees ~**95**crores allocated last year.

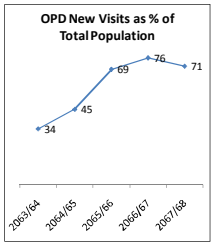
CPR- trends, contribution

- **Do we know the contribution of Social marketing on CPR ??**



PHC Revitalisation

Performance on Free Drug



- Required intervention by senior level after review of data of pervious year with >100% population having OPD visit.
- Amount Required for Subsidy is going up every year and budget is not enough to meet district demand
- Total budget of free drug program : ~65 crores
  - UNIT cost of drug per population Nrs 23
  - Projected unit cost for 30% population on international standards Nrs 78 per person

Free Drug Programme-Comparision

Status of OPD Visit (%)		
District	2066-67	2067-68
SANKHUWASABA	97	98
OKHALDHUNGA	107	125
SAPTARI	86	78
SIRAHA	77	91
KAVRE	74	82
SYANGJA	76	81
PARBAT	106	114
ROLPA	95	78
SALYAN	98	100
BARDIYA	79	90
SURKHET	105	110
DAILEKH	99	111
JAJARKOT	87	101
BAJURA	117	112
ACHHAM	105	117

- Around 17 districts reporting more than 100 percent of population doing OPD visit in 2067/68
- Dadeldhura reported 239 % and Humla reported 194%of population visiting OPD in 2067/68

Epidemiology and Disease Control

- No diarrhoeal outbreaks reported this year
  - Regional level preparedness and planning done
  - Integrated Campaigns have shown to be instrumental
- Malaria control program well placed to transit to pre-elimination phase-
  - good progress made in last few years
- MDA for Lymphatic Filariasis –
  - Good coverage except in some urban areas
  - Eleven co-incidental deaths reported from some districts , investigated and
  - MDA strategy revised accordingly to avoid such events and their reporting

Financial Management

Budget vs Expenses Status-DoHS

FY	Annual Budget (Rs. In Lakhs)	Expenditure (Rs. In Lakhs)	Expenditure (%)
2067/68	149,710	119,223	79.70
2066/67	134,168	108,207	80.65
2065/66	119,046	97,163	81.60

Irregularities Clearance Status of last three years (In lakhs)

FY	Total Irregularity	Irregularity Clearance	Clearance %
2067/68	23,094	10,606	45.90
2066/67	18,900	6,184	33.00
2065/66	14,959	4,267	28.00

HR Management (as of 2068-8-7)

- **Doctors' Postings**
  - Total number of Scholarship Doctors at duty posting : 257
  - Doctors' in Short-term contract service: 19
  - Total No. of Posting : 276
  - Highest nos. posted in Kailali -10
  - Lowest nos. posted in Siraha (1), and no posting in Bajura
- **Upgrading and posting of VHW/MCHW according to government decision**
- **Average time given spent by program managers in their offices last year(samples)**
  - **Around 30% by District managers**
  - **Around 40-45% by division directors**
  - **Around 60 % by Director General**

Do the achievement reflect upon the attendance ???

HR Management Issues

- Lack of clear schedule of transfer of staff. No staff transfer since last two years by department of health services
- High demand for postings especially in newly created post of upgraded health institutes
- High demand for "deputations" (KAAJ)
- Immediate need to fulfill the vacant positions; both officer and non-officers level

3. General Observations of Regional Review Meeting FY 2067/2068

Observations: Regional Reviews

- Innovations in regional review methodology
- All reviews attended by high level officials of MOHP including Honorable minister and Secretaries
- All the D/PHO chiefs were present at all the regional reviews.
- Most of the Medical Superintendents were present from hospitals (regional, sub-regional and zonal)
- All regional directors attended almost all technical sessions

Lack of resource is not a constrain: Lessons from far-west

- Two case studies
  - Sunnikot SHP, Bajhang
  - Santada HP, Achham

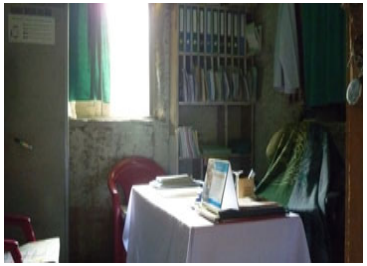
An example from

SUNNIKOT SHP BAJHANG

पहिलाको उप स्वास्थ्य चौकी

अहिलेको उप स्वास्थ्य चौकी

प्रशासन तथा कार्यालय प्रमुखका कक्ष



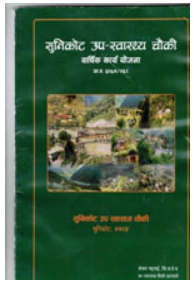
ओ.पि.डि तथा औषधि वितरण कक्ष

मातृ सेवा तथा परिवार नियोजन कक्ष

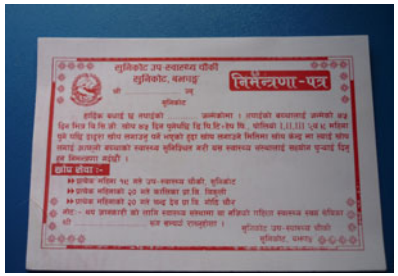

औषधि भण्डार कक्ष

तालिम कक्ष

जेष्ठ नागरकि सम्मान कार्यक्रम




Invitation Card for Routine Immunisation



Calendar distribution to pregnant women reminding 4 ANC

Lack of resource is not a constrain Attitude & Commitment makes the difference

सुन्दर सुदुर पश्चिम दुर्गम हिमाली जिल्ला बझाङ मा रहेका स्वास्थ्यको पाहुच बाट वञ्चित ९दात दुखदा खानका औषधि खाइने, बच्चा जन्माउन मसलदा छोरीले बाजि बच्चा ठाम्ने अवस्था मा रहेका जनतालाई एक स्वास्थ्यकर्मि भएर सिमित साधन र स्रोतका बाबजुद स्वास्थ्य सेवा प्रदान गर्न पाउदा राष्ट्र सेवक कर्मचारी भएकोमा गर्व महशुस गर्दछु

केशव भट्टराइ,
मि.अ.डे.म सुनिकोट उप स्वास्थ्य चौकी, बझाङ

We all can bring the change!! Together if we work.....

धन्यवाद !

Progress on Agreed Actions
Joint Annual Review -2011

Dr BR Marasini
Ministry of Health & Population
16 January 2012

Background

- First Aide Memoire for Nepal Health Sector programme –II
- New tradition – document jointly signed by health secretary and EDP chair in July 2011 in an effort to promote the ownership
- Understanding of one Aide Memoire in one year only

Progress on Agreed Actions

1. A time bound action plan for SM and FP scale up with an indicative cost be prepared and presented in next JCM and include in the next AWPB- 30 October 2011-
- Family Health Division of DoHS requested for preparation of action plan as above and will be presented in next JCM

Progress on Agreed Actions

2. Reassess the target for immunisation in confirming with the forthcoming census and NDHS (November 2011)- preliminary results of both the surveys published but awaiting for the final result
3. Immunization trust fund and immunisation act (August 30, 2011)- concept note and draft act prepared- this included in the finance minister's budget speech in the parliament as well

Progress on Agreed Actions

4. Detail implementation modalities prepared for integrated planning, review and monitoring of all child health programme (July 30, 2011)- completed
5. OMS in consultation with MOGA and MoF to initiate recruitment and for training for pre-service and in-service training (December 2011)- partially completed

Progress on Agreed Actions

6. Contracting out the NGOs/CSOs for TI
- Provide TA for selection and contracting out NGO/CSO
- TA to strengthen national M & E system
- Expedite actions for pending HIV Bill approval (July 31, 2011)
- Progress- contracting out done, M & E framework prepared, HIV bill still not finalized

Progress on Agreed Actions

7. Environmental health and hygiene multi-sectoral technical committee and water quality surveillance team & mainstreaming WASH with ongoing health programs (August 30, 2011)
- Progress- Interaction with WASH related organizations done, but detail workout is underway and establishment of regional public health laboratory in one region is underway

Progress on Agreed Actions

8. Develop an improvement action plan to improve public and private hospitals for enhancing quality of care and for strengthening the public health laboratory and blood transfusion services (July 30, 2011)
- Progress- 14 teams formed to monitor hospitals and reports prepared, public health laboratory policy and blood transfusion act prepared

Progress on Agreed Actions

9. Draft AWPB of 2011-12 to be discussed in JCM (July 10 2011)- done
10. (a) Implement a tracking tool for GAAP (b) Indicator to measure progress of GAAP © operalization of GAAP, GESI, and results framework and updating every year (January 16, 2012)
- Progress- two workshops held on GAAP, service tracking survey done- suggestions of revised GAAP

Progress on Agreed Actions

11. (a) Development of financial management improvement action plan- linked with e-AWPB and FMIS (b) training to accountants (c) computerieing accounting system (November 2011)
- Progress- software development is underway and training of accountants is ongoing

Progress on Agreed Actions

12. Adopt procurement of goods, works, and services through single door practice (August 30, 2011)
- Progress- partially done

13. Resolve transportation delays of drugs and medical supplies from district to health facilities (August 30, 2011)- partially done
- Physical assets management unit- established in Management Division,DoHS

Progress on Agreed Actions

14. Practice of preparation and updation of procurement plan in civil work along with AWPB and monitoring of health facilities under construction-ongoing
-

Progress on Agreed Actions

15. A costed HRH development plan- nearly finished
- OMS for entire MOHP and DoHS functional posts- work is underway
- OMS for national public health laboratory, nutrition section of CHD and other critical HRH- underway
- Develop financial and non-financial incentive to retain health workers in remote areas- done, but yet to be accepted by MoF

Progress on Agreed Actions

16. Optimal synergy between MoHP and academic instituitions (August 30, 2011)- a consultative meeting held and a task force proposed to work out the modalities

17. Accreditation guidelines for health facilities and health training instituitions (November 30, 2011)- hospital accreditation guideline prepared, but for health training instituitions necessary works underway

Progress on Agreed Actions

18. National health training centre to national health training academy (July 2012)-preliminary work initiated

19. Incremental capacity enhancement strategic plan (July 31,2012)- document prepared

20. GESI orientation to central level staffs and equip GESI (August 30 2011)- initiated

Progress on Agreed Actions

21. Conduct more social audits by using score cards (December 31, 2011)- community score card piloting is ongoing

22. Pilot one stop crisis center for GBV patients (June 31, 2012)- three centers established

22. Develop policy on social health protection aligned with health financing strategy (June 2012)- draft prepared

Progress on Agreed Actions

23. Joint technical assistance arrangement- under discussion only

24. Provide information (both physical and financial progress) related to directly funded programs (November 30 every year)- received from SDC

Conclusions

- Progress on agreed actions is partially fulfilled
- The Aide Memoire finalised very late

Commitments and Accountability

How are we doing with regards to our commitments under NHSP-2?

An assessment by the EDPs

Joint Annual Review NHSP 2, January 2012

Commitments and Accountability

- How did we conduct the assessment?

1. We compiled all the commitments we signed up to from SOI, IHP and JFA
2. We assessed to what extent the objectives were being met

Mutual Accountability Score Card
For the period covering July 2011-July 2012

	Accountability Element	Indicators	Resp.	Strongly Agree	Agree	Neither Agree nor disagree	Disagree	Strongly disagree
1.1	MoHP to consult and seek the Signatories agreement on the AWPB as presented to Parliament in each fiscal year and consult with the Signatories on any substantial deviation from the agreed 1AWPB	Adequate process consultation made and final AWPB shared and Agreed by Sep 30.	MoHP			X		
1.2	EDPs will provide tentative annual contribution to the GON by March 15	NHSP2 partners provide indicative contribution to GoN by March 15.	EDPs		X			
1.3	EDPs will confirm their annual contribution upon agreement on upcoming AWPB	1.3.1 Pool funding partners confirm their annual contribution upon agreement on AWPB by Sep 30.	EDPs			X		
		1.3.2 EDPs provide tentative three-years rolling contribution to NHSP 2 by					X	

Observations from the assessment

- **On joint planning**

- Progress made in the early indication of tentative contributions from the EDPs.
- Improvements necessary in the AWPB consultation process, the process for subscribing to the AWPB and more realism towards EDP internal processes to commit.

Observations from the assessment

- **On coordination and joint consultation**

- Good progress in JAR/JCM schedule and in coordination of Technical Assistance and Technical Cooperation.
- Improvements necessary in the schedule of meetings of the Health Sector Development Partners Forum and the development of a rolling 3-year procurement plan.

Observations from the assessment

- **On harmonisation**

- Good progress in the use of common reporting formats and avoiding additional reports and in alignment with NHSP 2.
- But still too many EDP-specific monitoring activities and a common program for country systems strengthening needs to be agreed upon in order for EDPs to increasingly use those systems.

Observations from the assessment

- **On transparency**

- MoHP well informed about EDPs contributions, both in the red book and outside.
- But accounting for expenditures by NGO to a large extent not reported, inclusion of civil society in consultations still a big issue and MoHP website not updated.

Observations from the assessment

- **On M&E and reporting requirements**

- No changes are made in requirements without consultation. Clarifications are needed for some of the commitments (technical review, output-based progress report).

Observations from the assessment

- **On fiduciary**

- Resources are channeled to the end user on a timely basis. However, still major problems persist with regards to delays in IPR/FMR and complete audit report submission, audit observation follow-up and in updating the Financial Management Improvement Plan

EDP "project" support for the current FY

Broken down in "Financial support" earmarked or not earmarked (pooled) and Other, collectively dubbed as "Technical Assistance"

	ADB	AusAID	DFID	GFATM	GAVI	GIZ	JICA	KfW	Norway	SDC	UNAIDS	UNFPA	UNICEF	USAID	WB	WFP	WHO	Grand Total	
Financial resources																			
1. Earmarked			57	4,055			3,500				331	7,800	1,000			3,838		20,581	15%
2. Not earmarked (pool)	5,500	11,200			4,887		3,500								27,000			52,087	39%
Technical Assistance																			
Costs	951		600	5,800	10,493	2,657	2,650	786		402	1,000	200	3,181	1,100	31,645	200	26	104	61,995	46%
Total	951		6,100	17,057	14,548	7,544	2,650	786	7,000	402	1,000	200	3,712	8,900	32,645	27,200	26	3,942	134,663	100%

NB:
1) in US$ 000
2) approximate and tentative figures
3) TA: all resources that do not flow through GON/MOHP system / are not managed by MoHP
4) 1 US$ = 72.5 Nfs
5) highlighted: not verified

In short:

Financial Resources		
Earmarked	20,581	15%
Not earmarked (pooled)	52,087	39%
Technical Resources	61,995	46%
Total	134,663	100%

And then there are the expectations – as opposed to commitments

- Fixed percentage of budget financed by EDPs:
- Unrealistic and undesirable expectation: not the way commitments by development partners are made – not a single one – and would sustain dependency.

And then there are the expectations – as opposed to commitments

- All financial details of TC/TA provided to GoN:
- Governed by bilateral agreements.

And then there are the expectations – as opposed to commitments

- Unconditional use of government systems:
- Unrealistic expectation: use of government systems is driven by the integrity and performance of those systems.

And then there are the expectations – as opposed to commitments

- Longer-term predictability of EDP contributions:
- Unrealistic expectation: not under the control of local EDPs – but we support the aspiration.

Thank You!

Updates on Financial Management: Progress, Challenges and Way forward (JAN.16-18,2012)

Mr. S.P. Simkhada
Under Secretary (Finance)

Outline of the Presentation

1. Status of Health Sector Budget in National Budget
2. Current Budget Status (2011/12)
3. Status of Recurrent & Capital wise Budget Utilisation
4. Status of Centre and District Budget Utilisation
5. Status of Line Item wise Expenditure
6. Status of Source wise Budget Utilisation
7. Status of Irregularities
8. Progress made
9. Major Challenges
10. Way Forward

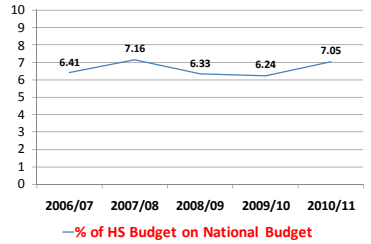
Status of Health Sector Budget in National Budget

FY 2006/07 to 2010/11

In '000' NRs.

FY	National Budget	Health Sect. Budget	% of HS Budget on National Budget	Health Budget Growth	Growth %
2006/07	143,912,000	9,230,000	6.41	1,675,000	22.17
2007/08	168,996,000	12,098,583	7.16	2,868,583	31.08
2008/09	236,015,897	14,945,964	6.33	2,847,381	23.53
2009/10	285,930,000	17,840,466	6.24	2,894,502	19.37
2010/11	337,900,000	23,813,993	7.05	5,973,527	33.48

% of Health Sector Budget in National Budget



Budget of FY 2011/12

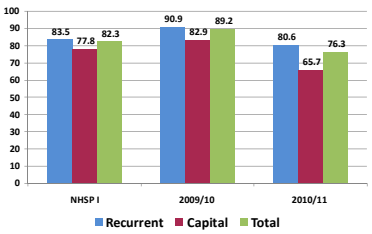
- National Budget NRs.**384,900,000** thousands
- Health Sector Budget NRs. **24,934,885** thousands.
- It is **6.48** Percent of National Budget.

Status of Recurrent/Capital Budget Utilisation

In '000' NRs.

Particulars	NHSP I (2004/05-2009/10)	2009/10	2010/11
Total			
Annual Budget	68,310,643	17,840,466	23,813,993
Expenditure	56,250,699	15,913,860	18,175,831
Utilisation %	82.35	89.20	76.32
Share of Expenditure %	100	100	100
Recurrent			
Total / Annual Budget	54,575,602	14,127,406	17,054,304
" " Expenditure	45,567,716	12,836,622	13,737,924
" " Utilisation %	83.49	90.86	80.55
Share of Expenditure %	81.01	80.66	75.58
Capital			
Total / Annual Budget	13,735,041	3,713,060	6,759,689
" " Expenditure	10,682,983	3,077,238	4,437,907
" " Utilisation %	77.78	82.88	65.65

Absorption % of Recurrent and Capital Budget

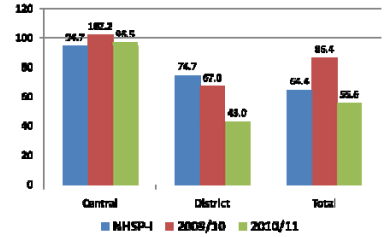


Status of Central & District wise Budget Utilisation

In '000' NRs.

Particulars	NHSP I (2004/05-2009/10)	2009/10	2010/11
Total			
Annual Budget	68,310,643	17,840,466	23,813,993
Expenditure	56,250,699	15,913,860	18,175,831
Absorption/Utilisation %	82.35	89.20	76.32
Central			
Annual Budget	35,258,840	7,592,090	10,784,054
Expenditure	25,334,876	5,816,172	7,414,920
Utilisation %	71.85	76.61	68.76
District			
Annual Budget	33,051,803	10,248,376	13,029,939
Expenditure	30,915,823	10,097,688	10,760,911
Utilisation %	93.54	98.53	82.59

Status of Central & District-wise Budget Utilisation

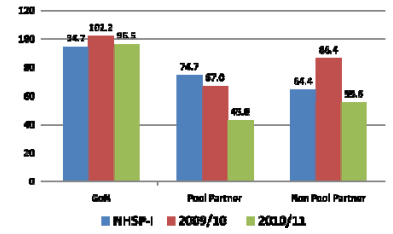


Status of Source Wise Budget Utilisation

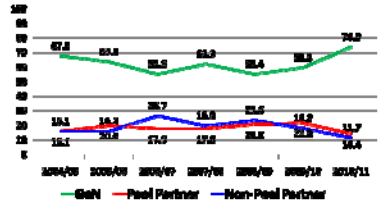
In '000' NRs.

Particulars	NHSP I (2004/05-2009/10)	2010/11
GoN Funding		
Total/Annual Budget	35,486,320	13,930,195
Expenditure	33,591,670	13,444,840
Utilisation %	94.66	96.52
Pool Partner Funding		
Total/Annual Budget	14,702,106	6,070,576
Expenditure	10,982,789	2,611,867
Utilisation %	74.70	43.03
Non-Pool Partner Funding		
Total/Annual Budget	18,122,217	3,813,222
Expenditure	11,676,239	2,119,124
Utilisation %	64.43	55.57

Status of Source Wise Budget Utilisation



Trend in Expenditure by Source

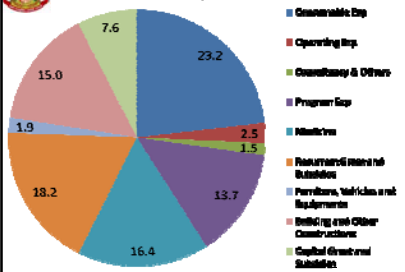


Status of Line Item-wise Expenditure

In '000' NRs.

SN	Line Items	Exp. of 2010/11	% of Total Exp.
1	Consumable Expenditure	4,212,626	23.18
2	Operating Expenditure	459,635	2.53
3	Consultancy & Others	277014	1.52
4	Program Expenditure	2,495,926	13.73
5	Medicine	2,983,840	16.42
6	Recurrent Grant and Subsidies	3,308,883	18.20
7	Land acquisition	0	0
8	Furniture, Vehicles and Equipments	345,487	1.90
9	Building and Other Constructions (including renovation)	2,720,927	14.97
10	Capital Grant and Subsidies	1,371,493	7.55
	Total	18,175,831	100

Line Item-wise Expenditure of 2010/11

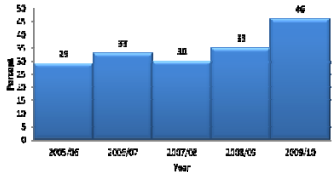


Status of Irregularities and Clearance

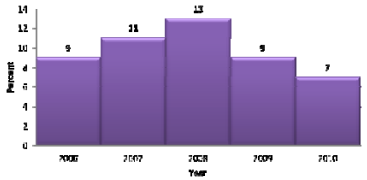
In '000' NRs.

Particulars	2006/07	2007/08	2008/09	2009/10
Clearance of irregularities Total IRREG. until 09/10 Nrs. (2,370,000)	33%	30%	35%	46%

Trends In Clearance Of Irregularities



Proportion of Irregularities against the Audited Expenditures



Progress Made

- *Concept Note on Transaction Accounting and Budget Control System (TABUCS)*
- OBB Workshop Conducted
- *Web-Based Electronic Annual Work Plan and Budget (eAWPB) Developed*
- *Service Tracking Survey Conducted*
- *Procurement Training Conducted*
- *Implementation of G F S / Established PEFA(IU)*

Major Challenges

- Direct budget execution by some EDPs, weak forecasting of external assistance and separate reports and audits from EDPs
- *Challenge related to Budget Preparation*
- *Challenge related to Budget Execution*
- *Challenge related to Accounting*
- Challenge related to Auditing
- *Recording and Reporting and Monitoring*

Way Forward

- Prepare the implementation mechanism of TABUCS, implement as a pilot in selected districts
- upgrade the existing eAWPB and make the provision of analysing the procurement plan
- Develop human resource capacity to use technology based solutions
- Interaction programme with OAG and Public Accounts Committee
- Strengthen the existing audit committee through regular meetings
- Develop the financial monitoring indicators and implement the monitoring mechanism through the active participation of DoHS and RHD
- Developing the internal control system

Joint Annual Review

Ministry of Health and Population
Department of Health Services

(January 16 – 18, 2012)

Dr. Mingmar G. Sherpa, Director
Logistics Management Division

PROGRESS ON

Nepal Health Sector Programme-II's
Governance and Accountability
Action Plan (GAAP)

(LMD related GAAP are 4.3, 5.1, 5.2, and 6.2)

Improve Quality of Asset Management

- Regular updating of inventory of all assets Distt-PHC
  - Inventory Management Software developed and in place
- Improve inventory software for non-consumable and strengthen LMIS
- Service contracted Bio-medical Engineers for maintenance of Eq.
- Revised Procedure Guideline for Auctioning, Disposal and Write-Off in 2010
  - Approved by Ministry of Finance and Auditor General's Office
  - The Guideline can be used in other Sector and Ministries

PROCUREMENT

- **Forecasting of Health Commodities**
  - Contraceptive, Essential Drugs, Vaccines & Syringes, HIV/AIDS & other Program related items.
- **Consolidated Procurement Plan**
  - Goods, Services & (Works)?? in coordination with different Divisions & Centre
- **Multiyear Procurement**
  - Contraceptives, Essential Drugs & Equipments
- **Training for strengthening procurement capacity**
  - At the centre, working with TAs & Consultants & Abroad
  - At the district level by LMD/NHTC in Public Procurement Act 2063 and Public Procurement Regulations 2064 in 56 districts

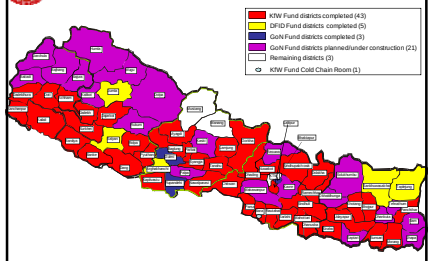
PROCUREMENT contd..

- **E-Bidding**
  - Servers procured and installed
  - Software for ICB & NCB (in Nepalese) prepared
  - Interaction with bidders conducted
- **Quality Assurance of Procured Commodities**
  - Pre & Post Shipment Tests for Drugs and for Equipments where possible.

STORAGE / WARE HOUSES

- Construction of Warehouses
  - By 2013, only three districts remains to be constructed
  - Detailed Master Plan and Architecture design for Regional Medical Store developed.
  - Master Plan for Central Store & Pathliya Store has been developed. Detailed estimation is going on and MoPH has provided budget to start the process to **complete within three years.**

District Health Storeroom Construction



A Typical District Warehouse

Essential drugs arranged in steel racks

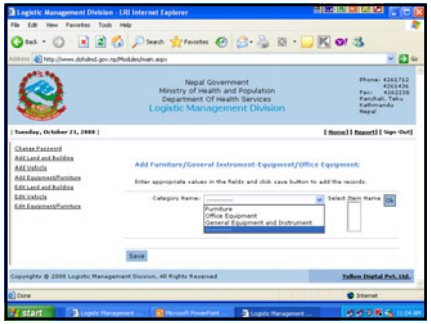
Cold Chain Room

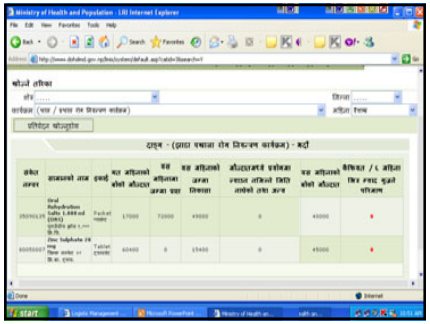
Commodities-cartoons placed on wooden pallets

Detailed Architectural Design of Regional Medical Store

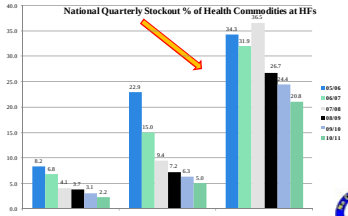
Timely Availability of Drugs and Supplies

- Introduction of Multiyear Procurement for Drugs & Equipment has began
- Budget Allocation to the Districts, Regions and certain Hospitals for Local Procurement
- ACDP (Annual Commodity Distribution Plan) for Contraceptives in place.
- Pull System has been introduced in all 75 districts (Training Conducted & in full operation). Distt- HFs
- Quarterly Pipeline Meetings held to assure commodity status
- Web Based Logistics Management Information System in operation.
- Marked reduction in stock outs, wastage and expiry of drugs and medicines in Health Facilities





Timely Availability of Drugs and Supplies



Promoting Clean/Solar Energy

- LMD completed installation of solar power back up system in 10 SDP with support from WHO (2010)
- Process to install in 40 new Health Facilities (2011/12)

Recommendations to Strengthen Integrated Logistics System

Human Resources for Logistics

- HR at the Centre – LMD
  - Bio-Er, Bio-Tech, Mech-Er, Pharmacist, Comp-Op, Civil Er & WPS-Sup
- HR at the Regional Medical Stores
  - Bio-Tech, Comp-Op, Ref-Tech. & WPS-Sup
- HR at the Districts
  - Medical Store Keeper (Pharmacy Ass. /HA)
  - Bio-Tech, Comp-Op & WPS-Sup

Strengthening Physical Facilities

- Sub-Regional Medical Stores-
  - Udayapur (Katari),
  - Pokhara,
  - Jumla,
  - Kavre and
  - Dadeldhura
- Cold Storage at the Districts
- Medical Stores at the District Hospitals & PHCs

Problems

- Procurement Plan
- Financial Rules (>40% in last Trim.; >20% in last month)
- Budget Assurance for Multi year Procurement.
- Inadequate Procurement Planning from the Programme Divisions.
- Lack of cooperation from the Nepal Rastra Bank (LC-Opening)
- Irrelevant Complaints Lodging / Delay
- Inadequate TA assistance.

Time Taken for an ICB

- Procurement Plan & Budget – 2 months
- ICB publication- 1.1/2 month
- Evaluation & Award - 1. month
- Bank Formalities- ½ month
- Delivery of commodities 6 months
- In ideal situation, total time 11months

Issues raised by WB

- No pro. Plan by civil works
- Quantity revision, delay in evaluation
- Contract signing without fulfilling bank's NOL pre con.
- Bidding cancellation without bank's concurrence
- Delayed HIV/AIDS service contract signing.

Thank You!

Government of Nepal

Ministry of Physical Planning and Works

Department of Urban Development and Building Construction

Babar Mahal, Kathmandu

HEALTH INSTUITIONAL BUILDING CONSTRUCTION PROJECT

Highlights on Building Construction & Maintenance

for

Joint Annual Review (JAR) - FY 2067/2068

Presented by: Shyam Kishor Singh, Chief, Health Building Unit

Date: BS 2068.10.2-4 (Jan 16-18, 2012)

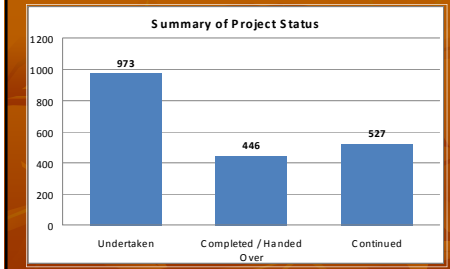
Place: Hotel Soaltee, Kalimati

Progress Status Summary by Base Year
(FY 2061/062 – 2067/068)

Base Year	Undertaken	Completed/Not Handed Over	Continued	Handed Over
2061/062	74	-	2	72
2062/063	40	-	1	39
2063/064	101	3	7	91
2064/065	166	31	26	109
2065/066	113	20	55	38
2066/067	299	25	256	18
2067/068	180	-	180	-
Total	973	79	527	367

Note: FY 2068/069 175 projects (inclusive of Ayurbed Dept.) has been added

1



2

Budget and Expenditure Summary by Fiscal Year for Development Programme

Budget FY	Budget (Rs. 000)	Expenses (Rs. 000)	Expenses Percent
2061/062	2,27,786	94,945	42
2062/063	7,66,026	3,73,470	49
2063/064	6,04,781	4,36,656	72
2064/065	10,35,929	8,49,383	82
2065/066	15,22,643	13,60,890	89
2066/067	22,16,530	18,15,531	82
2067/068	30,64,513	24,46,092	80
Total/Average	**94,38,208**	**73,76,967**	**78**

Note: NRs. 2,67,00,00,000.00 Budget Allocation for this FY 2068/2069

3

Major Issues and Corrective Efforts

Issues	Problems / Implications	Efforts for Improvement
Quality in Construction	• Inexperienced contractor • Poor workmanship of masons and bar benders •Unavailibility of skilled human resources in remote areas.	•Enforcement of construction guideline prepared by DUDBC (stress on quality and standard practices) • Intensive technical supervision by division staffs •Compulsory material testing •Educating about material standards and specification •Training of engineers, sub engineers and masons •Stepping-up monitoring •Adoption of standard design incorporating guidelines as prescribed by National Building Code.

4

Major Issues and Corrective Efforts

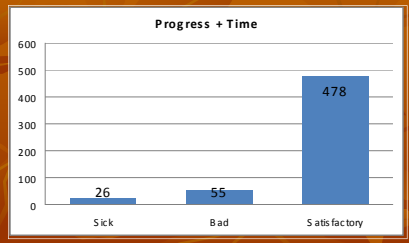
Issues	Problems / Implications	Efforts for Improvement
Time over-run and cost-over run	• Pre-condition to make available "free" building site ❖ Formulation of Plan and programme without conformity with the site ❖Delay in selecting "building site" ❖Conflict between communities in deciding location ❖Delay in approval from Forest Office if site is a community forest ❖Unsuitable land– steeps slow, swampy land, water logged area, site without utility and services, poor accessibility ❖Seismic design increases cost of building by 15 to 20% (Steel cost increased by 3%)	• Preparation and enforcement of building construction management guidelines •Advance planning – with upfront provision of land • e-bidding initiated (Direct curtailing finished and competition has been increased) • Initiated action to meet the procurement process as stipulated in JFA. •SBD Documents for both NCB / ICB with guidelines prepared in line with JFA and in final stages to be sent for endorsement from concerned authorities.

Major Issues and Corrective Efforts

Issues	Problems / Implications	Efforts for Improvement
Handover	•Some completed projects are still not handed over to Health Instituitions	•Handover process has been formulated for completed buildings after Joint monitoring by DUDBC and Health Staffs
Increments of Sick Projects	•Time, Cost, Quality, Handed over	•Building constructions management guideline has formulated and Special efforts has been given to sick projects

6

Sick/Bad/Satisfactory Project List Identified using Criteria :- Time, Cost, Quality and Handover



7

Monitoring Plan

Monitoring Institution	Activities and Frequency	Reporting Mechanism
District Joint Coordination Committee (DUDBC Division Office, DHO)	•DUDBC Division Office arranges a meeting with DHO; the joint committee reviews the field progress and issues on a quarterly basis	• DUDBC Division Office submits the minute of the joint review meeting to HBU/Dept on a quarterly basis

8

Monitoring Plan

Monitoring Institution	Activities and Frequency	Reporting Mechanism
DUDBC Division Offices	**•Division Engineers visit each site at critical milestone events** (Layout setting, foundation laying, plinth finishing, column-concerting, lintel setting, roofing)	•Division office prepare consolidated progress report and submit to the District Health Office (DHO) and Health Building Unit (HBU) / Department on a monthly basis

9

Monitoring Plan

Monitoring Institution	Activities and Frequency	Reporting Mechanism
Department (DUDBC)	•HBU/Dept review the monthly report submitted by Division offices and the Minutes of JCRM •HBU/Dept visit critical sites in all five regions on a quarterly basis •DDG (Building) and Monitoring Section / Team from Dept. visits the selected sites annually	•HBU/Dept submits progress as well as the key findings of the field report to DDG (Building) and DG/Dept. •DDG (Bldg) reviews and submits progress report to DG/Dept; Department of Health (DOH) and Ministry of Health and Population (MOHP) on a monthly basis

10

Monitoring Plan

Monitoring Instituition	Activities and Frequency	Reporting Mechanism
Joint Central Coordination Committee (NPC, MOHP, DOH, DUDBC, EDPs)	•HBU/Dept arranges JCCC meeting at MOHP on a quarterly basis •JCCC visits the selected sites annually •JCCC reviews the annual progress and the findings from the field monitoring in the annual meeting	•JCCC prepares and submits the recommendations to DOH/MOHP for further actions

11

~~ SOME PHOTOGRAPHS ~~

12

Nursing Quarter Building, Jomsom Hospital, Mustang

13

HP Building, Kaure, Dang

14

Jaleswor Hospital, Jaleswor Mahottari, (Under Finishing)

15

4 Unit Doctor Quarter, Bheri Zonal Hospital

16

BEOC Building, Magaragadhi, Bardiya

17

BEOC, Building, Dolpa

18

District Health Office, Kalikot
(Under Construction)

19

PHO Building, Surkhet

20

Maternity Room Building in Lakuri, Dailekh

21

CEOC Building Construction, Sindhuli

22

Family Doctor Quarter, Inaruwa

23

PHCC, Chisapani, Khotang

24

Ghyaru HP, Manang

25

HP Chitithala, Lamjung

26

Salija HP, Parbat

27

Post Mortem Bldg, Ramechhap

28

Store Building in Lumbini Zonal Hospital

29

HP Bhurung Tatopani, Myagdi

30

HP Tukuche, Mustang

31

Thank You

Progress on Commitments to UN Secretary General's Strategy on Maternal and Child Health

Dr. BR Marasini
MoHP

Outline of the Commitments

1. Ensure at least 70% of PHCs offer EOC
2. Improve Child Nutrition
3. Integration and Expansion of CB-IMCI and CB-NCP
4. Reduce Unmet Need for Family Planning by 18%
5. Maintain de-worming and micronutrient supplementation coverage at over 90%
6. Fund free maternal health services among hard-to-reach populations
7. Recruit, train and deploy 10,000 additional SBAs
8. Maintain de-worming and micronutrient supplementation coverage at over 90%
9. Use of cash transfers to pregnant and lactating mothers
10. Make family planning services more adolescent friendly
11. Encourage PPP to raise awareness and increase access and utilisation

1. Ensure atleast 70% of PHCs offer EOC

- In order to increase the institutional delivery, NHSP-II has clearly outlined the need to invest in expansion of BEOC and CEOC sites
- Training and deployment of the necessary HR to make these facilities operational on-going
- Till date there are 100 CEOC sites, 112 BEOC sites and birthing centres (PHC - 81, HP - 533 and SHP -336 respectively)
- Currently 53% PHCs offer BEOC services

2. Improve Child Nutrition

- Nutritional Assessment and Gap Analysis conducted and based on the recommendation a Multi-sectoral Nutrition Plan is under development with the leadership of NPC
- To address a major issue of stunting, strengthening of community based IYCF is introduced along with introduction of MNPs in the high risk districts
- Considering global acute malnutrition (GAM) at the range of 13-27% in various districts, Community Based Management of Acute Malnutrition (CMAM) is piloted in five high risk districts. The plan is to expand CMAM to at least 35 high risk districts

2. Improve Child Nutrition…

- Fourteen Nutritional Rehabilitation Homes (NRH) for the management of severe acute malnutrition have been established in various district and zonal hospitals
- Nutrition Emergency Cluster has been activated since June 2010 to address nutrition related humanitarian as well as silent emergencies

3. Integration and Expansion of CB-IMCI and CB-NCP

- The NHSP-II gives a clear road-map for the integration of CB-NCP into the nationally scaled up CB-IMCI and safe motherhood programme
- CB-NCP has been scaled up to 25 address the major killer diseases for new-born which accounts for around 54% of neonatal deaths
- The process of integration of CB-NCP into CB-IMCI is on-going
  - Integration of nutrition, WASH into the CB-IMCI protocol and training
  - Integration in the training manuals for health-facility level has been completed
  - Integration at the community level is on-going
  - Process to develop the referral package for sick newborn and children is under way

4. Reduce Unmet Need for Family Planning by 18%

- CPR in Nepal increased from 26% (1996) to 44.2% (2006) but has since stagnated.
- The unmet need for Family Planning is 24.6% (2006)
- Fertility has dropped from 4.6 children per woman in 1996 to 3.1 in 2006
- The National Family Planning Policy and Strategy are being reviewed to increase CPR, to reduce unmet need and to reduce total fertility

5. Double the Coverage of PMTCT from 40% to 80%

- Efforts have recently started on PMTCT with coverage hovering around only 8%
- To improve the PMTCT coverage:
  - According to the new WHO guideline on PMTCT 2010, Nepal has opted for option B for PMTCT and has developed the National guideline on PMTCT
  - PMTCT has been included in the SBA curricula and the orientation of PHNs on PMTCT is being undertaken
  - FHD, CHD and NCASC have been working in close collaboration to expand the PMTCT coverage with the focus on districts with high burden of HIV infection
- Further efforts are needed to develop the modality of integrating PMTCT in maternal and child health

6. Fund free maternal health services among hard-to-reach populations

- The free delivery services **"Aama Programme"** has been introduced which has the provision of free delivery service, financial incentive to mother and the service providers.
- The **"Aama Programme"** has been scaled up in all 75 districts of Nepal

7. Recruit, train and deploy 10,000 additional SBAs

- Training of SBAs has been on-going with the supports of development partners
- Currently there are total of 2560 SBAs trained (Total of 909 SBAs were recruited last year)
- Continuous monitoring of the SBA training programme is on-going with emphasis on quality improvement

8. Maintain de-worming and micronutrient supplementation coverage at over 90%

- Biannual distribution of Vitamin A and De-worming tablets have been regularly done to all children less the five years of age
- The coverage for both Vitamin A and De-worming tablets in the age group of <5years children stands above 90%
- School deworming program was initially introduced up to grade five in all public schools of 45 Districts and now have been scaled up to all 75 Districts including all students up to Grade ten
- Intensification of maternal and neonatal micronutrient program has been introduced in 71 out of 75 districts of the country – this includes iron tablets distribution to pregnant and lactating mothers through FCHV with more than 70% coverage

8. Maintain de-worming and micronutrient supplementation coverage at over 90%...

- MNPs to 6-24 months children linked with IYCF piloted in six districts (with around 75% coverage) and will be scaled up to additional 9 districts within 2012.
- Universal Salt Iodisation has been implemented nationally with a high coverage of 80%
- The government has made flour fortification with multiple micro-nutrients mandatory for all Roller Mill
- Zinc for the management of diarrhoea has been introduced in all the districts and all community and facility based health workers have been trained on Zinc for the management of diarrhoea

9. Use of Cash Transfers to Pregnant and Lactating Mothers

- A four-arm (IYCF, Counselling, Control) randomised control trials under way with formative research to find out effective grant delivery modality

10. Make Family Planning Services more Adolescent Friendly

- FHD has finalised a National ASRH Programme in 2011
- NHSP II plans to upgrade 1000 health facilities into adolescent-friendly services (AFSs) with the purpose of contributing to a reduction in adolescent fertility rate (AFR)
  - So far 450 health facilities are included in the National ASRH Programme
- Adolescent-focused public health sector response is being supported by IEC/BCC interventions from NHEICC and NGOs, local stakeholders and service providers
- Family planning, including HIV and STI services, are gradually being provided in an adolescent-friendly manner – in line with a comprehensive approach to adolescent sexual and reproductive health

11. Encourage PPP to Raise Awareness and Increase Access and Utilisation

- the **"Aama Programme"** has partnered with registered private health care service providers to provide delivery care, giving pregnant women the choice of opting for public, or approved commercial or non-profit service providers for free delivery care
- For uterine prolapse, selected private sector facilities provide treatment free of cost to the client (the government compensates the private health facilities).
  - As of 2011, more than 11,000 women are treated for uterine prolapse and among them more than 95% have been treated by the private sector
- For specific family planning services, the government provides the private sector with contraceptive commodities and the private providers reciprocate by providing expenditure for service delivery and logistics to certain public health facilities

Thank You

M&E Framework and Platform for NHSP – II

Dr. Padam Bahadur Chand
Chief
Public Health Administration Monitoring and Evaluation Division
Ministry of Health and Population
Kathmandu, Nepal

Background

- Vision of NHSP II –
  - To increase access to and utilisation of quality essential health care services;
  - To reduce cultural and economic barriers to accessing health care services
  - To improve the health system to achieve universal coverage of essential health services.

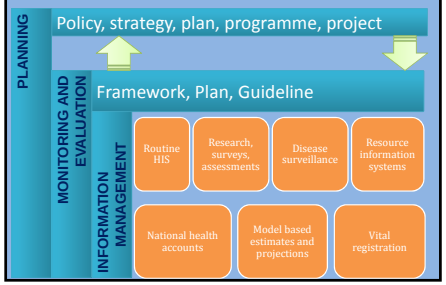
"Partnership with non-state actors"

Strong M&E mechanism is not only required to measure the success of programme but also to ensure accountability.

M&E in NHSP II

- Focus of M&E at national level - **Impact and Outcome**
- Additional information
  - **Disaggregation** by caste/ethnicity, and income quintile
- **Research, survey, assessment** are an integral part of M&E
- Need to monitor progress for indicators included in the **Results Framework and GAAP**

Conceptualising NHSP – II from M&E Perspective



Current Situation

(issues and problems - based on recent studies)

- Result framework is **bit complex** and needs further clarity
- Mechanisms for M&E are **fragmented**
- In the absence of a central M&E Framework and Plan the Results Framework is **not systematically linked and institutionalised**.

Current situation cont'd

(issues and problems - based on recent studies)

- **National M&E framework not in place, nor result framework is clear and implementable**
- **No co-ordinated sector-wide support in M&E.**
- **M&E plan and guideline not adequate nor guided by national framework (with no clear, mutually agreed-upon plans and guidelines)**

Current situation cont'd

(issues and problems - based on recent studies)

- **Improper Institutional arrangement (MoHP and below level)**
- **Inadequate capacity (number, type, and skill) – Inadequate monitoring and evaluation expertise at MoHP and DoHS**
- **Translation of information into decision-making process is limited at all levels.**
- **Limited conceptual clarity (e.g. HSIS, M&E, MIS and other information systems)**

Current situation cont'd

(issues and problems - based on recent studies)

- **Overambitious systems, with too much being asked in terms of information and methods**
- **Inadequate integration and linkage - efforts, actions, systems, and outputs** (e.g. no uniform coding system)
- **Inadequate financial resource allocation for M&E**
- **Concerns about data quality and mis-match in the figures reported**

Progress to strengthen M&E for NHSP II (Current situation)

- **Current progress in M&E to support NHSP II**
  - NDHS survey 2011 *(MoHP, New Era, ICF Macro)*
  - Nepal Living Standards Survey (NLSS III) and Census (CBS)
  - Service Tracking Survey *(MoHP/NHSSP)*
  - MDG Need Asssessment *(NPC)*
  - National Health Account Budget Analysis (MoHP/NHSSP)
  - Some activities are undergoing and planned *(NHSSP/DFID)*
  - Survey, assessments, researches are ongoing *(different division/centre, institutes and organizations)*
  - Youth and Adolescent Survey (MoHP) etc.
  - **M&E Matrix for NHSP II – 1st draft prepared** *(WHO)*

Progress to strengthen cont'd

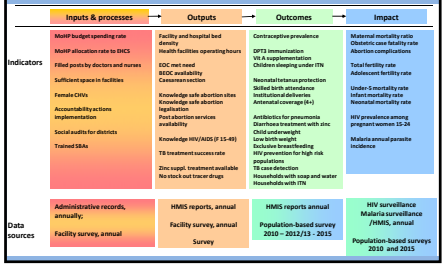
Features of M&E Matrix for NHSP II (draft, proposed)

- M&E framework using **logical and results-chain concept**
- **Indicator**
  - Type reviewed
  - Re-arranged according to six building blocks of health systems
- **Describes**
  - Data source (all available)
  - Frequency,
  - Responsibility,
  - Level of data analysis,
  - Data quality assessment,
  - Data dissemination, communication and feedback,
  - Trends and targets (for each indicator)

System Building Blocks

- SERVICE DELIVERY
- HEALTH WORKFORCE
- INFORMATION
- MEDICAL PRODUCTS, VACCINES & TECHNOLOGIES
- FINANCING
- LEADERSHIP / GOVERNANCE

M&E framework for NHSP II- using logical and results-chain concept



How we can improve the situation (what approach should we adopt)

- **System strengthening**
- **National Ownership**
- **Alignment**
- **Harmonisation**

Way Forward

(PHAM&ED/MoHP is planning)

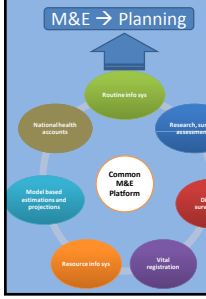
- **Finalize M&E framework for NHSP II**
- **National (country) M&E roadmap**
- **Comprehensive M&E platform**
- **M&E implementation plan and guidelines**

Way Forward

(PHAM&ED/MoHP is planning)

- **Guided information sources**
- **Implement M&E framework**
- **Integrate/linkage**
- **Appropriate instituitional and human resource arrangement**

"Comprehensive, Integrated and Institutionalized One Country-led monitoring, evaluation and review platform"



What is expected from Development Partners

- **Financial and technical support**
- **Contribute for national and sub-national M&E platform**

Thank You !

queries, comments, feedback, and suggestions …

Aid Effectiveness Principles and MOF Initiatives

Bhuban Karki
Under Secretary/ Programme Manager
Foreign Aid Co-ordination Division
Ministry of Finance

Principles of Paris Declaration

- Ownership: Country ownership of their own priorities and plans instead of donors prioritise and impose priorities on aid recipients
- Harmonization and Alignment: Greater coordination and consistency with country priorities instead of donor priorities un-cordinated imposing high transaction costs on recipients

Accra Agenda for Action

- Strengthening country ownership over development: broadening country level policy dialogue on development, developing capacities of developing countries to lead and manage development and strengthening use of country system.

Defining Aid Effectiveness

- Arrangement for planning, management and development of aid that is efficient, reduces transaction costs, and is targeted towards development outcomes including poverty reduction (OECD)

Contd…

- Managing for Development Results: Resources Channeled through governments own budgetary and planning systems with a result focus instead of parallel implementation systems weakened national planning, budgeting and implementation (Process oriented)

Contd…

- Building more effective and inclusive partnership for development: reduce costly fragmentation of aid, increase aid's value for money(untie aid), work with all development actors (incl South South Coop), deepen engagement with civil society.

Defining Aid Effectiveness

- Arrangement for planning, management and development of aid that is efficient, reduces transaction costs, and is targeted towards development outcomes including poverty reduction (OECD)

Contd…

- Mutual Accountability: Both donors and the recipients are responsible and accountable instead of limited accountability by donors for the consequence of their policies or decision.

Contd...

- Delivering and Accounting for Development Results: Developing countries will strengthen the quality of policy design, implementation and assessment by improving information system; will be more accountable and transparent to policy and results: developing countries will facilitate parliamentary oversight, pub disclosure of revenues

Contd…

- Change the nature of conditionality to support ownership: limited set of mutually agreed conditions based on national dev strategy.
- Medium term predictability of aid: Developing countries will strengthen budget and planning process for managing resources while donors will provide regular and timely information on their rolling 3-5 year forward expenditure plans.

4th High Level Contd…

- Effective state and non-state institutions design and implement their own reforms and hold each other to account
- Developing countries increasingly integrate (South-South Cooperatrion)

Main Objectives of the Project:

i. Design and implement Nepal Aid Management Platform,
ii. Implement revised Foreign Aid Policy and National Action Plan for Aid Effectiveness,
iii. Have greater ownership and enhance capacity of NPC and key line ministries to engage aid effectiveness reform (i.e. Implement Capacity Development Strategy)

Contd…

- Change the nature of conditionality to support ownership: limited set of mutually agreed conditions based on national dev strategy.
- Medium term predictability of aid: Developing countries will strengthen budget and planning process for managing resources while donors will provide regular and timely information on their rolling 3-5 year forward expenditure plans.

MOF Initiatives

- 2008 Monitoring Survey
- Joint Evaluation of the Implication of the Paris Declaration, Phase II (2010)
- 2011 Monitoring Survey 11
- Local Donors Meeting (bi-monthly)
- Nepal Development Forum
- NPPR
- Nepal Participated in Paris, Accra and Busan High Level Forum

Main Objectives of the Project:

i. Design and implement Nepal Aid Management Platform,
ii. Implement revised Foreign Aid Policy and National Action Plan for Aid Effectiveness,
iii. Have greater ownership and enhance capacity of NPC and key line ministries to engage aid effectiveness reform (i.e. Implement Capacity Development Strategy)

4th High Level Forum on Aid Effectiveness, Busan, Korea

- Aid is only a part of the solution to development. It is now time to broaden our focus and orientation from aid effectiveness to effective development.
- New Framework includes: strong, sustainable and inclusive growth, Govt's own revenue plays a greater role in financing their development needs. So Govts are more accountable for Dev results.

Developing Capacities for Effective Aid Management

- Development Partners: UNDP, DFID, DANIDA
- Implementing Partner: Ministry of Finance
- Other Partner: National Planning Commission, Ministry of Health, Ministry of Education and Ministry of Local Development
- Project Budget: $ 1.5 million

Major Activities

- Aid Information Management Platform
- Implement Foreign Aid Policy and National Action Plan for Aid Effectiveness
- Implement Capacity Development Strategy in MOF, NPC and key line ministries

Aid Information Management Platform:

- Carried out need/technical assessment of MOF, NPC, MOLD, MOE and MOH for Aid information database by Gateway Foundation.
- MOF has contracted with DG for three years to implement Aid Management Platform (AMP)
- AMP Prototype Installed at MOF: Customization will be carried out as per requirement
- After successful piloting in MOF, AMP will be rollout in NPC and key line ministries from next year

Plan Ahead:

- Rolling out of AMP to more line ministries
- Integration of AMP with other system (BMIS, FMIS)
- Public Viewing of AMP
- Finalise the FAP
- Dissemination of FAP
- Implement approved CD Strategy for NPC and each ministry
- Facilitate GON officials' participation in knowledge sharing events
- OrganiSe overseas and in-country training packages based on CD Strategy Plan

Thank You

Implement Foreign Aid Policy (FAP)

- MOF has revised the FAP which is in the process of finalisation
- Workshop conducted to finalize the FAP

Progress Achieved

1. AMP
   - 490 ongoing projects entered
   - Rolled out to all DPs
2. Capacity Development
   - 147 govt officials trained
3. Analytical
   - FAP redrafted

Implement Capacity Development Strategy in MOF, NPC and Line Ministries

- Conducted trainings on Managing for Development Results, Negotiation Skills, Sector Wide Approach, Project Appraisal, Meeting Management and Facilitation and English Language based on Capacity assessment of NPC and line ministries through a team of international experts from UNDP RCB,

Some Issues and Challenges

- Partnership with Donor Agencies and Line Ministries especially on AMP
- Funding Gap
- Sustainability

HRH Strategic Plan 2011-2015

Joint Annual Review

17 January, 2012

Process of developing the HRH Strategic Plan

Nov 2010: CCF mechanism established; stakeholder workshop; Technical Committee (TC) & 5 TWGs formed

Nov 2010 – June 2011: HRH problems identified; HRH situation analyzed; strategies developed & refined; broad set of activities drafted

Sept-Dec. 2011: Draft Plan produced, reviewed & refined by stakeholders; activities costed, preliminary projections developed

Process of developing the HRH Strategic Plan (cont'd)

- **Jan 2012:** Draft Plan presented to **CCF** for approval
- All the constituencies of stakeholders participated in the **CCF** meeting
- At present, feedbacks from **CCF** being incorporated
- Final draft will be forwarded for due approval

The Plan covers 4 years from 2011 to 2015 and is aligned with the timeframe of the NHSP-2

Data & Inputs for the Plan

- NHSP-2 – main source document
- Other MoHP, DoHS and govt reports
- HuRIS (MoHP) & PIS (MoGA)
- Professional Councils
- Technical Working Groups
- Stakeholder inputs including MoHP, MoE, NPC, MoE, MoGA, Academia, Professional Councils & Associations, Training Institutions , EDPs, I/NGOs

Provides a good starting point but data incomplete for private sector

HRH Problems

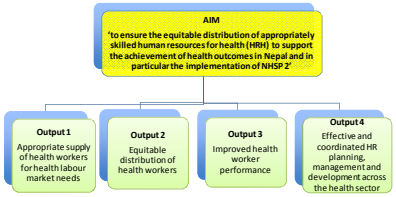
Four key problem areas identified in the Nov 2010 Workshop

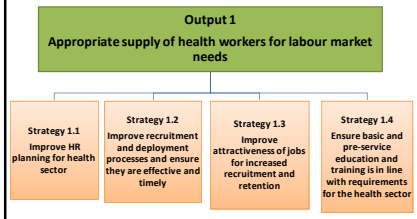
1. Shortage of HRH and imbalance between supply and demand
2. Maldistribution of staff, especially in remote and rural areas
3. Poor staff performance (productivity, quality, and availability)
4. Fragmented approaches to human resource planning, management and development

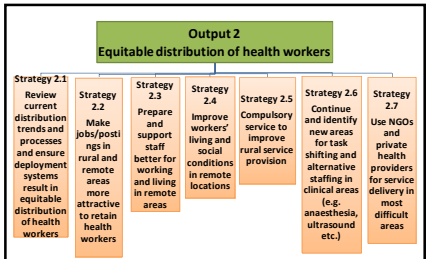
Contextual issues that will impact on HRH

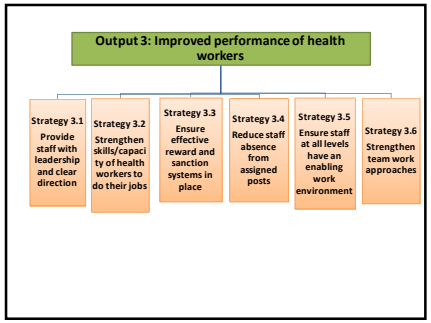
- Federalization and decentralization of HRH functions and management of service delivery
- Revised National Health Policy
- Service delivery requirements & new technologies
- Labour market participation
- Greater involvement of private sector & PPPs
- Health sector financing
- Population growth & its dynamics
- Disease burden
- Other political, legal, economic and social factors

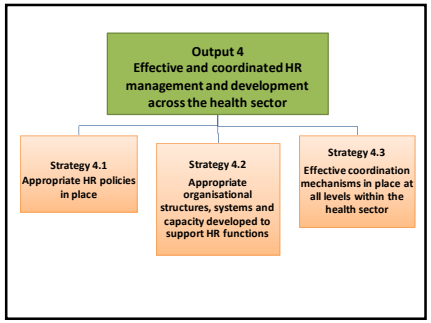
Aim and Outputs of the Plan







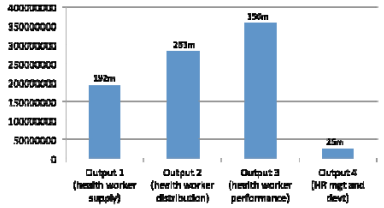




Priority Activities for 2012 (next 6 months)

- Establishing HRH profile for government health workforce and workforce in private and NGO health sectors
- Developing a Health Workforce Plan to determine HRH requirements for short, medium and long term
- Strengthening HR information management systems and capacity for the generation of HRH information to support workforce planning, management and development decisions

Total cost of implementation by outputs (NRs)



Preliminary Projections

- Preliminary projections (basic, minimum) for government health workers:
- Projections include key cadres including doctors, nurses, HAs and paramedics
- Estimated requirements of approx. **14,230** over next 4 years
- More detailed long term projections will be developed in 2012

Requirements for implementing the plan

- Political commitment e.g. approval of Plan
- Mechanisms to coordinate and provide strategic oversight
- Supportive policies, structures, systems and capacity
- Annual costed HRH implementation plans (AWPB)
- Information management & monitoring and evaluation systems to monitor inputs and assess impact
- Financial resources
- Multi-sectoral participation, collaboration & ownership
- EDP support

Acknowledgements

- Senior MoHP Officials for their guidance, feedback and support
- All those who contributed in developing the evidence based, costed HRH Strategy
- GHWA/WHO for their financial support
- NHSSP for technical assistance

Thank You

EDPs/MoHP Joint Field Visits

i.) Field Visit Observation- Dhading
ii.) Field Visit Observation-Urban Health
iii.) Field Visit Observation-Kapilvastu-Arghakhanchi-Nawal Parasi

Briefing on Joint Monitoring

Group-2
(Dhading)

Briefing on Joint Monitoring

Group consisted of:

- **Dr. Bal Krishna Suvedi-MoHP (Dhading)**
- **Ms. Tara Gurung – AusAID (Dhading+Kathmandu)**
- **Mr. Tej Ojha – GIZ (Dhading)**
- **Mr. Ratna Lal Shrestha – DOHS/PRD (Dhading+Kath.)**
- **Dr. Markus Behrend – GiZ (Kathmandu)**
- **Mr. Shankar Pandey – KfW (Kathmandu)**
- **Dr. Nastu Sharma – AusAID (Kathmandu)**
- **Dr. Nancy Gerein- NHSSP (Kathmandu)**
- **Mr. Tekabe Belay- World Bank (Kathmandu)**

Monitoring Team at Naubise Health Post:

Dhading District

One of the better performing districts in health

9 January, 2012

- Visited
  - Naubishe Health Post, Naubise
  - Gajuri Primary Health Care Center (PHC)
  - Rajmarg Samudayik Hospital, Malekhu

10 January, 2012

- Visited:
  - Dhading District Hospital
  - DHO Office & interaction with district stakeholders
  - Murali Bhanjyang Sub- Health Post and PHC-ORC

General Observations : Dhading……..1

Access to Services:

- Generally good but still challenging for many from remote rural areas despite programs such as *Gaun Ghar* Clinic + Health Service Delivery Points (*Swasthya bindu – 7 in #*) + rural ultrasound + specialised health clinics.
- *Swasthya bindu* an innovative way to address some of the access issues but sustaining it will be a challenge if not institutionalised within the health system.

Supplies:

- Drug – good, except for Iron and ORS in some occasion
- Community Drug Programme still successfully run by the District Hospital

General Observations : Dhading……..2

Governance and Accountability:

- Citizen charter in all facilities visited, except the community hospital. Provision of complaint box at the District hospital.
- CDO mentioned no reporting of corruption but acknowledged possible misuse of funds in works through APM in local bodies.
- Most payments through Treasury Single Account – has reduced workload but delay in payment processing at times due to poor server capacity of DTCO.
- CDO raised the issue of regulating and monitoring of pvt health service providers. There are two pvt hospitals & a # of clinics.

General Observations : Dhading……..3

Monitoring and Evaluation:

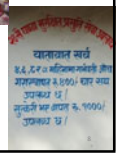
- Almost 50% of health facilities can not be physically monitored for 6 months of the year due to poor access in monsoon.
- Collection of HMIS data generally look fine but SBAs requested for uniform registers for hospitals and rural health facilities.
- Partnership in monitoring. Women Development Office also monitors some of the MNH activities and shares observations with the DPHO.

General Observations : Dhading……..4

Maternal Health – Aama Programme:

- 4 ANC visit good through "*Gaun Ghar* Clinic" and rural ultrasound clinics. Evidence of marginalised accessing service.
- Instituitional delivery progressing well but reach of women from remote areas still challenging due to poor access and lack of awareness.

- Questions around sustainability of CEOC at the District hospital as it is run by contracted MDGP & Anesthetist.
- Similarly, a number of birthing centres being operated by contracted SBAs supported by local government. While this demonstrates good partnership raises serious issue around quality & long-term sustainability of the programme.



General Observations : Dhading……..5

Human Resource Management:

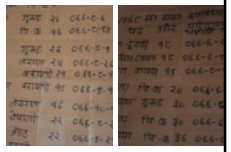
- Increased scope of work but no increase in staffing.
- Many vacant positions – no permanent recruitment in the MoHP for the last 2 yrs.
- There are fewer female staff than desired.
- Many positions funded by local government demonstrating good coordination.
- Many staff both at the local & district facilities are on short-term contract increasing the risk of discontinuing a number of critical services.
- Interlocutors reported staff absenteeism as high as 50% in remote areas for health facility in-charge.
- DPHO emphasised on the need for more qualified health professionals at different levels to deliver quality health services.

General Observations : Dhading……..6

Other Female and Adolescent Health Issues:

- Uterine-prolapse : reported as high by the Women Development Officer and the FCHVs.
- Teenage pregnancy: In one particular VDC, there were quite a few women giving birth as young as 16 years of age.

- Adolescent health
- High case of abortion in the district hospital – about 7 CAC a day.
- Increase in female health worker but still insufficient.



General Observations : Dhading……..7

Partnership:

- In the District and the facilities visited, partnership with the local government and the communities generally very strong. For e.g. the construction budget under health this year only 1.3 million but mobilised 10m.
- A number of staff / health facility building / equipment / community mobilisation funded by the local government.

General Observations : Dhading……..8

Management of Health Facilities:

- Leadership and the quality of health facility management committee was the driving force
- Health Care Waste Management an issue in almost all facilities

Lessons:

- Leadership
- Partnership
- Co-ordination

Dhading Observation

Naubise Health Post

- Services Offered: Excellent
- Collaboration with local government - Excellent
- Social Mobilisation - Excellent
- Human Resources- Very Good (+ 5 staff)
- Logistics management- very good
- Governance & Transparency- Very Good
- Physical Infrastructure- very good
- Equipments – sufficient
- Recording & Reporting – very good

- Grading: 9/10
- Striking feature: All at optimum level
- Our Evaluation: **" Model Health Post of Nepal"**

Dhading Observation

Rajmarg Samudayik Hospital:

- Services Offered: below optimum
- Collaboration with DHO - Limited
- Social Mobilisation - Good
- Human Resources- satisfactory
- Logistics Management- OK (own pharmacy)
- Governance & Transparency- OK
- Physical infrastructure- very good
- Equipments – sufficient
- Recording & Reporting – Good
- Received Npr. 2.5 mil. from the GoN (MoHP) for the construction of a building which is not being monitored by the DPHO at the District
- Running on loss. Receives only 10 patient on average but has a staff strength of 22

- Grading: 4/10
- Striking feature: trying to survive
- Our Evaluation: " moderate"

Dhading Observation

Gajuri PHC:

- Services offered: OK
- Collaboration with local government - limited but potential
- Social Mobilisation - little
- Human Resources- OK (only government staff)
- Logistics Management- good
- Governance & Transparency- Good
- Physical Infrastructure- OK
- Equipments – sufficient
- Recording & Reporting – good

- Grading: 6/10
- Striking feature: Running Satellite clinic (Samudayik Swasthya Bindu) to marginalised community and people living at distance (5 wards)
- Area for improvement: Leadership (Both HF & HFMC)
- Our Evaluation: " Average"

Dhading Observation

District Health Office:

- Coordination with DDC and other sector agencies-Very Good
- Program Planning & Implementation- Good
- Local Resource Mobilisation –Very Good
- Human Resources Management-Good / Fair (Model)
- Logistics Management (drug & supplies)-Good
- Monitoring and Supervision-Good but physical monitoring to remote areas insufficient.
- Governance & Transparency – Good/Fair
- Physical Infrastructure- Fair
- Recording & Reporting –Good

- Grading: 7/10……
- Striking feature: Continuation of the present encouraging trend
- Our Evaluation: Very good

Dhading Observation

Dhading District Hospital:

- Services Offered: Excellent (More than expected)
- Collaboration with Local Government - Excellent
- Social Mobilisation - Excellent
- Human Resources- Good (vacant positions but few on contracts)
- Logistics Management- very good (runs CDP also)
- Governance & Transparency- Good
- Physical Infrastructure- Inadequate (congested, limited space)
- Equipments – Limited
- Recording & Reporting – good

- Grading: 7/10
- Striking feature: Services of Zonal Hospital by infrastructure of District Hospital
- Our Evaluation: " Services very good, but limited infrastructure-example:OPD operating in Lab-unit"

Dhading Observation

Murali Bhanjyang Sub- Health Post:

- Services Offered: Good
- Collaboration with DHO – Very Good
- Social Mobilisation – Very Good
- Human Resources- satisfactory
- Logistics Management- Good (Store-good, all drugs available)
- Governance & Transparency-(moderate)
- Physical Infrastructure- fair (own building with **birthing center**/delivery service)
- Equipments – sufficient
- Recording & Reporting – Good

- Grading: 7/10
- Striking feature: Has 3 PHC-outreach building, owned by community
- Our Evaluation: " very good"

General Observation of District

- Limited slum areas
- Industries concentrated in Highway Corridor
- 2-community and 2-private hospitals, Fair coordination and relation with DHO/District hospital
- Public health facilities (52)-District hospital-1, PHC-2, HP-25 (including the recent upgrade), SHP- 24
- HPs and SHPs in the district refer patients to District Hospital, District Hospital and Health facilities in Highway corridors refer to different Hospitals in Kathmandu, Mostly-Bir, Teaching, Maternity and Patan hospitals, mostly by ambulance & public transport
- Most of the health facilities offer the services as mandated
- Out of 52 Public Health Facilities, (HFs), 48 HFs providing delivery services. Most of the ANMs hired from the VDC financial support.

General Observation of District

- Health Infrastructure situation –fair
- Power and power backup-fair
- Water supply and sanitation situation-fair
- Health care waste management-poor
- Average time to reach health facility-2 hrs
- Average waiting time-1 hr
- Drug and supplies-good
- Medical equipment-fair

Areas for improvement:

- HR-VHW upgrading with original job description, continuation of hired ANMs in contract
- Infrastructure including power, water supply and sanitation
- Lack of coordination with DUDBC and less ownership and saying of HFs/officials during planning and construction of health buildings in the district.

THANK YOU

URBAN HEALTH FINDINGS

Visit Date 11th & 12th January, 2012

Team Members

- AusAID
- GIZ
- UNICEF
- NHSSP
- The World Bank
- UNDP
- DOHS
- NGO (HERD)

Places and People Visited

Day 1

- District Public Health Office, Mr. KB Chand, Kathmandu
- KMC Urban Health Clinic, Lainchaur
- KMC Urban Health Clinic, Koteswor
- NGO - Health Research and Social Development Forum (HERD),

Day 2

- Manohara Community Health Centre – NGO clinic working for slum/squatter settlements
- Public Health and Social Welfare Division, Kathmandu Metropolitan City (KMC), Dr Baburam Gautam, Chief
- Lalitpur Sub Metropolitan City, Public Health and Social Welfare Division
- Lalitpur Urban Health Clinic
- NGO run VCT Centre - SACT

Background : Urban Population

- As of 2001, 58 municipalities (33 in 1990s)-likely to increase in coming years to over 90.
- 4.5 million urban population: 17% of national total
- 11.9% urban population annual growth rate, increasing by 7% each year, could reach to 15 million by 2035
- Kathmandu
  - highest decadal population growth (60.93 %) compared to all Nepal (14.99 %) – CBS 2011
  - highest population density (4408) - National (181) per sq.kms.
  - accelerated urban expansion of 25% per year resulted in slum and squatter settlements

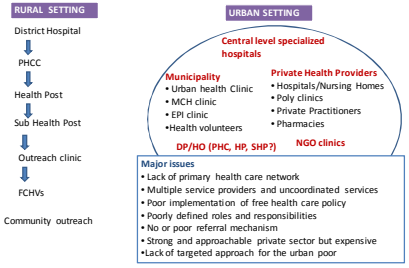
Slum and Squatter: Kathmandu

- **Squatter** - heterogeneous settlements are those communities where people have settled on land without any legal rights to be there, neither as tenants nor owners, no legal land ownership
  - Established in 50 years ago but few numbers compared to present (increased from 17 in 1985 to **45 in 2008**)
  - 29 located along river banks - vulnerable in many ways
  - Manohara is the largest squatter along the Hanumante River
  - 16 settlements are relatively small located in public land, starting from 20 households
- **Slum** – long established and homogenous settlements occupied by socially deprived lower caste people having poor access to public services (Lumanti, 2001)
  - Unlike squatter settlements, the residents of slums generally own their land and house and have formal title papers (lalpurja) to prove this

URBAN HEALTH
Key Findings

- Lack of urban health care delivery structures
- EHCS package – not delivered in organised manner
- Referral mechanisms not defined and followed
- UH Clinics are operating in isolation in a settings provided by municipality or local clubs
- NGO clinic better organised than municipality

Basic Health Service Delivery



EHCS Delivery Context in Ktm & Lalitpur

- Kathmandu Metropolitan City –1.8 million population
  - 21 Urban Health Clinics
  - NGO Clinics
  - Private Teaching Hospitals
  - Few Health Facilities under DPHO
  - Community Health Volunteer
  - Central Hospitals, Public Teaching Hospitals
- Lalitpur Sub-Metropolitan City – 0.3 million population
  - 2 Urban Health Clinic (6 days a week)
  - 20 MCH Clinics (half a day in a week)
- Urban Health Network – approx 700 volunteers
- Central Hospitals - Patan Hospital, Mental Hospital

Summary – what we saw

Clinics	Available Services	Infrastructure	Management
UHC 1 under KMC (3-6 clients/day)	EPI, FP, TB, ANC/PNC,	1 room	-Inactive mgt committee - no routine training - no career progression -Irregular logistics
UHC 2 under KMC (10-15 clients/day)	EPI, FP, TB, ANC/PNC,	3 rooms	-Abolished drug scheme and no clarity of fund management -Career progression
MCHC – NGO clinic (25-30 clients/day)	All EHCS, specialised service, community outreach	7 rooms	-Good community participation - regular report to DPHO - no supply of free drugs as per GoN policy
UHC 1, Lalitpur (10-15/day)	EPI, MCH, FP, TB,	2 rooms	-Inadequate resource - strong volunteer network
NGO run VCT (15-18/day)	VCT – HIV and FP	sufficient	- Well functional VCT centre with support from FHI

UH Emerging Themes

Issues	Opportunities
No policy and EHCS delivery plan	Urban Health Policy under development
Inadequate resources	PHCRD providing funds through DHO
Lack of clarity in roles and responsibilities	-Address in the urban health policy - Reactivation of coordination committee (MoHP and MoLD, DHO and Municipality)
Low priority to health from municipality (0.5% allocation of total municipal bgt)	-Community involvement in planning (use health networks) - Decentralised planning process -
HR in municipality under-emphasised Inadequate HR/Poor motivation	- HR development plan - recruitment of long-term staff
Poor infrastructure	- refurbishment plan
Poor access to EHCS	- service expansion and community involvement
Quality assurance	- development and implement QA process

UH Emerging Themes contd….

Issues	Opportunities
Hygiene	Basic water and sanitation supply
No/poor referral system	Define urban health service delivery model with referral services
Documentation and reporting	- HMIS, data audit and financial accounting
Irregular and inadequate supply	- implement free EHCS policy, revisit supply management
Accountability	- activation of health management committee -Use of community health network
Poor coordination	- coordination committee between MoHP and MoLD, DHO and Municipality

Points for Consideration

- Need a pro-poor urban health policy, then a strategy which:
  - Clearly defines roles and responsibilities of two Ministries and modalities for working together eg. resource allocation, HR issues, technical support from MOHP to municipalities
  - Defines a model for delivering EHCS services and for referrals
- Defines partnerships:
  - Public-public between 2 Ministries and between DHO and Municipalities
  - Public-private with NGOs, with for profit institutions, with volunteers
  - Links NGOs who are providing services to free care policy for drugs (as is done currently for vaccines and TB drugs)

Points for Consideration

- Need GIS mapping of urban populations and services, both private and public, followed by further disaggregated data on issues of the urban poor, in order to develop urban health strategy
- Urban health care demonstrates a gross inequity in terms of government-provided services, an inequity which is growing because the urban poor population is growing.
  - KMC – 1.8 m people, 21 clinics seeing a few hundred people per month, Lalitpur – 300,000 people, 2 urban clinics and weekly MCH services.
  - What about in other urban settings?

Thank You

Joint Field Visit Observations

Date: 9th-13th January , 2012

Districts Visited

- Nawalparasi
  - Dumkauli PHCC
- Kapilvastu
  - District Hospital
  - Pakadi Health Post
  - DDC
  - SEFA community Health Centre (Private)
- Argakhanchi
  - Thada PHCC
  - Sitapur Sub-Health Post
  - CDO
  - DHO

Team Composition

- Government of Nepal
- WHO
- GAVI
- UNFPA
- NHSSP/DFID
- USAID
- AUSAID
- AIN

Dumkauli PHC

Observation

- Good availability of drugs and other consumables
- District drug stores well maintained, reasonably well functioning pull system
- Functional labour rooms
- Infra-structure-New construction going, difficult access/marginal land
- Work flow pattern not as per floor plan design
- Water and sanitation is an issue
- 24 hours Back up power in health facility as well as hospital a problem resulting in wastage of medicines

Observation

- Labour rooms were functional, maternal health drugs and equipment were available
- All facilities using partograph
- IEC materials and protocols were available
- Register well maintained

Taulihawa District Hospital

Observation

- Good leadership -Health Facility Operational Management Committee well functional-Nawalparasi
- Poor leadership-HFoMC not functional-Kapilvastu
- Need of pre-service training/orientation for health workers before deputation
- FCHV well motivated in Argankachi
- Amma Funds are provided as re-imbursement and are paid by Health Worker
- ANM effectively contracted for only 4/12 months annually
- Low CPR and Low TFR, high migration (quarter of population) and high HIV prevalance, 3 VCTs and No ARTs-Argakhachi

Recommendation

- Focus on low performing Districts like Kapilvastu
- Sub-district targeted intervention
- Community empowerment
- Need to strengthen the Health Facility Operational Management Committee

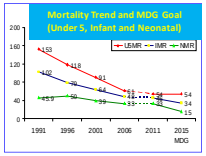
Sitapur PHC

Thank You

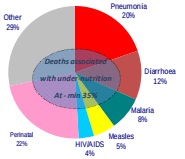
Overview
Multi-sectoral Nutrition Plan

by
Atma Ram Pandey,
Joint Secretary,
Social Development Division, NPC

NEPAL IS ON TRACK TO REACH MDG4: REDUCING CHILD MORTALITY

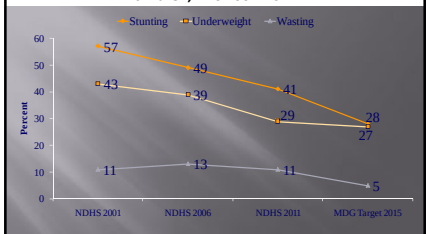


Without Improvement in Nutrition, Further Child Mortality Reduction is Less Likely



Sources:
EIP/WHO. Black et al, 2008. The Lancet Series on Maternal and Child Under-nutrition

General Malnutrition Still a challenge: Trends among Under 5 children, DHS 2001-2011

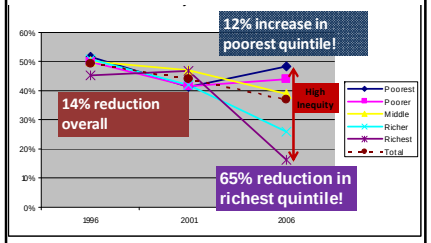


% of women with a BMI <18.5 kg/sq.m, at 24.4% at 2006 from 28.3% in 1996

Source: NDHS 2011, Preliminary Report

MARKED INEQUITY: Wealth Quintiles, Ecology, Ethnicity

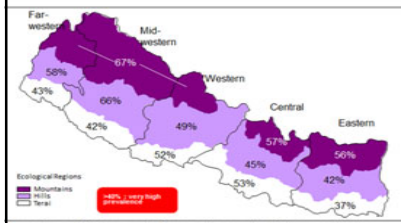
Nutrition context: trend in stunting prevalence by wealth index



Ref: DHS 2001 and 2006. Adapted from Ramu Bishwakarma. Social Inequalities in Child Nutrition in Nepal. August 2009 (Background paper for Nepal Nutrition Assessment and Gap Analysis, November 2009)

Marked Disparity Across the Regions

Child Stunting High in Mid/Far West Mountain/Hills



Percentage of children under 5 years who are classified as moderately or severely stunted

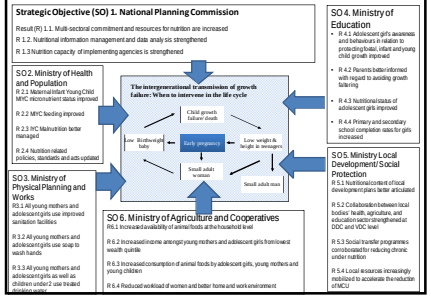
Nutrition Multi-Sectoral Reviews: (2011)

- **Nutrition reviews by sector:** Health; Agriculture, Education, Physical Planning and Works, and Local development
- **Defined scope:** Global and national evidences for 'what works': ***essential nutrition specific*** *interventions through the Health sector* **&** ***nutrition sensitive*** *interventions through other sectors*
- **Systematic consultation:** through Reference Group Meetings by sector at key stages and All Reference Group Meetings to identify the cross-sectoral linkages

Costed Multi-sectoral Nutrition Plan of Action (2011-2012)

- **Clear leadership:** the NPC and actively involving health & other sectors
- **Focused:** the first 1,000 days of life and stunting reduction
- **Addressing the immediate, underlying and basic factors:**
  - women and children's access to health and nutrition;
  - safe water & sanitation; and
  - education and inequity.
- **Emphasis on decentralised implementation:** initially in selected districts (2012-2014)
- **Vision to gradually scale up:** to all other districts by 2016 ***(A new approach: learning by doing)***

Multi-sectoral Nutrition Planning Framework



Organization of MSNP

- Chapter I: Introduction
- Chapter II: Plan
- Chapter III: Management Structure
- Chapter IV: Financing, Implementation Plan and Monitoring and Evaluation
- Annexes: Situation analysis: Stunting in Nepal
  Sectoral review reports
  Logical Frameworks:
  ✓NPC MSN Programme, activities and budget, monitoring and evaluation tools
  ✓Sectoral logframes and action plans

Chapter I: Introduction

Background to MSNP

- Ministry of Food and Agriculture +FAO plan 1970
- NPC: Nutrition coordination committee 1977 leading to nutrition strategies 1978/86
- JNSP 1985-90
- NPAN'1998
- National Nutrition Policy and Strategies (MoHP) 2004
- NPC TWG: NPAN 2007 draft
- NAGA: 2009

Rationale: why?

Improvement in nutritional status results to

- Better immunity, lowered death rates, decreased morbidity, protection from diseases in adult life
- Improved growth
- Improved cognitive development
- Increased productivity
- Increased GDP
- Achieving MDGs

Rationale: How?

- Nutrition specific interventions: feeding and care practices and protection from illnesses

aimed at individuals, mainly through health sector

- Nutrition sensitive: food availability, affordability and access, quality, utilization

aimed at families and communities mainly through non-health sectors

i.e. agriculture, education, local development, water supply and sanitation sectors

Chapter II: Plan

Goal

- To enhance human capital, especially among the poorer segments of the society

Purpose

- to improve maternal and child nutrition by accelerating the reduction in maternal and child under nutrition through implementation of nutrition specific and nutrition sensitive interventions aimed at the "window of opportunity of 1000 days from Pregnancy to 24 months"

Outcomes, Outputs, Activities

MSNP has total of

- 3 Outcomes
- 8 Outputs
- 27 Activities

Three Major outcomes

1: Policies, plans and multi-sectoral coordination improved at national and local levels

2: Practices that promote optimal nutrition behaviours improved leading to enhanced nutritional status

3. Strengthened capacity of central and local governments on nutrition to provide basic services in an inclusive and equitable manner

Eight Major Outputs

Outcome 1: ***2 Outputs***

1.1: Policies and plans updated/reviewed to incorporate nutrition specific indicators at national and local government levels

1.2: Multi-sectoral coordination mechanisms functional at national and local government levels

Outcome 2: ***4 Outputs***

2.1: Maternal and child care service utilization pattern changed

2.2 : Adolescent girls' education , life skills and nutritional status improved

2.3 : Reduced episodes of diarrheal diseases and ARI among mothers, adolscents and IYC

2.4 : Feeding behaviors improved with increased availability and access to appropriate food (in quality, quantity, frequency and safety)

Outcome 3: ***2 Outputs***

3.1 : Capacity of national and local government enhanced to provide appropriate support to improve maternal and child nutrition

3.2 : Multi-sectoral nutrition information updated and linked both at national and local government level

Schedule for roll out and scale up

- Gradual and incremental
- First year: 6 districts
- Each starting districts to start work in 2 VDCs and expand gradually so that by the end of the year 50% of VDCs are covered
- Selection criteria: Based on 13 set of indicators (malnutrition, poverty, HDI, Water sanitation, ecology, region, delivery by SBAs, school enrollment, Girls/boys enrollment etc)
- Second year: additional 12 districts
- Third year: further 16 districts
- Fourth year: additional 15 districts: 59 by the end of 4 years
- Fifth: additional 16 districts: total 75 districts
- Not all VDCs will be covered, cover at least 50%, those most disadvantaged!

- MSNP implementation period (First Phase): 2012-2016

Chapter III and IV

Management, Financial and M/E for MSNP Implementation

National

- National Nutrition and Food Security Steering Committee chaired by the Honorable Vice-Chairman of NPC (HLNFSC) formed.
- Nutrition Coordination Committee (NCC) and Food Security Coordination Committee (FSCC) to be formed under the chairmanship of respective members of NPC.
- Technical Committee comprising key technical experts from government, development partners, the private sector, academia, and civil society under NCC to coordinate technical matters.
- Nutrition Secretariat: Nutrition information management& M/E, Advocacy & coordination and capacity building) to be established.

High Level Nutrition & Food Security Steering Committee

Hon'ble Vice Chairman, National Planning Commission (NPC)	Chairperson
Hon'ble Members (3-Health, Agri, Commerce), NPC	Member
Secretary Ministry of Agriculture and Cooperatives	Member
Secretary Ministry of Health and Population	Member
Secretary Ministry of Local Development	Member
Secretary Ministry of Commerce and Supplies	Member
Secretary Ministry of Finance	Member
Secretary Ministry of Education	Member
Secretary Ministry of Physical Planning and Works	Member
Secretary Ministry of Women Children and Social Welfare	Member
Experts 4 (Nutrition, Food Security and Commerce & Supply)	Member
Member Secretary, National Planning Commission	Member Secretary
Joint Secretary, Social Development Division, NPC	Co-Member Secretary

TOR of HLNFSC

HLFNSC will be responsible for policy direction, guidance, and oversight function as well as

- to formulate macro policies on Multisectoral Nutrition and Food security
- to ensure internal and external resources
- to advocate and make commitment at national and international level
- to assess and review the programme implementation
- to coordinate sectoral policies and programmes on food security and nutrition

Decentralizing MSN Mechanism

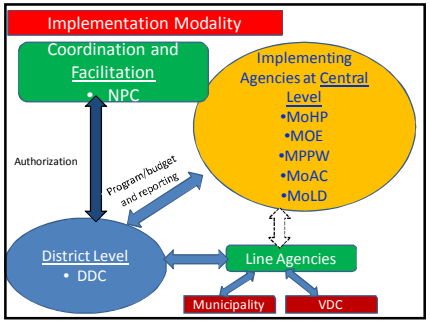
- District Level Nutrition and Food Security Steering Committee chaired by DDC Chairperson
- Municipality Nutrition and Food Security Steering Coordination Committee chaired by Mayor
- VDC level Nutrition and Food Security Steering Coordination Committee chaired by VDC Chairperson

Proposed District level: Food Security and Nutrition Steering Committee

• DDC Chair	Chairperson
• Local Development Officer	Member
• Chief, Line Agencies (Agriculture, Livestock, Health, Education, Drinking Water) -	5 Member
• Women Development Officer	Member
• Executive Officer, Municipality	Member
• Chair, District NGO Federation	Member
• Chairman, FNCCI	Member
• Representative, development partners & I/NGOs working at district level	Member
• Information & Documentation Officer, DDC	Member
• Programme Officer, Social Development Section, DDC	Member
• Planning Officer, DDC	Member Secretary

Proposed TOR of Local Level Committee

- Review and endorse nutrition related programmes that will be implemented in the Local Bodies and recommend its Council for approval, in line with the district adoption of the multi-sectoral nutrition plan
- Incorporate nutrition indicators in the LBs Periodic and Annual Plans
- Review progress of implementation of nutrition programmes
- Carry-out multi-sectoral coordination to reduce chronic malnutrition in the LBs



Implementation Modality

- Programs preparation and submission by VDCs and municipalities through district line agencies
- District line agencies prepare and submit program and budget to DDC through District Food and Nutrition Steering Committee
- DDC submits program and budget to line ministries
- Line ministries submit annual program and budget to NPC High Level Food and Nutrition Steering Committee
- Secretariat established at NPC will compile and submit central and district level programs to MoF for budget allocation
- Approval of central and district level programs and budget allocation
  - to the line ministries for central level programmes
  - to the DDC/DDF for district level programmes

...Modality

- For district level programmes and budget, MoF will provide authorization to the NPC and NPC will provide authorisation to the DDCs
- Line ministries will implement central level programs and monitor district level programmes
- DDC will allocate budget from DDF and implement programmes through line agencies with programme coordination from District Food and Nutrition Steering Committee
- Joint monitoring by District Food and Nutrition Steering Committee and submit joint progress report to the DDC
- DDC will review programme progress and submit report through line ministries
- Line ministries will compile district level reports and submit integrated report to High Level Steering Committee – Joint Review by High Level Steering Committee at central level

Tentative Costing for MSNP

$@72
Rs. 000

Output	2012	2013	2014	2015	2016	Total
1.0 Maternal and child care behaviours and service utilization pattern changed to improve maternal and child nutrition.	634753	594224	594224	594224	594224	3001651
2.0 Feeding behaviours improved with increased availability and access to appropriate food (in quality, quantity, frequency and safety).	36000	43900	149900	203900	304200	737900
3.0 Policies and plans updated/reviewed to incorporate nutrition specific indicators at national and local governance levels.	34995	41950	46930	45685	58135	227695
4.0 Multi-sectoral coordination mechanisms functional at national and local government level.	27588	29474	33692	37692	43872	172318
5.0 Capacity of national and local government enhanced to provide appropriate support to improve maternal and child nutrition.	35696	38346	42726	45206	52406	214320
6.0 Multi-sectoral nutrition information updated and linked both at national and local government level	3690	8970	16010	22610	33610	84890
Total	**772682**	**756864**	**883482**	**949317**	**1086447**	**4438774**
Total US$	**10584.68**	**10368**	**12102.49**	**13004.34**	**14882.84**	**60805.12**

Role of Coordinating Agency (NPC)

- Advocacy and Communication: Nutrition Sensitive Intervention
- Coordinating: Policy and Institutional
- Resource Managing: allocation and mobilisation of resources; Joint Planning and Budgeting
- Monitoring and Evaluation: System Strengthening and Joint Monitoring, Review and Evaluation
- Capacity Enhancing: Training and Capacity Development of HR related to Nutrition

Role of Sectoral Ministries

- Mainly responsible for
  - mainstreaming nutrition in sectoral programs
  - mobilization of resources and implementation through their regional and district networks.
  - providing technical backstopping
  - carrying out monitoring and evaluation of the implementation process.

Role of EDPs and I/NGOs

- Support and Strengthen Government System
- Joint Planning, Budgeting, Monitoring and Review
- Joint Financial Arrangement (JFA) and provide support to the government Budget System

Areas Where Focused Attention and Support is Required

- Continuous Advocacy to Sustain National Commitment on SUN
  - GoN (Hon'ble Prime Ministers) expressed country's commitment in LDCs meeting Istanbul and SUN meeting New York on improving nutrition through multisectoral approach
  - Sensitization and Advocacy at national and sub-national levels to maintain commitment on scale up nutrition (SUN)
  - Focused attention to increased budget allocation for Nutrition across the sectors
- Capacity building
  - In-depth capacity assessments needed for all sectors (building on NAG A findings)
  - Multiple level capacity development strategy at Community, District and Centre
  - Scale up district models will greatly influence capacity building approach – economies of scale must be sought
- Monitoring and Evaluation
  - Multisectoral Nutrition Information System (NIS) including a set of core indicators by sector for the MOLD to track progress
  - Build in evaluation for the initial phase: Base- and End-line survey
- Resource Mobilisation
  - The multi-sectoral nutrition package has been costed with priority focus on the first 1,000 days of life and on what is proven effective to reduce chronic malnutrition (Nepal based costing)
  - Mobilisation of resources initially in the selected model districts and to scale up gradually to the remaining districts

Next Steps

- Submit to HLNFSC for Endorsement and Further Review
- Proceeding to Cabinet Approval
- Launching Programme
- Budgetary Resources and Commitment
- Phased Plan for Implementation, 6 Districts for Year 1
- More detailed strategies and plans on: Multi-sectoral Nutrition Advocacy & Communication, Nutrition Capacity Development, and Monitoring & Evaluation

NHSSP Nepal Health Sector Support Programme

Readiness of Comprehensive Emergency Obstetric and Neonatal Care (CEONC)

CEONC 'Readiness' Study

- **Imperative:**
  - Readiness of CEONC vital for saving lives of pregnant women and newborn babies
  - Findings of the maternal mortality study 2009
- **Study Purpose:**
  - Experience with CEOC funds
  - How ready are our CEONC sites?
    - What are the bottlenecks?
    - What works? What does not? Why?

What is CEONC ?

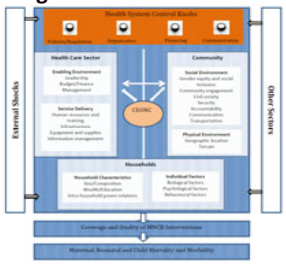
Standards for Basic and comprehensive EmOC

Basic EmOC (BEOC) Functions (Performed in a health centre without the need for an OT)	**Comprehensive EmOC (CEOC) functions** (Requires an OT and and is usually performed in district hospitals)
▪ IV/IM antibiotics ▪ IV/IM oxytocics ▪ IV/IM anticonvulsants ▪ Manual removal of placenta ▪ Assisted vaginal delivery ▪ Removal of retained products ▪ Newborn resuscitation	All 7 Basic EmONC functions plus ▪ Caesarean section ▪ Blood transfusion

Functionality of CEONC service

- *Presence of CS service for the last three months*

Guiding Framework



Ergo A, Eichler R, Koblinsky M and Shah N. 2011. *Strengthening Health Systems to Improve Maternal, Neonatal and Child Health Outcomes: A Framework. Washington DC, MCHIP.*

Methodology

Qualitative

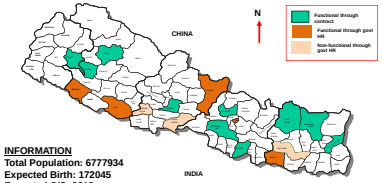
- *In-depth interviews*
  - District Public/Health Officer
  - Medical Superintendent
  - Nurse In-charge
  - SBA
  - Anaesthesia Assistant
  - HDC chairperson/member
- *Focus group discussions*
  - Mothers (users and non-users of institutional delivery in 3 districts)

Quantitative

- *Record Review*
  - Maternity and OT register
  - HMIS and EOC reporting

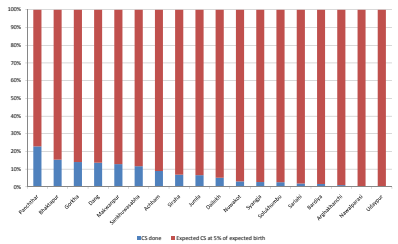
- **Time Frame:** May to October 2011

Service Availability



INFORMATION
Total Population: 6777934
Expected Birth: 172045
Expected C/S: 8818
CS done: 639
CS as % expected birth: 0.4%

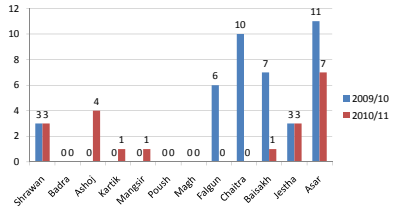
Caesarean section performed as percentage of total expected CS



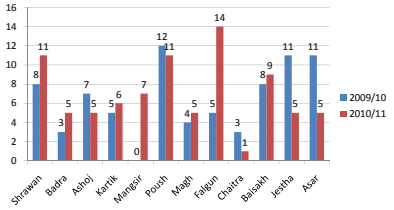
CS Availability

Functional	2009/10	2010/11
1 to 3 months	Achham, Arghakhanchi, Bardiya Dang, Jumla, Lahan, Udaypur Nawalparasi, Syangja Solukhumbu(10 districts)	Arghakhanchi, Sarlahi, Jumla, Lahan, Udaypur, Nawalparasi, Nuwakot, Solukhumbu(8 districts)
3 to 6 months	Bhaktapur, Dailekh, Nuwakot, Sarlahi	Dailekh, Sankhuwasabha, Hetauda, Syangja
6 to 9 months	Gorkha	
More than 9 months	Hetauda, Panchthar, Sankhuwasabha	Bardiya, Bhaktapur, Achham, Dang, Gorkha, Panchthar(6 districts)

CS number - Dailekh District 2009/2010 - 2010/2011



CS number - Panchthar District 2009/10 -2010/11



Human Resources

CEONC Team	Positive factors	Foci for Improvement
Contracted through CEONC fund	• Enabled CS to happen • Less burden on management • Help with setting up of OT • Skill transfer	• High relative cost • Effect on staff morale • Contractual agreement not followed (Hetauda, Nuwakot)
Through government sanctioned post	• Less cost • Sustainable	• Transfer (Unplanned, no skill matching) • One person vs. 24/7

Inadequate number of trained personnel for c-section.
E.g. No facility visited had more than one AA and most a single CS provider
Only one nurse (SN/ANM) available for the entire inpatient department (especially at night)

Training

	Positive Factors	Foci for Improvement
Skills	• SBA and AA training appreciated • ASBA providing services	• Limited exposure in CS for complications (ASBA) • Lack of team approach
Policies/ Regulations	• Liberal policy for hiring HR (CEOC fund) • ASBA training for MBBS • AA training	• No provision for bond after training • Issues of AAs having 3/6 months of training • Issues regarding AHWs providing anaesthesia

MDGP: unpopular career choice; no commitment to stay in post
General health group/career ladder
Less attractive for doctors

HR and Training Recommendations

- CEONC fund to be continued as transitional strategy till the OBGYN/MDGP post not created or filled in districts
- All CEONC districts should have at least one MDGP/OBGYN and 1-2 ASBA plus support team (AA, OT nurse)
- ASBAs to be placed where MDGP/MD Gynae/Obs or DGO
- Follow up and mentoring after ASBA training (where MDGP/OBGYN not there)
- District bond needed after any training
- Well planned skill matched transfer mechanism needed to ensure a CEONC team

Operation Theatre — Infrastructure

Dang — Sankhuwasava — Lahan

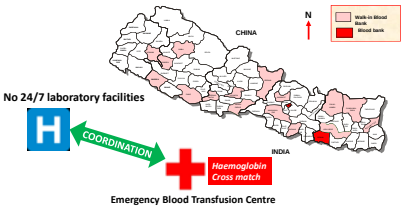
Operation Theatre — Infrastructure...

Majority of the districts had problem with the OT table

Achham — Jumla — Sarlahi — Dailekh

Miscellaneous — Infrastructure...

Map of CEOC Study Districts showing Blood Transfusion Facility



Recommendations — Infrastructure...

Up-date CEONCs to present day standard

Establish earmarked budget for regular repair and maintenance

Recruit regional bio-medical technician to support all CEONC site regularly and on-demand

Install robust waste management system and monitor functionality

Equipment & Supplies

Availability of Drugs

Oxytocin	$MgSO_4$	Cal. Gluconate	Nefidipine	Chlorine Powder
Available in all districts	Not found in **Lahan, Sarlahi and Parasi**	Not found in **Lahan, Trisuli, Sarlahi and Parasi**	Not found in **Parasi, Bardiya, Dang, Dailekh, Sarlahi, Jumla**	Procurement difficulty reported in **Hetauda, Achham and Trisuli**

Autoclave

Small and need to be replaced

- **Sarlahi**
- **Achham**
- **Syangja**

Fridge not accessible

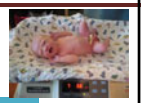
- **Syangja**
- **Solukhumbu**
- **Jumla**

Equipment & Supplies

Newborn Resuscitation Table

Equipment & Supplies

Newborn Resuscitation Table



Needed

Newborn resuscitation table	Newborn resuscitation equipment
Bardiya, Gorkha, Sarlahi	Jumla, Lahan, Udaypur

Equipment & Supplies

Recommendations

- Ensure oxygen supply, anesthesia system and newborn equipment in all CEONC
- Implement system to improve resupply and maintenance of OT equipment on demand
- More attention to be paid to the "Pull" rather than the "Push" system of procurement
- Ensure system in place for effective monitoring of supplies and equipment

Management and Organisation

	Positive Factors	Foci for Improvement
Leadership	• Exceptional leadership (eg. Gorhka, Achaam) • HDC Leadership (eg. Panchthar)	• Weak leadership; • Frequent transfer • Separation of D(P)HO and MS contributes to confusion and communication gaps
Management	• Monthly staff meetings, Mobile reporting system and leave reporting and patient complaint system (Gorkha) • Proactive use of local resources to cover budget gap	• No hospital management training • Returned CEONC funds through lack of clarity • Limited team building • Lack of coordination between the hired and the local service providers (Trisuli) • Lack of coordination between infrastructure planning and HR deployment at Ministry level

Management and Organisation

	Positive Factors	Foci for Improvement
Team Work	• Nexus between DPHN, MS and Nurse In-charge Sankhuwasabha • Unique DHO support and mentoring to CS provider (Achham)	• Conflict among teams in some places
Communication	• Development of system for communication by mobile including reporting maternal deaths; leave; absence and institutional delivery in one place (Gorkha)	• Poor coordination and communication leading to ignorance of HDC about CEOC fund • Inconsistent use of mobile phones for communication as relies on individual initiative in all but one place

Management and Organisation Recommendations

Management orientation for HDC, hospitals directors and managers needed

Clarify roles and relationship between D(P)HO and MS (budgeting and staffing)

Coordination between the hired team and local team for facilitating skill transfer albeit informally

Develop simplified user friendly guidelines for CEOC fund and procurement of HR

Develop joint planning mechanism for utilization of the CEOC fund

Monitoring and Reporting

	Positive Factors	Foci for Improvement
Maternity and OT Registers	• Relatively well maintained records	• Examples of poor record maintenance (eg. Sarlahi) • Neo natal resuscitation column not on maternity registers, only outcome and APGAR
HMIS and EOC monitoring	• 8 out of 18 were reporting monthly EOC data • Monthly reports sent by computer to DHO in all but 3 facilities	• Discrepancy between HMIS and On-site EOC data • EOC monitoring data recording and reporting –not uniform (Sarlahi and Hetauda) • 10 using tally sheets to record events eg. Lahan, Bhaktapur, Syangja
Data for Decision Making		• Little evidence of local data being used for decision making

Monitoring and Reporting Recommendations

- Efforts to improve motivation to collect, report correct information
- More systematic approach to recording and reporting numbers of maternal and perinatal deaths prior to discharge
- Include neonatal resuscitation in maternity register form

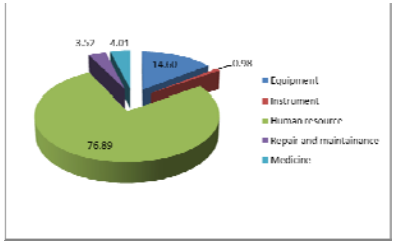
Budgets and Financial Management

	Positive Factors	Foci for Improvement
Level of funding	Free Care CEOC fund Aama Surakshya Fund FHD fund to recruit nursing staff Local funding	• Underused CEOC funds due to eg. lack of candidates to fill posts • Differential pay for same job dependent on fund source
Timing and security of funding		• Delayed release of funding in fiscal year • Uncertain future of CEOC fund
Financial reporting and management		• High variability in interpretation of financial management and reporting requirements • Variable understanding of funding guidelines

Budget and Finance
CEOC fund Allocation vs. Expenditure

Districts	Budget Allocation	Expenditure	% Expended
Sarlahi	3500000	2287500	65
Arghakhachi	3000000	1442393	48
Bardiya	3000000	349050	12
Syangja	3500000	2338500	67
Sankhuwasabha	3500000	3374875	96
Solukhumbu	3060000	350000	11
Dailekh	3500000	3111356	89
Gorkha	2000000	1352060	68
Accham	4000000	2286273	57

Share of Expenditure from CEOC Fund



Budgeting and Financial Management
Recommendations

- Implement multi year procurement budgets for CEONC service
- Speed up budget release
- Increase flexible use of unspent funds to support continuity of service in high demand districts
- User friendly guidance for financial management and reporting requirements

Some voices…..

- *"We are struggling with the realities…all the time…. cautious and tactical in case management if the family is aggressive or demanding…..we tell them that there is no doctor so the patient is better off elsewhere."*

  AA
- *"I do what is within my capacity, if there is hostility, I send such patients away…."*

  MS
- *"There is no support from management; we are discouraged and told to avoid risks while dealing the patients and refer the patient out if the patient party is demanding."*

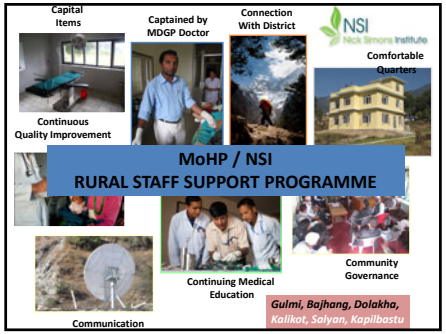
  SBA
- *"We are totally on our own….nobody ever comes to support us if we get into trouble, not even the HDC"*

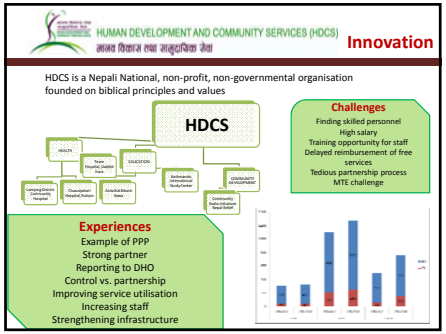
  Nurse In-charge
- *"We must be careful and provide services with utmost caution…. There is fear… and we are fighting all the time… Staffs have been threatened; their chairs lifted and thrashed on the ground before them, they have even been followed to their quarters by the angry relatives."*

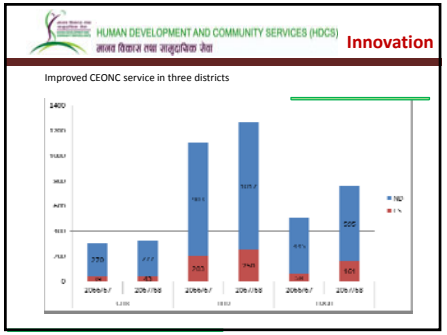
  SBA
- *"I am scared during night duty…. I feel that I am alone while facing hostile behaviour from the patient's family. If there was a serious mishap, there would be no one to back me up……!"*

  Nurse in-charge

Public Private Partnership







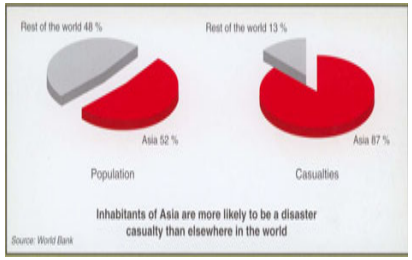
Seismic Vulnerability & Hospitals in Kathmandu

Joint Annual Review
17 Jan, 2011

Disasters & Developments

Over the past two decades, over 200 million people per year have been affected by disasters. According to the UK Government's Department for International Development (DFID): "Disasters hold back development and progress towards achieving"

Asia & Disasters



Nepal

- *The hotspot of disasters*

(World Bank, 2005)

- *It is the 20th most disaster prone countries in the world*

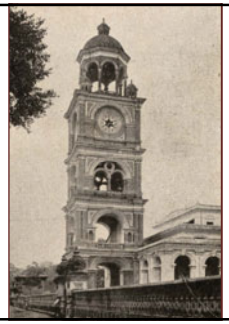
A 2004 study (UNDP/BCPR,) ranked Nepal as the 11th most at risk country to earthquakes and the 30th with respect to floods.

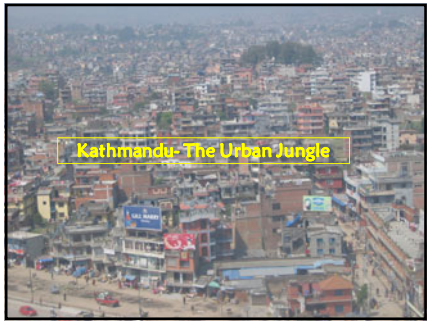
Recently it is also believed that Nepal is at 6th position among the most at risk countries due to climate change.

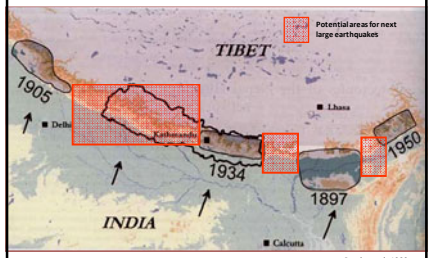
- **Almost every Nepali is under threat of disasters of more than two kinds.**
- **In an average about 943 people die every year (based on data between 1983-2005)**
- **Kathmandu is one of the few cities in the world at a very high alert due to Earthquake disaster.**

1934 Eq. Loss of life

Place	Men	Women	Total
Kathmandu	254	225	479
Outskirts of Kathmandu	79	166	245
Patan	250	297	547
Outskirts of Patan	871	826	1,697
Bhaktapur	433	739	1,172
Outskirts of Bhaktapur	65	91	156
Totals for Kathmandu Valley	1,952	2,344	4,296

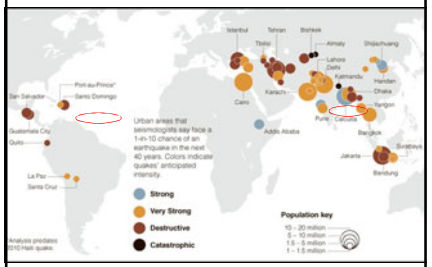






Pandey et al., 1999

PREDICTED IMPACT OF EARTHQUAKE



Casualty

KVERMP, 1998 (Population-1.5M):
- Death: 40,000
- Injury: 95,000

2010 Estimate with Population: 3.0M
- **Death: 100,000**
- **Serious Injury: 100,000**
- **Moderate Injury: 200,000**

? Hospital

- **Are they able to handle situation like this?**

Structural/Non-Structural Assessments

Year	Events (structural/non-structural assessments)
2002	Structural assessment of 14 hospitals (9 hospitals in Kathmandu Valley + 5 hospitals outside valey)
2003	Non-structural seismic assessment of 10 hospitals (5 in Kathmandu valley + 5 hospitals outside valley)
2006	Earthquake Vulnerability Assessment of Epidemiology and Disease Control Division Building at Teku, Kathmandu
	Earthquake Vulnerability Assessment of National Public Health Laboratory Building at Teku, Kathmandu
2007	Earthquake Vulnerability Assessment of Blood Bank Buildings at Districts Centers Nepal
2009	Re-habilitation of Patan Hospital Emergency Wing
	Kathmandu declaration on protecting health facilities from disasters "Twenty-seventh Meeting of Ministers of Health Kathmandu 7-8 September 2009"
2010	Detailed Structural Assessment of Patan Hospital
2011	Rapid Structural Assessment of Bir Hospital

Summary of Findings

- All hospitals will be out of function if there MMI IX level earthquake.
- If MMI VIII is considered 80% of hospitals would go completely out of function posing life safety hazard to medical staff & patient.
- Remaining 20% will not pose threat to life but would go out of function for long time.

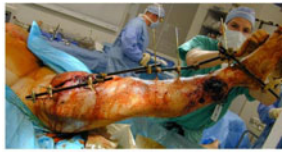
Demand vs. Capacity of hospital after disasters

- Demand on different types of health services like out-patient, in-patient, treatment and surgery .
- Large and Continued influx of patients rescued from disasters .
- According to WHO, the demand will come to normal admittance level after a week, but in developing countries, the demand generally do not come to normal level so fast and actually takes several weeks.

Components of functionality after an Earthquake

- Structural components- include columns, beams braces; floor or roof sheathing, slabs, load-bearing walls
- Non-structural components - everything except the columns, floors, beams, etc.
- Functional components

Half of lower leg injury in Haiti were amputated



A Safe Hospital …

will not collapse in disasters, killing patients and staff;

… can continue to function and provide its services as a critical community facility when it is most needed; and

… is organised, with contingency plans in place and health work-force trained to keep the network operational.

Why Focus…Safe Hospitals

- are a community's lifeline in normal times and are especially critical in times of disaster.
- Yet time and again, they have been severely damaged or left unable to function in the aftermath of disasters.
- They are also powerful symbols of social progress and a prerequisite for stability and economic development.

Initiatives

- The NRRC and the GON identified five flagship areas of immediate action for Disaster Risk Management in Nepal;
- Currently, WHO is assigned as the lead coordinating agency for the "Hospital Safety" component of the Flagship 1.
- For the first time MOHP allocates NRs. 20 m. in capital cost for retrofitting.
- HEOC to be started soon in MOHP.
- DFID /WHO working on updating previous assessments
- ECHO funded project.

The MOHP Identified Priority Hospitals

Hospitals to be retrofitted and priority activities for hospital safety in emergencies to be in place.

– Tribhuvan University Teaching Hospital (TUTH),
– Birendra Army Hospital,
– Civil Services Hospital,
– Patan Hospital,
– Bir Hospital,
– Kanti Children Hospital, and
– Maternity Hospital

Excellent hospital buildings which have been built in the last 5 years

Good Basic Designs Poor Construction.

Retrofitting Works

- **Description:** Peru, September 2007. The city of Pisco lost 97% of its hospitals beds during the earthquake. However, a recently retrofitted wing of the The San Juan de Dios Hospital withstood the force of the earthquake, proving once again that this strategy helps.

San Juan De Dios Hospital

Current Need

❖ Result of various assessment shows the immense need to take action for mitigation.

❖ Mitigation measures are taken for safeguarding the hospital functionality after disaster.

❖ For this purpose works of structural and non-structural retrofitting must be undertaken .

❖ This will reduce the present vulnerability of existing hospitals.

❖ One or two hospital should be taken as a pilot hospital to be retrofitted.

Issues

- Diverse and complex nature of control of hospital development, being split among so many ministries, has hampered the development of a unified approach
- Many of the public hospital buildings built 15 years back are much vulnerable structurally.
- An extensive private sector further complicates the problem.
- At a hospital level, medical plans for developing capacity have given rise to haphazard construction programmes and potentially unsafe structures.

UK Announces new support for Earthquake Preparedness in Nepal

It will reconstruct at least 162 schools damaged in the Sikkim earthquake in September 2011, and develop a national plan to improve the seismic safety of hospitals.

The Rt Hon Alan Duncan, UK Minister

- "I have been extremely focused on the earthquake risk in Nepal since my first visit to Nepal as a UK Minister. An earthquake in Kathmandu has all the components of a cataclysmic tragedy. This is a risk that the UK cannot ignore.

Are We Prepared ?

- Emergencies are generally taken seriously, when it occurs
- - when it does not occur for a long time – preparedness is forgotten.
- When emergencies occur, there nothing to deal with.

Development Partners Supporting NHSP2

Health Sector Support
- AusAID
- DFID
- GAVI
- KfW
- World Bank

Programme Support
- ADB
- JICA
- Global Fund
- SDC
- UNAIDS
- UNICEF
- UNFPA
- USAID
- WHO

Do You Want Us To Be In This Situation?

Waiting for A Helping Hand

Thank You

INGOs Contributing to Health Sector in Nepal

Effort towards reaching MDGs and NHSP II

Ministry of Health and Population
Nepal Health Sector Programme II
Joint Annual Review Meeting
January 17, 2012

Outline

- Members in the AIN working in Health and Nutrition
- AIN Mission
- Contribution made in 2011

Mission

- AIN aims to be a strong, proactive, and accountable network of INGOs in Nepal which promotes poverty reduction, sustainable peace and equitable development, human rights, social inclusion and good governance among its members and their partners.
- AIN members have been engaging and coordinating with other development and humanitarian actors, including government bodies, NGOs, NGO associations, and funding partners.

Mapping of INGOs contributing to Health Sector in Nepal

- To document and disseminate efforts AIN members has been making to improve the health and survival in line with Nepal Health Sector Program II (2010-15)
- To strengthen the relationship with Government of Nepal, civil society and External development partners for catalytic investment in health
- To realize the contribution of INGO's working in Nepal to reach the MDGs 1, 4, 5 and 6

Health Sector INGOs Priority Areas for the year 2011

- Maternal health and family planning
- Adolescent health
- Child health (Nutrition, IMCI, Newborn and Immunization)
- School Health and Nutrition
- Malaria Control and prevention

Health Sector INGOs Priority Areas for the year 2011

- Physical Rehabilitation center for disability
- Leprosy and TB
- Health System Strengthening-Human Resource For Health
- Health Promotion and Advocacy
- Water and Sanitation
- Mental Health

Contribution

- **Contribution in Health- Approximately 62 million USD which has increased by thrice fold in last 3 years**
- **Works in all 75 districts but not all the VDCs are covered**
- **Works both in rural as well as in urban sector**
- **More focus in Mid-western and Far-western Region**
- Strengthening NGOs since INGOs work in partnership with NGOs
- Knowledge sharing: Replicate International best practices

Finally,

- Community Participation
- Advocacy
- Strengthening of Health system
- Inter-sectoral coordination

Experience Sharing on

Key Reforms in Regional Health Sector Mid and Far Western Region

Regional Health Coordination Team (RHCT), M & FWR
(July 2007 to Dec 2011)

- Mahendra Prasad Shreshtha
Regional Director
RHD Far Western Region, Dipayal

Wednesday, 11 January, 2012

Outline

- Context
- Brief of RHCT
- Jointly developed tools and techniques
- Tangible results in regional health sector reform
- Challenges
- Way forward

Some Issues affecting Health Sector at Regional/District Level

- central decision making power resulted into a less transparent system,
- weak local ownership,
- weak linkage between planning and resource allocation process among District, Region and Centre,

Regional Health Coordination Team (RHCT)

- **Formation of RHCT** in Dec 2007 under the leadership of RHD – MWR & FWR
- **Objective**: To bring Government and non-state actors together to co-ordinate the programmes and resources for better results in terms of maximising coverage and improving access to quality health care services and improve health governance

Why the RHCT needed?

- Poor co-ordination (programme and resources) between state and non-state actors – harmonisation and alignment
- Trickling down the spirit of SWAp at region and districts

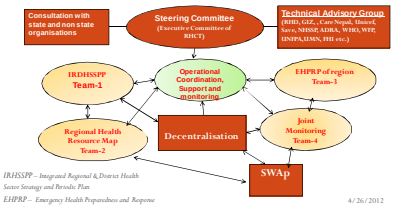
Role of RHCT

- Strengthen partnership among state and non-state actors
- Strategic steering of health management at regions
- Better alignment and harmonisation of actors – norms, systems, objectives
- Minimization of ad-hoc, scattered and unaligned programmes and resources
- Strengthening of decentralisation, including local health governance, in the health sector

Participants on RHCT Meeting

How we work together?

RHCT- A flexible Steering Structure at Regional Level with a network of teams set up



IRHSSPP – Integrated Regional & District Health Sector Strategy and Periodic Plan
EHPRP – Emergency Health Preparedness and Response Plan of Region

Progress made through RHCT

- Process and result oriented through team approach- *Health Sector strategy and Integrated planning process*
- Better partnership and working relations between actors with frank and open discussion on pertinent issues.
- Evidence based action- *indentified issues and challenges*
- Better enable RHD to identify regional health issues and possible resources to address them
- Sharing of programme and process learning among different actors

Progress made through RHCT…

- Development of Regional Health Resource Map- MWR
- Tools for Health Sector(district and regional) planning process- concept note, Flow chart, Assessments tools (Self, Social, Technical), Software of data analysis
- Regular joint monitoring and supervision
- Innovative review mechanism – inclusion of private actors, recognition of performance, etc.
- Performance Based Management System in 14 districts

26-Apr-12

Major Challenges

- **Different interests of different health actors** – state and non-state actors at district and region
- **Vertical and horizontal coordination and networking** - programme and resources
- **Quality of leadership and management at different level-** Unclear roles and decision making process
- **Mechanical monitoring & supervision**
- **Un-contextual Human Resource** – poor motivation, absenteeism, low retention, frequent transfer
- **Poor Satisfaction of both Health Providers and Consumer**
- **Weak instituitional Memory**- documentation and sharing

26-Apr-12

Ways Forward

- **AWPB at regional level-** Linkage with local planning and budgeting
- **Joint monitoring framework at all level-** (To identify evidence for advocacy, planning and financing)
- **Flexible financial management to address local issues.** (Linkage between community and health facilities)
- **Accountability and Governance-** Need based health sector planning, better practice of social inclusion in health, social audit, etc.

26-Apr-12

Thank You!

26-Apr-12

Preliminary Findings from the Nepal National Health Accounts (2006/07- 2008/09)

Dr. Bal Krishna Subedi
Prabha Baral
MoHP
Ghanshyam Gautam
GIZ

Background

- The Nepal National Health Account 2000/01-2002/03 was the first officially produced report in 2006.
- Second round of NNHA was carried out in 2009 covering the period 2003/04 to 2005/06
- This is the third round effort, for the year 2006/07 to 2008/09

Methodology

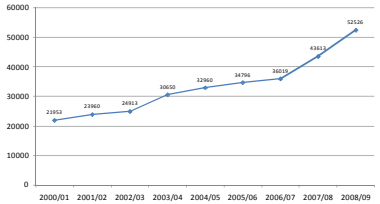
- Estimates are based on the concepts and accounting framework of the Organisation for Economic Co-operation Development- System Health account(OECD-SHA 1st)
- OECD –SHA 2000 was modified to suit the Neplease Health System (Framework for NNHA- provided by first round)
- Several studies were carried to complete the third round NNHA estimate

Contd…..

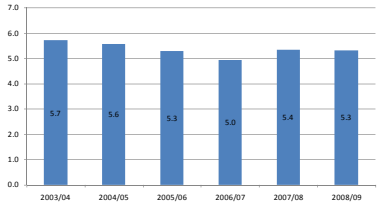
- Public Expenditure Review
  - Government expenditure on Health
  - Donor Expenditure survey
  - Autonomous bodies/State owned Enterprises Survey
  - Local bodies expenditure Survey
- Private Hospital and Nurshing Home Survey
- Private Clinics and Pathology Survey
- Medical, Nursing and Paramedical school Survey
- Pharmaceuticals Expenditure Survey

Trend of Total Health Expenditure (THE)

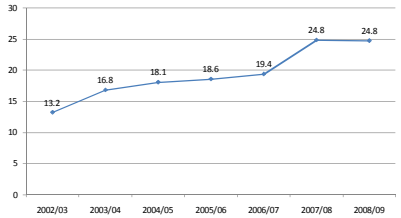
(Current Price in million NRs.)



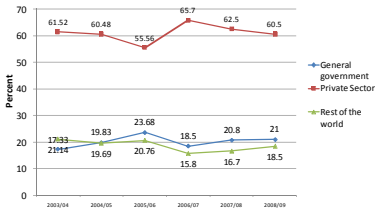
THE as % of GDP



Per capita THE (in US$)



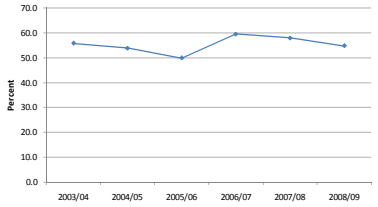
Total health expenditure by source



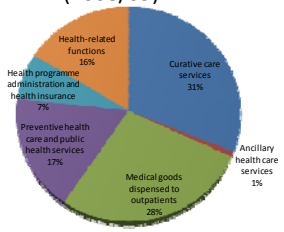
Contd…

		2003/04	2004/05	2005/06	2006/07	2007/08	2008/09
Private sector	Pvt ins. Entp.	0.0	0.0	0.0	0.2	0.2	0.2
	OOP	55.9	54.0	50.0	59.6	58.0	54.8
	NGO	4.6	4.2	4.3	4.4	2.5	3.8
	Corporation	1.1	2.3	1.3	1.6	1.8	1.8
Rest of the world	EDP	8.7	6.4	7.9	8.8	9.4	10.8
	INGO	12.4	13.3	12.8	6.6	7.2	7.5
	Other donor	0.0	0.0	0.0	0.4	0.0	0.2

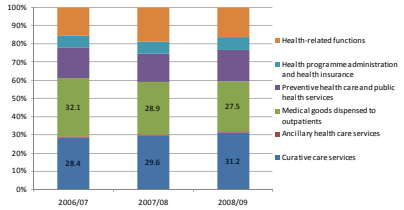
Share of OOP spending in THE



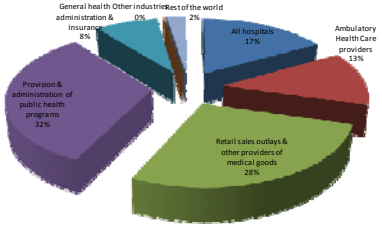
Composition of THE by Functions (2008/09)



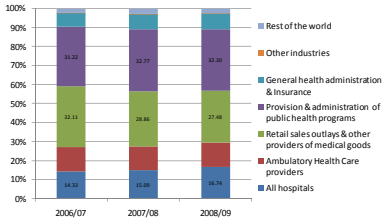
Trend of THE by functions



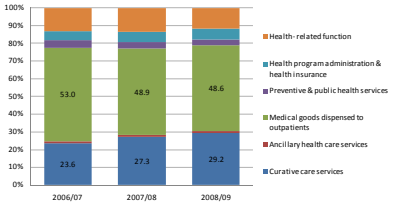
Composition of THE by providers, 2008/09



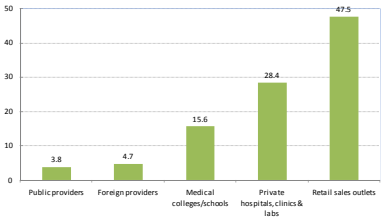
Trend of THE by providers



OOP spending by functions



OOP spending by providers



Limitations

- Does not capture expenditure on informal providers (e.g. traditional healers, etc.)
- Current data recording system of financial information is less compatible with NHA format
- The problem like non-response and double counting errors

Contd…

- Extrapolation was used to estimate Expenditure on Private health insurance
- We do not have household survey data on health expenditure therefore OOP was estimated on the base of user fees
- Acknowledge- Financial and technical support was provided by WHO/ GIZ.

Strategic Directions and Expenditure Priorities for the next AWPB

Presented at:
Joint Annual Review Meeting
January 2012

Dr. B. K. Suvedi
Chief
Policy, Planning and International Cooperation Division
Kathmandu, Nepal

Scaling up Community Based and Instituitional Interventions

- **Community Based Newborn Care Programme (CB-NCP)**
- **Nutrition Care and Rehabilitation Programmes**
- **Emergency Obstetric care and delivery care**
- **HIV/AIDS Care and Support**
- **Disease Control Programmes**

Maintaining the Quality of Existing Programmes

- **Maternal Health (CEOCs, BEOCs, Birthing Centres)**
- **IMCI programme**
- **Free Health Care Programme**
- **Immunisation**
- **Family Planning**
- **Tuberculosis Control**
- **Care and support for HIV/AIDs**
- **Malaria Control**

Integrating Programmes

- **Incentive for ANC visits with Aama Programme**
- **CB-IMCI and CB-NCP**
- **PMTCT with ANC**
- **Nutrition Programmes**
- **Training Programmes**

- **Revitalising family planning programme**
- **Strengthening local health governance system**
- **Strengthening supply side interventions**
- **Mainstreaming GESI**
- **Expanding the benefits package and population coverage of free care**

Partnerships

- **Inter- Governmental- example: Urban health programme, where MoHP provides 50% of the funds and the municipality 50%**
- **Government and EDP and I/NGO- example: child health, maternal health and disease control for (demand creation by I/NGOs and service provision by government)**
- **Government and private sector- example: Aama programme, uterine prolapse surgery**
- **Government and NGO and community- example: establishing birthing centres**

Multi -sectoral Collaboration and Cooperation

- **Local Health Governance**
- **Management of Uterine Prolapse**
- **Nutrition care and support**
- **HIV/AIDS Control**
- **WASH**
- **Hospital Service Delivery (MoHA, MoGA, MoLD, MoD, MoE)**
- **Health Insurance**

Instituitional Development

- **Health Sector Information System (HSIS)**
- **National Centre for Nutrition**
- **National Health Training Academy**

New Strategies for Health System Development

- **Implementation of the Human Resource Strategy**
- **Development of a Health Financing Strategy**

Top Priorities for Service Delivery

Service	Components
Child health	Scaling up CB-NCP and sustaining quality IMCI
	Community and institution based nutrition
	MR Campaign and routine immunisation
	Maintenance of existing programmes
Maternal health	Scaling up CEOC sites and birthing centres
	FCHV programme
	Family planning
	Scaling up of management of uterus prolapse
	Quality maintenance of existing programmes
	Control and management of gender based violence
Disease control	Elimination of Kala-azar and Lymphatic Filariasis
	Pre-elimination of malaria
	Control of dengue
	Outbreak Response

Top Priorities for Service Delivery (Contd…)

TB, HIV/AIDS	Scaling up care and support programme
	Quality maintenance of national tuberculosis control programme
Free health care	Universal free care (HP/SHP/PHCC levels)
	Targeted free care at district hospitals Health Insurance Community Drug Programme
New elements of EHCS	Piloting of community based mental health programme
	Piloting of basic oral health programme

Top Priorities for Health System Development

Health system	Components
Human resources	Implementation of new HRH strategy
	Production of critical human resources
	Retention of medical doctors and nurses
	Training of SBAs, Aneasthetic Assistants, and Biomedical Technicians
Finance	Health financing strategy development
	Output based budgeting system
	Web-based TABUCS
Construction	Completion of existing constructions
	Priority constructions as required by service expansion plan
	Construction/expansion of CEOC at referral and central hospitals

Contd...

Procurement	e-submission of bids
	Multi-year contracting: construction, drugs, commodities, services
	Monitoring supply of drugs and medical supplies
	Quality purchasing
Drugs and Equipment	Revision of listed essential drugs for free care
	Inventory of equipment
Information and Evidence	Quality improvement of HMIS
	Operation research

Key Areas

HSS	Service delivery
	Multi-year contracting: construction, drugs, commodities, services
	Monitoring supply of drugs and medical supplies
	Quality purchasing
Drugs and equipment	Revision of listed essential drugs for free care
	Inventory of equipment
Information and evidence	Quality improvement of HMIS
	Operation research

Thank You

Annex 3

JAR Reports

Government of Nepal
Ministry of Health and Population
Joint Annual Review
of
Nepal Health Sector Programme II

16th to 18th January 2012

Soaltee Crown Plaza
Kathmandu, Nepal

Reports Index

1. Results Framework
2. GAAP
3. Financial Management Report
4. Progress Report on Performance with regards to Procurement & Infrastructure
5. Highlights of Findings from Health Research Reports carried out in 2011 in Nepal
6. Partnership, Alignment & Harmonisation in the Health Sector
7. Opportunities, Challenges & Obstacles in Implementation of NHSP II
8. Strategic Directions and Expenditure Priorities for the Next AWPB
9. Progress Report of GESI & Progress Against the Framework

Progress Report on Indicators in NHSP-2 Results Framework

Report Prepared for Joint Annual Review (JAR)
January, 2012

Government of Nepal (GON)
Ministry of Health and Population (MoHP)
Ramshahpath, Kathmandu

Table of Contents

ACRONYMS

AFR	Adolescent Fertility Rate
AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante Natal Care
API	Annual Parasite Incidence
ARI	Acute Respiratory Infection
BEOC	Basic Emergency Obstetric Care
CEOC	Comprehensive Emergency Obstetric Care
CMR	Child Mortality Rate ($_1q_4$)
CPR	Contraceptive Prevalence Rate
CS	Caesarean Section
DoHS	Department of Health Services
EAP	Equity and Access Programme
e-AWPB	Electronic Annual Work Planning and Budgeting
EDCD	Epidemiology and Disease Control Division
EHCS	Essential Health Care Services
EOC	Emergency Obstetric Care
EOCM	Emergency Obstetric Care Monitoring
FCHV	Female Community Health Volunteer
FHD	Family Health Division
FSW	Female Sex Workers
GAAP	Governance and Accountability Action Plan
GBV	Gender Based Violence
HIV/AIDS	Human Immune Deficiency Virus/Acquired Immune Deficiency Syndrome
HMIS	Health Management Information System
HP	Health Post
IBBS	Integrated Biological and Behavioural Surveillance
IDU	Intravenous Drug Users
IMR	Infant Mortality Rate ($_0q_1$)
JAR	Joint Annual Review
MICS	Multiple Indicator Cluster Survey
MMR	Maternal Mortality Ratio
MoF	Ministry of Finance
MoHP	Ministry of Health and Population
MSM	Men having Sex with Men
MSW	Men Sex Workers
NCASC	National Centre for AIDS and STD control
NDHS	Nepal Demographic Health Survey
NFHP	Nepal Family Health Programme
NHSP-2	Nepal Health Sector Programme-2
NHTC	National Health Training Centre
NMR	Neonatal Mortality Rate
NTC	National Tuberculosis Centre
ORS	Oral Rehydration Salts
PHCC	Primary Health Care Centre
PPICD	Policy Planning and International Co-operation Division
RF	Results Framework
SBA	Skilled Birth Attendant
STS	Service Tracking Survey
TFR	Total Fertility Rate
U5MR	Under 5 Mortality Rate

Executive Summary

This report assesses the performance of the NHSP-2 in terms of progress towards the achievement of indicators in the results framework.

Remarkable progress was made against the targets for a number of the results framework indicators. These included the Total Fertility Rate (TFR), Under 5 Mortality Rate (U5MR), decrease in the percentage of underweight children, and tuberculosis case detection rate and cure (success) rate. The malaria annual parasitic incidence (API) was maintained at 0.15 during this year. The targets for the percentage of children receiving all basic vaccines, and the percentage of births in a health facility were also met. The met need for Emergency Obstetric Care (EOC) was 42 percent and the percent of facilities providing post abortion family planning was 87 percent. The number of women with comprehensive knowledge of AIDS far exceeded the target. The target for children who received antibiotics for Acute Respiratory Infection (ARI) was also met. A total of 909 Skilled Birth Attendants (SBAs) were trained against the target of 1134. A social audit was conducted in 40 percent of health facilities.

The considerable decline in TFR noted above was achieved, in spite of the Contraceptive Prevalence Rate (CPR) target not being met. Child health targets including the Infant Mortality Rate (IMR), Neonatal Mortality Rate (NMR), and provision of zinc supplementation for children with diarrhoea fell short of achieving the stipulated targets. Targets for emergency obstetric care (percentage of PHCCs providing all BEOC signal functions and percentage of districts with at least one facility providing all CEOC functions) and for health posts offering delivery and family planning were not met. Unfilled posts for nurses at hospitals and doctors at PHCCs resulted in the HR target for doctors and nurses positions in PHCC and hospitals not being met and only 15 percent of health facilities had no stock out of at least one essential drug in the last one year. Utilising of community-based emergency funds by clients was very low and a long way off the target.

1. Background

The Nepal Health Sector Programme-2 (NHSP-2) (2010-2015) started in 2010 to implement the national health strategies with the following three main objectives: to increase access to and utilisation of quality essential health care services; to reduce cultural and economic barriers to accessing health care services and harmful cultural practices in partnership with non-state actors; and to improve the health system to achieve universal coverage of essential health care services (EHCS). EHCS for NHSP-2 covers eight programmes, namely, reproductive health, child health, communicable disease control, non-communicable disease control; oral health; eye care; rehabilitation of the disabled; environmental health and curative care. The roles of state and non-state actors to implement the national health strategies and to achieve its objectives have been emphasised in the NHSP document.

2. Objectives

This report assesses the performance of the NHSP-2 in terms of progress towards the targets in the results framework.

3. Progress

The NHSP-2 was initiated in 2010, and remarkable progress has been made during a one year period for a number of result framework indicators (Table 1). Despite a lack of increase in the CPR, the TFR decreased and the target for 2011 was met. The target for U5MR was achieved; however, the targets for IMR and NMR were not (Table 2). The percentage of underweight children decreased from 34 to 29. The achievement for the tuberculosis case detection rate and cure (success) rate exceeded the target. The Malaria API was maintained at 0.15 during this year. The percentage of children receiving all basic vaccines exceeded the target. The percentage of births in a health facility target was also met. The target for women with comprehensive knowledge of AIDS far exceeded the target. The target for children with ARI who received antibiotics was also met. A total of 909 SBAs were trained against the target of 1134. Social audit was conducted in 40 percent of health facilities. The met need for EOC was 42 percent while the health facilities providing post abortion family planning was 87 percent, however, no targets were set to monitor these against.

Table 1: Indicators that have been achieved in 2011

Indicator	Target 2011	Achieved 2011
Total Fertility Rate	3.0	2.6
Under-five Mortality Rate	55	54
% of children under five years of age, who are underweight	34	28.8
Tuberculosis case detection rate (%)	75	76.3
Tuberculosis case success rates (%)	89	90
Malaria annual parasite incidence per 1,000	0.15	0.15
% of children that have received all basic vaccines by 12 months of age	85	86.6
% of births delivered in a health facility	27	28.1
% of women aged 15-49 with comprehensive knowledge about AIDS	24	71
% of children under the age of five who had symptoms of Acute Respiratory Infection (ARI) and who received antibiotics	30	41
% of clients satisfied with their health care at district facilities	68	96
% of health facilities subjected to social audits	0	40

The considerable decline in TFR noted above was achieved, in spite of the Contraceptive Prevalence Rate (CPR) target not being met. This may be due to spousal separation given the large number of males migrating for work. The exact causality needs to be examined for future family planning programming. The IMR and NMR also fell short of achieving the stipulated target. This may be because community programming to address mortality among neonates was started only recently as a pilot in selected districts of the country. Provision of zinc supplementation for children with diarrhoea failed to meet the target.

Only 3 percent of clients utilised community based emergency funds, a long way off the target 19 percent. The percentage of PHCCs providing all BEOC signal functions was 21 percent, just missing the target of 23 percent. Only 11 percent of HPs were providing 24/7 delivery services, and short term contraception (hormonal and non-hormonal), implant and IUCD services, whereas the target was 45 percent. Only 61 percent of the sanctioned doctors and nurses positions in PHCC and hospitals were filled while the target was 85 percent. The failure to meet the target was largely due to sanctioned posts for nurses at hospitals and doctors at PHCCs not being filled. The caesarean-section rate and percentage of districts with at least one facility providing all CEOC signal functions (due to lack of provision of caesarean sections and blood transfusions) fell short of its target. Only 15 percent of health facilities had no stock out of essential drugs in the last fiscal year against the target of 70 percent of facilities experiencing no stock outs.

The number of HPs and PHCCs compared to the population are way below target. To address this, a new policy needs to be formally endorsed linking coverage to population

size. Currently the health facility establishment policy is based on geographical units, not population size: i.e. one SHP per VDC, one HP per Ilaka, one PHCC per electoral constituency, one hospital per district.

Table 2: Indicators that have not been achieved in 2011

Indicator	Target 2011	Achieved 2011
Contraceptive Prevalence Rate (modern methods) for currently married women	48	43.2
Infant Mortality Rate	44	46
Neonatal Mortality Rate	30	33
% of children under-5 with diarrhoea that have been treated with zinc	7	6.2
% of community –based emergency funds granted	19	2.8
% of PHCCs that provide all BEOC signal functions	23	21
% of health posts that provide delivery services 24/7 and short term hormonal and non-hormonal and IUCD and implants	45	11
C-section rate	4.0	2.3
% of sanctioned doctors and nurses posts at PHCCs and hospitals that are filled	85	61
Number of HPs per 5,000 population	1	0.13
Number of PHCCs per 50,000 population	1	0.39
% of health facilities with no stock-outs of 'essential drugs' in last 1 year	70	15
Number of Skilled Birth Attendants trained	1,134	909

4. Sources of information

The main sources of information for the results framework indicators are Census 2011, Health Management Information System (HMIS), Nepal Demographic and Health Survey (NDHS) 2011, Service Tracking Survey (STS) and administrative records within the Department of Health Services and Ministry of Health and Population. Some data sources are yet to be made available, such as the Census 2011, which provides the MMR. Similarly, although some information from the NDHS 2011 preliminary report has been available, the main report is planned to be disseminated in February / March 2012. Hence, many achievements could not be compared with targets for accessing the result framework indicators. Focus needs to be given to developing a good quality vital registration system, as this will provide many key impact indicators such as MMR, TFR, U5MR, CMR, IMR and NMR.

Annex 1: Progress against Results Framework

The tables below present progress against targets in the NHSP-2 Results Framework. The impact indicators are presented in Annex 1 and the outcome indicators are presented in Annex 2. The Results Framework for NHSP-2 is presented in Annex 3.

Annex 1: Impact Indicators

SN	Impact Indicator		Base line	Target	Progress by 2011		Remarks
			2010	2011	2011	Source	
1	Im1	Maternal Mortality Ratio (MMR)	250	250	Data awaited	Census 2011	The MMR for 2010 is based on an estimated linear decline from 539 in 1990-96 and 281 in in 2000-06 and not generated from study or survey. Census 2011 will provide MMR but it's unlikely to be available until mid 2012. Methodology for census and NDHS (sisterhood direct method) differ and hence are not strictly comparable.
2	Im2	Total Fertility Rate (TFR)	3.0	3.0	2.6	NDHS 2011	The baseline TFR for 2010 assumes a linear decline from 4.1 in 2001 to 3.1 in 2006. The TFR target (3.0) for 2011 and (2.75) for 2013 is already achieved.
3	Im3	Adolescent Fertility Rate (AFR) (Number of births per 1000 women aged 15-19 years)	98	na	81	NDHS 2011	The AFR for 2011 is not specified, however, the target reduction of AFR for 2013 is already achieved.
4	Im4	Contraceptive Prevalence Rate (CPR) (modern methods) for currently married women	48	48	43.2	NDHS 2011	The CPR target for 2010 is based on the increase from 39.3 in 2001 to 44.2 in 2006. From NDHS 2006 the estimate is available for all women (including currently married), whereas before 2006 estimate is available for currently married women only. CPR did not increase as per target.

SN	Impact Indicator		Base line	Target	Progress by 2011		Remarks
			2010	2011	2011	Source	
5	Im5	Under-five Mortality Rate	55	55	54	NDHS 2011	The U5MR target assumes an exponential decline from 91 in 2001 and 61 in 2006.
6	Im6	Infant Mortality Rate	44	44	46	NDHS 2011	The IMR target assumes an exponential decline from 64.4 in 2001 and 48 in 2006.
7	Im7	Neonatal Mortality Rate	30	30	33	NDHS 2011	The NNMR target assumes an exponential decline from 48.3 in 2001 and 38.6 in 2006.
8	Im8	% of children under five years of age, who are underweight	34	34	28.8	NDHS 2011	Achieved
9	Im9	HIV prevalence among men and women aged 15-49 years	0.33	na	na	NCASC	▪ NHSP II target is to halt and reverse trend in all categories ▪ The HIV prevalence target for 2015 is 0.20 not 0.30 as mentioned in original RF. ▪ The prevalence estimate for all categories listed will be available every 3 years from the NCASC survey.
		Men	Na	na	na		
		Women	Na	na	na		
		IDUs	Na	na	6.3		
		MSMs	Na	na	na		
		FSWs (Kathmandu)	Na	na	1.7		
		Migrant workers (Western)	Na	na	na		
		Migrant workers (Mid and Far western)	Na	na	na		
10	Im10	Tuberculosis case detection rate (%)	75	75	76.3	HMIS 10/11	Achieved. Prevalence of tuberculosis (per 100,000 people) is a proxy indicator for the MDG 6a target which is to have halted by 2015, and begun to reverse, the spread of HIV/AIDS, malaria and other global diseases.
11	Im11	Tuberculosis case success rates (%)	89	89	90	HMIS 10/11	
12	Im12	Malaria annual parasite incidence per 1,000	0.14	0.15	0.15	EDCD 10/11	Current malaria strategy is to maintain the API. But elimination of malaria is planned starting from 2013 which means an API of less than or equal to 0.01 (1 case per 10000 population).

Note: Source for Baseline is NHSP-2, Results Framework; na = not available

Annex 2: Outcome Indicators

SN	Outcome Indicator		Baseline	Target	Progress by 2011		Remarks
			2010	2011	2011	Source	
	1	**Objective 1: Increase access to and utilisation of quality essential health care services**					
13	1.1	% of children that have received all basic vaccines by 12 months of age	83	85	86.6	NDHS 2011	Baseline, National: NDHS 2006 Baseline, Rural: NFHP 2009 (rural districts)
		Rural	89	na	86.4		
		Lowest wealth quintile	na	na	Data awaited		
		Dalit	na	na	Data awaited		
		Adibasi /Janajati	na	na	Data awaited		
		Tarai / Madhesi / Other	na	na	Data awaited		
		Muslim	na	na	Data awaited		
14	1.2	% of pregnant women receiving iron tablet or syrup during the pregnancy of their last birth	59.3	82	Data awaited	NDHS 2011	NDHS defines it as the percentage of women who took iron tablets or syrup during pregnancy of last birth (combining those taking for less than 180 days + those taking 180 days or more) Disaggregated in Indicator 2.1, Objective 2
15	1.3	% of births assisted by a skilled birth attendant	18.7	na	36	NDHS 2011	NDHS defines it as the percentage of live births in the five years before the survey that were assisted by a skilled birth attendant (doctor, nurse or midwife). HMIS 2009/10: 29.4%; HMIS 2010/11: 32.6 Disaggregated in Indicator 2.3, Objective 2
16	1.4	% of live births delivered in a health facility	28.6	27	28.1	NDHS 2011 NDHS 2011	NDHS defines it as the percentage of delivery in a health facility among all the live births in the five years before the survey NDHS 2006, National: 17.7% NDHS 2006: Newar: 48%; Janajati: 14% Baseline, Rural: NFHP 2009
		Rural	26.7	na	25.4		
		Lowest wealth quintile	na	na	Data awaited		
		Dalit	9	na	Data awaited		
		Adibasi /Janajati	na	na	Data awaited		
		Tarai / Madhesi / Other	15	na	Data awaited		
		Muslim	12	na	Data awaited		
17	1.5	% of emergency obstetric care met need	31	na	42.2	EOCM, FHD 2010/11	Baseline: EOC monitoring (EOCM) data received from 38 districts in 2009/10.

SN	Outcome Indicator		Baseline	Target	Progress by 2011		Remarks
			2010	2011	2011	Source	
18	1.6	% of live births delivered by Caesarean Section	2.7	4.0	2.3	NDHS 2011 EOCM, FHD 2010/11	NDHS defines it as the percentage of delivery by Caesarean Section among all the live births in the five years before the survey. NDHS 2011 data awaited. The source for progress 2011 is EOCM, FHD.
19	1.7	Obstetric case fatality rate	na	<1%	<1%	EOCM, FHD	Based on reports received from 11 EOCM districts
20	1.8	% of women aged 15-49 aware of safe abortion sites	19	na	Data awaited	NDHS 2011	
21	1.9	% of women aged 15-49 aware of safe abortion legalisation	50	na	Data awaited	NDHS 2011	
22	1.10	% of women aged 15-49 experiencing abortion complications	14	14	Data awaited	NDHS 2011	
23	1.11	% of women aged 15-49 with comprehensive knowledge about AIDS	19.9	24	71	NDHS 2011	
24	1.12	% of children, under the age of five and had symptoms of Acute Respiratory Infection (ARI), who received antibiotics	25.1	30	41	HMIS 2010/11	NDHS 2006: 25.1%; NFHP 2009 (Rural): 29.2% NDHS 2011: Data awaited
25	1.13	% of children under five years of age, who are underweight	38.6	39	29	NDHS 2011	
26	1.14	% of all births with a reported low birth weight	33	32	Data awaited	NDHS 2011	
27	1.15	% of children, under six months of age, that are exclusively breastfed	30.6	35	Data awaited	NDHS 2011	
28	1.16	% of pregnant women attending at least 4 antenatal care visits during pregnancy	27.7	45	Data awaited	NDHS 2011	
		Rural	26	na	Data awaited		
		Lowest wealth quintile	na	na	Data awaited		
		Dalit	na	na	Data awaited		
		Adibasi /Janajati	na	na	Data awaited		
		Tarai / Madhesi / Other	na	na	Data awaited		
		Muslim	na	na	Data awaited		
29	1.17	% children aged 6-59 months that have received vitamin A supplements	90	90	Data awaited	NDHS 2011	
30	1.18.	% of children under-5 with diarrhoea treated with zinc **and** ORS	47.7	na	Data awaited	HMIS 2010/11	
31	1.19	% of children under-5 with diarrhoea that have been treated with zinc	na	7	6.2	NDHS 2011	Baseline, Rural: NFHP 2009
		Rural	6.6	na	6.3		
		Lowest wealth quintile	na	na	Data awaited		
		Dalit	na	na	Data awaited		
		Adibasi /Janajati	na	na	Data awaited		
		Tarai / Madhesi / Other	na	na	Data awaited		

SN		Outcome Indicator	Baseline	Target	Progress by 2011		Remarks
			2010	2011	2011	Source	
		Muslim	na	na	Data awaited		
32	1.20	% of children under-5 with diarrhoea that have been treated with ORS	29.3	na	39	NDHS 2011	
33	1.21	% of intravenous drug users (IDU) with access to HIV prevention services	56.9	76	Data awaited	NCASC	HIV Prevalence rate for IDU (Kathmandu): 20.7%
		% of men who have sex with men (MSM) with access to HIV prevention services	77.9	54	Data awaited	NCASC	HIV Prevalence rate for MSM (Kathmandu): 3.8% MSW (Kathmandu): 5.2%
		% of female sex worker (FSW) populations with access to HIV prevention services	40.8	65	Data awaited	NCASC	HIV Prevalence rate for FSW (Kathmandu): 2.2%
		% of migrants with access to HIV prevention services	8.3	na	Data awaited	NCASC	HIV Prevalence rate for Migrants: Western region: 1.4%; Far Western region: 0.8%; and Wives of migrants, Far Western region: 3.3%
34	1.22	% of households with soap and water at a hand washing station inside or within 10 paces of latrines	na	13	na	MICS	This indicator is now accepted globally as the most feasible proxy indicator to measure hand washing practices by observation.
	2	**Objective 2: Reduce cultural and economic barriers to accessing health care services and harmful cultural practices in partnership with non-state actors**					
35	2.1	Contraceptive prevalence rate (modern methods)	44.2	45	43.2	NDHS 2011	Baseline, NDHS 2006: Newar: 56%; Janajati:47%
		Married	na	na	Data awaited		
		Rural (married)	42.5	na	42.1		
		Lowest wealth quintile	30.3	43	Data awaited		
		Dalit	41	52	Data awaited		
		Adibasi /Janajati	47	55	Data awaited		
		Tarai / Madhesi / Other	68	na	Data awaited		
		Muslim	17	25	Data awaited		
36	2.2	% of pregnant women receiving iron tablets or syrup during the pregnancy of their last birth	59.3	82	Data awaited	NDHS 2011	
		Rural	na	na	Data awaited		
		Lowest wealth quintile	44.9	77	Data awaited		
		Dalit	na	82	Data awaited		
		Adibasi /Janajati	na	na	Data awaited		
		Tarai / Madhesi / Other	na	na	Data awaited		

SN	Outcome Indicator		Baseline	Target	Progress by 2011		Remarks
			2010	2011	2011	Source	
		Muslim	na	na	Data awaited		
37	2.3	% of live births assisted by a skilled birth attendant	18.7	na	36	NDHS 2011	Baseline, Rural: NFHP 2009; NDHS 2006, Rural: 14.3% Janajati: Baseline: 14%; Target 2011: 25%
		Rural	28.8	na	32.3		
		Lowest wealth quintile	7.5	20.3	Data awaited		
		Dalit	11	23	Data awaited		
		Adibasi /Janajati	na	na	Data awaited		
		Tarai / Madhesi / Other	13	24	Data awaited		
		Muslim	13	24	Data Awaited		
38	2.4	% utilising essential health care services (outpatient and in inpatient services)	na	90	na		
		Rural	na	na	na		
		Lowest wealth quintile	na	na	na		
		Dalit	na	na	na		
		Adibasi /Janajati	na	na	na		
		Tarai / Madhesi / Other	na	na	na		
		Muslim	na	na	na		
39	2.5	% of clients satisfied with their health care at district facilities	na	68	96	STS 2011	Satisfaction is a difficult variable to measure. STS included additional indirect questions (i.e. whether client would return to same facility and whether they would recommend to friend) as checks.
		Rural	na	na	Data awaited		
		Dalit	na	na	99		
		Adibasi /Janajati	na	na	97		
		Tarai / Madhesi / Other	na	na	95		
		Muslim	na	na	94		
40	2.6	% of community –based emergency funds granted	na	19	2.8	STS 2011	RF mentions Equity and Access Programme (EAP) districts only. STS covers non-EAP districts as well. Community based emergency funds have been established in 15 of the 16 EAP districts: PHCRD
		Rural	na	na	Data awaited		
		Dalit	na	na	4.5		
		Adibasi /Janajati	na	na	3.7		
		Tarai / Madhesi / Other	na	na	1.4		
		Muslim	na	na	0		

SN	Outcome Indicator		Baseline	Target	Progress by 2011		Remarks
			2010	2011	2011	Source	
41	2.7	One stop crisis centres to support victims of gender based violence within hospitals	na	Systems and training materials developed and piloted in 3 districts	Piloting initiated in 5 districts; training manual developed	Pop. Div. MoHP	
	3	**Objective 3: To improve health systems to achieve universal coverage of essential health care services**					
42	3.1	% of facilities providing abortion services with post abortion family planning services	50	na	87	STS 2011	
43	3.2	% of districts that have at least one facility providing all CEOC signal functions 24/7	na	na	23	STS 2011	
44	3.3	% of PHCCs that provide all BEOC signal functions	na	23	21	STS 2011	
45	3.4	% of health posts that provide delivery services 24/7 and short term hormonal and non-hormonal and IUCD and implant	na	45	11	STS 2011	
46	3.5	% of health facilities that have provisions for Zinc supplementation for treatment of diarrhoea cases	na	na	82	STS 2011	Facilities with zinc in stock at time of visit are considered as facilities with provision of Zinc
47	3.6	% of households with at least 1 long lasting insecticide treated bed net per 2 residents in all high-risk districts / areas	95	90	Data awaited	EDCD	Baseline: 95% in 13 high risk districts Programme is expanding to new high risk areas in 18 new districts. Nets are effective for 2 years.
48	3.7	% of children under 5 years who slept under a long lasting insecticide treated bed net the previous night in all high -risk districts / areas	61.2	70	Data awaited	EDCD	Baseline: 13 high risk districts MoHP has the target of 90% for 2015 (1 net per 2 residents in household). For use by children the target is 80% for 2015.
49	3.8	% of the MoHP budget spent annually	81.4	83	Data awaited	e-AWPB	Historical budget spent:- 70.16%, 75.74%, 80.61% and 81.37% from FY 2004/05 to 2007/08
50	3.9	% of the MoHP annual budget allocated to EHCS	75.4	75	Data awaited	e-AWPB	EHCS budget should be maintained at 75%.

51	3.10	% of sanctioned doctors and nurses posts at PHCCs and hospitals that are filled	82	85	61.3	STS 2011	Baseline: 2008/09
		Doctors - Hospitals	na	na	96.1		
		Doctors - PHCCs	na	na	51.9		
		Nurses - Hospitals	na	na	36.1		
		Nurses - PHCCs	na	na	76.0		
52	3.11	Number of HPs per 5,000 population	na	1	0.13	HMIS/CBS 2011	
53	3.12	Number of PHCCs per 50,000 population	na	1	0.39	HMIS/CBS 2011	
54	3.13	Number of hospital beds per 5,000 population	na		1.5	STS 2011	The figure in the table is for all hospitals. We have also computed for district hospitals, (as this was the original indicator) which is 0.4.
55	3.14	% of health posts that have infrastructure as per MoHP standard	na	na	na		MoHP standard for HP has been developed but not approved yet. STS in 2011 did not capture this information, but could be considered in 2012.
56	3.15	% of health facilities with no stock-outs of 'essential drugs' in last 1 year	na	70	15	STS 2011	We have changed original target stipulating 'tracer drugs' to 'essential drugs' as tracer drugs are yet to be defined.
57	3.16	Number of additional Female Community Health Volunteers (FCHVs) in post in the mountain and remote districts	48,514	50,000	52,161 (total) 6,791 (mountain)	FHD	Target is additional 5000 FCHVs by 2015; plus 2000 replaced due to attrition of original workforce. The progress shown in 2011 is cumulative.
58	3.17	% of actions identified in the governance and accountability action plan that have been implemented	na	90	75	HeSRU, MoHP	
59	3.18	% of health facilities subjected to social audits	na	0	40	STS 2011	
60	3.19	Comprehensive health care finance strategy approved by MoHP and MoF	na	na	na	MoHP	Not approved
61	3.20	Number of Skilled Birth Attendants trained	na	1,134	909	NHTC/ FHD	

Note: Source for Baseline is NHSP-2, Results Framework; na = Not available

Annex 3: Results Framework for NHSP-2

MDG/Impact Indicator	Achievement					Baseline Year	Target			Means of Verification	Remarks/Assumptions/Risks
	1991	1996	2001	2006	2009[1]		2010-11	2013	2015		
Maternal Mortality Ratio	539	539	415	281	229[2]	250	250	192	134	DHS 2011 and 2016[3]	Needs innovative programs and resources at the community level, and high-quality services available to remote, underprivileged and underserved populations.
Total Fertility Rate	5.3	4.6	4.1	3.1	2.9[4]	3.0	3.0	2.75	2.5	DHS 2011 and 2016	Assumes a continuous linear decline
Adolescent Fertility Rate 15-19 years per 1000 women	NA	127	110	98	NA	98	NA	85	70	DHS 2011 and 2016	
CPR (modern methods)	24	26.0	35	44	45.1[5]	48	48	52	67	DHS 2011 and 2016	Assumes a continuous linear decline; data source for verification--DHS 2011 and 2016. Year-round availability of FP commodities at service delivery sites. GoN budgets adequate each year to procure FP commodities.
Under-five Mortality Rate	158	118.3	91	61	50[6]	55	55	47	38	DHS 2011 and 2016	Assumes a continuous exponential decline; data source for verification--DHS 2011 and 2016.
Infant Mortality Rate	106	78.5	64	48	41[7]	44	44	38	32	DHS 2011 and 2016	Assumes a continuous exponential decline; data source for verification--DHS 2011 and 2016.
Neonatal Mortality Rate		49.9	43	33	20[8]	30	30	23	16	DHS 2011 and 2016	More than half infant deaths are neonatal so a focus of programme.
% of underweight children		49.2	48.3	38.6	39.7[9]	34	34	32	29	DHS 2011 and 2016	Weight-for-age < 2 SD.

[1] Achievements for 2009 should not be construed as trends. The sources are not necessarily nationally representative and the estimates may not be significantly different from 2006 estimates.
[2] Estimate from Suvedi, Bal Krishna, et al. *Maternal Mortality and Morbidity Study 2008/2009: Summary of Preliminary Findings. Kathmandu, Nepal. Family Health Division, Department of Health Services, Ministry of Health and Population, Government of Nepal.*
[3] NDHS scheduled for 2016 but requested to be conducted early so report is available 2015.
[4] Estimate from *Family Planning, Maternal, Newborn and Child Health Situation in Rural Nepal: A Mid-term Survey for NFHP II*, New ERA, September 30, 2009.
[5] *Family Planning, Maternal, Newborn and Child Health Situation in Rural Nepal…*
[6] *Family Planning, Maternal, Newborn and Child Health Situation in Rural Nepal…*
[7] *Family Planning, Maternal, Newborn and Child Health Situation in Rural Nepal…*
[8] *Family Planning, Maternal, Newborn and Child Health Situation in Rural Nepal…*
[9] *Family Planning, Maternal, Newborn and Child Health Situation in Rural Nepal…*

HIV prevalence among aged 15-49 years[10]	NA	NA	NA	NA	NA	0.49[11]	Halt and reverse trend (0.39 in 2010-11 and 0.30 in 2015)			TBD	HIV prevalence is currently concentrated among IDUs at 20.7% in 2009, MSMs at 3.8%, and 2.2% for FSWs in KTM; 1.4% for migrant workers in Western region,0.8% for migrants in Far Western region, and 3.3% for wives of migrants.
TB case detection and success rates (%)	NA	48 79	70 89	65 89	71[12] 88[13]	75 89	75 89	80 90	85 90	HMIS	MDG 6 target: Prevalence and death rates associated with tuberculosis. TB success rate was 88% in 2009. It should be at least maintained through 2015.
Malaria annual parasite incidence per 1,000	NA	0.54	0.40	0.28	NA		Halt and reverse trend			HMIS	MDG 6 target: Prevalence and death rates associated with malaria

Specific objective 1: Increase access to and utilization of quality essential health care services						
Outcome Indicator	**Baseline/ Year**	**Target**			**Means of Verification**	**Remarks/Assumptions/Risks**
		2010/ 11	**2013**	**2015**		
% of children under 12 months of age immunized against DPT 3 (PENTA) and measles (or fully immunized per HMIS scale up) disaggregated by all wealth quintiles and castes/ethnicities	83% fully immunised 2006 and 89% in rural districts 2009[14]	85%	85%	85%	HMIS and NDHS in 2011 and 2016	Percentage of fully immunised children should be above herd immunity regardless of wealth, caste or ethnicity.
Contraceptive prevalence rate (modern methods) (disaggregated by method, age, caste/ethnicity, wealth and region)	44% (2006) 45.1 (2009) rural	45%	52%	55%	HMIS and NDHS in 2011 and 2016	55.5% for women 15-49 living with husbands; 22.5% if husbands away (2009) rural
% of women who took iron tablets or syrup during the pregnancy of their last birth	59.3% (2006) and 81.3% in rural (2009)	82%	86%	90%	NDHS in 2011 and 2016	
% of deliveries by SBAs - disaggregated by all wealth quintiles and castes/ethnicities	18.7% in 2006 and 25% in 2008/9 (28.8% NFHP 2009 survey)		40%	60%	HMIS and NDHS in 2011 and 2016	Interventions targeted to poorest and excluded necessary to reduce disparities.
% of institutional deliveries - disaggregated by all wealth quintiles and castes/ethnicities	18% (2006)	27%	35%	40%	NDHS in 2011 and 2016	Wide disparities persist for ANC between wealth quintiles and castes/ethnicities.
% of EOC met need	31% (2008/09)		43%	49%	HMIS and NDHS in 2011 and 2016	HMIS

[10] The Ministry recognizes the MDG 6 target of halting and reversing the trend of HIV prevalence among pregnant women aged 15-24 years. However, a data source is not yet available.
[11] NCASC 2010 and UNAIDS April 2010 database
[12] 2008
[13] 2008
[14] All targets are national but evidence from 2009 survey of 40 rural districts is not.

% of Caesarean Section rate	2.7% (2006), 3.6% (2008/09)	4.0%	4.3%	4.5%	HMIS	HMIS 2008/09 report from 26 districts.
Obstetric case fatality rate		<1%	<1%	<1%	HMIS	
% knowledge of safe abortion sites	19% (2006)		35%	50%	Annual household surveys	97,378 women received safe abortions in 2007/08 at 202 listed sites.
% knowledge of safe abortion legalisation	50% (2006)		60%	75%	Annual household surveys	
Abortion complications	14% (2009)	14%	10%	7%		
% of women 15-49 with comprehensive knowledge about AIDS	19.9% (2006)	24%	32%	40%	NDHS 2011 and 2016	
% of children with symptoms of ARI treated with antibiotic	25.1% (2006), 29.2% (2009) rural	30%	40%	50%	NDHS 2011 and 2016	
% of underweight children under five years of age	38.6% (2006) 39.7% (2009)	39%	34%	29%	NDHS 2011 and 2016	45.5% stunted (ht-for-age < 2 SD) will also be reported by NDHS
% of low birth weight (or small) babies	33% (2006)	32%	27%	25%	NDHS 2011 and 2016	
% of children exclusively breastfed in the first 6 months	30.6% age 4-5 months (2006) 24.8% (2009) rural	35%	48%	60%	NDHS 2011 and 2016	
% of pregnant women attending at least 4 visits during pregnancy	27.7% (2006) 35.2% (2008)	45%	65%	80%	HMIS and NDHS 2011 and 2016	
% vitamin A coverage maintained for children aged 6-59 months	90% (2009)	90%	90%	90%	HMIS	Consistently almost universal.
% of diarrhoea cases among under-5 children treated with zinc (and ORS)	67.6% ORS+zinc (2007/08) 45.6% ORS; 6.6% zinc (2009) rural	7%	25%	40%	NDHS 2011 and 2016	Combined reporting in HMIS (2007/08). NDHS reports treatment with ORS and zinc separately.
% coverage of IDU, MSM, and FSW populations with prevention services increased from 76%, 54%, and 65% in 2009 to 80%, 60% and 70% respectively	Programme Coverage: FSW (KTM)- 40.8% (IBBS 2008) MSM (KTM) - 75.3% (IBBS 2009) MSW (KTM) - 77.3% (IBBS 2009) IDU (KTM) - 56.9% (IBBS 2009) Migrants, West –far west – 6.9% (IBBS 2008)	76% 54% 65%		80% IDU 60% MSM 70% FSW	UNAIDS supported surveys	HIV Prevalence: IDU (Kathmandu) – 20.7% (IBBS 2009) MSM (Kathmandu) – 3.8% (IBBS 2009) MSW (Kathmandu) – 5.2% (IBBS 2009) FSW (Kathmandu) – 2.2% (IBBS 2008) Migrant, Western region – 1.4% (IBBS 2008) Migrant, Far Western region – 0.8% (IBBS 2008) Wives of the migrants, Far Western region – 3.3% (IBBS 2008)
% of households with soap and water at a hand washing station inside or within 10 paces of latrines	N/A	13%	37%	53%	MICS, NDHS 2011 and 2016	This indicator is now accepted globally as the most feasible proxy indicator to measure hand washing practices by observation

Specific objective 2: Reduce cultural and economic barriers to accessing health care services and harmful cultural practices in partnership with non-state actors						
Outcome Indicators	**Baseline/Year**	**Target**			**Means of Verification**	**Remarks/Assumptions/Risks**
		2010/11	**2013**	**2015**		
Contraceptive prevalence rate (modern methods) for the poor (lowest and second wealth quintiles) and excluded castes	Poor: 35.5% Dalit: 44% Janajati: 47% Muslim: 17%	Poor: 43% Dalit: 52% Janajati: 55% Muslim: 25%	Poor: 46% Dalit: 55% Janajati: 58% Muslim: 28%	Poor: 49% Dalit: 58% Janajati: 61% Muslim: 31%	NDHS in 2011 and 2016 and HMIS for poor	
% of women who took iron tablets or syrup during the pregnancy of their last birth for women who are poor (lowest and second wealth quintiles) and excluded caste (Dalit)	44.9% in 2006 and 76.7% in rural districts in 2009; and 78% for Hill Dalits and 90% for Terai Dalits in 2009 rural districts	Poor: 77% Dalit: 82%	Poor: 81% Dalit: 85%	Poor: 85% Dalit: 88%	NDHS in 2011 and 2016 and HMIS for poor	
% of deliveries by SBAs for lowest and second wealth quintiles by 2015 and excluded caste (Dalits)	Poor: 7.5% Dalit:11% Janajati: 14% Muslim: 13% Other terai/madhesi: 13%	Poor: 20.3% Dalit: 23% Janajati: 25% Muslim: 24% Other terai/madhesi: 24%	Poor: 25.3% Dalit: 27% Janajati: 30% Muslim: 29% Other terai/madhesi: 29%	Poor:30% Dalit: 32% Janajati: 35% Muslim: 34% Other terai/madhesi: 34%	NDHS in 2011 and 2016 and HMIS for poor	
Utilisation of essential health care services (outpatient, inpatient, especially deliveries, and emergency) by targeted groups, and disadvantaged castes and ethnicities at least proportionate to their populations by 2015	62% for targeted 2 lowest quintiles in 2006 (and 57% in rural districts in 2009) as % of highest; 14%, 17.1% and 16.7% for Dalits using OPC, IPC and emergency (2008). 16.7% of population in sample districts	90%	90%	90%	HMIS	90% of highest quintile or 90% of population proportion. Targeted groups: based on Children < 5 for whom treatment sought for fever. Dalits: selected MCH services at district health facilities. District health facility surveys report Dalits using services proportionate to their population.
% of clients satisfied with their health care at district facilities among targeted groups, and disadvantaged castes and ethnicities by 2015	68.4% (2008) based on availability of range of services	68%	74%	80%	Annual district health facility surveys	
% use of available community-based emergency funds by the poor, and socially excluded groups (District with Equity and Access Programme)		19% in EAP districts	30%	50%	Annual district health facility surveys	

# of cases recorded and treated related to gender-based violence in health facilities	Treatment provided but no recording available	Systems and training materials developed and piloted in 3 districts	Pilot evaluated and system rolled out in 20 districts	Scaled up intervention nationwide	Annual district health facility surveys	

Specific objective 3: To improve health systems to achieve universal coverage of essential health care services						
Outcome Indicators	**Baseline/Year**	**Target**			**Means of Verification**	**Remarks/Assumptions/Risks**
		2010/11	**2013**	**2015**		
Availability of post-abortion family planning services in facilities increased	50% in 2006	NA	60%	80%	HMIS	
% of hospitals that have at least 2 ob/gyns, 2 anaesthesiologists, 10 staff nurses and blood service, including Voluntary Sterilization Care (VSC)		NA	60%	80%	HMIS, HuRIS and programme surveys	
% of PHCCs that provide BEOC, including SAC and at least 5 FP methods	1 BEOC site; 46 under construction; 15 planned next year (2007/08)	23%	50%	70%	HMIS and programme surveys	HMIS annual report 2007/08.
% of health posts that operate 24/7, including delivery services and at least 5FP methods		45%	60%	70%	HMIS	
Zinc supplementation for treatment of diarrhoea cases available at district facilities					HMIS	
At least 90% of households with at least 1 long lasting insecticide treated bed net per 2 residents in all high-risk districts and areas by 2015	95% in 13 high-risk districts to be extended to areas in additional 18 districts		90%	90%	Programme surveys	Programme is expanding to new high-risk areas in 18 new districts. Nets effective for 2 years.
At least 80% of children under 5 years who slept under a long lasting insecticide treated bed net the previous night	61.2% in 13 high-risk districts	70%	80%	80%	Programme surveys	The target for 2015 set by MoHP is 90%, which is the same as for 1 net per 2 residents in HHs. 80% is more realistic for use by <5 children.
At least 86% of the MoHP budget is spent by 2015	70.16%, 75.74%, 80.61% and 81.37% from FY 2004/05 to 2007/08	83%	84.5%	86%	e-AWPB	Reported by e-AWPB.
At least 75% of the MoHP budget has been allocated to EHCS by 2015	72.1% in FY 2008/09 and 75.4% in FY 2009/10	75%	75%	75%	e-AWPB	EHCS budget should be maintained at 75%
% of filled posts at PHCCs and district hospitals by doctors and staff nurses	89% at HPs and SHPs and 82% at DHs and PHCCs (2008-09)	85%	88%	90%	Annual district health facility surveys	Reported by latest trimester district health facility survey.

One health facility per 3,000-5,000 population: 1 HP (with 2 SBAs) per 5,000 population; PHCC (with 4 SBAs) per 50,000 population; and 1 district hospital bed per 5,000 population		NA		Nationwide	HMIS, Administrative record	New policy
% of sub-health posts that have sufficient space per MoHP standard (need baseline)				80%	TBD	
% of district facilities will have no stock outs of tracer drugs/commodities for more than one month per year by 2015	Up to 76.7% stock outs for more than a week in 2009	70%	80%	90%	Annual district health facility surveys	Delayed budget approval caused massive stock outs at district facilities in 2009.
Number of additional Female Community Health Volunteers (FCHVs) will have been recruited and deployed in the mountain region and remote districts	48,514 (2007/08)	50,000	52,000	53,514	HMIS and HuRIS	5,000 additional FCHVs by 2015 plus 2,000 replaced (attrition)
% of actions identified in the governance and accountability action plan have been implemented		90%	90%	90%		
% of district facilities will have been subjected to social audits	None to date	0%	15%	25%	Annual district health facility surveys	
A comprehensive health care finance strategy will be approved by 2012					MoHP and MoF approval	
5,000 SBAs by 2012 and 7,000 by 2015		1,134	5,000	7,000	HMIS and HuRIS	

Progress Report on

Governance and Accountability Action Plan (GAAP) -2010/11

Report Prepared for Joint Annual Review (JAR)

January 2012

Government of Nepal (GON)
Ministry of Health and Population (MOHP)

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1. Background

NHSP-2 highlights the fact that that putting a system in place and injecting resources for health may not achieve the intended results and impact if proper attention is not also given to health governance and accountability issues. To address this, a Governance and Accountability Action Plan (GAAP) was developed, incorporating measures to make services more client centred, and client accountable, with particular focus on the poor and excluded. MoHP has made this a priority, firmly committing to implementing the action plan as specified in NHSP-2. However, due to its cross-cutting nature, there are concerns on the part of MoHP and EDPs about the content of the GAAP, and the difficulties in monitoring its implementation, progress, and impact. A workshop was therefore convened to review the plan, which contributed to the development of consensus on reviewing and revising it to enable more effective implementation and monitoring. This report summarises the progress made in FY 2010/11 against the activities listed in GAAP framework (A*nnex 1*).

2. Objectives

This report outlines progress made against the GAAP in FY 2010/11. It also includes the current status of some activities which are contextually relevant.

3. Progress Made

MoHP has made good progress in implementing on the GAAP, despite the complications caused by the cross-cutting nature of GAAP activities and lack of clarity over roles and responsibility for collecting data. Specifically, the report highlights the progress made on enhancing the GAAP through workshops, research and system development.

3.1. GAAP Workshop

This workshop took place on 20th October 2011, with a total of 43 participants, including 21 from government and 22 from EDPs. The following recommendations were made:

- It would be beneficial to define clearly the purpose of the GAAP. Currently it does not assist implementation or monitoring, yet contains too much detail to be a high level strategic plan.

- The GAAP could be revised into a high level strategic document, with an associated implementation plan detailing operational activities, possibly reviewed annually. Annual monitoring plans could fit alongside this and be aligned to current reporting cycles to help reduce duplication and overlap.
- The original seven overarching GAAP objectives could be collapsed into five proposed new objective headings, as the original objectives overlap and sub-objectives are misplaced. It is recommended that these new be used as the basis for future revision of the plan.
- There is a crossover between activities and indicators, with indicators often presented as targets or activities, while many activities are one-off foundational activities that are not suitable for ongoing monitoring
- Activities are a mixture of high level and operational, complicating implementation purpose and indicator development. Activities could be divided into high level strategic and operational activities.
- Steps need to be taken immediately to assemble and activate the proposed joint task force as soon as possible, given that it is proposed that the revised GAAP be presented to the JAR in January 2012, with a pre-JAR meeting in December 2011. A progress report is required for the JAR; but since the new GAAP will not be available in time, it would be useful to agree a set of priority activities to report against for the JAR.
- There is a need for a focal unit to oversee and coordinate the implementation and monitoring of the GAAP.

3.2 Workshop on Output Based Budgeting

Output Based Budgeting (OBB) is a tool used in many countries to make social sector expenditure more result oriented and thus assist with the achievement of results and implementation of national policy. NHSP-2 recommends the introduction of OBB in the MoHP, and the overall objective of this workshop was to initiate a national discussion on this. The workshop made the following recommendations:

- These workshop recommendations will be used to initiate higher level dialogue.
- A working committee will be formed to decide on implementation modalities, first exploring the most pragmatic modality and required timeline. The committee is also expected to initiate further discussions with external development partners and other stakeholders.

- Once the committee determines the framework, it will be presented in a wider forum for discussion and finalisation.

3.3 Service Tracking Survey

Service Tracking Surveys (STS) were conducted to provide information on the delivery of priority services, including monitoring of the Aama programme and free health care. This has also tracked the indicators for GAAP, financial management, supply of drugs, human resources and progress against the NHSP-2 results framework. STS was conducted in a total of 169 health facilities in 13 districts, and preliminary findings were presented on 1st December 2011. STS will report against the GAAP indicators.

3.4 Progress of Specified Activities in GAAP

i. *Sector governance/ enabling environment*: A workshop on Output Based Budget (OBB) facilitated the development of a common understanding among stakeholders. Implementation of OBB is planned in some selected programmes after development of the framework recommended by the workshop. The GAAP workshop recommended OBB should start from FY 2012/13.

   MoHP and its units are trying to improve public disclosure systems by placing information of public interest on websites and other media sources. However, ensuring regular updating of websites remains a challenge. The Ministry has also established a link to the digital library, in which nearly 600 health related documents are placed. Application of social audits has been strengthened.

ii. *Stakeholders*: OAG has continued performance auditing for randomly selected MoHP programmes. Consultation is in progress with OAG to further strengthen and expand the coverage of performance auditing. In strengthening the system, key aspects that are required to be covered will be properly addressed.

iii. *Implementation capacity/ institutional capacity*: In order to implement NHSP-2 effectively, AWPB incorporates capacity development initiatives for staff and institutions, which has resulted in number of training programmes being provided to different levels of staff. Attention has also been given to allocation of resources for capacity enhancement of institutions and scaling up specific services.

   In order to meet current demands, O&M study of different institutions is ongoing under MoHP, with 15 surveys completed in different units across the country. These are at different stages in the approval process.

The Human Resources for Health (HRH) strategy has been drafted and is in process for approval. This will address current issues related to human resources including workforce projection and retention strategy. The Health Service Act and Regulations are also in the process of amendment, with the aim of addressing issues related to the health workforce. Recruitment of local staff on contract is being undertaken for different programmes.

To improve the quality of health services, all ongoing health facility constructions are in line with the standard designs prepared by Management Division/ DoHS. Orientation on quality improvement has been completed in all districts.

iv. *Financial Management:* In the process of establishing a computerised system for accounting and reporting, a concept note on Transaction Accounting and Budget Control System (TABUCS) has been developed. This will be used to develop new software to expedite the reporting process. The AWPB for this FY has activities for TABUCS.

Upgrading/ updating of the information system for physical assets management for health infrastructures has been initiated, to make it GIS and web based. The upgraded system will also support regular progress monitoring .Piloting for maintenance of medical equipment has been initiated in the mid and far western regions.

MoHP has made great progress in clearing audit irregularities, receiving a letter of appreciation for its excellent performance in clearing audit irregularities for FY 2010/11.

v. *Procurement:* An annual consolidated procurement plan has been prepared in coordination with different divisions and centres. Regular forecasting of drugs needed was carried out in line with the LMIS, with appropriate budgeting. A sound QA system for pre and post shipment is in place.

A multi-year contracting framework has been adopted for procurement of specified items. E-procurement was introduced for infrastructure work from 2010/11. For goods, online bidding software has been developed and trial phase of e-bidding will start from 2011/12.

vi. *Environment*: A waste management plan has been piloted in two hospitals. This will be further expanded, incorporating lessons learned. Waste management guidelines have been developed and orientation programmes for implementation completed in 40 districts.

Health sector contingency planning has been completed in 22 districts, and disaster management orientation at regional level.

Budget was provided for a one-stop crisis centre (to deal with GBV) in seven districts. Installation of solar power back-up system in 10 service delivery points has been completed.

vii. *Social/ equity access and inclusion*: Social audits were conducted in 150 health facilities across the country in FY 2010/11. Piloting of community score card is ongoing in four districts.

Institutional strengthening of GESI is in progress, with GESI steering committee established in the Ministry and a technical committee in the DoHS. Training on decentralisation was provided to 69 HFMCs in 2010/11.

4. Major Challenges

The MoHP has made significant improvements related to governance. The cross-cutting nature of the GAAP activities means that information on progress needs to be reported by a range of different agencies and from different sources. There is no institutional mechanism for coordinating information collection across different departments, centres, divisions, sectors, partners and levels. A common understanding on GAAP indicators and their reporting mechanisms needs to be harmonised within MoHP and DoHS. Specific challenges are:

- A number of the indicators cannot be easily measured. Many simply provide additional detail on activities, rather than defining what is required as evidence of progress.
- Many indicators are high level or outcome indicators and there are very few process indicators. Being able to assess progress towards the objectives (through process indicators) is particularly important given the long term scope of the some of the GAAP objectives.
- In some instances, the sources of data required as evidence against these indicators are either undefined or not currently available.

5. Way Forward

- *Joint (MoHP/ EDP) task force to review and revise the GAAP:* This will be convened following the recommendations of the workshop. It has been agreed that there should be three or four representatives from government and EDPs. The task force will review the GAAP as a whole and establish responsibilities for collecting data and reporting against the indicators. A sub-committee will be formed to focus specifically on the financial management element of the GAAP. This will be completed in 2012.
- Different initiatives have been taken to further improve financial and procurement management systems. Due attention will be given to strengthening the systems.
- The health workforce remains a critical challenge. To address this MoHP will make every effort to implement the HRH strategy.

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Annex 1: Governance and Accountability Action Plan (GAAP)

Key Objectives	Key Activities	Key Indicators	Progress to date
1. SECTOR GOVERNANCE/ ENABLING ENVIRONMENT			
1.1 Move towards output-based budgeting by revising AWPB through MTEF	• Output-based budgeting to start from FY 2010/11 • Pool funding partners to provide indicative commitments by 31 January of each year	• Output based budget prepared from FY2010/11	- A workshop on Output-Based Budgeting (OBB) was held in October 2011 with participation from NPC, FCGO MoHP, EDPs and DoHS. Following recommendations were made: - The workshop recommendations will be used to initiate higher level dialogue. - A working committee will be formed to decide on implementation modalities, first exploring the most pragmatic modality and timeline. The committee is expected to initiate further discussions with EDPs and other stakeholders. - Once the committee determines the framework, it will be presented in a wider forum for discussion and finalisation - OBB will be implemented in some selected programmes i.e. national training programme, TB programme, child health and Aama programme. - **The workshop on GAAP (20 October 2011) recommended introducing OBB from FY 2012/13.** - Commitments to be made by pool partners are mentioned in the respective agreements, which usually cover 3-5 years. On that basis indicative commitments by pool partners are received by 31 January of each year.
1.2 Implementation of transparency and disclosure measures	• Regular and timely public disclosure activities to be ensured through MoHP and DoHS website, with regular updates, radio/TV/ newspaper reports and HFMCs of programme budgets, contracts, procurement and activities • Report on disclosure procedures to be implemented in the annual progress report	• There is sufficient local level flow of information on budgets available and used, activities planned and undertaken. • Coverage of public disclosure systems and instruments used • Website is active	-MoHP website now discloses information on: - Programme details under different budget heads, with expected outputs; achievements of last FY; budget allocated for this FY 2011/12: - Budget allocation for different programmes under different budget headings (in English) - Breakdown of integrated district health programmes (in Nepali) - Budget by departments and divisions and programmes - District wise programmes and budget (in Nepali). - Action plan developed to accomplish the commitments made in budget speech 2011/12 - MoHP has established a link on its website to the digital library. Nearly 600 health related documents/ policies /research reports are placed in this library. Visit: www.elibrary-mohp.gov.np

			-LMD website updates tender notices, including specifications of drugs, medical consumables and equipment. - DoHS has developed standard websites for all 75 districts to increase access to information for the general public. However, little progress has been observed in updating of information by districts. - Details (name and incentives provided to women for delivering in a health institution) is being displayed publicly in all health facilities implementing Aama programme. - In order to avoid duplication of interventions, a comprehensive social audit guideline has been developed to cover the whole health programme. - Citizen charter is being displayed in all health facilities including free drugs list, incentives and services.
2. STAKEHOLDERS			
2.1 Ensuring periodic Performance Audit	• Identification of key aspects to be covered in the performance audit of NHSP-2 implementation plan by MoHP/ DoHS, in close coordination with pool partners and OAG • Timely discussions to be held in advance on how the performance audit can supplement regular ongoing process • Public and social audits to feed into performance audits	• Identification of key issues in relations to performance of districts and thematic areas against the programs' overall goals and objectives	- OAG has continued with performance auditing for randomly selected MoHP programmes. On the basis of the performance audit carried out, consultation is in progress with OAG to further strengthen the process and thus ensure its sustainability. - OAG has identified four districts and two programmes (HIV Board and Naradevi Hospital) for performance audit this year. In strengthening the system, key aspects to be covered will be properly addressed. - Finance section is currently discussing expansion of the coverage of performance audit through the OAG. For this finance section is planning to seek both technical and financial support from interested EDPs.
3. IMPLEMENTATION CAPACITY/ INSTITUTIONAL CAPACITY			
3.1 Ensuring adequate capacity development of institutions and human resources to effectively implement NHSP-2 implementation plan	• AWPBs to incorporate capacity development initiatives for different levels of staff • Adequate plans, budgets and activities to be provided for each year, in line with the needs of key institutions, bodies and staff at central, district and local levels	• Coverage of key activities, in line with the sequence of NHSP-2 planned implementation, in key institutions of health and other multi-sectoral bodies foreseen for NHSP-2 e.g. nutrition and HIV/AIDS	- Adequate budget for provision of services is provided to the health facilities, including all levels of hospital. - Budget allocated for the provision of retrofitting in Bir and Bhaktapur hospitals. -Construction of warehouses will be completed in 72 districts by 2013, and detailed master plan and architecture design developed for regional medical stores. - Additional financial resources have been allocated to make CEOC services functional (including local contract of HR) in selected hospitals - Provision of financial resources to organise operation camps for women suffering from uterus prolapse problem continues. - Provision of funding for referral cases in remote districts has benefited 55 women. - Comprehensive health camps organised in 8 districts .

			- In order to provide 24-hour quality delivery services, additional nurses were appointed on contract. - 4,515 new FCHVs received basic training and 3,562 FCHV kits were distributed in 2010/2011 - Basic training for municipality based FCHVs and urban health workers are included in the AWPB 2011/12. -Procurement capacity training completed in 56 districts. -In FY 2010/11, a total of 909 SBA were trained (a total of 2591) to date..
3.2 Ensuring adequate number and diversity of health workforce as per norms set by MoHP	• AWPB preparation and approvals to be carried out • AWPB to incorporate institutional development programme • Phase 1 of health facility block grants to be implemented in underserved districts • Implementation of remote area allowance (pending Cabinet approval) • Organisation and management survey to be carried out • Deployment and retention plan to be implemented • Strategies for recruitment of local staff and increasing diversity in the health workforce to be implemented	• Information on short supply/surplus of health workforce by health facilities and/or district health offices; and on underserved communities • Diversity of staff increased	

			- AWPB discussed at divisional, departmental, ministry, NPC and MoF level and approval sought. EDPs also participated in these discussions - Collected district and regional priorities and incorporated in AWPB of 2011/12. - MoHP has allocated block grants (NRs.10 million) for Doti, Kailali, Surkhet and Dang to implement the Local Health Governance Support Programme (LHGSP). -15 O&M surveys have been completed in different units across the country under MoHP. These surveys include: • Upgrading of 478 SHP to health post • Upgrading pf PHC to 15 bed hospitals in Malakheti (Kailali), Chandra Nigahapur (Rautahat), Rampur (Palpa), Pipra (Kapilvastu) • Upgrading of SHP/health post to PHC in Gelu HP(Ramechhap), Laampantar SHP (Sindhuli), Pataura SHP (Rautahat) • Expansion of existing facilities to 50 bed hospitals in Trishuli (Nuwakot) and Sarlahi • Expansion of Mental Hospital to 100 beds • Establishment of new regional ayurved hospital in western region • Provision of MDGP and Ob/Gyn for continuity of CEOC service in 38 district health facilities • Revision of existing structure of DDA • Revision of Entomology team in five RHD and central team in DoHS • Consent for nine survey reports has been received from MoF and is under consideration by the Cabinet. Others are in different stages of approval - HRH strategy has been drafted and is in the process of finalisation. It is likely to address current issues related to human resources, including a plan for developing workforce projection and retention strategy for remote areas. - Issues regarding transfer of health workforce are addressed in the proposed amendment of Health Service Rules. - Recruitment of local staff on contract is being undertaken for different programmes i.e. 800 ANM and 25 SN . - To make the health service more inclusive, the proposed amendment to the Health Service Act incorporates provision for 45% of the open competition posts to be set aside for separate competition between the following candidates only (by considering the percentage into cent percent): women (33), janjati (27), madhesi (22), dalit (9), disabled (5) from remote area (4).

3.3 Redeployment of health workforce	• Identification of number of health workers to be redeployed within VDC/municipality and district • Transfer of health workers from health facilities with surplus health workers to facilities with short supply	• Percent of health facilities with a surplus vs. percentage with a deficit	- Where the shortage of health workers is due to study or extraordinary leave, appointment of substitutes is on contract basis.
3.4 Improving quality of health services	• System for review of quality health services to be established by 31 January 2011 • Physical infrastructure (HP/SHP) to be expanded and improved and district hospitals strengthened	• Annual review of quality of drugs, equipment and facilities and social audits are conducted • Number of facilities meeting adequate standards	- Health facility level quality improvement and implementation guideline developed and orientation programme on quality improvement completed in all 75 districts by MD/DoHS. District quality improvement committees formed and fhealth facility level quality improvement committees in process. - Construction of 11 CEOC sites in district hospitals, 15 BEOCs in PHCCs, 46 birthing centres, 27 new hospital buildings, 64 PHCCs, 170 HPs, upgrading of 136 SHPs to HP, 36 different types of quarters, 1 children's hospital, support services (9 district stores, 3 post mortem buildings and expansion of blocks in 7 district hospitals) are ongoing. All these constructions are according to the standard designs prepared by Management Division. - Appreciative inquiry planning and review workshops for CEOC strengthening completed in hospitals last year, and there are plans for a further 5 hospitals this year. - MoHP planned 1,145 construction projects through DUDBC in recent years. Out of these, 359 projects have been completed and handed over to local health facility management committees, 62 projects are completed and waiting for handover, 286 projects will be completed this fiscal year and 438 are ongoing.
3.5 Strengthening quality assurance and M&E	• Disaggregated data collection system to be scaled up through HMIS • Other sectors to be linked with HMIS e.g. vital registration • Quarterly publication of health statistics and analysis • New guidelines and protocols for PHC system to be updated and prepared • Annual facility surveys to be carried out	• Disaggregated data and analysis is available. • HMIS report is published quarterly. • Facility survey conducted annually	- Piloting of ethnicity caste disaggregated information in 10 districts by HMIS section with funding support from UNICEF, but not yet functional in pilot districts. HSIS piloting in 3 districts extended. HSIS also disaggregates by ethnicity caste. It is planned to scale up disaggregation by ethnicity caste - HMIS is linked to settlements, road networks, district boundaries in SMNH GIS. Health GIS is completed in 42 districts and underway currently in 18 additional districts. Census 2011 included questionnaire to in generate MMR. - The health statistics are analysed and report shared with programme divisions and centres in DoHS and MoHP - Programme guidelines prepared and treatment protocol is in process of development - Facility survey (newly named Service Tracking Survey) conducted
4. FINANCIAL MANAGEMENT			

4.1 Adequate and timely financial management at central, district and health facility level	• Trimesterly FM reports covering all programme activities and all districts to be prepared and submitted on time • Computerised system for accounting and reporting to be established at MoHP and DHOs with networking facilities between them	• Trimesterly reports of adequate quality and coverage submitted for smooth disbursement of funds to the programme • Explore use of an integrated computerised system to link physical and financial progress	- FM reports and physical progress reports submitted trimesterly. New FMIS software was used for collecting the information, however, it did not work properly in many districts. This caused delay in submission of reports. The first FMR was also delayed because the detailed pro rata share for pool partners in FY 2011/12 was received only on 7 April 2011. - During the preparation of last trimester report of each FY all the figures should be verified against consolidated data prepared by FCGO. This usually causes the delay in reporting. - In the process of establishing a computerised system for accounting and reporting, a concept note on Transaction Accounting and Budget Control System (TABUCS) has been developed, based on wider consultation with concerned stakeholders. This will be used to develop new software to help expedite the reporting process. - Financing section is currently discussing to link the eAWBP and TABUCS. - MoHP has included a link to the procurement plan in its existing eAWPB.
4.2 Timely fund release to health facilities	• Adequate and timely support to be provided to districts for submission of AWPB • Clear system to be in place for norms and procedures for appraisal of plans and approval of budgets • Deadlines to be fixed for key budget decisions e.g. list of health facilities selected for new activities and block grants by the DoHS and DHO to be included in AWPB • Fund-flow tracking system software developed to be implemented	• Number of districts undertaking stakeholder consultations for plan preparation and budget approvals • Share of annual budget released in the first trimester by DoHS • Share of health facilities getting grants within one month after the beginning of FY • Implementation of fund flow tracking system • At least 85% absorption rate of committed funds for the health sector	- Development of planning guidelines is in progress. This will put in place a system of norms and procedures to be followed in planning process, from local level to central level. - Allocation of grants provided after submission of institutional AWPB. - Service tracking survey has contributed to analysisof financial management information, including fund flow tacking - Proposed software under TABUCS is expected to incorporate a fund flow tracking system. - A budget analysis report analysed the absorption capacity by programme and level of health facility (see budget analysis report 2011/12).

4.3 Improve the quality of asset management	• Inventory of all assets to be updated regularly by taking physical counts and reconciling results with records • Inventory software to be improved for non-consumable fixed assets and LMIS to be strengthened • Policy to be formulated for discarding obsolete equipment • Physical Assets Management Unit (building and equipment) to be created within management division in DoHS, with adequate staffing • Public-Private Partnerships to be introduced in contracting out district level monitoring of the quality of procured drugs and medical equipment. • District level capacity to be enhanced to comply with quality assurance of health care services • Adequate funds to be provided in AWPB for maintenance	• Updated asset inventory report submitted on an annual basis during the JAR • Staff position created/reallocated and filled • Verification of amount line budget item in AWPB	- Regular updating of inventory of assets is carried out by preparing stock supervision records of all assets at the end of FY. Records of all usable and unusable assets are included in the reports. - with introduction of web-based LMIS in 2008, real time information of key FP, MCH, ED, and EPI commodities are available on monthly basis. - Inventory Management Software introduced/ developed which will cover up to PHCC level for entry of data on non consumable items .-Upgrading /updating of physical asset management information for health infrastructure has been initiated, making it GIS and web based, the upgraded system will also support regular progress monitoring and reporting. - Revised Procurement Guidelines for Auctioning, Disposal and Write off developed in 2010 and approved by OAG and MoF - LMD recently service contracted biomedical engineers. - DoHS allocated total budget of NRs.100 million for maintenance of physical infrastructure at district level and below for this fiscal year. (NRs.950,000 for each D/PHO and budget allocated to selected hospitals, PHCCs and health posts according to their needs) -Also refer to 4.6
4.4 Update Financial Regulations for Hospitals and for Management Committees	• Update financial regulations for hospitals • Update financial regulations for management committees	• Acceptable Financial Regulations prepared for Hospitals and Management Committees	- Current AWPB has included an activity to prepare the financial guidelines for hospitals.
4.5 Operating procedure made transparent for non-state partners/NGOs	• Prepare Acts/ Regulations for non-state partners/ NGOs	• A separate working modality developed for Non-state Partners/NGOs involved in the health sector.	- ToR for preparation of PPP policy in the health sector have been developed and a consultant identified to carry out the study. - NGO contracting guideline has been developed for EAP implementation.
4.6 Adequate funds ensured for operation and maintenance of medical equipments and hospital buildings	• At least 2% of the budget for Operation and Maintenance (O&M) to be included in the AWPB for medical equipment and hospital buildings • O&M expenditures to be monitored	• At least 2% of budget is ensured for O&M in the budget.	- MoHP has initiated a pilot for maintenance of medical equipment in the mid and far western regions, with technical assistance from KfW. This fiscal year, MoHP allocated NRs.4.4 million and KfW provided NRs.22.2 Million for this programme

4.7 Prompt action on audit irregularities	• Audit irregularities clearance committee to be formed • Irregularities to be reduced to less than 20% every year.	• Audit irregularities reduced to less than 20% • Action Plan developed and implemented to rectify the weaknesses observed by the audits	- MoHP has received a letter of appreciation for its excellent performance in clearing audit irregularities for FY 2010/11 -The proportion of irregularities increased from 35% in FY 2008/9 to 46% in FY 2010/11. - The proportion of irregularities against audited expenditures has decreased from 9% in 2008/9 to 7% in 2009/10. - The audit monitoring and clearing meetings are convened under the leadership of the Secretary
5. PROCUREMENT			
5.1 Procurement at central and district level	• Prepare consolidated annual procurement plans • Provide training for strengthening procurement capacity at central and district levels • Engage procurement support for NHSP-II implementation • Revise procurement policy and guidelines for MoHP • Revise logistics management policy and guidelines • Ensure a sound Quality Assurance (QA) system, including pre and post shipment, is in place at central and district levels to monitor the quality of procured drugs • Enhance local capacity at district level to comply with QA	• Standards and procedures in place for procurement best practices • Districts reporting difficulties in procurement • Monitoring reports on procurement • Training conducted on procurement at least once a year for all DHOs and cost centres • QA is applied as a standard operating procedure at the centre as well as district level	- Review and updating of free drug list conducted for each level of health institution. - Monitoring plan developed for 25 districts where some form of irregularity was tracked during local procurement. - Annual consolidated procurement plan prepared in coordination with different divisions and centres. Regular forecasting of drugs needed carried out as per the LMIS, with appropriate budgeting. - Essential drugs provided in every health facilities. - Procurement plan developed for medical consumables, hospital furniture, electrical/ electronic equipment, IEC materials, printing of training materials, HMIS/LMIS forms, annual reports etc. - Procurement policy and guidelines for ICB, LMD follows the World Bank procurement guidelines and for NCB, LMD follows Public Procurement Act 2063 and Public Procurement Regulations 2064 - Logistics management policy and guidelines revised and annual procurement training provided for store keepers, accountants and DHO/ DPHO - Sound QA system for pre and post shipment is in place: (for ICB, pre and post shipment lab testing before dispatching to RMS is contracted to a third party, for NCB, post shipment inspection is done by store in-charges upon receipt)

5.2 Timely availability of drugs, equipment and supplies	• Multi-year framework to be adopted for contracting supply of essential drugs, commodities and equipment by 31 August 2010 • Consolidated (including goods, works, services for the whole ministry regardless of financing source) annual procurement plan to be made available on the website to all interested parties at cost price six months before the beginning of the fiscal year • Drug Act to be amended and Nepal Drug Research Lab given independent status. • E-procurement to be introduced	• Percentage of health facilities with tracer drug stock out	- Multi-year contracting framework adopted for procurement of the following items, Male Condom 2009/10 – 2010/11 Injectables 2009/10 – 2010/11 Oral Contraceptives 2010/11 – 2012/13 Medical Consumables for PHCRD 2010/11 - 2012/13 Drugs and Medical Consumables 2010/11 – 2012/13 Furniture/Equipment/Instrument 2010/11 – 2011/12 - Consultation with stakeholders in developing ToR to amend Drug Act is in progress. - E-procurement introduced in infrastructure development from 2010/11 by DUDBC. - On-line bidding software developed - Trial phase of e-bid submission to start from 2011/12 - Marked reduction observed in stock outs, wastage and expiry of drugs and medicines in health facilities
6. ENVIRONMENT			
6.1 Ensuring continued access to EHCS for all people in the face of emergencies, crisis and conflict situation	• Develop guidelines for immediate response and possible activities to deal with women and children and the poor affected by conflict • Provide annual contingency plans and budgets for districts incorporating RH and GBV issues • Ensure all health facilities have and implement a waste management plan	• Emergency contingency plan and initiatives to dealt with women and children in conflict situations	- Budget provided for one-stop crisis centre (to deal with GBV) in 7 districts - Waste management plan has been piloted in Bir Hospital and Western Regional Hospital. This will be further expanded incorporating lessons learned. - Waste management guidelines developed and orientation programme for implementation completed in 40 districts. - Budget allocated for purchasing essential materials, chemicals, waste bins and undertaking quality inspection visits to improve the quality of services in health facilities in all 75 districts. Budget allocated for construction of placenta pits in 350 facilities. - National workshop conducted on programme for mercury free health institutions. - Health sector contingency planning completed in 22 districts, and disaster management orientation at regional level with hospital emergency preparedness planning in 5 hospitals.
6.2 Promotion of clean/solar energy	• Kerosene to be replaced by solar energy	• Number of health facilities with cleaner and safer energy sources	- LMD completed installation of solar power back up system in 10 Service Delivery Points (SDP) with support from WHO (2010)

7. SOCIAL/EQUITY ACCESS AND INCLUSION			
7.1 Advancing the social inclusion of all citizens and ensuring government is more accountable	• Social audit guidelines to be updated and distributed to all stakeholders • Training and budget to be provided for undertaking social audits according to the guidelines • Capacity building to be provided for local HFMCs on GESI application • Capacity building to be provided for GESI units at all levels • Community scorecard for social audit information to be disseminated and used • GESI strategy to be translated into a set of activities with clear accountability for results.	• Districts and health facilities undertaking social audits according to the guidelines and their link to the next year planning cycle • Share/number of health facilities completing social audit by trimester by district • Random sample review of social audit reports and field verification • HMIS, independent surveys and social audits provide intermediate evidence of improved outcomes for women and excluded groups • 2011 and 2016 DHS registers improvements in health, nutrition and family planning outcomes for women and excluded groups	- First draft comprehensive Social Audit Guideline has been developed and is under consultation for finalisation after field testing. - Social audits conducted in 150 health facilities across the country in FY 2010/11. - Budget for social audit rollout included in 2011/2012 AWPB for 20 districts. - Piloting of community score card is ongoing in 4 districts. - GESI steering committee at MoHP and GESI technical committee at DoHS are established and oriented; GESI institutional mechanism approved by Steering Committee; Population Division at MoHP and PHC RD at DoHS have been identified as GESI focal divisions and are taking proactive leadership to roll out GESI strategy. - Establishment of GESI working group at regional and district levels is in process.
7.2 Health Facility Management Committees (HFMC) are established and effective	• Formation of representative HFMCs in all health facilities to be facilitated, with orientation on their roles and responsibilities and citizens' rights to health services. • Annual progress reports to include information on the existence and functioning of the HFMCs. • Local health personnel to be recruited through HFMCs.	• Number/share of health facilities with duly formed HFMCs by district	- 69 HFMCs received training on decentralisation in 2010/2011. Partner organisations working in the districts are conducting orientation for HFMCs. - Review of the work of HFMC capacity building guideline/ manual from the GESI perspective is ongoing.

Progress Report on

Financial Management -2010/11

Report Prepared for Joint Annual Review (JAR)

January, 2012

Government of Nepal (GON)
Ministry of Health and Population (MoHP)
Financial Management Section

Table of Contents

Executive Summary

The efforts made in the initial stage of NHSP-2 have made a great contribution in financial management, specifically in reducing the proportion of irregularities against audited expenditures and increasing the proportion of audit clearances. This report intends to briefly describe the progress made in financial management during FY 2010/11.

Government of Nepal's (GoN) committee on irregularity clearance, under the leadership of the Chief Secretary, has categorised the Ministry of Health and Population (MoHP) as an excellent performer in clearing the financial irregularities mentioned in the auditor general's report. MoHP has prepared a concept note on the Transactional Accounting and Budget Control System (TABUCS) and included it in the current AWPB-2011/12. Compared to the NHSP-2 first fiscal cycle, MoHP has made a significant improvement in preparing and submitting the financial monitoring reports (FMRs). The preliminary findings of the Service Tracking Survey (STS) were disseminated on 1st December 2011. The final report will include a separate chapter on the financial management. There has been a significant improvement in reducing irregularities against audited expenditures, from 9% in 2009 to 7% in 2010, and increasing the proportion of irregularity clearances, from 35% in 2008/9 to 46% in 2009/10. The direct budget execution and audit practices by some EDPs are the key policy level challenges to be addressed. MoHP is committed to develop the guidelines for an internal financial control system and procurement for hospitals. Additionally, MoHP is preparing for the implementation of TABUCS in selected districts and planning for its nationwide expansion.

1. Background

Financial management refers to the capacity to plan in accordance with national policy and fiscal framework, to prepare budgets and ensure their timely release, to ensure transparent and timely accounting for spending, and to provide follow up financial auditing of expenditure, including assessment of value for money. During NHSP-1 and the initial period of NHSP-2, activities were implemented to strengthen the financial management system and thereby improve performance in financial management. This has contributed to timely budget release, improved financial reporting and improved absorption capacity. In particular, efforts during the initial stage of NHSP-2 have already resulted in a reduction in audit queries at all levels and prompt response to any such queries that do arise.

2. Objectives

This report intends to briefly describe the progress made in the financial management during FY 2010/11. Specifically the report highlights the progress made on the systems development, expenditure patterns, auditing and addressing related queries, challenges faced and the way forward.

3. Progress Made

MoHP has made impressive progress in developing the financial management system, with a Web-based electronic Annual Work Plan and Budget (eAWPB) and reporting system. This has positively influenced the fund absorption capacity, despite late approval of the budget in FY 2010/11.

3.1 Concept Note on Transaction Accounting and Budget Control System (TABUCS)

With technical support from NHSSP, MoHP has prepared and submitted to DFID a concept note on the Transaction Accounting and Budget Control System (TABUCS), to request financial support. Activities related to TABUCS have been included in the AWPB 2011/12.

TABUCS is a simple accounting system which allows for the capture of basic accounting transactions at source level and enforces budgetary control procedures, so that no expenditure

can take place without an approved budget. Basic functions that might be included in the TABUCS are: processing of expenditures and payments; automatic posting of payments to ledger accounts; summary accounts; automatic processing of cash, bank receipts and revenues; automatic posting in cash and bank books; generation of all ledgers and accounting; and Management Information Systems (MIS) reports, including Financial Monitoring Reports (FMR). It is important to bear in mind that the proposed TABUCS will serve as a small but key component of the fully-fledged Financial Management Information System (FMIS) required by MoHP for comprehensive financial management at Ministry level. The payments and receipts management module typically captures data on all revenue and non-revenue receipts and all capital and revenue expenditure. A system which captures this data at spending unit level is called a transaction accounting system; TABUCS therefore provides the foundation on which a fully-fledged FMIS may be built in future (a detailed report can be obtained from NHSSP).

3.2 Financial Monitoring Report (FMR) Prepared and Submitted on Time

As the basis for disbursement of further funds by pool partners, the FMR must be submitted to the development partners within 45 days of the end of the relevant trimester. To address difficulties encountered with timely submission of this report, the Finance Section has developed a framework to expedite the preparation process. This has been effective in improving both quality and timeliness of the FMR, compared with the first NHSP-2 fiscal cycle. Importantly, GoN's decision to implement the 12-month financial reporting cycle in all 75 districts (there was 18-month financial reporting cycle for the 14 remote districts) has contributed to timely production of FMR. Since a major cause of delay is the time consuming process of collecting and compiling reports from the Financial Comptroller General's Office (FCGO), it is expected that the introduction of TABUCS will contribute to further improvements.

3.3. Web-Based Electronic Annual Work Plan and Budget (eAWPB) Developed

The eAWPB has two dimensions: (1) consistency with the national public financial management and planning systems introduced by the Ministry of Finance and National Planning Commission respectively and (2) alignment with the NHSP-2 document, to enable reporting against the results framework and Governance and Accountability Action Plan (GAAP). MoHP has made good progress with the first dimension and is working on the second. The current eAWPB is Web-based, which allows planners working in different divisions and centres to upload their plans directly from their offices, for consolidation by MoHP. The current eAWPB provides a procurement plan, which MoHP can share with EDPs. There is also provision for disaggregation

of information by facility level, region, gender, programme area and district. Further modifications of the eAWPB are required to integrate the budget with the plan, to enable analysis of the budget and expenditure in line with the NHSP-2 result framework and GAAP.

3.4 Budget Allocation by Districts

MoHP carried out an analysis of district budget allocations and expenditures to increase its understanding of the patterns of spending. This showed a remarkable increase in the budget allocated to district health offices, from 46.5% in FY 2007/08 to 69.5% in FY 2011/12. To provide further support to the districts, MoHP will prepare a consolidated budget and expenditure guideline and dispatch it to all districts.

3.5 Linking Monitoring Data with Programme Planning

During the budget analysis process there was substantial discussion about linking the monitoring data from the Health Management Information System (HMIS) with the AWPB. MoHP officials, NHSSP advisers and consultants have agreed to develop a framework for achieving this. Policy level guidance is required to formalise this task.

3.6 Service Tracking Survey Conducted

An important part of the monitoring plan for NHSP-2 is to undertake regular Service Tracking Surveys (STS) to provide information on the delivery of priority services, including monitoring of the Aama programme and free health care. This will enable tracking of indicators for financial management, supply of drugs, human resources and progress against the NHSP-2 results framework, and will provide the periodic information for GAAP. Since there is a good deal of overlap in the approaches for monitoring free care and Aama, it is proposed that these two be combined in one survey. The STS has five main purposes:

1. To provide specific information for monitoring indicators in the NHSP-2 results framework, incorporating Gender Equality and Social Inclusion (GESI), and GAAP
2. To provide information on resource tracking as an input into development of the National Health Financing Strategy
3. To monitor implementation of the Aama programme
4. To monitor implementation of free health care, including the financial management capacity of health facilities

5. To provide regular information on the functionality (readiness to provide), client experience and quality of priority health services.

STS was conducted in a total of 169 health facilities in 13 districts, and preliminary findings were presented on 1st December 2011. There will be a separate section on financial management.

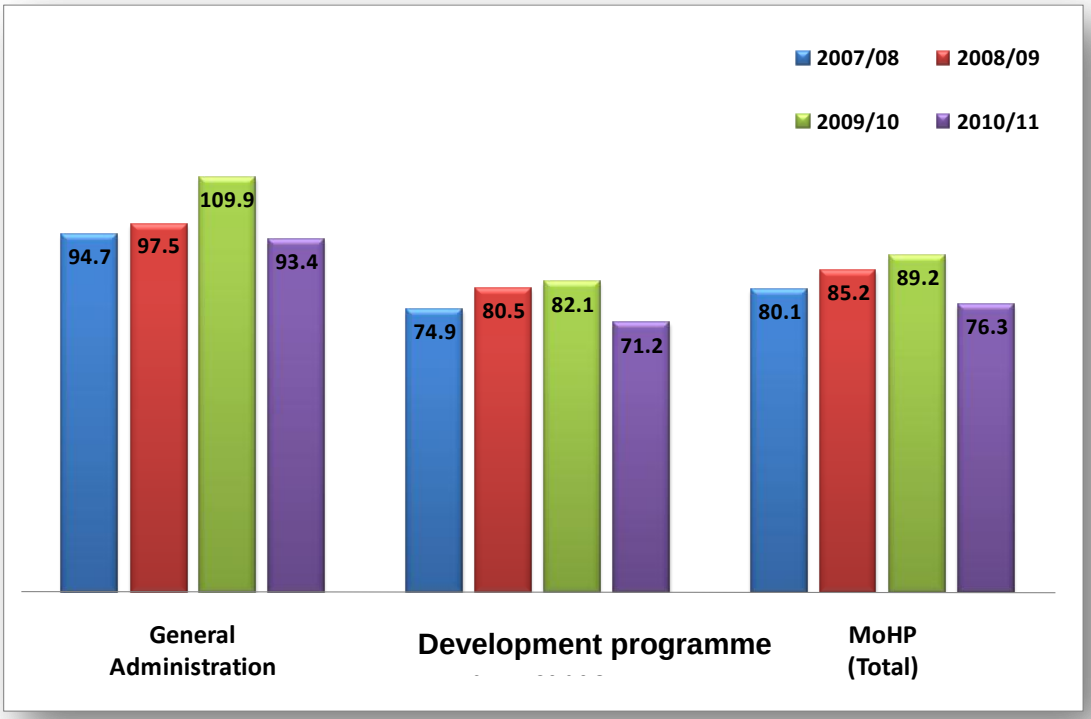
3.7 Procurement Training Conducted

The PPICD and financial management section has provided support for preparing an integrated procurement plan for goods. Some of the programmes developed annual procurement plans during approval of the AWPB. PPICD has provided training to planners from all divisions and centres to ensure the procurement plan is included in the eAWPB. Additionally, as a routine activity, procurement training (for goods and services) has been jointly provided by Logistics and Management Division and Finance Section of DoHS to appropriate personnel from all 75 districts.

3.8 Absorption of Budget

Figure 1 shows the total budget absorption capacity of MoHP by general and development programme.

Figure 1 – Budget absorption capacity



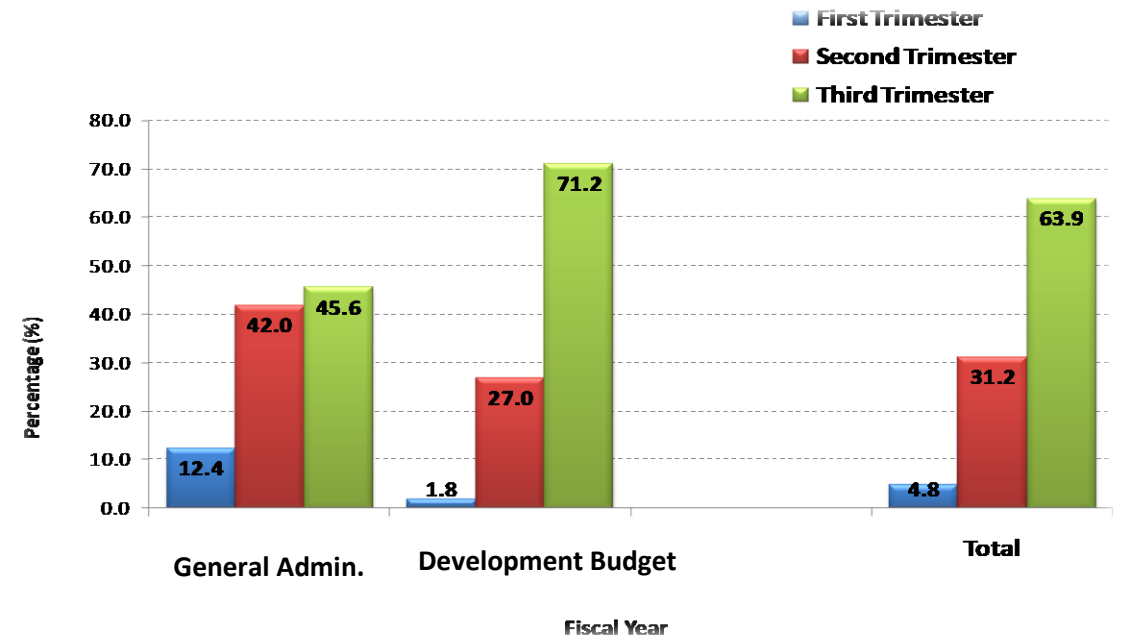
Source: MoHP, 2011

The overall budget absorption capacity of MoHP dropped by 13% with a decline of 16.5% in general administration and 11% in development programmes. The delayed budget approval from the parliament has caused the low absorption rate in FY 2010/11.

3.9 Trimester-wise Budget Spending

Almost two thirds (64%) of the annual budget was spent during the third trimester in FY 2010/11.

Figure 2: Trimester-wise Budget Spending



Source: MoHP, 2011

Notably, only 1.8 percent of the total budget was spent in the first trimester for development budget and 12.4 percent for general administration. Similarly, only 27.0 percent was spent on second trimester for development programmes while 42.0 percent was recorded for general administration.

3.10 Treasury Single Account (TSA)

The Treasury Single Account (TSA) is recommended by IMF in its Dec 2009 study report, and GoN took the decision to implement TSA in January 2010. In this system, governments' transactions are carried out through a single or limited set of bank accounts. The unified structure of the bank accounts gives a consolidated view of government cash resources at any given time and government monitors all its receipts and payments for cash management. Under the leadership of the Financial Comptroller General's Office (FCGO), TSA is being implemented at 38 District Treasury Comptroller's Offices (DTCO). Following are the major attributes of TSA:

- Treasury Accounts reside only at the Central bank
- Zero-balance single accounts at commercial banks for payments in place of multiple accounts
- Single cheque issuing agency in place of multiple cheques issuing agencies
- Zero-balanced single accounts for revenue collection at commercial banks

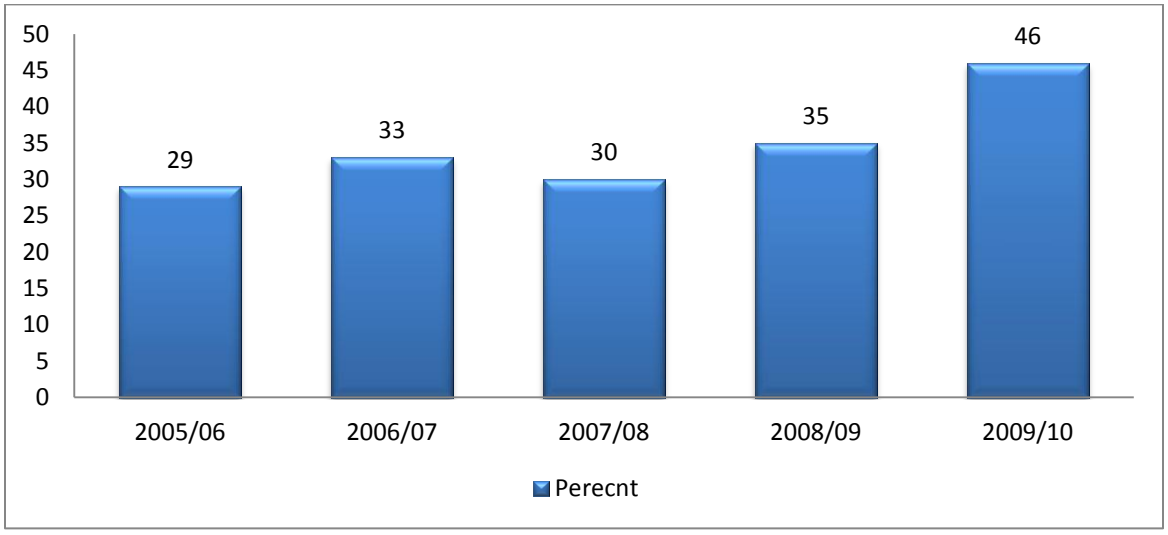
- End-of-day Settlement: all the balances of government accounts with commercial banks are brought to single treasury A/c in NRB at the end of the day.

The major contributions of TSA in the health sector have yet to be analysed systematically. However, TSA has contributed to addressing the issues related to idle cash balances in accounts, delays in financial reporting, no cash planning and forecasting, and no accurate information about treasury balances.

3.11 Increase in Clearance of Irregularities

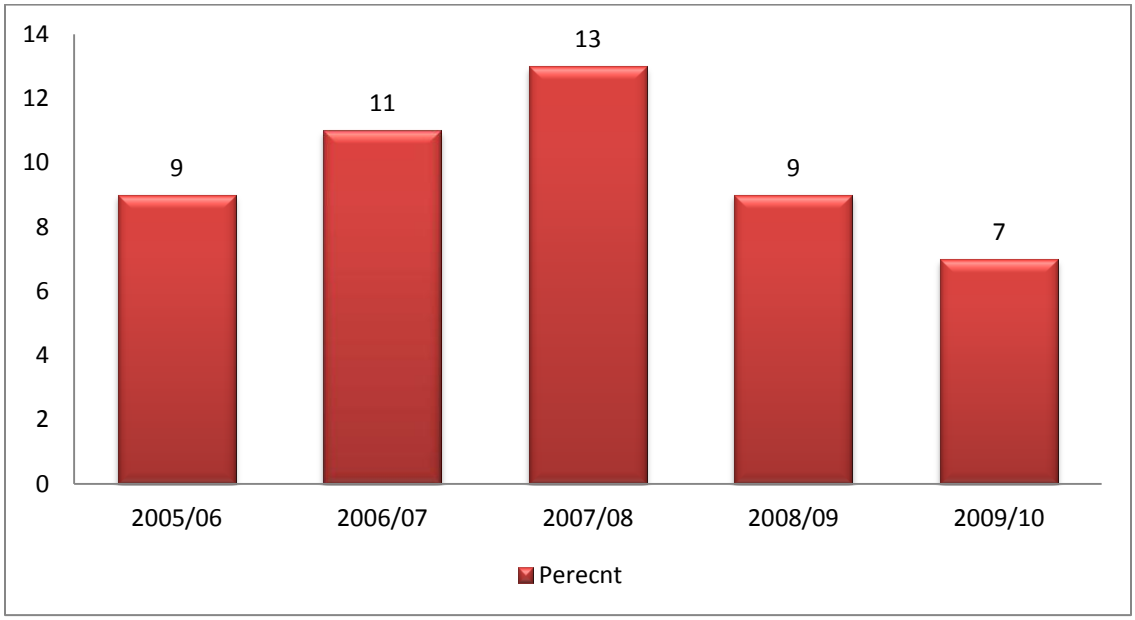
There has been a significant improvement in reducing the number of audit queries and improving the process of clearing those queries. However, a high level commitment is required to prevent the irregularities and ensure timely clearance. The broader nature of audit queries can be classified as non-compliance with legal provisions, weak internal financial control system and weak budget implementation. The current cumulative amount of total irregularity reported by OAG is NRs. 2,376 million; out of that 46% of the irregularities have been cleared up by MoHP. This progress has been appreciated by GoN's committee under the leadership of the Chief Secretary. The committee has listed MoHP as an excellent performer in clearing up the audit irregularities (***see the letter in annex1***).

Figure 3: Trends in Clearance of Irregularities



Furthermore, it is important to note that the proportion of irregularities against the total audited expenditure has decreased in fiscal year 2009/10.

Figure 4: Proportion of Irregularities against the Audited Expenditures



The proportion of irregularities against the audited expenditures has decreased from 9% in 2008/09 to 7% in 2009/10. The decreasing trend of irregularities and increasing clearance of irregularities demonstrates that the MoHP has made good progress in financial management.

3.12 Audit Observations and their Responses

OAG conducts the compulsory final audit of all the cost centres under the MoHP. It also conducts the performance audit randomly. This makes it more challenging for MoHP to mention all the queries and their responses to this brief report. It is important to note that MoHP has given a high priority to responding to the audit queries. Following are the highlights of the OAG's report:

- First highlight was on the audit irregularities which involve non-compliance with laws or improper use of funds/assets and are required to be regularised or recovered. This type of audit observation is system-related, requiring the responses from authorities at different levels.
- Second highlight was on the audit recommendations made by the OAG on observations and irregularities for regularising or for avoiding future repetition of the audit findings. MoHP through its audit committee acted promptly on the OAG's report and instructed all the cost centres to prepare the responses with evidence as stipulated in financial rules and regulations.

Table 1 below lists the major audit observations mentioned in the OAG's report and their responses.

Table 1: Audit Observations and Responses

S.N.	Audit Observations	Actions taken
1.	Following expenses as indicated in the NHSP financial statements have not been audited due to non-submission of books of accounts: 1.1 Child Health Programme NRs.72.82 million (funded by non-pooled partners: SCF USA, Care Nepal, JICA, Plan International) 1.2 Village Health Development NRs.68.19 million (Switzerland) Program, Dolkha and Ramechhap	-This is a broader PFM issue which been recommended by OAG in previous audit reports also. It is learnt that the international agencies listed in audit observation have their own institutional mandates for the final audit. In order to address this issue MoHP requires support from MoF and respective EDPs - However, MoHP has instructed DoHS to submit the response to the respective audit observations -DoHS has already submitted audit response to OAG
2	The Auditors have categorically stressed that all expenditures incurred under the budgetary allocation should come under the purview of the Office of the Auditor General	- MoHP agrees with this observation and instructed DoHS and other cost centres to comply with this observation - In order to address this issue MoHP requires support from EDPs
3	The Auditors have also qualified that the conditional grants amounting to Rs.97.69 million disbursed to the following six health institutions need to be audited: -70-3/4-305 Nepal Eye Hospital (NRs.26.00 million) -Bhaktapur Cancer Hospital (NRs.4.00 million) -70-3/4-336 Suresh Wagle MCC (NRs.10.50 million) -National Kidney Centre (NRs.14.69 million) -70-4-762 BP Koirala Lions Eye Study Centre (NRs.7.50 million) -70-3-763 Nepal Netra Jyoti Sangh (NRs.35.00 million)	- In the case of Suresh Wagle MCC and BP Koirala Lions Eye Study Centre, Tribhuvan University conducts internal audit and OAG conducts final audit. The internal audits have not been completed in both centres, causing problems in conducting final audit However, OAG has recently completed audit of BP Koirala Lions Eye Study Centre and Suresh Wagle MCC is currently preparing for final audit -For the other 4 hospitals, they have submitted the final audit reports conducted by independent auditors and submitted to MoHP. MoHP has sent the request letters dated 21/12/2011 to OAG for supplementary audit
4	Assets centrally purchased by the Logistics Management Division not being registered in the asset register of the recipient offices	-MoHP has instructed LMD to comply with this audit observation - LMD has sent instructional letters to all the cost centres

S.N.	Audit Observations	Actions taken
5	Concern about non-compliance with the procurement law. It is reported that 49 offices procured without preparing the procurement plan, when the law requires procurement should be included in the plan if it is more than Rs.1 million. Further, it has reported that DoHS and 62 Health Offices procured medicines and equipment worth Rs.236.24 million without any competition	-MoHP is committed to implement the GoN's rules and regulations. It has also instructed DoHS and concerned authorities to strictly follow the public procurement act and regulation - DoHS has instructed to all the cost centres that it will not release the further fund if the concerned cost centres fails to comply with the act and regulation
6	Evidence of expenses of funds received from various development partners (WHO, UNICEF and USAID) for polio vaccine campaign were not found to have been submitted for audit	-This observation is directly related to the direct funding from development partners. As mentioned in number one, MoHP requires support from MoF and concerned EDPs -The response to this observation has been submitted to OAG on 22/03/2011
7	The Auditors have raised concerns about more payments made than the approved rates. Various examples of such cases were cited in case of DHOs in Gulmi, Mahottari, Bajhang, Parsa, Rautahat, and Dhanusha for various purposes and programs	-MoHP is committed to implement the provisions made in the respective directives. In this context, MoHP has instructed DoHS to strictly implement the policy directives. MoHP has also instructed DoHS to provide necessary suggestions to take the actions in the case of any unjustifiable additional payments -MoHP has instructed DoHS to improve the financial monitoring systems at all cost centres

4. Major Challenges

Ministry of Health and Population (MoHP) has made a significant improvement in financial management. However, a number of challenges still need to be resolved:

4.1 Policy Level Challenge

MoHP is currently having technical discussions to address the concerns related to updating the website, disclosure of financial expenditures and documentation systems. Key policy level issues to be addressed are the practice of direct budget execution by some EDPs, weak forecasting of external assistance and separate reports and audits from EDPs.

4.2 Challenge related to Budget Preparation

A fundamental issue is that the budget preparation process is not sufficiently coordinated with the planning processes. The involvement of the finance section during the budget preparation

process needs to be further strengthened. Moreover, MoHP faces particular problems in forecasting amounts of foreign aid, which causes difficulties in preparation of a budget that includes external resources.

4.3 Challenge Related to Budget Execution

Delayed approval of budget was the major challenge for the proper execution of health budget. This delay also directly contributed to some cost centres violating the financial rules and regulations, specifically for the procurement. There are around 1,800 activities defined at DoHS level and around 500 for each district. The preparation and consolidation of performance information on all these activities requires considerable time and effort. The issue is exacerbated by lack of a technology based system for recording and monitoring these activities at the spending units. Additionally, under decentralised mechanisms the funds are routed to spending units through the DDC, creating another layer in fund flow.

4.4 Challenge Related to Accounting

The accounts of MoHP and its cost centres are maintained by FCGO/DTCO. The monthly process of reconciliation of accounts between FCGO/DTCO's reports and the records maintained by cost centres is generally late and some key expenditure information, especially the expenditures by programme activities, is not captured adequately.

4.5 Auditing

The Ministry of Finance has highlighted weaknesses in internal control mechanisms and requested FCGO to take steps to improve the situation. The devolution process does not require DTCO to conduct internal audits for devolved districts, recommending instead internal audit by independent auditors, copied to the DTCO. The DoHS does not have sufficient staff capacity to follow up a large number of internal audits and external audits on a timely basis.

4.6 Recording and Reporting and Monitoring

All cost centres do not send timely budget vs. actual expenditure to MoHP/DoHS. Also MoHP does not have any technology based solution to compile/consolidate budget vs. actual expenditure reports. FCGO provides budget vs. actual reports on a periodic basis to MoHP. However, these reports are based on particular heads of accounts and are not broken down by programmes.

5. Way Forward

- Develop and implement the guidelines on internal control system and procurement by the hospitals; MoHP is planning this for the current fiscal year.
- Prepare the implementation mechanism of TABUCS, implement as a pilot in selected districts and prepare a plan for the scale up at national level.
- Upgrade the existing eAWPB and make the provision of analysing the procurement plan.
- Develop human resource capacity in the areas of financial management and strategic planning and use of technology based solutions. This will require investment in financial and human resources to enhance capacity.
- Develop a system/ culture of compliance and accountability to ensure rules and regulations are used.
- Design and implement evaluation mechanisms (Social and Performance Audits, Evaluation Reports).
- An interaction programme with OAG and Public Accounts Committee will be organised where MoHP will share the audit status of MoHP.
- Strengthen the existing audit committee through regular meetings. Discussions and decisions on the audit related queries must be timely. The response system needs to be strengthened at the cost centre level.
- MoHP will develop the financial monitoring indicators and implement the monitoring mechanism through the active participation of DoHS and RHD.

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Annex 1: Letter of Appreciation

नेपाल सरकार

बेरूजु फछर्यौट मूल्यांकन र अनुगमन समिति

अर्थ मन्त्रालय भवन
सिंहदरबार, काठमाडौं
फोन नं. ४२११३१८

पत्र संख्या :- २०८१६९

चलानी नम्बर :- ५४

मिति: २०६८/६/१०

विषय:- धन्यावाद ज्ञापन ।

श्री सचिव
स्वास्थ्य तथा जनसंख्या मन्त्रालय,
रामशाहपथ, काठमाडौं ।

त्यस मन्त्रालयको २०६८ साल आषाढ मसान्त सम्मको बेरुजु फछर्यौट स्थितिको समिक्षा गर्दा ४५% प्रतिशत भन्दा माथि बेरुजु फछर्यौट भई दोश्रो लक्ष्य प्राप्त गरी "उत्कृष्ट" भएकोमा धन्यवाद ज्ञापन गर्दछु । चालु बर्ष पनि लक्ष्य अनुसार बेरुजु फछर्यौट हुनेनैछ भनि आशा एवं विश्वास लिएको छु ।

समितिबाट भएको परिपत्र अनुसार दोश्रो लक्ष्य प्राप्त भएकोले बेरुजु फछर्यौट कार्यमा प्रत्यक्ष रुपमा संलग्न कार्मचारीहरुलाई मात्र रु. ५,०००।- (पाँच हजार) नगद पुरस्कार प्रदान गर्न सकिनेछ र अन्तरगत विभागको हकमा सर्वोत्कृष्ट, उत्कृष्ट, सामान्य वा कारवाही गर्नु पर्ने के हो मन्त्रालयले हेरी निर्णय गर्नु हुन पनि अनुरोध गर्दछु ।

धन्यवाद !

१. बेरुजु फछर्यौट स्थिति :

रु. हजारमा

जम्मा बेरुजु	२,३७,६०,२९
फछर्यौट	१,०८,४२,८५
प्रतिशत	४५.६३

माधवप्रसाद घिमिरे
मुख्य सचिव
तथा
अध्यक्ष
बेरुजु फछर्यौट मूल्यांकन र अनुगमन समिति

Observation from Dr. Albertus Voetberg, World Bank / EDP Chair, January 2012

Dear Dr. Suvedi and Dr. Marasini,

We've gone through the financial management report and I'm afraid we have serious issues with the report, hence us sharing these with MoHP before the JAR. For now these are our observations:

- There is no reflection of issues and challenges that we have been raising through various follow-up letters on audit, implementation of GAAP and other related financial management actions. The report has no reference to financial management action plan contained in GAAP.

- The report has confidently stated that there has been improvement in financial reporting, with which we completely disagree. We have not yet received the third trimester progress report of FY2010/11 and the first trimester report of FY2011/12 is already overdue. The un-audited financial statement of FY2010/11 is also overdue and the audited financial statements of FY2010/11 is not likely to be received on time. The audit issue of FY2009/10 has yet not been resolved. We have not received satisfactory response to the audit issues raised in last year's audit -- yet the report says confidently that there are no significant audit issues.

- There are little evidences to state that MOHP has made impressive progress in developing the financial management system. We recognize and acknowledge the fact that initiatives are being undertaken in initiating eAWPB, TABUCS etc. but they are just starting to happen and we are yet to see the results from these initiatives.

- The statement made in 3.2 that FMRs are prepared and submitted on time is "simply incorrect".

- One positive statement made in the report is the MOHP effort in clearing the irregularity - an appreciation letter from the Chief Secretary has also been attached which appreciates the fact that MOHP has cleared 45% of the irregularities. But, there is no analysis of why such irregularities have occurred. What efforts are being undertaken to improve the control system so that such irregularities are substantially minimized in the first place? Facts presented in para 3.12 which details systemic weaknesses as highlighted in the auditor's report contradicts with the statement made in the report that MOHP has made impressive progress in financial management.

- In the list of references cited in the report, there is no reference to any of our earlier communications in financial management.

Summary

This report would have been useful if it conveyed a candid message. We also suggest that all our previous correspondences related to financial management be reviewed and the report responds to the queries raised. Finally, a clear time bound action plan with clear responsibility of concerned divisions/units to address all these issues would have been a practical way forward that could be easily monitored and measured.

Best Regards,

Bert

Progress Report on

Performance with regard to Procurement

Report Prepared for
Joint Annual Review (JAR)
January, 2012

Government of Nepal (GON)
Ministry of Health and Population (MoHP)
Ram Shah Path, Kathmandu

Table of Contents

Executive Summary

Procurement of work and goods has been a major GAAP concern. The Logistics Management Division (LMD) had a more successful year than the last, with most of the procurement being achieved, and multi-year procurement and electronic bidding process being introduced. However, the procurement process should start even earlier and needs to include all sub-units within MoHP. Technical Assistance by the consultants has been useful but is still not adequate and has been in a more supervisory role than actual efficiency enhancement of Logistics Management Division. Procurement team and Biomedical Engineers are being trained from time to time for capacity building but as the pending work needs to be accomplished side by side, the time given is not sufficient.

Though Procurement is an important component of Logistics Management Division, many other areas like Forecasting of all the Health Commodities, Goods Storage / Cold Storage, Distribution up to the level of Districts and modernizing Logistics Management Information System by introducing Web-Based reporting from all the 75 districts has been a drastic improvement in the system.

As far as the storage is concerned, 54 district store buildings have been completed and the rest are in process. New construction is now being planned for the 30-year old Central Store. This will be constructed under the direct supervision of Logistics Management Division.

Considerable progress has been made in improving systems for infrastructure planning and management, which will support improved quality of health care services. Construction and maintenance planning and maintenance are more evidence based and timeliness of plans and completion of construction work is better. This year, 170 health facilities were planned, and selection of the construction sites was completed on time; they are in process for design and estimates. The total estimated cost for these projects is about US$33 million. A total of 561 construction projects are ongoing, at an estimated cost of around US$112 million. About 50% of these are expected to be completed by end of July 2012. Among these, 24 have been categorized as “bad projects”, with little or no progress achieved. Action has been taken in the form of sending or publishing notices to the contractors and progress has been reported from the districts.

Implementation of standard designs and integrated designs has already resulted in significant cost saving and improved service provision, and these benefits are expected to further increase in the future. The introduction of e-bidding has facilitated more efficient and transparent tendering. Improved site selection processes have eliminated many of the

problems previously created by inappropriate sites that are costly to develop and unsuitable in terms of access and service provision. Plans for updating and upgrading the comprehensive computer based Health Infrastructure Information System (HIIS), which maintains information on inventory and operational status of health buildings, are moving ahead. This will significantly increase its usefulness to planners, policy makers, EDPs, researchers and others, and will support decentralisation of planning.

Priorities for the immediate future are: (1) Completion of upgrading and updating of the HIIS; (2) Capacity building of HIIS staff and decentralisation of the system (3) Institutionalising the proposed planning cycle.

1. Background

1.1 Procurement

Concerning Issues of procurement, this report represents an updating of the progress that has been made since the last report in January 2011.

1.2 Infrastructure

In a context of substantial shortages of appropriate, quality infrastructure, good management of existing and new physical assets is a priority for the MoHP, in order to create an enabling and safe environment for provision of quality services and to ensure retention of human resources. GoN is working to institutionalise evidence based planning of construction, operation and maintenance of health infrastructures and to ensure effective management with efficient utilisation of resources that promotes equitable distribution and access to health care at all levels of health facility. Appropriate and clear policies, strategies, plans, standards and guidelines are being developed, combined with enhancement of the skills of implementers to enable them to take new developments forward effectively.

2. Objectives

2.1 Procurement

The objective of this annual account is to provide an update of the procurement issues that have been overcome and to report upon lessons learned and challenges to further improvement.

2.2 Infrastructure

The following objectives have been identified for work in this area:

- To support evidence based infrastructure planning and maintenance through strengthening, institutionalising and supporting decentralisation of the Health Infrastructure Information System (HIIS).
- To develop the capacity of technicians working at the Department of Urban Development and Building Construction (DUDBC) and its district offices to adopt standard designs of health facilities, and develop standard protocols to increase quality, accountability and transparency in the construction process.

3. Progress and Achievements

3.1 Procurement

Draft Procurement Plan was organised by meeting all Divisions within DoHS and pooling their requirements. A consolidated plan was submitted to the World Bank on 22 September. This is a considerable change from last year because it was done by an external technical assistant. It was not matched with the usual systems and caused much delay and the plan has not been approved yet. However, the World Bank has allowed us to go on with the procurement process while it is being planned. Multiyear procurement has already started for many important commodities and soon Electronic Bid Submission will be in place too. Infrastructure like Server Installation and broadband connections have already been completed. Service Procurement has been started from this year and five contracts were awarded for the HIV/AIDS programme. Next year, we intend to widen the process to encompass *all* organs within MoHP and start the process in January 2012 so that a draft plan is ready to be dovetailed into the AWPB when it has its first meeting in March. If this goes to design, we should have achieved for the first time a Procurement Plan approved by the World Bank *before* the beginning of the next FY (2012-2013).

3.1.1 Goods

A total of 19 contracts were let during this period.

Multi-annual procurement has been improved with a further two contracts being signed for 3-years for Oral Contraceptive Pills and Injectables.

Those that have been let are:

i. **Oral Contraceptive Pills**
ii. **EPI and Other Vaccines**
iii. **SMNH Equipment**
iv. **EDS for Primary Health Services**
v. **Cold Storage and Cold Chain Equipment, Generators etc.**
vi. **Male Condoms**
vii. **Injectables DMPA**
viii. **Drugs and Medical Consumables**
ix. **Fortified Flour**
x. **Contraceptive Implants – 3-&5-year efficacy**
xi. **Computer Server & Firewall**
xii. **AD & Reconstitution Syringes and Intra Uterine Devices (IUD)**
xiii. **Insecticides**
xiv. **Printed Materials**

xv. **DEC Tablets**
xvi. **Test Kits for: Kala-Azar, Dengue Fever, and Chemicals for Cell Culture and Vaccine Production**
xvii. **Kits for: Vasectomy, Minilap, IUD, Implants, OT Tables and Lamps, and other hospital equipment**
xviii. **Office Electronic Equipment**
xix. **Office Furniture**

The following were unsuccessful or not yet completed:

i. Vehicles. This procurement failed as, due to the late provision of the budget in 2010, the time ran out to complete the purchase. LMD has requested funding from the Ministry of Finance but, as of writing, that has not been forthcoming. Efforts are being made for the budget.
ii. Medicine for Epidemic and Natural Disaster Control. This was cancelled due to non responsive bids. It has been included in the Procurement Plan for 2011-2012.

Procurements already launched for 2011-2012:

i. EPI Vaccines, Other Vaccines, Syringes and Safety Boxes
ii. Medical and Non-Medical Equipment
iii. Fortified Flour
iv. Tablets for Topical Usage, Medicines and Surgical Goods
v. Male Condoms
vi. IUD and Lubricant Gel and Condoms (these are to be transferred)

Procurements in preparation:

i. Medical Equipment for Birthing Centres, CEOC, BEOC
ii. Refrigeration Goods etc.
iii. Insecticides
iv. Printing Materials
v. EDCD/LCD/CHD Medicines
vi. Office Accessories

3.1.2 Service Procurement.

Of the original six Consultants' Services for the provision of NGOs to conduct HIV/AIDS Tech Assistance to the Most at Risk Populations (MARPs) five NGOs have been contracted. The sixth – for Female Sex Workers – was annulled at the request

of the World Bank to avoid duplication as the intervention was already being conducted by USAID. The five signed contracts were for:

i. Men who have Sex with Men/Male Sex Workers/Third Gender
ii. Prisoners
iii. Migrants and their families
iv. Injecting Drug Users
v. People Living with HIV

The following have been launched:

Consultant Services for CB-NCP Training has been launched and Pre- Shipment Inspection and Laboratory Testing are in preparation.

3. 2. Infrastructure

Progress has been made in many areas.

3.2.1 Improved Timeliness of New Project Planning

This year, 170 health facilities were planned and selection of the construction sites was completed on time, in July, an encouraging improvement on previous years. Further improvements in the planning process are expected in the near future, based on a proposed planning calendar, which will expedite the survey and estimation process and preparation of procurement plans, and support use of more realistic figures. Details of the various facilities planned for this fiscal year are shown in Table 1 below. The total estimated cost for these projects is about US$33 million (dollar conversion based on exchange rate at the time of bid preparation).

All the projects planned this year are below the threshold for international competitive bidding and below the threshold for prior review by World Bank. DUDBC sent the procurement plan to World Bank for review, following which it was revised and is now being prepared for dispatch. It took little longer to prepare the revised plan, due to problems in compiling old records and documents.

All the planned projects for the year are in process for design and estimate, and some have already gone for tendering through the National Competitive Bidding (NCB) process, established under the Public Procurement Act. Standard Bidding Documents, revised last year by WB and DUDBC with support from NHSSP, are being used for the process and are being prepared for publishing. This will provide separate bidding documents and guidelines

with a checklist for the data required, making the process easier for district technical staff to manage the tendering process at district level.

Table 1: Infrastructures Planned in Fiscal year 2011/12

SN	Type of Facilities	Nos	Budget Head
1	One unit doctor's quarter building	11	70-4-855
2	Two-staff quarter building	1	70-4-855
3	Four-staff quarter building	13	70-4-855
4	BEOC	9	70-4-855
5	Birthing Centre	24	70-4-855
6	Health Post	80	70-4-855
7	Store Building	10	70-4-855
8	PHCC building	10	70-4-855
9	PHO	10	70-4-855
10	Quarter for regional health directorate	1	70-4-620
11	Bldg. const. Naradevi Ayurvedic Pharmacy	1	70-4-756
	Total	170	

3.2.2 Ongoing Projects: Accelerating Progress

A total of 561 construction projects are ongoing, at an estimated cost of around US$112 million. Of these, 14 are ayurveda related constructions and the rest are regular health facilities. Table 2 below shows the numbers and costs for each type of ongoing facility construction.

Table 2: Number and Estimated Cost for Different Types of Ongoing Construction

SN	Type of Facilities	Nos	Budget in US$ in million	Budget Head
1	Ayurveda	14	1.4	70-4-756
2	ANM quarter in health post	3	0.1	70-4-858
3	BEOC in PHCC	15	1.5	70-4-858
4	CEOC in district hospital	11	1.283	70-4-858
5	Doctor's quarter building	22	1.83	70-4-858
6	Health post	170	32.247	70-4-858
7	Hospital building	27	25.51	70-4-858

8	Hospital new block construction	7	4.84	70-4-858
9	Hospital expansion and repair and maintenance	1	0.5197	70-4-858
10	Birthing centres	46	2.0572	70-4-858
11	Health Post reconstruction	1	0.0209	70-4-858
12	District store building	9	0.085	70-4-858
13	Post mortem building	3	0.0392	70-4-858
14	PHCC building	64	23.74	70-4-858
15	District public health office	17	5.14	70-4-858
16	Staff quarter building (7 numbers four family quarter in District Hospital and 4 numbers 2 family in PHCC)	11	0.79	70-4-858
17	Health post building for upgraded sub health posts.	136	9.07	70-4-858
18	Children's hospital in Lahan	1	1.11	70-4-768
19	Miscellaneous building	1	0.83	
	Total	**542**	**112.112**	

Some of the ongoing projects date back to the base year, 2005/06 (61/62), and it was observed during analysis of the ongoing projects that about 26 of these need special attention. DUDBC has contacted the contractors and actions have been initiated to expedite construction. A list of these "chronic projects" includes examples such as Bardibas District Hospital and Golbazaar Birthing Centre, neither of which even has the land for construction yet, as the land provided by the concerned authority and community turned out to be disputed. Twenty four constructions have been categorised as "bad projects" and action has been taken in the form of sending or publishing notices to contractors. Some of the contractors have also been fined. This has yielded results and progress has now been reported from the districts.

DUDBC is working to reduce the numbers of chronic and bad projects, and out of the 561 ongoing projects, about 50% are expected to be completed by end of July 2012.

Six of the ongoing projects are above the threshold for international competitive bidding and subject to prior review, as specified by the Joint Financing Agreement. Details for these projects are still being worked out, but as soon as the detailed bid documents are ready they will be sent to World Bank for review and "no objection for tendering". The projects subject to prior review are:

- Construction of children's hospital in Lahan
- Hospital block construction in Dhaulagiri Zonal Hospital
- Building block construction in Burtibang District Hospital
- Bajura District Hospital construction
- Kapilvastu District Hospital construction
- Bhojpur District Hospital construction

3.2.3 Progress Towards Reducing Construction, Management and Maintenance Costs

The implementation of standard designs is significantly reducing both direct and indirect costs. Previously, different buildings for health posts, PHCCs and district hospitals were often planned and constructed at different times, based on demand and available resources, with each building having its own support services, such as water, electricity etc. This resulted in very high overall construction costs, with further implications for repair and maintenance costs. On some older sites, where buildings were located in an ad hoc way, poor linkages between different units mean higher service provision costs, and service provision may be so difficult that buildings are not used, leaving huge investments lying idle. The current practice of integrating all units into a single design has led to considerable cost savings. Similarly, bidding costs are reduced by having a single tender instead of several.

Cost saving is achieved in a number of ways:

- Properly designed centralised services reduce the need for expensive and scarce land. Space is appropriately planned, and designed to accommodate future expansion. Economies of scale are gained in transport, establishing the construction site, supervision, monitoring and the cost of tools and machinery.
- Construction work is faster and cheaper with an integrated design because there is a single plinth area and less foundation work. The cost of construction will also be reduced over time, as the technicians learn the standard construction techniques, many of which can be replicated in similar conditions.
- Small projects mean small contracts, with smaller, less experienced contractors, often associated with poor quality work and more expensive construction. For a larger integrated construction, an 'A' level contractor or even an International Competitive Bidder can be obtained, with better experience, technology and skills available, resulting in better building quality and skill transfer, and economies of scale.

- Support service costs are reduced since the same support service is used by all units. A single septic tank, retaining walls and service road can serve for all, with a huge saving in land development and support services.
- Under the latest integrated design, the entire administration can be handled by a smaller central unit, a saving in the cost of everyday management, regular maintenance and repair work. These designs support both horizontal and vertical development, allowing for future expansion using the same service units.
- Since all the new buildings conform to the National Building Code regarding seismic design, electrical and sanitary work, the quality is improved, with more resistance to natural calamities, and extension of the productive life of the building.
- The well designed unit linkages of a standard integrated design promote efficient movement for facility staff, so that a smaller staff can achieve more work in the same time. Each unit, including accommodation, is designed to create an enabling environment for staff, with user-friendly fittings and fixtures that promote easy building management, resulting in increased productivity.

3.2.4 Promotion of Better Quality Services

Units have been designed for easy flow of patients and service providers, reducing crowding and supporting quality service delivery. This will reduce pressure on service providers and stress for patients. Multi-purpose rooms have been provided to accommodate additional caseloads that may occur during epidemics and enabling the hospital to expand its services within the existing building. With different services available within a single unit, both patient and staff time are saved and clients and providers feel more satisfied with the service.

The passage of “dirty out and clean in” has been considered, with separate flows designed for each purpose. Properly used, this will greatly reduce infection rates, which is a problem even in the best private facilities in Nepal, mainly due to poor design. Appropriate finishing for floors and walls enables proper cleaning and prevents bacterial accumulation. The flooring is resistant to damage by cleaning agents, saving on repair and maintenance costs.

3.2.5 E-Bidding as an Efficient Monitoring Tool

The e-bidding system established at DUDBC has enhanced the capacity to monitor progress and quality in the bidding process in many ways:

- Bidding irregularities were identified and addressed, for example construction which should have been ICB was found to be have been published under NCB and immediately stopped.

- Six tenders were found to be constructions that had not been not formally authorised by Management Division, and this was settled.
- Deviations from the agreed Standard Bidding Document were observed in bidding documents published by some divisions, and deviations were found in the drawings published with the bids. DUDBC has been informed of this and asked to correct it.
- E-bidding has eliminated the risk of cartelling during bidding, to bar other bidders from participating. The overall impact in terms of monetary benefit will be assessed after bidding for this fiscal year is complete.

3.2.6 Improved Site Selection and Land Development Process

Site selection, site layout and estimation are important initial stages of construction. Previous practices sometimes resulted in high development costs and selection of sites with poor accessibility and/or located far from the community served and even the service providers' residences. DUDBC now reviews, and in many cases rejects altogether, any site development that will cost above 10% of the building construction cost. This saves money that might otherwise be wasted on inappropriate sites. Proper layout has also tremendously decreased the costs of land development. For example, almost NRs.10 million was saved on land development costs for the health post at Khaula Lakuri in Parbat. Cancellation or moving of a construction on the basis of inappropriate site gives a clear message, usually resulting in local people providing a better site. This policy is clearly stated in the draft standard guidelines and will replace the previous policy of constructing buildings only on donated land, which is often located away from the community or market centres and therefore of low value. We believe that considerable money has been saved in land development costs during this year, and this requires further study for more accurate assessment.

3.2.7 Development of the Health Infrastructure Information System

The Health Infrastructure Information System (HIIS) is a comprehensive computer based system which maintains information on inventory and operational status of health buildings (those used for services and management functions), enabling their proper maintenance and management for better health care service delivery. Data is supplemented by building image files and building plan diagrams, allowing electronic visual assessment of the state of buildings and their maintenance and reconstruction requirements.

To cater for the needs of planners, policy makers, EDPs, researchers and others, and to support decentralisation, it has been agreed that the system should be updated, upgraded and made GIS based, to incorporate linkages to other planning features and ultimately make

it web-based. Terms of reference have been prepared and are in process for approval. Updating has been planned and initiated as follows:

a) Revision of data survey questionnaire to provide more detail
b) Identification of additional requirements for data collection and maintenance, including:
    - Building status (planned, under contract, under construction/reconstruction etc)
    - Ownership status (rented, own building)
    - Continuous data maintenance (in addition to annual survey data maintenance)
    - Defining and implementing standard codes for institution type, building type, purpose
    - Costs (estimations by field engineers, planners, budget allocated and spent)
c) Upgrading of software to meet needs for planning, budgeting, policy development and GIS linkage
d) Inclusion of data for the final two districts (73 of the 75 already included and operational)
e) Incorporation of standard designs that can be compared with the existing actual design
f) Updating of budgets, plans and photographs for recently completed building work with a system for DUDBC to continue updating themselves
g) Addition of all data on upgrading work for the last five years (eg SHPs to health posts, health posts to PHCCs and PHCCs to hospitals)
h) Addition of spatial planning dimensions (eg road connections, transport issues, relevant details of geographical terrain, settlement patterns such as market centres, service availability, catchment area, proximity of other health facilities) to enable analysis of location suitability
i) Upgrading so that the system can hold all the information and dimensions required to declare a building functional, based on comparison with the standard designs
j) Space to incorporate information on equipment for each facility and flexibility to be linked with human resource or other information systems within MoHP
k) Inclusion of formats for procurement plans and progress reporting that can be regularly updated online by the central and divisional offices of DUDBC, thus improving accuracy and saving time spent on preparation, compilation and updating of procurement plans, which is currently all done at central level
l) Making the system GIS based and easily linked with the Health Facility Atlas
m) Standardising building identities in coordination with relevant sectoral agencies (such as High Level Commission for Information and Technology and HMIS section of Management Division).

4 Lessons Learned

4.1 Procurement

- Procurement planning process need to start earlier for the next cycle so that there is enough time to think rather than to make mistakes and untimely corrections.
- For every procurement, whether it be Goods, Services or Work it has become clear that one or more of the unsuccessful bidders will go to court to stall the process. This involves delay and takes considerable effort from the purchaser to go ahead. This practice is a teaching / learning process for the supplier and purchaser.
- Widening the competition has been very difficult. Six international well respected Suppliers were contacted and asked why they were not found to be bidding. All replied that they are unable to compete on price with Suppliers from the Sub-Continent, and that their commodities were invariably of superior quality to those on offer. This will always prove true as long as there is compulsion to buy the cheapest Goods rather than looking at a combination of quality and price.

4.2 Infrastructure

- Before a site is selected, proper scientific land assessment, based on evidence and proven standard practices, saves time and money at all later stages of construction, and results in a better end product.
- Timely selection of sites and proper cost estimates carried out before the AWPB is developed helps ensure the procurement plan is prepared on time.
- Proper need assessments and review of the availability of resources according to spatial conditions should be carried out before estimates and designs are finalised. All stakeholders should be involved in the need assessment.

5 Major Challenges

5.1 Procurement

- District level procurement is a major concern. The procurement training to the District Officers, Accountants and Storekeepers are being conducted by LMD to improve the efficiency.
- It has been learnt that because of the multi-natured goods procurement it is not possible to accomplish the procurement with one or two specialist or experts only so there should be provision to hire experts as required while training to the existing staff go side by side.

5.2 Infrastructure

- Completing projects on time and avoiding extensions can be difficult, especially in Tarai areas, where the political and security situation is unpredictable. While every effort is

made to deal strictly with contractors when delays occur, local pressures do cause very real problems.

- Efforts are ongoing to establish and institutionalise a proper record keeping system within DUDBC, with a pool of people who fully understand procurement plan preparation and the needs of World Bank, MoHP and other donors.
- It can be challenging to monitor different sites and keep paper work in good order with scattered cost centres and sites, sometimes in difficult terrain where transport is minimal.
- Slow progress or no progress in construction is mainly due to factors such as:
    - Land dispute or no land
    - Dispute with the contractor due to conflict about use of specified materials or quality or non-availability of certain materials
    - Safety and security issues

6 Way Forward

6.1 Procurement

With full cooperation from the External Development Partners LMD would definitely be able to achieve its objectives but the extent and scope of assistance & partnership needs to be reassessed and discussed.

6.2 Infrastructure

Priorities for the immediate future are:

- Upgrading and updating of the HIIS
- Capacity building of HIIS staff and decentralisation of the system
- Institutionalising the proposed planning cycle
- Building capacity of DUDBC in planning health infrastructure, including training staff to use the standard designs.

Highlights of Major Health Related Research and Studies Carried out in 2011 in Nepal

Report Prepared for Joint Annual Review (JAR)

January, 2012

Government of Nepal (GON)
Ministry of Health and Population (MoHP)
Ramshahpath, Kathmandu

Table of Contents

1. Background

The health system in Nepal is dramatically changed from what it was a few decades ago. The change in political system, technological improvement, increased urbanisation and connectivity, change in the development process, enhanced access to information and services, and the promotion of equity and social inclusion, among many other changes have shaped a new reality in the country. These and other factors, in one way or another, have profoundly impacted on the epidemiological and health seeking behaviour patterns of the people. As a result, new and unique opportunities as well new challenges are now arising. Facing this new reality calls for rethinking the concept of government roles and public policy. It is time for innovation, for building new decision making capabilities, and for consolidating and ensuring stability and the effective operation of our health policy. With rising expectations and demand for health services, the responsibility of the government in providing an efficient and purposeful health system, covering all aspects including protecting economically and socially vulnerable groups, combating poverty, ensuring universal coverage or social health protection, promoting equity, mobilising financial and human resources, protecting against catastrophic payments and so on has considerably increased. We should not underestimate the significance of those challenges, which place a premium on enhancing the efficiency and productivity of the country.

1.1. Objectives and Methods

The objective of this report is to assemble the findings from various health research reports, articles published and studies conducted in 2011 to facilitate the policy makers to use this evidence for policy purposes. This is not a systematic review, and does not validate nor ensure the relevance of the design, or advocate the health policy, but is just a collecting and highlighting of evidence from various sources available to the researcher in the given time. The research reports were collected through email communications, visit to the research institutions/organisations, collection from the library of Nepal Health Research Council, and web searching of the research institutions in December 2011. All research reports, articles published or studies carried out in 2011 that were available or accessible by the researcher within the given time are included in this study. The main findings of the reports and articles are

summarised in this report and the evidence is categorised into different groups that are relevant to existing major health policies for Nepal.

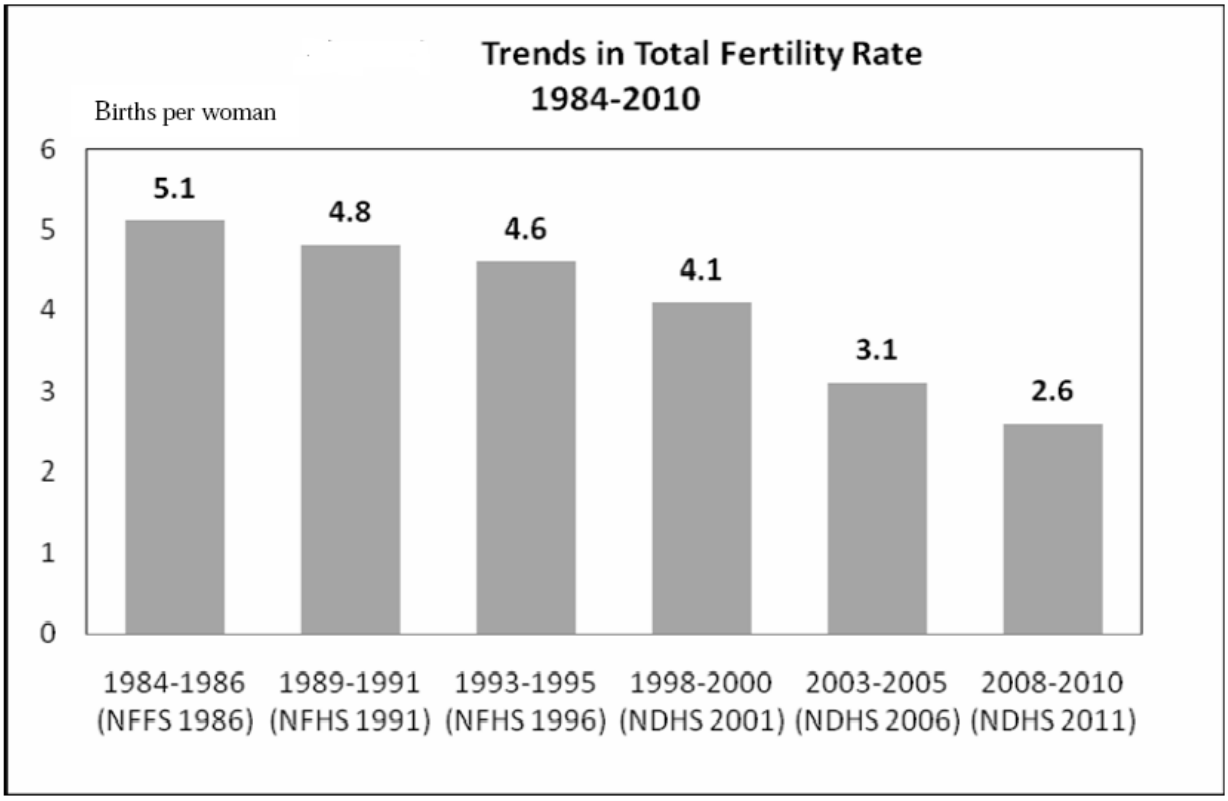
2. Analysis

2.1 Nepal Demographic and Health Survey (2011 NDHS)

2.1.1 Total Fertility Rate

According to the preliminary results of the Nepal Demographic and Health Survey (NDHS) 2011, the Total Fertility Rate (TFR) calculated for the three years preceding the survey is 2.6 births per woman age 15-49. Urban-rural differentials in Nepal are obvious, with rural women (2.8 births) having an average of over one child more than urban women (1.6 births). The overall age pattern of fertility as reflected in the age specific fertility rates (ASFR) indicates that childbearing begins early. Fertility is low among adolescents and increases to a peak of 187 births per 1,000 among women age 20-24 and then decreases thereafter. A comparison of the three-year rate shows that fertility has declined over the last two decades from 5.1 children per woman during the period 1984-1986 to 2.6 during the period 2008- 2010. The 2011 NDHS data show that fertility among rural and urban women has declined by half a child each from the levels reported in the 2006 NDHS.

Fig.1: Trends of TFR



Source: MOHP, New ERA and Macro International, (NDHS 2011)

The results suggested in Nepal over the past 15 years show that current use of modern contraception has increased from 26 percent in 1996 to 44 percent in 2006 and then declined slightly in 2011. There is a shift in the use of modern methods.

2.1.2 Vaccination Coverage

The 2011 NDHS also collected information on the coverage of vaccinations for all children under age five. Information on vaccination coverage was obtained in two ways—from health cards and from mothers' verbal report. Results show information on vaccination coverage for children 12-23 months, who should have been fully immunised against the major preventable childhood illnesses. Nearly nine in ten children (87 percent) were fully immunised and 96 percent of the children received BCG, DPT 1, and polio 1. The proportion of children receiving the third dose of DPT and polio is slightly lower (91 percent and 92 percent, respectively), as is the proportion receiving the measles vaccination (88 percent). There are only slight variations in children fully immunised by gender, residence, and ecological zones. Children in the Terai are less likely to be fully immunised than children in the other zones (84 percent compared with 88-89 percent) (Table 1).

Table 1: vaccination status

Percentage of children age 12-23 months who received specific vaccines at any time before the survey (according to a vaccination card or the mother's report), and percentage with a vaccination card, by background characteristics, Nepal 2011

Background characteristic	BCG	DPT 1	DPT 2	DPT 3	Polio 1	Polio 2	Polio 3	Measles	All basic vaccina-tions[2]	No vaccina-tions	Percentage with a vaccination card	Number of children
Sex												
Male	96.2	96.1	94.3	91.4	96.4	94.9	92.3	89.1	87.5	2.8	37.6	501
Female	96.2	96.6	94.7	91.3	96.7	94.8	92.0	86.3	85.7	3.0	30.2	499
Residence												
Urban	96.9	98.9	94.4	93.6	99.7	96.1	95.9	91.2	88.7	0.0	38.7	97
Rural	96.1	96.1	94.5	91.1	96.2	94.7	91.8	87.4	86.4	3.2	33.4	903
Ecological zone												
Mountain	93.7	93.7	90.4	90.4	94.3	91.1	91.1	90.9	88.2	4.3	25.9	75
Hill	96.3	96.5	95.4	93.4	96.3	95.7	93.5	90.4	89.5	3.2	35.1	402
Terai	96.4	96.6	94.4	89.9	97.0	94.7	91.3	85.3	84.1	2.5	34.1	523

Source: MOHP, New ERA and Macro International, (NDHS 2011)

2.1.3 Childhood mortality rates

Neonatal, post-neonatal, infant, child, and under-five mortality rates are shown in the results for cohorts of children born in three consecutive five-year periods before the survey. Under-five mortality for the most recent period (0-4 years before the survey or 2006–2010) is 54 deaths per 1,000 live births. This means that one in 19 children born in Nepal dies before their fifth birthday. Eighty-five percent of deaths among children under five occur during the first year of life: infant mortality is 46 deaths per 1,000 live births. During infancy, the risk of neonatal deaths and post-neonatal deaths is 33 and 13 deaths per 1,000 live births, respectively (table 2).

Table 2: Child mortality rate

Early childhood mortality rates

Neonatal, post-neonatal, infant, child, and under-five mortality rates for five-year periods preceding the survey, Nepal 2011

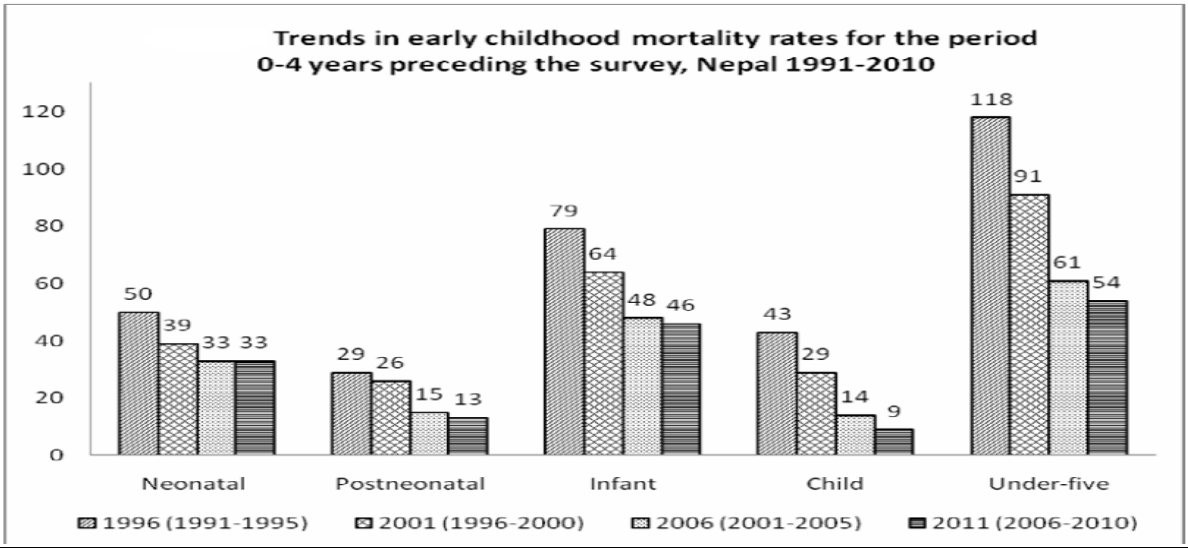
Years preceding the survey	Approximate calendar year	Neonatal mortality (NN)	Postneonatal mortality (PNN)[1]	Infant mortality (1q0)	Child mortality (4q1)	Under-five mortality (5q0)
0-4	2006-2010	33	13	46	9	54
5-9	2001-2005	37	23	60	10	70
10-14	1996-2000	45	25	70	19	87

[1] Computed as the difference between the infant and neonatal mortality rates

Source: MOHP, New ERA and Macro International, (NDHS 2011)

The survey indicates that while mortality has been declining in the past, the pace has slowed in the most recent years. For example, infant mortality declined from 79 per 1,000 live births during the period 1991-1995 to 64 per 1,000 live births during the period 1996-2000, and to 48 per 1,000 live births during the period 2001-2005, but only to 46 per 1,000 live births in the most recent five year period (2006-2010).

Fig 2: Trends in child mortality rates



Source: MOHP, New ERA and Macro International, (NDHS 2011)

2.1.4 Breastfeeding

The result shows that 88 percent of children less than two months of age are exclusively breastfed, but this percentage drops sharply at subsequent ages. Overall, 70 percent of children under six months are exclusively breastfed. This is a remarkable improvement since 2006, when only 53 percent of children of the same age were exclusively breastfed (Table 3 below).

In general, the nutritional status of children in Nepal has improved over the last decade. Fifty seven percent of children were stunted in 2001 compared with 41 percent in 2011 and 43 percent of children were underweight in 2001 compared with 29 percent in 2011. However, the proportion of children who are wasted declined only slightly from 13 percent in 2006 to 11 percent in 2011.

Table 3: Breastfeeding

Age in months	Not breast-feeding	Exclusively breastfed	Breastfeeding and consuming plain water only	Breastfeeding and consuming non-milk liquids[1]	Breastfeeding and consuming other milk	Breastfeeding and complementary foods	Total
	Percent distribution of youngest children under two living with their mother by breastfeeding status						
0-1	1.8	87.7	4.8	0.0	5.4	0.3	100.0
2-3	0.0	73.7	12.4	0.0	10.9	2.9	100.0
4-5	0.6	53.3	12.1	1.1	10.5	22.6	100.0
6-8	0.5	14.1	15.3	0.0	5.0	65.2	100.0
9-11	2.7	2.1	3.7	0.3	0.5	90.6	100.0
12-17	6.8	0.3	0.3	0.0	0.4	92.3	100.0
18-23	5.7	0.0	0.0	0.0	0.0	94.3	100.0
0-3	0.7	79.2	9.4	0.0	8.8	1.9	100.0
0-5	0.7	69.6	10.4	0.4	9.4	9.5	100.0
6-9	1.0	11.5	13.0	0.0	4.1	70.4	100.0
12-15	7.5	0.5	0.2	0.0	0.6	91.2	100.0
12-23	6.3	0.2	0.1	0.0	0.2	93.2	100.0
20-23	7.4	0.0	0.0	0.0	0.0	92.6	100.0

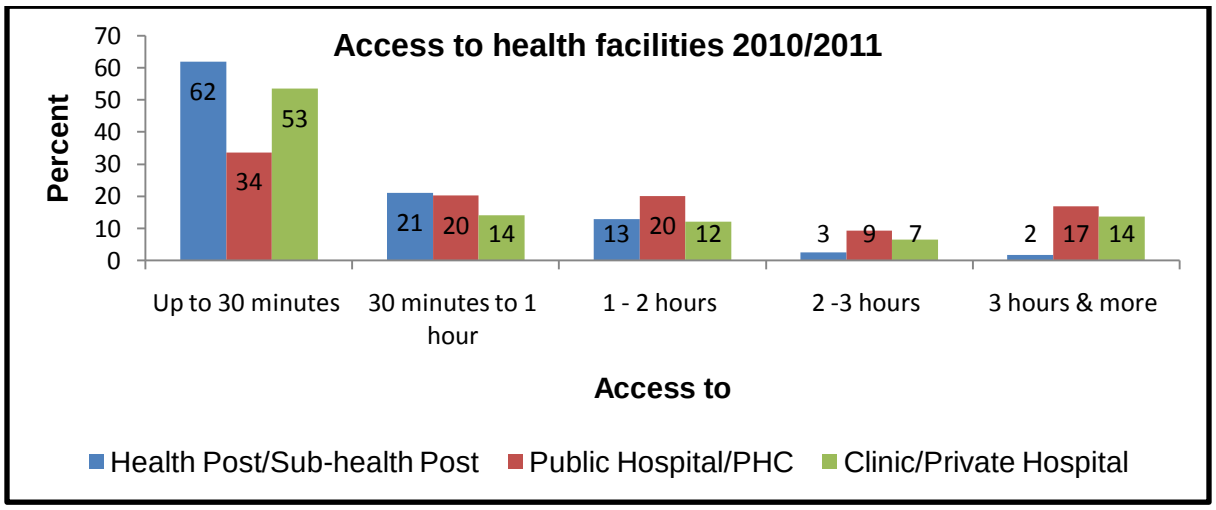
Source: MOHP, New ERA and Macro International, (NDHS 2011)

2.2 Third Nepal Living Standards Survey (NLSS III, 2010/2011)

2.2.1 Access to health facilities

Central Bureau of Statistics (CBS) carried out Nepal Living Standards Survey (NLSS III) and gathered data on Nepali households' access to health facilities. Households' access to a certain facility is measured in terms of time taken for one-way travel to that facility, irrespective of transport mode (foot or vehicle). The result suggests that about 62 percent of the households in the country are within 30 minutes reach to the nearest health post or sub health post. Moreover, 34 percent of households can reach hospitals or PHCC within 30 minutes.

Fig.3: Access to health facilities



Source: CBS, 2011 (NLSS III)

2.2.2 Childhood Immunisation status

About 64 percent of children between 13-59 months old are fully immunised. Gender gap is relatively small. The inequality in immunisation status by geographical regions and consumption quintiles are given in tables 4 and 5.

Table 4: Immunisation status by geographical regions

Percentage of Immunization status of children aged under five years

(Percent)

	Fully immunized			Partially immunized			Not immunized		
	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls	Total
Development Region									
Eastern	70.1	70.2	70.1	28.3	27.0	27.7	1.6	2.8	2.2
Central	62.6	58.7	60.7	34.7	38.0	36.3	2.7	3.3	3.0
Western	71.5	67.5	69.5	27.2	27.9	27.5	1.3	4.5	2.9
Mid West	67.9	66.5	67.2	31.0	31.8	31.4	1.1	1.7	1.4
Far West	43.3	51.2	47.0	52.4	41.5	47.3	4.3	7.3	5.7
Ecological Zone									
Mountains	65.7	63.3	64.6	32.1	30.9	31.5	2.3	5.8	3.8
Hills	65.4	62.4	63.9	32.1	33.0	32.6	2.5	4.6	3.6
Tarai	64.0	64.4	64.2	34.2	33.3	33.8	1.8	2.3	2.0
Urban/ Rural									
Urban	69.5	74.1	71.8	27.2	25.5	26.4	3.3	0.4	1.9
Rural	63.9	61.6	62.8	34.2	34.3	34.2	1.9	4.1	3.0

Source: CBS, 2011 (NLSS III)

Table 5: Immunisation status by consumption quintile

Percentage of Immunization status of children aged under five years

(Percent)

	Fully immunized			Partially immunized			Not immunized		
	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls	Total
Consumption Quintile									
Poorest	61.4	57.8	59.5	35.6	36.3	36.0	3.1	5.9	4.5
Second	61.8	65.1	63.3	36.8	31.5	34.4	1.4	3.4	2.3
Third	67.1	63.4	65.2	29.8	34.2	32.1	3.1	2.4	2.7
Fourth	71.2	63.4	67.2	28.0	33.8	31.0	0.8	2.8	1.8
Richest	67.4	77.7	71.7	31.0	22.3	27.3	1.7	0.0	1.0
Nepal	64.7	63.4	64.1	33.2	33.0	33.1	2.1	3.5	2.8

Source: CBS, 2011 (NLSS III)

2.2.3 Health Consultations

People were asked whether they were ill or not within the last 30 days. Of the total population, 20 percent reported having some sickness or injury within the last 30 days. About 69 percent of people with an acute illness reported to have consulted with some kind of medical practitioner: 28 percent consulted paramedics, followed by doctors - 25 percent, pharmacists - 16 percent, and traditional and other healers - 2 percent. About 63 percent of people visited private health institutions, the remainder visited government institutions. Health consultations by institutions, gender, geographical regions, consumption quintile are shown in tables 6 and 7.

Table 6: Health consultations by institution types

Percentage of health consultations for acute illnesses by type of institution

	Government Institution						Private health institution					
	Sub-Health Post	Health Post	Public health center	Hospital	Other	Sub-total	Phar-macy	Clinic	Private hospital	Other	Sub-total	Total
Gender												
Male	12.3	7.8	2.1	11.0	2.2	35.3	25.6	28.8	5.2	5.1	64.7	100.0
Female	13.7	8.0	2.9	11.6	2.3	38.5	25.0	26.3	5.4	4.8	61.5	100.0
Development Region												
Eastern	13.5	9.4	1.7	10.8	2.2	37.6	24.4	28.9	4.0	5.2	62.4	100.0
Central	9.0	6.3	1.9	11.4	2.2	30.8	25.1	29.3	7.9	6.8	69.2	100.0
Western	14.3	6.1	3.6	11.1	1.0	36.1	23.3	31.6	4.3	4.6	63.9	100.0
Mid West	20.6	10.8	4.4	10.9	5.4	52.0	27.6	15.4	3.2	1.8	48.0	100.0
Far West	12.5	10.7	1.7	14.2	0.6	39.7	32.3	22.2	4.2	1.6	60.3	100.0
Ecological Zone												
Mountains	23.8	9.1	4.9	20.3	0.0	58.1	22.7	7.0	6.1	6.2	41.9	100.0
Hills	19.6	10.7	3.9	11.1	1.3	46.5	21.4	22.4	5.7	3.9	53.5	100.0
Tarai	7.4	5.8	1.4	10.6	3.1	28.4	28.2	32.9	4.9	5.6	71.6	100.0
Urban/ Rural												
Urban	1.1	1.8	1.0	21.3	1.7	26.8	20.9	38.8	10.3	3.1	73.2	100.0
Rural	15.5	9.1	2.8	9.3	2.4	39.1	26.2	25.1	4.2	5.3	60.9	100.0

Source: CBS, 2011 (NLSS III)

Table 7: Health consultations by institution types and consumption quintile

Percentage of health consultations for acute illnesses by type of institution

	Government Institution						Private health institution					
	Sub-Health Post	Health Post	Public health center	Hospital	Other	Sub-total	Pharmacy	Clinic	Private hospital	Other	Sub-total	Total
Consumption Quintile												
Poorest	19.7	8.7	2.9	5.4	1.3	38.0	32.5	19.7	2.3	7.5	62.0	100.0
Second	16.6	9.1	2.7	10.1	2.3	40.9	28.8	21.9	2.6	5.8	59.1	100.0
Third	13.5	10.6	3.3	10.7	2.7	40.8	22.5	28.0	4.4	4.4	59.2	100.0
Fourth	10.9	7.0	1.7	13.8	2.2	35.6	24.7	30.0	6.0	3.7	64.4	100.0
Richest	4.8	3.4	2.1	16.0	2.7	29.0	18.6	37.3	11.3	3.9	71.0	100.0
Nepal	13.0	7.9	2.5	11.3	2.3	37.0	25.3	27.5	5.3	5.0	63.0	100.0

Source: CBS, 2011 (NLSS III)

The results suggest that on average, total cost of treatment at a government health facility is slightly higher than that at a private health institution. A disaggregation of the costs of treatment into diagnostic cost, medicine cost and travel costs etc. is given in table 8.

Table 8: mean expenditure by gender and consumption quintile

Mean expenditure of last consultation in Government and Private institution for acute illness

(Current NRs)

	Government institution				Private institution			
	Diagnostic & other service cost	Medicine cost	Travel cost	Total cost	Diagnostic & other service cost	Medicine cost	Travel cost	Total cost
Gender								
Male	230	655	134	1,019	212	811	72	1,095
Female	379	776	132	1,286	172	690	69	931
Consumption Quintile								
Poorest	228	497	56	781	53	568	43	663
Second	90	545	54	688	136	648	45	829
Third	225	689	112	1,025	202	909	83	1,194
Fourth	495	800	282	1,577	196	685	57	938
Richest	640	1,215	168	2,022	340	893	118	1,351
Nepal	312	722	133	1,167	191	748	70	1,010

Source: CBS, 2011 (NLSS III)

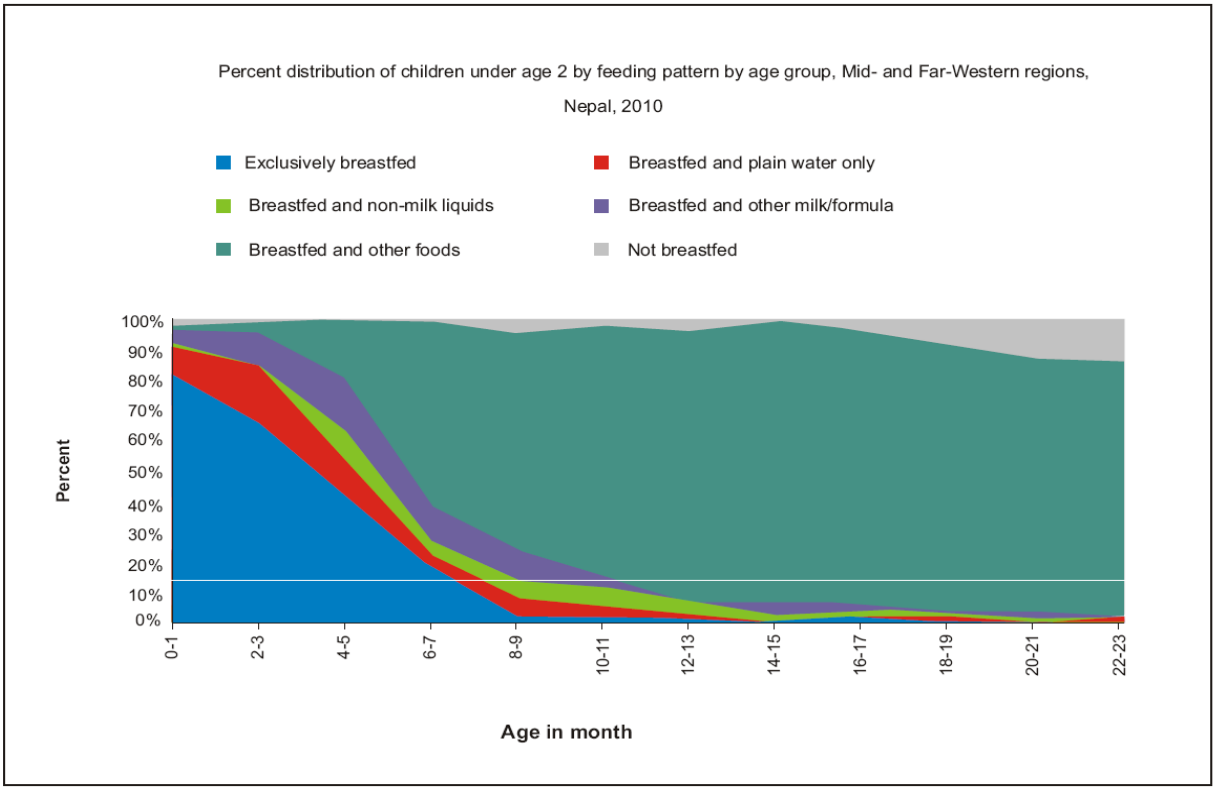
2.3 Nepal Multiple Indicator Cluster Survey (MICS)

The Nepal Multiple Indicator Cluster Survey (MICS) was carried out in 2010 and published in 2011 by the Central Bureau of Statistics (CBS). Financial and technical support was provided by the United Nations Children's Fund (UNICEF).

2.3.1 Breastfeeding

The results from the preliminary report indicated that about 82 percent of children ages 0-1 month are exclusively breastfed. Among children that are 2- 3 months old, this percentage declines sharply to about 66 percent. After five months, the percentage of children that are exclusively breastfed drops to approximately 18 percent.

Fig. 4: Breastfeeding indicators



Source: GoN, CBS and UNICEF, 2011

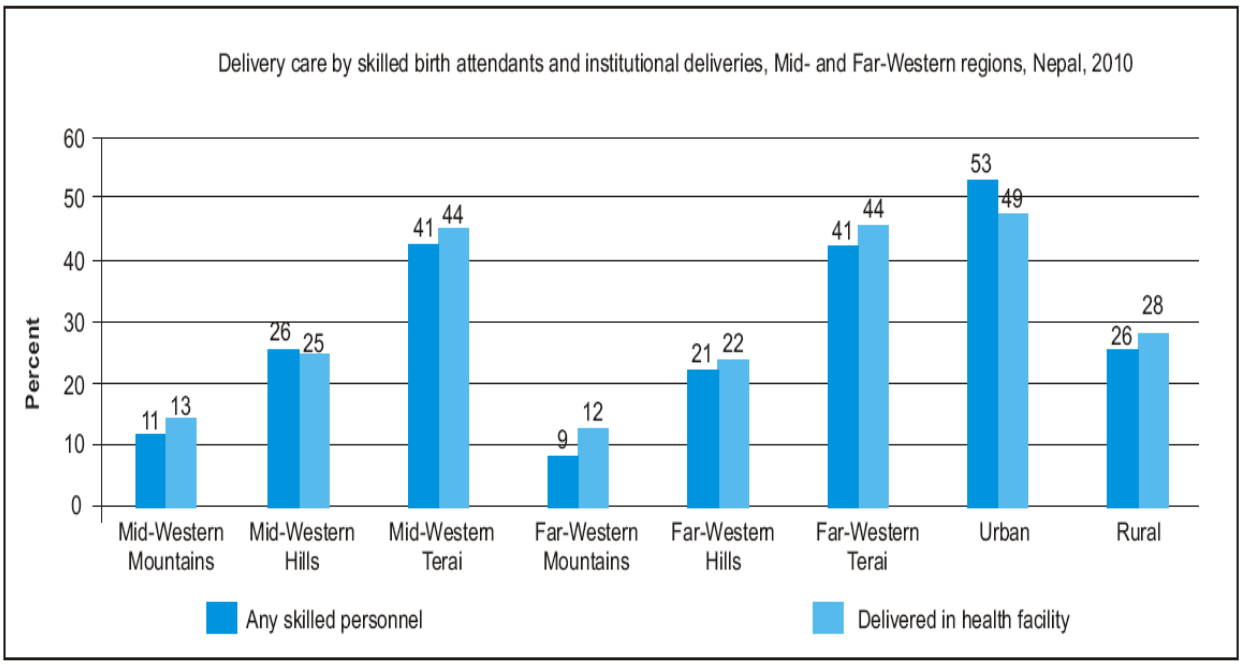
2.3.2 Childhood vaccinations

The results suggested that in Mid- and Far-Western regions of Nepal, almost 89 percent of children age 12-23 months have received BCG vaccination before their first birthday. However, only 67.5 percent have received the recommended three doses of DPT before the first birthday and just 77.4 percent have received three doses of polio vaccine. A total of 83.4 percent are immunised against measles. Approximately 35 percent of children age 1-4 years in the Far-Western region and only about one-fourth of children (26.5 percent) in the Mid-Western region are immunised against Japanese encephalitis.

2.3.3. Antenatal and delivery care

Of those women aged 15-49 years who had had a live birth in the two years preceding the survey, around 45 percent received antenatal care (ANC) at least once by skilled personnel, and 40 percent received ANC at least four times by any provider. Twenty-nine percent were attended to by a skilled birth attendant, defined as a doctor, nurse or auxiliary midwife in this analysis. The same proportion of women delivered in a health facility. Delivery care by skilled birth attendants and institutional deliveries are limited in the mountains and rural areas. Home delivery is very high, at 69 percent, where most deliveries take place without the support of skilled birth attendants.

Fig. 5: Percent of delivery care by providers



Source: GoN, CBS and UNICEF, 2011

2.3.4 Female literacy, child labour, early marriage and knowledge of HIV/AIDS

Overall, in the Mid- and Far-Western regions, only 74 percent of young women age 15-24 are literate. Among women living in the poorest quintile households, the literacy rate is 49 percent. In contrast, the literacy rate is 90 percent among women in the richest quintile households.

Concerning child labour, 44 percent of children age 5-14 years are involved in child labour in the Mid- and Far- Western regions.' Child labour' is defined as work that exceeds a minimum number of hours, depending on the age of a child and on the type of work. Children in rural areas are more likely to be involved in child labour than their counterparts in urban areas (46 percent compared to 31 percent). Similarly, female children are more likely to be involved in labour than male children (48 percent compared to 41 percent).

Regarding early marriage, in these regions of Nepal, 60 percent of women age 20-49 were first married or in union (living together with a man as if married) before age 18. Differences across wealth quintiles exist: 66 percent of women from the poorest households were married before age 18, compared to 54 percent from the richest households. More than half (56 percent) of women aged 15-49 in these regions have heard of AIDS, with younger women reporting a higher rate of awareness. For young women age 15-24, only about one-third have comprehensive knowledge about HIV prevention.

2.4 Government Health Financing System

Health Sector Support Programme (GIZ) Department of Health Services assessed the existing health care financing of Nepal in a report entitled "**Assessment of the Government Health Financing System in Nepal: Suggestions for Reform**" designed to support the health financing system to be more efficient and equitable. The assessment relies on secondary information from various agencies and primary information gathered from interviews with key informants and consultations with stakeholders. This review of the government health financing system builds on existing studies and ongoing discussions on the direction of reform. It provides a rapid assessment of the different provider payment systems in use and identifies ways of improving social health protection in Nepal. The key reforms recommended in the report are:

- Improve access of the poor to specified services: Access of the poor to specified health services, which are in theory being provided by the government for free, should be

facilitated by allocating sufficient financial resources and simplifying procedures for utilisation.

- Merge funding arrangements for social health protection: The merging of scattered funds under the proposed Social Health Protection Centre would help to allocate resources more efficiently and simplify administrative and reporting procedures, thereby reducing the administrative costs of managing funds.
- Introduce strategic purchasing: Government resources should be allocated where they have the most impact using budgets and reimbursements that mitigate the differences between rich and poor areas and that reward facilities that are performing well.

2.5 Demand Side Financing

Adhikari SR, Prasai D P and Sharma SK assessed the demand side financing schemes in Nepal with support from Oxford Policy Management Ltd. The report entitled "**A Review of Demand-Side Financing Schemes in Nepa**l" has three primary objectives: 1) assessing the effects in terms of coverage and utilisation, and identifying the bottlenecks of each scheme; 2) assessing the recent status of fund management; and 3) exploring the scope for integration and the possibility of improved efficiency for DSF schemes. The study mainly relied on secondary data; however, some data were used from primary sources to explore the situation as a case study.

Most of the schemes adopted consumer as well as provider mechanisms to improve the results. Major bottlenecks identified include awareness of the schemes and utilisation of services. DSF schemes, particularly the Aama Programme, also create new problems in the system. People generally bypass the lower level of health facilities so that lower levels of facilities are underutilised while hospitals or referral hospitals are overcrowded. Likewise, some programmes disproportionately consume hospital resources and implicitly give less priority to other programmes. For example, due to the flow of demand for delivery services, Operating Theatre (OT) rooms, equipment and human resources are occupied, and women who need surgical treatment of Uterine Prolapse (UP) must wait longer.

Delays in government budget release and allocation without rigorous demand analysis result in some facilities facing financial problems. Some studies indicated false claims by institutions and

their staff, although the recent trend of false claims is declining compared to previous assessments.

DSF schemes are operating independently under the Department of Health Services (DoHS) under a number of different divisions. Each scheme has its own operational guidelines, reporting, recording, and monitoring and supervision mechanisms which add to transaction costs. As an example, we estimated transaction costs of the Aama Programme. The share of transaction costs of the Aama Programme is almost 9 percent. Some of the schemes, such as the DSF scheme for FCHVs, may have higher transaction costs due to their complex procedures. We recommend merging the Aama Programme and the Four ANC Visit schemes. For other schemes we suggest the development of a mechanism for joint planning and monitoring to reduce transaction costs and improve the efficiency of the schemes.

2.6 Public Expenditure Review on Health

Adhikari SR, reviewed public health expenditure on health for 2006/07 to 2008/09 with financial support of GIZ. **Public Expenditure Review on Health for the Period from 2006/07 to 2008/09** provided insights on how to achieve better value for money and patterns of expenditure. This review provided an update on the fiscal data for general government health spending for the three-year period 2006/07 through 2008/09, and analysed important policy issues that are raised and highlighted in these data. Three main sources of funding for public expenditure on health: government, EDPs and others, and their contributions are exhibited in the following table 9. Over 45 percent of total public expenditure on health is now contributed by the government and an almost equal contribution to the total expenditure is made by the EDPs. State-owned enterprises, local bodies and autonomous universities contributed almost 6 percent to the total public expenditure on health from their own or internal sources.

Table 9: Summary of sources of public expenditure on health (NRs in millions)

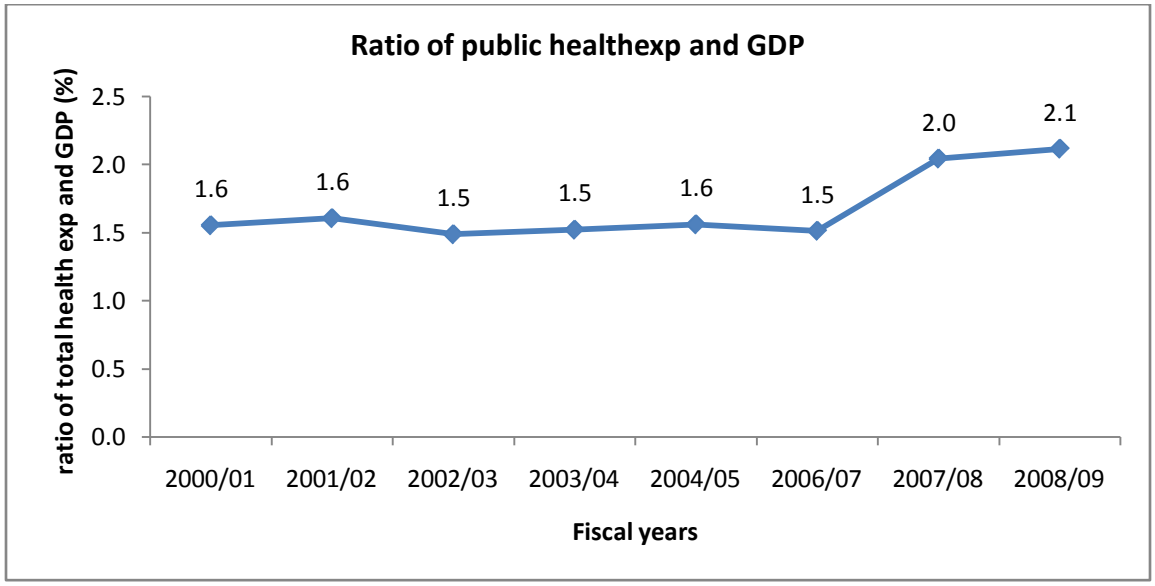
	2006/07		2007/08		2008/09	
Source of financing	**Amount**	**%**	**Amount**	**%**	**Amount**	**%**
NS1.1.1 Government of Nepal	**4,320.10**	**43.59**	**6,807.30**	**45.76**	**8,128.79**	**47.09**
Development (NS1.1.1.1)	428.73	4.33	1,666.52	11.20	1,604.53	9.29
Regular (NS1.1.1.1)	3,891.36	39.26	5,140.78	34.55	6,524.26	37.79

Earmarked tax (NS1.1.1.2)	-	-	-	-	-	-
NS9.1 External Development Partners	**4,821.02**	**48.64**	**6,965.74**	**46.82**	**7,865.39**	**45.56**
NS2.5 State-owned enterprises	**472.52**	**4.77**	**701.23**	**4.71**	**794.82**	**4.60**
NS2.5 Autonomous universities	**94.69**	**0.96**	**186.29**	**1.25**	**227.54**	**1.32**
NS1.1.2 Local bodies	**203.04**	**2.05**	**217.14**	**1.46**	**246.71**	**1.43**
District Development Committees	8.92	0.09	13.12	0.09	12.41	0.07
Municipalities	7.06	0.07	6.48	0.04	4.96	0.03
Village Development Committees	187.06	1.89	197.53	1.33	229.34	1.33
Total public spending	**9,911.36**	**100.00**	**14,877.70**	**100.00**	**17,263.24**	**100.00**

Sources: Adhikari, PERH, 2011

The ratio of public expenditure on health with gross domestic product (GDP) shows almost constant until FY 2006/07. There is an increasing trend of the ratio after FY 2006/07.

Fig.6: Ratio of total public health expenditure and Gross domestic product (GDP)



Sources: Adhikari, PERH, 2011

2.7 Nutrition study

Nepal Health Research Council has recently carried out a nutritional related study entitled "**Infants Feeding Knowledge, Practices and Hindering Factors in Kathmandu Valley**" with objective of assessing the knowledge, practices and hindering factors for proper feeding practices among under one year children of Kathmandu valley. The result suggested that out of 335 respondents, 35.8 percent had initiated complementary feeding before 6 months. Similarly, 34 percent had not started complementary food yet and remaining 30 percent had started after 6 months. The main factors for starting complementary feeding before 6 months were insufficient breast milk, cultural factors (Pasni at 5 months for female child), working mothers and family pressure. The main complementary food given to the child was lito.

Among the total respondents practice of exclusive breast feeding was found in 35.8 percent. Similarly, 38.2 percent breast fed with complementary food, 18.8 percent breast fed along with water and 6.6 percent breast fed with other milk. Among the respondents with a child of less than six months, 51.3 percent practiced exclusive breast feeding. Similarly, the practice of exclusive breast feeding (complete breast feeding up to 6 months) was found in 22.5 percent of mothers with a child of 6 months or older.

The most frequent reason given for not being able to practice exclusive breast feeding was the low production of breast milk. The conclusion of this study is that only having knowledge is not sufficient to transfer it in to practice. Other factors hinder mothers from feeding their children properly, such as diet of lactating mother, support of family members, a mother-friendly environment, economic condition of the family, working mother etc. So, we should consider such factors for improving infant feeding practices.

2.8 Aama Surakshya Karyakram

NHRC and UNFPA regional Office have carried out a study entitled "**In-depth review of effectiveness and efficiency of Aama Surakshya Karyakram to address barriers in accessing maternal health services in Nepal**. The study utilised both quantitative and qualitative tools and techniques to fulfil the objective of the study, which was to address the barriers to access the maternal health services. The results of the study demonstrate that the implementation of Aama Surakshya Karyakram (ASK) is progressive, and there is a gradual increase in institutional deliveries. Literature review revealed that false claims for institutional

delivery made by health providers were reduced to 4 percent in the year 2010 from 24 percent in the year 2009.

One-third of mothers decided by themselves to come to the health facility. Most mothers did not face distance as access barrier as two-thirds of them were residing near to the health facility (within reach of 60 minutes). Nearly all mothers (98%) had received the maternal health services immediately on arriving in the health facility and said there were no language barriers within the facility. Less than half of the mothers (40%) failed to receive the knowledge of transport incentive and said that they were satisfied with the quality of health services, but for the maternal health treatments offered, almost all (98%) were satisfied. All mothers were satisfied with the information provided for the health services. Only one-tenth of the mothers indicated that it compensated their transport cost. All the mothers were aware of free maternal and child health care services including delivery care. They did not have any idea about whether the cash payment was basically provided as transport incentive or for some other purposes.

In order to build confidence on the sustainability of the ASK among district level personnel, central level authorities must provide adequate human resources, increase the number of SBAs, provide essential equipment (delivery sets, forceps etc.), and release the budget in time. Nine-tenths of the sampled health facilities showed no evidence regarding annual planning and budgeting done for ASK. All health workers agreed that reporting system was still poor. It was quite interesting to observe that none of the PHCCs were found to perform any financial or social audits. However, all hospitals were performing financial audits Although majority of health facilities (80%) displayed the citizen charter, only 60 percent had displayed information on ASK in the same citizen charter. We also found that most of the health facilities (90%) had not displayed data related to ASK in the notice board of health facility.

2.9 Essential Health Care and Free Maternity Services

Resource Centre for Primary Health Care (RECPHEC) has carried out a study entitled **"Field Study on Essential Health Care and Free Maternity Services in Nepal"** with the objective of identifying, analysing and assessing the implications and effectiveness of the government programme, especially the free health care service and safe maternity programme. The results demonstrated that Sub-health posts and local private medical centres were the most preferred options for households to visit for treatment of general health problems. Out of the households surveyed 22 percent visit private health facilities, 46 percent visit SHPs, 19 percent visit HPs

and 11 percent visit hospitals for general health problems. It is interesting to note that despite the provision of free health services in government health facilities, 22 percent of the households prefer to visit private providers.

The average walking distance time for the households to reach the health facility was reported to be 36 minutes and 60 percent have no transportation facilities. On an average, a member from a household was found to be visiting government health facilities at least once a month. Out of these visitors, largest proportion (45%) went for diagnosis purposes, 34 percent for immunisation, and 19 percent for health related inquiries. Out of the surveyed households, 79 percent of the respondents reported that they are aware about maternity services. Despite this, only one fifth of the households reported having taken the free maternity service. The survey figures indicate that more households benefit from free maternity service in the Terai (29%) compared to Hill (25%) and Mountain (14%) despite the fact that more people are unaware about maternity services in Terai (64%) compared to Hill (85%) and Mountain (89%). The long distance to birthing centres and unavailability of reliable emergency transportation facilities are key barriers when it comes to benefiting from maternity services in rural areas of Hill and Mountain districts. Of those who received services from government health facilities, 76 percent reported that they received incentives. Average duration of getting the incentives after the delivery was reported to be 54 days. Out of those who received the incentives, 31 percent received it within a week, 66 percent within 3 months and remaining 4 percent within one year.

2.10 Millennium Development Goals Needs Assessment

Government of Nepal, National Planning Commission and United Nations Development Programme published a report on MDG entitled **"Millennium Development Goals Needs Assessment for Nepal 2010"** to show the national commitments for the implementation of development interventions identified to meet the MDGs. An extensive costing exercise of identified strategic interventions required to ensure attainment of Nepal's MDG targets by 2015 resulted in table 10 (a, b, c and d). For meeting MDGs 4, 5, and 6 (health), the total resource requirement is NRs 105.68 billions, of which only NRs 84.89 billion is available. There are serious funding gaps to meet MDGs. A detailed picture of total resources needs, availability and gaps estimated for five years is provided in the following tables.

Table 10 (a, b, c and d) resource needs, availability and gaps to achieve targets for MDGs

[redacted] Resource Needs, Availability and Gaps to achieve targets of the MDGs for 2011-2015 *(NRs in Billion)*

Goal	2011-2015 Need	Availability	Gap
Goal 1	379.96	277.10	102.86
Goal 2 Education	344.501	167.32	177.18
Goal 3 Gender	27.59	12.62	14.97
Goals 4,5,6 Health	105.68	84.89	20.79
Goal 7	273.72	159.06	114.67
Road Infrastructure	264.35	243.38	20.97
Total	**1,395.80**	**944.37**	**451.44**

Total estimated resource needs for implementing strategic interventions *(NRs in millions)*

Goal	2011	2012	2013	TYP total	2014	2015	2 year total	2011-2015
Goal 1	**57,237**	**65,318**	**73,897**	**196,452**	**85,652**	**97,855**	**183,507**	**379,959**
Poverty	47,285	53,323	59,715	160,323	69,046	78,641	147,687	308,010
Agriculture	9,952	11,995	14,182	36,129	16,606	19,214	35,820	71,949
Goal 2 Education	**35,330**	**46,025**	**63,184**	**144,539**	**97,371**	**102,592**	**199,963**	**344,501**
Goal 3 Gender	**3,495**	**4,483**	**5,491**	**13,469**	**6,525**	**7,593**	**14,118**	**27,587**
Goals 4,5,6 Health	**15,972**	**17,971**	**21,015**	**54,958**	**23,899**	**26,827**	**50,726**	**105,684**
Goal 7	**44,303**	**49,341**	**54,698**	**148,342**	**60,431**	**64,950**	**125,381**	**273,723**
Environment	7,265	7,510	7,755	22,530	8,024	8,311	16,335	38,865
Energy	28,246	30,596	33,224	92,066	36,333	39,744	76,077	168,143
Water and sanitation	8,792	11,235	13,719	33,746	16,074	16,895	32,969	66,715
Road infrastructure	42,234	52,190	54,359	148,783	57,558	58,007	115,565	264,348
Total	**198,571**	**235,328**	**272,644**	**706,543**	**331,436**	**357,824**	**689,260**	**1,395,802**

Total resource availability for implementing strategic interventions *(NRs in millions)*

Goal	2011	2012	2013	TYP total	2014	2015	2 year total	2011-2015
Goal 1	**43,028**	**48,518**	**53,026**	**144,572**	**61,205**	**71,322**	**132,527**	**277,099**
Poverty	38,420	42,527	45,237	126,184	51,078	58,156	109,234	235,418
Agriculture	4,608	5,991	7,789	18,388	10,127	13,166	23,293	41,681
Goal 2 Education	**32,930**	**32,916**	**33,076**	**98,922**	**32,974**	**35,427**	**68,401**	**167,323**
Goal 3 Gender	**1,543**	**1,926**	**2,404**	**5,873**	**3,000**	**3,745**	**6,745**	**12,618**
Goals 4,5,6 Health	**12,329**	**14,199**	**16,808**	**43,336**	**19,329**	**22,228**	**41,557**	**84,893**
Goal 7	**27,387**	**31,177**	**32,500**	**91,064**	**30,754**	**37,240**	**67,994**	**159,058**
Environment	1,084	1,234	1,483	3,801	1,795	2,171	3,966	7,767
Energy	17,418	20,025	20,066	57,509	21,036	22,053	43,089	100,598
Water and sanitation	8,885	9,918	10,951	29,754	7,923	13,016	20,939	50,693
Road infrastructure	40,640	48,183	47,301	136,124	51,300	55,952	107,252	243,376
Total	**157,857**	**176,919**	**185,115**	**519,891**	**198,562**	**225,914**	**424,476**	**944,367**

Total resource gaps for implementing strategic interventions *(NRs in millions)*

Goal	2011	2012	2013	TYP total	2014	2015	2 year total	2011-2015
Goal 1	**14,209**	**16,800**	**20,871**	**51,880**	**24,447**	**26,533**	**50,980**	**102,860**
Poverty	8,865	10,796	14,478	34,139	17,968	20,485	38,453	72,592
Agriculture	5,344	6,004	6,393	17,741	6,479	6,048	12,527	30,268
Goal 2 Education	**2,400**	**13,109**	**30,108**	**45,617**	**64,397**	**67,165**	**131,562**	**177,179**
Goal 3 Gender	**1,952**	**2,557**	**3,087**	**7,596**	**3,525**	**3,848**	**7,373**	**14,969**
Goals 4,5,6 Health	**3,643**	**3,772**	**4,207**	**11,622**	**4,570**	**4,599**	**9,169**	**20,791**
Goal 7	**16,916**	**18,164**	**22,198**	**57,278**	**29,677**	**27,710**	**57,387**	**114,665**
Environment	6,181	6,276	6,272	18,729	6,229	6,140	12,369	31,098
Energy	10,828	10,571	13,158	34,557	15,297	17,691	32,988	67,545
Water and sanitation	-93	1,317	2,768	3,992	8,151	3,879	12,030	16,022
Road infrastructure	1,594	4,007	7,058	12,659	6,258	2,055	8,313	20,972
Total	**40,714**	**58,409**	**87,529**	**186,652**	**132,874**	**131,910**	**264,784**	**451,436**

Source: GoN and UNDP

2.11 Selected articles published in journals

Manandhar SR et al published an article entitled "**Analysis of Perinatal Deaths and Ascertaining Perinatal Mortality Trend in a Hospital"** in Journal of Nepal Health Research Council with the objective of analysing perinatal deaths and ascertaining perinatal mortality trends of Kathmandu Medical College Teaching hospital in the last 8 year period. The result suggested that in the first perinatal death audit, the perinatal mortality rate (PMR) was recorded as 30.7 per 1000 births and extended perinatal mortality rate (EPMR) as 47.9 per 1000 births, whereas in the fifth perinatal death audit (Apr '10 – Mar '11) PMR was recorded as 14.4 per 1000 births and EPMR as 19.6 per 1000 births. In Wigglesworth's classification, in the first perinatal death audit, most of the perinatal deaths were in group IV (41%) reflecting more asphyxial deaths; however in the fifth audit, group III mortality (41%) was highest, indicating death of low birth weight or preterm babies. In the first audit, stillbirth rate (SBR) excluding <1 kg was 18.1 per 1000 births and early neonatal deaths (ENND) excluding <1 kg was 12.9 per 1000 live births. In the fifth audit, SBR (excluding <1 kg) and ENND rate (excluding <1 kg) were 7.1 per 1000 births and 7.2 per 1000 live births respectively, reflecting a declining trend of both SBR and ENND rate in the hospital.

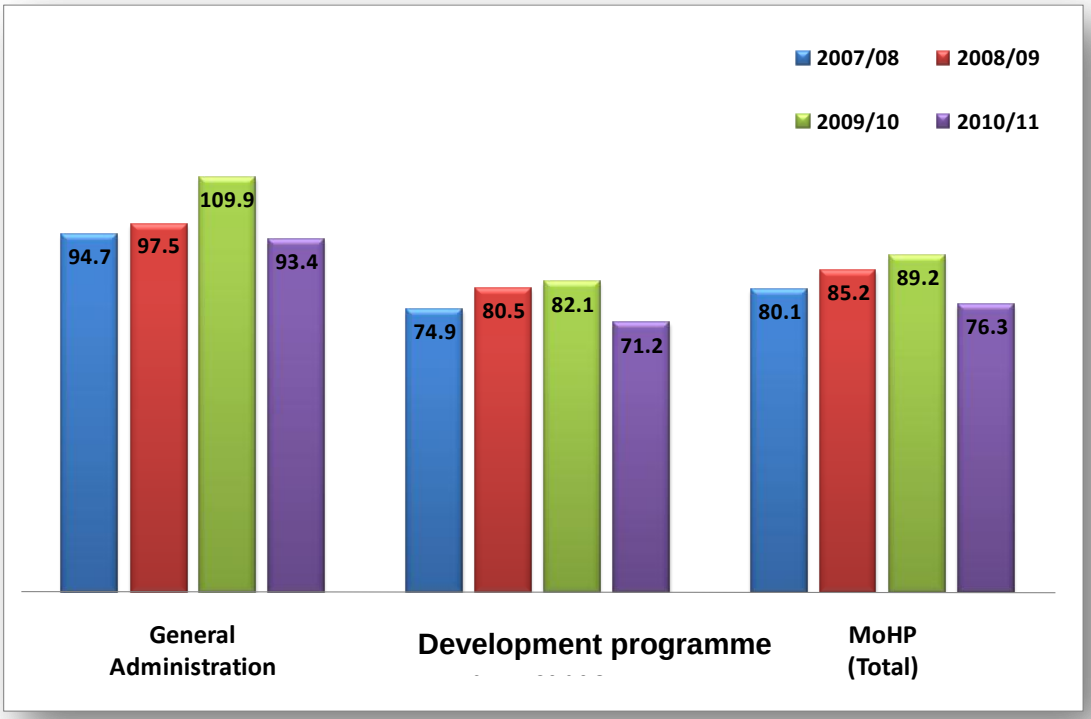
The article concluded that distinct declining trend in PMR, EPMR, SBR and ENND rates at KMCTH were noted. As asphyxial deaths have been reduced significantly, more intensive efforts are needed to prevent premature births with care of preterm and very low birth weight babies.

Joshi et al published an article entitled **Lower Urinary Tract Infection and Bacterial Colonisation in Patients with Double J Ureteral Stent** in Journal of Nepal Health Research Council with the aim of investigating the bacteriology of urinary tract infections associated with indwelling DJ stent. A total of 46 cases were included. Mean age in years was 35.70 (10- 78 years). Males were 22 and females 24. Eleven patients (23.91%) had stent placed less than 30 days and 35 patients (76.08%) had it for 30 or more days. DJ indwelling time was in between 12-86 days. Bacterial colonies were found in 28.3% (13 of 46) of the urine samples and 30.4% (14 of 46) from the tip of the DJ stent segment. Of the pathogens identified, E. coli was found to be the most common. An increased stent colonization rate was associated with implantation time, and female sex. On urine culture 70.21% had no growth, 14.89% E. coli, 4.25% Klebsiella,

3.8 Absorption of Budget

Figure 1 shows the total budget absorption capacity of MoHP by general and development programme.

Figure 1 – Budget absorption capacity



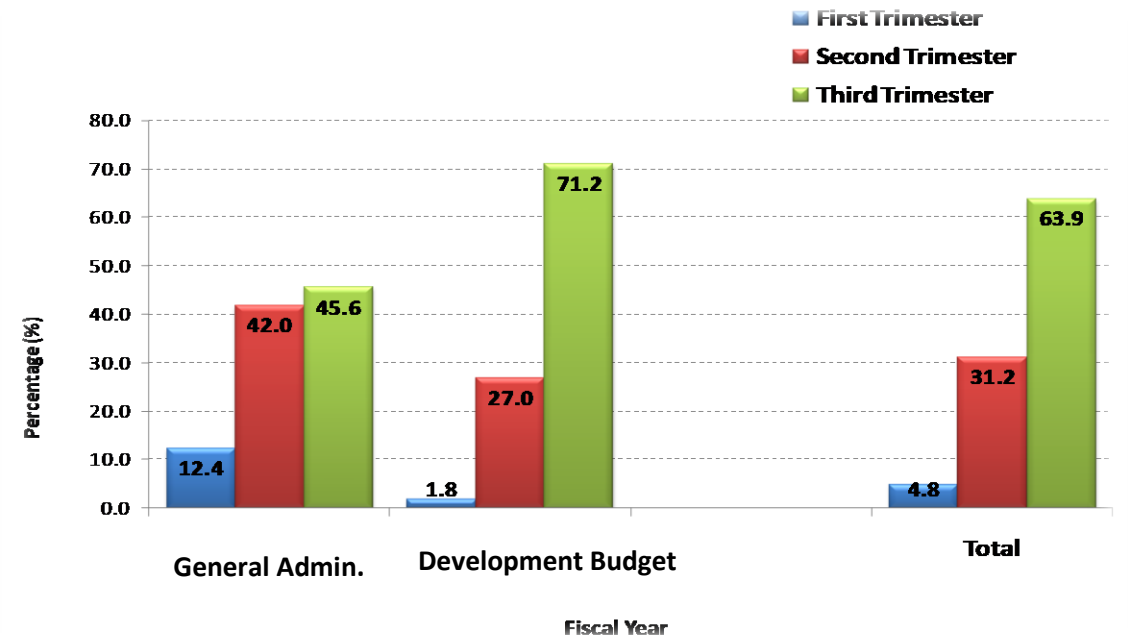
Source: MoHP, 2011

The overall budget absorption capacity of MoHP dropped by 13% with a decline of 16.5% in general administration and 11% in development programmes. The delayed budget approval from the parliament has caused the low absorption rate in FY 2010/11.

3.9 Trimester-wise Budget Spending

Almost two thirds (64%) of the annual budget was spent during the third trimester in FY 2010/11.

Figure 2: Trimester-wise Budget Spending



Source: MoHP, 2011

Notably, only 1.8 percent of the total budget was spent in the first trimester for development budget and 12.4 percent for general administration. Similarly, only 27.0 percent was spent on second trimester for development programmes while 42.0 percent was recorded for general administration.

3.10 Treasury Single Account (TSA)

The Treasury Single Account (TSA) is recommended by IMF in its Dec 2009 study report, and GoN took the decision to implement TSA in January 2010. In this system, governments' transactions are carried out through a single or limited set of bank accounts. The unified structure of the bank accounts gives a consolidated view of government cash resources at any given time and government monitors all its receipts and payments for cash management. Under the leadership of the Financial Comptroller General's Office (FCGO), TSA is being implemented at 38 District Treasury Comptroller's Offices (DTCO). Following are the major attributes of TSA:

- Treasury Accounts reside only at the Central bank
- Zero-balance single accounts at commercial banks for payments in place of multiple accounts
- Single cheque issuing agency in place of multiple cheques issuing agencies
- Zero-balanced single accounts for revenue collection at commercial banks

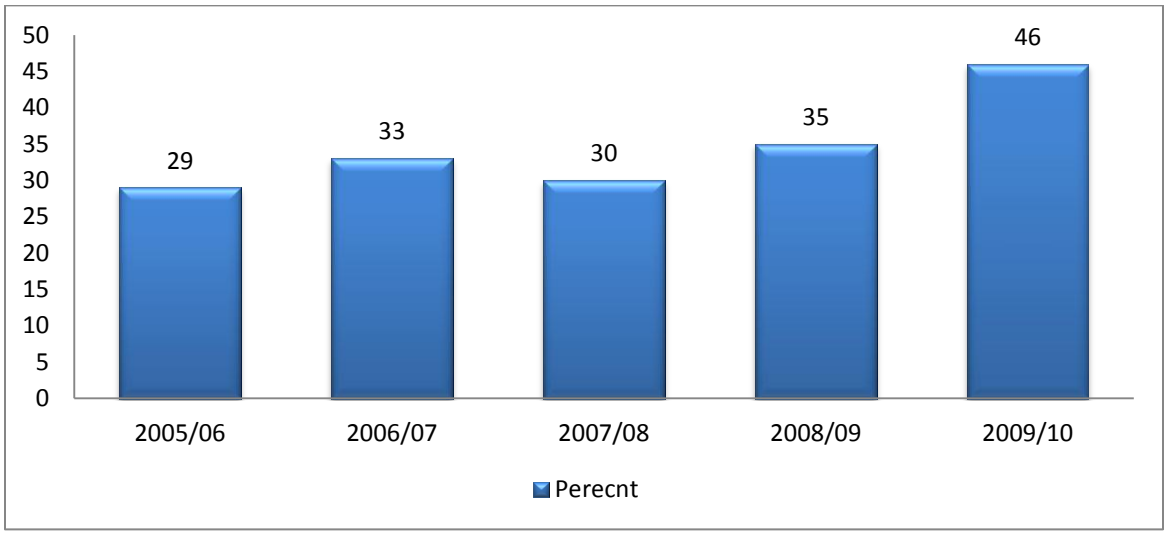
- End-of-day Settlement: all the balances of government accounts with commercial banks are brought to single treasury A/c in NRB at the end of the day.

The major contributions of TSA in the health sector have yet to be analysed systematically. However, TSA has contributed to addressing the issues related to idle cash balances in accounts, delays in financial reporting, no cash planning and forecasting, and no accurate information about treasury balances.

3.11 Increase in Clearance of Irregularities

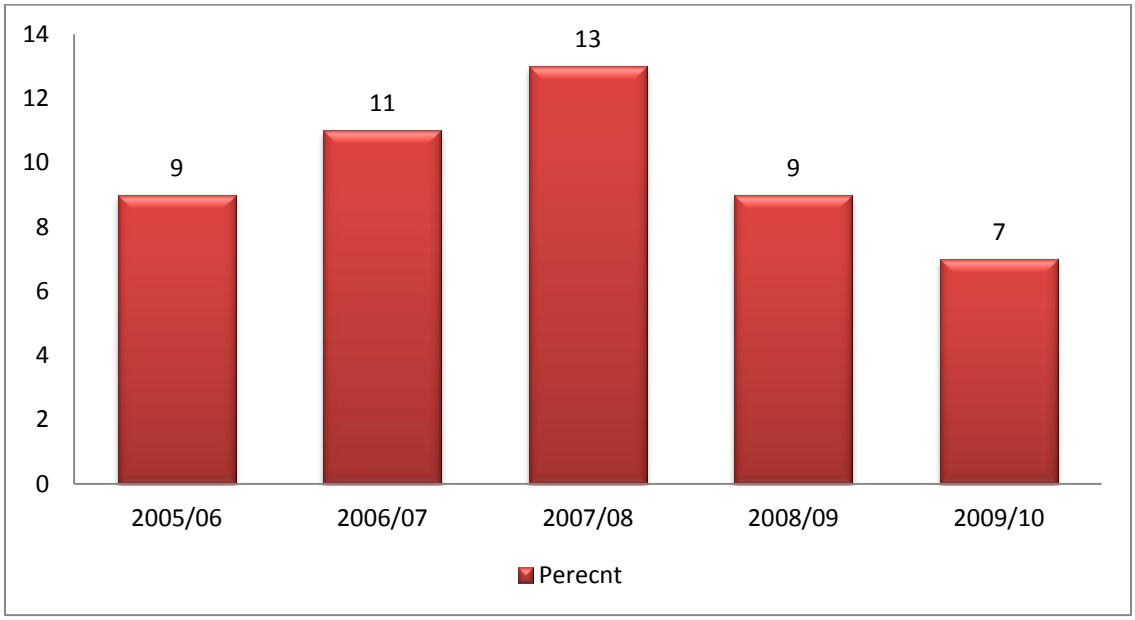
There has been a significant improvement in reducing the number of audit queries and improving the process of clearing those queries. However, a high level commitment is required to prevent the irregularities and ensure timely clearance. The broader nature of audit queries can be classified as non-compliance with legal provisions, weak internal financial control system and weak budget implementation. The current cumulative amount of total irregularity reported by OAG is NRs. 2,376 million; out of that 46% of the irregularities have been cleared up by MoHP. This progress has been appreciated by GoN's committee under the leadership of the Chief Secretary. The committee has listed MoHP as an excellent performer in clearing up the audit irregularities (***see the letter in annex1***).

Figure 3: Trends in Clearance of Irregularities



Furthermore, it is important to note that the proportion of irregularities against the total audited expenditure has decreased in fiscal year 2009/10.

Figure 4: Proportion of Irregularities against the Audited Expenditures



The proportion of irregularities against the audited expenditures has decreased from 9% in 2008/09 to 7% in 2009/10. The decreasing trend of irregularities and increasing clearance of irregularities demonstrates that the MoHP has made good progress in financial management.

3.12 Audit Observations and their Responses

OAG conducts the compulsory final audit of all the cost centres under the MoHP. It also conducts the performance audit randomly. This makes it more challenging for MoHP to mention all the queries and their responses to this brief report. It is important to note that MoHP has given a high priority to responding to the audit queries. Following are the highlights of the OAG's report:

- First highlight was on the audit irregularities which involve non-compliance with laws or improper use of funds/assets and are required to be regularised or recovered. This type of audit observation is system-related, requiring the responses from authorities at different levels.
- Second highlight was on the audit recommendations made by the OAG on observations and irregularities for regularising or for avoiding future repetition of the audit findings. MoHP through its audit committee acted promptly on the OAG's report and instructed all the cost centres to prepare the responses with evidence as stipulated in financial rules and regulations.

Table 1 below lists the major audit observations mentioned in the OAG's report and their responses.

Table 1: Audit Observations and Responses

S.N.	Audit Observations	Actions taken
1.	Following expenses as indicated in the NHSP financial statements have not been audited due to non-submission of books of accounts: 1.1 Child Health Programme NRs.72.82 million (funded by non-pooled partners: SCF USA, Care Nepal, JICA, Plan International) 1.2 Village Health Development NRs.68.19 million (Switzerland) Program, Dolkha and Ramechhap	-This is a broader PFM issue which been recommended by OAG in previous audit reports also. It is learnt that the international agencies listed in audit observation have their own institutional mandates for the final audit. In order to address this issue MoHP requires support from MoF and respective EDPs - However, MoHP has instructed DoHS to submit the response to the respective audit observations -DoHS has already submitted audit response to OAG
2	The Auditors have categorically stressed that all expenditures incurred under the budgetary allocation should come under the purview of the Office of the Auditor General	- MoHP agrees with this observation and instructed DoHS and other cost centres to comply with this observation - In order to address this issue MoHP requires support from EDPs
3	The Auditors have also qualified that the conditional grants amounting to Rs.97.69 million disbursed to the following six health institutions need to be audited: -70-3/4-305 Nepal Eye Hospital (NRs.26.00 million) -Bhaktapur Cancer Hospital (NRs.4.00 million) -70-3/4-336 Suresh Wagle MCC (NRs.10.50 million) -National Kidney Centre (NRs.14.69 million) -70-4-762 BP Koirala Lions Eye Study Centre (NRs.7.50 million) -70-3-763 Nepal Netra Jyoti Sangh (NRs.35.00 million)	- In the case of Suresh Wagle MCC and BP Koirala Lions Eye Study Centre, Tribhuvan University conducts internal audit and OAG conducts final audit. The internal audits have not been completed in both centres, causing problems in conducting final audit However, OAG has recently completed audit of BP Koirala Lions Eye Study Centre and Suresh Wagle MCC is currently preparing for final audit -For the other 4 hospitals, they have submitted the final audit reports conducted by independent auditors and submitted to MoHP. MoHP has sent the request letters dated 21/12/2011 to OAG for supplementary audit
4	Assets centrally purchased by the Logistics Management Division not being registered in the asset register of the recipient offices	-MoHP has instructed LMD to comply with this audit observation - LMD has sent instructional letters to all the cost centres

S.N.	Audit Observations	Actions taken
5	Concern about non-compliance with the procurement law. It is reported that 49 offices procured without preparing the procurement plan, when the law requires procurement should be included in the plan if it is more than Rs.1 million. Further, it has reported that DoHS and 62 Health Offices procured medicines and equipment worth Rs.236.24 million without any competition	-MoHP is committed to implement the GoN's rules and regulations. It has also instructed DoHS and concerned authorities to strictly follow the public procurement act and regulation - DoHS has instructed to all the cost centres that it will not release the further fund if the concerned cost centres fails to comply with the act and regulation
6	Evidence of expenses of funds received from various development partners (WHO, UNICEF and USAID) for polio vaccine campaign were not found to have been submitted for audit	-This observation is directly related to the direct funding from development partners. As mentioned in number one, MoHP requires support from MoF and concerned EDPs -The response to this observation has been submitted to OAG on 22/03/2011
7	The Auditors have raised concerns about more payments made than the approved rates. Various examples of such cases were cited in case of DHOs in Gulmi, Mahottari, Bajhang, Parsa, Rautahat, and Dhanusha for various purposes and programs	-MoHP is committed to implement the provisions made in the respective directives. In this context, MoHP has instructed DoHS to strictly implement the policy directives. MoHP has also instructed DoHS to provide necessary suggestions to take the actions in the case of any unjustifiable additional payments -MoHP has instructed DoHS to improve the financial monitoring systems at all cost centres

4. Major Challenges

Ministry of Health and Population (MoHP) has made a significant improvement in financial management. However, a number of challenges still need to be resolved:

4.1 Policy Level Challenge

MoHP is currently having technical discussions to address the concerns related to updating the website, disclosure of financial expenditures and documentation systems. Key policy level issues to be addressed are the practice of direct budget execution by some EDPs, weak forecasting of external assistance and separate reports and audits from EDPs.

4.2 Challenge related to Budget Preparation

A fundamental issue is that the budget preparation process is not sufficiently coordinated with the planning processes. The involvement of the finance section during the budget preparation

process needs to be further strengthened. Moreover, MoHP faces particular problems in forecasting amounts of foreign aid, which causes difficulties in preparation of a budget that includes external resources.

4.3 Challenge Related to Budget Execution

Delayed approval of budget was the major challenge for the proper execution of health budget. This delay also directly contributed to some cost centres violating the financial rules and regulations, specifically for the procurement. There are around 1,800 activities defined at DoHS level and around 500 for each district. The preparation and consolidation of performance information on all these activities requires considerable time and effort. The issue is exacerbated by lack of a technology based system for recording and monitoring these activities at the spending units. Additionally, under decentralised mechanisms the funds are routed to spending units through the DDC, creating another layer in fund flow.

4.4 Challenge Related to Accounting

The accounts of MoHP and its cost centres are maintained by FCGO/DTCO. The monthly process of reconciliation of accounts between FCGO/DTCO's reports and the records maintained by cost centres is generally late and some key expenditure information, especially the expenditures by programme activities, is not captured adequately.

4.5 Auditing

The Ministry of Finance has highlighted weaknesses in internal control mechanisms and requested FCGO to take steps to improve the situation. The devolution process does not require DTCO to conduct internal audits for devolved districts, recommending instead internal audit by independent auditors, copied to the DTCO. The DoHS does not have sufficient staff capacity to follow up a large number of internal audits and external audits on a timely basis.

4.6 Recording and Reporting and Monitoring

All cost centres do not send timely budget vs. actual expenditure to MoHP/DoHS. Also MoHP does not have any technology based solution to compile/consolidate budget vs. actual expenditure reports. FCGO provides budget vs. actual reports on a periodic basis to MoHP. However, these reports are based on particular heads of accounts and are not broken down by programmes.

5. Way Forward

- Develop and implement the guidelines on internal control system and procurement by the hospitals; MoHP is planning this for the current fiscal year.
- Prepare the implementation mechanism of TABUCS, implement as a pilot in selected districts and prepare a plan for the scale up at national level.
- Upgrade the existing eAWPB and make the provision of analysing the procurement plan.
- Develop human resource capacity in the areas of financial management and strategic planning and use of technology based solutions. This will require investment in financial and human resources to enhance capacity.
- Develop a system/ culture of compliance and accountability to ensure rules and regulations are used.
- Design and implement evaluation mechanisms (Social and Performance Audits, Evaluation Reports).
- An interaction programme with OAG and Public Accounts Committee will be organised where MoHP will share the audit status of MoHP.
- Strengthen the existing audit committee through regular meetings. Discussions and decisions on the audit related queries must be timely. The response system needs to be strengthened at the cost centre level.
- MoHP will develop the financial monitoring indicators and implement the monitoring mechanism through the active participation of DoHS and RHD.

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Progress Report on

Performance with regard to Procurement

Report Prepared for
Joint Annual Review (JAR)
January, 2012

Government of Nepal (GON)
Ministry of Health and Population (MoHP)
Ram Shah Path, Kathmandu

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Executive Summary

Procurement of work and goods has been a major GAAP concern. The Logistics Management Division (LMD) had a more successful year than the last, with most of the procurement being achieved, and multi-year procurement and electronic bidding process being introduced. However, the procurement process should start even earlier and needs to include all sub-units within MoHP. Technical Assistance by the consultants has been useful but is still not adequate and has been in a more supervisory role than actual efficiency enhancement of Logistics Management Division. Procurement team and Biomedical Engineers are being trained from time to time for capacity building but as the pending work needs to be accomplished side by side, the time given is not sufficient.

Though Procurement is an important component of Logistics Management Division, many other areas like Forecasting of all the Health Commodities, Goods Storage / Cold Storage, Distribution up to the level of Districts and modernizing Logistics Management Information System by introducing Web-Based reporting from all the 75 districts has been a drastic improvement in the system.

As far as the storage is concerned, 54 district store buildings have been completed and the rest are in process. New construction is now being planned for the 30-year old Central Store. This will be constructed under the direct supervision of Logistics Management Division.

Considerable progress has been made in improving systems for infrastructure planning and management, which will support improved quality of health care services. Construction and maintenance planning and maintenance are more evidence based and timeliness of plans and completion of construction work is better. This year, 170 health facilities were planned, and selection of the construction sites was completed on time; they are in process for design and estimates. The total estimated cost for these projects is about US$33 million. A total of 561 construction projects are ongoing, at an estimated cost of around US$112 million. About 50% of these are expected to be completed by end of July 2012. Among these, 24 have been categorized as “bad projects”, with little or no progress achieved. Action has been taken in the form of sending or publishing notices to the contractors and progress has been reported from the districts.

Implementation of standard designs and integrated designs has already resulted in significant cost saving and improved service provision, and these benefits are expected to further increase in the future. The introduction of e-bidding has facilitated more efficient and transparent tendering. Improved site selection processes have eliminated many of the

problems previously created by inappropriate sites that are costly to develop and unsuitable in terms of access and service provision. Plans for updating and upgrading the comprehensive computer based Health Infrastructure Information System (HIIS), which maintains information on inventory and operational status of health buildings, are moving ahead. This will significantly increase its usefulness to planners, policy makers, EDPs, researchers and others, and will support decentralisation of planning.

Priorities for the immediate future are: (1) Completion of upgrading and updating of the HIIS; (2) Capacity building of HIIS staff and decentralisation of the system (3) Institutionalising the proposed planning cycle.

1. Background

1.1 Procurement

Concerning Issues of procurement, this report represents an updating of the progress that has been made since the last report in January 2011.

1.2 Infrastructure

In a context of substantial shortages of appropriate, quality infrastructure, good management of existing and new physical assets is a priority for the MoHP, in order to create an enabling and safe environment for provision of quality services and to ensure retention of human resources. GoN is working to institutionalise evidence based planning of construction, operation and maintenance of health infrastructures and to ensure effective management with efficient utilisation of resources that promotes equitable distribution and access to health care at all levels of health facility. Appropriate and clear policies, strategies, plans, standards and guidelines are being developed, combined with enhancement of the skills of implementers to enable them to take new developments forward effectively.

2. Objectives

2.1 Procurement

The objective of this annual account is to provide an update of the procurement issues that have been overcome and to report upon lessons learned and challenges to further improvement.

2.2 Infrastructure

The following objectives have been identified for work in this area:

- To support evidence based infrastructure planning and maintenance through strengthening, institutionalising and supporting decentralisation of the Health Infrastructure Information System (HIIS).
- To develop the capacity of technicians working at the Department of Urban Development and Building Construction (DUDBC) and its district offices to adopt standard designs of health facilities, and develop standard protocols to increase quality, accountability and transparency in the construction process.

3. Progress and Achievements

3.1 Procurement

Draft Procurement Plan was organised by meeting all Divisions within DoHS and pooling their requirements. A consolidated plan was submitted to the World Bank on 22 September. This is a considerable change from last year because it was done by an external technical assistant. It was not matched with the usual systems and caused much delay and the plan has not been approved yet. However, the World Bank has allowed us to go on with the procurement process while it is being planned. Multiyear procurement has already started for many important commodities and soon Electronic Bid Submission will be in place too. Infrastructure like Server Installation and broadband connections have already been completed. Service Procurement has been started from this year and five contracts were awarded for the HIV/AIDS programme. Next year, we intend to widen the process to encompass *all* organs within MoHP and start the process in January 2012 so that a draft plan is ready to be dovetailed into the AWPB when it has its first meeting in March. If this goes to design, we should have achieved for the first time a Procurement Plan approved by the World Bank *before* the beginning of the next FY (2012-2013).

3.1.1 Goods

A total of 19 contracts were let during this period.

Multi-annual procurement has been improved with a further two contracts being signed for 3-years for Oral Contraceptive Pills and Injectables.

Those that have been let are:

i. **Oral Contraceptive Pills**
ii. **EPI and Other Vaccines**
iii. **SMNH Equipment**
iv. **EDS for Primary Health Services**
v. **Cold Storage and Cold Chain Equipment, Generators etc.**
vi. **Male Condoms**
vii. **Injectables DMPA**
viii. **Drugs and Medical Consumables**
ix. **Fortified Flour**
x. **Contraceptive Implants – 3-&5-year efficacy**
xi. **Computer Server & Firewall**
xii. **AD & Reconstitution Syringes and Intra Uterine Devices (IUD)**
xiii. **Insecticides**
xiv. **Printed Materials**

xv. **DEC Tablets**
xvi. **Test Kits for: Kala-Azar, Dengue Fever, and Chemicals for Cell Culture and Vaccine Production**
xvii. **Kits for: Vasectomy, Minilap, IUD, Implants, OT Tables and Lamps, and other hospital equipment**
xviii. **Office Electronic Equipment**
xix. **Office Furniture**

The following were unsuccessful or not yet completed:

i. Vehicles. This procurement failed as, due to the late provision of the budget in 2010, the time ran out to complete the purchase. LMD has requested funding from the Ministry of Finance but, as of writing, that has not been forthcoming. Efforts are being made for the budget.
ii. Medicine for Epidemic and Natural Disaster Control. This was cancelled due to non responsive bids. It has been included in the Procurement Plan for 2011-2012.

Procurements already launched for 2011-2012:

i. EPI Vaccines, Other Vaccines, Syringes and Safety Boxes
ii. Medical and Non-Medical Equipment
iii. Fortified Flour
iv. Tablets for Topical Usage, Medicines and Surgical Goods
v. Male Condoms
vi. IUD and Lubricant Gel and Condoms (these are to be transferred)

Procurements in preparation:

i. Medical Equipment for Birthing Centres, CEOC, BEOC
ii. Refrigeration Goods etc.
iii. Insecticides
iv. Printing Materials
v. EDCD/LCD/CHD Medicines
vi. Office Accessories

3.1.2 Service Procurement.

Of the original six Consultants' Services for the provision of NGOs to conduct HIV/AIDS Tech Assistance to the Most at Risk Populations (MARPs) five NGOs have been contracted. The sixth – for Female Sex Workers – was annulled at the request

of the World Bank to avoid duplication as the intervention was already being conducted by USAID. The five signed contracts were for:

i. Men who have Sex with Men/Male Sex Workers/Third Gender
ii. Prisoners
iii. Migrants and their families
iv. Injecting Drug Users
v. People Living with HIV

The following have been launched:

Consultant Services for CB-NCP Training has been launched and Pre- Shipment Inspection and Laboratory Testing are in preparation.

3. 2. Infrastructure

Progress has been made in many areas.

3.2.1 Improved Timeliness of New Project Planning

This year, 170 health facilities were planned and selection of the construction sites was completed on time, in July, an encouraging improvement on previous years. Further improvements in the planning process are expected in the near future, based on a proposed planning calendar, which will expedite the survey and estimation process and preparation of procurement plans, and support use of more realistic figures. Details of the various facilities planned for this fiscal year are shown in Table 1 below. The total estimated cost for these projects is about US$33 million (dollar conversion based on exchange rate at the time of bid preparation).

All the projects planned this year are below the threshold for international competitive bidding and below the threshold for prior review by World Bank. DUDBC sent the procurement plan to World Bank for review, following which it was revised and is now being prepared for dispatch. It took little longer to prepare the revised plan, due to problems in compiling old records and documents.

All the planned projects for the year are in process for design and estimate, and some have already gone for tendering through the National Competitive Bidding (NCB) process, established under the Public Procurement Act. Standard Bidding Documents, revised last year by WB and DUDBC with support from NHSSP, are being used for the process and are being prepared for publishing. This will provide separate bidding documents and guidelines

with a checklist for the data required, making the process easier for district technical staff to manage the tendering process at district level.

Table 1: Infrastructures Planned in Fiscal year 2011/12

SN	Type of Facilities	Nos	Budget Head
1	One unit doctor's quarter building	11	70-4-855
2	Two-staff quarter building	1	70-4-855
3	Four-staff quarter building	13	70-4-855
4	BEOC	9	70-4-855
5	Birthing Centre	24	70-4-855
6	Health Post	80	70-4-855
7	Store Building	10	70-4-855
8	PHCC building	10	70-4-855
9	PHO	10	70-4-855
10	Quarter for regional health directorate	1	70-4-620
11	Bldg. const. Naradevi Ayurvedic Pharmacy	1	70-4-756
	Total	170	

3.2.2 Ongoing Projects: Accelerating Progress

A total of 561 construction projects are ongoing, at an estimated cost of around US$112 million. Of these, 14 are ayurveda related constructions and the rest are regular health facilities. Table 2 below shows the numbers and costs for each type of ongoing facility construction.

Table 2: Number and Estimated Cost for Different Types of Ongoing Construction

SN	Type of Facilities	Nos	Budget in US$ in million	Budget Head
1	Ayurveda	14	1.4	70-4-756
2	ANM quarter in health post	3	0.1	70-4-858
3	BEOC in PHCC	15	1.5	70-4-858
4	CEOC in district hospital	11	1.283	70-4-858
5	Doctor's quarter building	22	1.83	70-4-858
6	Health post	170	32.247	70-4-858
7	Hospital building	27	25.51	70-4-858

8	Hospital new block construction	7	4.84	70-4-858
9	Hospital expansion and repair and maintenance	1	0.5197	70-4-858
10	Birthing centres	46	2.0572	70-4-858
11	Health Post reconstruction	1	0.0209	70-4-858
12	District store building	9	0.085	70-4-858
13	Post mortem building	3	0.0392	70-4-858
14	PHCC building	64	23.74	70-4-858
15	District public health office	17	5.14	70-4-858
16	Staff quarter building (7 numbers four family quarter in District Hospital and 4 numbers 2 family in PHCC)	11	0.79	70-4-858
17	Health post building for upgraded sub health posts.	136	9.07	70-4-858
18	Children's hospital in Lahan	1	1.11	70-4-768
19	Miscellaneous building	1	0.83	
	Total	**542**	**112.112**	

Some of the ongoing projects date back to the base year, 2005/06 (61/62), and it was observed during analysis of the ongoing projects that about 26 of these need special attention. DUDBC has contacted the contractors and actions have been initiated to expedite construction. A list of these "chronic projects" includes examples such as Bardibas District Hospital and Golbazaar Birthing Centre, neither of which even has the land for construction yet, as the land provided by the concerned authority and community turned out to be disputed. Twenty four constructions have been categorised as "bad projects" and action has been taken in the form of sending or publishing notices to contractors. Some of the contractors have also been fined. This has yielded results and progress has now been reported from the districts.

DUDBC is working to reduce the numbers of chronic and bad projects, and out of the 561 ongoing projects, about 50% are expected to be completed by end of July 2012.

Six of the ongoing projects are above the threshold for international competitive bidding and subject to prior review, as specified by the Joint Financing Agreement. Details for these projects are still being worked out, but as soon as the detailed bid documents are ready they will be sent to World Bank for review and "no objection for tendering". The projects subject to prior review are:

- Construction of children's hospital in Lahan
- Hospital block construction in Dhaulagiri Zonal Hospital
- Building block construction in Burtibang District Hospital
- Bajura District Hospital construction
- Kapilvastu District Hospital construction
- Bhojpur District Hospital construction

3.2.3 Progress Towards Reducing Construction, Management and Maintenance Costs

The implementation of standard designs is significantly reducing both direct and indirect costs. Previously, different buildings for health posts, PHCCs and district hospitals were often planned and constructed at different times, based on demand and available resources, with each building having its own support services, such as water, electricity etc. This resulted in very high overall construction costs, with further implications for repair and maintenance costs. On some older sites, where buildings were located in an ad hoc way, poor linkages between different units mean higher service provision costs, and service provision may be so difficult that buildings are not used, leaving huge investments lying idle. The current practice of integrating all units into a single design has led to considerable cost savings. Similarly, bidding costs are reduced by having a single tender instead of several.

Cost saving is achieved in a number of ways:

- Properly designed centralised services reduce the need for expensive and scarce land. Space is appropriately planned, and designed to accommodate future expansion. Economies of scale are gained in transport, establishing the construction site, supervision, monitoring and the cost of tools and machinery.
- Construction work is faster and cheaper with an integrated design because there is a single plinth area and less foundation work. The cost of construction will also be reduced over time, as the technicians learn the standard construction techniques, many of which can be replicated in similar conditions.
- Small projects mean small contracts, with smaller, less experienced contractors, often associated with poor quality work and more expensive construction. For a larger integrated construction, an 'A' level contractor or even an International Competitive Bidder can be obtained, with better experience, technology and skills available, resulting in better building quality and skill transfer, and economies of scale.

- Support service costs are reduced since the same support service is used by all units. A single septic tank, retaining walls and service road can serve for all, with a huge saving in land development and support services.
- Under the latest integrated design, the entire administration can be handled by a smaller central unit, a saving in the cost of everyday management, regular maintenance and repair work. These designs support both horizontal and vertical development, allowing for future expansion using the same service units.
- Since all the new buildings conform to the National Building Code regarding seismic design, electrical and sanitary work, the quality is improved, with more resistance to natural calamities, and extension of the productive life of the building.
- The well designed unit linkages of a standard integrated design promote efficient movement for facility staff, so that a smaller staff can achieve more work in the same time. Each unit, including accommodation, is designed to create an enabling environment for staff, with user-friendly fittings and fixtures that promote easy building management, resulting in increased productivity.

3.2.4 Promotion of Better Quality Services

Units have been designed for easy flow of patients and service providers, reducing crowding and supporting quality service delivery. This will reduce pressure on service providers and stress for patients. Multi-purpose rooms have been provided to accommodate additional caseloads that may occur during epidemics and enabling the hospital to expand its services within the existing building. With different services available within a single unit, both patient and staff time are saved and clients and providers feel more satisfied with the service.

The passage of “dirty out and clean in” has been considered, with separate flows designed for each purpose. Properly used, this will greatly reduce infection rates, which is a problem even in the best private facilities in Nepal, mainly due to poor design. Appropriate finishing for floors and walls enables proper cleaning and prevents bacterial accumulation. The flooring is resistant to damage by cleaning agents, saving on repair and maintenance costs.

3.2.5 E-Bidding as an Efficient Monitoring Tool

The e-bidding system established at DUDBC has enhanced the capacity to monitor progress and quality in the bidding process in many ways:

- Bidding irregularities were identified and addressed, for example construction which should have been ICB was found to be have been published under NCB and immediately stopped.

- Six tenders were found to be constructions that had not been not formally authorised by Management Division, and this was settled.
- Deviations from the agreed Standard Bidding Document were observed in bidding documents published by some divisions, and deviations were found in the drawings published with the bids. DUDBC has been informed of this and asked to correct it.
- E-bidding has eliminated the risk of cartelling during bidding, to bar other bidders from participating. The overall impact in terms of monetary benefit will be assessed after bidding for this fiscal year is complete.

3.2.6 Improved Site Selection and Land Development Process

Site selection, site layout and estimation are important initial stages of construction. Previous practices sometimes resulted in high development costs and selection of sites with poor accessibility and/or located far from the community served and even the service providers' residences. DUDBC now reviews, and in many cases rejects altogether, any site development that will cost above 10% of the building construction cost. This saves money that might otherwise be wasted on inappropriate sites. Proper layout has also tremendously decreased the costs of land development. For example, almost NRs.10 million was saved on land development costs for the health post at Khaula Lakuri in Parbat. Cancellation or moving of a construction on the basis of inappropriate site gives a clear message, usually resulting in local people providing a better site. This policy is clearly stated in the draft standard guidelines and will replace the previous policy of constructing buildings only on donated land, which is often located away from the community or market centres and therefore of low value. We believe that considerable money has been saved in land development costs during this year, and this requires further study for more accurate assessment.

3.2.7 Development of the Health Infrastructure Information System

The Health Infrastructure Information System (HIIS) is a comprehensive computer based system which maintains information on inventory and operational status of health buildings (those used for services and management functions), enabling their proper maintenance and management for better health care service delivery. Data is supplemented by building image files and building plan diagrams, allowing electronic visual assessment of the state of buildings and their maintenance and reconstruction requirements.

To cater for the needs of planners, policy makers, EDPs, researchers and others, and to support decentralisation, it has been agreed that the system should be updated, upgraded and made GIS based, to incorporate linkages to other planning features and ultimately make

it web-based. Terms of reference have been prepared and are in process for approval. Updating has been planned and initiated as follows:

a) Revision of data survey questionnaire to provide more detail
b) Identification of additional requirements for data collection and maintenance, including:
    - Building status (planned, under contract, under construction/reconstruction etc)
    - Ownership status (rented, own building)
    - Continuous data maintenance (in addition to annual survey data maintenance)
    - Defining and implementing standard codes for institution type, building type, purpose
    - Costs (estimations by field engineers, planners, budget allocated and spent)
c) Upgrading of software to meet needs for planning, budgeting, policy development and GIS linkage
d) Inclusion of data for the final two districts (73 of the 75 already included and operational)
e) Incorporation of standard designs that can be compared with the existing actual design
f) Updating of budgets, plans and photographs for recently completed building work with a system for DUDBC to continue updating themselves
g) Addition of all data on upgrading work for the last five years (eg SHPs to health posts, health posts to PHCCs and PHCCs to hospitals)
h) Addition of spatial planning dimensions (eg road connections, transport issues, relevant details of geographical terrain, settlement patterns such as market centres, service availability, catchment area, proximity of other health facilities) to enable analysis of location suitability
i) Upgrading so that the system can hold all the information and dimensions required to declare a building functional, based on comparison with the standard designs
j) Space to incorporate information on equipment for each facility and flexibility to be linked with human resource or other information systems within MoHP
k) Inclusion of formats for procurement plans and progress reporting that can be regularly updated online by the central and divisional offices of DUDBC, thus improving accuracy and saving time spent on preparation, compilation and updating of procurement plans, which is currently all done at central level
l) Making the system GIS based and easily linked with the Health Facility Atlas
m) Standardising building identities in coordination with relevant sectoral agencies (such as High Level Commission for Information and Technology and HMIS section of Management Division).

4 Lessons Learned

4.1 Procurement

- Procurement planning process need to start earlier for the next cycle so that there is enough time to think rather than to make mistakes and untimely corrections.
- For every procurement, whether it be Goods, Services or Work it has become clear that one or more of the unsuccessful bidders will go to court to stall the process. This involves delay and takes considerable effort from the purchaser to go ahead. This practice is a teaching / learning process for the supplier and purchaser.
- Widening the competition has been very difficult. Six international well respected Suppliers were contacted and asked why they were not found to be bidding. All replied that they are unable to compete on price with Suppliers from the Sub-Continent, and that their commodities were invariably of superior quality to those on offer. This will always prove true as long as there is compulsion to buy the cheapest Goods rather than looking at a combination of quality and price.

4.2 Infrastructure

- Before a site is selected, proper scientific land assessment, based on evidence and proven standard practices, saves time and money at all later stages of construction, and results in a better end product.
- Timely selection of sites and proper cost estimates carried out before the AWPB is developed helps ensure the procurement plan is prepared on time.
- Proper need assessments and review of the availability of resources according to spatial conditions should be carried out before estimates and designs are finalised. All stakeholders should be involved in the need assessment.

5 Major Challenges

5.1 Procurement

- District level procurement is a major concern. The procurement training to the District Officers, Accountants and Storekeepers are being conducted by LMD to improve the efficiency.
- It has been learnt that because of the multi-natured goods procurement it is not possible to accomplish the procurement with one or two specialist or experts only so there should be provision to hire experts as required while training to the existing staff go side by side.

5.2 Infrastructure

- Completing projects on time and avoiding extensions can be difficult, especially in Tarai areas, where the political and security situation is unpredictable. While every effort is

made to deal strictly with contractors when delays occur, local pressures do cause very real problems.

- Efforts are ongoing to establish and institutionalise a proper record keeping system within DUDBC, with a pool of people who fully understand procurement plan preparation and the needs of World Bank, MoHP and other donors.
- It can be challenging to monitor different sites and keep paper work in good order with scattered cost centres and sites, sometimes in difficult terrain where transport is minimal.
- Slow progress or no progress in construction is mainly due to factors such as:
    - Land dispute or no land
    - Dispute with the contractor due to conflict about use of specified materials or quality or non-availability of certain materials
    - Safety and security issues

6 Way Forward

6.1 Procurement

With full cooperation from the External Development Partners LMD would definitely be able to achieve its objectives but the extent and scope of assistance & partnership needs to be reassessed and discussed.

6.2 Infrastructure

Priorities for the immediate future are:

- Upgrading and updating of the HIIS
- Capacity building of HIIS staff and decentralisation of the system
- Institutionalising the proposed planning cycle
- Building capacity of DUDBC in planning health infrastructure, including training staff to use the standard designs.

Highlights of Major Health Related Research and Studies Carried out in 2011 in Nepal

Report Prepared for Joint Annual Review (JAR)

January, 2012

Government of Nepal (GON)
Ministry of Health and Population (MoHP)
Ramshahpath, Kathmandu

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1. Background

The health system in Nepal is dramatically changed from what it was a few decades ago. The change in political system, technological improvement, increased urbanisation and connectivity, change in the development process, enhanced access to information and services, and the promotion of equity and social inclusion, among many other changes have shaped a new reality in the country. These and other factors, in one way or another, have profoundly impacted on the epidemiological and health seeking behaviour patterns of the people. As a result, new and unique opportunities as well new challenges are now arising. Facing this new reality calls for rethinking the concept of government roles and public policy. It is time for innovation, for building new decision making capabilities, and for consolidating and ensuring stability and the effective operation of our health policy. With rising expectations and demand for health services, the responsibility of the government in providing an efficient and purposeful health system, covering all aspects including protecting economically and socially vulnerable groups, combating poverty, ensuring universal coverage or social health protection, promoting equity, mobilising financial and human resources, protecting against catastrophic payments and so on has considerably increased. We should not underestimate the significance of those challenges, which place a premium on enhancing the efficiency and productivity of the country.

1.1. Objectives and Methods

The objective of this report is to assemble the findings from various health research reports, articles published and studies conducted in 2011 to facilitate the policy makers to use this evidence for policy purposes. This is not a systematic review, and does not validate nor ensure the relevance of the design, or advocate the health policy, but is just a collecting and highlighting of evidence from various sources available to the researcher in the given time. The research reports were collected through email communications, visit to the research institutions/organisations, collection from the library of Nepal Health Research Council, and web searching of the research institutions in December 2011. All research reports, articles published or studies carried out in 2011 that were available or accessible by the researcher within the given time are included in this study. The main findings of the reports and articles are

summarised in this report and the evidence is categorised into different groups that are relevant to existing major health policies for Nepal.

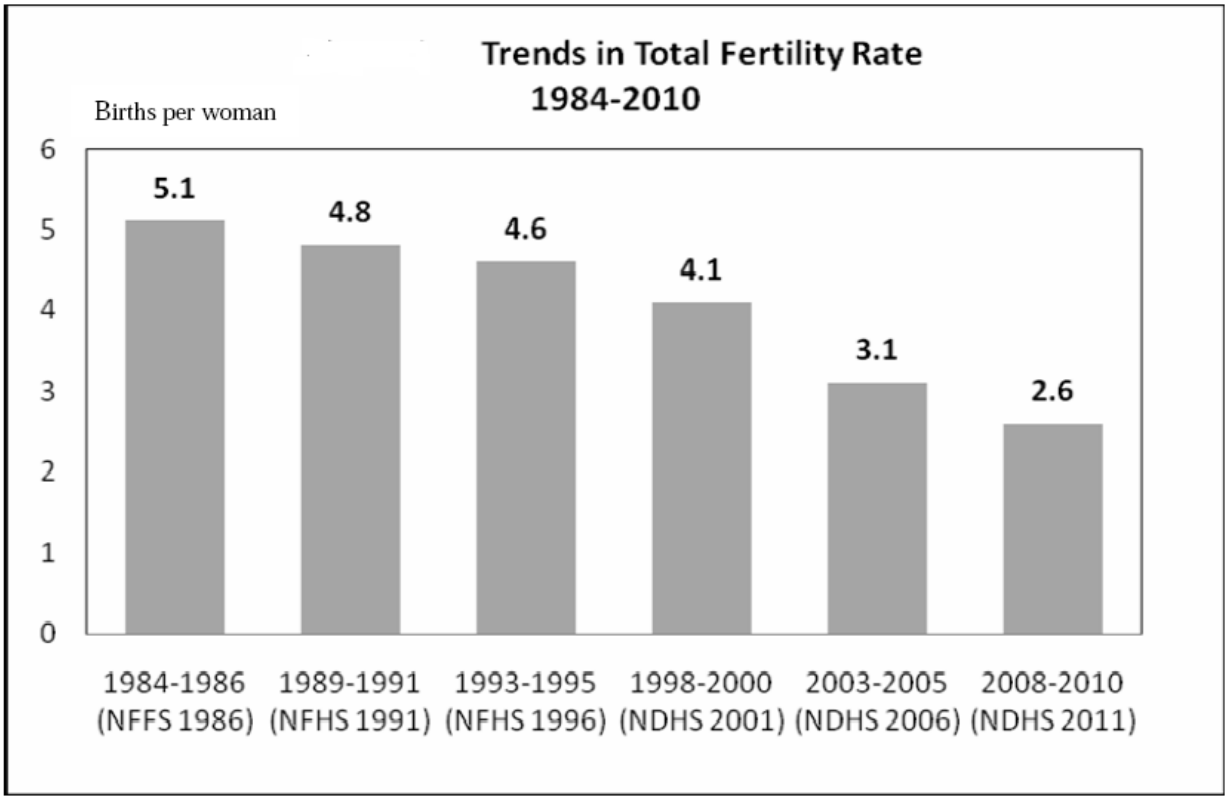
2. Analysis

2.1 Nepal Demographic and Health Survey (2011 NDHS)

2.1.1 Total Fertility Rate

According to the preliminary results of the Nepal Demographic and Health Survey (NDHS) 2011, the Total Fertility Rate (TFR) calculated for the three years preceding the survey is 2.6 births per woman age 15-49. Urban-rural differentials in Nepal are obvious, with rural women (2.8 births) having an average of over one child more than urban women (1.6 births). The overall age pattern of fertility as reflected in the age specific fertility rates (ASFR) indicates that childbearing begins early. Fertility is low among adolescents and increases to a peak of 187 births per 1,000 among women age 20-24 and then decreases thereafter. A comparison of the three-year rate shows that fertility has declined over the last two decades from 5.1 children per woman during the period 1984-1986 to 2.6 during the period 2008- 2010. The 2011 NDHS data show that fertility among rural and urban women has declined by half a child each from the levels reported in the 2006 NDHS.

Fig.1: Trends of TFR



Source: MOHP, New ERA and Macro International, (NDHS 2011)

The results suggested in Nepal over the past 15 years show that current use of modern contraception has increased from 26 percent in 1996 to 44 percent in 2006 and then declined slightly in 2011. There is a shift in the use of modern methods.

2.1.2 Vaccination Coverage

The 2011 NDHS also collected information on the coverage of vaccinations for all children under age five. Information on vaccination coverage was obtained in two ways—from health cards and from mothers' verbal report. Results show information on vaccination coverage for children 12-23 months, who should have been fully immunised against the major preventable childhood illnesses. Nearly nine in ten children (87 percent) were fully immunised and 96 percent of the children received BCG, DPT 1, and polio 1. The proportion of children receiving the third dose of DPT and polio is slightly lower (91 percent and 92 percent, respectively), as is the proportion receiving the measles vaccination (88 percent). There are only slight variations in children fully immunised by gender, residence, and ecological zones. Children in the Terai are less likely to be fully immunised than children in the other zones (84 percent compared with 88-89 percent) (Table 1).

Table 1: vaccination status

Percentage of children age 12-23 months who received specific vaccines at any time before the survey (according to a vaccination card or the mother's report), and percentage with a vaccination card, by background characteristics, Nepal 2011

Background characteristic	BCG	DPT 1	DPT 2	DPT 3	Polio 1	Polio 2	Polio 3	Measles	All basic vaccina-tions[2]	No vaccina-tions	Percentage with a vaccination card	Number of children
Sex												
Male	96.2	96.1	94.3	91.4	96.4	94.9	92.3	89.1	87.5	2.8	37.6	501
Female	96.2	96.6	94.7	91.3	96.7	94.8	92.0	86.3	85.7	3.0	30.2	499
Residence												
Urban	96.9	98.9	94.4	93.6	99.7	96.1	95.9	91.2	88.7	0.0	38.7	97
Rural	96.1	96.1	94.5	91.1	96.2	94.7	91.8	87.4	86.4	3.2	33.4	903
Ecological zone												
Mountain	93.7	93.7	90.4	90.4	94.3	91.1	91.1	90.9	88.2	4.3	25.9	75
Hill	96.3	96.5	95.4	93.4	96.3	95.7	93.5	90.4	89.5	3.2	35.1	402
Terai	96.4	96.6	94.4	89.9	97.0	94.7	91.3	85.3	84.1	2.5	34.1	523

Source: MOHP, New ERA and Macro International, (NDHS 2011)

2.1.3 Childhood mortality rates

Neonatal, post-neonatal, infant, child, and under-five mortality rates are shown in the results for cohorts of children born in three consecutive five-year periods before the survey. Under-five mortality for the most recent period (0-4 years before the survey or 2006–2010) is 54 deaths per 1,000 live births. This means that one in 19 children born in Nepal dies before their fifth birthday. Eighty-five percent of deaths among children under five occur during the first year of life: infant mortality is 46 deaths per 1,000 live births. During infancy, the risk of neonatal deaths and post-neonatal deaths is 33 and 13 deaths per 1,000 live births, respectively (table 2).

Table 2: Child mortality rate

Early childhood mortality rates

Neonatal, post-neonatal, infant, child, and under-five mortality rates for five-year periods preceding the survey, Nepal 2011

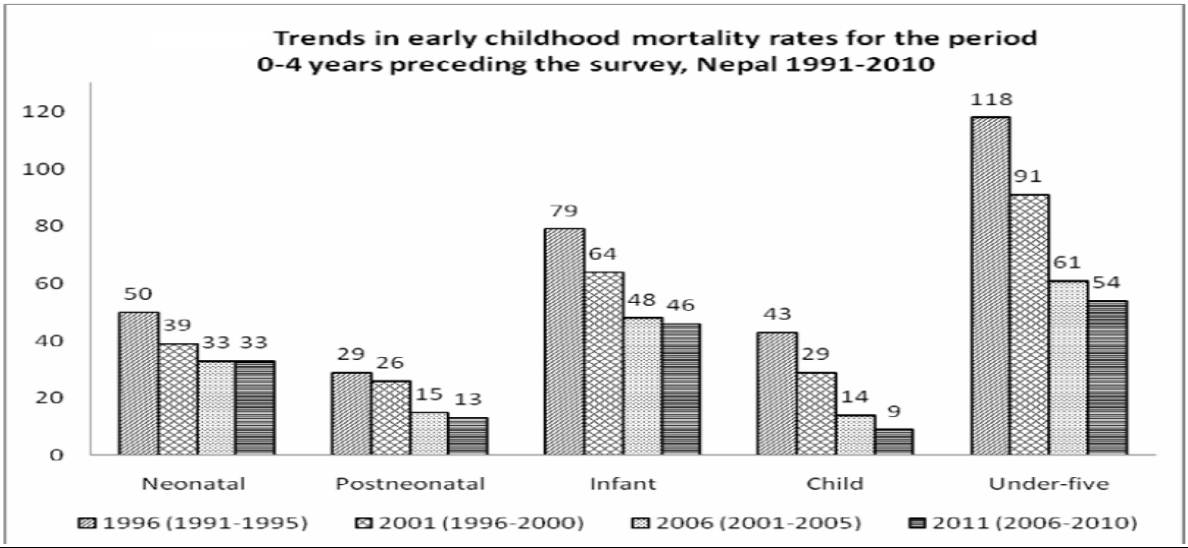
Years preceding the survey	Approximate calendar year	Neonatal mortality (NN)	Postneonatal mortality (PNN)[1]	Infant mortality (1q0)	Child mortality (4q1)	Under-five mortality (5q0)
0-4	2006-2010	33	13	46	9	54
5-9	2001-2005	37	23	60	10	70
10-14	1996-2000	45	25	70	19	87

[1] Computed as the difference between the infant and neonatal mortality rates

Source: MOHP, New ERA and Macro International, (NDHS 2011)

The survey indicates that while mortality has been declining in the past, the pace has slowed in the most recent years. For example, infant mortality declined from 79 per 1,000 live births during the period 1991-1995 to 64 per 1,000 live births during the period 1996-2000, and to 48 per 1,000 live births during the period 2001-2005, but only to 46 per 1,000 live births in the most recent five year period (2006-2010).

Fig 2: Trends in child mortality rates



Source: MOHP, New ERA and Macro International, (NDHS 2011)

2.1.4 Breastfeeding

The result shows that 88 percent of children less than two months of age are exclusively breastfed, but this percentage drops sharply at subsequent ages. Overall, 70 percent of children under six months are exclusively breastfed. This is a remarkable improvement since 2006, when only 53 percent of children of the same age were exclusively breastfed (Table 3 below).

In general, the nutritional status of children in Nepal has improved over the last decade. Fifty seven percent of children were stunted in 2001 compared with 41 percent in 2011 and 43 percent of children were underweight in 2001 compared with 29 percent in 2011. However, the proportion of children who are wasted declined only slightly from 13 percent in 2006 to 11 percent in 2011.

Table 3: Breastfeeding

Age in months	Not breast-feeding	Exclusively breastfed	Breastfeeding and consuming plain water only	Breastfeeding and consuming non-milk liquids[1]	Breastfeeding and consuming other milk	Breastfeeding and complementary foods	Total
	Percent distribution of youngest children under two living with their mother by breastfeeding status						
0-1	1.8	87.7	4.8	0.0	5.4	0.3	100.0
2-3	0.0	73.7	12.4	0.0	10.9	2.9	100.0
4-5	0.6	53.3	12.1	1.1	10.5	22.6	100.0
6-8	0.5	14.1	15.3	0.0	5.0	65.2	100.0
9-11	2.7	2.1	3.7	0.3	0.5	90.6	100.0
12-17	6.8	0.3	0.3	0.0	0.4	92.3	100.0
18-23	5.7	0.0	0.0	0.0	0.0	94.3	100.0
0-3	0.7	79.2	9.4	0.0	8.8	1.9	100.0
0-5	0.7	69.6	10.4	0.4	9.4	9.5	100.0
6-9	1.0	11.5	13.0	0.0	4.1	70.4	100.0
12-15	7.5	0.5	0.2	0.0	0.6	91.2	100.0
12-23	6.3	0.2	0.1	0.0	0.2	93.2	100.0
20-23	7.4	0.0	0.0	0.0	0.0	92.6	100.0

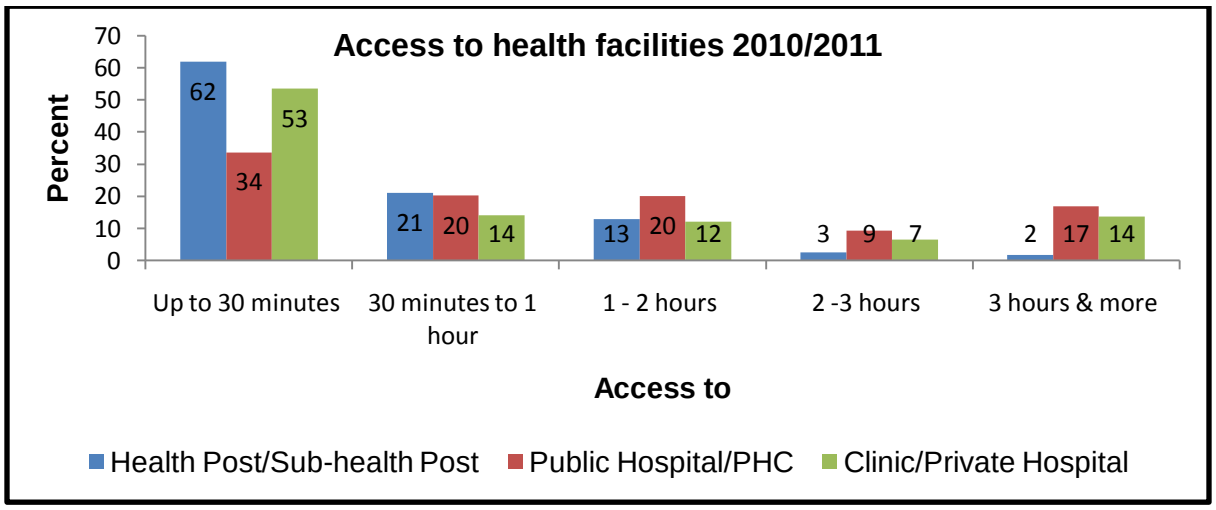
Source: MOHP, New ERA and Macro International, (NDHS 2011)

2.2 Third Nepal Living Standards Survey (NLSS III, 2010/2011)

2.2.1 Access to health facilities

Central Bureau of Statistics (CBS) carried out Nepal Living Standards Survey (NLSS III) and gathered data on Nepali households' access to health facilities. Households' access to a certain facility is measured in terms of time taken for one-way travel to that facility, irrespective of transport mode (foot or vehicle). The result suggests that about 62 percent of the households in the country are within 30 minutes reach to the nearest health post or sub health post. Moreover, 34 percent of households can reach hospitals or PHCC within 30 minutes.

Fig.3: Access to health facilities



Source: CBS, 2011 (NLSS III)

2.2.2 Childhood Immunisation status

About 64 percent of children between 13-59 months old are fully immunised. Gender gap is relatively small. The inequality in immunisation status by geographical regions and consumption quintiles are given in tables 4 and 5.

Table 4: Immunisation status by geographical regions

Percentage of Immunization status of children aged under five years

(Percent)

	Fully immunized			Partially immunized			Not immunized		
	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls	Total
Development Region									
Eastern	70.1	70.2	70.1	28.3	27.0	27.7	1.6	2.8	2.2
Central	62.6	58.7	60.7	34.7	38.0	36.3	2.7	3.3	3.0
Western	71.5	67.5	69.5	27.2	27.9	27.5	1.3	4.5	2.9
Mid West	67.9	66.5	67.2	31.0	31.8	31.4	1.1	1.7	1.4
Far West	43.3	51.2	47.0	52.4	41.5	47.3	4.3	7.3	5.7
Ecological Zone									
Mountains	65.7	63.3	64.6	32.1	30.9	31.5	2.3	5.8	3.8
Hills	65.4	62.4	63.9	32.1	33.0	32.6	2.5	4.6	3.6
Tarai	64.0	64.4	64.2	34.2	33.3	33.8	1.8	2.3	2.0
Urban/ Rural									
Urban	69.5	74.1	71.8	27.2	25.5	26.4	3.3	0.4	1.9
Rural	63.9	61.6	62.8	34.2	34.3	34.2	1.9	4.1	3.0

Source: CBS, 2011 (NLSS III)

Table 5: Immunisation status by consumption quintile

Percentage of Immunization status of children aged under five years

(Percent)

	Fully immunized			Partially immunized			Not immunized		
	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls	Total
Consumption Quintile									
Poorest	61.4	57.8	59.5	35.6	36.3	36.0	3.1	5.9	4.5
Second	61.8	65.1	63.3	36.8	31.5	34.4	1.4	3.4	2.3
Third	67.1	63.4	65.2	29.8	34.2	32.1	3.1	2.4	2.7
Fourth	71.2	63.4	67.2	28.0	33.8	31.0	0.8	2.8	1.8
Richest	67.4	77.7	71.7	31.0	22.3	27.3	1.7	0.0	1.0
Nepal	64.7	63.4	64.1	33.2	33.0	33.1	2.1	3.5	2.8

Source: CBS, 2011 (NLSS III)

2.2.3 Health Consultations

People were asked whether they were ill or not within the last 30 days. Of the total population, 20 percent reported having some sickness or injury within the last 30 days. About 69 percent of people with an acute illness reported to have consulted with some kind of medical practitioner: 28 percent consulted paramedics, followed by doctors - 25 percent, pharmacists - 16 percent, and traditional and other healers - 2 percent. About 63 percent of people visited private health institutions, the remainder visited government institutions. Health consultations by institutions, gender, geographical regions, consumption quintile are shown in tables 6 and 7.

Table 6: Health consultations by institution types

Percentage of health consultations for acute illnesses by type of institution

	Government Institution						Private health institution					
	Sub-Health Post	Health Post	Public health center	Hospital	Other	Sub-total	Phar-macy	Clinic	Private hospital	Other	Sub-total	Total
Gender												
Male	12.3	7.8	2.1	11.0	2.2	35.3	25.6	28.8	5.2	5.1	64.7	100.0
Female	13.7	8.0	2.9	11.6	2.3	38.5	25.0	26.3	5.4	4.8	61.5	100.0
Development Region												
Eastern	13.5	9.4	1.7	10.8	2.2	37.6	24.4	28.9	4.0	5.2	62.4	100.0
Central	9.0	6.3	1.9	11.4	2.2	30.8	25.1	29.3	7.9	6.8	69.2	100.0
Western	14.3	6.1	3.6	11.1	1.0	36.1	23.3	31.6	4.3	4.6	63.9	100.0
Mid West	20.6	10.8	4.4	10.9	5.4	52.0	27.6	15.4	3.2	1.8	48.0	100.0
Far West	12.5	10.7	1.7	14.2	0.6	39.7	32.3	22.2	4.2	1.6	60.3	100.0
Ecological Zone												
Mountains	23.8	9.1	4.9	20.3	0.0	58.1	22.7	7.0	6.1	6.2	41.9	100.0
Hills	19.6	10.7	3.9	11.1	1.3	46.5	21.4	22.4	5.7	3.9	53.5	100.0
Tarai	7.4	5.8	1.4	10.6	3.1	28.4	28.2	32.9	4.9	5.6	71.6	100.0
Urban/ Rural												
Urban	1.1	1.8	1.0	21.3	1.7	26.8	20.9	38.8	10.3	3.1	73.2	100.0
Rural	15.5	9.1	2.8	9.3	2.4	39.1	26.2	25.1	4.2	5.3	60.9	100.0

Source: CBS, 2011 (NLSS III)

Table 7: Health consultations by institution types and consumption quintile

Percentage of health consultations for acute illnesses by type of institution

	Government Institution						Private health institution					
	Sub-Health Post	Health Post	Public health center	Hospital	Other	Sub-total	Pharmacy	Clinic	Private hospital	Other	Sub-total	Total
Consumption Quintile												
Poorest	19.7	8.7	2.9	5.4	1.3	38.0	32.5	19.7	2.3	7.5	62.0	100.0
Second	16.6	9.1	2.7	10.1	2.3	40.9	28.8	21.9	2.6	5.8	59.1	100.0
Third	13.5	10.6	3.3	10.7	2.7	40.8	22.5	28.0	4.4	4.4	59.2	100.0
Fourth	10.9	7.0	1.7	13.8	2.2	35.6	24.7	30.0	6.0	3.7	64.4	100.0
Richest	4.8	3.4	2.1	16.0	2.7	29.0	18.6	37.3	11.3	3.9	71.0	100.0
Nepal	13.0	7.9	2.5	11.3	2.3	37.0	25.3	27.5	5.3	5.0	63.0	100.0

Source: CBS, 2011 (NLSS III)

The results suggest that on average, total cost of treatment at a government health facility is slightly higher than that at a private health institution. A disaggregation of the costs of treatment into diagnostic cost, medicine cost and travel costs etc. is given in table 8.

Table 8: mean expenditure by gender and consumption quintile

Mean expenditure of last consultation in Government and Private institution for acute illness

(Current NRs)

	Government institution				Private institution			
	Diagnostic & other service cost	Medicine cost	Travel cost	Total cost	Diagnostic & other service cost	Medicine cost	Travel cost	Total cost
Gender								
Male	230	655	134	1,019	212	811	72	1,095
Female	379	776	132	1,286	172	690	69	931
Consumption Quintile								
Poorest	228	497	56	781	53	568	43	663
Second	90	545	54	688	136	648	45	829
Third	225	689	112	1,025	202	909	83	1,194
Fourth	495	800	282	1,577	196	685	57	938
Richest	640	1,215	168	2,022	340	893	118	1,351
Nepal	312	722	133	1,167	191	748	70	1,010

Source: CBS, 2011 (NLSS III)

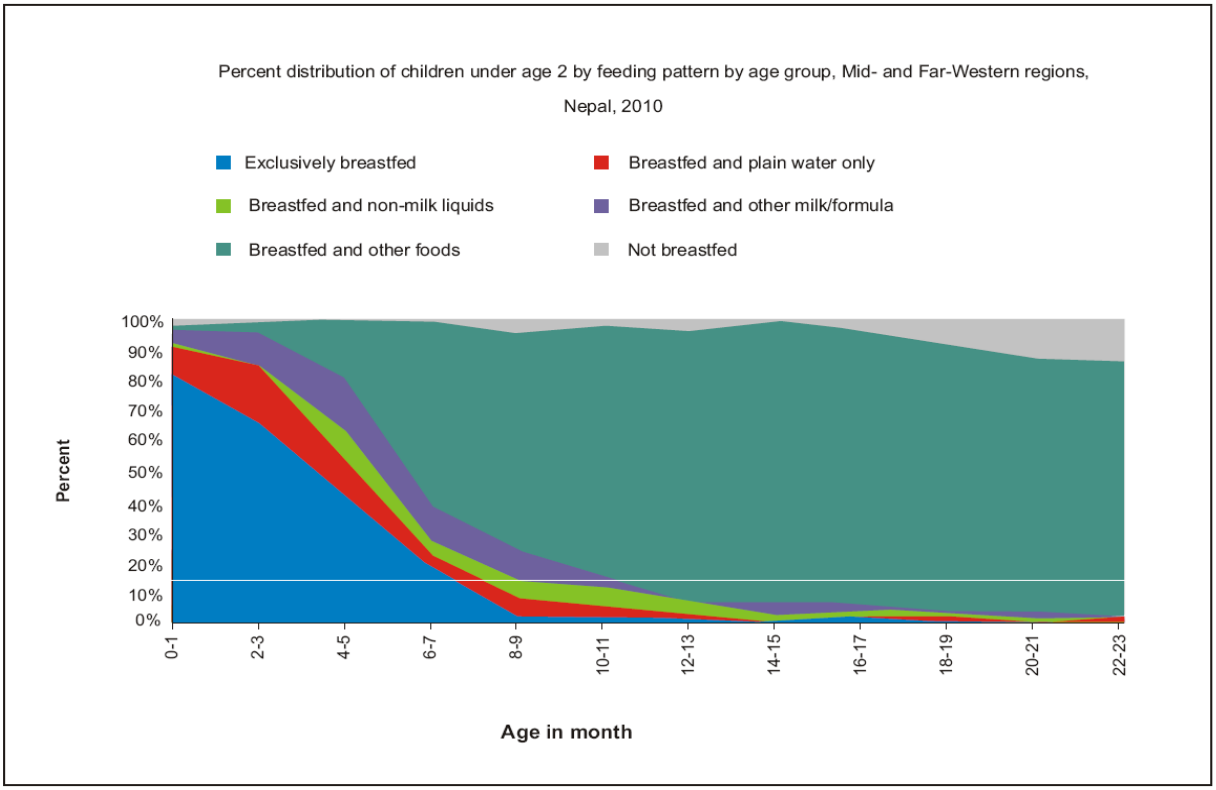
2.3 Nepal Multiple Indicator Cluster Survey (MICS)

The Nepal Multiple Indicator Cluster Survey (MICS) was carried out in 2010 and published in 2011 by the Central Bureau of Statistics (CBS). Financial and technical support was provided by the United Nations Children's Fund (UNICEF).

2.3.1 Breastfeeding

The results from the preliminary report indicated that about 82 percent of children ages 0-1 month are exclusively breastfed. Among children that are 2- 3 months old, this percentage declines sharply to about 66 percent. After five months, the percentage of children that are exclusively breastfed drops to approximately 18 percent.

Fig. 4: Breastfeeding indicators



Source: GoN, CBS and UNICEF, 2011

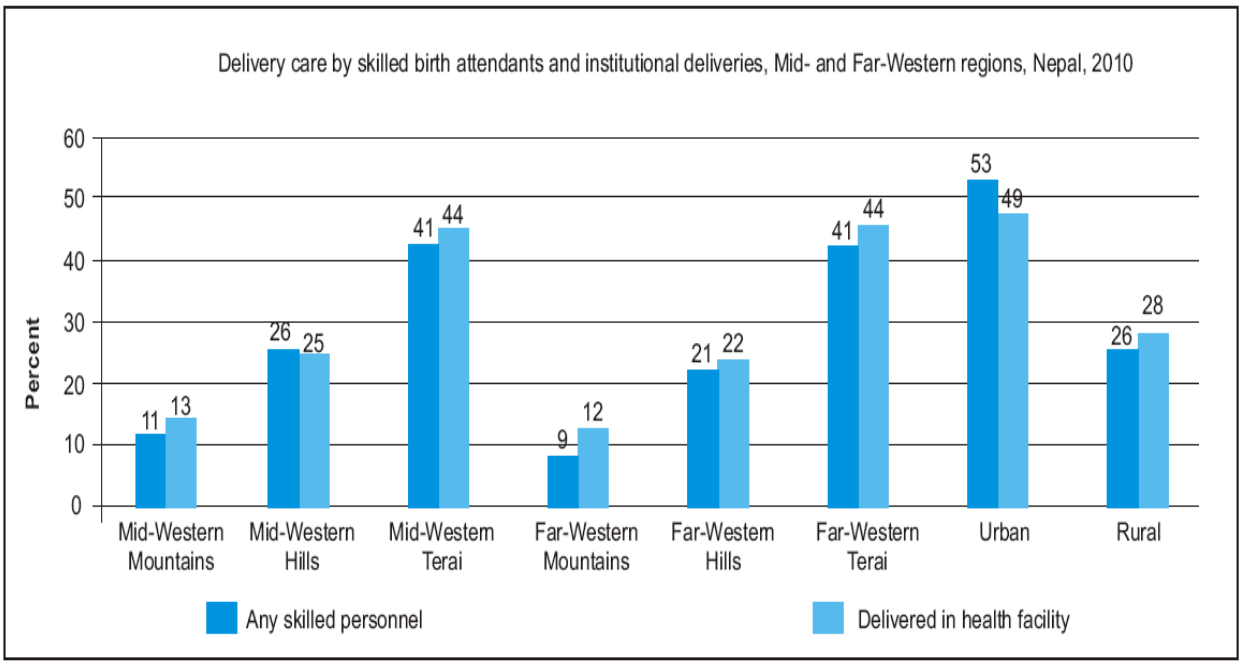
2.3.2 Childhood vaccinations

The results suggested that in Mid- and Far-Western regions of Nepal, almost 89 percent of children age 12-23 months have received BCG vaccination before their first birthday. However, only 67.5 percent have received the recommended three doses of DPT before the first birthday and just 77.4 percent have received three doses of polio vaccine. A total of 83.4 percent are immunised against measles. Approximately 35 percent of children age 1-4 years in the Far-Western region and only about one-fourth of children (26.5 percent) in the Mid-Western region are immunised against Japanese encephalitis.

2.3.3. Antenatal and delivery care

Of those women aged 15-49 years who had had a live birth in the two years preceding the survey, around 45 percent received antenatal care (ANC) at least once by skilled personnel, and 40 percent received ANC at least four times by any provider. Twenty-nine percent were attended to by a skilled birth attendant, defined as a doctor, nurse or auxiliary midwife in this analysis. The same proportion of women delivered in a health facility. Delivery care by skilled birth attendants and institutional deliveries are limited in the mountains and rural areas. Home delivery is very high, at 69 percent, where most deliveries take place without the support of skilled birth attendants.

Fig. 5: Percent of delivery care by providers



Source: GoN, CBS and UNICEF, 2011

2.3.4 Female literacy, child labour, early marriage and knowledge of HIV/AIDS

Overall, in the Mid- and Far-Western regions, only 74 percent of young women age 15-24 are literate. Among women living in the poorest quintile households, the literacy rate is 49 percent. In contrast, the literacy rate is 90 percent among women in the richest quintile households.

Concerning child labour, 44 percent of children age 5-14 years are involved in child labour in the Mid- and Far- Western regions.' Child labour' is defined as work that exceeds a minimum number of hours, depending on the age of a child and on the type of work. Children in rural areas are more likely to be involved in child labour than their counterparts in urban areas (46 percent compared to 31 percent). Similarly, female children are more likely to be involved in labour than male children (48 percent compared to 41 percent).

Regarding early marriage, in these regions of Nepal, 60 percent of women age 20-49 were first married or in union (living together with a man as if married) before age 18. Differences across wealth quintiles exist: 66 percent of women from the poorest households were married before age 18, compared to 54 percent from the richest households. More than half (56 percent) of women aged 15-49 in these regions have heard of AIDS, with younger women reporting a higher rate of awareness. For young women age 15-24, only about one-third have comprehensive knowledge about HIV prevention.

2.4 Government Health Financing System

Health Sector Support Programme (GIZ) Department of Health Services assessed the existing health care financing of Nepal in a report entitled "**Assessment of the Government Health Financing System in Nepal: Suggestions for Reform**" designed to support the health financing system to be more efficient and equitable. The assessment relies on secondary information from various agencies and primary information gathered from interviews with key informants and consultations with stakeholders. This review of the government health financing system builds on existing studies and ongoing discussions on the direction of reform. It provides a rapid assessment of the different provider payment systems in use and identifies ways of improving social health protection in Nepal. The key reforms recommended in the report are:

- Improve access of the poor to specified services: Access of the poor to specified health services, which are in theory being provided by the government for free, should be

facilitated by allocating sufficient financial resources and simplifying procedures for utilisation.

- Merge funding arrangements for social health protection: The merging of scattered funds under the proposed Social Health Protection Centre would help to allocate resources more efficiently and simplify administrative and reporting procedures, thereby reducing the administrative costs of managing funds.
- Introduce strategic purchasing: Government resources should be allocated where they have the most impact using budgets and reimbursements that mitigate the differences between rich and poor areas and that reward facilities that are performing well.

2.5 Demand Side Financing

Adhikari SR, Prasai D P and Sharma SK assessed the demand side financing schemes in Nepal with support from Oxford Policy Management Ltd. The report entitled "**A Review of Demand-Side Financing Schemes in Nepa**l" has three primary objectives: 1) assessing the effects in terms of coverage and utilisation, and identifying the bottlenecks of each scheme; 2) assessing the recent status of fund management; and 3) exploring the scope for integration and the possibility of improved efficiency for DSF schemes. The study mainly relied on secondary data; however, some data were used from primary sources to explore the situation as a case study.

Most of the schemes adopted consumer as well as provider mechanisms to improve the results. Major bottlenecks identified include awareness of the schemes and utilisation of services. DSF schemes, particularly the Aama Programme, also create new problems in the system. People generally bypass the lower level of health facilities so that lower levels of facilities are underutilised while hospitals or referral hospitals are overcrowded. Likewise, some programmes disproportionately consume hospital resources and implicitly give less priority to other programmes. For example, due to the flow of demand for delivery services, Operating Theatre (OT) rooms, equipment and human resources are occupied, and women who need surgical treatment of Uterine Prolapse (UP) must wait longer.

Delays in government budget release and allocation without rigorous demand analysis result in some facilities facing financial problems. Some studies indicated false claims by institutions and

their staff, although the recent trend of false claims is declining compared to previous assessments.

DSF schemes are operating independently under the Department of Health Services (DoHS) under a number of different divisions. Each scheme has its own operational guidelines, reporting, recording, and monitoring and supervision mechanisms which add to transaction costs. As an example, we estimated transaction costs of the Aama Programme. The share of transaction costs of the Aama Programme is almost 9 percent. Some of the schemes, such as the DSF scheme for FCHVs, may have higher transaction costs due to their complex procedures. We recommend merging the Aama Programme and the Four ANC Visit schemes. For other schemes we suggest the development of a mechanism for joint planning and monitoring to reduce transaction costs and improve the efficiency of the schemes.

2.6 Public Expenditure Review on Health

Adhikari SR, reviewed public health expenditure on health for 2006/07 to 2008/09 with financial support of GIZ. **Public Expenditure Review on Health for the Period from 2006/07 to 2008/09** provided insights on how to achieve better value for money and patterns of expenditure. This review provided an update on the fiscal data for general government health spending for the three-year period 2006/07 through 2008/09, and analysed important policy issues that are raised and highlighted in these data. Three main sources of funding for public expenditure on health: government, EDPs and others, and their contributions are exhibited in the following table 9. Over 45 percent of total public expenditure on health is now contributed by the government and an almost equal contribution to the total expenditure is made by the EDPs. State-owned enterprises, local bodies and autonomous universities contributed almost 6 percent to the total public expenditure on health from their own or internal sources.

Table 9: Summary of sources of public expenditure on health (NRs in millions)

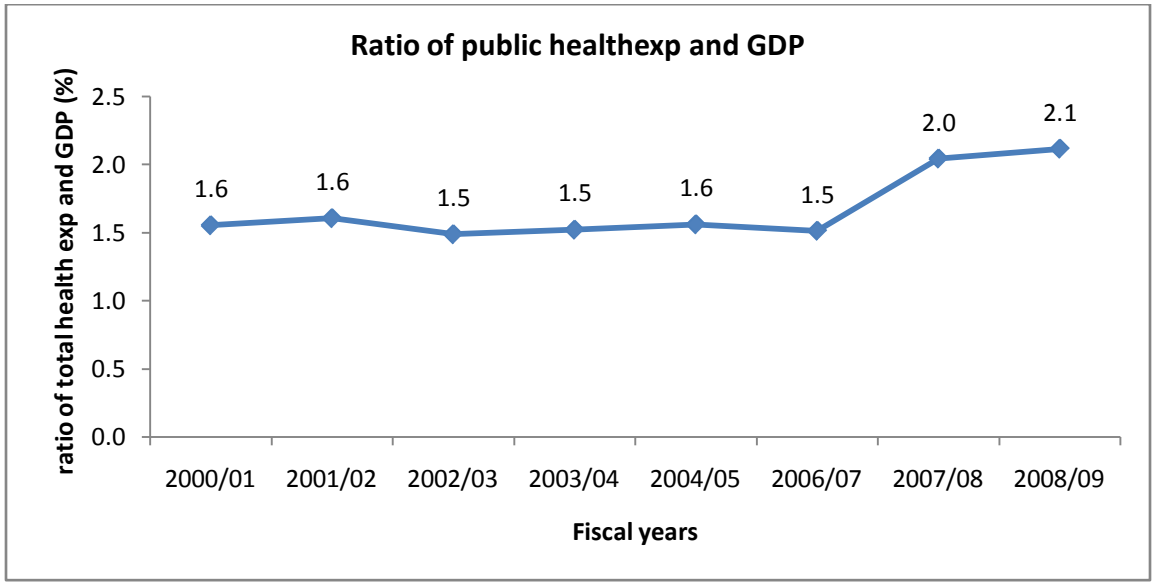
	2006/07		2007/08		2008/09	
Source of financing	**Amount**	**%**	**Amount**	**%**	**Amount**	**%**
NS1.1.1 Government of Nepal	**4,320.10**	**43.59**	**6,807.30**	**45.76**	**8,128.79**	**47.09**
Development (NS1.1.1.1)	428.73	4.33	1,666.52	11.20	1,604.53	9.29
Regular (NS1.1.1.1)	3,891.36	39.26	5,140.78	34.55	6,524.26	37.79

Earmarked tax (NS1.1.1.2)	-	-	-	-	-	-
NS9.1 External Development Partners	**4,821.02**	**48.64**	**6,965.74**	**46.82**	**7,865.39**	**45.56**
NS2.5 State-owned enterprises	**472.52**	**4.77**	**701.23**	**4.71**	**794.82**	**4.60**
NS2.5 Autonomous universities	**94.69**	**0.96**	**186.29**	**1.25**	**227.54**	**1.32**
NS1.1.2 Local bodies	**203.04**	**2.05**	**217.14**	**1.46**	**246.71**	**1.43**
District Development Committees	8.92	0.09	13.12	0.09	12.41	0.07
Municipalities	7.06	0.07	6.48	0.04	4.96	0.03
Village Development Committees	187.06	1.89	197.53	1.33	229.34	1.33
Total public spending	**9,911.36**	**100.00**	**14,877.70**	**100.00**	**17,263.24**	**100.00**

Sources: Adhikari, PERH, 2011

The ratio of public expenditure on health with gross domestic product (GDP) shows almost constant until FY 2006/07. There is an increasing trend of the ratio after FY 2006/07.

Fig.6: Ratio of total public health expenditure and Gross domestic product (GDP)



Sources: Adhikari, PERH, 2011

2.7 Nutrition study

Nepal Health Research Council has recently carried out a nutritional related study entitled "**Infants Feeding Knowledge, Practices and Hindering Factors in Kathmandu Valley**" with objective of assessing the knowledge, practices and hindering factors for proper feeding practices among under one year children of Kathmandu valley. The result suggested that out of 335 respondents, 35.8 percent had initiated complementary feeding before 6 months. Similarly, 34 percent had not started complementary food yet and remaining 30 percent had started after 6 months. The main factors for starting complementary feeding before 6 months were insufficient breast milk, cultural factors (Pasni at 5 months for female child), working mothers and family pressure. The main complementary food given to the child was lito.

Among the total respondents practice of exclusive breast feeding was found in 35.8 percent. Similarly, 38.2 percent breast fed with complementary food, 18.8 percent breast fed along with water and 6.6 percent breast fed with other milk. Among the respondents with a child of less than six months, 51.3 percent practiced exclusive breast feeding. Similarly, the practice of exclusive breast feeding (complete breast feeding up to 6 months) was found in 22.5 percent of mothers with a child of 6 months or older.

The most frequent reason given for not being able to practice exclusive breast feeding was the low production of breast milk. The conclusion of this study is that only having knowledge is not sufficient to transfer it in to practice. Other factors hinder mothers from feeding their children properly, such as diet of lactating mother, support of family members, a mother-friendly environment, economic condition of the family, working mother etc. So, we should consider such factors for improving infant feeding practices.

2.8 Aama Surakshya Karyakram

NHRC and UNFPA regional Office have carried out a study entitled "**In-depth review of effectiveness and efficiency of Aama Surakshya Karyakram to address barriers in accessing maternal health services in Nepal**. The study utilised both quantitative and qualitative tools and techniques to fulfil the objective of the study, which was to address the barriers to access the maternal health services. The results of the study demonstrate that the implementation of Aama Surakshya Karyakram (ASK) is progressive, and there is a gradual increase in institutional deliveries. Literature review revealed that false claims for institutional

delivery made by health providers were reduced to 4 percent in the year 2010 from 24 percent in the year 2009.

One-third of mothers decided by themselves to come to the health facility. Most mothers did not face distance as access barrier as two-thirds of them were residing near to the health facility (within reach of 60 minutes). Nearly all mothers (98%) had received the maternal health services immediately on arriving in the health facility and said there were no language barriers within the facility. Less than half of the mothers (40%) failed to receive the knowledge of transport incentive and said that they were satisfied with the quality of health services, but for the maternal health treatments offered, almost all (98%) were satisfied. All mothers were satisfied with the information provided for the health services. Only one-tenth of the mothers indicated that it compensated their transport cost. All the mothers were aware of free maternal and child health care services including delivery care. They did not have any idea about whether the cash payment was basically provided as transport incentive or for some other purposes.

In order to build confidence on the sustainability of the ASK among district level personnel, central level authorities must provide adequate human resources, increase the number of SBAs, provide essential equipment (delivery sets, forceps etc.), and release the budget in time. Nine-tenths of the sampled health facilities showed no evidence regarding annual planning and budgeting done for ASK. All health workers agreed that reporting system was still poor. It was quite interesting to observe that none of the PHCCs were found to perform any financial or social audits. However, all hospitals were performing financial audits Although majority of health facilities (80%) displayed the citizen charter, only 60 percent had displayed information on ASK in the same citizen charter. We also found that most of the health facilities (90%) had not displayed data related to ASK in the notice board of health facility.

2.9 Essential Health Care and Free Maternity Services

Resource Centre for Primary Health Care (RECPHEC) has carried out a study entitled **"Field Study on Essential Health Care and Free Maternity Services in Nepal"** with the objective of identifying, analysing and assessing the implications and effectiveness of the government programme, especially the free health care service and safe maternity programme. The results demonstrated that Sub-health posts and local private medical centres were the most preferred options for households to visit for treatment of general health problems. Out of the households surveyed 22 percent visit private health facilities, 46 percent visit SHPs, 19 percent visit HPs

and 11 percent visit hospitals for general health problems. It is interesting to note that despite the provision of free health services in government health facilities, 22 percent of the households prefer to visit private providers.

The average walking distance time for the households to reach the health facility was reported to be 36 minutes and 60 percent have no transportation facilities. On an average, a member from a household was found to be visiting government health facilities at least once a month. Out of these visitors, largest proportion (45%) went for diagnosis purposes, 34 percent for immunisation, and 19 percent for health related inquiries. Out of the surveyed households, 79 percent of the respondents reported that they are aware about maternity services. Despite this, only one fifth of the households reported having taken the free maternity service. The survey figures indicate that more households benefit from free maternity service in the Terai (29%) compared to Hill (25%) and Mountain (14%) despite the fact that more people are unaware about maternity services in Terai (64%) compared to Hill (85%) and Mountain (89%). The long distance to birthing centres and unavailability of reliable emergency transportation facilities are key barriers when it comes to benefiting from maternity services in rural areas of Hill and Mountain districts. Of those who received services from government health facilities, 76 percent reported that they received incentives. Average duration of getting the incentives after the delivery was reported to be 54 days. Out of those who received the incentives, 31 percent received it within a week, 66 percent within 3 months and remaining 4 percent within one year.

2.10 Millennium Development Goals Needs Assessment

Government of Nepal, National Planning Commission and United Nations Development Programme published a report on MDG entitled **"Millennium Development Goals Needs Assessment for Nepal 2010"** to show the national commitments for the implementation of development interventions identified to meet the MDGs. An extensive costing exercise of identified strategic interventions required to ensure attainment of Nepal's MDG targets by 2015 resulted in table 10 (a, b, c and d). For meeting MDGs 4, 5, and 6 (health), the total resource requirement is NRs 105.68 billions, of which only NRs 84.89 billion is available. There are serious funding gaps to meet MDGs. A detailed picture of total resources needs, availability and gaps estimated for five years is provided in the following tables.

Table 10 (a, b, c and d) resource needs, availability and gaps to achieve targets for MDGs

[redacted] Resource Needs, Availability and Gaps to achieve targets of the MDGs for 2011-2015 *(NRs in Billion)*

Goal	2011-2015 Need	Availability	Gap
Goal 1	379.96	277.10	102.86
Goal 2 Education	344.501	167.32	177.18
Goal 3 Gender	27.59	12.62	14.97
Goals 4,5,6 Health	105.68	84.89	20.79
Goal 7	273.72	159.06	114.67
Road Infrastructure	264.35	243.38	20.97
Total	**1,395.80**	**944.37**	**451.44**

Total estimated resource needs for implementing strategic interventions *(NRs in millions)*

Goal	2011	2012	2013	TYP total	2014	2015	2 year total	2011-2015
Goal 1	**57,237**	**65,318**	**73,897**	**196,452**	**85,652**	**97,855**	**183,507**	**379,959**
Poverty	47,285	53,323	59,715	160,323	69,046	78,641	147,687	308,010
Agriculture	9,952	11,995	14,182	36,129	16,606	19,214	35,820	71,949
Goal 2 Education	**35,330**	**46,025**	**63,184**	**144,539**	**97,371**	**102,592**	**199,963**	**344,501**
Goal 3 Gender	**3,495**	**4,483**	**5,491**	**13,469**	**6,525**	**7,593**	**14,118**	**27,587**
Goals 4,5,6 Health	**15,972**	**17,971**	**21,015**	**54,958**	**23,899**	**26,827**	**50,726**	**105,684**
Goal 7	**44,303**	**49,341**	**54,698**	**148,342**	**60,431**	**64,950**	**125,381**	**273,723**
Environment	7,265	7,510	7,755	22,530	8,024	8,311	16,335	38,865
Energy	28,246	30,596	33,224	92,066	36,333	39,744	76,077	168,143
Water and sanitation	8,792	11,235	13,719	33,746	16,074	16,895	32,969	66,715
Road infrastructure	42,234	52,190	54,359	148,783	57,558	58,007	115,565	264,348
Total	**198,571**	**235,328**	**272,644**	**706,543**	**331,436**	**357,824**	**689,260**	**1,395,802**

Total resource availability for implementing strategic interventions *(NRs in millions)*

Goal	2011	2012	2013	TYP total	2014	2015	2 year total	2011-2015
Goal 1	**43,028**	**48,518**	**53,026**	**144,572**	**61,205**	**71,322**	**132,527**	**277,099**
Poverty	38,420	42,527	45,237	126,184	51,078	58,156	109,234	235,418
Agriculture	4,608	5,991	7,789	18,388	10,127	13,166	23,293	41,681
Goal 2 Education	**32,930**	**32,916**	**33,076**	**98,922**	**32,974**	**35,427**	**68,401**	**167,323**
Goal 3 Gender	**1,543**	**1,926**	**2,404**	**5,873**	**3,000**	**3,745**	**6,745**	**12,618**
Goals 4,5,6 Health	**12,329**	**14,199**	**16,808**	**43,336**	**19,329**	**22,228**	**41,557**	**84,893**
Goal 7	**27,387**	**31,177**	**32,500**	**91,064**	**30,754**	**37,240**	**67,994**	**159,058**
Environment	1,084	1,234	1,483	3,801	1,795	2,171	3,966	7,767
Energy	17,418	20,025	20,066	57,509	21,036	22,053	43,089	100,598
Water and sanitation	8,885	9,918	10,951	29,754	7,923	13,016	20,939	50,693
Road infrastructure	40,640	48,183	47,301	136,124	51,300	55,952	107,252	243,376
Total	**157,857**	**176,919**	**185,115**	**519,891**	**198,562**	**225,914**	**424,476**	**944,367**

Total resource gaps for implementing strategic interventions *(NRs in millions)*

Goal	2011	2012	2013	TYP total	2014	2015	2 year total	2011-2015
Goal 1	**14,209**	**16,800**	**20,871**	**51,880**	**24,447**	**26,533**	**50,980**	**102,860**
Poverty	8,865	10,796	14,478	34,139	17,968	20,485	38,453	72,592
Agriculture	5,344	6,004	6,393	17,741	6,479	6,048	12,527	30,268
Goal 2 Education	**2,400**	**13,109**	**30,108**	**45,617**	**64,397**	**67,165**	**131,562**	**177,179**
Goal 3 Gender	**1,952**	**2,557**	**3,087**	**7,596**	**3,525**	**3,848**	**7,373**	**14,969**
Goals 4,5,6 Health	**3,643**	**3,772**	**4,207**	**11,622**	**4,570**	**4,599**	**9,169**	**20,791**
Goal 7	**16,916**	**18,164**	**22,198**	**57,278**	**29,677**	**27,710**	**57,387**	**114,665**
Environment	6,181	6,276	6,272	18,729	6,229	6,140	12,369	31,098
Energy	10,828	10,571	13,158	34,557	15,297	17,691	32,988	67,545
Water and sanitation	-93	1,317	2,768	3,992	8,151	3,879	12,030	16,022
Road infrastructure	1,594	4,007	7,058	12,659	6,258	2,055	8,313	20,972
Total	**40,714**	**58,409**	**87,529**	**186,652**	**132,874**	**131,910**	**264,784**	**451,436**

Source: GoN and UNDP

2.11 Selected articles published in journals

Manandhar SR et al published an article entitled "**Analysis of Perinatal Deaths and Ascertaining Perinatal Mortality Trend in a Hospital"** in Journal of Nepal Health Research Council with the objective of analysing perinatal deaths and ascertaining perinatal mortality trends of Kathmandu Medical College Teaching hospital in the last 8 year period. The result suggested that in the first perinatal death audit, the perinatal mortality rate (PMR) was recorded as 30.7 per 1000 births and extended perinatal mortality rate (EPMR) as 47.9 per 1000 births, whereas in the fifth perinatal death audit (Apr '10 – Mar '11) PMR was recorded as 14.4 per 1000 births and EPMR as 19.6 per 1000 births. In Wigglesworth's classification, in the first perinatal death audit, most of the perinatal deaths were in group IV (41%) reflecting more asphyxial deaths; however in the fifth audit, group III mortality (41%) was highest, indicating death of low birth weight or preterm babies. In the first audit, stillbirth rate (SBR) excluding <1 kg was 18.1 per 1000 births and early neonatal deaths (ENND) excluding <1 kg was 12.9 per 1000 live births. In the fifth audit, SBR (excluding <1 kg) and ENND rate (excluding <1 kg) were 7.1 per 1000 births and 7.2 per 1000 live births respectively, reflecting a declining trend of both SBR and ENND rate in the hospital.

The article concluded that distinct declining trend in PMR, EPMR, SBR and ENND rates at KMCTH were noted. As asphyxial deaths have been reduced significantly, more intensive efforts are needed to prevent premature births with care of preterm and very low birth weight babies.

Joshi et al published an article entitled **Lower Urinary Tract Infection and Bacterial Colonisation in Patients with Double J Ureteral Stent** in Journal of Nepal Health Research Council with the aim of investigating the bacteriology of urinary tract infections associated with indwelling DJ stent. A total of 46 cases were included. Mean age in years was 35.70 (10- 78 years). Males were 22 and females 24. Eleven patients (23.91%) had stent placed less than 30 days and 35 patients (76.08%) had it for 30 or more days. DJ indwelling time was in between 12-86 days. Bacterial colonies were found in 28.3% (13 of 46) of the urine samples and 30.4% (14 of 46) from the tip of the DJ stent segment. Of the pathogens identified, E. coli was found to be the most common. An increased stent colonization rate was associated with implantation time, and female sex. On urine culture 70.21% had no growth, 14.89% E. coli, 4.25% Klebsiella,

Actinobacter, 2.12% Ecoli/kleb, multiple org, psuedomonas. Ten patients (21.7%) had positive urine culture before stent insertion. Thirteen patients (28.3%) were shown to have positive urine culture on stent removal. Fourteen patients (30.4%) had positive DJ stent culture.

KC NP et al published an article entitled "**Community Participation and Mobilisation in Community-Based Maternal, Newborn and Child Health Programmes in Nepal** in Journal of Nepal Health Research Council with the objective of analysing the degree of community participation and mobilization in community-based maternal, newborn and child health programmes and their potential implication in acceleration towards achieving Millennium Development Goals 4 and 5. The study is based on analysis of the existing national community based maternal, neonatal and child health programmes in terms of degree of community mobilisation and participation for ownership and sustainability of programmes. Furthermore, a qualitative assessment was carried out to assess the level of engagement of community structures in community based maternal, newborn and child health programme.

None of the national community based maternal, newborn and child health programmes used the community action cycle approach and there was minimal level of involvement of community networks. The mother's groups had been least engaged in identifying and solving the maternal, newborn and child health problems and Female Community Health Volunteers were engaged in delivering messages at the household level and not through the mother's groups.

Though the Community Action Cycle was studied in Nepal and it was found effective to achieve the objectives, getting its lessons into practice to design community health programmes is lacking. The mother's groups need to be revitalised to ensure their active participation in identifying, analysing and agreeing on steps to solve the problems related to maternal, neonatal and child health so that care seeking and utilisation of health services will be further enhanced. The national strategies need to explore the possibilities of incorporating the community action cycle frame into its programmes, test the frame and ensure its implementation in the national community based programmes in order to improve health outcomes of mother, newborn and children.

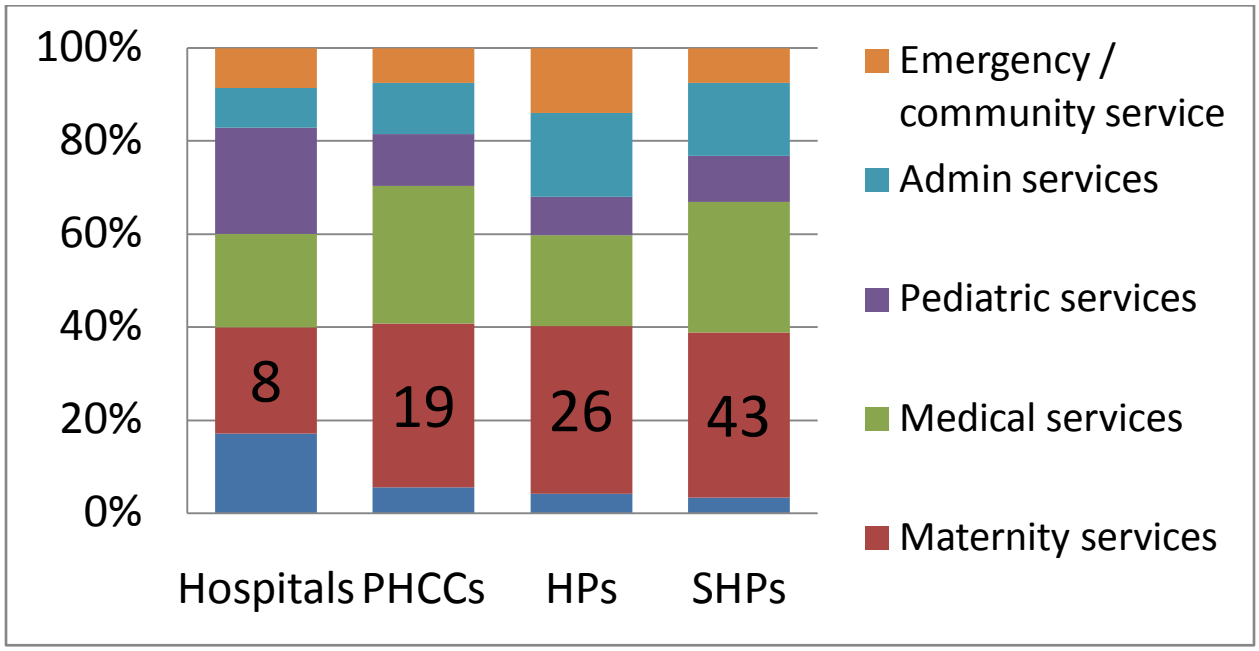
Pradhan YV et al published an article entitled **Fitting Community Based Newborn Care Package into the health systems of Nepal in journal of Nepal Health Research Council**

with objective of exploring the designing of Community Based Newborn package Community-based strategies for delivering effective newborn interventions are an essential step to avert newborn death, in settings where the health facilities are unable to effectively deliver the interventions and reach their population. Effective implementation of community-based interventions as a large scale program and within the existing health system depends on the appropriate design and planning, monitoring and support systems. This article provides an overview of implementation design of Community-Based Newborn Care Package (CB-NCP) program, its setup within the health system, and early results of the implementation from one of the pilot districts. The evaluation of CB-NCP in one of the pilot districts shows significant improvement in antenatal, intrapartum and post natal care. The implementation design of the CB-NCP has six different health system management functions: i) district planning and orientation, ii) training/human resource development, iii) monitoring and evaluation, iv) logistics and supply chain management, v) communication strategy, and vi) pay for performance. The CB-NCP program embraced the existing system of monitoring with some additional components for the pilot phase to test implementation feasibility, and aligns with existing safe motherhood and child health programs. Though CB-NCP interventions are proven independently in different local and global contexts, they are piloted in 10 districts as a “package” within the national health system settings of Nepal.

2.12 Service Tracking Survey

Ministry of Health and Population and Nepal health Sector Support Programme (NHSSP) recently carried out a **Service Tracking Survey** in 13 districts of Nepal. NHSSP has shared some preliminary results in various categories such as Human Resources for Health Analysis, Free Essential Health Care, Drug Availability & Storage, and Financial Management, among others. Some of the results are shared in this report. The report suggested that the Aama programme contributes to increase the institutional delivery; however, facilities perceived that maternity services are more insufficient in peripheral health facility than hospitals.

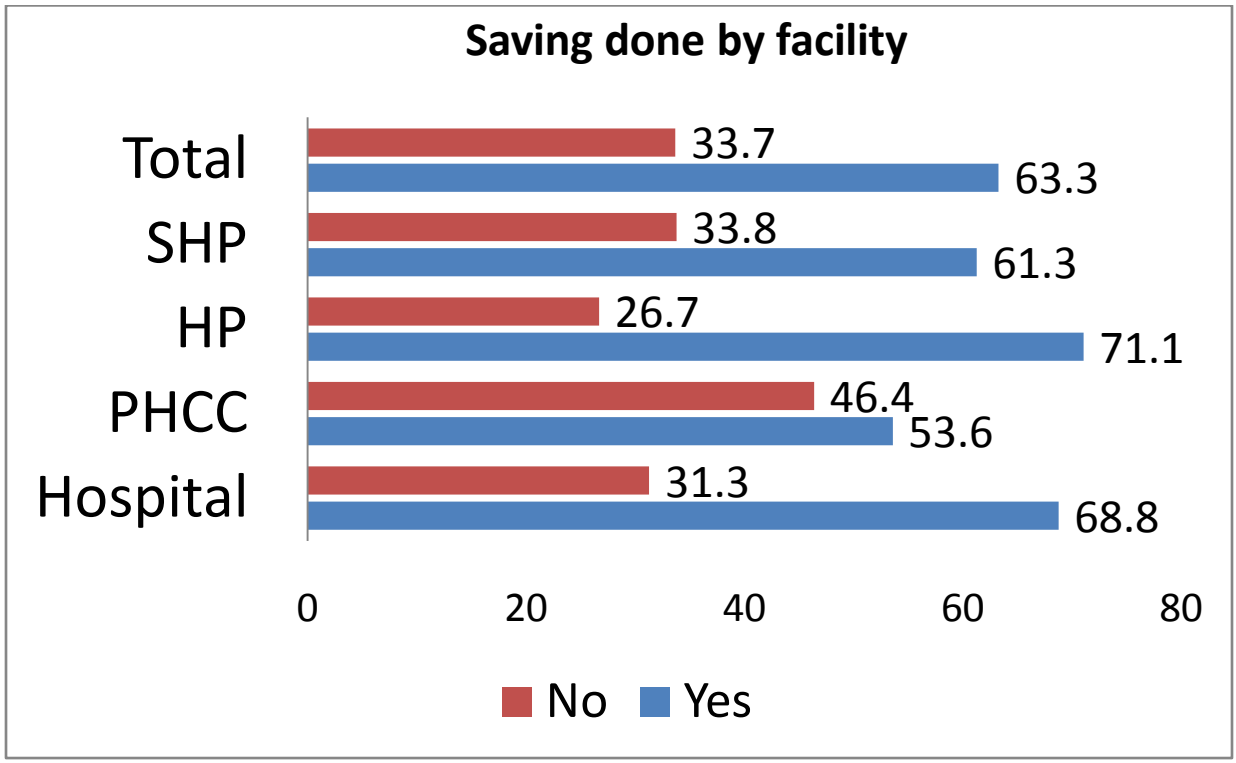
Fig.7 Facility perceived insufficiency of services



Source: NHSSP

Regarding the financial management of the facilities, all hospitals have prepared their financial reports; however, only 36 percent PHCC, 10 percent HP and 10 percent of SHP prepared financial reports. Preparing the financial report is not compulsory for the facilities but it helps to update the facilities' financial management. Amongst the health facilities, the health posts are able to save more money than others. The results reveal that 7% of PHCCs claim to have no water source and 11% for both HPs and SHPs respectively; similarly 3%, 10% and 28% of PHC, HP and SHP respectively don't have toilets. In all health facilities it is found that second major part of the budget is allocated to infrastructure and equipment. Similarly, some problem of distribution drugs was found; for example, some essential drugs are found stocked out in some facilities while the same drugs are found expired in other facilities.

Fig.8 Saving resources by the facilities



Source: NHSSP

2.13 Portfolio performance and Aid effectiveness

Nepal portfolio performance review (NPPR) and **Aid effectiveness** report that has recently been published by the Ministry of Finance is a key dialogue mechanism between Government of Nepal and its Development partners (DPs) over the past 10 years in Nepal. The theme of NPPR 2011 is relevant as the overall aid effectiveness agenda is in discussion globally. Over the past 10 years, the government of Nepal has made significant efforts to improve aid effectiveness. For example, NPPR brings DPs and Government agencies together annually to identify bottlenecks in the implementation of development programmes and to agree on concrete steps to address them. It identified 18 key actions.

The report clearly pointed out that Sector-Wide Approaches (SWAps) in Education and Health have significantly contributed to improving harmonisation, alignment and mutual accountability in their respective sectors. Results-based management is stronger in these sectors and there are efforts to better coordinate technical assistance activities. Overall, the adoption of SWAps or

Programme Based Approaches (PBAs) seems to have a positive impact on development results. While existing SWAps and PBAs have seen positive change, the implementation of similar approaches in other sectors has been slower than anticipated. GoN and development partners should jointly agree on the sectors or sub-sectors where such approaches should be implemented in the short term. Technical Assistance remains fragmented. Recent OECD analysis of fragmentation in Nepal over the period 2005-2009 shows that for almost all sectors and donors, the increase in the volume of aid over this period has been marked with an increase in fragmentation (number of donors per sector) and proliferation (number of sectors per donors). The report identified key areas of challenges and their reform for improved portfolio performance in Nepal namely, reform of public finance management, reform in public procurement, reform in human resource management, reform in managing for development results and mutual accountability.

2.14 Nepal Adolescent and Youth Survey 2011

The Nepal Adolescent and Youth Survey (NAYS), was carried out by the Population Division, MOHP to have a comprehensive understanding of the situation of Adolescents and Youth in Nepal. The purpose of the survey was to generate specific data that would be useful for government to formulate policies, plans and programme interventions related to various dimensions of adolescents and youth (A&Y) ages 10-24 years in Nepal. The result suggested that A&Y have good knowledge of methods of contraceptive, for example, condom (99%), pills (68%), injectible (70%), female sterilizations (65%), male sterilizations (58%), emergency contraception pill (21%), withdrawal (18%) and other methods (18%). Knowledge of contraception among A&Y of Nepal varies considerably across age groups, rural- urban, regions and ecological zones.

Table 11: Sources of knowledge of contraceptive methods by selected background characteristics, Nepal (in percent)

Background Characteristics	Condom	Pills	Injectibles	Female Sterilization	Male Sterilization	Emergency e- Pills	Withdrawal	Other	N
Age group									
10-14	98.86	47.9	54.84	48.37	39.73	7.77	4.15	8.94	1732
15-19	98.51	76.7	76.34	71.80	66.54	23.75	22.13	20.8	2153
20-24	98.51	79.1	79.75	76.44	69.08	31.96	29.02	24.9	1323
Rural-Urban									
Rural	98.60	66.1	68.62	63.93	56.00	18.11	17.06	15.4	4034
Urban	98.79	73.49	75.03	69.56	66.12	28.82	20.83	26.3	1173
Region									
Eastern	98.93	73.84	80.03	60.54	51.67	19.75	17.14	13.9	1126
Central	98.21	61.88	64.30	66.10	51.92	14.48	15.08	14.1	1359
Western	98.66	62.76	70.35	68.14	64.97	27.74	29.17	20.9	1042
Mid-Western	98.98	67.25	65.44	53.03	50.11	14.78	10.19	13.9	570
Far Western	98.51	70.53	67.39	76.95	75.55	18.23	11.39	19.5	549

Kathmandu valley	98.90	76.73	70.86	67.76	65.92	31.38	19.58	32.2	561
Caste/Ethnicity									
Dalit	99.03	60.54	63.61	65.14	53.30	17.47	16.78	13.3	503
Disadvantaged Janajatis	98.50	69.68	73.66	58.04	54.14	19.00	16.77	14.8	1229
Disadvantaged Non-Dalit Terai Caste Groups	98.21	55.90	57.74	69.28	43.26	8.06	10.17	9.80	676
Religious Minorities	98.36	44.45	52.43	53.90	41.80	10.03	11.41	18.5	147
Relatively Advantaged Janajatis	98.94	69.64	74.53	68.50	66.72	27.86	24.40	24.8	438
Upper Caste Groups	98.69	73.06	73.56	68.01	65.70	25.10	20.29	21.74	2215
Educational Level									
No education	98.25	32.30	35.35	59.03	24.64	5.38	5.39	6.09	224
Primary	98.27	39.54	49.17	42.60	37.33	5.62	5.88	6.75	991
Secondary	98.67	70.20	71.67	64.14	58.40	16.37	14.18	15.3	2443
SLC and above	98.85	86.98	85.88	82.17	76.30	38.78	33.25	30.1	1550

Nepal	**98.63**	**67.73**	**70.05**	**65.19**	**58.27**	**20.52**	**17.90**	**17.9**	**5208**

Other includes Norplant, Calendar and Female condom

Source: Nepal A&Y Survey, 2010.

Free Essential health care service is one of the important interventions in the health sector. The survey result demonstrated that seven in every ten A&Y have heard about the government's free health service. Of those who have heard about the services, 57 percent have utilised the services, and among those who have utilised the services, 71 percent were satisfied with the government's free health services.

Table 12: Knowledge about Government free health programmes, their utilisation and satisfaction levels (in percent)

Background Characteristics	% heard about Govt. free health program	% received Govt. free health services	Extent of satisfaction about Govt. free health services				
			Satisfied	Neither satisfied or dissatisfied	Unsatisfied	Total	N
Age group							
10-14	57.43	59.53	73.74	15.47	10.79	100.0	2273
15-19	81.57	54.19	69.46	18.16	12.38	100.0	2135
20-24	83.19	55.94	67.23	19.79	12.98	100.00	1525
Sex							
Male	71.57	57.21	64.11	18.64	17.25	100.00	2911
Female	70.57	56.01	76.70	16.50	6.80	100.00	3022
Rural-Urban							
Rural	70.75	60.57	70.60	17.19	12.21	100.00	5056
Urban	72.26	41.07	70.10	19.62	10.29	100.00	877
Region							
Eastern	73.07	58.40	72.48	15.52	12.00	100.00	1444
Central	76.77	61.18	67.15	19.83	13.03	100.00	1863

Western	66.89	58.60	71.91	17.82	10.27	100.00	1100
Mid-Western	59.93	50.75	73.50	18.87	7.63	100.00	542
Far Western	70.51	68.32	71.32	11.34	17.34	100.00	705
Kathmandu valley	73.18	28.22	69.69	24.92	5.39	100.00	279
Ecological zone							
Mountain	63.76	67.15	84.12	9.55	6.33	100.00	457
Hill	70.41	53.76	73.70	19.65	6.65	100.00	2555
Terai	72.81	57.83	65.62	16.97	17.41	100.00	2921
Caste/Ethnicity							
Dalit	66.24	61.50	69.26	17.56	13.18	100.00	640
Disadvantaged Janajatis	69.65	58.14	74.07	16.25	9.69	100.00	1589
Disadvantaged Non-Dalit Terai Caste Groups	69.21	62.24	63.01	20.07	16.92	100.00	812
Religious Minorities	60.79	60.76	57.27	18.34	24.39	100.00	175
Relatively Advantaged Janajatis	74.8	43.26	70.38	21.15	8.48	100.00	349
Upper Caste Groups	74.05	54.94	72.07	16.97	10.96	100.00	2368
Nepal	**71.06**	**56.59**	**70.53**	**17.55**	**11.92**	**100.00**	**5933**

Source: Nepal Adolescent and Youth Survey, 2010.

Table 13 shows that 73 percent of A&Y have heard about any type of STIs. Among them, 99 percent heard about HIV/AIDS followed by Syphilis (58%). A lower percent of A&Y age 10-14 have heard about syphilis and at least one STI compared to other age groups. By place of residence, the percentage of A&Y who have heard of STIs is higher in urban areas compared to rural.

Table 13: Knowledge of STIs/HIV/AIDS (In percent)

Types of STIs and HIV/AIDS heard about						
Background characteristics	% of respondents heard about at least one STIs	Gonorrhoea	Syphilis	Heard about others	HIV/AIDS	N
Age group						
10-14	51.74	16.24	33.30	0.95	98.25	3,439
15-19	91.67	41.69	68.97	1.41	98.81	4,428
20-24	89.42	43.92	69.14	1.04	99.12	2,930
Sex						
Boys	76.12	34.43	58.85	1.09	98.89	5,411
Girls	70.44	33.92	56.44	1.24	98.54	5,384
Rural-Urban						
Rural	70.42	30.63	55.91	1.16	98.70	8,307
Urban	84.20	46.07	63.47	1.17	98.76	2,489
Region						
Eastern	69.71	38.79	59.71	0.97	98.71	2,359
Central	67.66	26.14	52.66	1.69	98.53	2,683
Western	79.86	34.67	62.78	1.29	98.53	2,241
Mid-Western	66.78	30.63	55.79	1.02	99.15	1,190
Far Western	77.99	28.79	54.63	1.05	98.84	1,141
Kathmandu valley	87.40	51.13	59.98	0.34	98.94	1,183
Caste/Ethnicity						
Dalit	63.64	25.03	48.84	1.02	99.16	999
Disadvantaged	71.60	29.73	54.51	1.31	98.63	2,809

Janajatis						
Disadvantaged Non-Dalit Terai Caste Groups	55.48	17.55	40.69	1.19	98.23	1,046
Religious Minorities	52.16	16.97	33.61	0.86	99.29	247
Relatively Advantaged Janajatis	86.14	50.11	66.34	0.87	98.76	929
Upper Caste Groups	81.86	40.17	64.63	1.17	98.74	4,766
Educational Level						
No education	44.53	8.90	22.07	0.58	98.70	583
Primary	43.68	7.57	22.56	0.88	98.45	2,064
Secondary	90.15	31.55	59.48	1.35	98.57	5,129
SLC and above	99.71	61.73	85.40	1.14	99.15	3,020
Nepal	73.18	34.19	57.65	1.16	98.72	10,797

Source: Nepal Adolescent and Youth Survey, 2010.

Table 14 indicates that nearly one in every five (18%) of A&Y reported having ever used alcohol, followed by use of cigarettes/tobacco (13%) and major drugs (6%). Use of alcohol increases with age and the level of education. The proportion of boys who reported having ever used liquor (such as home made alcohol, hard liquor, beer, and wine) was three times greater than girls. More than one-fourth of A&Y in urban areas (26%) drink alcohol, which is much higher than their rural counterparts (16%).

Similarly, the use of tobacco is found to be more among youths of 20-24 years age group (25%) than other groups, more in urban areas (18%) than in rural areas (11%), and more in Kathmandu valley (20%) than in other regions. Some use of cigarettes and tobacco is found among A&Y both without education (15%) and with education of SLC and above (22%). The

overall use of major drugs is low nationally, its use more or less the same as the national figures reported for 20-24 years age group, boys, urban areas, and Kathmandu valley.

Table 14: Experience of substance abuse by selected background characteristics, Nepal (in Per cent)

Background characteristics	Substance using habits				
	Liquor (Home made alcohol, Hard Liquor, Beer, Wine, etc)	Use of Cigarettes or Tobacco	Major Drugs*	Any Injectable/medicine	Others
Age group					
10-14	6.90	3.41	0.43	0.01	0.00
15-19	23.52	16.74	3.82	0.33	1.05
20-24	34.44	25.40	6.34	0.46	1.67
Sex					
Boys	28.31	23.88	5.78	0.43	1.54
Girls	9.29	2.22	0.13	0.01	0.00
Rural-Urban					
Rural	16.56	11.43	2.27	0.08	0.72
Urban	26.03	17.60	5.18	0.77	0.77
Region					
Eastern	22.88	13.33	1.96	0.16	0.00
Central	14.35	9.34	1.75	0.12	0.00
Western	15.40	12.87	2.39	0.00	0.00
Mid-Western	17.00	13.53	3.32	0.16	1.44

Far Western	11.87	12.33	4.05	0.13	40.68
Kathmandu valley	34.83	19.53	7.36	1.29	2.01
Caste/Ethnicity					
Dalit	18.75	15.39	3.58	0.23	2.85
Disadvantaged Janajatis	27.83	13.71	2.48	0.13	0.00
Disadvantaged Non-Dalit Tarai Caste Groups	10.14	10.94	0.87	0.00	0.00
Religious Minorities	8.05	11.86	2.03	0.00	0.00
Relatively Advantaged Janajatis	32.60	16.62	5.29	0.83	1.81
Upper Caste Groups	12.98	11.11	3.16	0.25	0.67
Educational Level					
No education	19.05	14.63	2.33	0.00	1.49
Primary	11.57	6.89	1.18	0.06	0.00
Secondary	17.11	11.99	2.49	0.16	1.69
SLC and above	31.48	22.07	6.37	0.66	0.00
Nepal	**18.46**	**12.66**	**6.37**	**0.22**	**0.73**
N	14,754	14,754	14754	14754	492

* Major drugs include marijuana and its products, opium or its products and cocaine

** Injectable/medicine includes any injectables/intravenous substance used without doctor's prescription and any medicines taken without doctor's prescription

Source: Nepal Adolescent and Youth Survey, 2010.

3. Discussion

Experience clearly tells us that we need good and reliable evidence from operational, implementation and health system research to design innovative health policy and improve the strategies for universal coverage of health services. Formulating health policy is a complex process. Policy makers, therefore, use evidence to improve the design of health policy and programmes and to reduce uncertainty in health outcomes by adopting better choices. Policy decisions remain uncertain if the evidence is doubtful and unreliable. Such evidence kills a culture of evidence-based policymaking. The analysis of research studies conducted in 2011 suggest that some of the studies have produced good and reliable evidence, but some have produced conflicting results and conflicting evidence because of respondents, the type of questionnaires and so on. For example, some of the results from NLSS and NDHS are conflicting. The review suggests that we have better evidence in maternal, newborn, child health, nutrition, family planning, access to health services and utilisation of health services.

The national representative research studies are engaged in producing evidence related to health outputs and outcomes; this evidence doesn't provide information concerning how we can improve the efficiency of the health system to produce health outputs or outcomes. This does not mean that we should not give priority to producing health output and health outcome related evidence, but it means that the production of research evidence should now be focused on service delivery, universal coverage, policy debates, cost effectiveness and allocative efficiency, health care financing, human resource management and other topics that support health reform and improving efficiency and equity in the production of health outcomes without reducing the existing research opportunities in other areas. If research evidence is produced without adopting scientific methods and using reliable data, there will be greater uncertainty in policy decisions and knowledge transformation. It will destroy a culture of evidence-based policy making. Evidence comes with varying degrees of uncertainty; researchers should minimize the uncertainty by using scientific tools and method of analysis and improve the quality of research outcomes. Operational, implementation, and health systems research is rarely found in Nepal, so that policy makers face the problem of determining "what works". Implementation research using rigorous methodology is urgently needed to identify the real problem and to correct the policy.

4. Conclusions

A credible measure of the health policy effects can be a powerful instrument for focusing the attention of policy makers on improvement of health indicators and promotion of health equity. The evidence produced using rigorous methodology and systematic research serves as an instrument to measure, describe, monitor, evaluate and analyse the existing health policy. Some of the components of essential health care services, for example maternal and child health services in Nepal, have significantly advanced evidence; however, other evidence, particularly concerning drug supply, health delivery, impact of free health care policy, and many other areas is rarely found. Producing evidence using scientific methods is necessary but not sufficient. It is also important to think clearly and systematically about how the health indicators can be improved and to act accordingly.

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A Report on
Partnership, Alignment and Harmonisation
In the Health Sector

Report Prepared for
Joint Annual Review (JAR)
January 2012

Government of Nepal (GON)
Ministry of Health and Population (MoHP)
Ramshahpath, Kathmandu

Contents

Executive Summary

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 External Development Partners (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 National Country Compact have been developed which have contributed in strengthening the overall aid effectiveness in the health sector.

Both NHSP-1 and NHSP-2 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).

The harmonisation of activities within EDPs has also improved over the years. The EDPs continue to regularly interact with one other in a formal group which has contributed to better harmonisation. Similarly, the INGOs working in the health sector have also organized themselves in a formal group. However, there is a gap in regular interaction among the INGOs and EDPs. There are mixed observations when it comes to alignment and harmonisation at regional and district levels. Even though the National Country Compact was signed in 2009, implementing the Compact has been slow.

More EDPs have become interested to join pool funding arrangements – currently there are four pool partners (DFID, World Bank, AusAid, GAVI) with KfW in process of joining. 'Pooling' TA has been a subject of much discussion over the years with concerns over the alignment of TA to the national priorities.

There is no overarching policy to guide Public Private Partnership in the health sector (efforts are currently underway to develop the policy). Some good practices on PPP are practised in the health sector; these include PPP in *Aama* programme, treatment of Uterine Prolapse, provision of family planning commodities, and referrals of tuberculosis cases.

Challenges that need tackling in future include improving the efficacy of TA, further improving the predictability of aid, improving the human resource situation, and instigating change processes to improve and strengthen partnership.

1. Background

The 2004 ***Health Sector Reform Strategy: An Agenda for Change*** envisaged a government led health sector, with increased harmonisation and alignment of partners and strong government stewardship. A Sector Wide Approach (SWAp) was initiated with letter of intent by GoN and supported by 12 health sector donors. To tackle challenges in areas such as sector coordination, harmonisation, performance monitoring and health care financing, and to further strengthen the SWAp and Paris Declaration on Aid Effectiveness, Nepal became one of the first wave of countries to be part of the International Health Partnership (IHP+) in 2007.

The Nepal Health Sector Programme 2010-2015 (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.

2. Objective

The objective of this report is to highlight progress, challenges, and ways forward in the arena of partnership, alignment and harmonisation in the health sector.

3. Progress and Achievements

3.1 Improving Partnership Environment Supports Improved MoHP Performance

As the 2004 SWAp continues to mature, there have been substantial improvements in sector management through joint partnership. With more partners adopting a programme approach, there are fewer independent projects. The consequent reduced overall transaction cost for the MoHP has contributed to a steady improvement in MoHP's budget absorptive capacity (from 69% in 2004/05 to 89.9 in 2009/10 and 76%[1] in 2010/11 (Tiwari et al., 2011). Aid fragmentation has also been reduced, owing to better partnership and harmonisation (Ministry of Finance, 2011).

Since 2005, there has been good progress in the formulation and implementation of clear result oriented strategies in the health sector. Both NHSP-1 and NHSP-2 were developed with joint participation of External Development Partners (EDP) and various other state and non-state stakeholders, indicating a greater focus on partnership in the health sector. Many

[1] *Even though the figure for 2010/11 marks improvement from that of 2004/05, it is nevertheless 13% lower than last fiscal year's absorption figure of 89%.*

EDP programmes and resources, including those of non-pool partners, are now linked to health sector results and strategies. This is a substantial improvement, achieved through joint commitments and better partnership over the years.

3.2 Mechanisms that have Strengthened Partnerships

Mechanisms have been developed to further strengthen donor harmonisation and alignment and foster partnership in the health sector. MoHP, EDPs and increasing numbers of non-state actors such as I/NGOs and civil society organisations, discuss and review national strategies and programmes at forums such as the Joint Annual Review (JAR) and Joint Consultative Meetings (JCM). Government endeavours to bring different actors into the JAR has increased and diversified participation. The efficacy of JAR as a platform for reviewing progress against results and instruments like Governance and Accountability Action Plan (GAAP) and IHP+ has improved over the years. However, there may be a need to further adjust the mechanism in order to engage more fully with partners in productive policy dialogue. At the implementation level, technical working groups have proved effective in harmonising activities among different actors.

Since 2004, the 12 health sector EDPs have met fortnightly as a formal group, with annual rotation of the chair and co-chair. This has certainly contributed to improved harmonisation among these EDPs and also a more coordinated approach to government interactions. The Association of INGOs in Nepal (AIN) also has a sub-group of agencies working in health, who meet regularly to coordinate activities. However, there appears to be no interaction between the AIN health group and the EDP group, which leaves a disconnect between two important sets of partners operating in the health sector. It may be argued that INGOs working in the health sector are primarily funded by the EDPs, and so their activities are naturally reflected through EDPs. However, this is not always the case and many INGOs operate with their own financial resources or those obtained from donors not based in Nepal, implementing programmes under agreements with Social Welfare Council. These remain outside the purview of the EDPs and MoHP.

More EDPs have become interested to pool their funds in the health sector. In 2012, German Development Bank (KfW) is expected to formally enter into the pool fund arrangement with EUR 10 million committed from Fiscal Year (FY) 2011/12 to 2014/15.

A Joint Financing Arrangement (JFA) signed between MoHP and EDPs (all pool partners: DFID, AUSAID, World Bank, GAVI HSS *plus* four non-pool partners: USAID, UNFPA,

UNICEF, WHO) clearly sets out harmonised procedures for performance reviews, financial management, and coordinating planning, monitoring and review exercises. The government considers this a positive step in fortifying partnership for improving overall sector management. The government also sees the JFA and impending Joint Technical Cooperation and Technical Assistance Arrangement (JTA) as instruments for encouraging all development partners to better align their contribution by using MoHP's Annual Work Plan and Budget (AWPB) framework. These instruments are also important steps towards establishing and utilising a single monitoring and evaluation framework for the health sector.

3.3 Improving the Effectiveness of Technical Assistance

Effective coordination and implementation of TA has been a subject of much discourse in the health sector. Under the auspices of the SWAp, both the government and EDPs have made earnest efforts to improve the utilisation of TA, but gaps remain. Issues include alignment of TA with national priorities, TA cost effectiveness, proper utilisation of TA, duplication of TA activities, under-utilisation of national knowledge and resources. To address these shortcomings and improve the efficacy of TA, the government and EDPs are working together to draft and endorse a Joint Technical Cooperation and Technical Assistance Arrangement (JTA) expected to come into effect from 2012. The JTA is intended to ensure government and EDPs commit to using TA to support specific result areas of NHSP-2, avoiding duplication. Terms of reference are being drafted to promote timely mobilisation and use of TA and increased use of national resources and knowledge. The JTA is expected to strengthen partnership and work for the overall aid effectiveness agenda. Furthermore, the JTA can also help identify areas of comparative advantage among the EDPs, creating synergy in the sector.

3.4 Improving Coordination at Regional and District Levels

The participation of local stakeholders and communities in health programmes has greatly improved over the years, although some mixed feelings prevail at regional and district levels about partnership, harmonisation and alignment. The absence of locally elected representatives undermines downward accountability and has adversely affected multi-stakeholder partnership and harmonisation in the sector (Ghimire, Baidya, & Thornton, 2010). The EDPs operating at district level seem to have been better at finding their comparative advantage than at the national level, and a 2010 survey showed minimal duplication in most programmatic areas, with the exception of HIV/AIDS. On the other hand, differing *modus operandi* of development partners often creates difficulty for the district level institutions coordinating activities. Agency specific reporting requirements may also tax the

limited capacity of local government institutions. Some efforts have been made by the regional health directorates of the Mid and Far West regions to foster better partnership among different actors engaged in the health sector in their regions, by setting up mechanisms such as the Regional Health Coordination Team and by starting to develop Integrated District Health Planning, which attempts to bring state and non-state health sector actors together.

3.5 Mapping Support

An Aid Management Platform (AMP) has been established in the Ministry of Finance to map support provided by development partners and monitor aid flow. AMP – established in 2009 – is a web-based tool that both the government institutions and development partners can use to plan, monitor, coordinate, track and report on foreign aid flows and funded programmes/activities. Effective utilisation of this tool by both MoHP and EDPs will contribute to better alignment and harmonisation. Implementation progress of AMP remains steady. As of September 2011, AMP encompasses 190 programmes/projects with cumulative volume of USD five billion. AMP so far is rolled out to 35 development partners and four line ministries (Development Gateway International 2011).

3.6 IHP+ Country Compact as an Instrument to Foster Partnership

The IHP+ Country Compact, the Nepal Health Development Partnership signed in February 2009, has reinforced earlier commitments to partnerships and aid effectiveness, contributing to continuing improvements in this area (International Health Partnership, 2010). This was helpful in the design of NHSP-2, on which EDPs and Government worked together. The Country Compact has also contributed to an increase in the role of civil society in the health sector, as during development phase of the Country Compact discussions of the IHP+ draft were led by civil society in all five regions (Pokharel, 2009).

3.7 Partnership with Non-State Actors and Other Sectors

Despite the lack of legal provisions or a sector wide policy and strategy to guide engagement with the private (for-profit and non-profit) sector through Public Private Partnership (PPP), individual programmes have established PPP strategies to support their work. Although their scope is limited, there are examples of good practice, as follows:

- In safe motherhood, the Aama programme has partnered with registered private health care service providers to provide delivery care, giving pregnant women the choice of opting for public, or approved commercial or non-profit service providers for free

delivery care. The government compensates private providers on a unit cost basis (cost depending upon the complexity of delivery).

- For treatment of uterine prolapse, regional health directorates assess and select service providers who express interest, and treatment is provided free of cost to the patient, with the provider compensated by the government. As of 2011, more than 11,000 women have been treated for uterine prolapse, and among them more than 95% have been treated by the private sector. [2]
- For specific family planning services, the government provides the private sector with contraceptive commodities and the private providers reciprocate by providing expenditure for service delivery and logistics to certain public health facilities.
- National Tuberculosis Centre (NTC) frequently orients and trains private health providers to identify and treat TB cases according to DOTS
- PPP are ongoing in eye care, kidney and cancer treatments, and management of district hospitals.

A Terms of Reference to develop the policy on PPP in the health sector has already been developed and currently a consultant is identified to conduct the situation analysis.

4. Lessons Learned

Partnership mechanisms such as the SWAp, the IHP+ Country Compact and the JAR have created greater harmonisation among some of the major donors and better collaboration with government, resulting in reduced overhead costs for both EDPs and MoHP and contributing substantially to the steady improvements seen in the effectiveness of MoHP planning and in spending. Aid fragmentation and duplication have been reduced and it is clear that more partners should be encouraged to participate in harmonisation efforts. The success of these harmonisation efforts rests on the commitment of all partners and the establishment of effective mechanisms for coordination.

5. Key Challenges

5.1 EDP Technical Contributions not Fully Harmonised

Despite improvements in harmonisation through the JAR and JCM, the government feels that EDPs have not fully entered into the spirit of harmonisation as outlined in the Paris principles. For example, despite the government's regular requests, EDPs have not consolidated and presented the details of their technical contribution to the health sector (Ministry of Health and Population, 2009, 2010a). Currently the AIN health group and EDPs

[2] *As reported by FHD/DoHS to the author*

do not interact enough to harmonise their support and some form of formal interaction mechanism needs to be established.

5.2 Poor Alignment with Government Institutions

While there has been a steady improvement in alignment of the EDPs with health sector policy and strategies, and aid flows are increasingly aligned to national priorities, alignment with the government institutional system remains weak (Ministry of Finance, 2011), mostly due to the large number of non-pool EDPs operating in the country, who make little use of GoN systems. Although the number of EDPs providing pooled funding has increased, as has the amount of total pooled funds, many projects and programmes are still funded by individual EDPs. Currently there are only four pool partners (The World Bank, DFID, AusAID and GAVI HSS), with KfW in the process of joining. In FY 20010/11, the total contribution of pooled funds is 63% of the total EDPs contribution in the health sector (Tiwari, et al, 2011). Even pooled funding at times imposes stringent procurement and financial management requirements beyond the current government capacity (Ministry of Health and Population 2010b), warranting external support.

5.3 Unpredictability of Aid Funding

Although the predictability of funds has improved over the years, with some EDPs able to make multi-year estimates, most are still not able to do this, and in particular INGO support channelled directly through Social Welfare Council by-passes MoHP. This hampers the predictability of support and weakens partnership in the sector. Not all EDP planning cycles are aligned with the government which further adds to the complications of mobilising resources and aligning support. More effort is required by all EDPs towards making multi-year commitments to improve the predictability of aid.

5.4 Human Resource Constraints

Many government staff (especially those working at the implementation level) are not adequately aware of the aid effectiveness agenda, including concepts of partnership, harmonisation and alignment. Comprehensive capacity development in this regard is required. Although MoF, through its Aid Effectiveness project, has recently begun training officials of different ministries on themes of aid effectiveness, the scope is limited, with a fairly small number of participants. There is a big scope for coordination at the local level to enhance partnership and improve service delivery.

5.5 Lack of Process for Change Management

Despite knowing that most IHP+ partner institutions around the world had not made adequate provisions for embarking on the change management process inherent to IHP+ (Conway, Harmer & Spicer, 2008) when the Country Compact was developed in Nepal, there was no explicit statement about how change management would be influenced. The tendency to conduct business as usual still persists among both Government and EDPs, undermining the efficacy of IHP+ as a partnership instrument.

5.6 Lack of Focus on IHP+

Although the IHP+ steering group, the Scaling-up Reference Group (SuRG), recognises that "better communication, particularly at country level, is urgently needed so that all stakeholders better understand the objectives of the IHP+ and its relationship to similar initiatives" (IHP+ Scaling-up Reference Group, 2008) many government and EDP officials and stakeholders either do not fully understand the scope of IHP+ or are completely oblivious of it.

5.7 Mapping of Technical Assistance

The overview (mapping) of technical assistance provided by the EDPs remains sketchy. It is not clear how the technical contributions are made for achieving specific NHSP II objectives.

6. Way Forward

Joint Technical Assistance:

Starting from this year, the EDPs are planning a joint technical assistance matrix to highlight their joint contribution to the health sector. A joint (EDP/ MoHP) field monitoring visit is planned in early 2012 and it is to be hoped that these initiatives will be further developed. Among other things, this is expected to better align technical assistance towards national strategies and make contributions explicit in achieving specific NHSP II objectives.

District and regional level harmonisation:

There needs to be a greater focus on improving partnership and harmonisation at district and regional levels, to better coordinate activities and help the authorities manage the multiple projects and different actors in their areas. Mechanisms for bringing state and non-state health sector actors together, such as the Regional Health Coordination Teams and development of Integrated District Health Planning in the Mid and far West regions, should be studied, and if feasible replicated in other regions in an appropriate form.

Increasing the effectiveness of IHP+:

The IHP+ Country Compact should be reviewed and adjusted in the light of new aid instruments such as JFA and JTA. Regular reports on progress against commitments in the Country Compact should be given during the JAR and other high level MoHP forums.

Institutionalising PPP:

A comprehensive policy and strategy to guide PPP in the health sector needs to be in place, with clear legal provision for implementation.

Endorsing the JTA:

The Joint Technical Cooperation and Technical Assistance Arrangement (JTA) is a potentially effective tool for aligning TA and fostering partnership in the health sector. It would be beneficial for the government to endorse the JTA as soon as possible.

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A Report

On Opportunities, Challenges and Obstacles in Implementation of Nepal Health Sector Programme II

Report prepared for
Joint Annual Review (JAR)
16th – 18th January, 2012

Government of Nepal (GON)
Ministry of Health and Population (MoHP)
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Contents

Executive Summary

The objective of this report is to compile a record of opportunities, challenges and obstacles related to implementation of NHSP-2. The major opportunities seen in the implementation of NHSP-2 are millennium development goals, good governance, increased coverage of essential health care, partnership with private sector and local community. The major challenges are equitable reduction of neonatal and maternal mortalities and underweight children, sustaining the existing coverage and further increasing the coverage of health care services, maintaining quality of care, improving management of hospitals, integrating PMTCT to ANC, elimination and pre-elimination of vector borne diseases, sustaining the cure rate of TB and managing multi-drug resistant TB. Translating the GESI strategy into action, retention of medical doctors and nurses in remote areas, fulfilling vacant positions of key health workers, fluctuating annual growth of budget, and e-submission of bids are additional major challenges to the health system. The major obstacles are yearly service contracts, fragmented procurement plans and the high demands of FCHVs for incentives. The following ways forward are suggested to address the above challenges and obstacles:

1. Scale up maternal and community based new-born health care programmes
2. Mainstream GESI
3. Formulate a targeted nutrition programme
4. Pilot and scale up nutrition programmes
5. Maintain quality in on-going programmes
6. Increase service coverage
7. Develop a coping strategy for excess demand for delivery care
8. New strategy for vector borne disease
9. Integrate IMCI with CB-NCP and Safe Motherhood
10. Integrate procurement plans
11. Develop policies, institutional and legal frameworks for PPP
12. Implement multi-year service contracts
13. Develop a rational approach to transfers

1. Background

The experiences and successes of NHSP-1 were used as the basis for planning and implementation of NHSP-2 (2010-2015). The sector wide approach (SWAp) continues and the essential health care package was expanded to address the needs of oral health, mental health, environmental health and hygiene, emergency and disaster management and primary prevention and management of non-communicable diseases, including accidents, injuries and effects of climate change on health. Weaknesses related to health system functions and inequities have been addressed by scaling up programmes for governance and accountability, gender and social inclusion, and additional financial resource mobilisation. Following the success of NHSP-1, more EDPs are participating in the pool fund and non-pool partners have signed the Joint Financing Arrangement in support of implementing NHSP-2. EDPs have agreed to prepare a joint technical assistance arrangement and there is consensus among partners to align and harmonise with the GoN system - a positive step to maximise programme results and aid effectiveness.

2. Objective

The objective of this report is to analyse opportunities, challenges and obstacles related to implementation of NHSP-2,

3. Progress and Achievements

3.1 Reduced Transfer of Care Providers

The ad hoc transfer of care providers at district level and below was very low in 2010/11, compared with 2009/10, when around 4,000 employees were transferred. A few transfers took place for the specific purpose of improving service delivery. This significant change has increased the availability of care providers at health facilities.

3.2 Increased Budget for Health

In recent years per-capita public spending on health has increased remarkably, from NRs.465 in 2009 to NRs.579 in 2010 (25% increase) and to NRs.650 in 2011 (12% increase).

3.3 Fostered Sectoral Coordination

MoHP has established a Policy Coordination Committee. The Reproductive Health Coordination Committee coordinates the RH activities of the various divisions of the DoHS. Three sub-committees cover safe motherhood and newborn health; adolescent health; and

family planning; all of which have become more active in recent years. Discussions have begun on integrating the maternal and child health programmes and the concept of continuum of care has become prominent. The Ministry has also established Country Coordination Facilitation forum to promote the dialogue on HR issues.

3.4 Improved Inter-Sectoral Coordination

Inter-sectoral collaboration and coordination has been important in revitalising primary health care initiatives, with the establishment of few urban clinics in the municipalities under partnership arrangements. Some municipalities have established more clinics using their own funds. Health related programmes such as HIV and AIDS, nutrition, environmental health and hygiene, WASH, health education and communication, waste management, and health infrastructure development have a significant role in health promotion and the achievement of health objectives. More interactive meetings and joint planning have been organised in recent years.

3.5 Developed Human Resource Strategy for Health

A five-year human resource development strategic plan has been developed and is being costed. This will guide the production, deployment, distribution and retention of health care providers.

4. Lessons learned

4.1 Disease Control is Possible in an Integrated Health Care Management System

Previous practice was to create vertical projects or project implementation units to deal with communicable diseases, but Nepal has demonstrated that an integrated health system can also successfully control and eliminate communicable diseases. Examples include leprosy, which has been eliminated, and polio, which is on the way to eradication. Kala-azar is well on the way to elimination and malaria has moved to the pre-elimination phase.

4.2 Need of additional resources for scaling up interventions

Plans were developed for scaling various programmes, such as CB-NCP, school health and nutrition programme, VCT, ART and PMTCT, filariasis elimination, blood transfusion services and birthing centres, but the scope was limited due to lack of funding. There was a marginal decrease in EDP funding from NRs.9.82 billion in 2009/10 to NRs.9.66 billion in 2011/12, which affected scaling up plans and maintenance of existing programmes.

4.3 Legal and Institutional Framework Needed for Implementation of PPP

Although some progress has been made in purchasing public services from the private sector, for example safe delivery care and treatment of uterine prolapse, the lack of an institutional and legal framework hampers this.

4.4 Need for the Right Mix of Quick Wins and More Difficult Challenges

Overall good results in terms of health outcomes can be achieved through a mix of scaling up health care services in "quick win" districts, such as those in the Terai, which are cost effective due to high caseloads and lower transport costs, and reaching more needy populations in remote "difficult to win" districts, where it costs more to reach fewer people.

4.5 Advanced SBAs Make a Difference at CEOC Sites

Although MDGPs were present in seven CEOC sites, they were not performing caesarean sections due to lack of a support team. When SBAs with advanced training were posted to these sites, the MDGPs began carrying out caesarean sections, making the CEOC site fully functional.

4.6 Appreciative Inquiry Develops Ownership Among Stakeholders

Implementing the appreciative inquiry process with the health management committee can help mobilise local resources for a hospital. In one example this resulted in a road link to the Syangja hospital to improve access, and the local government authority allocated 10% of the local road tax to the hospital, which is used to improve the quality of care provided.

4.7 Local Resource Mobilisation Can Attract Further Resources

In Hetauda a considerable amount of money was generated for development of the hospital, and some of this was used to hire an anaesthetist and other care providers, thus restoring surgical services in the hospital. There are many other examples of communities accessing resources to establish and operate their hospitals, PHCCs and birthing centres.

4.8 Community Action can Improve Safe Motherhood in Remote Areas

In a remote district like Solukhumbu, provision of a waiting home and the community ultrasound programme encouraged more women to come to the hospital for delivery. However, in districts where waiting homes were developed without community ultrasound programmes they remained underutilised, and in some cases have been converted into staff quarters or warehouses. This shows that community based interventions are essential to inform women and encourage them to deliver at a health facility.

4.9 Right Mix of Hospital and Mobile Services is Needed for Treatment of Uterine Prolapse

At present more than 80% of cases are managed through camps, where quality of care may be low due to lack of monitoring of care provided and lack of follow-up after treatment.

However, if all cases go to hospitals for surgery, the poor will be excluded. So the right mix of hospital based and good quality care at mobile clinics or camps is planned to ensure quality and equitable access to treatment for uterine prolapse.

4.10 Costed Multi-Year Planning Helps to Ensure Adequate Resources

Child Health Division has developed costed multi-year plans for EPI, which has helped the funding agencies to ensure resources for several years ahead and guides the programme managers in preparation of the AWPB. During budget discussions MoF is likely to cut the budget if the programme manager cannot produce a costed plan and evidence to support the AWPB proposal. Learning from the EPI and Nutrition initiative, Child Health Division has also planned costed multi-year plans for IMCI nutrition and CB-NCP to ensure adequate resources. Other programme divisions have also recognised the value of this approach.

4.11 Negotiation with Care Providers can Reduce Costs

A meeting was organised between care providers at referral hospitals and purchasing agencies (Insurance Sub-Committee of Lamahi and Tikapur, and PHC Revitalisation Division) to discuss payment mechanisms at Nepalgunj. The purchasing agency wanted capitation based payment for referred cases, but the private providers wanted to invoice based on the fees for services. After intense negotiation, the providers agreed to reduce the consultation fees by 75% and investigations by 50%. Purchasing agencies then agreed to pay fees for services. In addition, the care providers agreed to organise a mobile camp at least once in the catchment area of the community based health insurance.

4.12 Combined Vaccinations Reduce Costs

Combining the polio/NID, measles and rubella vaccinations has reduced the cost of vaccination and ensured that more children receive immunisation.

5. Opportunities

5.1 Good Governance

High priority has been accorded to good governance at all levels of the government system, with a directive from the Prime Minister to policy makers to improve public sector governance. This provides an opportunity for the health sector to access high level support for strengthening and expanding local health governance and improving transparency and accountability in service delivery. MoHP will place more emphasis on GAAP, and additional activities will be planned and implemented in the coming year to ensure good governance.

5.2 Reduced Poverty

The proportion of people below the poverty line declined from 31% in 2004 to 25% in 2011 (CBS 2011). With the known strong link between poverty, under-nutrition and disease prevalence, this provides an opportunity to eliminate kala-azar and other vector borne diseases, regarded as the diseases of poor, and reduce the proportion of underweight children.

5.3. Right to Free Basic Health Care

The Interim Constitution of Nepal endorses the concept of free of charge basic health care as a fundamental right of citizens. This poses a challenge to the health sector and an opportunity to design, plan and implement the basic health care package.

5.4 Partnerships with Community and Local Government

In 2010/11, many districts adopted the model of DHO/ community/ VDC partnership for the establishment and operation of local birthing centres. In addition, local governments have provided additional care providers to support service delivery. This has generated adequate resources for the establishment and operation of birthing centres and illustrates the opportunities for local resource mobilisation to improve services. Learning from these arrangements, more innovative partnership models will be explored and implemented at district level and below to mobilise local resources for service delivery.

5.5 Partnerships with Private Medical Colleges

There are 15 private medical colleges in the country and they have large number of hospital beds and facilities and to some extent they are underutilized. Unused beds, facilities, skills and expertise at private medical colleges could be used for public service delivery. At present Aama and uterine prolapse programmes are the only major examples of the public funding for private provision model. Based on learning from these, other models could be developed to take this concept further and in December 2011, a workshop was held to discuss the partnership modality.

5.6 E-Bidding

Public Procurement Management Office has instructed the line ministries to initiate the e-submission of bids. The Logistics and Management Division has completed the preparatory work for e-submission of bids (installation of server, web-server configuration, internet lease line and developing on-line bidding software). The trial phase of e-submission started from 2011/12. Some hospitals have successfully implemented e-submission of procurement bids and others are moving towards full e-bidding.

6. Challenges

The challenges faced by the health system are divided into three groups, related to outcomes, service delivery and the health system.

Outcomes

6.1 Reducing Neonatal Mortality

Despite the efforts of government and development partners, the neonatal mortality rate has remained at 33 per 1,000 since 2006, and this is a source of concern to MoHP, donors and technical support groups. The Community Based Newborn Care Programme (CB-NCP) achieved very limited coverage in the last two years and therefore had little overall effect. Infant mortality has only decreased slightly, from 48 per 1,000 in 2006 to 46 in 2011, and this is to be expected since NMR accounts for 71% of IMR. This issue is one the most challenging problems faced by the health sector, and requires rapid scaling up of the CB-NCP with institutional back-up.

6.2 Reducing the Maternal Mortality Ratio

This has been one of the successes in Nepal, as the MMR has been reduced from 539 per 100,000 live births in 1996 to 229 in 2009. However, further reducing the MMR, to achieve the MDG figure of 134 per 100,000 by 2015 is a major challenge to the health sector. More resources, technical advancement (CEOC sites), and advanced training for SBAs are needed to achieve this (Acuin et al, 2011). The unmet need for family planning is nearly 25% and is also a challenge to increase the coverage.

6.3 Inequity in the Nutritional Status of Children

Overall, the nutritional status of children in Nepal has slightly improved over the last decade. In 2006, 49% of children were stunted and 39% were underweight, decreasing to 41% and 29% respectively in 2011. However, the proportion of children who are wasted declined only slightly from 13% in 2006 to 11% in 2011. Most concerning is the fact that improvements have not been equitable, as the prevalence of stunting decreased by 65% among the richest quintile, but actually increased by 12% among the poorest quintile (Bishwakarma, 2009). Improving nutritional status of children is the second biggest challenge to the health sector.

Service delivery

6.4 Sustaining Existing Coverage

The NDHS preliminary findings indicate a drop in the 2011 Contraceptive Prevalence Rate (CPR) to 43% in 2011 from 47% in 2006. Analysis showed that use of modern contraceptive methods is highest among women with no education (48.8%), but decreases with increasing length of schooling, as it is lowest (34.6%) among those with SLC and higher qualifications. This poses a challenge, since educated persons are aware of the benefits of using modern family planning methods, but are choosing not to use them, so basic information dissemination will not change this. More encouragingly, immunisation has increased, with 86.6% of children fully immunised, and only 3% not immunised at all. The cure rate of DOTs is about 90%. While these figures are encouraging, sustaining and increasing them is a challenge.

6.5 Increasing Service Coverage

Increasing the coverage of zinc supplementation from 6% to 50%, as planned, is a huge challenge. Child Health Division and NGOs have also been active in distributing zinc tablets and have made significant contributions. However, the NDHS showed that coverage remained low. A formative research study is ongoing to identify the programmatic, technical and managerial bottlenecks of zinc supplementation, to enable CHD to develop and implement an aggressive plan to increase coverage.

Although 58% of mothers received antenatal care from a doctor or nurse/midwife for their most recent birth, only 36% of babies are delivered by a doctor or nurse/midwife, and 28% are delivered at a health facility, indicating that Nepal has a long way to go to meet the MDG target of 60% of births attended by a skilled provider (MoHP, New ERA, Measure DHS, and Macro International Inc., 2011).

6.6 Crowded Referral and Central Level Hospitals

Supply has not kept up with increasing demand for institutional delivery, especially at the higher level hospitals, as women are tending to by-pass the lower level facilities even for normal deliveries, believing they will receive better care at a larger hospital. A quick estimate of hospital capacities showed a deficit in the bed days required for delivery cases of 28,633, which means almost 20,000 women were obliged to either share beds with other women or sleep on the floor in the hospital. Since the number of care providers and logistics are

planned according to the number of beds, this also means providers were overstretched and supplies may not have been available, with associated implications for quality of care. These crowded conditions have been reported in the newspapers.

6.7 Ensuring Quality of Care

Quality of care is a challenge to the CB-IMCI, as logistical and technical support is needed for CB-IMCI and there is insufficient facilitative supervision to monitor community and institutional activities and provide the guidance. A few partners have either reduced their level of support or withdrawn completely from IMCI, redirecting their resources to CB-NCP. Some programme managers and care providers are also shifting their attention from CB - IMCI to CB-NCP.

The provision of free care, especially delivery care, poses quality challenges, as noted above. The establishment of birthing centres at peripheral levels, encouraged by the incentive programmes for institutional delivery, is a further concern. The minimum standards for equipment and facilities are not complied in many centres, there are no facilities for assuring privacy or for basic infection prevention measures and provision of counselling and educational information to women is inadequate. Under the free essential drugs scheme, prescribing patterns and availability of drugs often do not match, and care providers may prescribe drugs that are not listed as free essential drugs, so that clients have to purchase at a private pharmacy. Stock-out of drugs is still a problem in some health facilities.

6.8 Elimination and Pre-Elimination of Vector Borne Diseases

The MoHP is committed to eliminating kala-azar, and aims to reduce the incidence to less than 1 case per 10,000 population by 2015. A number of strategies such as vector and parasite control, surveillance, effective case management, community mobilisation, including a DSF scheme have been adopted, but this disease remains a challenge. For malaria, Nepal has moved from control to pre-elimination, which represents progress. Measures such as rapid diagnostic testing (RDT), revision of existing care provider guidelines, integrated surveillance system and international health regulations are part of the programme. Elimination of lymphatic filariasis is also progressing; mass drug administration and surveillance are in place.

6.9 Sustaining the Cure Rate and Managing Multi-Drug Resistant TB

The TB programme detected 76% of cases and had a treatment success rate of 90%. However, multi-drug resistance and TB-HIV co-infection poses a new and expensive

challenge to the national TB control programme. The latest estimate is 2.9% among new cases and 11.7% among repeat treatment cases (MoHP, 2011), a small but significant and possibly growing problem.

6.10 Integrating PMTCT with ANC

The approach of integrating PMTCT into antenatal care has been adopted by NCASC but more work is needed to achieve full integration of service delivery processes, protocols, planning and monitoring.

Health System

6.11 Translating the GESI Strategy into Action

The Gender Equality and Social Inclusion (GESI) strategy has received wide attention among policy makers, but translating policy into action is a major challenge. The inclusive health bill has been submitted to parliament in the last year. Both targeted and universal coverage approaches are needed, and there are many cross cutting issues of governance, leadership, service delivery, evidence and information, financing, and institutional development. All parts of the health system need to look at their activities and plans through the GESI lens and incorporate GESI into their programmes.

6.12 Expansion and Contraction of Annual Budget Growth

The annual growth rate of the health budget was 33.5% in 2010/11, up from 19.4% in 2009/10, but it increased to only 4.71% for 2011/12. This expansion and contraction of growth affects service delivery, as service outlets that had increased due to scaling up of new programmes, and quality assurance measures that had been initiated had to be cut because of a lack of funding caused by the large reduction of budget growth rate. New programmes planned under NHSP-2, such as mental health, oral health, adolescent health, strengthening of district hospitals could not be translated into the AWPB due to shortage of funds. The predictability of aid also remains a challenge to the health system. According to NHSP 2, a jointly agreed document, EDP's planned expenditure was NRs 10.7 billion (9.88 billion in 2009/10 price) in 2011/12, and NPC gave the ceiling to MoHP accordingly but only NRs 9.7 million was committed.

6.13 Policy and Legal Framework for PPP

The recent focus on expanding PPP to increase the reach of quality health care services for everyone (including free care) urgently requires policy and strategy formulation to guide partnerships with private sector agencies, covering quality assurance, scaling up of best practices, and making the best of available potential, especially for expanding specialised

services in rural areas. Private-sector confidence and investment is increasing but requires major legal reforms to overcome hesitation on the part of investors as well as ensure the public is fully protected.

6.14 Key Health Worker Positions Vacant

The records of the Department of Health Services showed that 10% of health worker positions remained vacant in the last year. The records of personnel management of MoHP showed that 25% of medical doctor positions were vacant. The vacant positions are likely to increase further, if inclusive health act is not approved in due time. The promotion and new recruitment processes are adversely affected by the lack of inclusive health act. The MoHP has submitted an inclusive health bill to parliament and is waiting for endorsement. The length of stay in post of these cadres is relatively short. Medical officers working under the scholarships have remained relatively longer in the remote districts. Thus posting and retention of care providers remains a major challenge to the health system, exacerbated by deputation.

6.15 Training 7,000 SBAs

While significant progress has been made in the training of SBAs, with 2591 so far trained by NHTC, and a total of 909 trained in 2010/11, achieving the target of 7,000 trained by 2015 (a further 5,000) will require major efforts. It will also be important to maintain the quality of training.

6.16 Collaboration and Cooperation

Health programmes such as nutrition, HIV/AIDS control, WASH, and local health governance need collaborative work. More effort is needed to coordinate and collaborate with other sectors and agencies.

6.17 Federal structure

Nepal is moving towards a federal structure. A high level state restructuring commission has been working for federal restructure. It is more likely to have the local, provincial and central level governments in the near future. Distribution of authorities, roles and responsibilities of various levels of health governance is a challenge to the health system. A transitional coping strategy is needed to distribute the funds, functions and functionaries between local, provincial and centre governments.

7. Major Obstacles

7.1 Yearly Service Contracts

Vaccinators, ANMs, nurses, physicians, MD general practitioners, Obstetrician/ Gynaecologists and many other technical persons are hired on annual service contracts. Due to the lengthy procurement process and delays in budget approval they in fact only provide care for six to eight months, and the process has to be repeated in the next year. This system also increases transaction costs and reduces the effectiveness. Multi-year contracting for commodity procurement is already in place, but not for service procurement.

7.2 Transfer of Key Programme Managers

Although transfer of care providers below district level has been very low, few programme managers at central and regional levels were transferred last year.

7.3 Fragmented Procurement Planning

Procurement has suffered from weak and inconsistent implementation of procurement regulations and oversight functions. These include timely preparation of procurement plans, and free and fair participation in the bidding process, with good specifications, bidding and evaluation processes. Procurement plans are also fragmented. There has been some improvement due to tightening of the mandatory requirement for the timely presentation of integrated procurement plans and for AWPB processing and enhanced accountability of the procurement team. Integration of procurement of construction, drugs and equipment, and services is needed to harmonise the procurement plan.

7.4 Demands of FCHVs

FCHVs have made a major contribution to health service delivery at community level, not only as change agents and motivators, but also in diagnosis and service provision, managing child and maternal health problems, creating awareness and health education. However, in recent year they have begun demanding more benefits for their work in few districts. Addressing these demands in a balanced and realistic way will be a challenge to the health system.

8. Ways Forward

1. *Scale up CB-NCP* in order to save newborn lives and ensure they are counted, costed, and monitored effectively. CB-NCP is developing a costed multi-year plan for scaling up and quality maintenance. From 10 districts in 2009/10 to 25 in 2010/11 the programme

will be scaled up to an additional 10 districts in 2011/12. An aggressive plan for further scaling up should be developed and implemented for all 75 districts by 2015.

2. *Mainstream GESI* to reduce the disparities in access to and utilisation of health services among the wealth quintiles, ethnic groups, and geographical areas. A GESI strategy should be incorporated into all programmes.

3. *Formulate a targeted nutrition programme* with multi-sectoral linkage to reduce the inequities in access to and use of health and nutritional services between ecological zones and among wealth quintiles, particularly reducing the prevalence of stunting among the poorest wealth quintile. Maternal nutrition has remained under the shadow and did not receive adequate attention. Therefore a maternal nutrition strategy needs to be developed.

4. *Scale up nutrition programmes* to achieve substantial improvements in the growth of young children and reduce child mortality. Nutritional status of women and young children is highlighted in the NHSP-2, and identified as a high priority area. Scaling up Infant and Young Child Feeding (IYCF), Community Management of Acute Malnutrition (CMAM) and Micronutrient Powder (MNP) distribution link with IYCF should be completed with a quality maintenance plan. Pilots such as School Health and Nutrition Programme (two districts), Food Fortification in Roller Mills and Chakki mills (one district), Maternal and Child Health Care (few VDCs of nine districts), Food Supplementation (Karnali Zone) and child cash grant should be evaluated and scaled up with adjustments. Due to the cross-cutting nature of nutrition, there is a need for inter-sectoral and inter-divisional coordination and collaboration within MoHP to work on adolescent and maternal nutrition, and nutrition for TB and HIV cases.

5. *Maintain quality in on-going programmes:* As discussed earlier, after a programme has been scaled up, it often receives less attention from programme managers and policy makers and quality may suffer as a result. Resources, drugs, and care providers should be assured to maintain quality of care at CEOC and BEOC sites, birthing centres, for free care (drug supply), CB-IMCI, growth monitoring, TB and HIV control, micronutrient deficiency control and clinical family planning services.

6. *Increase service coverage:* The coverage of maternal health services remains too low, with SBA assisted deliveries still only 33% (HMIS), met need for EOC less than 3% and CPR only 43.2% in 2011. This needs to be addressed.

7. *Develop a coping strategy for excess demand for delivery care:* Demand for delivery care has been the focus, without sufficient attention to the supply side, leading to overcrowding and reduced quality of care. There is an urgent need to develop a strategy for ensuring additional demand for care can be accommodated adequately.

8. *Promote new strategy for vector borne diseases* by preparing strategies and activities for eliminating kala-azar, and achieving pre-elimination of malaria and lymphatic filariasis, as a basis for their complete elimination.

9. *Integrate* IMCI with nutrition, PMTCT with ANC and CB-NCP with IMCI. As a general approach integration reduces costs and increases effectiveness.

10. *Develop policies, institutional and legal frameworks for PPP* to expedite the potential for tapping the unused capital, skills and expertise of the private sector, while ensuring national standards are adhered to**.**

11. *Implement multi-year service contracts* to reduce the transaction costs and ensure the consistent availability of care providers at service centres**.**

12. *A rational approach of transfer* of officials and district managers will be adapted to make the transfer more transparent and need based.

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Strategic Directions and Expenditure Priorities for the Next Annual Work Programme and Budget

Background Paper for Joint Annual Review (JAR) 16th – 18th January 2012

Government of Nepal (GON)
Ministry of Health and Population (MoHP)
Ramshahpath, Kathmandu

Contents

Executive Summary

The Millennium Development Goals (MDG), Three-Year Interim Plan (2010/11-2012/13), Nepal Health Sector Programme II (2010-2015), and Medium Term Expenditure Framework (MTEF) guide the strategic directions for Annual Work Plan and Budgets (AWPB) in the health sector. The expenditure priorities for the next year are child health, maternal health, disease control including TB and HIV/AIDs, free health care, community based mental and basic oral health. Regarding the health system development, priority will be given to output based budgeting, development of health financing strategy, filling positions and retention of doctors and nurses in remote areas, training of SBAs and biomedical technicians, completion of on-going construction, procurement of essential medicine and equipment, quality improvement of HMIS and strengthening local health governance.

Major strategic directions for the next AWPB are as follows:

i. Scaling up proven community and institution based interventions
ii. Maintaining quality of existing MDG related programmes
iii. Integrating fragmented programmes
iv. Revitalisation of family planning
v. Strengthening local health governance
vi. Strengthening supply side institution
vii. Mainstreaming GESI
viii. Expanding the benefits package and population coverage of free care
ix. Partnership
x. Multi-sectoral collaboration and cooperation
xi. Institutional development

1. Background

Nepal's commitment to the Millennium Development Goals (MDG), Three-Year Interim Plan (2010/11-2012/13), Nepal Health Sector Programme II (2010-2015), and Medium Term Expenditure Framework (MTEF) guide the strategic directions for Annual Work Plan and Budgets (AWPB) in the health sector. Further direction is provided by lessons from previous programme experiences and recently developed strategies, such as GESI, targeted approaches to social inclusion and universal free care. Reduction of under-five mortality, infant mortality and maternal mortality remain major challenges. The path to universal coverage is long and complex but Nepal's commitment is exampled by the introduction of universal free care at PHCCs, health posts and Sub Health Posts (SHP) in 2008 to increase access to and utilisation of essential health care services by poor and excluded groups. The Aama programme (providing free institutional delivery care and transport incentives to women) is being implemented at all public and certain approved (listed) private institutions irrespective of the level of facility. Development of the health financing strategy is progressing and expected to be completed by 2012, to ensure financial resources are available to achieve the required coverage. The existing differences between economic and social subgroups (wealth quintiles, ethnic groups and castes) in their access to and utilisation of health services and their health outcomes are considered unacceptable in Nepali society. The objectives of efficiency and equity must be addressed simultaneously rather than sequentially. To ensure this, existing appropriate strategies will be continued, with new additions to improve the health system and service delivery. Priority actions for the next few years are divided into those related to service delivery and those for the health system.

2. Major Strategic Directions

Major strategic directions for the next AWPB are:

- Scaling up proven community and institution based interventions
- Maintaining quality of existing MDG related programmes
- Integrating programmes
- Revitalisation of family planning
- Strengthening local health governance
- Strengthening supply side institutions

- Mainstreaming GESI
- Expanding the benefits package and population coverage of free care
- Partnership
- Multi-sectoral collaboration and cooperation.
- Institutional development

Further details of these are given below.

2.1 Scaling up Proven Community and Institution Based Interventions

Coverage of many recently initiated health care programmes is being scaled up, taking into account equity, efficiency and quality. Most of these new interventions are community based.

i) Community Based Newborn Care Programme (CB-NCP) has proved effective in achieving a 29% reduction in neonatal mortality and a substantial reduction in maternal mortality during a 33 month trial period in a limited number of districts (The Lancet, Volume 366, Number 9500, 26 November 2005). Prior to this the neonatal mortality rate had remained the same over a five year period (2006-11), at 33 deaths per 1,000 live births, accounting for 71% of infant mortalities. Initial assessment of four UNICEF supported CB-NCP pilot districts (Kavre, Chitwan, Palpa and Dang) suggests that neonatal mortality fell to 17 deaths per 1,000 live births, compared with the national average of 33, and the IMR to 24 deaths per 1,000 live births (UNICEF 2009). Early findings of the evaluation suggested that CB-NCP had contributed to improvements in ANC, institutional delivery, family planning and nutrition programmes. An evaluation in Bardia district showed that the proportion of home deliveries had declined from 66% to 19% (Karki et al 2011). The CB-NCP is a cost effective intervention, with an average provider cost of US$0·75 per person per year (compared with $0·90 for health service strengthening) in a population of 86,704. The incremental cost per Life-Year Saved (LYS) was $211 ($251), and expansion could rationalise start-up costs and technical assistance, reducing the cost per LYS to $138 ($179). The CB-NCP promotes equity as the poor people have easy access to a community based service through FCHVs. The CB-NCP was implemented in 10 districts in 2009/10, and scaled up to 15 districts in 2010/11, with an additional 10 districts planned in 2011/12. Scaling up to all 75 districts will be a priority.

ii) Emergency obstetric care and delivery care through functional and accessible CEOC sites is a challenge to the health system. CEOC sites are needed in 60 districts, but so far only 43 districts have CEOC sites, and these are predominantly in accessible districts. However, the CEOC sites increased from 93 sites (39 districts) in 2009/10 to 99 sites (43 districts) in 2010/11. There are virtually no CEOC sites in the remote hill and mountain districts. Scaling up CEOC to these remote areas is therefore a priority for achieving equity in access to and utilisation of this service for the poor and socially excluded. A key issue is the high cost of establishing a CEOC site and the time it takes to run smoothly. Furthermore, the cost per life saved would be higher in low HDI areas due to the low density of population and low utilisation of services. The number of BEOC sites has increased from 105 in 2009/10 to 159 in 2010/11, and the number of birthing centres has increased from 543 in 2009/10 to 859 in 2011. Further scaling up will be the priority of the next AWPB. It is worth noting that establishing these service sites is only part of the story; ensuring they remain functional is a further major challenge.

iii) Community based management of acute malnutrition and rehabilitation programmes*,* both community and institution based, will be evaluated in 2011/12 and scaled up in some additional districts. The community based nutrition programme includes counselling for infant and young child feeding, with growth monitoring, community management of acute malnutrition, distribution of fortified blended complementary flour, BCC (for social mobilisation and advocacy) and maternal nutrition. Nutrition for children and adolescents, social awareness programmes on nutrition and HIV/ AIDS are also included. There is a need to expand nutrition rehabilitation homes for management of severe malnutrition through PPP.

iv) HIV/AIDS care and support: The prevalence of HIV among people aged 15-49 declined from 0.39% in 2010 to 0.33% in 2011. Voluntary counselling and treatment for HIV/ AIDS, and services for prevention and treatment of opportunistic infections, PMTCT and ARV therapy are being expanded. So far ARV has been scaled up to 26 treatment centres and 10 sub-treatment centres, PMTCT to 22 centres plus 30 community based service points, and VCT to 196 centres including 124 private centres in 2009/10 (19 VCT sites are of unknown status). HIV/AIDS care and support needs further scaling up to reach the most needy groups and improve the quality of life of people infected and affected, and this will be a priority for the next AWPB, with a particular focus on equity issues and right based care.

v) Disease Control Programmes: Control of lymphatic filariasis has been scaled up from 40 districts in 2010/11 to 46 districts in 2011/12, through mass administration of drugs, and further scaling up is needed. Rabies control remains a challenge; a new programme to vaccinate and tag street dogs was developed and implemented in 12 districts in 2009/10 and scaled up to an additional three districts in 2011/12. Further scaling up is a priority. Japanese encephalitis vaccination has been scaled up from 27 districts in 2010 to 31 districts in 2011.

2.2 Maintaining the Quality of Existing Programmes

Although some EHCS programmes have already been scaled up across the country, assuring their quality is a major issue, as once scaled up, programmes often receive less attention from programme managers and policy makers.

i) Maternal Health*:* As noted above, the number of CEOC sites has doubled in the last five years (99 in 2011), the number of BEOC sites has tripled (159 in 2011) and the number of birthing centres quadrupled (859 in 2011) in last 5 years. A major concern is to improve the quality of SBA training and the training sites, as human resources are the key to good services. It is also essential to ensure skilled human resources remain in post, and where MDGPs or Obstetrician/ gynaecologists are on site, service output increases. Evidence shows that where CEOC teams are hired on contract and available for work for only six to eight months of the fiscal year, continuity & quality of care is compromised. Many birthing centres have only one ANM and she is at the facility at day time only. Essential equipment and medical supplies are inadequate in many birthing centres. Quality is therefore a priority to be addressed.

ii) IMCI Programme*:* As a relatively a new programme, CB-NCP is a higher priority for programme managers and technical assistance groups. Yet IMCI, scaled up to all 75 districts (2008), has demonstrated impact in reducing child and infant mortalities. As experienced FCHVs leave and new FCHVs begin working in communities, additional basic training is needed, and supportive supervision to maintain the quality, especially as new initiatives such as nutrition, HIV/AIDS, malaria and WASH will be added to the IMCI protocol. Recent resource constraints have limited these essential inputs, for example support has been reduced or diverted to CB-NCP. To maintain quality and sustain coverage, IMCI needs support in next year.

iii) Free Care Programme: The availability of drugs improved in the last year, but prescribing patterns and availability of drugs often do not match, forcing clients to purchase drugs from private drug stores. The free essential drugs list should therefore be reviewed and revised, to produce a new list of free essential drugs that properly addresses morbidity patterns in rural areas. Ensuring the availability of care providers remains a challenge, particularly medical doctors and nurses, and this needs to be addressed through development of a retention policy and incentive mechanism, to improve the quality of free care.

iv) Other Programmes: *Q*uality and universal coverage of immunisation, school health and nutrition programme, family planning, maternal health, TB, care and support (HIV/AIDs), and malaria control are priorities. Priorities for maintaining quality of nutrition related programmes are growth monitoring and counselling, prevention and control of iron deficiency anaemia, prevention, control and treatment of Vitamin A deficiency, prevention of iodine deficiency disorders, control of parasitic infestation by de-worming and emergency nutrition.

2.3 Integrating Programmes

Recognising the fact that small programmes increase costs and reduces effectiveness, a number of programmes will be integrated gradually.

i) Incentive for fourth ANC visit with Aama Programme*:* The guideline for merging these has already been developed and will be implemented soon. A similar effort will be made to merge the management of uterine prolapse with Aama programme in 2011/12.

ii) CB-IMCI and CB-NCP: At present these two community based programmes are being implemented by the same section of Child Health Division, with the same programme manager responsible for both. However, since CB-NCP is in the scaling up phase, which requires more support, while CB-IMCI already being implemented country-wide, there are implications for merging them. The target groups are also in continuum different, one being newborns and the other children. Merging will therefore be carried out in a phased manner, after piloting in few districts. Merging will be initiated in districts where both CB-IMCI and CB-NCP have been scaled up.

iii) PMTCT with ANC: A few meetings were organised to integrate PMTCT with ANC in the last year and the concept and modality of integration were approved. More work is needed for the integration of service delivery, supply of drugs and medical supplies, training, planning and monitoring, recording and reporting system.

iv) Training Programmes*:* In principle NHTC assesses the training needs of all human resources within the three departments of MoHP, and assists in meeting training needs by conducting training or providing technical support. Programme divisions should provide orientation to stakeholders on the programmes. However, a few trainings have been conducted by the concerned programme divisions, and these will now be integrated with the NHTC programmes to reduce costs and increase efficiency. NHTC will work closely with the divisions and centres to meet their training needs, as outlined in NHSP-2. The divisions and centres will explore possibilities for integrating their training plans, including monitoring.

2.4 Revitalising Family Planning Programme

Family planning improves quality of life for women and their families and contributes to safe motherhood, control of HIV/AIDS and STIs, but in recent years it has received less attention from policy makers with fewer resources. Revitalising the programme through a strategy for repositioning family planning is being implemented. Family planning will be part of safe motherhood and adolescent health programme. The increasing demand for long acting contraceptive methods, such as IUCD and implants, needs to be addressed to widen the choice of methods available for women. In addition, a targeted programme will be developed to reach under-served populations such as Muslims and those living in remote areas. Necessary resources will be allocated and partnerships developed with NGOs and non-health sector actors to expand the services.

2.5 Strengthening Local Health Governance System

The local health governance strengthening programme has been piloted in eight districts (Dang, Surkhet, Doti, Kailai, Morang, Sunsari, Rasuwa and Myagdi with support from NFHP, GIZ, Plan Nepal, WHO and NHSSP) to promote the role of local government units and improve accountability and transparency at local level. This has included the provision of formula based health grants to district level and below. This also improves the transparency and accountability

and support implementation of GAAP. Local government units identify local needs, set priorities, allocate resources and prepare plans, with the participation of local people. Evaluation of the effectiveness of this approach in improving local governance is awaited, so that two years' learning can be used as a basis for scaling up.

MoHP has transferred purchasing and regulation of functions to district health offices, including purchase of the services of health workers and technologies. DHOs also now have authority for accrediting private hospitals and nursing homes.

2.6 Strengthening Of Supply Side Institutions

To address the low demand for health care services, a demand side financing strategy was adopted in 2006, and this has been successful in generating demand for maternal and child health services. However, since the supply of services has remained the same for the last ten years, the capacity to provide for this increased demand is insufficient. As a result, hospitals are overcrowded and quality has suffered. Increasing supply of services is therefore a priority for the next AWPB.

2.7 Mainstreaming GESI

The health sector has made immense efforts to respond to the national mandate for social inclusion, through pro-poor, pro-disadvantaged and pro-women programmes. An operational plan will be prepared for incorporating GESI in training programmes from 2012/13, with further incorporation in the following year. Priority activities will include preparations for incorporating GESI activities into existing policies and programmes, generating evidence for mainstreaming GESI, piloting targeted programmes for poor and socially excluded groups, monitoring access to services and their utilisation and monitoring health outcomes.

2.8 Expanding the Benefits Package and Population Coverage of Free Care

A working group has suggested adding a further 13-15 essential drugs to the list for health posts and SHPs, 22 for PHCCs and 24 for district hospitals. The financial and treatment implications of this need to be carefully studied. Creation of the position of medical officer at health post level has also been suggested, starting from high population VDC to increase services available at

that level. Both ideas for increasing the population coverage of free care need serious attention in the next AWPB.

2.9 Partnerships

These are classified into four types: (1) government agencies, for example in the urban health programme, where MoHP provides 50% of the funds and the municipality 50%; (2) government & EDP, I/NGO, such as in child health, maternal health and disease control, under which demand creation work is carried out by NGOs and service provision by government; (3) government & private, (4) government & NGO and community. In 2010/11 clinics were established in few municipalities and operated under a partnership arrangement, using guidelines developed, and this will be continued in the coming fiscal year. In government & EDP & I/NGO partnerships, partners provide the skills, expertise and funds for implementation of EHCS. Both public funding for private provision and private funding for public provision are practised, helping to enhance equity in financing and distribution of services and efficiency of spending. The model of government partnership with academics and private sector is the basis for the Aama programme and management of uterine prolapse. Under this arrangement the public sector purchases services from I/NGO and private hospitals, with over 44 hospitals listed as private providers. Government to NGO and community partnerships have mobilised local resources, skills and expertise for the establishment and operation of birthing centres and is common practice in village communities. All four types of partnership arrangements will be further refined and implemented in the next year and new models will be explored and piloted for infrastructure development and service delivery.

2.10 Multi -Sectoral Collaboration And Cooperation

These are evident in local health governance, management of uterus prolapse, nutrition care and support, HIV/AIDS control, WASH and hospital service delivery. Joint meetings have been held to foster coordination and collaboration and networking will be established in the appropriate fields. This approach will be further promoted for increased synergy.

2.11 Institutional Development:

The nutrition related programmes fall in various divisions of the DoHS. Maternal and adolescent nutrition partly fall under the family health division and partly under the child health division; the nutrition component of TB and HIV/AIDS control falls under the respective centres. The intensity of the nutrition programme increased significantly after NHSP 2. Similarly, the health management information system (HMIS) will gradually upgraded & a national information centre will be developed to implement HSIS. The national public health laboratory will be strengthened to revamp public health activities. The preparatory work for upgrading national health training centres to national health training academy will be carried out. The organisation and management survey will be carried out in 2010/11 to establish and strengthen these institutions.

3. New Programmes Piloted or Initiated

3.1 Nutrition

a. Community based programmes are being piloted and include expansion of infant and young child feeding counselling, with GMP, expanded community management of acute malnutrition, MNP linked with IYCF, expansion of distribution of fortified blended complementary flour, BCC (social mobilisation and advocacy) and maternal nutrition. It also covers adolescent and child nutrition, social awareness on nutrition and HIV/ AIDS.

b. Institution based management of acute malnutrition is being piloted and includes expansion of nutrition rehabilitation homes for the management of severe malnutrition

c. Micronutrient deficiency control programme has new components such as mandatory fortification of wheat flour with iron folic acid and vitamin A/ micronutrients at roller mills and strengthening of universal salt iodisation, through enforcement of legislation. Piloting of fortification will be carried out in chakki mills in selected districts.

3.2 Community based mental health was added to EHCS by the NHSP-IP-2. Meetings have taken place to prepare a service package in 2010/11. A mental health package was developed for care providers at district hospitals, PHCCs and health posts/ SHPs in 2009/10. In 2010/11 a total of 112 paramedics were trained in mental health case management, to sensitise stakeholders about the mental health programme. A new pilot programme is planned in seven districts in 2011/12 (Illam, Dhankuta, Dolakha, Surkhet, Dailekha, Doti, and Bajhang). Some

preparatory work has been undertaken for selection of control districts, development of referral linkages with institutional care, a piloting plan with indicators, cost estimates, preparation of human resources for providing mental health care, provision of drugs and other logistics, collaboration/partnerships with the NGO sector, integration of community based mental health care into primary health care, and a sustainability plan. Further work is needed.

3.3 Basic oral health has been added as an element of EHCS. A total of 200 care providers were trained in 2010/11. Management Division will train a further 280 providers in 2011/12. Preparatory work is needed, such as development of a basic oral health care package, piloting plan with indicators, cost estimates, preparing human resources for oral health care, provision of oral drugs and other logistics, collaboration with the school health programme, integration into primary health care, and a sustainability and monitoring plan with indicators.

3.4 Urban health programme: A few health clinics were established with partnership arrangements. In collaboration with municipalities, some preparatory work has been undertaken, such as selecting and orienting urban FCHVs, establishment of more urban health clinics, ensuring a safe environment and quality control of water. This is a priority for improving the health status of the urban poor.

3.5 Dengue control programme was designed a few years ago at central level, but limited to surveillance. Last year's dengue outbreak forced the government to design and implement a control programme in the endemic districts, and on the basis of need and available resources priority has been given to piloting the dengue control programme in 10 districts. The dengue case management guideline has been revised and improved by adding WHO suggestions. A quick reporting system has been developed to help control outbreaks. An electronic reporting system is also in place.

3.6 Measles and rubella campaign**:** Guidelines have been prepared, and preparatory work for design and planning must be completed before February 2012. The campaign will be completed in a phased manner. Similarly school TT was initiated in 10 districts in 2010/11.

3.7 Non-communicable disease control**:** The tobacco control bill was passed and enforced from 2010/11, with regulations drafted and district level law enforcement officers identified. BCC will reinforce the need for changes in lifestyle and behaviour.

4. Evaluation of Piloted or New Programmes

- Evaluation of CB-NCP programme is underway and waiting major findings.
- Evaluation of CB-health insurance programme is underway and waiting major findings.
- Evaluation of ethnicity and caste-based disaggregation of service statistics is underway and waiting major findings.
- Evaluation of micronutrient power (MNP) is underway and waiting major findings.
- Evaluation of community management of acute malnutrition (CMAM) is completed
- The adolescent sexual and reproductive health, piloted in five districts in 2009/10 and expanded to an additional five districts, is waiting for evaluation for scaling up.
- Nutrition related pilot programmes, such as school health and nutrition programme (two districts) ongoing , food fortification in roller mills and chakki mills (one district), maternal and child health care (nine districts) completed and food supplementation and child grant (Karnali) are awaiting evaluation.

5. Specific New Strategies for Health System Development

5.1 Implementation of the Human Resource Strategy

The MoHP prepared a costed human resource strategy for health in 2011, giving priority to the production, deployment and retention of critical human resources (MDGP, Ob/Gyn, advanced SBA, anaesthetic assistants). Retention of medical officers has improved (evidenced by fewer complaints in newspapers), but 12 CEOCs have become non-functional due to the lack of surgically skilled doctors or anaesthetic assistants. Models in practice for improving retention include scholarships for care providers with bonding for three to five years' work (NSI model), and retention/ performance based incentives for care providers. A retention/ performance based incentive package was developed for medical doctors and nurses in remote areas two years ago and awaits implementation. Other options include creation of more opportunities for medical doctors and nurses who work in remote areas, with complementary schemes such as career advancement, national and international exposure. MoHP will explore more models for retention and pilot them.

The strategy covers the NHSP II period. Implementation of strategies and prioritised activities incorporated in the strategy will be of priority to MoHP.

5.2 Developing a Health Financing Strategy

Some analyses were completed to inform the health financing strategy, including: fiscal space, budget and expenditure analysis, and demand side financing. Papers have been prepared for areas such as policy options for benefit package development, policy options for social health protection interventions, review of benefit package. Others are in progress, such as benefit incidence analysis, analysis of out of pocket payments, service tracking survey and purchase of services. Development of a health financing strategy will be completed and endorsed by the end of 2012.

5.3 Other Health System Strengthening Strategies

- Output based budgeting will be piloted in 2012/13 for Health Training, TB, Child Health, Immunisation and Aama Programme.
- Expansion of SBA training will be carried out.
- Implementation of a financial management improvement plan for NHSP-2.
- Completion of ongoing health institution construction and new construction as required in the service expansion plan.
- Multi-year procurement of essential drugs and services should be implemented, with quality assurance provision.
- Integrated procurement plan
- Harmonisation of efforts between MoHP and EDPs is essential.
- Monitoring of free health care is needed.
- Quality improvement of HMIS.

6. Expenditure Priorities for the Next AWPB

The expenditure priorities of MoHP are guided by the MTEF, 2nd Three-Year Plan, MDGs and free health policy. The expenditure priorities are set on the basis of equity, efficiency and cost effectiveness.

The top priorities are given in following table.

Top Priorities for Service Delivery

Service	Components
Child health	Scaling up CB-NCP and sustaining quality of IMCI
	Community and routine immunisation
	MR campaign and routine immunisation Maintenance of existing programmes
Maternal health	Scaling up CEOC sites and birthing centres
	FCHV programme
	Family planning
	Scaling up of management of uterus prolapse
	Quality maintenance of existing programmes
	Control and management of gender based violence
Disease control	Elimination of Kala-azar and Lymphatic Filariasis
	Pre-elimination of malaria
	Control of dengue
	Outbreak response
TB, HIV/AIDS	Scaling up prevention, care and support programme
	Quality maintenance of national tuberculosis control programme
Free health care	Universal free care
	Targeted free care at district hospitals
	Health Insurance
	Community Drug Programme
New elements of EHCS	Piloting of community based mental health programme
	Piloting of basic oral health programme

Top Priorities for Health System Development

Health system	Components
Human resources	Implementation of new HRH strategy
	Production of critical human resources
	Retention of medical doctors and nurses
	Training of advanced SBAs, SBAs, AA, and biomedical technicians
Finance	Health financing strategy development
	Output based budgeting system
	Web-based TABUCS
Construction	Completion of existing construction
	Priority constructions as required by service expansion plan
	Construction of big birthing centres at referral and central hospitals
Procurement	e-submission of bids
	Multi-year contracting: construction, drugs, commodities, services
	Monitoring supply of drugs and medical supplies
	Quality purchasing
Drugs and equipment	Revision of listed essential drugs for free care
	Inventory of equipment
Information and evidence	Quality improvement of HMIS
	Operation research

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Progress Report on
Gender Equality and Social Inclusion
for NHSP-2

Report Prepared for Joint Annual Review (JAR)

January 2012

Government of Nepal (GON)
Ministry of Health and Population (MoHP)
Ramshahpath, Kathmandu

Table of Contents

Executive summary

Prioritising gender equality and social inclusion (GESI) is a major aspect of the NHSP-2 goal of improving the health status of the people of Nepal, especially women, the poor and excluded. Considerable progress can be seen.

A GESI Steering Committee has been formed at MoHP to provide policy guidance for mainstreaming GESI in the health sector, and GESI Technical Working Groups are being formed in Department of Health Services (DoHS), Regional Health Directorates (RHDs) and District Health Offices (DHOs). They will provide technical guidance for operationalisation and for implementation of the GESI Strategy. Specific activities have been undertaken to address Gender based Violence (GBV). Work is proceeding toward the establishment of Social Service Units (SSUs) in hospitals. Social Audit Operational Guidelines is being developed and will be piloted. A review of training programmes conducted by different health institutions that assesses the level of GESI integration has been prepared.

The Equity and Access Programme (EAP) now operates in 21 districts, and aims to empower women, particularly the poor and excluded, their families and local stakeholders to secure Maternal and Newborn Health (MNH) rights. Advocacy at local, district and national levels for MNH is a core pillar of the programme. GESI specialists are working in each Regional Directorate, and providing technical support for GESI mainstreaming in the regions.

Important lessons learned are that a clear mandate enables smooth implementation, that addressing GBV issues requires a holistic approach that the poor and excluded must be targeted if they are to be reached, and that raising awareness of rights and social inclusion improves service delivery and accountability. Challenges include ensuring the effectiveness of the OCMCs and services to GBV survivors. Clear identification of the poor is an issue for effective SSUs. Multi-year contracting with NGOs is required for the continuous community level work required for social mobilisation. Ethical challenges are faced in districts where demand is increased but the availability of quality health services remains low. The disaggregation needed to understand the issues of different social groups is another challenge.

Many steps are identified for the way forward.

1. Background

The goal of NHSP-2 is to improve the health status of the people of Nepal, especially women, the poor and excluded. Its mission, strategic direction and values all prioritise gender equality and social inclusion. This is in line with the different efforts of the Government of Nepal (GoN) over the last decade or so to transform Nepal into an inclusive and just state.

Nepal has a diverse population of different caste and ethnic groups. Over centuries some social groups have received better opportunities than others because of gender, caste and ethnicity based practices and due to geographic location. The health indicators of social identity groups such as Dalits, disadvantaged Indigenous People (Adibasi Janajati), some Madhesi groups, Muslims, persons with disabilities and people living in remote districts are lower compared to some other more advantaged groups. There is also gender-differentiated progress in health, with women experiencing poorer development. Gender and social inclusion (GESI) has consequently emerged as a core development concern for all sectors, including the health sector, in Nepal.

The health sector has made immense efforts to improve the health outcomes of Nepal's citizens, and has responded positively to the national mandates of inclusion through its pro-poor and pro-women programmes. Since 2007, the Government's initiatives of pro-poor targeted free health-care policies, coupled with the AAMA programme for maternity services, have seen considerable success. NHSP-2 includes a specific objective to address these, and has put in place impressive plans with disaggregated objectives and indicators. A GESI strategy for the health sector has been included in the NHSP-2. A National Action Plan on Gender based Violence (GBV) coordinated by the Office of the Prime Minister and Council of Ministers and with commitments of 11 ministries, including Ministry of Health and Population (MoHP), has been implemented since November 2010. MoHP has responded to these mandates and has initiated various responses to address inclusion. The NHSP-2 GAAP indicators have two objectives from a Social/Equity Access and Inclusion perspective: i. Advancing the social inclusion of all citizens and ensuring government is more accountable, and ii. Health Facility Management Committees (HFMC) are established and effective. This report presents the progress, achievements and lessons regarding GESI.

2. Objectives

The objective of this report is to provide an update on the initiatives taken by MoHP and its partners on mainstreaming gender equality and social inclusion and addressing key issues experienced by women, the poor and excluded in accessing health services.

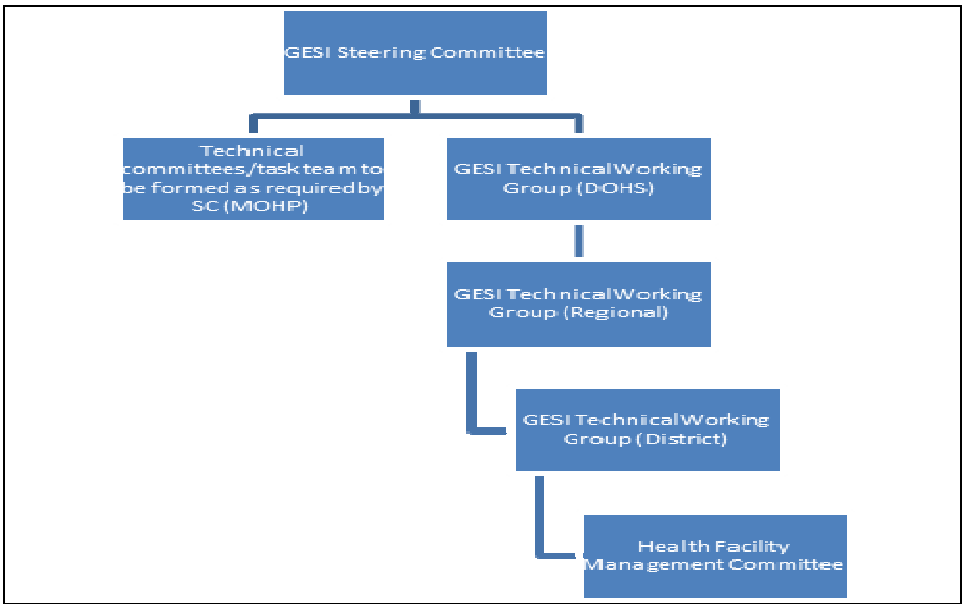
3. Progress and achievements

This progress update is against the GESI strategy framework, objectives, GAAP indicators and of activities undertaken as necessitated by the NHSP-2 results framework.

3.1 Mainstreaming gender equality and social inclusion

The location of GESI responsibility in the health government structure has been developed and approved. (Refer to Figure 1 for GESI mainstreaming modalities and Annex 1 for the approved concept note). A GESI Steering Committee at MoHP has been formed under the Chair of Secretary which will provide policy guidance for institutionalising and mainstreaming GESI in the health sector. Institutional modalities (GESI Technical Working Groups) in DoHS, Regional Health Directorates (RHDs) and District Health Offices (DHOs) have been approved and are in the process of being formed. Their responsibilities will be to provide technical guidance for operationalisation and for implementation of the GESI Strategy. Orientation and capacity building processes are planned and are being implemented. HFMCs too will be oriented on GESI related responsibilities.

Figure 1:GESI mainstreaming modalities



Source: Approved concept note for mainstreaming GESI in the health sector, MoHP, 2011

3.2 *Addressing Gender based Violence (GBV)*

- *Hospital based One stop Crisis Management Centres (OCMCs*): OCMCs will be established in seven districts this FY. These have been identified after a scoping exercise covering hospitals in 10 districts was conducted by the Population Division, jointly with the Department of Women and Children. OCMCs have been launched in all seven districts: Makawanpur, Bardiya, Kanchanpur, Doti, Baglung, Panchthar and Sunsari. Preparatory activities have been carried out to establish an OCMC centre in the Maternity Hospital, Thapathali, Kathmandu. Improved guidelines for OCMC have been approved by the Chief Secretary after incorporating feedback from the scoping exercise.

- *16 Days GBV campaign:* Awareness programmes, radio jingles, workshops, rallies, orientations, interviews on FM radio and meetings with journalists were organised at regional and district level during the 16 days of activism. This developed some sensitivity about violence against women and girls and an understanding about GoN's plans to address GESI. It positioned RHDs as leading coordinators for GBV related work and initiated a multi-stakeholder approach to addressing GBV.

3.3 *Social Service Units (SSU)*

A rapid assessment of social service units currently available in hospitals (Patan, Bir, Maternity, and Kosi Zonal) was conducted. This identified that social services are also being

provided to targeted groups by zonal and other tertiary hospitals, and led to the recognition that it is essential for MoHP to first understand what services are being provided, and what are the mechanisms, good practices and lessons. The SSUs can only be established based on this assessment. This will inform the implementation of the SSU in future. (Refer below for the steps in Way Forward.)

3.4 *Developing Social Audit Guidelines*

Under the guidance of a technical committee formed under the Primary Health Care Revitalisation Division (PHC-RD), a draft of social audit guidelines and an operational manual have been prepared based on stakeholder consultations and a review of existing guidelines of AAMA and Free Health Care, and of the current practices in different ministries (such as the Ministry of Local Development and the Ministry of Education). Currently, draft social audit guidelines and operational manuals have been circulated to different stakeholders for wider consultation and a final draft for piloting (field testing) will be produced. After the first few audits, which will be considered as piloting the guidelines, a technical review meeting will revise them as necessary. Then social audits will be conducted in different government health facilities of 20 districts through the Annual Work Plan Budget (AWPB) of 2011/2012 and the results will be shared during the next Joint Annual Review (JAR). Similarly, training to concerned DHO/health facility and NGOs staff on community score card is completed and piloting of community score card in some VDCs of four districts (Morang, Dang, Doti and Rasuwa) have been implemented with the technical support of World Bank.

3.5 *Review of MoHP Training Curriculums*

Under the guidance of a technical committee, an inventory of the training programmes conducted by different health institutions has been prepared and the level of GESI integration in the training assessed. A few core training programmes are to be identified for in-depth review from a GESI perspective and revisions will be undertaken based on the Technical Committee's decisions.

3.6 Equity and Access Programme (EAP)

EAP aims to empower women, their families and local stakeholders to secure Maternal and Newborn Health (MNH) rights; its target is the poor and excluded. It engages with poor and excluded women through local women's groups, and mobilises support from family members and the local community. Through information and group mobilisation the programme seeks to empower poor and excluded women to seek appropriate MNH care, demand their MNH rights and seek accountability of local health providers and duty bearers. Alliances between

women's groups and networks strengthen women's and community voices for MNH and increases their influence on health providers and local and district authorities for better and more responsive MNH services. Advocacy at local, district and national levels for MNH is a core pillar of the programme.

The Family Health Division (FHD) started Equity and Access Programme implementation in fiscal year 2008/09 (under AWPB) with two districts (Gorkha and Kanchanpur), and gradually expanded into 16 districts (9 districts in 2009/10 and 16 in 2010/011) and planned for expansion into a further five districts this year. Until last year, the EAP technical focus was primarily on safe motherhood and newborn health rights, and the programme was implemented by contracting local NGOs on a yearly basis. From this fiscal year, however, the programme is housed in PHC-RD in line with the expanded scope of its coverage (including Safe Motherhood, Neonatal and Child Health (SMNCH), Free Health Care, Reproductive Health (RH), Nutrition etc.). This year EAP implementation is planned for a total of 21 districts, and the NGO contracting process is already being started.

3.7 GESI Specialists at Regional Level

In line with the vision of NHSP-2, there is a provision of GESI Technical Assistance (TA) support team in each regional health directorate. GESI specialists are working with the Regional Directorates and providing technical support for GESI mainstreaming in the annual work plan implementation across the regions. Since GESI specialists have been posted in the regions, they have identified their counterparts and are working together to identify the regional priorities. One of the major supports they have provided to RHDs has been in preparing and facilitating regional annual health reviews from a GESI prospective. A short session on GESI was included in the review and presented GESI related case studies. The GESI Specialists have also made a huge contribution in documentation of review outcomes and report writing. With the provision of GESI Specialist, the RHDs have been acting as leading coordinators for GESI, and are providing active facilitation support to the districts. The RHDs are also preparing to form regional GESI technical working groups (multi-sectoral) to guide and facilitate the GESI mainstreaming process across the regions. In addition, the RHDs are providing technical support to selected districts in setting up OCMCs for GBV survivors. Similarly, RHD is initiating the analysis of regional information and situations from a GESI prospective, and is preparing a mapping of vulnerable populations to address the basic health needs of the poor and excluded.

3.8 GESI Activities in AWPB and the Implementation Status

MoHP allocated a reasonable amount of health budget for GESI, including GBV. This year the AWPB made budget provision especially for developing a GESI implementation plan, capacity development at different levels, establishing One-stop Crises Management Centres for GBV survivors and Social Service Units at different hospitals to address the needs of women, the poor and excluded. Similarly, budget provision was also made for targeting the Equity and Access Programme, functionalising disaggregated reporting in selected districts, youth and adolescent focused information and counselling support, and targeted funds for referral from remote districts.

4 Lessons learned

4.1 Clear mandate enables smooth implementation

The clear framework of NHSP–2 and the GESI strategy have provided the direction necessary for GESI related activities to be planned and implemented. Similarly the National Action Plan on Addressing Gender Based Violence and its regular reporting mechanisms have clearly given momentum to work in this area.

4.2 Addressing GBV issues requires a holistic approach

In order to prevent GBV and also to inform the survivors of the services available in hospitals it is essential to work on the demand side as well. Additionally a coordinated approach must ensure that GBV survivors are supported in all aspects, including rehabilitation within the family and community.

4.3 Targeting the poor and excluded:

Within a universal coverage approach, targeting the poor and excluded is essential if they are to be reached, regardless of the resources available. This is fundamentally a moral argument.

4.4 Raising awareness of rights and social inclusion

Raising awareness of rights and social inclusion among service users and service providers is effective in improving service delivery and accountability.

5 Key Challenges

5.1 Effective OCMCs

Ensuring that OCMCs are effective and able to support gender based violence survivors requires very dedicated attention and support. There is little existing experience as this is a new concept in Nepal. Human resource capacity for this also needs to be strengthened; counsellors with the required skills and understanding are limited. On-going technical assistance by regional and central teams will be essential.

5.2 Effective service to GBV survivors

Providing effective service to GBV survivors from the OCMC requires coordination between five Ministries: Ministry of Home, Ministry of Women, Children and Social Welfare, Ministry of Law and Justice, Ministry of Health and Population, Ministry of Local Development. Lack of a blended guideline for the overall functioning of OCMC with clear coordination mechanisms have created a challenge for these Ministries to work together coherently.

5.3 Clear identification of the poor

Clear identification of the poor is a challenge for effective functioning of SSUs as robust tools for categorisation according to well-being is not possible. Alternative mechanisms to ensure that the non-poor do not take advantage of the situation have to be identified.

5.4 Need for multi-year contracting

Ensuring continuous services at the community level requires a multi-year agreement with NGOs. Multi-year contracting is important for continuous work at the community level as otherwise NGOs and other providers find it difficult to work regularly with the community. Community empowerment through Social Mobilisation work (such as the EAP type of programme) requires long term involvement and engagement with the community and cannot be left in the middle if the contract finishes.

5.5 Ethical challenges

Ethical challenges must be faced in districts where demand is being increased yet where the availability of quality health services remains low. In these areas, referral related delays in reaching care could be expected to increase with potentially negative health outcomes.

5.6 Challenges of disaggregation

The disaggregation necessary for real understanding of the disparities and issues of different social groups is a challenge as the Health Management Information System (HMIS) and other planning and monitoring systems still need to be revised to include such dimensions.

6 Way forward

- Backstopping support and monitoring of the recently inaugurated OCMCs will be done. The regional team will play an important role in this work.
- A GESI Implementation plan has to be developed to translate NHSP-2 commitments and the GESI strategy into action.
- Guidance on how to mainstream gender equality and social inclusion in the health sector will be prepared based on inputs collected through consultations.
- Orientation of GESI Technical Working Groups and Regional level workshops for common understanding on GESI and for inputs into the guidance notes and implementation plan are planned.
- The Equity and Access Programme is from this year housed in PHC-RD with the mandate of a wider scope of coverage, including Safe Motherhood, Neonatal and Child Health, Reproductive Health/Family Planning, Nutrition and Free-care. EAP is not simply for health message dissemination and advocacy; it is more about social mobilisation and community empowerment. As such it requires continuous engagement with and involvement of the community in its own process and cannot be left in the middle if the NGO contract finishes. Therefore multi-year contracting is important for NGOs to work continuously at the community level.
- Operational research will be designed and conducted to inform the implementation of NHSP-2 objective number 2: “To reduce cultural and economic barriers to accessing health care services and harmful cultural practices in partnership with non-state actors”. This is required in order to understand the barriers and inform the development of appropriate MoHP strategies
- An assessment of how well women, the poor and excluded have been able to access free health care services is being conceptualised. The study will be done under the guidance of PHC-RD once the concept note and ToRs are finalised.
- Social audits will be conducted in 20 districts and the lessons will be used to inform the next AWPB.
- In two hospitals, a detailed review of actual social services being provided (what services, who accesses, how it is implemented, what lessons) will be conducted. Based on this on-site observation and the lessons learned, a consensus of key stakeholders will be developed regarding the implementation modalities of SSU, within the framework of the existing guidelines.

References

- Nepal Health Sector Programme (NHSP) II (2010-2015), Ministry of Health and Population, Government of Nepal.
- Health Sector Gender Equality and Social Inclusion (GESI) Strategy 2010, Ministry of Health and Population, Government of Nepal.
- Concept Paper on Institutional Mechanisms for Gender Equality and Social Inclusion Mainstreaming across the Ministry of Health and Population 2011, Government of Nepal.
- Hospital Based One-stop Crisis Management Centre (OCMC) Operational Manual 2010, Ministry of Health and Population, Government of Nepal.
- Social Service Unit Implementation Guidelines 2010, Ministry of Health and Population, Government of Nepal.

Report on Gender Equality and Social Inclusion against Annex 3 Strategic Framework, NHSP-2

Strategy	Working policy	Report on GESI related progress in 2011 against the working policy provisions
OBJECTIVE 1: DEVELOP POLICIES, STRATEGIES, PLANS AND PROGRAMMES THAT CREATE A FAVOURABLE ENVIRONMENT FOR INTEGRATING (MAINSTREAMING) GESI IN NEPAL'S HEALTH SECTOR.		
Strategy 1. Ensure inclusion of GESI in the development of policies, strategies, plans, setting standards, and budgeting, and advocate for use of such policies, standards and budget provisioning at the central level.		
Review the existing policy, law and guidelines to make them GESI inclusive.	1. Integrate GESI in existing health policy, regulations and guidelines. 2. Advocate for health as a fundamental human right in constitution. 3. Include the standards for integration of GESI in second NHSP. 4. Develop mechanisms for regular policy feedback. 5. Revise HMIS to improve health monitoring on GESI. 6. Identify and recommend expansion of health facilities to locations with high concentration of underserved poor & excluded.	1. GESI provisions were clarified in Maternal, Newborn and Child Health, Adolescent Sexual and Reproductive Health Communication Strategy developed by NHEICC, One Stop Crisis Management Centre and Social Service Unit Guidelines and integrated in Social Audit Guidelines. These have been raised in Urban Health Policy development process. 4. Institutional structures of GESI Steering Committee and Technical Working Groups were approved (refer point 29 for details)
Make necessary policy provisions to include GESI related issues in plans, programmes, and budgeting.	7. Develop policy for identification of poor and excluded groups. 8. Develop implementation guidelines and ensure implementation. 9. Develop policy measures to promote GESI in human resource management. 10. Develop provisions for poor and excluded groups to receive free secondary and tertiary health care services. 11. Formulate provisions for compulsory social auditing to make health services inclusive, transparent and accountable. 12. Incorporate GESI in e-AWPB programmes and MoHP activities. 13. Advocate to the MoF and NPC for regular budget provisioning of GESI in AWPB. 14. Formulate provision for health cooperatives for easier access of poor and excluded to health services. 15. Develop provision for Health Insurance to increase access to health services of poor and excluded. 16. Formulate provision for media to disseminate health care messages and inform about facilities for poor and excluded groups.	8. Development of GESI implementation guidelines is in progress. 9. GESI related provisions were added in the HRH Strategy. 10. Provision of free health care was expanded up to the district hospital level. Similarly, Social Service Unit Guidelines were developed with provisions for the poor, vulnerable and marginalised to receive free secondary and tertiary health care services. 11. Draft of Social Audit Operational Manual was prepared after a review and is to be piloted in 21 facilities of 2 districts and implemented in 20 districts in the current fiscal year through AWPB and will be continued from next year onward as a regular activity. 12. AWPB had budget provision for developing a GESI implementation plan, capacity development at different levels, setting-up of one stop crises management centres for GBV survivors and social service units in four different zonal hospitals; for a targeted Equity and Access Programme, functionalising disaggregated reporting in selected districts, youth and adolescent focused information and counselling support and targeted fund for referral from remote districts. The provision of GESI budget in AWPB will be increased each year. 15. DoHS has been evaluating health insurance schemes implemented in 6 government health facilities and 6 non-governmental health facilities with TA support from GIZ during this fiscal year. 16. There is provision of communication budget for the D/PHO in AWPB to disseminate health messages in local languages through local media.

Strategy	Working policy	Report on GESI related progress in 2011 against the working policy provisions
Strategy 2: Prioritise GESI in planning, programming, budgeting, monitoring and evaluation at local levels (DDC, DHO, DPHO and VDC) to ensure services are accessible and available to the poor, vulnerable and marginalised castes and ethnic groups.		
Create an environment whereby programme planners, managers and directors will include issues related to GESI in making plans, programmes, budgeting, monitoring and evaluation.	17. Address GESI issues in plans, programmes and budgets. 18. Develop GESI indicators as necessary, disaggregate the HMIS, monitor and report performance of target groups. 19. Define roles and responsibilities for monitoring and evaluating performance of target groups. 20. Develop mechanisms/ processes to review the progress from a GESI perspective periodically.	17. RHD was supported by regional GESI TA for mainstreaming GESI into the regional health system strengthening processes, including the annual review and in the documentation of the review outcomes. This will inform the next planning cycle. 20. GESI Technical Working Group of DoHS has initiated a review of the achievements and areas of improvement in the programmes run by the different divisions from a GESI perspective.
Include GESI related issues in programme implementation by health service providers.	21. Operationalise guidelines to facilitate access and utilization of health services by the poor and excluded. 22. Ensure that the work of every health institutions includes GESI.	21. The process for developing GESI operational guidelines has started with orientation of TWG. Regional level workshops will provide inputs for the draft guidelines which will then be finalised after discussion with the GESI Steering Committee
Coordination and participation among concerned organisations for GESI.	*23.* Coordinate with MLD, MoF and NPC to allocate more budget for GESI in DDCs, VDCs and Municipalities. *24.* Coordinate and implement with DDCs, VDCs, and Municipalities to attract their social development budgets in the health sector. *25.* Continue handover of health facilities at local level and make the HFOMC inclusive. *26.* Coordinate/partnership with district-and village-level NGOs working in health sector. *27.* Coordinate with Ministries, I/NGOs and local bodies to integrate GESI in their programmes. *28.* Create trust between health care providers and communities. *29.* Policy provisions to make local bodies responsible to develop participatory inclusive plans, implement and monitor. *30.* Transfer knowledge, skills, resources and materials to local bodies to meet the needs of the target groups.	25. HFOMC training/orientation guidelines are being revised to integrate GESI responsibilities as approved by the GESI Steering Committee. 26. Equity and Access (EAP) programme, which seeks to empower poor and excluded women to seek appropriate MNH care, demand their MNH rights and seek accountability of local health providers and duty bearers, is planned in 21 districts and NGO contracting process is ongoing. 27: RHD with support of Regional GESI TA s is analysing regional information and situation from a GESI perspective and preparing vulnerable mapping to address the basic health needs of the poor and excluded. This will provide evidence for programming and interactions. 28. Interaction between health service providers and community people (right holders) is on-going in EAP and partner supported districts. 29. MoHP and MoLD along with EDP partners, are piloting local health governance strengthening programmes (LHGSP) in 8 districts of Nepal.
Strategy 3: Establish and institutionalise GESI unit/desk at the MOHP, DOHS and divisions of the DOHS, regional directorates, and DHO/DPHO, and Social Service Units for GESI at central, regional, sub-regional, and zonal hospitals.		
a) Establish Social Service Units (SSU) in hospitals.	31. Establish and operationalise Social Service Units in central, regional, sub-regional, zonal, and district hospitals.	31. A rapid assessment of Social Service Units currently available in hospitals (Patan, Bir, Maternity, and Kosi Zonal) was conducted. This identified that social services are being provided to targeted groups by zonal and other tertiary hospitals. Hence MoHP will first assess what services are being provided, what are the mechanisms, good practices and lessons. This assessment will inform the implementation of the SSUs.

Strategy	Working policy	Report on GESI related progress in 2011 against the working policy provisions
b) Establish GESI Unit/Desk at different levels of the health sector.	32. Establish GESI and internalisation of GESI unit within MoHP, DoHS, RHDs, and D(P)HOs.	32. The location of GESI responsibility in the health government structure has been developed and approved. A GESI Steering Committee at MoHP has been formed with Secretary as Chair. This will provide policy guidance for institutionalising and mainstreaming GESI in the health sector. Similarly, a GESI technical committee has also been formed at DoHS level with the Director General as Chair. This will provide practical guidance to operationalise GESI in programming and implementation. GESI Technical Working Groups in RHDs and DHOs have been approved and are in the process of being formed. Their responsibilities will be to provide technical guidance for operationalisation of the GESI Strategy. Provision of a GESI focal person in each hospital has been approved by the secretary. Orientation and capacity building processes are planned and are being implemented. HFOMCs will also be oriented on GESI related responsibilities and the guidelines revised to specifically include GESI responsibilities.
OBJECTIVE 2: ENHANCE THE CAPACITY OF SERVICE PROVIDERS AND ENSURE EQUITABLE ACCESS AND USE OF HEALTH SERVICES BY THE POOR, VULNERABLE AND MARGINALISED CASTES AND ETHNIC GROUPS WITHIN A RIGHTS-BASED APPROACH.		
Strategy 4: Enhance the capacity of the service providers to deliver essential health care service to poor, vulnerable, marginalised castes and ethnic groups in an equitable manner and make service providers responsible and accountable.		
Improve service delivery mechanism by service providers for the poor, vulnerable and marginalised caste and ethnic groups.	33. Sensitise health workers, SSU and GESI focal point at all levels, FCHVs, and HFOMCs on GESI. 34. Implement behaviour change training for the health workers, FCHVs and local HFOMCs. 35. Strengthen capacity of FCHVs and NGOs to provide proper information to target groups on health services. 36. Include GESI content in the health sector education and training curricula.	33. GESI orientation to MoHP, especially Population Division, Steering Committee and Technical working Group of DoHS was completed. At the regional level, RHD staff were oriented by the Regional GESI specialists. 36. Under the guidance of a technical committee, an inventory of the training programmes conducted by different health institutions has been prepared and the level of GESI integration in the training assessed. A few core training programmes (FCHV training, upgrading training of AHWs BCC and GBV) have been identified for in-depth review from a GESI perspective and revisions will be undertaken based on the Technical Committee's decisions.
Strategy 5: Address GESI-related barriers by properly identifying target groups, ensuring remote communities are reached, and emphasising programmes to reduce morbidity and mortality of the poor, vulnerable and marginalised castes and ethnic groups.		
Increase access of the target groups to universal and targeted free care programmes.	37. Develop criteria to identify poor and excluded groups and provide them with "Free Health Check-up Cards" for secondary- and tertiary-level health care services and referrals. 38. Ensure equitable and meaningful participation of target groups and women in HFOMCs. 39. Ensure meaningful participation of poor and excluded groups in social audits of health services.	39. Social audit guidelines have provisions to include women, the poor and socially/geographically excluded, in the consultation process in the community and encourage the meaningful participation of women, the poor and excluded.

Strategy	Working policy	Report on GESI related progress in 2011 against the working policy provisions
Increase the use of Mother and Child Health and Free delivery services by the target group.	**i) Develop special programmes for women, poor, and excluded (women and children) to increase their access to MCH services and free deliveries.** 40. Support increasing use of neonatal and postnatal care services, institutional deliveries, nutrition, and childhood immunisation. 41. Mobilise and train/strengthen FCHVs and NGOs to increase target groups' access to services. 42. Provide assistance on awareness raising, IEC/BCC programmes, outreach services to pregnant women.	40. Budget provision for transport incentive under Aama programme has been increased. Similarly, incentives to pregnant women who complete 4 ANC check-ups on time and give birth at health facility have been continuing for the last 2 years. 41. Provision was made last year for EAP implementation in 15 districts for community mobilisation through local NGOs.
	ii) Address gender based discrimination which constrains access of women (of different social groups) to health care services, especially institutional deliveries. 43. Collaborate with women's CBOs /NGOs on gender and social based discrimination. 44. Conduct community and family counselling on GBV. 45. Promote regular work attendance of female health workers.	43-45 OCMCs will be established in seven districts this FY. These have been identified after a scoping exercise covering hospitals in 10 districts was conducted by the Population Division, jointly with the Department of Women and Children. OCMCs have been launched in four districts: Makwanpur, Bardiya, Kanchanpur and Doti. Orientation regarding OCMCs has been done in Panchthar Hospital. Preparatory activities have been carried out to establish an OCMC centre in the Maternity Hospital, Thapathali, Kathmandu. Improved guidelines for OCMCs have been approved by the Chief Secretary after incorporating feedback from the scoping exercise. *16 Days GBV campaign:* Awareness programmes, radio jingles, workshops, rallies, orientations, interviews on FM radio and meetings with journalists were organised at regional and district level during the 16 days of activism. This developed some sensitivity about violence against women and girls and an understanding about GoN's plans to address GESI. It positioned RHDs as leading coordinators for GBV related work and initiated a multi-stakeholder approach to addressing GBV.
Conduct context specific analysis of current issues in the health sector and design and implement specific interventions for specific poor, vulnerable and marginalised caste and ethnic groups and areas (Regional and/or District).	**iii) Promote service expansion in geographically inaccessible/remote regions.** 46. Conduct mapping of the areas and increase outreach and mobile health camps and community health clinic programmes for the target groups. 47. While establishing new HP/SHP, select a site most appropriate for the target groups' access and use.	46. Regional GESI TA are supporting RHD in preparing a mapping of vulnerable populations to address the basic health needs of the poor and excluded.
	iv) . Expand services in low HDI districts. 48. Focus on community and outreach programmes in the 35 low HDI districts. 49. Ensure programmes are focused at less populated areas to make the target groups feel health as their fundamental right.	48. MoHP initiated a public health promotion programme last year. There is a provision for comprehensive health camps in remote districts and those with poor health care services.

Strategy	Working policy	Report on GESI related progress in 2011 against the working policy provisions
	v) Make provision for regional programmes to address unmet health issues and needs of women, poor and excluded. 50. Promote programmes like publicity campaigns, outreach services, counselling services and orientations to free care. 51. Conduct special activities to reach Dalits. 52. Implement special programmes such as providing monetary incentives to those using EHCS.	
Strategy 6: Enhance or modify services to be sensitive to GESI and ensure access is equitable and services are delivered uniformly without regard to social status.		
Give emphasis to special activities to provide adequate and quality services.	53. Ensure the presence of female doctors at all district hospitals. 54. Make a provision for local language speaking staff at service delivery sites. 55. Allow the district-level health organisation to adopt district-specific GESI policy, if needed. 56. Conduct social audits.	56. Social audits are planned in 21 districts in current FY (as discussed above).
OBJECTIVE 3: IMPROVE HEALTH SEEKING BEHAVIOUR OF THE POOR, VULNERABLE AND MARGINALISED CASTES AND ETHNIC GROUPS WITHIN A RIGHTS-BASED APPROACH.		
Strategy 7: Develop and implement Information Education and Communication (IEC) programmes to improve health seeking behaviour of the poor, vulnerable and marginalised groups.		
Develop and disseminate targeted IEC materials that will bring changes in behaviour of target groups.	57. Prepare and distribute enough audio visual, pictorial, etc information and publicity materials. 58. Include the target groups' programme in publicity and communication materials of MoHP. 59. Develop skills at the local level for producing information materials, especially in remote areas.	57. Provision of financial resources for communication activities in district health offices and regional health directorates. Practice of utilising central level prototype of radio and TV messages in local languages through local media and materials.
Increase the use of appropriate media.	60. All media allocate appropriate time for broadcasting health service news. 61. Emphasise use of effective media and local languages. 62. Increase information communication on GESI among health institutions. 63. Include appropriate media programming for low HDI districts and districts with diverse language. 64. Conduct regular monitoring on quality of communication services.	62. MOHP developed BCC/IEC communication on SMNCH, and an Adolescent and RH communication strategy.

Strategy	Working policy	Report on GESI related progress in 2011 against the working policy provisions
Strategy 8: Empower the target groups to demand their rights and conduct their roles while realising their responsibilities.		
a) Increase the target groups' awareness of their health rights and of free health care services, and enhance their capacity to make the service providers accountable.	**vi) Empowerment.** 65. Conduct activities for the target groups to make them aware of their rights/responsibilities and capable of taking leadership roles. vii) **Information, Education and Communication** 66. Conduct publicity campaigns on how to access and properly utilise health services. 67. Create door-to-door consumer committees and orient them to conduct effective awareness and information dissemination to the target groups. 68. Develop and conduct orientation and awareness campaigns for change in health seeking behaviours. 69. Promote women's participation and conduct awareness on equal treatment of both male and female children. 70. Provide orientation on women's reproductive health rights.	65. Provision was made last year for EAP implementation in 15 districts for community mobilisation through local NGOs. 66. MOHP developed BCC/IEC communication on SMNCH, and an Adolescent and RH communication strategy (as stated above). Similarly, provision has been made of financial resources for communication activities in district health offices and regional health directorates. Practice of utilising central level prototype of radio and TV messages in local languages through local media and materials.

Annex 4

Aide Memoire

NEPAL HEALTH SECTOR PROGRAM II (NHSP II)
The Second Joint Annual Review (JAR), January 16-18, 2012.
AIDE-MÉMOIRE

1. Background

The second Joint Annual Review (JAR) of the Nepal Health Sector Program II (NHSP II) took place from January 16-18, 2012, organized by the Ministry of Health and Population (MOHP) and with participation by various line agencies of the Government of Nepal GON) , External Development Partners (EDPs), civil society organizations and other state and non-state actors. The full list of participants is reflected in Annex 1. MOHP prepared a number of reports as outlined in the Joint Financing Arrangement and these reports formed the basis for the discussions during the JAR. The reports will soon be available on MOHP's website. This Aide-Mémoire summarizes the main issues discussed and agreed actions. The Aide Mémoire will be complemented by a number of reports documenting the progress made in several areas of NHSP II.

2. Progress

The JAR made a systematic assessment of the performance of NHSP II against its stated objective as elaborated in the results framework. This assessment was based on data from the Nepal Demographic and Health Survey (NDHS 2011), the Service Tracking Survey (STS 2011) and the Health Management Information System (HMIS). The results from the two surveys are preliminary and the full and final DHS report, which contains disaggregated results by income and social groups, will be made available next month. Two tables summarizing the achievements against the targets are presented in Annex 2. The assessment shows that the results are mixed: while good progress has been made in a broad range of indicators, there are areas where performance is lagging and require focused attention in the coming year.

Good progress has been made in a number of areas. The target for the Under-5 Mortality Rate was met (NDHS 2011) and the percentage of children receiving all basic vaccines has increased significantly from 83 in 2006 to 86.6 percent in 2011 and exceeded the target (HMIS, verified by NDHS 2011). The percentage of births attended by skilled birth attendant has increased significantly to 36.0 in 2011 from 18.7 percent in 2006 (HMIS, verified by NDHS 2011). Similarly the percentage of children under 5 with Acute Respiratory Infections who received antibiotics increased from 25.1 in 2006 to 41 percent in 2011 (HMIS) and exceeded the target. The percentage of health facilities with social audit reached 40 percent against the end of project target of 25 percent (STS 2011). The Total Fertility Rate (TFR) has declined from 3.0 to 2.6 between 2006 and 2011 (NDHS 2011). Tuberculosis case detection rate and cure (success) rates exceeded the targets at 76.3 and 90 percent respectively (HMIS). The Malaria Annual Parasite Incidence (API) was maintained at 0.15 during this year HMIS).

However progress is not uniform across all indicators. Child health targets including the Infant Mortality Rate (IMR) (NDHS 2011), Neonatal Mortality Rate (NMR) (NDHS 2011), and provision of zinc supplementation for children with diarrhea (HMIS) fell short of achieving the

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stipulated targets. A total of 909 SBAs were trained against the target of 1134 (HMIS). At 21 percent, the percentage of primary health care centers (PHCCs) providing all Basic Emergency Obstetric Care (BEOC) signal functions also falls slightly short of the target of 23 percent (STS 2011). There is a slight decrease in the Contraceptive Prevalence Rate (CPR, modern methods) from 44.2 percent in 2006 to 43.2 percent to date, despite the fact that the TFR continues to decline as mentioned above. Of significant concern is the availability of health services: only 11 percent of health posts provide both 24/7 delivery services and short term contraception (hormonal and non-hormonal), implant and Intra-Uterine Contraceptive Device (IUCD) services, against the target of 45 percent (STS 2011). Similarly, only 61 percent of the sanctioned doctors and nurses positions in PHCCs and hospitals were filled while the target was 85 percent (STS 2011). In order to address this issue, however, MOHP has addressed this issue through the employment of 365 doctors who completed their medical education with the support of scholarships to work in health facilities (district hospitals and Primary Health Care Centers) outside Kathmandu valley.

3. Issues and agreed actions

The following focuses on key issues raised and an action agreed, and does not document the full account of detail of the discussions.

*i) **Strategic direction and expenditure priorities:*** The presentation and report on the strategic direction and expenditure priorities for the forthcoming fiscal Year (FY) were in line with NHSP II but more detail is required on the way future activities and expenditures will prioritize the areas in which the indicators are lagging.

> ***Action**:* It was agreed that the Ministry and EDPs will elaborate on the priorities and associated expenditures outlined in the first draft 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.

*ii) **Monitoring and evaluation:*** Absence of a national M&E framework has resulted in a weak M&E system. Moreover, the further use of data for decision making will need continued priority. In addition, progress at the JAR was presented against the 2010 Results Framework (RF) although the RF was revised late 2011.

> ***Action**:* 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.

*iii) **Technical assistance:*** There was an expressed concern by the Department of Health Services (DOHS) on the type and quality of technical assistance (TA) provided by EDPs and the extent to which it contributes to the results of NHSP II and capacity development. Given the

time elapsed between now and the design stage of NHSP II, there was a suggestion to review TA requirements.

> ***Action:*** It was agreed that such assessment 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 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.

iv) Fiduciary: Financial management continues to be a challenge for MOHP and shows little improvement over previous years. Delays in submitting Financial Monitoring Reports (FMRs), unresolved audit issues, and the unsatisfactory status of financial management action plan of the Governance and Accountability Action Plan (GAAP) are examples of these weaknesses. In summary the issues are: a) the third trimester report of FY2010/11 was submitted with delays and the first trimmest report FY2011/12 is already overdue; b) the unaudited financial statements of FY2010/11 is also overdue; and c) the audit issue of FY2009/10 has yet not been resolved. No satisfactory response was received to the audit issues raised in last year's audit. Finally, despite previous commitment, procurement plans have never been produced in time to be incorporated in the AWPB document.

> ***Action:*** 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.

v) Drug stock-outs: A large proportions of health facilities are facing stock outs of essential drugs. According to the Department of Health Services, the Logistics Management Division and the Management Division, this is mainly due to lack of distribution from district stores to health facilities.

> ***Action:*** 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.

vi) Participation of NGOs and the private sector in national programs: The ministry has expressed its disappointment with some private and non-government health institutions' unwillingness to participate in national programs such as the Aama program. At the same time it appears that the institutions' reservation to participate in the program is partly to avoid the risk of reimbursement being denied for the services delivered. This situation can be managed if an explicit contractual agreement is entered between MOHP and the institutions concerned where payments are made based on verified performance.

> *Action:* It was agreed that the Ministry will start a performance based payment system with hospitals, including NGO and private sector facilities, during the next Fiscal year. Performance indicators and the modalities will be elaborated by end of April 2012.

vii) Physical asset management: The need to further consolidate the physical asset management initiatives was once again highlighted in the JAR based on an assessment of the functionality of physical assets across the health system. While an adequate level of funding needs to be assured for the completion of on-going infrastructure projects and related equipment, it is also crucial that adequate budgetary allocations are made for the maintenance of health facilities and medical equipment.

> *Action:* 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 ongoing 527 infrastructure projects.

viii) Medical Waste Management: During the field trips it was observed that the practice of health waste management at the level of health facilities leaves much to be desired and that this poses a hazard to personal and environmental health.

> *Action:* The MOHP will print the Environmental Health Impact Assessment (EHIA)-plan and Environmental Management Framework-plan and organize a workshop in order to disseminate and 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.

ix) Urban Health: The responsibility for the financing and provision of health services in municipalities lies with the Ministry of Local Development (MOLD) and MOHP has the responsibility of providing technical assistance to MOLD. However, little interaction exists between the two ministries on the subject and urban health is allocated very little priority by MOLD as became obvious from observations during the field trip. This has led to a situation whereby the urban poor have limited access to priority programs unless they can afford to access them from private sector facilities or the few NGOs operating health facilities in municipalities.

Action: 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.

x) ***Gender Equality and Social Inclusion (GESI):*** NHSP II contains a clear GESI strategy and encouraging progress has been made with a number of programs initiated to address the issues of inequity and Gender-Based Violence. These programs will be scaled up during the next FY. However, it is clear that addressing inequity issues will require the attention and efforts of all programs and systems – i.e. GESI will need to be mainstreamed into everyday planning and implementation.

Action: All departments, divisions and centers will be encouraged to take into consideration the issue of reaching the under-served and include specific actions and budgets in their workplan and budget for the next Fiscal Year as a way of demonstrating commitment to GESI priorities.

xi) Harmonization and alignment: The JAR takes note of KfW, German Financial Cooperation joining the Joint Financing Arrangement as a pooling partner on January 27, 2012.

Action: All stakeholders look forward to an agreement with the GoN on finalizing the Joint Technical Assistance Arrangement (JTAA) within FY 2011/12.

4. Next steps

a) The JCM will be held in the fourth week of March 2012.

b) The National Planning Commission and the Ministry of Finance will be invited to JCMs.

c) The Mid Term Review (MTR) of NHSP II will take place during the 2013 based on an independent review of progress against NHSP II as set out in the JFA. MOHP and EDPs will prepare for and agree the format and timing of the MTR during the next JCM, including any additional analysis, activities or resources that may be required for the review.

d) The partners and MOHP have agreed that this Aide Mémoire will be classified as a public document.

e) The dates for the JAR 2013 will be January 28, 29 and 30, 2013

Signed for the Ministry of Health and Population, Dr Praveen Mishra, Secretary

Government of
Ministry of Health &

Singed for the External Development Partners, Dr. Bert Voetberg, EDP Chair

Date: February 16, 2012

Annex 1: Participating Organisations in Joint Annual Review , 16th -18th January 2012

	Name of Organisation (EDPs)	Name of Organisation (I/NGOs & Other Professional Organisations)	Name of Organisation (Government)	Name of Organisation (Hospitals/Councils/Associations/Academics)
1	DFID	CARE Nepal	Ministry of Health & Population	Nepal Eye Hospital
2	World Bank	Family Planning Association of Nepal	Department of Health Services	Patan Academy of Health Sciences
3	GAVI	Nepal Family Health Programme	Ministry of Finance	Nepal Nursing Association
4	WHO	Save The Children	National Tuberculosis Center	Nepal Public Health Association
6	UNFPA	IPAS	Department of Urban Development & Building Construction	Institute of Medicine
7	USAID	Rotary International	Nepal Health Research Council	Nepal Health Economics Association
8	AusAID	Health Research and Social Dev. Forum	Regional Health Directorate (RHD), Eastern Region	BP Koirala Institute of Health Sciences, Dharan
9	KfW	Nepal Netra Jyoti Sangh	RHD, Central Region	Kathmandu School of Medical Sciences
10	GIZ	International Vaccine Institute, South Korea	RHD, Far Western Region	Association of NGO Hospitals
11	UNICEF	Good Neighbours International	RHD, Mid Western Region	
13	UNAIDS	Population Services International	DPHO, Bhaktapur	
14	UNDP	New Era	DPHO, Kathmandu	
15	KOICA	UCSF-University of California San Fransisco	DPHO, Lalitpur	
16	SDC	RTI - Neglected Tropical Disease	Department of Ayurveda	
17	NHSSP	Netherlands Leprosy Relief	Department of Drug Administration	
19	UNODC	CHPRS	Kathmandu Metropolitan City	
20		Merlin	Sahid Gangalal National Heart Center	
21		The Kathmandu Post	TU, Teaching Hospital	
22		Himalayan Media	Teku Hospital	
23		Resource Center for Primary Health Care	Cancer Hospital, Chitwan	
24		Child Welfare Scheme	Nepal Army Hospital	
25		SAIPAL	Nepal Police Hospital	
26		SABIN Vac. Intl.	Ayurvedic Hospital	
27			Bir Hospital	
28			Maternity Hospital	
29			National Planning Commission	

Government of Nepal
Ministry of Health & Population

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Annex 2: Key indicator tables

Table 1: Indicators that have been achieved in 2011

Indicator	Target 2011	Achieved 2011
Total Fertility Rate	3.0	2.6
Under-five Mortality Rate	55	54
% of children under five years of age, who are underweight	34	28.8
Tuberculosis case detection rate (%)	75	76.3
Tuberculosis case success rates (%)	89	90
Malaria annual parasite incidence per 1,000	0.15	0.15
% of children that have received all basic vaccines by 12 months of age	85	86.6
% of births delivered in a health facility	27	28.1
% of women aged 15-49 with comprehensive knowledge about AIDS	24	71
% of children under the age of five who had symptoms of Acute Respiratory Infection (ARI) and who received antibiotics	30	41
% of clients satisfied with their health care at district facilities	68	96
% of health facilities subjected to social audits	0	40

Table 2: Indicators that have not been achieved in 2011

Indicator	Target 2011	Achieved 2011
Contraceptive Prevalence Rate (modern methods) for currently married women	48	43.2
Infant Mortality Rate	44	46
Neonatal Mortality Rate	30	33
% of children under-5 with diarrhoea that have been treated with zinc	7	6.2
% of community –based emergency funds granted	19	2.8
% of PHCCs that provide all BEOC signal functions	23	21
% of health posts that provide delivery services 24/7 and short term hormonal and non-hormonal and IUCD and implants	45	11
C-section rate	4.0	2.3
% of sanctioned doctors and nurses posts at PHCCs and hospitals that are filled	85	61
Number of HPs per 5,000 population	1	0.13
Number of PHCCs per 50,000 population	1	0.39
% of health facilities with no stock-outs of 'essential drugs' in last 1 year	70	15
Number of Skilled Birth Attendants trained	1,134	909