

**Progress Report on  
Opportunities, Challenges, Lessons Learned and  
Strategic Directions in the Implementation of the  
Nepal Health Sector Programme-2  
2011/12**

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## EXECUTIVE SUMMARY

This report intends to present the existing opportunities, challenges, lessons learned and strategic directions in the implementation of NHSP-2. The major opportunities to implementation of NHSP-2 are the existing policy environment, i.e. free essential health care and international commitments such as the millennium development goals, improved annual planning through Joint Consultative Meetings (JCMs), the initiation of business plans of key centres and divisions, improved governance and financial management practices, improved sector coordination, improved service delivery, funding assurance through the Medium Term Expenditure Framework (MTEF), increased contributions from local authorities, application of IT solutions, and a significant movement towards mainstreaming Gender Equality and Social Inclusion (GESI).

During the last fiscal year the Ministry of Health and Population (MoHP) has faced some challenges including delays in the budget approval process, weak financial reporting, delays in the procurement process, issues related to recruitment and deployment of human resources, issues related to the expansion of family planning and nutrition programmes in hard to reach areas, increased interest in direct funding, weak reporting of the funds generated at the local level, implementation of GESI across the system and scale-up of the reform areas.

At the same time MoHP has learned some lessons, including an increased interest in pooled funds, bringing evidence into policy, health system strengthening through improvement in subsectors, revision of frameworks and policies based on evidence and changing needs, more policy level understanding regarding health financing, documentation of locally generated revenues and their expenditure patterns, improving the quality of care in the higher level health facilities and regularising the reporting system from hospitals.

Based on the above mentioned opportunities, challenges and lessons learned MoHP has set its strategic directions including periodic review of the implementation progress of the committees and frameworks, implementation of an HR strategy, integration of the various information systems, strengthening and implementing the M&E framework, development of a health financing strategy, expansion of EHCS service towards universal coverage, integration of demand side financing schemes under the social health protection framework and introducing and implementing performance based grants in hospitals.

## TABLE OF CONTENTS

Executive Summary.....	i
Table of Contents .....	ii
Acronyms.....	iv
1 Introduction .....	1
1.1 Background .....	1
1.2 Objective .....	1
2 Opportunities.....	2
2.1 Improved annual planning .....	2
2.2 Improved governance and financial management practices.....	3
2.3 Improved sector coordination .....	3
2.4 Improved service delivery .....	4
2.5 Funding assurance through the Medium Term Expenditure Framework.....	4
2.6 Increased contributions from local authorities .....	4
2.7 Application of IT solutions .....	5
2.8 Significant movement towards mainstreaming GESI.....	5
3 Challenges.....	6
3.1 Delay in budget approval process .....	6
3.2 Weak financial reporting.....	6
3.3 Delay in procurement process .....	6
3.4 Issues related to recruitment, deployment and transfer of human resources .....	7
3.5 Issues related to the improvement in the health related targets.....	7
3.6 Increased interest in direct funding .....	8
3.7 Weak reporting of the funds generated at the local level.....	8
3.8 Implementation of GESI across the system .....	8
3.9 Quality assurance and scaling up the programme.....	8
4 Lessons learned.....	10
4.1 Increased interest in pooled funding .....	10
4.2 Bridging evidence into policy .....	10
4.3 Health system strengthened with improvement in subsector .....	10
4.4 Revision of frameworks and policies based on the evidence and changing needs .....	10
4.5 More policy level understanding of health financing .....	11
4.6 Documentation of locally generated revenues and their expenditure pattern .....	12
4.7 Improve the quality of care.....	12
4.8 Regularise the reporting system from health facilities .....	12
5 Strategic Directions .....	13
5.1 Periodic review of implementation progress of the committees and frameworks .....	13
5.2 Implementation of the HRH strategy.....	13
5.3 Integration of the various information systems .....	13
5.4 Strengthen and implement the M&E framework .....	14
5.5 Development of a health financing strategy and additional funding .....	14
5.6 Expansion of EHCS service towards universal coverage .....	14
5.7 Integration of demand side financing schemes .....	14
5.8 Introduce and implement the performance based grant in all hospitals. ....	14

References..... 16

## ACRONYMS

AWPB	Annual Work Plan and Budget
CB-NCP	Community Based Newborn Care Programme
DDC	District Development Committee
eAWPB	electronic Annual Work Plan and Budget
EDPs	External Development Partners
EHCS	Essential Health Care Services
FCGO	Financial Comptroller General's Office
FMIP	Financial Management Improvement Plan
FMRs	Financial Monitoring Reports
FY	Fiscal Year
GAAP	Governance and Accountability Action Plan
GESI	Gender Equality and Social Inclusion
GoN	Government of Nepal
HEFU	Health Economics and Financing Unit
HR	Human Resources
JCM	Joint Consultative Meeting
LMIS	Logistics Management Information System
M&E	Monitoring and Evaluation
MoHP	Ministry of Health and Population
MTEF	Medium Term Expenditure Framework
NHSP	Nepal Health Sector Programme
OAG	Office of Auditor General
PFM	Public Financial Management
PHCC	Primary Health Care Centre
PPICD	Policy Planning and International Cooperation Division
SBA	Skilled Birth Attendant
SHP	Sub Health Post
STS	Service Tracking Survey
TABUCS	Transaction Accounting and Budget Control System
TSA	Treasury Single Account
VDC	Village Development Committee

# 1 INTRODUCTION

## 1.1 Background

Nepal's commitment to the Millennium Development Goals (MDGs), the Three-Year Interim Plan (2010/11-2012/13), the Nepal Health Sector Programme-2 (2010-2015), and the Medium Term Expenditure Framework (MTEF) guide the strategic direction for the Annual Work Plan and Budgets (AWPB) in the health sector. The main official framework document describing policy directions is the 1991 Health Policy<sup>1</sup>. The overriding vision articulated in the NHSP-2 document is to scale up the current free essential health care policy of the government to achieve universal coverage. The results framework establishes clear targets for improved coverage of priority services and priority groups (many indicators are broken down by wealth quintiles and some by gender, age and ethnic group). Targets are also set for the use of community based emergency funds by the poor, and financial targets are set for the proportion of the MoHP budget spent (absorption) and the proportion of the budget allocated to Essential Health Care Services (EHCS), which indicates the efficiency of spending. The lessons learned from NHSP-1 were used as the basis for the development and implementation of NHSP-2 (2010-2015). The sector wide approach (SWAp) continues and the essential health care services package (securing more than 75% of the total MoHP budget) 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. Increasing numbers of development partners are now participating in the Redbook, and non-pool partners have signed the Joint Financing Arrangements (JFA) which supports the functional implementation of NHSP-2. In the initial two years of NHSP-2 the weaknesses related to health system functions and inequities have been addressed through scaling up programmes for governance and accountability, gender equality and social inclusion, the introduction of the financial management improvement plan (FMIP) and improvement in the implementation of JCMs.

## 1.2 Objective

The objective of this report is to analyse the opportunities, challenges and lessons learned in the implementation of NHSP-2. It further explains the MoHP's strategic directions for the fiscal year 2013/14.

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<sup>1</sup> [http://moHP.gov.np/english/publication/national\\_health\\_policy\\_1991.php](http://moHP.gov.np/english/publication/national_health_policy_1991.php)

## 2 OPPORTUNITIES

The major opportunities seen in the implementation of NHSP-2 are the existing national policy environments and international commitment on the millennium development goals. More importantly, the human resources for health (HRH) strategy has been endorsed by the Council of Ministers. This will guide the production, deployment, distribution and retention of health care providers. In FY 2012/13 MoHP drafted a State Non-State Partnership Policy for the Health Sector. Although some progress has been made in purchasing public services from the private sector, for example the Aama programme and treatment of uterine prolapse, the lack of an institutional and legal framework hampers proper implementation and expansion.

### 2.1 Improved annual planning

The Nepal Health Sector Programme (NHSP-2) and the Gender Equality and Social Inclusion (GESI) strategy for the health sector require an improved annual work planning and budgeting process and the provision of equitable essential health care services (able to secure more than 75% of the MoHP budget in the initial three years of NHSP-2 implementation) with respect to geographical area, gender, caste and economic condition. An enhanced annual work plan and budget for the health sector with a structured business plan is an essential foundation for more effective and efficient health service delivery. In 2012, both MoHP and External Development Partners (EDPs) have made remarkable progress in making Joint Consultative Meetings (JCM) result oriented. As a result the concerned centres and divisions prepared a business plan which provides information on the following subjects for fiscal year 2012/2013:

- Annual budget
- Major activities
- Procurement
- Programme implementation strategies
- Targets
- Governance related activities
- Gender equality and social inclusion activities
- Requirements for technical assistance
- Constraints.

MoHP has carried out this exercise with the active participation of the concerned centres and divisions. A number of lessons have been learned that should enable the collection of more comprehensive information in the next business plan 2013/14. For detailed information visit [www.moHP.gov.np](http://www.moHP.gov.np).

Additionally, 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. This eAWPB provides a procurement plan which MoHP can share with EDPs. The new development includes a provision for district planning, enabling centres and divisions to prepare district wise plans. There is also a provision for disaggregation of information by facility level, region, gender, programme area and district. More importantly, the revised version of the eAWPB also provides for expenditures which are in line with the NHSP-2 result framework. For detailed information visit [www.moHP.gov.np](http://www.moHP.gov.np).

Considerable progress has been made in improving systems for infrastructure planning and management, and this has supported an improved quality of health care services. Construction is more evidence-based and the timeliness of planning and the completion of construction work have been enhanced. This year a large number of completed infrastructures have been handed over. The number of sick projects has decreased by half. Standard bidding procedures and documents are now being used. The Health Infrastructure Information System (HIIS) updating and upgrading work has been completed, and can now regularly produce the updated procurement plan and progress reports. HIIS can also provide information on the overall situation of health infrastructure in Nepal and the total repair and maintenance cost required to be invested. For detailed information visit [www.nhssp.org.np](http://www.nhssp.org.np).

At the implementation level, the appreciative inquiry (AI) process in health facility operation and in management committees has proven to be very effective in generating and mobilising local resources for the health facilities. In one example this resulted in a road link to the Syangja hospital to improve access. More importantly, the district development committee (DDC) decided to allocate 10% of the local road tax to the hospital, which is used to improve the quality of care provided.

## **2.2 Improved governance and financial management practices**

MoHP has made good progress in the implementation of the Governance and Accountability Action Plan (GAAP) at all levels (please find details in the JAR report on GAAP). This provides an opportunity for the health sector to strengthen and expand local health governance and to improve the transparency and accountability in service delivery. MoHP has also made impressive progress in developing and implementing a Financial Management Improvement Plan (FMIP) and a financial management system with a Web-based electronic Annual Work Plan and Budget (eAWPB), and in completing the software development for the Transaction Accounting and Budget Control System (TABUCS). This has positively influenced the fund absorption capacity, despite a delay in preparing and approving the budget in FY 2011/12. The FMIP has been prepared and endorsed by the MoHP. The FMIP, which is an addendum to the plan contained in the GAAP, intends to strengthen the MoHP's current practices on financial planning, accounting procedures, its internal control system, financial reporting, monitoring, auditing and transparency measures. The plan also intends to enhance the capacity of the human resources working in the planning and financial management sectors. The objectives and their indicators are included in the following table. The FMIP draws on audit observations and also on the categories of the internationally-recognised standardised approach to public financial management known as PEFA – the Public Expenditure and Financial Accountability framework ([www.pefa.org](http://www.pefa.org)). The overall thrust of implementing the FMIP is to reduce fiduciary risk and to improve overall financial accountability in the health sector. More importantly, MoHP has taken the lead role in introducing the TABUCS while NHSSP provides technical assistance and DFID provides the financial support. The TABUCS implementation plan, the selection of 11 pilot spending units, and draft software have been prepared. For detailed information, visit [www.nhssp.org.np](http://www.nhssp.org.np).

## **2.3 Improved sector coordination**

In 2012, MoHP has formed a Public Financial Management (PFM) committee with the participation of both pool and non-pool partners. Additionally, it has established a Policy Coordination Committee. The Reproductive Health (RH) 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. The Ministry has also

established a Country Coordination Facilitation forum to promote dialogue on HR issues. Health related programmes such as those on 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. In order to respond to the increasing interest in multi-sectoral coordination in health, the Government of Nepal (GoN) has endorsed a Multi-Sector Nutrition Plan (MSNP, 2013-2017) which is housed at the National Planning Commission. For detailed information please see the JAR report on partnership, alignment and harmonisation in the health sector.

#### **2.4 Improved service delivery**

Nepal has demonstrated that an integrated health care delivery 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. The national TB control programme has made substantial progress in reducing the burden of TB. Child Health Division and NGOs have also been active in distributing zinc tablets and have made significant contributions. Nepal has made significant progress in safe motherhood with a big shift in the use of all types of institutional delivery. While significant progress has been made in the training of Skilled Birth Attendants (SBAs), with 3,637 so far trained by the National Health Training Centre, achieving the target of 7,000 trained by 2015 will require major efforts. There are 18 private medical colleges in the country with more than 6,000 hospital beds and a wide range of curative care which are generally underutilised. Unused beds, facilities, skills and expertise at private medical colleges could be used for public service delivery. At present the Aama and uterine prolapse programmes are the only major examples of the public funding for private provision model. For detailed information please see the JAR report on the M&E framework.

#### **2.5 Funding assurance through the Medium Term Expenditure Framework**

The Government of Nepal, National Planning Commission and Ministry of Finance (MoF) provide the budget ceiling to the sub-sector through the provisions of the Medium Term Expenditure Framework (MTEF). This has been useful in strengthening the planning process at MoHP. The MTEF provides the total budget ceiling for three fiscal years, which is instrumental for making decisions about health interventions that require a time frame. More importantly, the MTEF contributes to ensuring the predictability of external funds. For detailed information visit [www.mof.gov.np](http://www.mof.gov.np).

#### **2.6 Increased contributions from local authorities**

The Service Tracking Survey (STS) identified the MoHP as the main financier for all levels of health facilities. For Sub Health Posts (SHPs), local government, meaning village development committees (VDCs), are the second largest source of income. The study's SHPs were found to have the most diverse income sources, with international donor agencies providing almost a fifth of their income. Salaries were the main expenditure item for all the facilities, representing between a third and a half of facilities' budgets. Out of the 169 health facilities surveyed, the vast majority (94%) had bank accounts. No marked difference was seen between facility types. However, further analysis by

ecological zone showed differences between regions, with only 85% of facilities in the mountain districts having a bank account. For detailed information visit [www.nhssp.org.np](http://www.nhssp.org.np).

## **2.7 Application of IT solutions**

The Health Management Information System (HMIS) is the main IT hub which compiles and analyses the indicators related to Nepal's health care delivery system. Over the years HMIS has gained a reputation for maintaining the data quality. However, there are some pertinent issues related to obtaining more disaggregated data, comparing HMIS data with survey data and integrating the other IT solutions i.e. Logistics Management Information System (LMIS), Human Resources Management Information System (HuRIS), eAWPP and TABUCS. More importantly, the service statistics collected by HMIS need be used in the AWPB process. During the budget analysis process substantial discussion was held about linking the monitoring data from the HMIS with the eAWPB. MoHP agrees to develop a framework for achieving this. Policy level guidance is required to formalise this task.

## **2.8 Significant movement towards mainstreaming GESI**

Under the leadership of the Director General of DoHS a GESI committee was formed in 2011. Technical Working Groups (TWGs) with the clear roles have been formed both at MoHP and at DoHS. In addition, TWGs have been formed in the five Regional Health Directorates (RHDs) and in fifty-one districts. GESI focal persons have been nominated in all RHDs and in seventy-five District (Public) Health Offices (D(P)HOs). Terms of Reference (ToRs) have been developed for all groups, and committee members have been given GESI orientation. GESI is integrated in the Annual Work Plan Budget and the Annual Business Plan. The NHSP-2 Implementation Plan has a section on GESI and has also integrated GESI in other national programmes. A process is on-going for improved disaggregation of selected indicators in HMIS. The National Health Training Centre conducted a GESI review of five curricula and has initiated a process for developing GESI modules and materials to be inserted into these curricula. For detailed information see the JAR report on GESI.

## 3 CHALLENGES

MoHP understands that there despite the improvements and opportunities a number of challenges need to be addressed. The current challenges can be addressed through increased financial resources and improved partnership with external and local development partners.

### 3.1 Delay in budget approval process

Delayed approval of the budget was the major challenge for the proper execution of both priority and other activities. This delay also directly contributed to some cost centres violating the financial rules and regulations, specifically concerning procurement and payment of incentives to the clients. There are about 1,700 activities defined at DoHS level and about 300 for each district. The preparation and consolidation of performance information on all these activities requires considerable time and effort. The issue is exacerbated by the lack of a technology based system for recording and monitoring these activities at the level of the spending units. Additionally, under decentralised mechanisms the funds are routed to the spending units through the DDC, creating another layer in the fund flow. More importantly, in the absence of parliament and consensus government there is no complete budget in FY 2012/13. MoHP has received an instruction to adhere to less than last year's expenditure of NPR 16.58 billion. This is a main concern of the EDPs and programme managers, and will hamper service delivery across the country.

### 3.2 Weak financial reporting

All cost centres do not send timely budgets vs. actual expenditure to MoHP/DoHS. Moreover, MoHP does not have any technology based solution to compile and consolidate budget vs. actual expenditure reports. The Financial Comptroller General's Office (FCGO) provides budget vs. actual reports on a periodic basis to the MoHP. However, these reports are based on particular account heads and are not broken down by programmes. The STS identified that all the hospitals reported having developed a financial report for the previous fiscal year. This practice was less widespread in lower level facilities, with only 36% of Primary Health Care Centres (PHCCs), 27% of health posts and 10% of SHPs having done so. It is important to note that PHCCs, health posts and SHPs are not spending units (or cost centres) and thus are not required to produce financial reports. They nevertheless have to submit receipts to clear advances obtained from their district health offices. Some differences appeared between ecological regions, with 32% of facilities from the mountains, 31% from the hills and 21% from the tarai having prepared a financial report. Most facilities reported that they had not conducted an internal financial audit or a final audit in the last fiscal year. While 75% of the hospitals had prepared both, only between 9% and 40% of the other facilities had prepared one and/or the other. It is important to note that resources are being generated at the local level. However, in the absence of financial reporting MoHP cannot give the total health expenditure (THE). The current practice is to capture the expenditure against the budget allocated by MoHP. For detailed information, visit [www.nhssp.org.np](http://www.nhssp.org.np) or see the JAR report on financial management.

### 3.3 Delay in procurement process

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 consolidated procurement plans. Integration of procurement of construction, drugs and equipment, and services is needed to harmonise the procurement plan. Budget was not approved and sanctioned for the service contract of web-based LMIS in 75 districts and for the service contract of distribution and transportation of health commodities from districts to health facilities. District level procurement is a major concern, and Logistics Management Division is conducting procurement training to the District Officers, Accountants and Storekeepers. It has been learned that due to the varied nature of goods being procured, the procurement cannot be accomplished with only one or two specialists or experts. Provision should be made to hire experts as required while also training the existing staff. For more detailed information please see the JAR report on procurement.

### **3.4 Issues related to recruitment, deployment and transfer of human resources**

The JAR report on the M&E framework shows that in 2012, 56% of sanctioned posts for doctors are filled at district hospitals, and the figure for PHCCs is reported to be very low, at 19%. Similarly, 82% of sanctioned positions for nurses are filled at district hospitals, with the number in the PHCCs being lower, at 62%. The vacant positions are likely to increase further, if an inclusive health act is not approved in due time. The promotion and new recruitment processes are adversely affected by the lack of an inclusive health act. The MoHP has submitted an inclusive health bill to parliament and is waiting for endorsement. This explains why the posting, transfer and retention of care providers remains a major challenge to the health system. Different authorities within MoHP have contracted vaccinators, auxiliary nurse midwives, nurses, physicians, MD general practitioners, obstetrician/gynaecologists and many other health human resources. MoLD also contracted ANMs in some birthing centers. 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. There is a general understanding that this system is less efficient and reduces effectiveness. Multi-year contracting for commodity procurement is already in place, but not for service procurement.

### **3.5 Issues related to the improvement in the health related targets**

Despite the efforts of government and development partners, the neonatal mortality rate (NMR) 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. The infant mortality rate (IMR) 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. The Maternal Mortality Rate (MMR) was reduced from 539 per 100,000 live births in 1996 to 229 in 2009 and has been one of the successes in Nepal. However, achieving the MDG target of 134 per 100,000 by 2015 remains a major challenge. The unmet need for family planning is nearly 27% and increasing the coverage is another challenge. The Contraceptive Prevalence Rate (CPR) fell to 43.1% in 2011 from 47% percent in 2006. 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, and this decreased 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. Improving the nutritional status of children is one of the biggest challenges to the health sector. For more information please see the JAR report on the M&E framework.

### **3.6 Increased interest in direct funding**

Although the predictability of funds is improving as some EDPs make multi-year funding commitments, most EDPs are not able to do this. In particular, INGO support channelled directly through the Social Welfare Council bypasses the MoHP. This hampers the predictability of support and weakens partnerships working in the sector. On the other hand, due to the lack of capacity and resources, the government's financial system remains weak, which may increase the fiduciary risk for partners. Also, not all EDP planning cycles are aligned with the government cycle, which adds to the complications of mobilising resources and aligning support. More effort is needed by EDPs to make multi-year commitments to improve the predictability of aid. For more detailed information please see the JAR report on partnership.

### **3.7 Weak reporting of the funds generated at the local level**

Currently, there is no national mechanism to capture the local revenues and expenditures that are occurring in the health facilities. This indicates that MoHP has no institutional mechanism to report the total health expenditure under its umbrella. For more detailed information please see the JAR report on financial management.

### **3.8 Implementation of GESI across the system**

A key challenge is to ensure implementation of plans that have been included by different divisions and centres in their AWPBs and Annual Business Plans. Budget cuts have also affected GESI sensitive interventions that they had planned. Effectively implementing the social audit guidelines, the GESI operational guidelines and the Equity and Access Programme, and ensuring that the institutional structures for GESI are functional require adequate resources and dedicated attention by all concerned. For more detailed information please see the JAR report on GESI.

### **3.9 Quality assurance and scaling up the programme**

Increasing the utilisation of health services may not improve health outcomes unless the services are also characterised by excellence in delivery along with benchmarks for good quality. The quality of care can greatly influence clients' health seeking behaviour in a positive direction. It can result in the greater use of health facilities, better uptake of health programmes by individuals and communities, and can lead to better health outcomes for the population. Despite assertions about the importance of quality, this remains one of the most challenging areas for health policy makers (WHO 2006). The STS shows that most birthing centres were providing routine deliveries (98%), with over three-quarters providing them on a 24 hour basis (77%). However, fewer than three-quarters of comprehensive emergency obstetric and neonatal care (CEONC) facilities (71%) provided all CEONC signal functions on a 24 hour basis, and this comprised merely 31% of hospitals, resulting in only 39% of districts with at least one facility providing all CEONC functions at all times. Fewer than half of all basic emergency obstetric and neonatal care (BEONC) facilities (41%) provided all BEONC signal functions on a 24 hour basis; one-fifth of PHCCs were doing so (21%), with slightly less doing so on a 24 hour basis (18%). The main gaps in service were the provision of blood transfusions at CEONC facilities (with 29% not providing these), and services to remove retained products and provide assisted deliveries at BEONC facilities (with 23% and 36% respectively not providing these on a 24 hour basis). More importantly, however, almost all clients (96%) were satisfied with their health care at health facilities. Furthermore,

only a small percentage (3%) reported that the service provider had been rude or very rude to them. For detailed information visit [www.nhssp.org.np](http://www.nhssp.org.np).

## 4 LESSONS LEARNED

As explained above MoHP has a blend of opportunities and challenges that can be translated into effective programme planning which will ultimately help achieve the national targets and international commitments. In the fiscal year 2011/12, MoHP has learned a number of lessons that can be considered in the programme planning process.

### 4.1 Increased interest in pooled funding

A sector wide approach (SWAp) was endorsed and supported by 11 health sector donors. In 2007, to tackle the challenges of sectoral coordination, harmonisation, performance monitoring and health care financing, and to further strengthen the SWAp, Nepal became one of the first wave of countries to join the International Health Partnership (IHP+). There are currently five pooled funding partners (DFID, World Bank, AusAid, GAVI HSS, and KfW) supporting the implementation of NHSP-2 and more EDPs are interested in joining. However, only AusAID has entered the SWAp since 2004 and important donors like India and China operate outside of it. There has been much discussion about pooling technical assistance to address concerns over the alignment of technical assistance with national priorities. For more detailed information please see the JAR report on partnership.

### 4.2 Bridging evidence into policy

MoHP has made a significant move in bridging evidence into policy by integrating the Aama and 4ANC programmes. A number of studies suggested that integration of these programmes would increase efficiency by reducing the costs required for administration, printing, monitoring and human resources. MoHP can expand this practice in other programme interventions.

### 4.3 Health system strengthened with improvement in subsector

Evidence shows that the Aama programme has directly contributed to expansion of delivery services in the peripheral level health institutions and private sector hospitals. An increasing number of Sub-Health Posts are now providing delivery services. Almost all medical colleges across the country are implementing the Aama programme - free delivery services. This has contributed to increasing the coverage and more people are utilising the services. This has also contributed to having larger caseloads in higher level health facilities and many hospitals are expanding their services by using the unused space allocated for other services or departments. In another area, the Public Procurement Management Office has instructed line ministries to initiate the e-submission of bids. The Logistics and Management Division has started e-bidding, which has a very positive impact in terms of value for money. Some hospitals have successfully implemented the e-submission of procurement bids and others are moving towards full e-bidding.

### 4.4 Revision of frameworks and policies based on the evidence and changing needs

In order to address changing needs and make the NHSP-2 result framework more comprehensive the MoHP has revised the framework and named it the M&E framework. In 2012, the MoHP prepared the implementation plan of NHSP-2, and is also revising the GAAP. In the sub sector, the MoHP approved an Safe Delivery Incentive Programme (SDIP) revised guideline carefully designed to meet the recommendations of a process evaluation and rapid assessment. Considering the early

implementation experiences and feed-back from hospital staff, MoHP revised the Aama programme guidelines to cover the actual costs of providing free institutional delivery and to clarify several components related to free delivery services. The Aama guideline was then published to specify the services to be funded, the tariffs for reimbursement and the system for claiming and reporting on free deliveries each month. The need for integration of the Aama programme with the 4 ANC programme was felt necessary in order to ease implementation of the programme and reduce administrative costs. Thus, a second revision of the Aama programme guidelines was carried out mainly to incorporate guidelines on providing the 4ANC incentive and to address some of the programmatic issues.

#### **4.5 More policy level understanding of health financing**

The Health Economics and Financing Unit (HEFU) was established in 2002, staffed by two health economists (by training, although the positions were administrative officer and statistical officer) on deputation, and by statistical and administrative officers. Close interaction with the Finance Section meant that the staff members were able to utilise information provided through the Financial Management Information System (FMIS) of the Financial Comptroller General's Office (FCGO) facilitated by an electronic link. Core products initiated by HEFU were a regular Health Public Expenditure Review (HPER) and National Health Accounts (NHA). An NHA framework was produced in 2003 and 2004 and the first NHA in 2005<sup>2345</sup>.

Emphasis was placed on contracting out studies; it was never anticipated that the MoHP would have the capacity to undertake large scale studies, but that it would be equipped with the technical skills to contract effectively and undertake smaller scale policy related work using existing data. Some of the support received was channelled to the Nepal Health Economics Association - for example for the Facility Efficiency Study<sup>6</sup>, which was designed as a standalone product as well as contributing to the NHA. Capacity in health financing within the MoHP and DoHS is limited by lack of technically qualified staff. HEFU, the main unit within MoHP with responsibility for health financing currently has no technical staff with an expertise in health financing. A creative approach is therefore required to engage with stakeholders and build capacity within the health sector. In this context, MoHP has taken some initiative to prepare a health financing strategy and also prepare a national health insurance policy. Steering and technical committees are formed to produce the relevant policies, strategies and the plans. In recent years Nepal has initiated innovative health financing policies and programmes such as free delivery, free health care, community health insurance, incentives to women for four antenatal check-ups, and the Female Community Health Volunteer incentive model. These policies and programmes intend to reduce the financial barriers to seeking care, provide relief to poor families, promote the utilisation of essential health care services, increase maternal and newborn survival, and ultimately improve the health status of the Nepalese people.

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<sup>2</sup> HEFU (2003). Public expenditure review of the health sector. Kathmandu: Health Economics and Financing Unit, Ministry of Health, HMG Nepal.

<sup>3</sup> HEFU (2004). Public expenditure review of the health sector. Kathmandu: Health Economics and Financing Unit, Ministry of Health, HMG Nepal.

<sup>4</sup> Council, H.N.B. (2003). Proposed Framework for Nepal National Health Accounts. Kathmandu: Ministry of Health, Nepal.

<sup>5</sup> Prasai, D., Karki, D., Sharma, T., Ganwali, D., Subedi, G., & Singh, A. (2006). Nepal National Health Accounts, 2001-2003. Kathmandu: GoN/Ministry of Health and Population.

<sup>6</sup> Nepal Health Economics Association (2004). Public Health Facility Efficiency Survey. Kathmandu: Submitted to District Health Strengthening Project (DHSP)/British Council.

#### **4.6 Documentation of locally generated revenues and their expenditure pattern**

The MoHP's annual work plan and budget does not capture some of the locally generated revenues and their expenditure. The STS suggests that facilities across the board receive a large part of their income from sources not included in the MoHP's annual work plan and budget (AWPB): around 35-40% for hospitals, PHCCs and health posts, and more than 50% for SHPs. This could potentially have far-reaching consequences for the way in which the health system is managed towards outputs and outcomes as facilities do not report to government authorities on a large part of their revenue and expenditure. The government therefore has limited information on what these other sources of income are spent on and the extent to which their allocation contributes to achieving health sector goals. Furthermore, international agencies sometimes provide funding to health facility management committees directly. MoHP has learned the lesson that these revenues and expenditures need to be captured.

#### **4.7 Improve the quality of care**

The STS reported that the top three recommendations were the same for maternity clients and outpatients, with both stressing that the provision of a free service was the main priority (50% and 44% respectively). This was followed by a request for better cleanliness (40% and 31% respectively) and more helpful staff (31% and 35% respectively). Maternity clients also felt that it was important to provide incentive payments on time (24%) and to improve privacy (17%), while outpatients felt the waiting time needed to be reduced (22%) and staff should be more skilled and competent (21%). Both felt that increasing the number of beds was important (20% and 18% respectively). MoHP understands the importance of quality of care across the health care delivery outlets. As pointed out by some studies, quality can be ensured with the provision of enough space and proper referral mechanisms.

#### **4.8 Regularise the reporting system from health facilities**

Reporting of both service statistics and financial data has been found to be weak. It is important to note that failure to capture the service statistics from higher level hospitals have impact on the higher caseloads in these hospitals. The STS reported that all hospitals prepared the financial report, but this was less common in lower level facilities, with only 36% of PHCCs, 27% of health posts and 10% of SHPs reporting. The most common reason for facilities not producing a financial report was because they did not feel there was a need (44%). A lack of relevant human resources (22%) and not having a responsible person (13%) were other key reasons. This suggests the necessity to take the immediate actions to ensure the timely and quality financial reporting.

## 5 STRATEGIC DIRECTIONS

Although there is no clear model suggested for moving towards a federal structure, there is a widespread expectation of local, provincial and central level governments. The design of health systems and defining the functions of the various levels remains a significant challenge to the MoHP. In this context, MoHP requires internal preparation which can address the guidance from the GoN.

### 5.1 Periodic review of implementation progress of the committees and frameworks

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 and the progress monitoring process needs to be formally introduced in the MoHP. The development of a framework will contribute to harmonising the roles and functions of the various committees formed in the MoHP, DoHS and below. A special focus need to be given to minimise duplication and improve the efficiency of these committees. Child Health Division has developed costed multi-year plans for the Expanded Programme of Immunisation, which has helped the funding agencies to ensure resources for several years ahead and guides the programme managers in preparation of the AWPB.

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.

### 5.2 Implementation of the HRH strategy

In 2012, MoHP prepared a costed human resource strategy for health, giving priority to the production, deployment and retention of critical human resources (MDGP, Ob/Gyn, advanced SBA, anaesthesia assistants). Retention of health human resources, however, has not been reported to be improved in the fiscal year 2011/12. Models in practice for improving retention include scholarships for care providers with bonding for three to five years' work (the NSI model), and retention and performance based incentives for care providers. A retention and performance based incentive package was developed for medical doctors and nurses and awaits implementation. Other options include the creation of more opportunities for medical doctors and nurses who work in remote areas, with complementary schemes such as career advancement, education, national and international exposure. The MoHP will explore more models for retention and pilot them. Implementation of strategies and its prioritised activities will be a priority for the MoHP.

### 5.3 Integration of the various information systems

Vertical reporting is getting more preference bypassing regular HMIS system in recent years. In addition to HMIS there are other functional information systems under the MoHP. In a first attempt at integration, the MoHP will strengthen the current information systems, make them compatible with each other and strengthen the institutional home to manage the integration process. It may take some

time to have integration in practice; however, MoHP will provide to use the respective information systems while making its decisions.

#### **5.4 Strengthen and implement the M&E framework**

The MoHP has recently revised the monitoring and evaluation framework and will report its progress based on this framework. In this particular context, it requires strengthening the capacity of responsible entities and their staff members. This is particularly important because the framework needs to cover the changing health needs and their reporting through the proper information systems.

#### **5.5 Development of a health financing strategy and additional funding**

Some analyses were completed to inform the health financing strategy. These include: benefit incidence analysis, fiscal space analysis, budget and expenditure analysis, national health accounts, the service tracking survey and demand side financing. Papers needs to be prepared for areas such as policy options for benefit package development, policy options for social health protection interventions, a review of the benefit package and purchase of services. Development of a health financing strategy will be completed and endorsed by the end of 2013. More importantly, additional resources are required for scaling up various programmes i.e. CB-NCP, B/CEONC service, expansion of delivery services in the higher level health facilities, the school health and nutrition programme, VCT, ART and PMTCT, filariasis elimination, blood transfusion services, and non-communicable diseases. However, the scope is limited due to lack of sufficient funding from both national treasury and EDPs.

#### **5.6 Expansion of EHCS service towards universal coverage**

Reducing the neonatal mortality rate is one the most challenging problems faced by the health sector, and requires rapid scaling up of the CB-NCP with institutional back-up. More resources to provide quality service in the higher level health facilities, technical advancement (CEONC sites), and advanced training for SBAs are needed to achieve the MDG targets. Family planning improves the quality of life for women and their families and contributes to safe motherhood and the control of HIV/AIDS and STIs, but in recent years it has received less attention allocating less resources. Family planning is part of safe motherhood and adolescent health programmes. The increasing demand for long acting contraceptive methods, such as IUCDs and implants, needs to be addressed to widen the choice of methods available for women, especially from hard to reach areas. In addition, a targeted programme needs to be developed to reach under-served populations such as Muslims and those living in remote areas. Necessary resources will be allocated to strengthen the current essential health care programme (towards universal coverage).

#### **5.7 Integration of demand side financing schemes**

Learning from the Aama and 4ANC programme integration, MoHP will take the necessary steps to integrate the demand side financing schemes under the wider framework of social health protection as far as possible.

#### **5.8 Introduce and implement the performance based grant in all hospitals.**

In order to strengthen capacity and ensure timely reporting from hospitals MoHP will start implementing performance based grants in selected hospitals. MoHP is currently reviewing the grants

agreement with seven non-state hospitals and preparing the contracts for these hospitals. Learning from this will gradually be expanded to all hospitals.

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