

*Nepal Health  
Sector Programme -*  
**Implementation  
Plan**  
(NHSP-IP)

2004 – 2009



His Majesty's Government  
Ministry of Health

October 2004

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**Ashok Kumar Rai**  
Minister for Health

His Majesty's Government  
**Ministry of Health**



Phone: 4-262534 (Off.)  
5-523031 (Res.)  
Fax: 4-262565  
Ramshahpath, Kathmandu  
Nepal

Ref. No. ....

Date : .....

## Preface

Despite the harsh reality of poverty combined with the difficult terrain, the country as a whole has covered much ground in protecting the people from major health risks and increasing people's average life span over the years. With more than 49,000 village based Female Community Health Volunteers, Nepal's basic health infrastructure is linked all the way to the villages. We have several challenges – the maternal mortality ratio is very high, the infant/child mortality rate needs to bring within the acceptable level and control of communicable diseases is another serious challenge. Despite of these challenges there are some success stories too - the infant/child mortality rate declined significantly in 1990s. Likewise the total fertility rate has markedly declined and the life expectancy has also increased. We are awaiting for Polio Eradication, Vitamin A distribution is one of the successful program, leprosy elimination is in good progress & recently we have started measles elimination campaign – first in South Asia Region.

These gains and efforts are encouraging, but not enough. Our foremost challenge is to narrow the existing health gap between the urban and rural areas. Meeting such challenge calls for a many fold increase in health spending and better management of the available resources. The WHO Commission on Macroeconomics and Health has shown that in a developing country at least US\$ 34 per person per year will be required to provide a basic package of health care services to all. With per capita income of US\$ 269 per annum and with so many competing demands, Nepal may not be able to mobilise the required resources for health from her internal sources alone.

Realising these objectives at the ground requires a holistic package of health sector reform in operation. With this in mind, MoH has reconstituted Nepal Health Sector Reform Committee (NHSRC) under the chairmanship of Health Minister. I am very pleased to see the result in the form of this document “**Nepal Health Sector Program – Implementation Plan (NHSP-IP)**”. I believe that the document will be able to guide us particularly in achieving the health component of the Millennium Development Goals as set out in HMG's Poverty Reduction Strategy Paper, Nepal's 10<sup>th</sup> Five Year Plan, and its fiscal framework.

The 10th Five Year Health Plan, covering the period between 2002-2007, has focused on the policy objectives like (a) Making essential health care services (EHCS) available to all people, (b) Establishing decentralised health system to encourage peoples' participation, (c) Establishing Public-private –NGO partnership in the delivery of health care services, and (c) Improving the quality of health care through total quality management of human, financial and physical resources, which has been well packaged in this document.

The letter of intent signed for its implementation by a large number of partners has encouraged me very much. I acknowledge with much appreciation that this document is prepared through a much wider participation of several governmental, non-governmental, external development partners, private sectors including the print and media representatives. I would like to thank and congratulate all our partners for their univocal partnership efforts towards mitigating Nepal's health challenges.

While I assure you of my full commitment, I request for a similar unwavering partnership support from all for implementing this collective wisdom – **“Nepal Health Sector Program – Implementation Plan (NHSP-IP)”**

I like to thank all, involved in development of this important document.

September 2004

  
**Ashok Kumar Rai**  
Minister of Health



**Dr. Banshidhar Mishra**  
State Minister for Health

His Majesty's Government  
**Ministry of Health**



Phone: 4-262587(Off.)  
4-4373495 (Res.)  
4-4374135 (Res.)

Ramshahpath, Kathmandu  
Nepal

Ref. No. ....

Date : .....

## Forewords

There is a close relation between poverty and health & studies in other countries has shown that health can be one of the poverty reduction strategies. To reduce the poverty HMG has prepared Poverty Reduction Strategy Paper and HMG also has shown its commitment to achieve the Millennium Development Goals. Ministry of Health also has prepared a Second Long Term Health Plan. Putting all these documents together, Health Sector Strategy: An agenda for Reform prepared and to implement the policies and programmes it has outlined, Ministry of Health has developed Nepal Health Sector Programme – Implementation Plan (NHSP-IP) 2004 – 2009.

Nepal Health Sector Programme – Implementation Plan (NHSP-IP), as I have understood, is a comprehensive document and has addressed the contemporary health issues such as improvement of the health status of mother & children, control of communicable diseases and increase the access & coverage of essential health care services. This program also aims to further decreasing fertility rate, provide quality health services and bring effectiveness and efficiency in the health care.

The needs of health care especially for mothers and children are not adequately met by the existing health delivery system. Every Nepalese should be aware of the fact that the curable infectious diseases, maternal/perinatal and nutritional conditions cause half of all deaths and 80 percent of deaths among under-five children. Similarly, we also know that the burden of diseases, in Nepal, as mentioned earlier is five times greater than in China and 50 percent greater than in India - both of neighbouring countries. The issue of safety net to poor and underprivileged is emerging as a great challenge to Ministry of Health. I am fully confident that with the implementation of NHSP-IP we will be able to meet the health needs of mother and children as well as providing safety net to vulnerable populations.

Decentralization in health services was started in 1970s with hospital autonomy – to bigger hospitals but significant progress could not be made at the district and community level health facilities. The present program of decentralization under NHSP-IP can be a milestone in decentralization of health services and it will be in the spirit of local governance act – 1999.

So, I am pleased to note that this NHSP-IP has significantly considered the above priority conditions and, I am satisfied with the wider involvement of stakeholders and representatives in its development process. Therefore, I would like to thank all involved or contributed during the development process of this document.

Now, I am hopeful that all the stakeholders will support the MoH in its successful implementation with the same level of spirit they have contributed for its development.



**Dr. Bansidhar Mishra**  
State Minister of Health  
Ministry of Health

September 2004



His Majesty's Government  
**MINISTRY OF HEALTH**

His Majesty's Government of Nepal  
Ministry of Health

Tel No. 4-262590,4-262862  
Fax No. 977-1-4262896

Ramshah Path, Kathmandu  
Nepal.

Ref. No.

## Acknowledgement

There is growing concern for improvement of health status from all stake holders in Nepal. Provision of equitable access to health care for attainment of an acceptable level of health and better quality of life by creating more equitable distribution of resources is the dominant concern of Nepal, today. In accordance with this, at the policy level efforts are underway to reform the national health system. Several analytical works were undertaken during the last few years. For example: Operational Issues and Prioritisation of Resources in the Health Sector; Public Expenditure Review; Strategic Analysis to Operationalize the Second Long Term (Twenty years) Health Plan; Medium Term Strategic Plan; Medium Term Expenditure Framework and exercise for the health component of the Tenth Five Year Plan: the first PRSP of Nepal. Most of these and other similar reports have concluded that the MoH should focus on and deal with those health problems which are disproportionately and maximally contributing to the highest level of mortality and burden of diseases. All these reviews and studies indicated for development of a coherent strategy on the health sector where all interested parties can assist to contribute to better health outcomes.

With all above considerations, "Health Sector Strategy: An agenda for Reform" has been prepared and approved by the Council of Ministers in December 2003. Following the strategy development a Programme Preparation Team (PPT) constituted in June 2002 was engaged to develop a fully costed "Nepal Health Sector Programme – Implementation Plan" (NHSP-IP) in order to implement the strategy in practice. During its development policy-makers, law-makers, external development partners, non-governmental organisations, academia private sector and other relevant stakeholders were deeply involved through series of workshops, meetings, seminars, group works, contribution of international and national consultants was availed.

I deeply appreciate the great efforts made by all those involved in these processes and look forward for the strategy and the plan being translated into action by enhancing the partnership among all stakeholders. I am thankful to DHSP for its assistance to publish this document.

**Dr. Mahabir Krishna Malla**

Acting Secretary and

Chief Specialist

Policy Planning and

International Cooperation Division

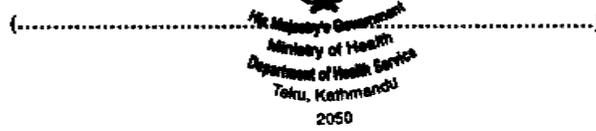
Ministry of Health

September 2004



His Majesty's Government  
Ministry Of Health  
**DEPARTMENT OF HEALTH SERVICES**

Tel : 261436  
: 261136



Pachali, Teku  
Kathmandu, Nepal.

Ref. No. :

Date : .....

## Few Words

Nepal Health Sector Program – Implementation Plan (NHSP-IP) has been developed in order to meet the Health Sector Strategy: an Agenda for Reform. This effort is in light of the National Health Policy 1991 and the Second Long Term Health Plan with priority issues needed to be tackled in the immediate future. This Strategy now have been translated into a programme document. As part of the preparation process of the Nepal Health Sector Programme – Implementation Plan (NHSP-IP), we conducted a series of stakeholder consultations in the form of workshop, meetings and group exercises including a Log Frame Workshop. The Log Frame workshop has been finalised the log frame to be used for the NHSP-IP including milestones to track down the progress.

During the preparation of the NHSP-IP, emphasis has been put on efficiency, quality and proper resource mobilization to realize the need of a realistic plan. We have planned to decentralise the responsibility for service delivery to local bodies combined with a performance management system. This will also involve integrating the separate disease based programmes which currently have their own financing and performance management systems. A plan for an appropriate devolution as envisaged in the LSGA is a key to success.

Both decentralisation and contracting with other providers will involve developing new roles, responsibilities and skills for the MoH/DoHS and local bodies. An appropriate capacity building programme as well as an effective monitoring system will be in place to ensure it happens.

I hope that NHSP-IP will adequately respond the reforms needs identified and achieve the goal set for the MDGs. I would like to request all stakeholders including the inputs providers and implementers to be part of the process and actively involve in implementation of the plan in spirit of letter of intent signed earlier from respective areas of field for the improved health status of the Nepalese population.

Thank you.

Dr B.D. Chataut

Director General

Department of Health Services

September 2004

# Acronyms and Abbreviations

AIDS	Acquired Immune Deficiency Syndrome	DPHO	District Public Health Office/ Officer
ANC	Ante-Natal Care	DRF	Debt Relief Fund
APIP	Annual Program Implementation Plan	DTO	District Treasure Office
APR	Annual Program Review	EDCD	Epidemiology and Disease Control Division
AR	Annual Review	EDPs	External Development Partners
AWPB	Annual Work Plan and Budget	EHCP	Essential Health Care Programme
BCC	Behaviour Change Communication	EHCS	Essential Health Care Services
BoD	Burden of Disease	EHSP	Essential Health Support Programme
CB-IMCI	Community Based Integrated Management of Childhood Illness	EOC	Essential Obstetric Care
CD	Curative Division	EPI	Expanded Program of Immunisation
CDP	Community Drug Programme	FCGO	Financial Controller General Office
CHD	Child Health Division	FHD	Family Health Division
CHI	Community Health Insurance	FMIS	Financial Management Information System
CMR	Child Mortality Rate	GDP	Gross Domestic Product
CPR	Contraceptive Prevalence Rate	HEFU	Health Economics and Financing Unit
CTEVT	Council for Technical Education and Vocational Training	HIV	Human Immuno-deficiency Virus
DALYs	Disability Adjusted Life Years	HMGN	His Majesty's Government of Nepal
DDA	Department of Drug Administration	HMIS	Health Management Information System
DDC	District Development Committee	HP	Health Post
DEP	Directly Executed Projects	HPI	Human Poverty Index
DfID	Department for International Development	HQ	Head Quarter
DG	Director General	HR	Human Resource
DHO	District Health Office/ Officer	HRD	Human Resources Development
DHS	Demographic Health Survey	HSRC	Health Sector Reform Committee
DoA	Department of Ayurved	HSRS	Health Sector Reform Strategy
DoHS	Department of Health Services	HuRDIS	Human Resource Development Information System
DOTS	Directly Observed Treatment Short Course	I/NGO	International/ Non Governmental Organisations

IDUs	Intravenous Drug Users	NHTC	National Health Training Centre
IEC	Information, Education, Communication	NLSS	Nepal Leaving Standard Survey
IMR	Infant Mortality Rate	NSMP	Nepal Safe Motherhood Program
JAPR	Joint Annual Program Review	NPC	National Planning Commission
JAR	Joint Annual Review	NPHL	National Public Health Laboratory
JICA	Japan International Co-operation Agency	NTC	National Tuberculosis Centre
LAN	Local Area Network	OPD	Out Patient Department
LMD	Logistic Management Division	PAD	Project Appraisal Document
LMIS	Logistics Management Information System	PHC	Primary Health Centre
LSGA	Local Self Governance Act	PNP	Public NGO Partnership
LTHP	Long Term Health Plan	PPICD	Policy, Planning and International Cooperation Division
MD	Management Division	PPP	Public Private Partnership
MDGs	Millennium Development Goals	PPT	Program Preparation Team
MIS	Management Information System	PR	Prevalence Rate
MMR	Maternal Mortality Ratio	PRGF	Poverty Reduction Grant Fund
MoE	Ministry of Education	PRSP	Poverty Reduction Strategy Paper
MoF	Ministry of Finance	RTC	Regional Training Centre
MoH	Ministry of Health	SHI	Social Health Insurance
MoLD	Ministry of Local Development	SHP	Sub Health Post
MTEF	Medium Term Expenditure Framework	SLTHP	Second Long Term Health Plan
MTR	Mid Term Review	STD	Sexually Transmitted Diseases
MTSP	Medium Term Strategic Plan	SWAp	Sector Wide Approach
NCASC	National Centre for AIDS and STD Control	SWs	Sex Workers
NDHS	National Demographic Health Survey	TA	Technical Assistance
NGOCC	NGO Co-ordination Committee	TB	Tuberculosis
NGOs	Non Governmental Organisations	TFR	Total Fertility Rate
NHA	National Health Account	TIMS	Training Information Management System
NHEICC	National Health Education, Information & Communication Centre	TRC	Technical Review Committee
NHSP-IP	Nepal Health Sector Program – Implementation Plan	TT	Tetanus Toxoid
		VDC	Village Development Committee
		WAN	Wide Area Network

# Executive Summary

1. His Majesty's Government of Nepal (HMGN) is committed to bringing about tangible changes in the health-sector development process. The aim is to provide an equitable, high quality health care system for the Nepalese people. Towards this aim, and in line with the Poverty Reduction Strategy Paper, Millennium Development Goal and the Tenth Five-Year Plan 2002-7, HMGN has formulated the Health Sector Strategy: An Agenda for Reform 2003.
2. A shared vision, agreed priorities and a commitment to work together exists between the Ministry of Health (MoH) and the External Development Partners (EDPs). This commitment has been formalised in a "Statement of Intent to Guide the Partnership for Health Sector Development in Nepal", to which the MoH and all the EDPs are joint signatories. The statement details the principles of and mechanisms for the Partnership (the full Statement is shown in Annex 1).
3. An underlying intention of the Health Sector Reform Strategy (HSRS) is to move the health sector towards strategic planning and a Sector Wide Approach (SWAp). The HSRS sets out three Programme Outputs (Prioritised Essential Health Care Services, Decentralised Management of Health Facilities, and Role for the Public Private Partnership); and five Sector Management Outputs (Sector Management, Financing and Resource Allocation, Management of Physical Assets, Human Resource Development, and Integrated Management Information System). Thus, there are a total eight HSR Outputs.
4. The Nepal Health Sector Strategy Implementation Plan (NHSP-IP) provides operational guidelines for implementing the outputs of the Health Sector Reform Strategy during its first five years. Since June 2002, a Programme Preparation Team (PPT) has been supporting formulation of NHSP-IP, coordinated by the Policy, Planning and International Cooperation Division (PPICD) of the MoH and technically supported by all the EDPs. The Health Sector Reform Committee (HSRC), under the leadership of the Honourable Health Minister, is overseeing and guiding the overall formulation of the NHSP-IP ensuring it is concurrent with the Health Sector Strategy.
5. The Goal of the Health Sector Strategy is:

Achievement of the health sector Millennium Development Goals in Nepal with improved health outcomes for the poor and those living in remote areas and a consequent reduction in poverty.

And its Purpose is:

To improve the health status of the Nepalese population through increased utilisation of essential health services delivered by a well managed health sector.

This is based on the objective of the 2<sup>nd</sup> Long Term Health Plan (1997-2017)

“A health system in which there is equitable access to coordinated quality health care services in rural and urban areas, characterized by: self-reliance, full community participation, decentralization, gender sensitivity, effective and efficient management, and private and NGO sector participation in the provision and financing of health services resulting in improved health status of the population”

6. NHSP-IP is the implementation plan for the Nepal Health Sector Strategy in its first five years. As such it has the strategy's purpose as its goal and for the first phase a purpose which is to:
  - increase the coverage and raise the quality of Essential Health Care Services (EHCS), with a special emphasis on improved access for poor and vulnerable groups; through
  - an efficient sector wide health management system developed with provision of adequate financial resources

The indicators of the health sector strategy at goal level relate to the achievement of the MDGs. These and the indicators for the purpose of the strategy are set out in Annex 7 where a logframe for the sector strategy is presented.

***The purpose level indicators are:***

**Maternal Mortality Ratio** decreased from 539/100,000 live births (DHS 1996) to 325 in 2006 and 300 in 2009.

10<sup>th</sup> Plan - 300

**Infant Mortality Rate** decreased from 64/1000 live births (DHS 2001) to 50 in 2006 and 45 in 2009

10<sup>th</sup> Plan – 45

**Under-Five Mortality Ratio** decreased from 91/1000 live births (DHS 2001) to 70 in 2006 and 65 in 2009

**Total Fertility Rate** reduced from 4.1 (DHS 2001) to 3.8 in 2006 and 3.5 in 2009.

10<sup>th</sup> Plan – 3.5

**Contraceptive Prevalence Rate** increased from 39% (DHS 2001) to 43% in 2006 and 47% by 2009.

10<sup>th</sup> Plan – 47

**Skilled attendance at birth** increased from 13% (DHS 2001) to 22% in 2006 and 35% by 2009.

10<sup>th</sup> Plan – 40

**Percentage of children immunized against measles and DPT3** increased from 71% (DHS 2001) to 78% in 2006 and 85% by 2009.

**Knowledge of at least one programmatic method of preventing HIV transmission** increased from 37.6% (DHS 2001) to 75% for women and 50.8% (DHS 2001) to 85% for men.

**Proportion of HMGN budget allocated to health** increases from 5% at present to 6.5% in 2006 and 7% in 2009

***The purpose level indicators for NHSP are more closely related to the delivery of health services rather than the health outcomes of the Sector Strategy. They are:***

- Proportion of the population with access to responsive EHCS.
- Proportion of population utilising prioritized EHCS services.
- Number of health facilities under decentralised management.
- Number of service delivery contracts with NGO and private sector.
- Percentage of expenditure born by locally generated resources.
- Increased allocation of HMGN budget on health sector.

The two log frames are thus closely related but distinctive as one sets a long term focus on health outcomes and the other is an implementation plan for the first five years of the strategy.

The health Sector Strategy and NHSP-IP's Log frames are presented in Annex 7.

7. In addition to the health outcome and health service outputs which frame the indicators the Health Sector Strategy is Reform Strategy which aims to change the way the sector operates.

The specific policy reforms which have been agreed by HMGN are set out in Annex 5.

The remainder of this document sets out the proposals for implementing the strategy as agreed by HMGN and its major development partners in 2003/04. NHSP is an operational plan. As such it is living document that will be changed and developed as the programme unfolds. It is the Sector Strategy that sets the long term indicators and the Policy Reforms. NHSP however can and will change and adapt as the strategy is implemented.

8. The NHSP-IP has two main features. It has a number of *new actions*, which are part of the Agenda for Reform of the Health Sector. These are superimposed upon an extensive existing programme of Essential Health Care Services (EHCS) operating at varying levels of success. The key focus of the NHSP is to increase the coverage and raise the quality of the EHCS, with special emphasis on improved access for poor and vulnerable groups. Achievement of this is expected to result in greater utilisation of EHCS by the total population and ultimately to improved health status.

9. In order to achieve the NHSP Outputs a number of activities have been identified. These fall into three types:
  - a. Entirely new actions/activities
  - b. Strengthening or restructuring of existing activities
  - c. Continuation of existing activities as part of the EHCS
10. In Chapter 3, new activities and strengthening activities (i.e. type a. and b. activities) are detailed and key indicators of achievement highlighted. Existing activities (type c.) for EHCS are described in Annex 4. The NHSP-IP is intended as a dynamic document to which new actions will be added as the need emerges during the implementation process. In outline the new actions and strengthening activities identified to-date are:

**Output One:** Prioritised EHCS

1. Costing of and resource allocation for EHCS
2. Redefine institutional arrangements for delivering EHCS
3. Develop systems for priority access for poor and vulnerable groups
4. Strengthen Outpatient Services
5. Enhance Behaviour Change Communication (BCC) activities

**Output Two:** Decentralised health management

1. Introduce Local management of Sub-Health Posts
2. Create Hospital autonomy and initiate resource mobilization

**Output Three:** Private and NGO sector developed

1. Establish district level Health Co-coordinating Committees.
2. Establish sub-committees or workgroups for specific program areas to co-ordinate the work of government, donor and I/NGO groups
3. Up-date Inventory of existing Private/NGO/Public involved in health sector, by district
4. Define an appropriate Public/Private/NGO/ mix for each district
5. Set quality standards and regulatory mechanisms for private and NGO sector service delivery.

**Output Four:** Sector Management

1. Strengthen joint MoH/donor annual planning, programming, budgeting and monitoring cycle
2. Strengthen ongoing MoH/Donor programmatic collaboration
3. Strengthen Sector Management at the Central Level
4. Strengthen Regional and District Management
5. Capacity building at central and district levels
6. Assess institutional and organisational arrangements systematically.
7. Re-define roles and responsibilities throughout the health system.

**Output Five:** Financing and resource allocation

1. Identify health sector priorities and re-allocate resources to those services.
2. Explore alternative financing arrangements, such as community health insurance, explored.
3. Develop national guidelines for user fee practices and other payments in public facilities
4. Strengthen drug financing mechanisms to support increased and equitable availability of essential drugs

**Output Six:** Management of physical assets

1. Improve product selection and quality
2. Strengthen commodity distribution system
3. Expand and strengthen drug financing mechanism
4. Implement National Drug Policy in relation to essential drug
5. Strengthen Logistics Management Information System (LMIS)
6. Strengthen disaster relief commodities management
7. Establish quality and safety policies and systems

**Output Seven:** Human Resource Development

1. Locate HRD unit in an appropriate MoH structure and reform it.
2. Improve personnel management system in a effective way
3. Improve co-ordination and quality of in-service training
4. Provide training in newly identified areas of training needs
5. Improve co-ordination between the Ministry of Education (MoE), MoH and CTEVT for pre-service education.

**Output Eight:** Integrated MIS and QA Policy

1. Develop and establish integrated Management Information System
2. Establish and implement Quality Assurance (QA) Policy

11. There are a number of programmes and activities that are beyond the scope of NHSP-IP but complimentary to the eight NHSP Outputs. Although they are not given priority for additional public funding in the short term, it is expected that many will grow through private investment.
12. Increased resources for health care and good financial management are at the core of a better health system. Chapter 4 describes the existing resources for health care in Nepal, estimates the funding gap for the EHCS and systems for financial management. In terms of financial sustainability, the NHSP is expected to result in:
  - Increased contribution of the government to the health sector.
  - Increased contribution of EDPs to meet the health sector financing gaps.
  - Improved allocation of resources to essential health care services.
  - Increased cost-effectiveness through potential cost-savings.
  - Increased mobilisation of resources through local bodies in spirit of LSGA

13. Implementation arrangements are described in the final chapter, Chapter 5. Most difficult to introduce and with the most far-reaching consequences for reform, are the management changes required. The major changes expected are:
  - HMGN assuming responsibility for implementation of projects currently managed by the EDPs (and their contracted agencies).
  - Decentralisation to local bodies.
  - MoH and Central Departments moving towards a facilitator/financing role, rather than the current provider role.
  
14. The document completes with a description of the programme planning, monitoring and review process. HMGN and EDPs have agreed to participate in joint planning and review exercises. Benefits of joint exercises will be:
  - Both Government and EDPs fully engaged by the reform process
  - Improved co-ordination of strategies
  - Transparency of contributions by EDPs and the Government

# Introduction

## 1.1 Background

1. His Majesty's Government of Nepal (HMGN) is committed to bringing about tangible changes in the health status of Nepalese population through health-sector development process. The aim is to provide an equitable, high quality health care system for the Nepalese people. Towards this aim, and in line with the Poverty Reduction Strategy Paper, Millennium Development Goals and the Tenth Five-Year Plan 2002-7, HMGN has formulated the Health Sector Strategy: An Agenda for Reform 2003.
2. A shared vision, agreed priorities and a commitment to work together exists between the Ministry of Health (MoH) and the External Development Partners (EDPs). Given the relatively short history of democratic government in Nepal, the current political tensions and the earlier tendency of EDPs to pursue their own priorities with discrete programmes in separate geographic areas, this convergence is a major achievement. Now the need to bring the private and NGO sectors into the planning process, and to engage local communities in the health reform process to ensure services are responsive to their needs, has been recognised
3. Since June 2002, a Programme Preparation Team (PPT) has been supporting formulation of the Nepal Health Sector Programme - Implementation Plan (NHSP-IP), which is coordinated by the Policy, Planning and International Cooperation Division (PPICD) of the MoH and technically supported by all the EDPs. The NHSP-IP is the operational guideline for achieving the goals and visions of the Health Sector Reform Strategy. The Health Sector Reform Committee (HSRC), under the leadership of the Honourable Health Minister, is overseeing and guiding the overall formulation of the NHSP-IP. Sixteen studies have been conducted on many aspects of health sector development and reform. These studies (summarised in Annex 2) provide the basis for analysis and suggest a way forward for reform.
4. The situational analyses and thinking behind the reform strategy are detailed in the Health Sector Reform Strategy (HSRS) document. Therefore, in the interests of brevity, the rationale for the NHSP-IP is presented below in a summarised form.

## 1.2 Programme Rationale

### 1.2.1 The Rationale for the Programme is:

- a. Continuing low health status and considerable disparities in health across social groups, geographic regions and gender.
- b. A need to increase utilisation of quality health care services.
- c. Recognition that this demands reform of the current health care system.

The assumption is that, even in the existing political and economic environment, reform of the health care system will increase utilisation of quality health care services, which in turn will result in improved health status and reduction in health disparities.

### 1.2.2 Health Status and Disparities in Health

1. Over the last twenty years, there has been notable success in some areas of health service delivery in Nepal specifically in the field of child health and infectious disease control. However, the health indicators remain low compared to other developing countries in the region.
2. The main causes of death and disability are infectious and parasitic diseases, perinatal and reproductive ill health. Table 1.1 sets out the burden of disease in terms of overall mortality and in terms of Disability Adjusted Life Years. This shows that, while half of all deaths are caused by the Group I category of diseases, and half are caused by the remaining combination of Group II and III categories, over two thirds of all lost Disability Adjusted Life Years (DALYs) are caused by Group I causes.

**TABLE 1.1** COMPARISON OF "DEATHS BY CAUSE" AND DALYS LOST BY CAUSE

Causes of Death	Cause Specific Deaths as % of All Deaths	DALYs Lost as % of All DALYs Lost
Group I: Infectious diseases and maternal, perinatal and nutritional problems.	49.7%	68.5%
Group II: Non-communicable and congenital problems.	42.1%	22.8%
Group III: Injuries and accidents.	6.9%	8.7%
Unclassified.	1.0%	0.0%

SOURCE: Health Sector Strategy - Agenda For Change, 2002

3. There is evidence of an increase in newly emerging and re-emerging diseases e.g. Japanese encephalitis, malaria, kala-azar, HIV/AIDS and tuberculosis. With improving health services and overall quality of life, prevalence of non-communicable diseases is on an increasing trend, though not to the same extent as in many other low-income countries.
4. The highest risk groups are children under five, particularly females, who account for 52.5% of all female deaths, and women of reproductive age. Although children under 5 years old represent only 16 percent of the population, they account for over 50% of the total DALYs lost from all causes, and 80% of the under-five deaths are due to Group I causes. Women 15 – 44 years old

experience a 26% higher loss of DALYs than men in the same age group. Much of this excess loss is related to problems due to pregnancy.

5. Health disparities are most evident across the urban-rural divide and in the most hard to reach areas, the mountains, where access

to health care and other services is particularly poor (Table 1.2). High illiteracy rates (especially for women), limited human resource (HR) capacity and poor HR management are also associated with lower health status.

**TABLE 1.2 MORTALITY BY AREA OF RESIDENCE**

Area of Residence	Infant Mortality Rate	Under 5 Mortality Rate
Urban	60.4	93.6
Rural	100.2	147.0
Mountains	132.3	201.0
Hills	85.5	131.3
Terai (Plains)	104.3	147.3

### 1.2.3 Challenges to the Health Care System

The key challenges to the health system are:

- a. Find means of increasing overall (public and private) resources for health care.
- b. Ensure essential services (i.e. services which produce the greatest reduction in health burden) and the poorest people, receive the greatest share of public subsidies.
- c. Improve the efficiency and acceptability of publicly provided services.
- d. Improve the value (high quality at reasonable cost) of privately provided services.

### 1.2.4 Policy Response to these Challenges

Government policies have been consistent in confirming its commitment to equity and meeting the needs of the poor through the delivery of essential health services:

- A Poverty Reduction Strategy Paper (PRSP), based on the work of the Public Expenditure Review Commission, has been endorsed by HMGN.
- The 1999 Local Self-Governance Act sets out a framework for decentralised delivery of health care.
- The Second Long Term Health Plan (SLTHP) 1997–2017 defines the responsibilities of HMGN
  - to ensure that an essential health care package is available to all regardless of ability to pay.
  - to ensure policies and strategies are in place for health needs that fall outside the essential package
  - to regulate the private health market/sector
- The SLTHP put special emphasis on improving the health status of the very poor and other vulnerable groups whose health needs often go unmet.
- The Medium-Term Expenditure Framework July 2002 categorised health budget in three prioritised health services and awarded first priority to Essential Health Care Services (EHCS).
- The Health Sector Strategy – Agenda for Change, 2002 sets out the agenda for health reform

### 1.2.5 Implications for Management of the Health Sector

1. These policy directives have wide-ranging implications for the management of the health sector. The NHSP has a number of management outputs that reflect this. In any system where change is necessitated, changes in institutional arrangements and human resource management are

- among the most difficult to bring about. Implementation of the NHSP requires re-definition of roles, responsibilities and powers of the MoH, the Department of Health Services and the Regional Directorates and a remodelling of roles through out the health system.
2. Changes to be introduced by NHSP are not the first re-organisations faced by the health sector. Since 1993, the organisational arrangements at the central level have been reformed at least three times, most recently in 2000-2001. The decentralisation process initiated in 1999 is now in transition and the respective roles and responsibilities of the DoHS, the Regions, the Districts, sub district levels and other Ministries, in particular, MoLD and National Planning Commission (NPC) are yet to be finalised. MoLD in consultation with other ministries is developing detailed guidelines in relation to this.
  3. Systems need to be created for devolving human resource management and financial powers to lower levels. Lessons learnt from current pilots (e.g. sub-health posts in 25 districts have been handed over to Village Development Committees), need to be incorporated during the creation of these systems. There needs to be a detailed assessment of new skills required to meet new roles, and where gaps exist, steps taken to develop the necessary capacity.
  4. These and other sector management issues are at the core of the NHSP implementation plan. Re-casting the health sector will need painstaking care, consideration and patience by all involved in the process. It will also need a willingness to accept change by those most affected by the reforms, the health sector personnel. HMGN and the EDPs are committed to the health reform process. The purpose of this document is to provide the framework for working through it.

# Vision, Strategy, and Implementation Approach

## 2.1 Vision Statement

The vision of the Nepal Health Sector is to bring about improvement in the health status of the entire Nepalese population with provision of equal opportunity for quality health care services through an effective health system and thus develop healthy and capable human power to support poverty alleviation.

## 2.2 Health Sector Reform Strategy

1. The rationale for the HSRS has been described in Chapter One. Specific results expected from implementation of the HSRS are:
  - Better value for clients from the out-of-pocket expenditure that constitutes 70-75 percent of health care expenditure.
  - Ensured access by the poor and vulnerable to an EHCS.
  - More efficient public health services
  - Ensured access to services outside the EHCS
  - Effective monitoring and evaluation of sector performance
2. The HMGN is moving towards output-based planning from the traditional input based planning. The emphasis of the reform strategy is on outputs and health outcomes. The HSRS is regarded as a move towards strategic planning and a Sector Wide Approach (SWAp).

3. Health sector reform will be an ongoing process for the duration of the fifteen-year period to the end of the long-term health plan. HMGN is concerned that the outputs for the first five years are realistic and achievable.
4. HMGN have set the following three programme outputs and five sector management outputs which will be the core of the reform programme over the next five years.

## 2.3 Outputs of the Health Sector Reform Strategy

The summary of the 3 programme outputs and 5 sector management outputs are written as:

### BOX 2.1 OUTPUTS OF THE HEALTH SECTOR REFORM STRATEGY

#### Programme Outputs

##### Output 1

The priority elements of an Essential Health Care Service costed, allocated the necessary resources and implemented. Clear systems in place to ensure that the poor and vulnerable have priority for access.

##### Output 2

Local bodies responsible and capable of managing health facilities in a participative, accountable and transparent way with effective support from the MoH and its sector partners.

##### Output 3

The role of the private sector and NGOs in the delivery of health services recognised and developed with participative representation at all levels which ensure consumers get access to cost effective high quality services that offer value for money.

#### Sector Management Outputs

##### Output 4

Coordinated and consistent Sector Management (planning, programming, budgeting, financing and performance management) in place within the MoH supported by the

EDPs, to support decentralised service delivery with the involvement of the NGO and private sectors.

##### Output 5

Sustainable development of health financing and resource allocation across the whole sector including alternative financing schemes in place.

##### Output 6

Structure and systems established and resources allocated within the MoH for the effective management of physical assets and procurement, distribution and rational use of drugs, supplies, and equipment.

##### Output 7

Clear and effective Human Resource Development policies, planning systems, and programmes developed and functional.

##### Output 8

Comprehensive and integrated management information system for the whole health sector designed and functional at all levels.

Quality Assurance mechanisms in place for public and private sectors.

## 2.4 Nepal Health Sector Programme- Implementation Plan

1. The NHSP-IP will work towards achieving the HSRS Outputs (henceforth called NHSP Outputs) described above. For implementation purposes, thirteen Programme Strategic Objectives and eleven Sector Management Strategic Objectives have been identified. A description of these objectives and which Outputs they relate to are given in the next chapter (Chapter 3).

### 2.4.1 Phased Implementation

1. The first phase of implementation will include planning nationally for each of the four components of the EHCS incorporating all resources available (HMGN, EDPs and INGOs). The second phase will be district-wise implementation of the EHCS delivery with the focus on improving the management capacity and ensuring all necessary resources (staff, finance and commodities).
2. The sequencing of implementation is complex and it will take careful planning to work out which groups of activities must be completed before the next set of activities can begin (dependant activities) and which can be pursued independently. Phasing and sequencing is still being worked out and will be added to Chapter 5 of this document.

### 2.4.2 Coordination

1. EDP assisted projects provide important support for all EHCS areas both at the central and field levels. It is important that this support be closely co-coordinated with overall program needs. At the central level, EDPs will participate in mechanisms established for co-coordinated program management and assist in national level management and program development tasks as agreed between the government and each agency.
2. At the field level, the aim is to mainstream successful EDP supported programmes into public sector management. In the case of innovations and pilots, agreement will be made between the MoH and EDPs and will be reflected within the national planning and budgeting framework. Both central and field support for EHCS programs will be reflected in the appropriate AWPB, even if these are currently solely and directly EDP funded and/or implemented.
3. Mechanisms for coordination and integration of separately managed projects into the sector programme are both a pre-requisite for successful implementation of NHSP and an expected Output. Actions towards this Output are described in Chapter 3 and steps to be taken to facilitate programme implementation are presented in Chapter 5.



# Programme Description

## 3.1 Introduction

1. The NHSP-IP is the operational guideline for implementing the outputs of the Health Sector Reform Strategy during its first five years. It presents a roadmap for this implementation. It will run from July 2004 - July 2009. This will cover the remaining period of the HMGNs Tenth Five-Year Plan (2002-7) and take into account its MTEF. During year three (2006/7) there will be a review of the NHSP-IP, the outcome of which will be used to adjust programming to better support the 11th 5-year plan which will start in July 2007.

## 3.2 The Essential Health Care Services (EHCS)

1. The NHSP-IP has two main features. It has a number of **new actions** which are part of the Agenda for Reform of the Health Sector. These are superimposed upon an extensive existing programme of Essential Health Care Services (EHCS) operating at varying levels of success (Table 3.1)
2. The EHCS shown in table 3.1 below can be categorised into 4 elements:
  - a) Family Planning, Safe motherhood and Neonatal health
  - b) Child Health
  - c) Communicable Disease Control
  - d) Out-patient Care

**TABLE 3.1 ESSENTIAL HEALTH CARE SERVICES: CURRENT PERFORMANCE AND FUTURE NEEDS**

Service	Burden of Disease	Program Coverage	Success of Model	Main Programme Needs
Family Planning	Indirect	50%	***	Expansion
Safe motherhood	3%	13%	*	Trials & Expansion
Perinatal care	14%	13%	*	Trials
CB-IMCI	19%	43%	***	Expansion & Trials
EPI	7%	60%	***	Expansion
Polio	<1%	90%	****	Maintenance & Eradication
TT Campaigns	1%	>85%	****	Expansion
Vitamin A	5%	81%	****	Maintenance
Iodine	<1%	91%	***	Maintenance
Other nutrition	5%	38%	*	Trials
Tuberculosis	7%	84%	****	Expansion & Maintenance
Leprosy	<1%	75%?	***	Expansion & Elimination
HIV/AIDS/STD	3%	?	**	Expansion & Trails
Malaria/VBD	<1%	>50%	***	Expansion & Trials
Outpatient services	7%	70%	**	Strengthen and Expansion
<b>TOTAL</b>	<b>70%</b>			

NOTE: Available models have been scored as:

\*\*\*\* - Excellent model in Nepal with demonstrated success

\*\*\* - Mostly successful but unclear how to obtain optimal coverage

\*\* - Some program aspects have successful models, but not most.

\* - No large -scale successful model in Nepal.

NOTE: Coverage figures are from the 2001 DHS (FP, SM/ Perinatal, EPI, Polio, and Vitamin A) from the 2057/58 Annual Report (Iodine, Other nutrition, Tuberculosis, Leprosy) or program reports (CB-IMCI, TT campaigns, Malaria).

3. The key focus of the NHSP is to increase the coverage and raise the quality of the EHCS, with special emphasis on improved access for poor and vulnerable groups. Achievement of this is expected to result in greater utilisation of EHCS by the total population and ultimately move to improved health status.

### 3.3 Strategies to Achieve NHSP Outputs

This section details actions and activities under the NHSP. Implementation of these activities will, collectively, result in achievement of the Programme Outputs. The programme activities fall into three types:

- a. Entirely new actions/activities
- b. Strengthening or restructuring of existing activities
- c. Continuation of existing activities

This section describes type a. and b. activities. Full details of existing activities for EHCS are provided in Annex 4.

## Output 1

- ◆ The priority elements of an Essential Health Care Service costed, allocated the necessary resources and implemented.
- ◆ Clear systems in place to ensure that the poor and vulnerable population have priority for access.

### **Output 1 - will be led by the Director General, Department of Health Services**

#### ***Purpose***

The priority elements of an Essential Health Care Service costed, allocated the necessary resources and implemented.

Clear systems in place to ensure that the poor and vulnerable have priority for access.

#### ***Indicators***

- 50% of health facilities provide prioritized EHCS according to National Standards by 2006/7
- 50% of population will be utilizing the prioritized services by 2006/7
- Increased utilisation of the prioritised EHCS by the vulnerable groups/population
- 60% of health facilities provide minimum level of acceptable standards of quality EHCS
- Increased access for poor utilising EHCS with prepaid CHI with subsidised premium

An essential element of ensuring that EHCS is available as planned, will be the process of defining it according to available resources and building consensus on how priorities will be set. MoH will work towards achieving this clarity by

#### *I. Refining the definition of the content of EHCS*

- The exact interventions to be included in EHCS will be agreed through consensus building within MoH and with stakeholders on the criteria and rationale for the choice of interventions to be included

Agreeing the priority of EHCS in relation to other services

- There will be further clarification on how EHCS interventions will be treated differently from those not included in EHCS e.g. with regard to priority for financing, and systems for ensuring access.

Costing of EHCS and matching it with available resources

- In Year 1 a costing exercise will be carried out with support from EDPs. This will be a large exercise and completion of unit costs for different types of services and facilities is expected in Year 2.

- Concurrent with the costing exercise a framework will be developed for coordinated financing of the EHCS by the MoH and EDPs. Central and field support for EHCS will be reflected in the national planning and budgetary framework or in an appropriate AWPB even if these are currently directly EDP funded and or implemented.

The implementation of EHCS will be further enhanced by the following

- i. Redefined institutional arrangements for delivering EHCS
- ii. Systems for priority access for poor and vulnerable groups
- iii. Strengthened Outpatient Services
- iv. Behaviour Change and Communication (BCC)

## *II. Redefined institutional arrangements for delivering EHCS*

### *Actions*

1. See Output 4 below for a list of actions to be taken to redefine Central and District level institutional arrangements for delivering the EHCS.

## *III. Systems for priority access for poor and vulnerable groups*

### *Actions*

1. Poverty criteria: Criteria to identify the poor will be finalised and incorporated in the decentralised reform actions.
2. Expansion of EHCS in underserved areas: The MoH will develop an equity-based formula for resource allocation taking account of the factors influencing access and equity. These include poverty levels, population covered, terrain, number and types of facilities. This will allow expansion of EHCS in currently underserved areas. Increased accessibility will be created through outreach and referral services for the poor.
3. Subsidised drugs and services: There will be continued expansion of the Community Drug Program, allowing individual public facilities to charge for essential drugs to ensure they are maintained in stock, while providing free or lower priced prepaid services for the poor. Consideration will be given to allocation of essential drug budgets to favour poorer areas so that prices charged will be lower or (zero) in the poorest areas. In addition the MoH will prepare detail guidelines for free EHCS and hospital services for the poor. Free services will be provided to the patients (for leprosy, TB, HIV/AIDS, malaria etc.) using a rights-based approach. The distance for health care and cost during deliveries will be taken into consideration for the poor.
4. Safety net: Appropriate mechanisms will be developed and tested for public sector financing for a safety net for the poor accessing these services and for catastrophic illnesses.
5. Rehabilitation: Rehabilitation will be given high priority to the poor in conflict and displaced areas.
6. Participation: In fully decentralised districts, representative from the poor and marginalised communities will be invited to participate during the district health planning and evaluation process.

#### IV. Strengthened Outpatient Services

1. EHCS outpatient services are those curative care visits, not covered under another EHCS programme, which can be managed cost-effectively with the standard set of essential drugs and equipment found at the SHP and HP level (or comparable services at a higher-level facility or in the private sector). Outpatient services are difficult to evaluate in terms of burden of disease impact, but most reviews of both public and private services have found low utilization, poor prescribing practices and public dissatisfaction with performance. The total OPD new visits (HP/SHP/PHC), as a percentage of total population, was 33.4% in 2000/1/ and 35.8% in 2001/2 (Annual Report /NHMIS).

Strengthening outpatient services as an EHCS is an important component of overall health sector reform, and requires actions related to several NHSP outputs.

##### *Actions*

1. Continued expansion of the Community Drug Program, allowing individual public facilities to charge for essential drugs so as to maintain them in stock, while having free or lower priced prepaid services for the poor (see finance);
2. Switch to a "pull" system of essential drug ordering and local purchasing under overall price negotiation by the centre to minimize prices for public and NGO health facilities (see also Output 6 below);
3. Consideration of preferential allocation of essential drug budgets to favour poorer areas so that prices charged will be less (or eliminated) in the poorest areas while maintaining drugs in stock (see also Output 6 below);
4. Improving staff motivation and performance for outpatient care by decentralising aspects of personnel management to municipality and village health management committees (see Output 2 and 8 below);
5. Promotion of rational use of drugs with the effective implementation of standard treatment schedule and essential drug list, through training and monitoring and supervision;
6. Review of methods to increase the quality or cost-effectiveness of public and private sector diagnosis and prescription behaviours, with support and expansion of those methods that can clearly justify their costs (see also sector management and public private partnerships below). Prevention of misuse of antibiotics will be given particular attention.
7. Adequate essential infrastructure with provision of timely repair and maintenance system. This will necessitate a full Physical Facilities Needs Analysis. It will include four activities: (1) the formulation, or review and re-formulation, of norms and standards for the provision of infrastructure, (2) a full-scale survey of existing infrastructure, including its state of repair, brand name and company, purchase date and cost incurred, (3) a comparison of the survey findings with the formulated or re-formulated norms to determine the infrastructure gap, and (4) the agreement of priority criteria in order to guide the acquisition of necessary infrastructure. This will be conducted in Year 1.

*V. Behavior Change and Communication (BCC)*

1. Although not an EHCS program area itself, BCC cuts across all programmes. EHCS services require changes in household level behaviours and expectations. This is not only true for preventive services, but for timely treatment of illnesses (in which dangerous delays are common). A combination of mass media, local media and effective community mobilisation has been a characteristic of a number of nationally and sub-national successful EHCS programs in Nepal and will be a critical component for improving other services (e.g. safe motherhood, newborn care, etc.).

*Actions*

1. Complete a comprehensive review and strategy formulation for BCC in the areas of Family Planning and Maternal and Child Health by August 2004.
2. Provide adequate funding for BCC to support individual EHCS programs in accordance with the national strategy and as proposed in AWPBs (either of direct program divisions/centres or the NHIECC).
3. Dissemination of IEC through health workers and community influential at the community level
4. Integration of IEC/BCC across all EHCS package
5. Use of all possible channels of communication (mass-media) approach for promoting health education and communication.

## Output 2

Local bodies responsible and capable of managing health facilities in a participative, accountable and transparent way with effective support from the MoH and its sector partners.

**Output 2 - will be led by Chief Specialist, Policy, Planning and International Cooperation Division, MoH**

*Purpose*

Local bodies responsible and capable of managing health facilities in a participative, accountable and transparent way with effective support from the MoH and its sector partners.

*Indicators*

- Decentralised health modalities are implemented in all districts in phase-in manner by 2006/7, in identified decentralized health management districts that are capable, responsible and accountable
- These identified districts will have their own health sectoral units/sections by 2006/7
- At least 5 districts will have their own five year plan including health by July 2005 and 45 districts will have district plan by the end of Tenth Plan

- At least 1800 health facilities managed by local health management committees by 2006/7
- At least 5 hospitals functioning as autonomous units by 2006/7 and 10 by 2009

Nepal, through the 1999 Local Self-Governance Act and subsequent guidelines, has embarked on a multi-sectoral process of decentralisation of government functions, including health services. Decentralisation of peripheral health facilities will be designed to address those aspects of health facility management and services that are currently identified as problems amenable to local solutions, while at the same time avoiding large changes in programs that have successful models. Key problems to be addressed through decentralisation include:

- Poor staff motivation and accountability, resulting in short working hours, long absences, poor attitudes towards patients and low performance in key services. Shifting some personnel management functions to local health committees may result in better staff accountability and an increased ability to replace poorly performing staff.
- Inadequate supplies of basic commodities and essential drugs. These issues are being addressed through logistics and physical assets management reforms (see above).
- Neglect of facility and equipment maintenance. Local management of facilities is expected to generate additional support for maintenance.

Some problems with peripheral health services are not amenable to solution solely through decentralisation (e.g. improving maternal care) and programs with good or moderate current levels of success need to have their successful approaches continued. This will require maintenance of central standards for key components of these services, while details of implementation in the local context can be decentralised.

#### *Actions*

The focal Division will prepare a strategy for decentralisation by August 2004. The strategy will take a phased approach in the short to medium term, in order to take account of the social, economic and political diversity of local systems in Nepal and the concomitant differences in local capacity. The focus will be on preparing for devolution through a hybrid system in which more responsibilities and resources will be transferred to the district health office, and the role of the DDC to take on new responsibilities will be increased. The strategy will establish how EDPs will support district level delivery within a sector wide approach as an interim measure before project implementation is handed over in full to government. The strategy will also address hospital autonomy

Efforts will be made to meet the capacity implications in line with the roll out of decentralisation, according to the following process: (a) the extent of devolution will be determined through a functional analysis; (b) there will be an assessment of the capacity needed, which will be compared with existing capacity to determine the capacity gap; (c) a capacity building programme will be designed and implemented.

**Actions already identified, to be included in the strategy, are as follows:***1. Local Management of Sub-Health Posts (SHP)*

Decentralisation of Sub-Health Posts (SHP) to Village Development Health Management Committees (VDCs) has already begun in 2002 and will be completed in 25 districts by July 2004. Expansion to all districts is planned over the next few years. Once the health management committees assume full ownership of the local level management, the committees will design the benefit packages, prioritise their EHCS and financing mechanism with technical backstopping and information updates from DPHOs as local health unit of the DDCs. A decision has been taken to form a "Local Health Facility Operation and Management Committee" to run the SHP

*2. Hospital Autonomy and Resource Mobilisation*

Hospital Development Boards have been formed for all government hospitals above the district level. This has recently been extended to 12 district hospitals and will expand further as experience is gained. The MoH, in addition to providing capacity development for performance management and quality standard setting, will extend autonomy to all public sector hospitals. There will be piloting of contracting out hospital services. Options for Hospital Funding include:

- i. Develop a system of charges for hospital services together with assessment and subsidy for those unable to pay.
- ii. Refine the concept of Social Health Insurance and how it will be applied to hospitals.
- iii. Encourage hospitals to make use of income from charges to improve the quality of services.

To increase the willingness of the population to pay for services the quality of the services must be improved concurrently with the introduction of user fees.

Autonomy for hospitals will be created in a phased manner over the course of 5 years. Presently, Nepal lacks the human resources and management infrastructure to introduce autonomy rapidly. Preparation will involve training a cadre of hospital administrators and adoption of written guidelines for policies and procedures for autonomous hospitals.

## Output 3

The role of the private sector and NGOs in the delivery of health services recognised and developed with participative representation at all levels which ensure consumers get access to cost effective high quality services that offer value for money.

**Output 3 - will be led by the Chief Specialist, Policy Planning and International Cooperation Division, MoH**

**Purpose**

The role of the private sector and NGOs in the delivery of health services recognised and developed with participative representation at all levels which ensures consumers get access to cost effective high quality services that offer value for money.

**Indicators**

- Redefined partnership roles and responsibilities in MoH and the departments' document.
- At least 5 hospitals under the management of the private sector and NGOs.

The private sector and NGOs make an important contribution to health provision in Nepal. Various agreements and operating modalities exist between MoH and NGOs and private providers, and in many cases these are vital for supporting EHCS programmes and directly providing curative care which cannot be covered by public expenditure.

The NGO (and EDP project staff) contribution includes middle level management support for specific EHCS programmes (e.g. tuberculosis, leprosy), co-ordinated planning and supervision with the district level (all EHCS programmes), training (e.g. CB-IMCI, tuberculosis, leprosy, CDP), evaluation (e.g. Vitamin A, Iodine, CB-IMCI) and direct provision of services, especially for reproductive health and HIV control. NGO provided support often has important advantages over public services in terms of flexibility, accountability, innovations, and a strong sense of mission. With regard to the contribution of the private sector, most curative care visits, even in rural areas, occur in drug shops and private provider offices (who are often public providers during government working hours) rather than in government health facilities. A substantial proportion of reproductive health services and HIV prevention activities also occur through private providers and social marketing. In urban areas there has been a rapid expansion of private speciality providers and hospitals.

HMGN intends to develop this contribution further. The HSS states that the 'public sector will develop a major new role in working with the private / NGO sector', and identifies four areas where this will operate: sustainable financing; providing an integrated approach to delivery EHCS; quality assurance by government; and pharmaceuticals, other consumables and new technology. The Division within MoH responsible for taking this forward is Policy, Planning and International Cooperation Division. EDPs will consider earmarking specific monies from pooled funds (assuming availability), which will be transferred to the NGO / private sector, once partnership modalities are drawn up

**Output 3 will be operationalised as follows:***Year 1:*

- The development of a strategy for partnership with NGOs and the private sector will be developed. This will be based upon consultation with all stakeholders, and learning from current experiences in the sector. It will also draw on some of the studies which have recently been undertaken. The strategy will clarify the strategy and rationale for PPPs, address the roles of MoH, NGOs, and private providers in the sector, and address how each should develop their

contributions, with a particular focus on the role of MoH as facilitator. The capacity development needs of each will be identified and creative strategies identified for meeting these, based on an approach of both partnership and self responsibility. The strategy will take account of how partnerships are to be coordinated and operated in an environment of decentralised service delivery, and pay special attention to how all parties can work together to deliver HSS and the NHSP. There will also be consultation and a decision on what services are to be eligible for public financing through NGOs and private providers. The strategy development may entail some sort of mapping exercise to establish the contribution of the NGO and private sectors, both in terms of the services they currently and potentially could provide and who the current and potential beneficiaries are. This last point will be particularly important to ensure that best use is made of any public funds channelled through private organisations. This strategy, and a supporting workplan will be completed by the end of Year 1 (milestone). The workplan will contain agreed indicators for implementing the strategy.

- The harmonisation of EDP procedures to facilitate NGO / private sector support through government modalities. Those EDPs currently supporting NGOs will work with the rest of the EDP group and MoH to harmonise, as much as possible, the way in which their support to NGOs the private sector is managed and funded. Ideally there will be a move towards:
  - Financial contributions being made through the budget, even if this involves earmarking.
  - Achieving the best mix of government management of EDP funded NGO / private sector contracts and I/NGO management of such contracts. Where EDP procedures preclude government management then efforts should be made to harmonise reporting and management procedures.

At a minimum EDPs will work with HMG/N and their partner NGOs or private organisations to ensure that they participate in arrangements for coordination and planning even where they are not receiving government funding.

#### *Years 2 + 3*

The following activities will be undertaken:

- Building capacity in MoH, in order to ensure adequate regulation, monitoring and implementation of professionals, facilities and services.
- Enabling the private sector and NGOs to prepare for potential opportunities in new geographical or technical areas.
- Developing specific modalities of partnership at central and district level, with appropriate coordination mechanisms which facilitate integrated planning of services, especially EHCS.

#### *Years 4 + 5 (Into the 11th 5-year Plan cycle)*

- New service provider agreements will be let with NGOs and the private sector. These will cover all forms of partnerships, including those that involve the transfer of public resources to the private and NGO sector.

## Output 4

Coordinated and consistent Sector Management (planning, programming, budgeting, financing and performance management) in place within the MoH supported by the EDPs, to support decentralised service delivery with the involvement of the NGO and private sectors.

### **Output 4 - will be led by Chief Specialist, Policy, Planning and International Cooperation Division, MoH**

#### ***Purpose***

Coordinated and consistent Sector Management (planning, programming, budgeting, financing and performance management) in place within the MoH supported by the EDPs, to support decentralised service delivery with the involvement of the NGO and private sectors

#### ***Indicators***

- Partnership policy and framework document.
- Number of joint annual planning and review.

#### *1. Co-coordinated Sector Management*

The Policy, Planning and International Cooperation Division of the MoH is the prime responsible agency for coordinating the sector management of the NHSP-IP. The DoHS is responsible for management and implementation of the EHCS.

#### *Actions*

The MoH will carry out the following activities:

1. Strengthen joint MoH/donor annual planning, programming, budgeting and monitoring cycle
2. Strengthen ongoing MoH/Donor programmatic collaboration
3. Strengthen Sector Management at the Central Level
4. Strengthen Regional and District Management

MoH has initiated an annual work plan and budget exercise from FY 2003/4 involving all MoH, Departments and divisions/EDPS, NGOs and private sector. This process will be strengthened during NHSP-IP period. MoH envisages that this process would strengthen health sector co-ordination, and ensure collaboration of all stakeholders

#### *2. Capacity Building*

Capacity building related activities cut across NHSP-IP as the plan itself aims to develop capacity within the sector as a whole to meet the health needs of Nepal. However In order to consolidate thinking about capacity development there will be a systematic and thorough assessment of capacity carried as a distinct activity in the first year of implementation of NHSP-IP. This will help to achieve a clearer definition of the process and operation of decentralisation and the roles of the centre and districts.

The following definition of capacity will be used throughout implementation as a way of focusing on the results to be achieved: When MoH and the decentralised delivery system have capacity then it will be possible to see in it the following 7 things:

1. The division of labour within all parts of MoH and within the decentralised delivery system is optimal and clear.
2. There is leadership in the sector i.e. there is capacity in MoH to create a vision and to strategize, and that the sector indeed has a 'good' vision and 'good' strategies.
3. MoH has financial resources to match its mandate and plans; or alternatively, its mandate and plans match its resources
4. MoH and the decentralised system have human resources - the right number, mix and level of skills - to match its mandate and plans.
5. MoH and the decentralised system, has material, physical resources to match its plans and mandate.
6. MoH has the information that is needed to carry out operations, monitor and evaluate them,
7. The people who work in MoH and the decentralised system work productively: both work practices and management practices are adequate. These capacities are reflected in staff salaries and career prospects, particularly with respect to increased productivity in remote areas.

The following approach to capacity building will be employed:

- a. A horizontal analysis and agreement on the division of labour and roles and functions among all organisations engaged in health care at the national level, including MoH, the private sector and NGOs, and other government organisations delivering health care.
- b. A vertical analysis and agreement on the division of labour and roles and functions between MoH, and the decentralised delivery system.
- c. An internal analysis of roles and functions within each level of the organisation.

This approach will include a review of staffing needs and deployment or redeployment of staff. There will also be a continued emphasis on general productivity improvement; this will be essential to help close the resource gap, thus ensuring more cost effective delivery of services within the available resources.

***Some of the specific issues to be addressed are as follows:***

*2.1 Central Level.*

During the initial stages of implementation of the NHSP, roles and responsibilities within the MoH and DoHS will be realigned. Increasingly government is assuming management of projects currently implemented by different EDPs. In addition, new functions will be generated as part of the health sector reform process including contract management, performance management and co-ordination. To carry out these expanded/new roles effectively, capacity within the MoH and the DoHS will need to be strengthened. This process is a high priority. MoH will conduct a highly participatory institutional assessment and realignment process to incorporate the new roles and responsibilities as well as change management arrangements. Support from ministries of Finance and General Administration will be vital in this process.

During the period of capacity building, skill gaps will be met through technical assistance (TA). MoH in collaboration with the EDPs will conduct a Needs Assessment. Based on the assessment report a TA plan will be formulated and will be reflected in the individual AWPB.

## *2.2 District Level*

The focus of capacity building for the district and regional management will be co-ordinated planning and implementation to deliver the EHCS. District level support has been biased towards the more heavily populated and easily accessible parts of the country, the Terai districts and the Kathmandu Valley. These areas provide larger outputs in terms of assisted people at lower costs and easier accessibility. In addition, personnel are more motivated to stay in the more accessible and populated areas. There will be a systematic assessment of institutional and organisational arrangements as well as capacity of the district and regional management including the roles and relationship with decentralised set up of the HMGN. The roles of the District Health offices will be redefined with relationship identified with the handing over of the SHPs to the VDC. Conflict in some parts of the country could potentially adversely affect service delivery and uptake, and will influence decisions around phasing and prioritisation of services. This issue will be addressed when drawing up District Level work plans in order to minimise the impact, and ensure service continuity through the most appropriate means e.g. local NGOs and the private sector.

### *Key Indicator*

By the end of 5 years (in 2006/7) decentralised planning, programme and budgeting system established.

## **Output 5**

**Sustainable development of health financing and resource allocation across the whole sector, including alternative financing schemes in place**

**Output 5 - will be led by the Head of the Health Economics and Financing Unit (HEFU), MoH**

### ***Purpose***

Sustainable development of health financing and resource allocation across the whole sector, including alternative financing schemes in place.

### ***Indicators***

- At least 10% of health expenditure borne by elected local bodies e.g. DDC, VDC, Municipalities in public health facilities by 2006/7;
- At least 5% of health expenditure borne by local community in public health facilities by 2006/7 e.g. CDP, CHI

- Increased financial contribution from private sector
- Increased target population served under alternative health financing schemes
- 60% of the target population access to affordable and quality care

Nepal has made significant progress in the health sector during the period of the 9th Plan (1997-2002). The public sector has defined its priorities far more precisely, and has improved the focus on promotive and preventive health services and on a limited package of curative health services. The first half of the 1990s saw the share of public expenditure devoted to these priorities fall sharply, from 77% in 1991-92 to 57% in 1997-98. The 9th plan reversed this decline, with the share of these priority programmes increasing to 64% in 2001-2. The Medium Term Expenditure Framework for 2002-3 to 2004-5 has allocated 72% of the health budget to these expenditures. They are defined as 'Priority 1'. The 9th Plan also saw some significant gains in health status: the proportion of children with full vaccination coverage increased from 37% in 1991 to 66% in 2001, and the reduction in child mortality over the plan period exceeded the target.

#### *Actions<sup>1</sup>*

##### *1. Public Financing, Health Sector Priorities and Resource Allocation*

In keeping with the priorities established in the MTEF and the realities of limited public financial resources for the health sector, the government will gradually reduce financing of tertiary (priority three) and most secondary (priority two) care, allocating a higher proportion of resources to priority EHCS. The costing exercise for EHCS described under actions for Output 1 will quantify the resources needed for EHCS. This will provide hard information from which to determine how much of the total public resources need to be reallocated to EHCS (also see Chapter 4, section 4.7 for discussion on the resource gap for EHCS).

##### *2. Alternative Financing Arrangements*

Alternate financing arrangements will be promoted, in particular for hospital and speciality care, but also for some curative care under the priority EHCS (e.g. outpatient services). However, appropriate mechanisms will be developed and tested for public sector financing for safety net for the poor accessing these services and catastrophic illnesses. MoH will provide the guidelines regarding user fees and safety net arrangements and the DoHS will monitor the implementation process with support from the Regional and District offices.

In general, the proportion of public financing including those of EDPs for the provision of EHCS will be around 70% to be achieved during this plan period. This has been already endorsed through fiscal framework of HMG. The MoH will develop an equity based allocative formula for resource allocation taking account of the factors influencing access and equity. These include poverty levels, population covered, terrain, number and types of facilities, etc.

<sup>1</sup> For background for these actions and other financing issues see details in chapter 4

### 3. *Public Facility Charges and Finance*

Most curative health facilities services are not free to the user. In the urban areas, the government has permitted the central, regional and zonal level hospitals to charge user fees from the patient under the Development Committee Regulations. The users' fee charge rates vary depending upon the type of services required at the health facilities. MoH will develop national guidelines with respect to user fee practices and other payments in public facilities particularly regarding exemptions to the poor and the provision of some kind of safety net.

### 4. *Community and Social Health Insurance Schemes.*

The Ministry of Health intends to initiate alternative financing schemes such as community and social health insurance schemes as a means to supplement the government health sector-financing source. Social Health Insurance (SHI) is a mechanism for financing and purchasing/delivering health care to workers in the formal sector regulated by the government. Currently there are no such schemes in Nepal, though a small number of agencies provide medical benefit packages, including membership of private insurance schemes, to their employees. MoH will consider implementing pilot SHI schemes and replicating the appropriate schemes based on piloting experience.

### 5. *The Community Health Insurance (CHI) Scheme*

This is suitable for the informal sector and it covers a variety of schemes with variations in (a) target groups, (b) provider arrangements, (c) benefits of services, (d) exemption arrangements for vulnerable groups, (e) means of contributing, (f) degree and type of cross subsidy and (g) administrative mechanisms. There are already a small number of community health insurance schemes (including Community Drug Program) within Nepal. CHI schemes are attractive as they provide the opportunity to link the activities into local management processes. MoH is considering working closely with different CHI schemes and using them to provide information for developing an approach for wider replication elsewhere in Nepal.

### 6. *Drug Financing Mechanisms*

(Discussed under Output 6)

## Output 6

Structure and systems established and resources allocated within the MoH for the effective management of physical assets and procurement, distribution and rational use of drugs, supplies, and equipment.

**Output 6 - will be led by Director General, Department of Health Services and Regional Health Directorates**

**Purpose**

Structure and systems established and resources allocated within the MoH for the effective management of physical assets and procurement, distribution and rational use of drugs, supplies, and equipment to ensure continuous availability of essential drugs, equipment and medical supplies in all health facilities maintained to MoH norms and standards.

**Indicators**

- Stock outs of EHCS indicator health commodities fall to 65 % by 2005/6 and 0% by 2009
- Drug Financing Schemes are implemented in at least 50% districts by 2006/7
- Procurement decisions are made based on information generated by LMIS by 2006/7

Reforms in the logistics and physical asset management system over the next five years will involve extensive decentralisation of functions better performed at lower levels and increased relationships with the private sector. These will result in improved availability of essential drugs, commodities, and equipment to support health programs.

**Actions***1. Product Selection and Quality*

These will be improved by reforming MoH procurement policies and capacity at local and central levels.

- Purchase authority for commodities will be transferred to districts (where private suppliers can guarantee price and availability) while maintaining nationally negotiated prices, both for government and sanctioned NGO and INGO facilities. This will gradually reduce the need for LMD/DoHS to distribute drugs to districts.
- Quality assurance procedures and compliance testing of drugs (through DDA, LMD and private laboratories) will be strengthened.
- The process of integrating MoH's programs that still directly procure commodities (tuberculosis, epidemiology and disease control division) into the LMD procurement system will continue.

*2. Commodity Distribution*

This will be improved through decentralised decision-making, infrastructure development and strengthened management systems.

- The annual indent essential drug procurement system will be converted from a "push" to a "pull" system, as is already used for key commodities for EHCS programs.
- Donated, internationally procured and special handling products (e.g. vaccines) will continue to be distributed through the LMD system, requiring improvement in stores (construction of stores at the district level and modernisation of high level facilities). Training in storekeeping, inventory control and distribution procedures will be continued as needed.
- Transportation funds for distribution costs will be delegated to regional and district levels, with the exception of sensitive products and emergency backup in case decentralised distribution fails.
- Where possible, direct delivery of commodities to regional rather than central stores will be arranged.

### 3. *Drug Financing Mechanisms*

These will be strengthened to support increased and equitable availability of essential drugs. The Community Drug Programme (CDP) allows local health facilities to charge a subsidised price for drugs prescribed with income used to purchase additional drugs or support other health facility needs. The government is committed to increasing the coverage of CDPs over the next few years and the LMD will continue to support training, materials development and operationalisation of CDPs. However, when the redistribution of functional responsibilities as well as policies for alternate financing mechanisms are undertaken the responsible division for these activities will change.

### 4. *National Drug Policy*

This will be more effectively implemented to maintain, safeguard and promote the health of people by making self-reliant in drug production, ensuring the availability of quality drugs at affordable price and in quantities sufficient to cover the need of every corner of the country.

### 5. *Logistics Management Information System (LMIS)*

This will aim to strengthen and improve resource utilisation and other MoH information system efforts. Multiple activities will be undertaken to strengthen the LMIS including selective decentralisation of data processing to the district level, potential inclusion of CDP commodities in the LMIS and revisions of reports and reporting mechanisms to increase ease of use by decision-makers.

### 6. *Logistics Human Resource and Organisational Structure*

This will be developed to ensure commodity availability and rational drug use. The LMD will be restructured within the current personnel ceiling to better meet its current responsibilities. Current training of all levels of logistics staff will continue with refinements and consideration will be given to creating a health logistics cadre separate from general administrative categories.

### 7. *Disaster Relief Commodities Management*

This will be strengthened either by involving LMD in provision of drugs and supplies for disaster relief (currently done by EDCD and EDPs) or at least tracking distribution of such products to avoid wastage when they enter the regular distribution channels.

### 8. *Quality and Safety*

Policies and systems will be established to improve the quality and safety of health services. The MD will work with the Physical Assets Management Project to develop and implement practical plans for safe management of biomedical wastes for all levels of health facilities. A health care technology policy and strategy defining standards of health facilities have been approved which will be the basis for future investment in creating health facilities. An inventory, which describes the situation of all physical facilities, will be prepared. As per need identified the new construction and maintenance of the physical facilities will be carried out.

## Output 7

Clear and effective Human Resource Development policies, planning systems, and programmes developed and functional.

### **Output 7 - will be led by Chief, Human Resources and Financial Management Division, MoH**

#### ***Purpose***

Clear and effective Human Resource Development policies, planning systems, and programmes developed and functional.

#### ***Indicators***

- 50% of the public health facilities will have appropriate mix of HR by 2006/7
- Staff available to provide services in 35% at any given time
- HR Master plan updated and incorporated in HR management

The effective ongoing planning, deployment and management of the government employed health workforce will be essential for the delivery of NHSP-IP.

#### ***Actions***

1. *As a matter of priority, the MoH will reform its HRD unit and locate it in an appropriate place and provide adequate technical skills and high level organisational access to perform the following policy level functions:*
  - Manage production of long term, medium and annual HR plans. This will be carried out in close co-ordination with relevant units, in particular when new health worker types, levels, or personnel policies may be needed (e.g. maternal care) and for programs with intensive training requirements.
  - Develop and test instruments for district level human resource planning.
  - Undertake or oversee research into the deployment, management, training and performance of health service staff. This will include, where appropriate donor project/INGO and private sector staff when these contribute substantially to total performance (e.g. district level EHCS programme management).
  - Develop HR policy options that can better achieve health, health service and human resource objectives, and advise senior management on HR matters. Policy controls for HR may include legislation, licensing, incentives, subsidies, tax provisions, contracts, regulations and recruitment rules (e.g. preferring local staff). In support of this the Health Act will be updated and brought into practise as part of the effort to enhance staff motivation
  - Monitor HR and HR management performance.
  - Introduce cost sharing approach in training,
  - Ensure that human resource development is carried out appropriately within the decentralised system. This will involve clarifying the role of MoH in HRH after full decentralisation with job description of all kinds of personnel

- Address the key issue of ensuring the availability of staff throughout the country including remote and conflict ridden districts. Specific incentives and motivational packages will be developed to mobilise and retain the necessary workforce, supported by regular auditing of staffing levels.
- Ensure linkages with other stakeholders such as Public-Private Health Institutions, not only in relation to pre-service training (see below), but also in the areas of professional regulation, workforce planning and skills mix profiling.

## 2. *Personnel Management*

The MoH will improve its personnel management functions (located primarily in the MD/DoHS) through:

- Full support of the HuRDIS (Human Resource Development Information System), in particular for skilled staff, to provide the data necessary for HRD planning and for the transparent application of personnel rules.
- Expansion of human resource information tracking to include major training courses (included in the Training Information Management System (TIMS)).
- Clearer and more consistent application of personnel rules based on policies proposed by the HRD unit and approved by the MoH (to be tracked with HuRDIS data by the HRD unit).

## 3. *In-service Training*

Training co-ordination and quality will be improved through the following measures:

- Ministry of Health/DoHS divisions and centres will define the medium term training strategies to achieve their programmatic objectives and include annual plans for training in their AWPB submissions, so that training plans will be well integrated with other aspects of program management. Training proposals will be aggregated and reviewed by NHTC for consistency with overall HRD goals and policies. Adjustments, if needed, will be made in consultation with the program directors to avoid duplication, fragmentation or excessive total training time for specific workers.
- Division Chiefs/Directors and relevant EDPs through committees/working groups will determine, in conjunction with training experts, how to design specific training courses to include elements associated with successful learning of new skills (e.g. interactive practice-based training, high quality pre-tested training materials and job aides, improved training sites, on-the-job training, follow-up supervision by trainers, etc.)
- Training will be provided either by NHTC (in those areas where it has the needed skills and facilities) or by specialised training services (e.g. for laboratory skills) or may be contracted out to suitable NGOs or companies. All major training of government health staff will be reported to the information system (e.g. TIMS) to allow accurate tracking of training status.
- Programme committees and workgroups will monitor the training received and adjust training provisions as needed to maintain quality and cost-effectiveness.
- Cost-effective approach will be tested for integrating the training as well as delivery of training programmes.
- Upgrading training will be conducted in areas where there is a lack of appropriately trained human resources.

- Training follow up will be developed as a regular part of the overall training system and training impact assessment will also be conducted.
- New training as identified needs by use of new health care technology will be done by NHTC.

#### 4. *Pre-service Education*

Recent development of the private sector educational institutions for medical, dental, nursing and allied courses necessitates better co-ordination between the Ministry of Education (MoE) and MoH. MoH through its human resource policy and skilled personnel projection models will recommend the MoE in the decision of prioritising the type of educational institutions' approval process. The MoH will collaborate with the MoE, Universities', health science programmes and CTEVT for improving the quality of education and also the health priorities to be reflected in the curriculum for these courses. The overall process will be co-ordinated in consultation with the NPC.

## Output 8

- ◆ Comprehensive and integrated management information system for the whole health sector designed and functional at all levels.
- ◆ Quality Assurance mechanisms in place for public and private sectors

### **Output 8 - will be led by the Director, Management Division, DoHS**

#### ***Purpose***

Comprehensive and integrated management information system for the whole health sector designed and functional at all levels.

Quality Assurance (QA) operational across public and private sectors

#### ***Indicators***

- Comprehensive and integrated information system in place at all levels by 2007
- Quality Assurance Policy for public and private sectors created and implemented.

#### 1. *Integrated Management Information System*

An Integrated Management Information System (MIS) will be key in moving towards a Sector Wide Approach. Integration of information from epidemiological, service delivery, personnel, financial and logistics systems is essential. During the process of integration care will be needed to ensure information flows from the individual information systems are not disrupted nor information lost through integration.

## 2. *Quality Assurance*

There are several quality assurance projects currently being implemented. However, these are largely along disease specific lines e.g. TB, malaria, leprosy, reproductive and child health and coordination and sharing of materials and lessons learnt are limited. Coordination between professional councils and international agencies is poor. The I & QC section is weak and there is no legislation to enforce quality standards in private health institutions. There is a lack of interface between medical schools and health provider institutions, and available protocols, guidelines and standards are not implemented or enforced. Awareness of the concept and practice of QA among health professionals is low.

### *Actions*

1. Development of Quality Assurance Unit/DoHS with a clearly defined mandate.
2. All health facilities will develop their own Vision and Mission statements and these will include statements of the quality of care.
3. Available standards and protocols will be implemented with enough training in their use and with proper supervision (for safer motherhood, family planning, child health, communicable diseases and outpatient care). Emphasis will be on the peripheral level where majority of the EHCS are provided.
4. The disease specific standards and treatment guidelines will be made available to all facilities
5. The Curative Division in the MOH will be equipped with enough capacity and authority to ensure that the private hospitals fulfil the requirements also after receiving permission to start operating.
6. Performance indicators are defined and adopted in priority areas of health services
7. For better health outcomes client rights policy and legislation will be developed to safeguard the quality of services provided, importance of quality is included in the training and job descriptions of health care personnel and health care ethics are promoted through training.
8. Standards for health care will be revised when necessary and implemented at all sectors (public, private and I/NGO). Client perspectives are included at facility level for the satisfactory services



# Health Financing and Financial Management

## 4.1 Economic and Social Benefits

For individuals and families, good health is the foundation for personal development and economic security, as good health is a prerequisite for intellectual, physical, and emotional growth, the capacity to learn at school and to be productive at work.

A healthy population contributes to poverty reduction and to long-term economic growth of a country. The Child Mortality Rate (risk of dying by age 5 per 1000 live births) is a highly significant predictor of economic performance (World Development Report 1993). Nepal's high Under-5 mortality rate of 104 per 1000 live births is matched by a low GNP per capita of US\$ 220 (The State of the World's Children 2001). Under 5 years mortality in 2002 was 81 for males and 87 for females while per capita GDP (PPP US\$) was 1310. Per capita total expenditure on health at average exchange rate was persistent at US \$12 in 1997-2001, while per capita expenditure on health at international dollar rate was increasing from \$58, to 60, 59, 61 and \$63 from 1997 to 2001 respectively (WHR 2003) Global data indicates that better health means more rapid economic growth. In turn, economic growth reduces poverty and improves health. The case for investing in health is very strong.

## 4.2 Poverty and Equity

In Nepal 37.7% of the population had below \$1 a day earning during 1990-2001 (HDR 2003 -UNDP).

**TABLE 4.2.1 POVERTY DISTRIBUTION**

Ecological Zone	% Below the Poverty	% Intensity of Poverty	% Severity of Poverty
Mountain	56	18.5	8.2
Hill	41	13.6	6.1
Terai	42	9.9	3.4
<b>Rural/urban</b>			
Rural	23	7	2.8
Urban	44	12.5	5.1
Nepal	42	12.1	5

SOURCE: Poverty in South Asia, 2003

**TABLE 4.2.2 POVERTY GAP**

Health Status	Poorest	Richest
IMRU	96.3	63.9
5MR	156.3	82.7
Underweight<2z score	59	31.8
<b>Health services:</b>		
Immunization (all)	32.4	71.1
<b>Medical treatment</b>		
Diarrhea prevalence Seen medically	32.2 9.5	20.7 18.3
Antenatal care (2+)	16.6	57.4
Delivery by HW	2.9	33.7

SOURCE: World Bank Analysis from 1996 Data

**TABLE 4.2.3 THE URBAN-RURAL GAP**

Item	Urban Rich	Rural Poorest	Rural Richest
Health status		96.5	71.7
IMRU5MR		156.8	90.5
Underweight <2z score	19.8	53.3	31.2
<b>HNP services</b>			
Immunization (all)	75.8	32.3	69
<b>Medical treatment</b>			
Diarrhea prevalence Medically seen	20 14.2	32.3 9.6	21 20
Delivery by HW	71.7	16.6	51.2

SOURCE: World Bank Analysis from 1996 Data

**TABLE 4.2.4 THE GENDER GAP**

No	Item	Male		Female	
		Poorest	Richest	Poorest	Richest
1	<b>Health status</b>				
	IMR	105	71.8	87.5	55.5
	Underweight <2z score	59.3	28.2	58.8	35.9
2	<b>Health services</b>				
	Immunization (all)	37.2	78.1	27.4	64.4
3	<b>Medical treatment</b>				
	Diarrhea (prevalence)	30.8	23.3	33.7	17.8
	Seen medically	9.7	11.6	5.6	12.9

SOURCE: World Bank Analysis from 1996 Data

The poorest areas measured by Human Poverty Index (HPI) are the Western Mountains, Mid-Western Mountains, hills and Terai, and Far-western Mountains and hills. Generally, mountains and Terai are relatively poorer than the hills. The HPI for the rural areas overall is 41.4 compared to 23.9 for the urban areas (% living under the poverty line). Large proportions of the poor live far away from health facilities: 57% of households belonging to the wealthiest income group can reach a health facility within half an hour, whereas only 29 % of the poorest group can reach a health facility in this time. The difference in utilisation of health services is reflected in terms of per capita health expenditure, where the richest households spend 8.7% and the poorest households spend 3.2% of their household expenditure on healthcare.

There are three dynamics to viewing inequalities in health

Realising these gaps there should be efforts in targeting the program to reach the underserved, the lowest access to health care. The absence of social safety nets or social protection for the poor in Nepal make higher barrier for the utilization of health care. Experiences from other developing countries showed that specific targeting for the poor and the underserved can effectively increase access to health care/health service utilisation.

There is an indication of inequity in the distribution of subsidy between the urban and rural areas, and subsequently among the rich and poor. Public subsidies inclusive of both current transfer and capital subsidy accounted for 28% of the total health budget (Rs. 3907.2 million) in 1998/99. However, these subsidies are not proportionally distributed. Most of these subsidies went to tertiary and secondary hospitals, and very little to district hospitals,

primary health centres and health posts. In reality about 56 percent of individuals use these facilities for health care in rural areas. But in terms of subsidy, these facilities received only about 3 percent

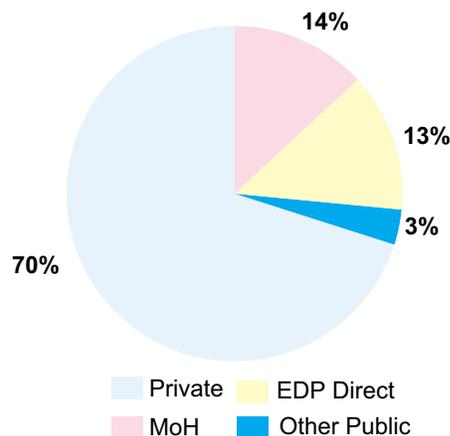
### 4.3 Health Expenditure and Financing

#### Composition of Health Expenditures

Relative to its South-Asian neighbours, Nepal spends a higher share of its GDP on health expenditures. According to the UNDP Human Development Report<sup>2</sup>, in 2000 Nepal spent 5.6 percent of its GDP on health. For comparison, India, the next highest spender in the region, spent 5.1 percent of its GDP on health over the same period. Despite these expenditures Nepal ranks poorly in the region across key health indicators. The country has one of the highest infant and maternal mortality rates and the lowest life expectancy at birth in the region.

One of the failings of health expenditures in Nepal has been the inability of health spending to reach the poor and disadvantaged through affordable access to health service. Unlike its South-Asian neighbours, most of Nepal's expenditures come from private out-of-pocket contributions, which in 2000 accounted for approximately 70 percent of total health expenditures (3.6 percent of GDP). The poor and disadvantaged in Nepal are less capable of accessing health services through private out-of-pocket contributions and are predominantly reliant on public health services that are currently inadequately resourced to fulfil that demand. Figure 4.3.1 illustrates the composition of the total health expenditures in Nepal.

FIGURE 4.3.1 **Composition of Health Expenditures in Nepal<sup>3</sup>**



Approximately 14 percent of total health expenditures in Nepal are channelled through the Ministry of Health and an additional three percent is spent by other ministries (e.g., MoF, MoD, MoE), autonomous bodies (e.g., universities) and local bodies (DDC, VDC and municipalities). In addition, direct expenditures by external development partners account for another 13 percent of health expenditures.

These estimates of total health expenditure suggest that Nepal spends approximately NRs. 1,200 per-capita (US \$ 16.8 per-capita) on health expenditures. This statistic on per-capita expenditure, however, must be balanced against the fact that health spending is highly uneven across income groups with

<sup>2</sup> UNDP, Human Development Report 2003

<sup>3</sup> These estimates are based on data collected for 2000/2001. Similar data for other years are not available but is unlikely to be significantly different for other years. The figure is most useful for illustrating the general composition of health expenditures in Nepal.

the majority of private expenditures coming largely from the few, relatively well off and spent primarily on curative and tertiary care.

Under the 10th Plan/PRSP, MoH is the line agency charged with implementing the NHSP-IP. Though private and other (non-MoH) public health expenditures complement the health sector strategy, the feasibility of NHSP-IP must be sized against resources available to MoH. Other public agencies (MoF, MoHA, MoD, MoESC) that provide health services may complement the NHSP objectives but do not play a direct role in implementing the strategy and are not accountable for any of the NHSP goals. Consequently, this analysis examines public health financing for the health sector strategy only in terms of MoH and does not account for expenditures from private contributions or other (non-MoH) public agencies.

### Trends in MoH Allocations

Government commitment to the health sector.

Budgetary allocations, rather than actual expenditures, provide a better indication of Government commitments because it abstracts from the problems of implementation capacity and uncertainty in revenue mobilisation.

Due largely to resource constraints and limits on domestic borrowing, Government budget as a share of GDP have been under pressure and this trend is likely to continue. Nevertheless, within the overall budgetary framework, allocations to MoH have registered a modest increase. Except for a decline in 2002/2003, which appears to have affected the overall Government budget, allocations for MoH has increased marginally from NRs. 4.6 billion in 2000/2001 to NRs 5.2 billion in 2003/2004 (the current fiscal year). This represents an increase from 5 percent to 5.1 percent of the total Government budget. The planned allocations for MoH over the next two years of the Medium Term Expenditure Framework (MTEF), through 2005/06, propose higher allocations to MoH. Based on current MTEF forecast, the share of Government budget to MoH is expected to increase to 5.5 percent by 2005/06. Table 4.3.1 illustrates the trend in MoH budget allocations.

**TABLE 4.3.1 TREND IN MOH BUDGET ALLOCATIONS (ACTUAL AND PROJECTED)**

Million NRs.	2000/2001	2001/2002	2002/2003*	2003/2004	2004/2005	2005/2006
Total Govt. Budget	91,620	99,792	96,125	102,040	111,659	121,182
- Annual Growth		8.9%	-3.7%	6.2%	9.4%	8.5%
- % of GDP	22%	22%	20%	19%	19%	19%
MoH Budget	4,605	5,191	4,872	5,201	5,839	6,564
- Share of Budget	5.0%	5.2%	5.1%	5.1%	5.2%	5.4%
- Annual Growth		12.7%	-6.1%	6.8%	12.3%	12.4%
- % of GDP	1.1%	1.2%	1.0%	1.0%	1.0%	1.0%
Note: 1 US = NRs	74.7	78.0	72.0			

\* The decline in budgetary allocations for 2002/03 is due mostly to the prioritisation approach in the MTEF, which was first implemented that year. Because many projects were cut as a result of the prioritisation, Government allocations declined. Relative to previous budget projection, the MTEF now provides a more realistic outlook of future Government commitments to MoH. (Considering the present positive trend in availability of resources, the target for the fiscal year 2005/6 might go up to 6.5% of the government budget).

The trends in budget allocation to MoH suggest that Government is committed to increasing public expenditures on health. When Government budgets have increased, allocations to MoH has grown more rapidly than the overall Government budget. This implies that either savings elsewhere or that some other part of the Government budget have been squeezed out to make more resources available to MoH. Given the increase in defence and security spending that have occurred over this period, the higher levels of budget allocation to MoH should be taken as an indication of the Government's strong commitment to the health sector.

Assuming that the NHSP-IP is first implemented in the upcoming fiscal year (2004/2005), NHSP-IP would extend through to 2008/2009. However, the current MTEF only extends out till 2005/06 and no other Government projections on the budgetary framework are available for beyond that year. Assuming that current trends are maintained, by 2008/09 allocations to MoH will be approximately NRs. 7.8 billion (or 5.5 percent of total Government budget). This budgetary outlook does not include the increased allocation to MoH considered as a scenario in the NHSP-IP. Under that assumption, budget allocation to MoH will increase to NRs. 10 billion by 2008/2009.

### Trends in MoH Expenditures

The increase in MoH allocations contrasts quite sharply against MoH expenditures. Over the last four years, between 1998/1999 and 2002/2003, MoH expenditures increased by annual average of 6 percent from NRs. 2.8 billion and NRs. 3.8 billion. Over the same period, total Government expenditures rose by an annual average of 9 percent from NRs. 59 billion to NRs. 84 billion. As a share of total Government expenditures, spending by MoH declined from 4.8 percent in 1998/1999 to 4.3 percent in 2002/2003. Table 4.3.2 illustrates the trend in MoH expenditures.

**TABLE 4.3.2 TRENDS IN MOH EXPENDITURES**

Million NRs.	1998/1999	1999/2000	2000/2001	2001/2002	2002/2003
Total Govt. Expenditures	59,579	66,272	79,835	80,072	84,006
- Annual Growth		11.2%	20.5%	0.3%	4.9%
MoH Expenditures	2,830	3,373	3,472	3,811	3,596
- Share of Govt. Expen.	4.8%	5.1%	4.3%	4.8%	4.3%
- Annual Growth		19.2%	2.9%	9.7%	-5.6%
- Per Capita (Rs.)	126	147	150	163	150
Direct EDP Expenditures*		1,377	2,437	3,309	
Govt (non-MoH) Agencies*		506	774	907	
Total Public Health Exp.		5,256	6,683	8,027	
Per Capital Public Health					
Exp (NRs)		230	288	343	
Public Health Exp. / GDP (%)		1.4%	1.6%	1.8%	
Note: 1 US = NRs	68.0	69.0	74.7	78.0	72.0

\* Direct EDP expenditures reflect spending by external development partners that are not reflected in the Government annual accounts. This and expenditures by Govt (non-MoH) agencies were based on data reported in the Public Expenditures Review of the Health Sector, July 2003, which only covered the three years 1999/2000 - 2001/2002.

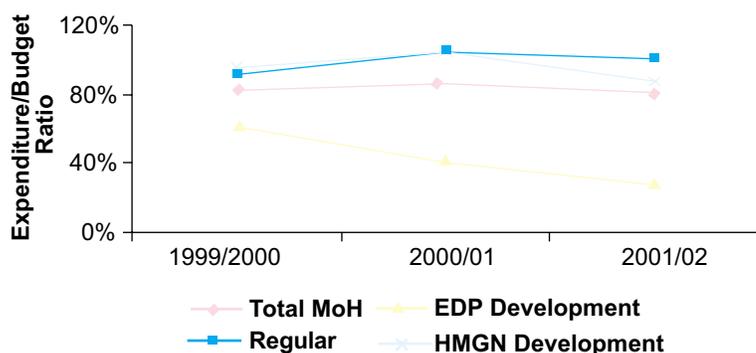
Though MoH expenditures have been erratic and often not kept pace with Government spending, it has made a perceptible impact on per-capita terms. On average, expenditures by MoH have grown faster than population and per-capita spending has increased from approximately NRs. 127 in 1998/1999 to NRs. 150 in 2002/2003, peaking at NRs. 163 in 2001/2002.

The moderate increase in expenditures by MoH has been supplemented by increases in direct expenditures by external development partners, which are not accounted for in the Government's accounting systems. Between 1999/2000 and 2001/2002, the only years for which data is currently available, direct expenditures by EDPs increased 50 percent from NRs. 1.4 billion to NRs. 3.7 billion. Some of this increase, however, offsets the decline in EDP funding that was being channelled through the Government's treasury. Over the same period, health expenditures by other (non-MoH) agencies increased by 80 percent from NRs. 500 million to NRs. 900 million. While most of the EDP funding goes towards essential health care, expenditures by other (non-MoH) Government agencies generally go towards secondary and tertiary services. Collectively, in per-capita terms, total public expenditures have increased by approximately 50% over the three years, from NRs. 230 (US \$ 3.5) to NRs. 343 (US \$ 5.1).

### Allocation-Expenditure Ratios in MoH Spending

Allocation and expenditure trends in MoH spending indicate a widening under-spend of MoH budgets. On average, between 1999/2000 and 2001/2003, years for which data is currently available, total MoH under-spend of allocated budgets has been around 80 percent. Trend from the three years suggest that most of the under-spend occurred within the EDP financed development budget. Figure 4.3.2 illustrates this trend.

FIGURE 4.3.2 Expenditure-budget Ratio For MoH Expenditures

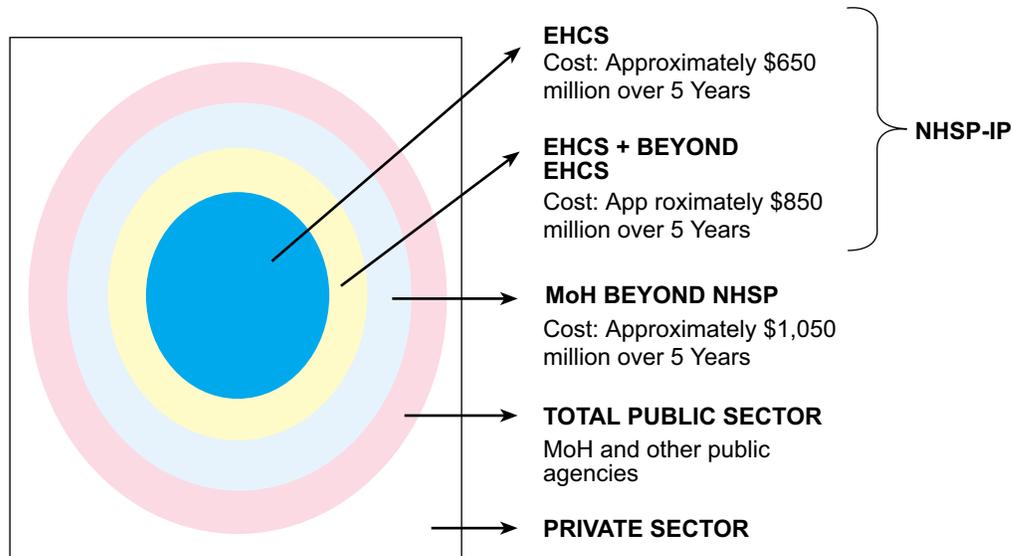


MoH have pointed that under-spend in the EDP often occur because a variety of different donor-specific fund release systems are used and the complexity slow down actual disbursements. Additionally, some of the EDP financed development budget is based on the estimated value of in-kind contributions, which can differ significantly from actual expenditures. A move towards a sector wide program that uses the Government accounting and release system would help in resolving some of these constraints.

### Composition of Expenditures Within MoH

The relationship of NHSP-IP and the health sector is illustrated in the figure above. NHSP-IP is represented by the two central circles and is delivered entirely through the MoH. However, some reform elements of NHSP-IP cover the whole health sector.

FIGURE. 4.3.3 **Composition of Health Sector Expenditures**<sup>4</sup>



The central circle represents the service focus of NHSP-IP on EHCS. The second circle represents the total of EHCS and services that are beyond EHCS, which include a variety of services beyond those listed as priority elements of EHCS in NHSP-IP (e.g., some district hospital services, and public health interventions towards non-Group one disease that contribute to reducing Nepal's mortality and morbidity). In addition, and as illustrated by the third circle from the centre, MoH also supports regional and specialist hospitals, though these do not constitute a direct part of NHSP-IP. Collectively, the three inner circles represent the total public expenditures through MoH.

About 20 percent of public expenditures on health, as represented by the fourth circle, are also channelled through other public agencies (e.g., Ministry of Finance, Defence, State Owned Enterprises, Universities, local agencies). These programs are not addressed in the NHSP-IP though they provide some EHCS.

Private expenditures on health constitute about 70 percent of the total health expenditures in Nepal. Though private sector is directly addressed in NHSP-IP, some proposed system reforms target private provisioning of health services through public-private partnerships and insurance schemes.

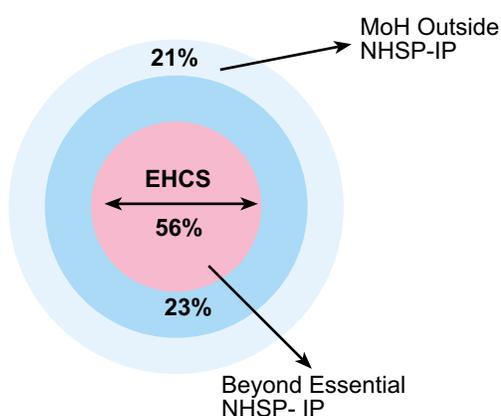
Under the health sector strategy and NHSP-IP, MoH expenditures should be viewed in three broad categories: (i) Expenditures on essential health care, (ii) Beyond Essential health care in NHSP-IP, and (iii) Outside NHSP-IP. The typical average share of expenditures in each category is illustrated in Figure 4.3.4. Because NHSP-IP is still to be implemented, these budget categories do not yet link

<sup>4</sup> Costs are illustrative and, for clarity, reflect only the lower end of available estimates.

directly with budget head/line items currently used by the MoH. The data presented in Figure 4.3.4 is extrapolated based on the budget for the current fiscal year (2003/2004) and is illustrative of past trends rather than indicative of future spending patterns.

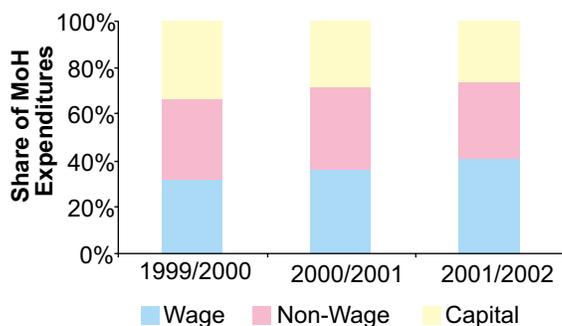
Currently, EHCS accounts for roughly 60 percent of the total MoH expenditures. Under NHSP-IP, EHCS is expected to increase to at least 65 percent of total MoH budget. Beyond essential NHSP-IP relates to strengthening the management capacity and reforms to support delivery of EHCS. In addition to NHSP-IP, MoH is also has oversight for programs and activities not specifically outlined in NHSP-IP. These include budget line items for Focal Point (e.g., Eye Hospital, BPKM Cancer Hospital, Health Institution Grants, Health Tax Fund Management Committee, etc), Curative Division (e.g., Bir Hospital, Kanti Hospital, Patan Hospital, Western Regional Hospital, etc) and Department of Ayurved.

FIGURE. 4.3.4 **Composition of MoH Expenditures by NHSP-IP Components**



The goal of increasing EHCS expenditures to 65 percent of total MoH budget implies that some reprioritisation must occur within the MoH to absorb the increase in EHCS expenditures. The share of funds going to beyond essential NHSP-IP or outside NHSP-IP should decrease in future years. Although the upcoming Annual Work Plan and Budget will more clearly delineate budget by inputs, there has been some effort to try and increase the share of EHCS expenditures. Under the current MTEF, for instance, the share of resources to EHCS was to increase to 65 percent by 2005/2006.

FIGURE. 4.3.5 **Composition of MoH Expenditures by Inputs**



Wages paid to HMGN public servants have increased over the last few years. This has affected the wage related spending in MoH as well, which increased from 32 percent of total MoH expenditures in 1999/2000 to 41 percent in 2001/2002. Figure 4.3.5 illustrates the trend in the MoH expenditures by inputs.

Under NHSP-IP, and at least in the initial phases, capital expenditures are expected to increase with the expansion in program coverage. At the same time, implementation of NHSP-IP will probably require expansion of non-wage related expenditures to about 35 percent. The increase in capital and non-wage recurrent expenditures will likely be met through reductions in other (wage) recurrent expenditures. Reductions in wage related expenditures are a broader Government objective and increased labour productivity will be the main

source for achieving this goal. Current estimates indicate that within MoH there is at least 30 percent under-utilised human resource capacity, which suggests significant room for efficiency gains.<sup>5</sup>

<sup>5</sup> Costing of the Nepal Health Sector Program Implementation Plan With Unit Cost of Essential Health Care Services (EHCS), World Bank, February 2004.

#### 4.4 Government Health Sector Budget Projections

During the Tenth Plan formulation, the HMGN has indicated the budget allocation for health sector. Table 4.1 below presents the total health budget estimates for the Tenth Plan Period. These projections do not include many EDP directly implemented projects that are not reflected in government budgets.

**TABLE 4.4.1 TENTH PLAN HEALTH EXPENDITURE ESTIMATES (RS IN MILLION)**

Source	Year 1/a	MTEF (yr 1-3)	Year 2-5	Total/ year 1-5
Regular budget	2170.5	6708.9	9353.1	11523.6
Development budget	2701.9	8943.3	13793.5	16495.4
<b>Total</b>	<b>4872.4</b>	<b>15652.2</b>	<b>23146.6</b>	<b>28019.0</b>
Foreign aid	1684.4	5575.3	8599.0	10283.4
Foreign aid % of total	34.6	35.6	37.1	36.7
Foreign aid % of dev. budget	62.3	62.3	62.3	62.3

a/ budget estimates,  
SOURCE: Tenth Plan Draft, 2002

#### 4.5 Estimation of EDP Resources

EDP resources in the public health sector appear in the government budgets (Redbook) if they are either contributed to the Ministry of Finance and spent in the same fashion as HMG funds, or if they are included in the Redbook as "direct" expenditures by the donors that do not pass through the government financial system. However, EPDs also finance a number of directly executed projects that are not listed in government budgets (although the global amount of foreign assistance may be registered with the government in various agreements).

In order to have a more realistic estimate of the resources available in health sector an attempt was made to estimate the magnitude of resources provided by EDPs that are not ordinarily captured in government budgets. A survey of EDPs in 2002 identified 96 directly executed projects with a total 2002/03 budget of Rs. 4561 million (about US\$ 58 million). This figure is only indicative due to missing data for some development partners and the possibility of double counting funds that were already found in the Redbook or contracted between EDPs. However, the figure implies that donor contributions are roughly the same size as HMG contributions to public health expenditures.

#### 4.6 Financial Framework (Resource Envelope)

The resource envelope is defined as the level of resources available in a given year or a projection of the level of resources, which are expected to be available from major sources in the coming years. It gives an indication as to whether proposed strategies, if their costs are properly estimated, are affordable.

The Programme Preparation Team (2002) made an attempt to estimate the overall resource envelope that will be available to the health sector over the Tenth Plan period. The projections have been made under three alternative scenarios based on the assumptions regarding the GDP and revenue growth rate, proportion of foreign assistance and internal borrowing in GDP, government expenditure allocation to health and to basic health care packages. Three alternative scenarios were set out - a base case (felt

**TABLE 4.6.1 KEY ASSUMPTIONS**

Assumption	Base Case/a	High Case	Low Case
1. GDP Growth Rate Constant Price Prices	4.6%	6.0 %	4.0%
2. Revenue Growth Rate	14.0 %	16.0%	10 %
3. Foreign Assistance as % of GDP	4.60 %	6.0%	4.0 %
4. Budget Deficit as % of GDP	2.7 %	2 %	3 %
5. Share of Health in Total Govt. Allocation	5.2 %	7%	4.0 %
6. Share of EHCS in govt. health expenditure	70%	75%	71.5%

a/ 2000/01 situation

to be the most realistic one), a high case (the most optimistic scenario) and a low case (a more pessimistic worst) scenario. The key assumptions involved in making the projections are given in Table 4.6.1. The base case assumptions are the prevailing situation (2000/01) as indicated by major macro economic indicators. For the base case, it is assumed that the present situation will continue in future as well.

- Resource envelope estimates for the health sector as well as for EHCS under different scenarios are presented in Table 4.6.2, Table 4.6.3 and Table 4.6.4 below.

**TABLE 4.6.2 HEALTH SECTOR RESOURCE ENVELOPE (BASE CASE)**

Year	In Rs million			In US\$ million (US\$=Rs78)s million		
	Red book/b	DEP/a	Total	Red book	DEP	Total
2002/03	5008	4561	9569	64.2	58.5	122.7
2003/04	5549	4029	9578	71.1	51.7	122.8
2004/05	6158	3995	10153	78.9	51.2	130.2
2005/06	6845	3982	10827	87.7	51.0	138.8
2006/07	7620	3960	11580	97.7	50.8	148.5
<b>Total</b>	<b>31180</b>	<b>20527</b>	<b>51707</b>	<b>399.7</b>	<b>263.2</b>	<b>662.9</b>

a/ PPT survey 2002

b/ projection (base case) assumptions are

- o GDP grows by 4.6% per annum
- o Revenue grows by 14% per annum
- o Share of foreign assistance in government budget will 4.6%
- o Government budget deficit will be 2.7% of GDP
- o Government allocation to health sector will be 5.2% of total health budget
- o EHCS accounts for 70% of health budget

**TABLE 4.6.3 HEALTH SECTOR RESOURCE ENVELOPE (HIGH CASE)**

Year	In Rs million			In US\$ million (US\$=Rs78)s million		
	Red book/b	DEP/a	Total	Red book	DEP	Total
2002/03	7186	4561	11747	92.1	58.5	150.6
2003/04	8078	4029	12107	103.6	51.7	155.3
2004/05	9097	3995	13092	116.6	51.2	167.8
2005/06	10263	3982	14245	131.6	51.0	182.6
2006/07	11597	3960	15557	148.7	50.8	199.5
<b>Total</b>	<b>46221</b>	<b>20527</b>	<b>66748</b>	<b>592.6</b>	<b>263.2</b>	<b>855.8</b>

a/ PPT survey 2002,

b/ projection (high case) assumptions are

- o GDP grows by 6% per annum
- o Revenue grows by 16% per annum
- o Share of foreign assistance in government budget will be 6%
- o Government budget deficit will be 2% of GDP
- o Government allocation to health sector will be 7% of total health budget
- o EHCS accounts for 75% of health budget

**TABLE 4.6.4 HEALTH SECTOR RESOURCE ENVELOPE (LOW CASE)**

Year	In Rs million			In US\$ million (US\$=Rs78)s million		
	Red book/b	DEP/a	Total	Red book	DEP	Total
2002/03	3609	4561	8170	46.3	58.5	104.8
2003/04	3895	4029	7924	49.9	51.7	101.6
2004/05	4207	3995	8202	53.9	51.2	105.1
2005/06	4547	3982	8529	58.3	51.0	109.3
2006/07	4918	3960	8878	63.0	50.8	113.8
<b>Total</b>	<b>21176</b>	<b>20527</b>	<b>41703</b>	<b>271.5</b>	<b>263.2</b>	<b>534.7</b>

a/ PPT survey 2002,

b/ projection (low case) assumptions are

o GDP grows by 4% per annum

o Share of foreign assistance in government budget will be 4%

o Government allocation to health sector will be 4% of total health budget

o Revenue grows by 10% per annum

o Government budget deficit will be 3% of GDP

o EHCS accounts for 71.5% of health budget

Given the assumption that 70% of the total available Redbook health budget will be allocated to essential health care package it is estimated that under the base case the priority EHCS will receive a total of Rs 21826 million in during the Tenth Plan period. If all DEP financing is assumed to be for EHCS total public financing will be Rs 42353 or US\$ million 543. This corresponds to approximately \$4.72 per capita annually of HMG and donors funds for EHCS.

## 4.7 Costs of EHCS and the Financing Gap

### Cost Estimate

MoH is the line agency charged with implementing the national health sector strategy. As described earlier, MoH expenditures flow towards NHSP-IP and other secondary/tertiary care components outside of NHSP-IP. Because of the fungibility of expenditures within MoH, it is more helpful to examine financing gap in terms of total MoH expenditures rather than narrowly for NHSP-IP. Such an analysis of the financing gap also better supports the analytical needs of the joint review.

Total cost estimates are highly uncertain. Much of this uncertainty is focused around costs estimates for meeting EHCS targets outlined in the NHSP-IP. Available studies indicates that costs for implementing EHCS could range between NRs. 370 (US \$ 5.1) per capita to NRs 865 (US \$ 12) per capita. MoH undertook an annual work plan and budgeting exercise for 2003/2004 for the NSHP-IP and recommended a first year EHCS budget of approximately NRs. 149 (US \$ 2.1) per capita. This indicative budget is 41% lower than low cost estimate reported in the literature. The indicative MoH budget of NRs. 149 per-capita is not a true cost estimate because it was planned to fit know resource availability. The range of cost estimates for EHCS is summarized in Table 4.7.1 below.

**TABLE 4.7.1 ESTIMATED HEALTH SECTOR COSTS FOR MOH**

	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Million NRs.	12,704	13,888	15,050	16,388	17,517	75,546
Million US \$	176	193	209	228	243	1,049
NRs. per Capita	514	550	583	621	651	
US \$ per Capita	7.14	7.64	8.10	8.63	9.04	
Share of GDP	2.5%	2.6%	2.7%	2.8%	2.8%	

NOTE: Year 1 = 2004  
1 US \$ = NRs. 72

the NSHP-IP and recommended a first year EHCS budget of approximately NRs. 149 (US \$ 2.1) per capita. This indicative budget is 41% lower than low cost estimate reported in the literature. The indicative MoH budget of NRs. 149 per-capita is not a true cost estimate because it was planned to fit know resource availability. The range of cost estimates for EHCS is summarized in Table 4.7.1 below.

Rather than analyse financing gap implications across the entire range of uncertainty, the analysis is built around the WB costing report. Given data limitation and uncertainty, the WB costing report best describes the minimum level of resources need to finance the NHSP-IP and the entire health sector. Based on the WB Costing Study, estimated annual costs of the health sector over five years are described in Table 4.7.2 below .

**TABLE 4.7.2 RANGE OF COST ESTIMATES FOR EHCS**

Source	Estimate (Cost per Capita)		Basis and Usefulness
MDG Costing Study	US \$ 12	NRs. 865	Estimated using MDG targets. More aggressive than NHSP-IP in the medium term. Provides a high end approximate.
WB Costing Report	US \$ 5.1	NRs. 370	Zero based costing more specifically for NHSP-IP targets and based on scaling up existing programs. Recognises uncertainty, particularly around overhead and M&E. Of available data, most relevant for analysis of financing gap.
NHSP-IP Annual Work Plan and Budget (AWPB), 2003-04	US \$ 2.1	NRs. 149	Developed by MoH as an illustrative annual work plan and budget for the first year of NHSP-IP. Does not reflect true costs because it was balanced against know resource availability. Limited in usefulness for estimating financing gap.

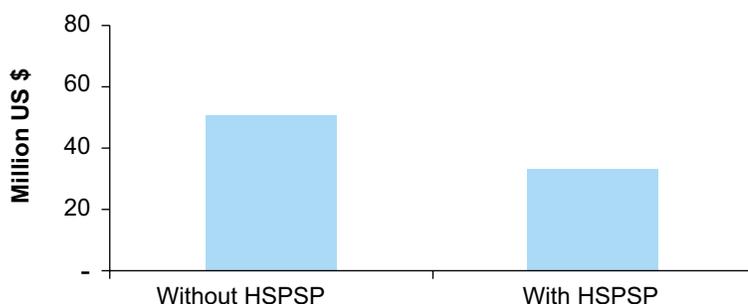
### Estimated Financing Gap

The current MTEF, which runs through to 2005/06, provides the best indication of the resources available to MoH for financing NHSP-IP. Under this framework, MoH has been allocated NRs. 5.2 billion for the current fiscal year, which rises to NRs. 6.5 billion by 2005/06. This estimate, however, does not factor in the projected increase in MoH allocation from 5 percent of total Government budget to 7 percent by 2008/2009, as described in the base scenario of NHSP-IP. Inclusive of this anticipated increase and assuming that total Government budgets continue to increase at the same pace beyond 2005/2006, total HMGN allocation to MoH by 2008/2009 will be NRs. 9.9 billion (US \$ 137 million). For purposes of this analysis, the assumption is that Government will steadily increase budget for MoH to reach 7 percent of total Government budget by 2008/2009.

Direct expenditures by EDP will be an important part of the financing gap. In 2001/02, direct EDP expenditures were NRs. 3.7 billion (US \$ 51 million). Although these expenditures have grown rapidly

over the last three years, for the purposes of estimating the financing gap we assume that direct EDP contributions will remain constant at 2001/02 levels. The only other known anticipated external incremental support towards MoH expenditures is the proposed Health Sector Program Support Project (HSPSP, US \$ 86 million over five years).

Figure 4.7.1 illustrates the estimated annual average financing gap for each of the five years of the plan, assuming that (1) external support is

**FIGURE 4.7.1 Estimated Financing Gap for Health Sector**


limited to 2001/2002 levels (without HSPSP) and (2) external support of 2001/2002 levels plus the proposed HSPSP (with HSPSP). Note that for clarity, this estimate abstracts from the variation in the financing gap across the years: the initial years have a slightly lower financing gap than the latter years.

At face value, this analysis suggests even with the HSPSP funding, the health sector would not be fully funded to achieve the targets in the NHSP-IP. Though the cost estimates used in estimating this financing gap reflects the low end of the spectrum, it should be balanced against the uncertainty that underlie those cost estimates. These cost estimates do not, for instance, account for efficiency gains or economies of scale. This financing gap represents approximately 15 percent of total sector costs. Given the significant under-utilized capacity at MoH and the investment in human resources proposed under NHSP, it may be possible to offset the financing gap remaining after HSPSP with efficiency gains alone.

The uncertainty in costs notwithstanding, the estimated financing gap has been developed with the best available data. It has important implications for management of the health sector, particularly around prioritisation. NHSP-IP currently includes target coverage of 52 percent in the first year and is scaled up to 67 percent by the last year of the program. Under the financing gap presented above, this target coverage would have to be reduced on average by 16 percent annually. Should such a financing gap remain after EDP support, MoH will have to reevaluate its scaling up plans. This is where the annual work plan and budget process will be most beneficial, and necessary, because it provides a rationalised mechanism for dealing with resource constraints. The financing gap also points to a need for developing an effective insurance system and public-private partnerships that can offset some of the gaps in public health expenditures. An effective health insurance system and better public-private partnerships are both goals of the NHSP-IP.

## 4.8 Financial Management

The present fund flow system and accounting system involves the following steps: (a) after the approval of budget from the Parliament, Ministry of Finance (MoF) issues authorisation letter to MoH, (b) MoH issues authorisation letter to the respective cost centres (say DoHS, project offices, districts) based on the respective plans and programs. Financial Controller General Office (FCGO), Auditor General and District Treasure Office (DTO) receive the carbon copies of the authorisation letter at the same time. (c) Based on the request of the cost centres, DTO releases fund as per the respective approved annual program, (d) the cost centres spend the budget and conduct internal audits.

The Health Economics and Financing Unit (HEFU) recently established under PPICD, MoH would provide technical support to the health sector on key health financing issues and to strengthen MoH capacity in financial management. HEFU has already taken initiatives to institutionalise and update national health accounts covering public, private, NGO and EDPs health sector expenditures at all levels of the health system. HEFU has developed a plan to institutionalise the collection of financial data integrating Red-book and non-Red book expenditures of decentralised units (hospitals, VDCs, DDCs, Municipalities) as well as direct funding (but reflected in red book) and expenditures in directly

executed projects by various EDPs into MoH management information system. HEFU has planned to establish the budget release and fund flow mechanism to operationalise the decentralised framework.

In moving towards costing the package of health services and developing a programme approach to budgeting, careful attention is needed to the assumptions on staff allocation and performance. Extension of programme budgeting to the entire budget will need careful design and support, especially for curative care where poor choice of output indicators can give perverse incentives. The costing of the health care interventions will need to explicitly address workload issues, and to recognise that costs can be driven down as performance management improvements enable productivity to increase.

**Financial Management System:** Late release of funds, resulting in several idle months at the beginning of the year is a problem. The approved budget will be allocated and cash needs forecast by trimester for all of the programmes, projects and spending units, identifying line item budgets in each case. This work will be started earlier, and be completed faster. In practice, even when there is a parliament, the numbers do not change once Cabinet approval has been secured, and as such work would start even before final approval is given. Steps will be taken to simplify the structure of the budget. Some of this reflects the chart of accounts, centrally determined by MoF and not able to be modified. However, there may be scope for consolidating programmes and projects within particular spending units in order to simplify and speed up the task. The MoF will be approached for assisting the financial reforms necessary to implement the NHSP-IP.

EDP practices also contribute to poor budget performance. Commitments are imperfectly co-ordinated with the Government budget cycle, resulting in FCGO being unwilling to release funding when the EDP resources are not irrevocably committed. The problems of overall shortfalls in EDP funding are by earmarking commitments to specific programmes, which means that a small overall shortfall can be a major disruption for specific programmes. In order to overcome these problems, Government and the EDPs will work closely together in framing the budget and the MTEF.

MoH will simplify and improve the financial management system (simple and effective release mechanism, integrated accounting system, and regular audits of the concerned organisation) in order to increase the absorptive capacity of the health sector. MoH will develop and introduce a common financial reporting framework for all EDPs. HEFU in consultation with EDPs will initiate the exercise in 2003/04 and MoH will introduce it from 2004/05.

## 4.9 Financial Sustainability

### Medium Term Fiscal Sustainability

Under the Government's 10<sup>th</sup> Plan/PRSP, and in the agreement with IMF on the PRGF, HMGN has announced plans to limit its fiscal deficit to under 5 percent of GDP and domestic borrowing to under 2 percent of its GDP by the end of the plan period (2006/2007). The sustainability of health sector program, therefore, needs to be assessed against these two limitations.

In the medium term, through 2008/2009 the last year of NHSP-IP the base case of NHSP suggests that Government could increase MoH's share of the total budget to 7 percent. Assuming that Government finances the increasing share to MoH through expansion of the total budget, rather than cuts in other programs, it will still be comfortably within the targets on the fiscal deficit and domestic borrowing. The analysis suggests that even with the increased Government expenditures, by 2005/2006 the fiscal deficit should decline to under 5 percent of GDP and continue to drop further in the out years. Similarly, by 2005/2006, domestic borrowing as a share of GDP will be well within 1 percent and remain low in the out years.

The fiscal impact of expansion of MoH budget is based on the IMF macro projections from October 2003 (for the PRGF) and hinges on two critical assumptions. First, real GDP growth rates are expected to rebound and remain at around 5.5 percent in 2005/2006 and beyond. Second, tax revenue as a share of GDP is expected to grow steadily, rising from 12.4 percent in 2003/2004 to 14 percent by 2007/2008. Though these projections are uncertain, especially given the fluid political and conflict situation, they appear reasonably achievable under the current scenario. GDP growth rate has picked up and is expected to meet the target of 4 percent for the current fiscal 2003/2004. At the same time, tax revenues posted higher than expected gains this fiscal year and are likely to grow further, particularly given the investments in the ongoing customs and tax reforms.

Considering the LSGA 1999 and decentralised health management as one of the HSRS outputs, it is anticipated that more resources will be mobilised in the local level ensuring financial sustainability.

### Cost Effectiveness

All the EHCS interventions listed in NHSP-IP appear to be highly cost-effective. For assessing cost-effectiveness, this analysis follows the international decision rule specified by the Commission on Macroeconomic and Health: *"interventions that avert one DALY for less than the average per capita income could be considered very cost-effective"*.<sup>6</sup> The cost-per-DALY, as a measure of cost-effectiveness, along with the cost-per-death averted for the EHCS interventions are summarised in Table 4.9.1 given below.

**TABLE 4.9.1 COST EFFECTIVENESS FOR EHCS INTERVENTIONS<sup>7</sup>**

Intervention	Cost per DALY (US \$)	Cost per Death Averted (US \$)
Vitamin A	1.0	1,405
TB	6.5	972
Iodine	8.1	NA
EPI	14.2	1,115
Family Planning	17.7	927
IMCI	24.8	3,984
Safe Motherhood	28.7	2,320
Leprosy	32.1	126,393
Outpatient Care	34.1	NA
HIV	42.5	1,521
Vector Borne	70.2	5,872

While the suggested cost-effectiveness provides some assurance for public provision of health services, there are other equally important equity and efficiency justifications for the program. Although Nepal spends 5.1 percent of its GDP on health, private-out of-pocket spending finances 70 percent of this expenditure. The poor have relatively little access to private contribution for health and, therefore,

<sup>6</sup> Hutubessy, et. al., Generalised cost-effectiveness analysis for national-level priority setting in the health sector, BioMed Central, 2003.

<sup>7</sup> The Essential Health Care Package of Nepal: A Cost Effective and Cost-Benefit Analysis, Sangest Health Solutions (prepared for the World Bank Mission in Nepal), February 11, 2004.

primarily reliant on public health services. In addition to their inability to pay for private health services, the catastrophic costs from illness, disability or death are disproportionately higher for the poor because they are less able to make inter-temporal income adjustments. An efficient insurance system that serves the poor does not currently exist, though efforts towards that are being supported in the NHSP-IP. In the short and medium term, public provision of health services, supplemented by private-public partnerships, is the only realistic way of making health services available to the vast majority of Nepalese.

Even with public provision of health services, many of the poor currently have no or limited access. Though 85 percent of the nation's population live in rural areas, only 51 percent of total public health expenditures service rural areas. This suggests failures in both the scope and management of health service delivery. The NHSP-IP attempts to remedy this problem by seeking to expand access to, and increase the use of, health services by the under-served populations. NHSP-IP also seeks to bring about management reforms at MoH to enhance the quality and efficiency of service delivery. Though private provisioning of health services will be part of long term strategy for Nepal, in the short and medium term public health services remain the only realistic option for reaching the majority of Nepalese.

Implementation of the NHSP-IP will result in:

- Increased contribution of the government to the health sector
- Increased contribution of EDPs to meet the health sector financing gaps
- Improved allocation of resources to essential health package
- Increased cost-effectiveness through potential cost-saving
- Increased mobilisation of resources through local bodies in spirit of LSGA

# Implementation Arrangements

## 5.1 Towards a Sector Wide Approach

### Features of Sector Wide Management

MoH intends to move towards a sector wide approach (SWAp) to managing the health sector, rather than having a series of projects with their own funding, management, implementation, and reporting arrangements. Key features of sector wide management, which will be introduced during NHSP-IP, are:

- a. The provision of a clear sector policy and strategic framework by the HSR that links the sector policies and the HSRS to NHSP-IP including the expenditure plans for the sector, so that the allocation of resources reflects the priorities for the sector.
- b. AWPB which specify the activities to be carried out under each strategic objectives and departments/divisions/centres.
- c. Reporting on activities and performance indicators against the plan, with common reporting and performance monitoring arrangements (rather than each funding and supporting agency having its own review process and missions).

At this stage EDPs may continue to provide support in kind (TA, commodities, and equipment) or in the form of earmarked grants or loans for specified activities or budget items. However, it is envisaged that all EDPs and other external sources will provide the necessary information on allocation which will be reflected in the HMGN budgetary system. PPCID will take the lead in documenting current EDP disbursement and reporting arrangement and those of government, and explaining how they fit together in order to guide debate about harmonisation.

On commencement of NHPS-IP MoH will work with EDPs to review each EDP project, in order to gauge consistency with the priorities and activities of the Implementation Plan and to agree on any necessary modifications to EDP support

It is expected that as health sector reforms progress and experience is gained in operating a sector management approach, a rising share of the external support will be provided through the pooled funding and common procedures including financial management. MoH and EDPs aim to sign a Code of Conduct by the end of Year One in order to operationalise harmonisation initiatives. This will include agreement about the role (within overall EDP assistance) of the project approach with its related funding mechanisms, at both national and district level. It will address the issue of the extent to which (and within what timeframe) HMGN will be able to take responsibility for implementation of all projects.

## 5.2 Overview of Management Changes

### Changes Envisaged

There are three major management changes envisaged during the implementation of the NHSP-IP. These are:

- a. HMGN taking responsibility for implementation of projects currently managed by the EDPs (and their contracted agencies).
- b. Decentralisation with clear performance management arrangements
- c. Central Departments moving towards a facilitator/financier role rather than the current provider role.

All these three management changes would require reorganisation within the health sector. The Institutional Assessment 2003 and the HSRS, 2002 provide necessary direction towards revisiting the current organisational arrangements. In the early years the MoH will concentrate on the functions and job descriptions related to their realignment.

The Work Procedure Manual, 2002 of the MoH provides the scope and functional responsibilities of the MoH and the Departments. MoH will focus on substantial capacity building programmes during the NHSP-IP period. Further work will be carried out in 2003/4 to effectively operationalise the reforms necessary to move towards SWAp.

### Role of the MoH

In line with the MoH Brief Introduction and Work Procedure Manual, 2002, the MoH will be responsible for the overall policy and planning; human resource policy and planning; financing and financial management; and sector monitoring and review. MoH, with support from technical assistance, will review some of the policies required to be updated or developed for delivering the NHSP-IP components.

The key institutional set-up of the sector programme will be the PPICD. Current capacity will need to be strengthened to enable them to become fully responsible for the joint planning, budgeting, monitoring and review process.

HEFU will provide the necessary technical backstopping through conducting National Health Accounts, Public Expenditure Review, policy briefs for alternative financing arrangements and overall economic analysis of the NHSP-IP including providing the resource envelope for each year.

### **Role of the DoHS**

The DoHS will be the main technical organisation for implementation of the NHSP-IP programme activities. The mobilisation of staff will be carried out by the DoHS with support from the decentralised units. The DoHS with its divisions will participate in the joint annual planning and review processes and their AWPB will be assessed based on agreed strategic objectives (see Chapter 3). The DG will be responsible for coordinating all divisions and their activities. Coordination with other departments will be established for concerned activities and programmes.

### **Role of the Regional Health Directorates**

Regional Directorates will act as the extended arms of the DoHS representing the department in provision of technical backstopping and supervisory support necessary for the district health offices and the hospitals.

### **Role of the District Health Office**

The role of district health offices will be vital for the delivery of priority EHCS. They will continue planning for service delivery but will change the planning modalities for provision of the EHCS in a package rather than individual projects. Their role will also be the provision of support management like, logistics, human resource development and training, financial management, and infrastructure development (when necessary). The district health offices in conjunction with the DDC will co-ordinate for effective decentralised management and promote public-private-NGO partnership in designing, planning and reviewing district plans.

## **5.3 Joint Planning, Monitoring and Review**

### **5.3.1 Advantages of Joint Planning and Review**

The government and EDPs have agreed to participate in a joint planning and monitoring exercise as a part of a HSRS. This exercise would have the following advantages:

- a. Support to sector reform initiated jointly by the government and the EDPs,
- b. Improve co-ordination of strategy and contributions
- c. Transparency of contributions by EDPs and the government.

### **5.3.2 Planning and Budgeting System**

The budget planning and implementation process is undergoing significant improvement through the introduction of the MTEF, the identification of priority areas of expenditure to be protected from spending cuts, the plans to unify the development and recurrent budget, and the progressive movement

towards a closer link between budgets and output targets. Improvements have also been made in the preparation of budget bids, and in submitting in-year claims for budget releases. However, there are continuing weaknesses that have had a negative effect on the delivery of health services.

The AWPB will be the critical document for deciding on the allocation of resources and for monitoring their use. Initially these plans and budgets will include only red book budget but gradually they should incorporate all activities; incorporating funds from all sources; they include performance indicators; they show activities to be carried out rather than just inputs.

The purpose of the AWPB is to show the planned activities for the year and the related expenditures, in order to:

- a. Ensure that the funds will be well used, on sound plans directed to achieving agreed objectives;
- b. Draw together related project and programme activities which are funded in different ways, to show the total investment and activities for each programme;
- c. Provide a mechanism for monitoring implementation and expenditures.
- d. Enhance MoH collaboration with EDPs, NGOs and private sector involving them in the annual planning and budgeting process.

At the same time, development of the operational plan for a programme provides a good opportunity for the newly defined programmes to start working together as a team and to look at how they can reduce duplication and share resources. The overall planning process and the cycle are shown as Annex 6.

Within the MoH the overall planning process will be co-ordinated by the PPICD while each department/division/centre will plan their AWPB through a common prescribed format. Once the AWPB are drafted by these units will be reviewed by the PPICD and Technical Review Committee (proposed) (TRC) comprised of technical staffs of the EDPs along with key officials of the PPICD and the DoHS. The TRC will recommend necessary revision after which Annual Review and Planning Committee/Board (proposed) under the Chair of the Secretary, MoH and membership from the ministries of health, finance, local development, planning commission and other governmental agencies would approve the AWPB. This is proposed to be little deviation from the current system for project approval process. The MoH will take necessary HMGN concurrence regarding the budget and planning autonomy process within the MoH.

### **5.3.3 Joint Financial Planning**

MoH will take joint responsibility with EDPs for the budget process so that they can work together strategically to establish the financial framework, minimise earmarking and create opportunities to access global funds. In order to facilitate joint planning and funding the sector, MoH will prepare an Annual Financing Plan following the steps given below:

- a. Agree on financial framework for the health sector for the respective year
- b. Estimate the total health sector requirement for a year by component or program identifying the total government contribution
- c. Collect contributions of EDPs of all kinds (cash and commodities etc.)

- d. Calculate the remaining financial requirements by component or programs
- e. Seek commitments of EDPs for their cash contribution to the government budget
- f. Estimate the remaining government contribution to the health sector

Under the joint planning and monitoring framework, EDPs would continue supporting the sectors in by:

- a. Direct support to health budget through red-book
- b. Provision of commodities and materials as a direct financing part of Red book health budget
- c. Technical assistance to the government
- d. Technical assistance to NGOs
- e. Direct grant support to NGOs

In order to maximise the resources available to the sector, MoH would engage in a pro-active search for new sources of EDP funding. A 'core' MTEF as already finalised by MoH and NPC and a 'high case' health MTEF (to achieve per capita \$12 health expenditure) would be prepared, emphasising how additional funds would enable more ambitious targets to be reached, especially relating to the MDGs and benefits to the poor.

#### 5.3.4 Monitoring

The current monitoring arrangements are fragmented. While the individual division and departments will conduct their regular monthly monitoring, for the components of EHCS, the DG will conduct monthly monitoring. The MD/DoHS will provide necessary coordination support for the purpose. It is proposed that the TRC (proposed) will conduct a quarterly monitoring session where major implementation obstacles would be raised by different divisions.

#### 5.3.5 Joint Annual Review

Most often the meaning of review or evaluation is interpreted within the context of two differing ideologies: "strategic control" and "strategic management". Strategic management organisations tend to evaluate in-depth operational issues through measuring (and defining) a large number of indicators (traditional vertical project approach). These organisations tend to be centralised, paternalistic and role culture dominated. Strategic control organisations, on the other hand measure organisational success through a few selected key outcome indicators. They usually have decentralised operational responsibilities, emphasise team approach and operate within a functional organisational culture.

Strategic control allows space for bottom-up organisational changes that top-down strategic management does not. The sector approach philosophy, the framework of NHSP-IP, subscribes to strategic control rather than strategic management ideology. The Joint Annual Review (JAR) will focus on macro level performance indicators and issues and should not, except exceptionally, review questions related to operational detail.

A set of performance indicators has been developed. The list of these indicators and their base status along with source of data are shown in Annex 7. It is expected that the strengthened MIS should provide most information necessary for performance management in addition to the DoHS, which

may be used to substantiate the MIS reports. In addition other qualitative surveys may be conducted to collect additional information on a periodic basis.

The key document for the JAR will be the NHSP-IP Logical Framework and the Reform Milestone Matrix, which appear in Annex 5.

NGOS and private sector stakeholders will be invited to take part in the annual review process in order to build participation and joint planning and implementation. Consideration will also be given as to the role that NGOs could play in carrying out some aspects of programme monitoring and evaluation

### **5.3.6 Joint Programme Evaluation**

A joint HMGN EDP will be conducted during Year 3 in order to evaluate programme progress, and as far as possible impact. The conclusions of this evaluation will be used to adjust programming to better support the 11<sup>th</sup> 5-year plan which will start in July 2007. MoH and EDPs will work together to ensure that adequate evaluation can be carried out at the right time e.g. by anticipating the need for well designed scientific studies at baseline, mid-term and end-line.

## Statement of Intent to Guide the Partnership for Health Sector Development in Nepal

### Context:

The Ministry of Health (MoH), with participation of the External Development Partners (EDPs) and other stakeholders and following extensive consultations during the last over two years, has developed the Nepal Health Sector Strategy: An Agenda for Reform. A sector program, Nepal Health Sector Program - Implementation Plan (NHSP-IP) has been developed based on the Health Sector Strategy. The Health Sector Strategy is to be used as a basis for joint planning and programming in the health sector. The key policy reforms outlined in the Health Sector Strategy include: decentralized delivery of Essential Health Care Services with increasing partnership of the private sector, strengthened Sector Management, and Human Resource Development. Concomitantly, HMGN has finalized the Tenth Five Year Development Plan (2002-2007), the Poverty Reduction Strategy Paper (PRSP). Primary focus of the health sector component of the Tenth Plan/PRSP is to ensure delivery of essential health care services nation-wide in order to significantly reduce the burden of disease and target the under-served and poor to ensure their increased access to essential health services. The health objectives of the PRSP and the defined strategies are fully consistent with those underscored in the Nepal Health Sector Strategy - An Agenda for Reform.

Rationale for the joint agreement (HMG and EDPs in the Health Sector) on the Statement of Intent.

This Statement of Intent is designed as a foundation document in order to establish a formal working partnership between the MoH and the participating EDPs, and to develop a common framework for joint planning and programming to support Nepal's development goals in the health sector, which in turn contribute to improved health of the people of Nepal. All parties recognize a need for coordinated partnership and acknowledge the importance of the "spirit of cooperation and collaboration" in Nepal. Therefore a formal commitment with the underlined operating principles and mechanisms is expected to improve the level of partnership between the MoH and the EDPs. The progress to date of the continued partnership is reflected by the collaboration extended by the EDPs in a) the preparation of the Second Long Term Health Plan, 1997; b) the continued collaboration and technical assistance in the development and design of Medium Term Strategic Plan, Health Sector Reform Strategy and the NHSP-IP; c) the consensus to work under a coherent strategic framework by developing the Health Sector Strategy; and d) a participatory exercise carried out during the NHSP-IP preparation process. This Statement of Intent also seeks to indicate a formal long-term partnership between Ministry of Health and the EDPs and to ensure the MoH of continued support from the EDPs, in order to implement the NHSP-IP, as an adequately funded and result driven quality work program implemented in an

efficient and cost effective manner to achieve the stated goals of PRSP. Signing on the Statement of Intent will establish and ensure a formal partnership for a strong joint working relationship maintained in a transparent and accountable manner. This is consistent with the vision of HMG as presented in the Foreign Aid Policy that all external partners contribute to joint resourcing of the health sector (joint planning, programming and review). Joint plans and programs will continue to be developed within a flexible financing and implementation framework that allows individual EDPs to provide support to the MoH in line with their organization/agency's mandate, mechanisms and other requirements.

The MoH and the EDPs agree to the following Principles of Partnership:

- a) The EDPs will ensure that all the assistance made by them in the sector will be fully consistent with the Health Sector Strategy - An Agenda for Reform.
- b) Harmonization of donor support in annual planning, review and reporting shall be encouraged. Financing of the sector shall be in accordance with each agency's mandate, financing mechanisms and other requirements.
- c) Develop and maintain a climate of transparency, openness and accountability and share relevant information with all partners to facilitate their contributions to health sector development.
- d) Work together in partnership to build consensus between the MoH and the EDPs on actions needed to support MoH's efforts to achieve the common vision.
- e) Based on the health care needs on the one hand and based on the estimate of financial resources likely to be made available from HMG and EDPs on the other hand, the MoH and EDPs agree to develop a prioritized spending framework. This framework will guide the allocation of all resources available from HMG and the EDPs.

The MoH and the EDPs agree to the following Implementation Mechanisms of the Partnership:

- a) Establish a formal Health Sector Development Partner Forum, which meets quarterly, and facilitates formal dialogue between the MoH and the EDPs. The meeting will be chaired by the Health Secretary/MoH.
- b) Following the current practice, there will be a joint annual MoH/ EDPs review of the Health Sector Program that will review the implementation progress and performance of the previous year and agree to adopt necessary reprogramming to achieve improvements in problem areas for the next year. Also annually the MoH and EDPs will identify priority actions and issues to be addressed in annual work programs and budget will be jointly developed and agreed upon.
- c) In case of a conflict of views between the MoH and the EDPs, both sides will sit together and endeavor to resolve the issues through consensus building and compromise.
- d) This Statement of Intent will be reviewed as required or when majority partners show evidence to do so and necessary amendment will be made.

### **Statement of Intent**

The signatories of this document reiterate their commitment to support HMGN to achieve its health development goal of establishing:

"A health system in which there is equitable access to coordinated quality health care services in rural

and urban areas, characterized by: self-reliance, full community participation, decentralization, gender sensitivity, effective and efficient management, and private and NGO sector participation in the provision and financing of health services resulting in improved health status of the population" (Second Long Term Health Plan, 1997)

To support the achievement of the above development goal and Tenth Five-year Development Plan (2002-2007), the MoH and EDPs seek to:

- a) Seek to Commit to the achievement of the common vision for health reform and development as above;
- b) Set priorities to improve the allocation of resources to achieve the common vision;
- c) Improve the efficiency and accountability of resource use with a focus on health outcomes;
- d) Ensure that health sector activities are guided by current best practice;
- e) Improve the co-ordination of external assistance to maximize its effectiveness to achieve the common vision.

**Signatories:**

- 1. His Majesty's Government/Ministry of Health \_\_\_\_\_
- 2. External Development Partners (EDPs) Representatives \_\_\_\_\_
- 2.1 Australian Agency for International Development (AusAID) \_\_\_\_\_
- 2.2 Department for International Development (DFID) \_\_\_\_\_
- 2.3 German Development Cooperation: Deutsche Gesellschaft für Technische Zusammenarbeit/ Kreditanstalt für Wiederaufbau (GTZ/KfW) \_\_\_\_\_
- 2.4 International Labor Organization (ILO) \_\_\_\_\_
- 2.5 Japanese International Cooperation Agency (JICA) \_\_\_\_\_
- 2.6 Swiss Agency for Development and Cooperation (SDC) \_\_\_\_\_
- 2.7 The World Bank \_\_\_\_\_
- 2.8 United Nations Children's Fund (UNICEF) \_\_\_\_\_
- 2.9 United Nations Population Fund (UNFPA) \_\_\_\_\_
- 2.10 United States Agency for International Development (USAID) \_\_\_\_\_
- 2.11 World Health Organization (WHO) \_\_\_\_\_

## Studies

### **Abstract of studies and assessment conducted for the preparation of NHSP-IP**

1. Estimation of realistic scenario of resource envelope (December 2002).
2. Review, assessment and synthesis of current EHCS delivery experiences and development of costed EHCS delivery modalities (February 2003).
3. Designing decentralized hospital services autonomy model with a phased plan (January 2003).
4. Study on decentralized EHCS management (February 2003)
5. Synthesis of alternate financing mechanisms and development of alternate financing and related financial management proposals (February 2003)
6. Synthesis of experiences of the Public-Private and Public-NGO Partnership and development of implementation modalities (on going)
7. Preparation of an inventory and standards of physical assets and facilities at all levels. (March 2003)
8. Assessment of LMD current capacity and development of the logistic management strategy (February 2003)
9. Identification of IEC/BCC strengths and weaknesses and preparation of IEC/BCC strategy including implementation plan (on going).
10. Analysis of HMIS strengths and weaknesses, identification of performance indicators, conducting a Service Delivery Survey for setting baseline and identification of interventions for HMIS strengthening (HMIS)
11. Review of HRD and identification of activities and inputs necessary for updating of the HRD Master Plan (on going).
12. Identification of inputs and activities for developing QM policy and programmes (on going)
13. Institutional Assessment of Nepal Health Sector (December 2002)
14. Social Assessment in consideration of gender and marginalised population including conflict areas (February 2003)
15. Economic assessment of the health sector strategy (Jan 2003)
16. Health care waste management in Nepal (March 2003)

## Organisation and Fuctioning of MoH Departments

1. The 'Work Procedure Manual, 2002' for the MoH specifies the divisions/department under the MoH and their scope of work and functions. The document describes that the MoH is responsible for policy and planning, human resource policy and mobilisation, financing and financial management and monitoring, evaluation and direction. But, in practice senior officials in the MoH are compelled to spend most of their time in personnel management and non-policy issues.
2. There are three Departments under the MoH. They are departments of Health Services (DoHS), Ayurved (DoA) and Drug Administration (DDA). At the DoHS, the Director General (DG) is organisational head with all programme management division/units working under the DG. The recent reorganisation includes converting the Planning Division of the Department into the Management Division with infrastructure and human resource development and information system as part of the Division. The Director of the Family Health Division is in charge of reproductive health care including safe motherhood, family planning and neonatal health. Other divisions within the DoHS are Child Health, Epidemiology Disease Control, Leprosy Control, and Logistic Management. There are five centres with a degree of autonomy: National Health Training Centre (NHTC), National Health Education, Information and Communication Centre (NHEICC), National Tuberculosis Control Centre (NTC), National Centre for AIDS and STD Control (NCASC) and National Public Health Laboratory (NPHL). The functional relationship between these centres and the divisions of the DoHS needs to be further clarified on cross cutting issues e.g. management, NHEICC and NHTC.
3. The DoHS and other departments are responsible for formulating programmes as per policy and plans, implementation, use of appropriated financial resources and their accountability, monitoring and evaluation, and mobilise the staff at implementation level. DDA is regulatory authority for assuring the quality and regulatory import, export, production, sale and distribution of drugs.
4. At the regional level, which is directly under MoH, the Regional Directors are responsible for technical backstopping as well as programme supervision. However, their role seems to be less clearly understood under the new arrangements and is also complicated by the decentralisation process, particularly for both the preventive and promotive health care and hospital services. At the regional level, there are regional and zonal hospitals, which have been given decentralised authority through the formation of boards. In addition, there are Regional Training Centre (RTC), Laboratory, TB centre (in some) and medical stores at the regional level.
5. At the district level and below, since the LSGA has been approved, DDC and VDC are functionally responsible for delivery of health services. Within the MoH, the structure varies between districts. Sixty-one districts being managed by the DHO with the support of the DPHO and remainder of

- the 14 are managed solely by the DPHO. The next level of health care is provided by the 178 PHCs. There are 705 health posts (HPs) and 3132 sub-health posts (SHPs) in the country.
6. The Policy Planning and International Cooperation Division (PPICD) of the MoH has undertaken the overall planning for the sector programme. A Health Economics and Financing Unit (HEFU) has been created within the PPICD to support the process. The role of HEFU includes financial management as well as providing the health economics support necessary for planning.

## Existing Activities for EHCS Included in NHSP-IP

### 1. Reproductive Health

The component of RH comprises two main interventions safe motherhood/new-born care and family planning. FHD/DoHS is responsible for achieving the strategic objectives of these interventions. These interventions have some successful models. During the first year both these interventions will be incorporated in the national plan. The important intervention for allocating resources will be interventions related to Safe motherhood and newborn care. The national safe motherhood plan will be updated incorporating the newborn care and safe abortion care. There will be some policy and management changes regarding alternative methods to improve the quality of delivery/newborn attendance.

#### ***Family Planning***

The current level of CPR all methods is 39.3%. The total demand for family planning is 67.1% of the MWRA of which 39.3% is met and 27.8% of need not yet met (11.4% for spacing and 16.4% for limiting). Unmet need has decreased from 31.0% in 1996 to 27.8% in 2001. Nepal's family planning programme is directed toward reaching couples with "unmet" needs and toward reducing the proportion of women who expressed "no demand" through information and awareness activities.

The long term targets of FP are as follows:

- Total Fertility Rate (TFR) will be reduced from 4.1 per women in 2001 to 3.5 per women by the end of the 10th Five-Year Plan and to 2.5 in 2017.
- Contraceptive Prevalence Rate (CPR) to 47% by the end of 10th Five Year Plan period and to 65% by 2017.
- Continued expansion of current models for FP programme with trials of alternatives to achieve actions for unmet needs and optimal coverage, in rural areas will be aimed.

The main strategic actions of Family Planning Programme are to assist individuals and couples to space and/or limit their children, prevent unwanted pregnancies, manage infertility and improve their overall reproductive health. Community-level volunteers (TBAs, FCHVs) are mobilized to promote condom distribution and re-supply of oral pills. Awareness on RH/FP is increased through various IEC intervention as well as active involvement of FCHVs and Mothers Groups as envisaged by the National Strategy for Female Community Health Volunteers. The services are designed to provide a constellation of methods that reduce, fertility, enhance maternal and neonatal health, child survival, and bring about a balance in population growth and socio-economic development, resulting in an environment that will help the Nepalese people to improve their quality of life.

Main strategies include (see National Reproductive Health Strategy):

- Increasing demand for FP services through BCC.
- Further increases in the accessibility and availability of integrated RH/FP services through a combination of static, outreach and referral services;
- Improving the quality of care in accordance with the National Medical Standards for contraceptive services, with special attention to counselling, infection prevention and management of side effects and complications;
- Increasing access to condoms through multiple channels, including health institutions and FCHVs.

### ***Safer Motherhood and New-born Care***

In Nepal maternal conditions during pregnancy and complications contribute 3% of the DALY lost. Most essential safe motherhood and newborn services currently covers 13% only and progress has been slow. Nepal has one of the highest maternal mortality ratios in the world (539 per 100,000 lb) and neonatal mortality rate 39/1000 lb. Delivery conducted by trained health personnel is 13% only. A number of field trials of interventions to improve care are underway. However, Four times ANC visit is considered standard to complete antenatal care. The status of four times antenatal visit was 16 percent in 2002 (MTEF) out of the total ANC first visit. Abortion complication is a major problem in Nepal and 20-27% of maternal deaths in the hospital are due to complication of abortion (Maternity Hospital 1993) and the Maternal Mortality and Morbidity study in 1998 showed that in the community 5% of the deaths are due to abortion. There are 29 sites in 21 districts providing PAC services in the country at present.

The targets set are:

- to contribute to the reduction of the MMR from the estimated rate of 539 per 100,000 live births to 340 by end of tenth plan and 300 by 2017;
- to contribute to the reduction of the Neonatal Mortality Rate from 39 per 1,000 to 32 by end of tenth plan (2006) and 15 by 2017
- to contribute to increasing delivery by health workers to 18% by end of tenth plan (2007) and 80% by 2017
- To contribute to increasing the percentage of women attending antenatal care service 4 times to 25% by end of tenth plan (2006) and 40 % by 2017.

Major Strategies include: Global experience shows that all pregnancies are at risk and maternal deaths are difficult to predict. Experience also showed that the avoidance of the three delays was imperative to achieve the goal of reduction of maternal mortality. These delays included, delay in seeking care, delay in reaching care and delay in receiving care. Recognising that every pregnancy is at risk, the following two major strategies have been adopted (Annual Report).

- Providing around the clock emergency obstetric care (either comprehensive or basic)
- Ensuring the presence of skilled attendants at deliveries, especially in the home setting.

Because the majority of women do not have access to maternal healthcare services due to social, economic, and political factors, medical interventions alone are not sufficient to reduce maternal

mortality. Specific non-health approaches are needed. Therefore, the Safe Motherhood Programme takes a multi-sectoral approach to include both health and non-health interventions that promote access to and utilisation of services (see also National Safe Motherhood Plan 2002-2017 and Neonatal Health Strategy - 2004).

The Family Health Division of the Department of Health Services developed the National Safe Motherhood Plan (2002-2017) which lays out various levels of outputs and activities. The long-term goal of the 15-year plan envisages establishment of BEOC and CEOC services in all 75 districts, skilled attendance of all births and increased access to emergency fund and transport services. Based on the above 15-year plan, the tenth five-year plan targets the establishment of Comprehensive Essential Obstetric Care (CEOC) services in 10 hospitals in the country.

Main Strategies actions:

- National and local advocacy and BCC to keep safe motherhood on the national policy agenda and to influence family and community attitudes
- Steady expansion in the number of functioning Comprehensive and Basic Emergency Obstetric Care centres towards a goal of adequate national coverage.
- Increased prioritization of skilled attendance strategy (for home based care by MCHWs, ANMs).
- Pilots and scale up of interventions to increase utilization of skilled attendance, use of emergency obstetric care, and improved neonatal care.
- Strengthen FCHV Programme by motivate and educate FCHVs and mothers for the best utilization of available services.

## 2. Child Health

There are four interventions in this component of the EHCS under the responsibility of **Child Health Division/DoHS**. These include Expanded Programme on Immunization (EPI) and National Immunization Days (NIDs), Control of Diarrhoeal Diseases (CDD), Acute Respiratory Infection (ARI), and Nutrition programme (Growth-monitoring). FCHV-based CDD/ARI activities are taking place in 14 districts, Vitamin A distribution in 73 districts and Integrated Management of the Child in four districts. Special efforts are being made to continue polio free status through successful NIDs including mopping up campaign (house-to-house polio-vaccine administration) and elimination of Maternal and Neonatal Tetanus (MNT).

The overall child health targets are

- IMR to reduce to 45/1000, Under 5 Mortality Rate to 72/1000 by end of 2007 and IMR 34/1000, and under 5 Mortality Rate 54/1000 by 2015 (MDG goal)
- EPI coverage 90%, continue Polio free status and elimination of MNT by 2005

The current successful model of Community based integrated management of childhood illnesses (CB-IMCI) will be expanded to all of Nepal. The National Child Health Plan will be developed. The current successful effort to Immunisation programme through routine EPI and polio eradication campaign will continue. New vaccines like Hepatitis B is already introduced and will be added in the

regular EPI programme. Neonatal Tetanus will be eliminated by 2005 by conducting MNT campaign. Measles vaccination coverage will be increased and its outbreak will be kept at low ebb. The current successful Vitamin A Distribution program will be maintained. A study will be conducted on the impact of mass deworming on nutrition. The current initiative of iodine deficiency control will be maintained with limited expansion and trials. Alternative models for prevention of childhood malnutrition will be piloted.

### ***CDD/ARI***

Diarrhoeal diseases are still a major problem for Nepalese children. Records show that it is the second most prevalent diagnosis in outpatient services. In the last fiscal year, the reported incidence of diarrhoea per 1,000 children under five years is 177 (2002), where as the proportion of new "severe dehydration" cases is 4.3 %. The majority (88.4%) of dehydration cases are treated with oral rehydration solution (ORS), while treatment with IV fluid was 5% (2002). The reported case fatality rate per 1000 among under-five children due to diarrhoea is 0.4. (Annual Report).

The ARI symptom prevalence among children is 23%. The ARI incidence increased during the last years. The percentage of new cases treated with antibiotics decreased from 47.7 to 47.1. The proportion of "severe pneumonia" among new cases decreased from 4.1% to 3.8% last year, while, reported cases of ARI are increasing every year, probably due to the community's increased accessibility to ARI-related health services.

The ARI Control Programme covers 75 districts, ten of which have a special strengthening programme of Community Based ARI/CDD. The major activity are being conducted are ARI case management, training for health workers, FCHV, CHWs. Community Based IMCI greatly increases the coverage of good quality services from about 20% to 60% of expected childhood pneumonia cases and is estimated to save about 4,000 lives per year (coverage is at 43% of the population). In ten ARI strengthening districts, CHWs treated more pneumonia cases than health workers treated in health facilities.

*Main strategies include:*

- Steady expansion of the **CB-IMCI model** to additional districts to achieve national coverage within five years.
- Maintenance of high coverage in currently covered districts
- Refinement and institutionalisation of the model and studies of potential gaps in coverage.

### ***Immunisation***

There has been a slight increase in vaccine coverage over the last years. However, evidence suggests that only 60% of children are fully vaccinated (2002). The reported coverage of different antigens at the national level was 94% for BCG, 80.3% for oral polio vaccine (OPV3), 80.3% for diphtheria, pertussis and tetanus (DPT3) and 75.6% for measles during the last year (Annual Report). For the eradication of Polio, NIDs and mop-ups were organised. These activities made substantial contributions towards the goal of eradicating polio from Nepal. Similarly steps for eliminating neonatal tetanus is being undertaken.

*Main Strategies include* (See details strategies in the National Immunisation Strategy 2002-2007).

- Improve the quality of routine EPI activities through micro planning of outreach sessions, community and health workers joint planning and monitoring of activities. This will include reduction in vaccine wastage and improve infection safety measures.
- Maintain the cold chain with steady expansion of vaccine storage to the HP level
- Continue advocacy and BCC for immunisation programmes through social mobilisation, FCHV, Health Workers at each level and mass media.
- Maintain the current system of special immunisation activities, NIDs and AFP surveillance to maintain interruption in polio virus transmission and achieve certification of eradication.
- Expand maternal neonatal tetanus programme to the remaining 23 districts and develop pilot strategies to maintain tetanus elimination.
- Expand inclusion of Hep B in the EPI schedule and introduction of auto destruct syringes nationwide by 2004/5
- Implement a system of second chance campaigns for reducing measles mortality and morbidity

### **Nutrition**

About half of the children are stunted and underweight in Nepal and 47% of the total under five children are malnourished to some degree. Vitamin A deficiency problem in Nepal is gradually reducing in 6-60 months children due to intensive work done in this area through National Vitamin A program. In April 2002 round, Vitamin A capsule mass distribution program was launched to 73 districts of Nepal. The coverage was found to be more than 90%. Policies pertaining to low dose vitamin A capsule supplementation to pregnant mothers & de-worming to pregnant mothers starting from 4 months with single dose de-worming tablet have been adopted and efforts have been made to increase the coverage of postpartum supplementation of Vitamin A.

Ministry of Health has initiated an external monitoring process in iodised salt at entry point level to control iodine deficiency disorder problem in Nepal in collaboration with multiple partners working in this area. Anaemia strategy has been revised and strategy to fortify wheat flour with iron had been finalised. Iron tablet demand was increased through intensification of iron tablet distribution program. There was also an increase in new growth monitoring visits that represents an increase of 11.56% in new visits of children under three years of age. The proportion of new cases of malnourished children visited to health facility decreased slightly at the national level from 18.3% to 15.8% (Annual Report).

*Main Strategies include*

- Maintain current national Vit. A semi-annual supplementation program and expand through appropriate use of Vit. A in sick child management and a pilot program of treatment of night blind pregnant women.
- Increase the availability and use of appropriately iodised salt through BCC and market measures.
- Expand the semi-annual mass deworming programme in children to all districts and evaluate its impact.
- Continue to promote and expand the use of iron-folate in pregnant women to reduce maternal anaemia (including a program of intensified antenatal supplementation and consideration of deworming in pregnancy).

- Continue to promote both health facility and community based growth monitoring and counselling. Increase awareness on breast feeding and young child feeding. Promote consumption of fortified complementary blended foods.

### 3. Communicable Disease Control

This section includes Tuberculosis, leprosy and HIV/AIDS prevention, and control. The successful Tuberculosis control programme in Nepal will be supported and maintained. The successful models of Leprosy control will be expanded and incorporated with the TB control programme. HIV/AIDS/STI will be expanded and some trials will be done.

#### ***Tuberculosis Control***

Tuberculosis contributes 7% of the total burden of disease. The status of Tuberculosis cases per 100,000 population in 2001 was 106. The national TB programme has made remarkable progress in implementing international standard model for TB control (DOTS) in Nepal starting 1996 and steadily increasing the coverage to 84% of the country's population by mid 2001. The combination of high case finding rate (70%) and high cure rate (90%) results in both direct savings of among those with active tuberculosis, and partial interruption in transmission producing steady declines in new tuberculosis cases over the years. As long as HIV prevalence remains low, this decline in tuberculosis burden in the population should be sustained. The main needs of this program are to complete expansion of DOTS to as much of the population as is practical, and to maintain the program at high levels of performance over the years. National Tuberculosis Centre has the overall responsibility through support of EDPs to achieve complete coverage.

Target of the TB control is to achieve 85% cure rate in new smear positive pulmonary tuberculosis cases and 70% case detection ratio in new smear - positive pulmonary TB cases. DOTS will be made available to all patient registered in NTP by 2006.

#### *Main Strategies include:*

- Continue expansion of DOTS, so as to make available to all patients registered in NTP and to the community level.
- Continue expansion in diagnostic and treatment sites (both public and private) to improve access and coverage and maintain quality.
- Establish treatment centre and sub-centre in HP and SHP and/or partnership at community level.
- Implement collaborative action with HIV/AIDS programme with TB/HIV co-infection.
- Conduct studies to deal with emerging issues such as drug resistance
- Promote PPP/PNP in expansion of DOTS
- Focus TB control activities in rural areas and urban poor communities.

**Leprosy Control**

Leprosy contributes 1% of the total burden of diseases. At the end of July 1982 there were 31,537 registered patients in the country with prevalence rate 21 per 10,000 populations. After the introduction of MDT, the prevalence rate in the country has gone down remarkably as the registered prevalence rate of 21 in 1982 reduced to 4.4 by mid July 2002 depicting 79 % deduction. Leprosy rates in Nepal have dropped although elimination has not yet been achieved. The current leprosy control program coverage is 75%.

World Health Assembly in 1991 passed a resolution for global elimination of leprosy by the end of year 2000. Since some countries including Nepal remained endemic, this targeted date has been extended to the end of year 2005 (WHO defines elimination as bringing down the prevalence rate to less than 1 cases per 10,000 population). Leprosy Control Division/DoHS has the responsibility through support of its EDPs to eliminate the leprosy.

**Target of Leprosy** control is to achieve a combination of high case detection rates with 90% or higher rates of MDT completion to further interrupt transmission of this disease and achieve an overall prevalence rate under 1/10,000 population (or less than 2,400 cases nationwide). So national Leprosy program aims for a final push towards the elimination of leprosy by the end of year 2005. The main program need is to maintain current services and consider whether alternative methods of case finding and holding are needed and reasonable to reach program goals.

*Main Strategies include:*

- A final push towards the elimination of leprosy from Nepal so as to reach the target of elimination before 2005.
- Provision of leprosy elimination services to the people nearest to their door step (up to SHP) through PHC system and by transferring the retained patients from referral centres to the health centres / district clinic.
- Provision of MDT to all registered cases for treatment in the country.
- Prevention of disability by early case detection and treatment; and
- Reductions of social stigma by increasing awareness about the disease through appropriate HE.

**Resources:** The programme receives technical, material and financial support from World Health Organization, The Leprosy Mission International, Sasakawa Memorial Health foundation, International Nepal Fellowship, Netherlands Leprosy Relief and Nepal Leprosy Trust and Others.

**Prevention and control of HIV/AIDS/STI**

The first cases of AIDS were reported in Nepal in 1988. Reliable surveillance data is scarce, however, available data indicates that HIV prevalence is currently around 0.5 percent in the general population. As of January 2003, the NCASC/MoH has reported 626 cases of AIDS and 2,665 HIV infections. UNAIDS/WHO estimate for 2002 around 60,018 people living with HIV/AIDS, and 2958 AIDS related deaths in

that year alone. However, the currently low prevalence among the general population masks an increasing prevalence in several groups: SWs in Kathmandu 17.3% (SACTS, 2000), IDUs 40.4% nation-wide, and 68% in the Kathmandu Valley (NCASC, 2000; FHI, 2002)). It is now evident that Nepal has entered a "**concentrated epidemic**", i.e. the HIV/AIDS prevalence consistently exceeds 5% in one or more sub-groups.

**The target** is to keep the prevalence <1% among general population. The estimated prevalence of HIV for 2015 (during the MDGs) is 2% among general population.

Prevention of HIV/AIDS is a multi-sectoral programme and it has consequences and interventions beyond the Health Sector only. However, it has been decided that the MoH will co-ordinate this multi-sectoral intervention and the ministry will be the focal point for implementation.

As such it is imperative that the programme is reflected in the NHSP-IP

Recently Nepal established a "National AIDS Council" chaired by the Prime Minister. The Council with representation from government, non-governmental organisations, private sector and civil society will take the lead in policy making and will advocate for multi-sectoral participation in the fight against HIV/AIDS in Nepal. In 2003, a multi-sectoral HIV/AIDS prevention and Control Strategy has been adopted which includes the guiding principles for the HIV prevention and care strategies and interventions in Nepal over the next five years. Moderate progress has been made in terms of public awareness and improved rates of protective behaviours among some risk groups. However, a "concentrated epidemic" situation exists in vulnerable groups and greatly increased efforts will be needed.

*Major strategies include (see National HIV/AIDS Strategy, 2003)*

- Prevention of STIs and HIV infection among vulnerable groups
- Prevention of new infections among young people
- Ensuring care and support for person infected and affected by HIV/AIDS
- Expansion of monitoring and evaluation
- Establishment of an effective and efficient management system.

#### **4. Control of Infectious Diseases and Zoonoses**

*The major strategies include:*

- Reduce morbidity and mortality due to infectious diseases
- Carry out epidemiological surveillance,
- Conduct outbreak investigation and response for the prevention and control of infectious diseases of epidemic potential and zoonoses.

The main actions are: Management of essential medicines and vaccines, capacity building for the prevention and control of Communicable diseases including outbreaks of diseases like Acute Diarrhoeal Diseases, Typhoid, Hepatitis (A & E), measles, Acute Respiratory Infection and Zoonoses like Rabies, Japanese Encephalitis and others plus snakebite management in central, regional, district levels including PHCs, HPs, SHPs, mobilization of local rapid response team during outbreaks etc.

### **Disaster Management**

The strategy is to focus more on the most vulnerable groups in health sector emergency planning by field level implementation of preparedness and disaster management initiatives in rural areas.

### **Vector Borne Disease (VBDs) Control**

There are three major VBDs as Malaria, Kala-azar and J. Encephalitis. The current initiatives for the Control of Vector Borne Diseases will continue but alternative models of control will be tested. The malaria and kala-azar control activities will be strengthened. Disaster preparedness and management initiatives will be strengthened.

### **Control of Malaria, Kala-Azar and Japanese Encephalitis**

**Malaria:** The first attempt to control malaria in Nepal was initiated in 1954 through the Insect Borne Disease Control Programme. Currently malaria control services are being provided free of cost to approximately 17.3 million people of 65 districts at risk of malaria. Out of Nepal's total population of 23.2 million approximately 74% are at malaria risk. The malaria incidence rate was 37 per 100,000 in 2001 (Annual Report). The VBDs contributes 1% of the total burden of diseases and the existing programme coverage is slightly over 50%.

**The targets of Malaria control** are to reduce or contain the Annual Parasite Incidence (API) at the level of 3/1000 population in malaria risk areas, to prevent mortality by 90%, reduce morbidity by 50% by the year 2007 and to reduce overall diseases burden of the community at risk of malaria.

**The major strategies of the malaria** program is to maintain a combined strategy of rapid diagnosis and treatment (both public and private) surveillance for outbreaks, focal household spraying in highly endemic areas and to contain outbreaks and drug resistance monitoring. The additional of treated bed nets to this strategy will be piloted and potentially expanded in the medium term.

**Kala-Azar** has been reported in 12 Terai districts. More than 5.5 million people in Nepal are believed to be at risk of this disease. Since 1980, a total of 15,155 cases and 231 deaths have been reported from this disease. The Kala-Azar Incidence Rate (KAI) for 2000/2001 was 23.45. The Kala-Azar Control Programme aims to reduce Kala-azar morbidity and mortality by applying the primary health care approach including active community participation, determine the efficacy of the first line drug SAG and prevent epidemics due to Kala-Azar. **The target** of the Kala-azar is to reduce it by 50% by the year 2005. **Major strategies of Kala-Azar** is the maintenance of a combined strategy of case treatment, and containment of outbreaks with focal household spraying. New strategies to be piloted

are community mobilisation for increased case finding and holding, use of new drugs for easier treatment and vector studies.

The current strategies of the **Japanese Encephalitis** are only to conduct surveillance and case treatment. Immunisation will be considered only if its cost-effectiveness is justified.

*The major actions of all the above programmes are:*

- BCC, surveillance, epidemic preparedness and response,
- Supply of essential medicines, vaccines and other commodities,
- Zoonoses control, early diagnosis and prompt treatment,
- Transmission risk reduction,
- Epidemiological capacity empowerment,
- Mapping of risk population and areas,
- Strengthening diagnostic facility,
- Monitoring and implementation of the cross boarder collaborative activities.

**EDCD/DoHS** is the responsible to implement the above strategies with support of the WHO, USAID, DRF Japan etc.

## Reform Milestones

### Nepal Health Sector Strategy, the NHSP, & Policy Reform

#### The Sector Strategy

The Nepal Health Sector Strategy (NHSS) is a commitment to achieving the improved health outcomes set out in HMGN 10<sup>th</sup> Five Year Plan, HMG's Poverty Reduction Strategy Paper and the MDGs. The NHSS proposes to take a strategic approach to reform making health services available to all especially the poor and disadvantaged groups in rural, remote areas, health service financing, delivery, performance and monitoring. It acknowledges the role of private and NGO service providers, the need for decentralisation of services so they are closer to the people they are intended to serve, the importance of peoples own 'out of pocket' spending on health and the problems of geography, income, access, utilization and awareness.

#### Nepal Health Sector Programme-Implementation Plan

The Nepal Health Sector Programme-Implementation Plan (NHSP-IP) has been designed as the basis for implementing the sector strategy over its first five years. NHSP-IP has taken account of the current service delivery and management systems; it has proposed how to move from where the Ministry of Health and its present resources (both human and financial) are towards the vision of the Sector Strategy. NHSP-IP is therefore incremental and pragmatic. As a result it has taken two years to move from the Strategy to an NHSP that can be implemented. Whilst NHSP-IP provides a good road map to start the journey it is important to keep a clear view of the destination. The detailed Logframe and Annual Work Plans link activities to the desired outputs. The EHCS is defined and has been costed but will require major institutional change if it is to be implemented as planned. There are also major policy reforms that are articulated in the Sector Strategy that are essential to delivering the programme. These policy reforms are not separate from NHSP-IP some are included and others set the context for its delivery. The agreement between HMGN, the World Bank and DFID is an agreement to implement the Sector Strategy not just only to finance NHSP-IP. The focus for the Mid Term and Five Year Reviews will therefore be on the progress towards the strategy whilst the annual reviews will focus more on the individual outputs. It is important to reaffirm the policy changes within the sector strategy and to identify what the key milestones towards their realisation are going to be.

#### Health Sector Strategy Purpose and Outputs

##### ***Purpose***

The emphasis of the strategy will be on outputs and health outcomes. Although the strategy covers

the fifteen-year period to the end of the Long-term health plan HMGN recognises that the outputs for the first five years have to be realistic and achievable. This means making choices and setting priorities. They will give priority to interventions which will help progress towards the MDGs. HMGN have set three programme outputs and five sector management outputs which will be the core of the reform programme over the next five years. They are:

### ***Programme Outputs***

1. The priority elements of an Essential Health Care Service – safe motherhood and family planning, child health, control of communicable disease, strengthened out patient care –will be costed, resourced and implemented. Clear systems will be in place to ensure that the poor and vulnerable have priority for access
2. Local bodies will be responsible and capable of managing health facilities in a participative, accountable and transparent way with effective support from the MoH and its sector partners.
3. The role of the private sector and NGOs in the delivery of health services is recognised and developed with participative representation at all levels. Clear systems are in place to ensure consumers get access to cost effective high quality services which offer value for money.

### ***Sector Management Outputs***

1. There will be coordinated and consistent Sector Management (planning, programming, budgeting, financing and performance management) in place within the MoH to support decentralised service delivery and the involvement of the NGO and private sectors.
2. Sustainable development of health financing and resource allocation across the whole sector including alternative financing schemes will be in place
3. A structure and systems will be established and resourced within the MoH for the effective management of physical assets and procurement and distribution of drugs, supplies and equipment.
4. Clear and effective Human Resource Development policies, planning systems and programmes will be in place.
5. A comprehensive and integrated management information system for the whole health sector will be designed and implemented at all levels

### ***Policy Reforms and Milestones***

Based on the detailed work undertaken by MoH in finalising the NHSP-IP and setting output related milestones the following are the proposed Policy Reforms and related milestones for the first phase of implementation of the Health Sector Strategy. These policy reforms reflect the strategic priorities in the Sector Strategy, take account of the NHSP activities and the report of the First Joint Annual Review, and reflect the commitments made progress and reforms reported to the Nepal Development Forum 2004.

The overarching Policy Reform is HMGNs adoption of the Health Sector Strategy which consolidates policy development to date and sets a clear commitment for the period to 2017 (the end of the 2nd Long Term Health Plan and the current and subsequent two 5 Year Plans).

The Health Sector Strategy stresses the role of donor assistance and harmonisation of that role in support of the Strategy itself forms a key reform.

The Health Sector Strategy sets the reforms in relation to the shift to EHCS, devolution of service delivery and a mixed economy of health provision.

Finally the move to sector wide management implies reform in the systems, structures and policies within the MoH and its financing and well as the changes in the relationship with other actors and agencies within the sector.

The seven key reforms which will be implemented by MoH and monitored and reviewed through the Joint Annual Review process are:

- Implementation of the Nepal Health Sector Strategy 2002
- Harmonization of donor assistance to the Health Sector based on the Aid Integration Process adopted at the Nepal Development Forum 2004
- Equity based resource allocation (human and financial) to District level and below to ensure access to and utilization by the poor
- Devolution of the entire health system with decentralisation to local bodies and deconcentration of MoH management
- A mixed economy of provision and financing of health; MoH adopting a new public sector role with an enabling, quality assurance role particularly at secondary and tertiary levels.
- MoH structures, planning, budgeting, and performance management re-structured to reflect and effectively implement the Sector Strategy
- Proportionate shift in expenditures from secondary and tertiary to EHCS and proportion of total HMGN budget allocated to health increased over the lifetime of the Health Sector Strategy

Health Sector Strategy/NHSP Output	Policy Reform	Year 1 Start of NHSP (2004-05)	Year 3 Mid Term (2006-07)	Year 5 End of NHSP (2009)
"A health system in which there is equitable access to coordinated quality health care services in rural and urban areas, characterized by: self-reliance, full community participation, decentralization, gender sensitivity, effective and efficient management, and private and NGO sector participation in the provision and financing of health services resulting in improved health status of the population" 2 <sup>nd</sup> Long Term Health Plan	MoH lead the implementation of the Nepal Health Sector Strategy 2003	Leadership and direction set by Secretary and senior managers. Roles and responsibilities for Policy, Planning and Co-ordination with EDPs, Private Sector, NGOs, civil society and local government established. Role and functions of HSRU and HEFU clarified with ToRs, appropriate staffing (skill mix and numbers) to co-ordinate and support sector reform and financing.	MoH leads Mid Term Review of NHSP and Annual Review of Health Sector Strategy Agreement over expansion of NHSP-IP in areas where success has been achieved and process for preparing next phase of programme support agreed	NHSP-IP successfully completed and follow on phase of programme support for the Health Sector Strategy in place

Health Sector Strategy/NHSP Output	Policy Reform	Year 1 Start of NHSP (2004-05)	Year 3 Mid Term (2006-07)	Year 5 End of NHSP (2009)
Harmonization of donor assistance to the Health Sector	MoH establish a new partnership relationship with Health Sector EDPs based on the Aid Integration Process proposed at the Nepal Development Forum 2004	Health Sector Development Partner Forum operational; system of Joint Annual Reviews in place; and the Statement of Intent 2004 implemented with a Code of Practice for EDP operational procedures	Full harmonization at the programme level with joint planning, review and reporting lead by MoH and a single annual workplan and budget for the sector	Expansion of harmonisation at the financial modality level with increased programmatic financial support
EHCS implemented with a poverty focus	Equity based resource allocation (human and financial) to District level and below to support EHCS implementation to ensure improved access to the poor	Plan for phased implementation with staffing norms, equity based resource allocation, and capacity building agreed. Poverty related health indicators agreed	50% of facilities at District level and below have appropriate staffing mix and are able to provide Prioritised elements of EHCS	75% of facilities at District level and below have appropriate staffing mix and are able to provide Prioritised elements of EHCS
Local Bodies managing with support	Devolution of the entire health system through decentralisation to local bodies and deconcentration of MoH management	MoH strategy for deconcentration of planning, budgeting, service delivery, quality assurance and monitoring approved. Plan for decentralisation of health services agreed between MoH and MoLD.	All key management functions delegated to Regional level; District level models in place Decentralisation implemented in partnership with MoLD and respective local bodies (when elected)	Management fully deconcentrated to District level (phased if necessary) Decentralisation process reviewed and evaluation of support needs to ensure equity and pro-poor focus
Role of private sector and NGOs developed giving consumers access to cost effective high quality services which offer value for money	A mixed economy of provision and financing of health care with MoH adopting a new public sector role of enabling and quality assurance particularly at secondary and tertiary levels.	Mechanisms for dialogue (Health Sector Fora) on policy, advocacy and service delivery with all stakeholders (private sector, NGOs, civil society, and local elected bodies) EDP projects and other support for NGOs and civil society included in sector planning	Strategy for establishing Public/Private Partnership (PPP) models with non State providers (NGOs, private sector, community groups etc.) At least 5 District Hospitals operating autonomously	Contracting out of tertiary level facilities At least 10 District Hospitals operating autonomously Partnership working established at all levels
Improved sector management (planning, programming, budgeting, financing and performance management)	MoH structures, planning, budgeting, and performance management re-structured to reflect and effectively implement the Sector Strategy	Approval of plan for restructuring of MoH at all levels, clarifying the roles Ministry and Department, Region and District; removing vertical management and emphasising support and servicing role to decentralised service delivery and deconcentrated management of the Sector Strategy outputs	District based planning, budgeting and performance management system developed MoH restructured including new Human Resource, Information and Communications; and Partnerships functions. Human Resource Development Policy finalised and resource implications incorporated into the MoH budget.	District based planning, budgeting, performance management, quality assurance and monitoring established in at least 50 Districts. Regional Directorates, Department of Health and Ministry have appropriate staffing and skill mix for their respective roles to further implement the Health Sector Strategy

Health Sector Strategy/NHSP Output	Policy Reform	Year 1 Start of NHSP (2004-05)	Year 3 Mid Term (2006-07)	Year 5 End of NHSP (2009)
Sustainable financing and resource allocation	Proportionate shift in expenditures from secondary and tertiary to EHCS and proportion of total HMGN budget allocated to health increased over the lifetime of the Health Sector Strategy	Phased reduction in tertiary level expenditure agreed Plans for increasing autonomy of District level hospitals agreed Proposals for PPP management of tertiary and secondary (District) hospitals agreed	Proportion of development expenditure on P1:P2:P3 categories reaches 67%:25%:8% as required by the MTEF with the agreed targets for the regular budget also met <sup>8</sup> . Spend on EHCS increased to 65% Proportion of total HMGN budget allocated to health increased to 6.5%	10 District Hospitals autonomous; private sector financing of all tertiary facilities Total HMGN expenditure on P1:P2:P3 categories moves towards 70%:20%:10% Spend on EHCS 70% Proportion of HMGN budget reaches at least 7% <sup>9</sup>

<sup>8</sup> P1:P2:P3 targets for regular budget are to be set by end July 2004.

<sup>9</sup> Targets for proportion of spending by category and proportion of overall budget will be reviewed at the Mid Term Review in the light of performance.

### **Action Plan for Reform Activities during Year 1**

The NHSP-IP sets out activities for the first year and these are developed in the Annual Work Plan and Budget. Some of the above reforms require additional corporate activities to ensure they are delivered. Here are some suggested actions that may be incorporated in a policy reform action plan managed by HSRU.

- Health Sector Development Partner Forum (HSDF) chaired by Health Secretary is established and meets quarterly to review the progress of implementation of reform policies
- HSRS is published in English and Nepali languages and massively disseminated at all levels of health and health related sectors
- Increased pool funding for implementing HSRS reforms availed through HSDF sustained advocacy/ effort
- Programme directors/DoHS relating to EHCS incorporate HSRS reform actions into their respective AWPB and reflect their progress in their unified quarterly report to Health Sector Development Partner Forum.
- Focal Point in MoH for review and monitoring established.
- 70% of 2004-2005 Health Budget allocated to EHCS delivered through health institutions at district and below.
- Funds for “Safety Nets-Maternal Health Funds established for purchasing Essential Obstetric and neonatal care services and emergency transportation for the hard core poor from the private/ NGP/Public sectors.
- Additional Safety Net Funds for purchasing health care for the “Conflict Victims” especially the Widows and Orphans including the victims themselves be established
- 50% of Sub-Health Posts and Health Posts specially in remote areas are functional to deliver EHCS

- Budget allocated/ implemented for ANM scholarships for qualified candidates from 30% of VDCs, preferably Dalit and Janajati starting from the poorest districts (identified by NPC-PRSP)
- Focal Point in MoH to plan, coordinate with CTEVT and implement the VDC level ANM scholarships is established/ functional
- The existing handing over of Sub Health Posts to VDCs over the last year is evaluated and lessons drawn
- The capacity of the existing intersectoral mechanisms for health like DDC and VDC level Health Committees and VDC level Health Management Committees augmented and empowered to implement the reform policies through their individual and sectoral responsibilities.
- VDCs/ Mothers' Group are involved in selecting the candidates for ANM Scholarships
- VDC/Mothers' Group are empowered to identify the hard core poor and refer to benefit from the Safety Nets of "Maternal Health Fund" and "Conflict Victims Health Funds" using locally relevant & NPC criteria
- Standard Medical Norms and Procedures of Good Practices established /mandated/ enforced through revised Nepal Health Act
- Provision of quality health care (EHCS & outside EHCS specially the conflict injuries) to the poor at cost price/subsidized rate/free through Public/Private and NGOs partnerships negotiated and established.
- The "fee for service" at government facilities for the hard core poor is waived.
- The existing MoH/HEFU pilot project on Community Based Health Insurance evaluated lessons used for scaling it through private sector with HMGN subsidizing the premium for the poor.

## Annual Planning Cycle Timetable

Date	Milestone and Responsibility	Comment
Sep	<b>1 Issue Planning Process Guidance.</b> Planning Division of MoH responsible for issue	Departments/Division/Units and others need to be provided with a clear timetable with dates for key events. These key dates include: <ul style="list-style-type: none"> <li>• Deadline for Reports for November Annual Review (JAR) of past fiscal year</li> <li>• Fixed dates for November Annual Review</li> <li>• Deadline for submission revised current year AWPB (Jan/Feb)</li> <li>• Deadline for submission next year draft AWPB (March)</li> <li>• Fixed date for Annual Plan Review (JAPR) (April)</li> </ul>
Jul to Jun	<b>2 Monthly Internal Reviews</b> DoHS, MoH with Planning division <b>3 4 monthly major Internal Reviews</b> Technical Review Committee for review of slow moving AWPB	Monthly implementation review of AWPB led by DG and other Departmental Head. July (check milestones old AWPB, finalise new AWPB); Sept (pre Nov AR, co-ordinate reports); Jan (revise current AWPB, start drafting new AWPB); March (co-ordinate & finalise draft new AWPB pre April APR); July.
Nov	<b>4 Undertake JAR. Part 1 - Previous Year Review</b> All stakeholder	EDPs and MoH review previous year Programme. Set Fixed date at Previous November AR
Dec	<b>5 Issue conceptual and process guidance.</b> <b>6</b> Planning and process guidelines issued by the Planning Division, MoH	Review findings of November APR. Provide guidance to Head of Department/Division/ Centre on conceptual framework and format for revision of current AWPB and content of new AWPB. Give resource envelope guidance for new AWPB
March/Apr	<b>7 Present Draft AWPB.</b> MoH responsible for presenting Operational Plans <b>8 Consolidate into APIP</b> <b>9 Undertake Joint Annual Plan Review - Review of AWPB.</b> All stakeholder	Head of Department/Division/Centre agree plans with Planning Division.  Donors and MoH agree basis of next year's plan.
Jun	<b>10 Revise and approve AWPB.</b>	
Jul	<b>11 Final AWPB adopted.</b> MoH responsible for formal adoption of AWPB	Any changes in AWPB made and plans formally adopted by MoH. Financial releases actioned.

## Annex 7

# Logical Framework Nepal Health Sector Strategy Incorporating The National Health Sector Programme (NHSP)

The Joint Annual Review (May 2004) was charged with reviewing the logframe for NHSP-IP and the previous Aide Memoire (April 2004) required revision of the indicators. The final draft logframe presented here has been discussed and agreed with MoH as part of the Appraisal Mission.

It has been agreed that the World Bank and DFID programme support, together with the project support of other donors, will be for the Health Sector Strategy as a whole, with NHSP comprising the core of the first phase of that strategy. In undertaking a final review of the logframe two issues emerged.

Firstly the NHSP logframe sets its goal and purpose at too low a level for the Health Sector Strategy. NHSP only covers the core EHCS and that only for the first five years so understandable its Goal and Purpose are at a lower level. The Goal of the Health Sector Strategy clearly relates to achieving progress towards the MDGs and reduction of poverty. This is spelt out clearly in the Strategy itself. The Purpose of the Health Sector Strategy to improve the health status of the Nepalese population through increased utilisation of essential services delivered by a well managed health sector. As the outputs relate to programme implementation in the first five years these are and should be the same for NHSP and the Health Sector Strategy. Setting the goal and purpose of the Health Sector Strategy at the higher level reasserts the policy context of the programme and of the donor support as was identified by the Joint Annual Review. HMGNs intention and that of the EDPs in providing support is the achievement of the Health Sector Strategy and this revision of the logframe re-establishes that intent.

Secondly the "nested logframes" proposed by the Joint Annual Review are relevant for monitoring NHSP-IP and have been used as a basis for finalising planning and budgeting for the first year. However they are less useful for monitoring progress of the overall sector strategy which as identified by the Joint Annual Review should be focusing at the policy and reform level. It is therefore suggested that the Health Sector Strategy Logframe and the Policy Reform Matrix should be the basis for monitoring and review of the Health Sector Strategy and output related "nested logframes" should be used as working documents for management and monitoring of NHSP-IP being regularly revised by MoH but they should not be used in programme monitoring.

The indicators for the Health Sector Strategy goal are proposed as the health specific and poverty related MDGs. By putting these as goal level indicators it is acknowledged that achieving them is not the expectation of the Sector Strategy alone but it is intended to contribute to progress towards these indicators. For the purpose the expected health outcomes during the five year first phase and the proportionate increase in HMGN budget allocation are considered appropriate indicators of

achievement of the purpose and also provide consistency with the World Bank HSPSP PAD results framework. At output level indicators have been revised in discussion with MoH to be more process oriented and targets are reduced so that as is usual in a programme approach it is progress rather than meeting a specific target that is the aim.

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Assumptions
<p><b>Goal:</b> Achievement of the health sector Millennium Development Goals in Nepal with improved health outcomes for the poor and those living in remote areas and a consequent reduction in poverty.</p>	<p><b>Progress towards health related MDGs (1990-2015):</b> <b>Proportion living on less than \$1 a day halved.</b> (From 38% to a target of 17%). <b>Child mortality reduced by two thirds.</b> (From 161.6 per 1000 to a target of 54) <b>Maternal mortality rate reduced by three quarters.</b> (From 539 per 100,000 live births to a target of 134). <b>To have halted the spread of HIV/Aids by 2015 and begun to reverse the trend.</b> <b>Incidence of malaria and other major diseases including TB halted and trend reversed.</b></p>	<ul style="list-style-type: none"> <li>• Nepal Demographic Health Survey (NDHS)</li> <li>• National Household Survey</li> <li>• National Livelihoods Survey</li> <li>• Other poverty related surveys developed under HMGNs</li> <li>• Poverty Monitoring and Analysis System PMAS.</li> </ul>	<ul style="list-style-type: none"> <li>• PRSP implemented</li> <li>• Political Stability</li> <li>• Economic growth continues</li> </ul>
<p><b>Purpose:</b> To improve the health status of the Nepalese population through increased utilisation of essential services delivered by a well managed health sector."A health system in which there is equitable access to coordinated quality health care services in rural and urban areas, characterized by: self-reliance, full community participation, decentralization, gender sensitivity, effective and efficient management, and private and NGO sector participation in the provision and financing of health services resulting in improved health status of the population"2nd Long Term Health Plan (Responsibility: Chief Specialist, PPICD, MoH, )</p>	<p><b>Maternal Mortality Ratio</b> decreased from 539/100,000 live births (DHS 1996) to 325 in 2006 and 300 in 2009.10th Plan - 300 <b>Infant Mortality Rate</b> decreased from 64/1000 live births (DHS 2001) to 50 in 2006 and 45 in 2009.10th Plan - 45 <b>Under-Five Mortality Rate</b> decreased from 91/1000 live births ( DHS 2001) to 70 in 2006 and 65 in 2009 <b>Total Fertility Rate</b> reduced from 4.1 (DHS 2001) to 3.8 in 2006 and 3.5 in 2009.10th Plan - 3.5 <b>Contraceptive Prevalence Rate</b> increased from 39% (DHS 2001) to 43% in 2006 and 47% by 2009.10th Plan - 47 (10th Plan runs from July 2002 - July 2007) <b>Skilled attendance at birth</b> increased from 13% (DHS 2001) to 22% in 2006 and 35% by 2009.10th Plan - 40 <b>Percentage of children immunized against measles and DPT3</b> increased from 71% (DHS 2001) to 78% in 2006 and 85% by 2009. <b>Knowledge of at least one programmatic method of preventing HIV transmission</b> increased from 37.6% (DHS 2001) to 75% for women and 50.8% (DHS 2001) to 85% for men. <b>Proportion of HMGN budget allocated to health</b> increases from 5% at present to 6.5% in 2006 and 7% in 2009</p>	<ul style="list-style-type: none"> <li>• NDHS- National Household Survey-</li> <li>• National Livelihoods Survey-</li> <li>• Other poverty related surveys developed under HMGNs PMAS.</li> </ul>	<ul style="list-style-type: none"> <li>• Overall environment (social, political, economic) is stable-</li> <li>• Strong political commitment-</li> <li>• PRSP implemented-</li> <li>• Decentralization health and other services</li> </ul>

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Assumptions
<p><b>Output 1</b> The priority elements of an Essential Health Care Service costed, allocated the necessary resources and implemented. Clear systems in place to ensure that the poor and vulnerable have priority for access. <i>(Responsibility: DG, DoHS)</i></p>	<p>1.1 50% of health facilities provide prioritized elements of EHCS by 2006/7 increasing to 75% in 2009. 1.2 50% of population will be utilizing the prioritized services by 2006/7 increasing to 75% in 2009. 1.3 Proportion of poor accessing skilled birth attendants increases. 1.4 Proportion of poor utilising EHCS with prepaid CHI with subsidised premium increases.</p>	<p>1.1 MoH and DHS reports 1.2 NLSS and other established surveys 1.3 Health poverty indicator set based on existing data/ surveys and others developed under the PMAS.</p>	<ul style="list-style-type: none"> <li>• Sustained government commitment</li> <li>• Conflict situation does not deteriorate to the extent that it significantly impacts on service delivery and utilization</li> </ul>
<p><b>Output 2</b> Local bodies responsible and capable of managing health facilities in a participative, accountable and transparent way with effective support from the MoH and its sector partners. <i>(Responsibility: Chief Specialist PPICD and PHAME Division, MoH)</i></p>	<p>2.1 Decentralized management of health facilities and involvement of local bodies in planning health services in all districts in phases. 2.2 Deconcentration of management to all Regions - at least 15 Districts by 2006 and 30 by 2009. 2.3 5 Districts having their own five year plan including health by 2006. 2.4 1800 sub health posts managed by health management committees by 2006 2.5 No of autonomous District Hospitals 5 by 2006, and 10 by 2009</p>	<p>2.1 DDC Annual Reports 2.2 District health profiles and plans</p>	<ul style="list-style-type: none"> <li>• Amendment of conflicting clauses in between LSGA and Health Act 1999</li> <li>• Local bodies are capable, responsible, representative and accountable</li> <li>• Resources are available from HMG and EDPs</li> <li>• DDCs and VDCs are elected and functional</li> </ul>
<p><b>Output 3</b> The role of the private sector and NGOs in delivering health services recognised and developed with participative representation at all levels to ensure consumers have access to cost effective high quality services that offer value for money. <i>(Responsibility: Chief Specialist, PPICD, MoH)</i></p>	<p>3.1 Redefined partnership roles and responsibilities in MoH and the departments' documents. 3.2 At least 5 hospitals fully transferred to NGO/private sector operation.</p>	<p>3.1 Minutes of meetings. 3.2 Private, NGO, community contracts</p>	<ul style="list-style-type: none"> <li>• Partners (EDPs, private sector, NGOs, etc) willing to cooperate.</li> <li>• HMGN has political will to enforce the private sector regulation and QA</li> </ul>
<p><b>Output 4</b> Coordinated and consistent Sector Management (planning, programming, budgeting, financing and performance management) in place within the MoH supported by the EDPs, to support decentralised service delivery with the involvement of the NGO and private sectors <i>(Responsibility: Chief Specialist, PPICD, MoH)</i></p>	<p>4.1 Restructuring of MoH with deconcentration to Regional and District level - planned, agreed, implemented. 4.2 District based planning, budgeting and management established. 4.3 Sector wide policy discourse, planning and monitoring.</p>	<p>4.1 MoH Annual Reports 4.3 HEFU Reports 4.3 Joint Annual Review Reports 4.4 Mid Term review and Evaluation.</p>	<ul style="list-style-type: none"> <li>• Harmonization of MoH and EDP relationship achieved.</li> <li>• Cooperation between EDPs maintained and improved</li> </ul>

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Assumptions
<p><b>Output 5</b> Sustainable development of health financing and resource allocation across the whole sector, including alternative financing schemes. (Responsibility: Head of HEFU, MoH)</p>	<p>5.1 At least 10% of health expenditure borne by elected local bodies e.g. DDC, VDC, Municipalities in public health facilities by 2006/7; 5.2 At least 5% of health expenditure borne by local community in public health facilities by 2006/7 e.g. CDP, CHI 5.3 Increasing financial contribution from private sector 5.4 Alternative health financing schemes established.</p>	<p>5.1 Annual budget of the government 5.2 Local bodies plans, budget and reports 5.3 Regional Directors and MoLD 5.4 Health institution records 5.5 National Health Accounts</p>	<ul style="list-style-type: none"> <li>Govt. gives priority to health sector programmes</li> <li>Local bodies are functional and districts plans prepared and implemented</li> <li>Alternative financing schemes are acceptable to the community</li> <li>Conducive environment is created for the participation of the private sector</li> </ul>
<p><b>Output 6</b> Structure and systems established and resources allocated within the MoH for the effective management of physical assets and procurement, distribution and rational use of drugs, supplies, and equipment. (Responsibility: DG, DoHS, and Regional Directors)</p>	<p>6.1 Stock out of health commodities minimized with effective monitoring 6.2 Drug Financing Schemes developed in at least 50% districts by 2006/7 6.3 All procurement decisions are made based on information generated by LMIS by 2006/7</p>	<p>6.1 Facilities reports and inspections by District and Regional Managers 6.2 Maintenance records kept at facilities 6.3 LMIS generated procurement document</p>	<ul style="list-style-type: none"> <li>Political stability</li> <li>Adequate health budget is available</li> <li>Adequate deconcentrated management capacity</li> </ul>
<p><b>Output 7</b> Clear and effective Human Resource Development policies, planning systems, and programmes developed and functional. (Responsibility: Chief, Human Resource and Financial Management Division, MoH)</p>	<p>7.1 50% of the public health facilities will have appropriate mix of HR by 2006/7 7.2 Staff available to provide services in 35% facilities at any given time 7.3 HR Master plan updated and incorporated in HR management</p>	<p>7.1 Personal record HuRDIS report 7.2 MoH HMIS and monitoring reports 7.3 HMC report on attendance verification</p>	<ul style="list-style-type: none"> <li>Health Service Act reformed</li> <li>Health personnel willing to learn new skills and accept redefined roles</li> <li>Management capacity enhanced and responsibilities delegated</li> </ul>
<p><b>Output 8</b> Comprehensive and integrated management information system for the whole health sector designed and functional at all levels with Quality Assurance (QA) operational across public and private sectors. (Responsibility: Director, Management Division, DoHS)</p>	<p>8.1 Comprehensive and integrated information system in place at all levels by 2007 8.2 Quality Assurance Policy for public and private sectors created and implemented.</p>	<p>8.1 Monitoring tools in place at all levels 8.2 Annual performance document 8.3 QA Policy doc.</p>	<ul style="list-style-type: none"> <li>Political stability</li> <li>Budget allocations grow</li> <li>Appropriate skill mix of MoH management</li> </ul>

Logical Framework for NHSP-IP Taking Health Sector Strategy Purpose as the Goal for the First Five Years.

**THIS LOGFRAME TO BE MANAGED BY THE CHIEF SPECIALIST, POLICY, PLANNING, AND INTERNATIONAL COOPERATION DIVISION, MOH**

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Assumptions
<p><b>Goal:</b> To improve the health status of the Nepalese population through increased utilisation of essential services delivered by a well managed health sector. <i>(Responsibility: Chief Specialist, PPICD, MoH, )</i></p>	<ul style="list-style-type: none"> <li>• Decrease in Maternal Mortality Ratio.</li> <li>• Decrease in Infant Mortality Rate.</li> <li>• Decrease in Under-Five Mortality rate.</li> <li>• Reduction in Total Fertility Rate.</li> <li>• Increase in Contraceptive Prevalence Rate.</li> <li>• Increase in skilled attendance at birth.</li> <li>• Increased percentage of children immunized against measles and DPT3.</li> <li>• Increased awareness of HIV transmission through knowledge of at least on correct method prevention.</li> </ul>	<ul style="list-style-type: none"> <li>• NDHS</li> <li>• National Household Survey</li> <li>• National Livelihoods Survey</li> <li>• Other poverty related surveys</li> </ul>	<ul style="list-style-type: none"> <li>• Overall environment (social, political, economic) is stable</li> <li>• Strong political commitment</li> <li>• PRSP implemented</li> <li>• Decentralization health and other services</li> </ul>
<p><b>Purpose:</b> Increase the coverage and raise the quality of Essential Health Care Services (EHCS) with a special emphasis on improved access for poor and vulnerable groups through an efficient sector wide health management system developed with provision of adequate financial resources</p>	<ul style="list-style-type: none"> <li>• Proportion of the population with access to responsive EHCS.</li> <li>• Proportion of population utilising prioritized EHCS services.</li> <li>• Decentralisation of facility management</li> <li>• No of service delivery contracts with NGO and private sector</li> <li>• Percentage of expenditure born by locally generated resources.</li> <li>• Increased commitment of HMGN budget.</li> </ul>	<ul style="list-style-type: none"> <li>• DHS Annual Reports.</li> <li>• NDHS.</li> <li>• Service Delivery Survey.</li> <li>• HEFU Reports.</li> <li>• HSRU Reports.</li> <li>• Annual Accounts</li> </ul>	<ul style="list-style-type: none"> <li>• Overall environment (social, political, economic) is stable</li> <li>• Strong political commitment</li> <li>• PRSP implemented</li> <li>• HMGN implements Decentralization</li> <li>• Senior management capacity and overall skill mix and staffing levels improve</li> <li>• Performance management effective.</li> </ul>
<p><b>Output 1</b> The priority elements of an Essential Health Care Service costed, allocated the necessary resources and implemented. Clear systems in place to ensure that the poor and vulnerable have priority for access. <i>(Responsibility: DG, DoHS)</i></p>	<p>1.1 50% of health facilities provide prioritized elements of EHCS by 2006/7 increasing to 75% in 2009.</p> <p>1.2 50% of population will be utilizing the prioritized services by 2006/7 increasing to 75% in 2009.</p> <p>1.3 Proportion of poor and those in remote areas accessing skilled birth attendants increases.</p> <p>1.4 Proportion of poor utilising EHCS with prepaid CHI with subsidised premium.</p>	<p>1.1 MoH and DHS reports</p> <p>1.2 NLSS and other established surveys</p> <p>1.3 Health poverty indicator set based on existing data/ surveys and others developed under PMAS</p>	<ul style="list-style-type: none"> <li>• Sustained government commitment</li> <li>• Conflict situation does not deteriorate to the extent that it significantly impacts on service delivery and utilization</li> </ul>
<p><b>Output 2</b> Local bodies responsible and capable of managing health facilities in a participative, accountable and transparent way with effective support from the MoH and its sector partners. <i>(Responsibility: Chief Specialist PPICD and PHAME Division, MoH)</i></p>	<p>2.1 Decentralized management of health facilities and involvement of local bodies in planning health services in all districts in phases.</p> <p>2.2 Deconcentration of management to all Regions - at least 15 Districts by 2006 and 30 by 2009.</p> <p>2.3 5 Districts having their own five year plan including health by 2006.</p> <p>2.4 1800 sub health posts managed by health management committees by 2006</p>	<p>2.1DDC Annual Reports</p> <p>2.2District health profiles and plans</p>	<ul style="list-style-type: none"> <li>• Amendment of conflicting clauses in between LSGA and Health Act 1999</li> <li>• Local bodies are capable, responsible, representative and accountable</li> <li>• Resources are available from HMG and EDPs</li> <li>• DDCs and VDCs are elected and functional</li> </ul>

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Assumptions
<p><b>Output 3</b> The role of the private sector and NGOs in delivering health services recognised and developed with participative representation at all levels to ensure consumers have access to cost effective high quality services that offer value for money. <i>(Responsibility: PPICD, MoH)</i></p>	<p>3.1 System for Sector Dialogue working and effective.3.2 No of autonomous District Hospitals 5 by 2006, 10 by 2009.</p>	<p>3.1 Minutes of meetings. 3.2 Private, NGO, community contracts</p>	<ul style="list-style-type: none"> <li>Partners (EDPs, private sector, NGOs, etc) willing to cooperate.</li> <li>HMGN has political will to enforce the private sector regulation and QA</li> </ul>
<p><b>Output 4</b> Coordinated and consistent Sector Management (planning, programming, budgeting, financing and performance management) in place within the MoH supported by the EDPs, to support decentralised service delivery with the involvement of the NGO and private sectors <i>(Responsibility: PPICD, MoH)</i></p>	<p>4.1 Restructuring of MoH with deconcentration to Regional and District level - planned, agreed, implemented. 4.2 District based planning, budgeting and management established. 4.3 Sector wide policy discourse, planning and monitoring.</p>	<p>4.1 MoH Annual Reports 4.3 HEFU Reports 4.3 Joint Annual Review Reports 4.4 Mid Term review and Evaluation.</p>	<ul style="list-style-type: none"> <li>Harmonization of MoH and EDP relationship achieved.</li> <li>Cooperation between EDPs maintained and improved</li> </ul>
<p><b>Output 5</b> Sustainable development of health financing and resource allocation across the whole sector, including alternative financing schemes. <i>(Responsibility: Head of HEFU)</i></p>	<p>5.1 At least 10% of health expenditure borne by elected local bodies e.g. DDC, VDC, Municipalities in public health facilities by 2006/7; 5.2 At least 5% of health expenditure borne by local community in public health facilities by 2006/7 e.g. CDP, CHI 5.3 Increasing financial contribution from private sector5.4 Alternative health financing schemes established.</p>	<p>5.1 Annual budget of the government 5.2 Local bodies plans, budget and reports 5.3 Regional Directors and MoLD 5.4 Health institution records 5.5 National Health Accounts</p>	<ul style="list-style-type: none"> <li>Govt. gives priority to health sector programmes</li> <li>Local bodies are functional and districts plans prepared and implemented</li> <li>Alternative financing schemes are acceptable to the community</li> <li>Conducive environment is created for the participation of the private sector</li> </ul>
<p><b>Output 6</b> Structure and systems established and resources allocated within the MoH for the effective management of physical assets and procurement, distribution and rational use of drugs, supplies, and equipment. <i>(Responsibility: DG, DoHS, and Regional Directors)</i></p>	<p>6.1 Stock out of health commodities minimized with effective monitoring 6.2 Drug Financing Schemes developed in at least 10% districts by 2006/7 6.3 All procurement decisions are made based on information generated by LMIS by 2006/7</p>	<p>6.1 Facilities reports and inspections by District and Regional Managers 6.2 Maintenance records kept at facilities 6.3 LMIS generated procurement document</p>	<ul style="list-style-type: none"> <li>Political stability</li> <li>Adequate health budget is available</li> <li>Adequate deconcentrated management capacity</li> </ul>

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Assumptions
<p><b>Output 7</b>                      Clear and effective Human Resource Development policies, planning systems, and programmes developed and functional.  <i>(Responsibility: Chief, Human Resource and Financial Management Division, MoH)</i></p>	<p>7.1 50% of the public health facilities will have appropriate mix of HR by 2006/7                      7.2 Staff available to provide services in 35% at any given time                      7.3 HR Master plan updated and incorporated in HR management</p>	<p>7.1 Personal record HuRDIS report                      7.2 MoH HMIS and monitoring reports                      7.3 HMC report on attendance verification</p>	<ul style="list-style-type: none"> <li>• Health Service Act reformed</li> <li>• Health personnel willing to learn new skills and accept redefined roles</li> <li>• Management capacity enhanced and responsibilities delegated</li> </ul>
<p><b>Output 8</b>                      Comprehensive and integrated management information system for the whole health sector designed and functional at all levels with Quality Assurance (QA) operational across public and private sectors.  <i>(Responsibility: Director, Management Division, DoHS)</i></p>	<p>Comprehensive and integrated information system in place at all levels by 2007                      Quality Assurance Policy for public and private sectors created and implemented.</p>	<p>8.1 Operational tool in place at all level                      8.2 Annual performance document                      8.3 QA Policy doc.</p>	<ul style="list-style-type: none"> <li>• Political stability</li> <li>• Budget allocations grow</li> <li>• Appropriate skill mix of MoH management</li> </ul>

## Logical Framework for NHSP-IP Output 1: Essential Health Care Services

### THIS LOGFRAME TO BE MANAGED BY THE DIRECTOR-GENERAL, DOHS

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Assumptions
<p><b>Goal:</b> Increase the coverage and raise the quality of Essential Health Care Services (EHCS) with a special emphasis on improved access for poor and vulnerable groups through an efficient sector wide health management system developed with provision of adequate financial resources</p>	<p>1.1 Proportion of the population with access to responsive EHCS 1.2 Proportion of population utilising prioritized EHCS services. 1.3 Decentralisation of facility management 1.4 No of service delivery contracts with NGO and private sector 1.5 Percentage of expenditure born by locally generated resources. 1.6 Increased commitment of HMGN budget.</p>	<ul style="list-style-type: none"> <li>• DHS Annual Reports</li> <li>• NDHS</li> <li>• Service Delivery Survey</li> <li>• HEFU Reports</li> <li>• HSRU Reports</li> <li>• Annual Accounts</li> </ul>	<ul style="list-style-type: none"> <li>• Overall environment (social, political, economic) is stable</li> <li>• Strong political commitment</li> <li>• PRSP implemented</li> <li>• HMGN implements Decentralization</li> <li>• Senior management capacity and overall skill mix and staffing levels improve</li> <li>• Performance management effective.</li> </ul>
<p><b>Purpose</b> The priority elements of an Essential Health Care Service costed, allocated the necessary resources and implemented. Clear systems in place to ensure that the poor and vulnerable have priority for access. <i>(Responsibility: DG, DoHS)</i></p>	<ul style="list-style-type: none"> <li>• 50% of health facilities provide prioritized elements of EHCS by 2006/7 increasing to 75% in 2009.</li> <li>• 50% of population will be utilizing the prioritized services by 2006/7 increasing to 75% in 2009.</li> <li>• Proportion of poor and those in remote areas accessing skilled birth attendants increases.</li> <li>• Proportion of poor utilising EHCS with prepaid CHI with subsidised premium.</li> </ul>	<ul style="list-style-type: none"> <li>• MoH and DHS reports</li> <li>• NLSS and other established surveys</li> <li>• Health poverty indicator set based on existing data/surveys</li> </ul>	<ul style="list-style-type: none"> <li>• Sustained government commitment</li> <li>• Conflict situation does not deteriorate to the extent that it significantly impacts on service delivery and utilization</li> </ul>
<p><b>Output 1</b> Decreased unmet need for family planning services and reduced total fertility rate <i>(Responsibility: Director FHD)</i></p>	<ul style="list-style-type: none"> <li>• Reduction in TFR (see Health Sector Strategy Goal)</li> <li>• Increase in CPR</li> </ul>	<ul style="list-style-type: none"> <li>• HMIS</li> <li>• NHDS</li> <li>• FHD records</li> </ul>	
<p><b>Output 2</b> Reduced maternal and new-born mortality through increased coverage of quality antenatal, skilled attendance, newborn, postpartum and EOC. <i>(Responsibility: Director, FHD)</i></p>	<ul style="list-style-type: none"> <li>• % of births attended by skilled personnel</li> <li>• Number BEOC and CEOC facilities per 500,000 population</li> <li>• % all births in EmOC facilities- % of women having minimum of 4 ANC check ups</li> <li>• % of 15-44 women receiving TT vaccines</li> <li>• %FCHV Activities Complete</li> </ul>	<ul style="list-style-type: none"> <li>• HMIS</li> <li>• NHDS</li> <li>• MoH records</li> <li>• FHD records</li> <li>• Facility records</li> </ul>	
<p><b>Output 3</b> Reduced IMR and CMR due to respiratory, diarrhoeal and other child health illnesses and improve child survival through an integrated programme. <i>(Responsibility: Director, CHD)</i></p>	<ul style="list-style-type: none"> <li>• % of children with pneumonia who receive appropriate treatment</li> <li>• % of children with diarrhoea who receive appropriate treatment</li> </ul>	<ul style="list-style-type: none"> <li>• HMIS</li> <li>• NHDS</li> <li>• CHD records</li> <li>• Special facility, community and user/non-user surveys</li> </ul>	

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Assumptions
<p><b>Output 4</b> Reduced under-5 mortality due to vaccine preventable diseases and increased immunization coverage to over 90% for all vaccines in all districts and reduce mortality and morbidity from associated diseases. (Responsibility: Director, CHD Division)</p>	<ul style="list-style-type: none"> <li>• % of less than 1-year children immunised against measles</li> <li>• % of children completely immunised</li> </ul>	<ul style="list-style-type: none"> <li>• HMIS</li> <li>• NHDS</li> <li>• EPI records</li> <li>• Special facility, community and user/non-user surveys</li> </ul>	
<p><b>Output 5</b> Reduced under-5 mortality and nutritional deficiencies in children and adults through strengthening Vit A supplementation, eliminating iodine deficiency disorders, reduced rates of nutritional anaemia and protein energy malnutrition. (Responsibility: Director, CHD Division)</p>	<ul style="list-style-type: none"> <li>• % of Vitamin A &amp; iodine deficiency program coverage</li> <li>• % of malnourished children (among 3 years)</li> </ul>	<ul style="list-style-type: none"> <li>• HMIS</li> <li>• Nutrition Section records</li> <li>• NHDS</li> </ul>	
<p><b>Output 6</b> Reduced mortality, morbidity and transmission of tuberculosis to such a level that it no longer remains a public health problem. (Responsibility: Director, NTC)</p>	<ul style="list-style-type: none"> <li>• % reduction of TB prevalence rates</li> <li>• Case finding and cure rates</li> <li>• Short Course (DOTS) available to all patients</li> </ul>	<ul style="list-style-type: none"> <li>• NTC records</li> <li>• DOTS treatment centre records</li> </ul>	
<p><b>Output 7</b> The elimination of leprosy and related public health problem and establish leprosy free society. (Responsibility: Director, Leprosy Division)</p>	<ul style="list-style-type: none"> <li>• % reduction of leprosy prevalence rates</li> <li>• Case detection rate</li> </ul>	<ul style="list-style-type: none"> <li>• HMIS</li> <li>• Leprosy Division records</li> <li>• Treatment Facility records</li> </ul>	
<p><b>Output 8</b> Reduced the spread and its impact of HIV/AIDS/STI so as prevent a generalised epidemic and to care for those already infected to maintain a healthy life style of Nepalese population. (Responsibility: Director, NCASC)</p>	<ul style="list-style-type: none"> <li>• HIV prevalence rate in general population</li> <li>• HIV prevalence rate in high risk pop.</li> <li>• % of vulnerable population using condoms for safe sex</li> </ul>	<ul style="list-style-type: none"> <li>• HMIS</li> <li>• VCTC records</li> <li>• Sentinel surveillance records</li> <li>• ANC, blood screening and STI treatment centre records</li> <li>• Special surveys of high risk groups</li> </ul>	
<p><b>Output 9</b> Reduced infectious, emerging and re-emerging disease burden of the infectious diseases, zoonoses and snakebite targeting at the improvement of health status of the population working through community based actions and partnerships building. (Responsibility: Director, Epidemiology &amp; Disease Control Division)</p>	<ul style="list-style-type: none"> <li>• Reduce annual incidence of morbidity and mortality due to infectious disease</li> </ul>	<ul style="list-style-type: none"> <li>• HMIS</li> <li>• Special facility, community and user/non-user surveys</li> </ul>	

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Assumptions
<p><b>Output 10</b> Increased capacity of the health sector to mitigate health effects of disaster by rapid response to disaster situation and to prepare for and respond to the situation <i>(Responsibility: Director, Epidemeology &amp; Disease Control Division)</i></p>	<ul style="list-style-type: none"> <li>• % districts with integrated DHO inputs to disaster preparedness and disaster management plans</li> </ul>	<ul style="list-style-type: none"> <li>• District Disaster preparedness plans</li> </ul>	
<p><b>Output 11</b> Reduced mortality and morbidity from Vector borne diseases (VBDs) like malaria, kala-azar, Japanese encephalitis, Filariasis etc., prevent, and control outbreaks of the VBDs. <i>(Responsibility: Director, Epidemeology &amp; Disease Control Division)</i></p>	<ul style="list-style-type: none"> <li>• Reduced Annual Parasite Incidence (Malaria) and malaria deaths</li> <li>• Annual Incidence of Visceral Leshmaniasis, Japanese Encephalitis</li> <li>• Surveillance and treatment of Japanese Encephalitis</li> </ul>	<ul style="list-style-type: none"> <li>• HMIS</li> <li>• Facility, community and user/non-user surveys</li> <li>• Endemic area treatment facility records</li> </ul>	
<p><b>Output 12</b> Reduced mortality and morbidity from common, readily treatable outpatient conditions by providing appropriate (early diagnosis, prompt treatment and immediate referral) quality services to all patients reporting to any health facility or PHC outreach sites thereby contributing to reduced duration of illness, reduced mortality and improved quality of life. <i>(Responsibility: Chief Specialist, Curative Division, MoH)</i></p>	<ul style="list-style-type: none"> <li>• Total OPD new visits % of total</li> <li>• % of population having access to responsive EHCS</li> </ul>	<ul style="list-style-type: none"> <li>• HMIS</li> <li>• NHDS</li> <li>• Facility, community and user/non-user surveys</li> </ul>	
<p><b>Output 13</b> Improved health status of the people by promoting healthy behaviour and by supporting access to and utilization of quality services with active involvement of community people <i>(Responsibility: Director, NHIECC)</i></p>	<ul style="list-style-type: none"> <li>• Change in targeted KAPB</li> <li>• % of people aware on healthy behaviour</li> <li>• Increased in service utilization</li> </ul>	<ul style="list-style-type: none"> <li>• HMIS</li> <li>• NHDS</li> <li>• Facility, community and user/non-user surveys</li> </ul>	
<p><b>Activities</b> See Annual Work Plans and Budget sections X</p>			

## Logical Framework for NHSP-IP Output 2: Decentralised Management of Health Services.

### THIS LOGFRAME TO BE MANAGED BY THE CHIEF SPECIALIST, POLICY PLANNING AND INTERNATIONAL COOPERATION DIVISION AND PUBLIC HEALTH ADMINISTRATION, MONITORING AND EVALUATION DIVISION, MOH

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Assumptions
<p><b>Goal:</b> Increase the coverage and raise the quality of Essential Health Care Services (EHCS) with a special emphasis on improved access for poor and vulnerable groups through an efficient sector wide health management system developed with provision of adequate financial resources</p>	<p>1.1 Proportion of the population with access to responsive EHCS 1.2 Proportion of population utilising prioritized EHCS services. 1.3 Decentralisation of facility management 1.4 No of service delivery contracts with NGO and private sector 1.5 Percentage of expenditure born by locally generated resources. 1.6 Increased commitment of HMGN budget.</p>	<ul style="list-style-type: none"> <li>• DHS Annual Reports</li> <li>• NDHS</li> <li>• Service Delivery Survey</li> <li>• HEFU Reports</li> <li>• HSRU Reports</li> <li>• Annual Accounts</li> </ul>	<ul style="list-style-type: none"> <li>• Overall environment (social, political, economic) is stable</li> <li>• Strong political commitment</li> <li>• PRSP implemented</li> <li>• HMGN implements Decentralization</li> <li>• Senior management capacity and overall skill mix and staffing levels improve</li> <li>• Performance management effective.</li> </ul>
<p><b>Purpose</b> Local bodies responsible and capable of managing health facilities in a participative, accountable and transparent way with effective support from the MoH and its sector partners. <i>(Responsibility: Chief Specialist PPICD and PHAME Division, MoH)</i></p>	<ul style="list-style-type: none"> <li>• Number of health facilities managed by local health management committees</li> <li>• Number of Districts undertaking planning, budgeting and management of health services capable, responsible and accountable manner.</li> <li>• Number of districts will have their own five year plan including health</li> <li>• Number of Districts with fully deconcentrated management responsibilities providing effective support to local bodies health roles.</li> </ul>	<ul style="list-style-type: none"> <li>• DDC Annual Reports</li> <li>• District health profiles and plans</li> <li>• HMIS</li> <li>• MoH records</li> </ul>	<ul style="list-style-type: none"> <li>• Amendment of conflicting clauses in between LSGA and Health Act 1999</li> <li>• Local bodies are capable, representative and accountable</li> <li>• Resources are available from HMG and EDPs</li> <li>• DDCs are functional</li> <li>• There is demand among hospitals to become autonomous.</li> <li>• Hospitals have the management capacity to function successfully as autonomous institutions.</li> </ul>
<p><b>Output 1</b> A realistic strategic plan and timeframe (that specifically address constraints inherent in the present security situation) for extending devolution of health service management and projections of human resource and capacity development needs to allow local planning, management and monitoring of EHCS in line with LSGA and MoH decentralisation plan. <i>(Responsibility: PHAME Division, MoH)</i></p>	<ul style="list-style-type: none"> <li>• Five year rolling plan (that specifically addresses constraints inherent in the present security situation) for extending devolved health service management developed and endorsed by MoH by July 2005.</li> <li>• Number of Districts with Plan implemented.</li> </ul>	<ul style="list-style-type: none"> <li>• MoH plan</li> <li>• DDC records</li> </ul>	

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Assumptions
<p><b>Output 2</b>                      Sub Health Post management decentralised to VDCs  <i>(Responsibility: PHAME Division, MoH)</i></p>	<ul style="list-style-type: none"> <li>• Number Sub Health posts formally handed over to VDCs</li> </ul>	<ul style="list-style-type: none"> <li>• MoH records</li> <li>• DDC and VDC records</li> </ul>	<ul style="list-style-type: none"> <li>• VDCs willing to manage Sub Health Centres</li> <li>• VDCs are capable of managing Sub Health Centres</li> </ul>
<p><b>Output 3</b>                      District hospitals establish Hospital Development Boards  <i>(Responsibility: PHAME Division, MoH)</i></p>	<ul style="list-style-type: none"> <li>• Number of District Hospital Development boards meeting monthly.</li> </ul>	<ul style="list-style-type: none"> <li>• DH records</li> </ul>	
<p><b>Output 4</b>                      Hospital autonomy  <i>(Responsibility: PHAME Division, MoH)</i></p>	<ul style="list-style-type: none"> <li>• Number of hospitals registered as autonomous.</li> </ul>	<ul style="list-style-type: none"> <li>• MoH records</li> </ul>	<ul style="list-style-type: none"> <li>• Hospitals wish to be autonomous and have the capacity to function autonomously</li> </ul>
<p><b>Activities</b>                      See Annual Work Plans and Budgets</p>			

**Logical Framework for NHSP-IP Output 3: Public Private Partnerships.**
**THIS LOGFRAME TO BE MANAGED BY THE CHIEF SPECIALIST, PPICD, MOH**

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Assumptions
<p><b>Goal:</b> Increase the coverage and raise the quality of Essential Health Care Services (EHCS) with a special emphasis on improved access for poor and vulnerable groups through an efficient sector wide health management system developed with provision of adequate financial resources</p>	<p>1.1 Proportion of the population with access to responsive EHCS 1.2 Proportion of population utilising prioritized EHCS services. 1.3 Decentralisation of facility management 1.4 No of service delivery contracts with NGO and private sector 1.5 Percentage of expenditure born by locally generated resources. 1.6 Increased commitment of HMGN budget.</p>	<ul style="list-style-type: none"> <li>• DHS Annual Reports</li> <li>• NDHS</li> <li>• Service Delivery Survey</li> <li>• HEFU Reports</li> <li>• HSRU Reports</li> <li>• Annual Accounts</li> </ul>	<ul style="list-style-type: none"> <li>• Overall environment (social, political, economic) is stable</li> <li>• Strong political commitment</li> <li>• PRSP implemented</li> <li>• HMGN implements Decentralization</li> <li>• Senior management capacity and overall skill mix and staffing levels improve</li> <li>• Performance management effective.</li> </ul>
<p><b>Purpose</b> The role of the private sector and NGOs in the delivery of health services recognised and developed with participative representation at all levels which ensures consumers get access to cost effective high quality services that offer value for money. <i>(Responsibility: Chief Specialist, PPICD, MoH)</i></p>	<ul style="list-style-type: none"> <li>• Redefined partnership roles and responsibilities in MoH and the departments' document.</li> <li>• Number of service delivery agreements with the private sector and NGOs.</li> </ul>	<ul style="list-style-type: none"> <li>• MoH Documents</li> <li>• Private/NGO contracts</li> </ul>	<ul style="list-style-type: none"> <li>• Partners (EDPs, private sector, NGOs, etc) willing or institutionally able to cooperate.</li> <li>• HMGN has political will to enforce the private sector regulation</li> </ul>
<p><b>Output 1</b> A coordinating body (with legal and contract management capacity) established within MoH, including other stakeholders, to coordinate, manage and monitor NGO and private sector partnerships which has the necessary legal and contract management expertise.</p>	<p>1.1 Coordinating body established and meeting monthly by Sept 2004</p>	<ul style="list-style-type: none"> <li>• MoH records</li> <li>• MoH meeting minutes</li> </ul>	<ul style="list-style-type: none"> <li>• Stakeholders wish to participate</li> </ul>
<p><b>Output 2</b> A realistic strategic plan and timeframe and regulatory framework produced by MoH and key stakeholders for the future development and extension of partnerships between MoH, NGOs and the Private Sector.</p>	<p>2.1 Strategic plan produced and endorsed by MoH by July 2005. 1.2 Plan implemented with "first wave" selected NGO and private sector partners by July 2006.</p>	<ul style="list-style-type: none"> <li>• MoH records</li> </ul>	<ul style="list-style-type: none"> <li>• MoH can implement a regulatory framework</li> </ul>

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Assumptions
<p><b>Output 3</b> More harmonised EDP procedures for partnerships with NGOs and the Private Sector</p>	<p>3.1 Number of EDPs whose financial contributions to partnerships are made directly through MoH budget (even if initially these are earmarked).</p> <p>3.2 Number of EDPs using harmonised reporting and management procedures.</p>	<ul style="list-style-type: none"> <li>• EDP/MoH records</li> <li>• EDP/MoH records</li> </ul>	
<p><b>Output 4</b> Service provider agreements in place for all forms of partnerships including those enabling transfer of public resources to NGOs and the Private Sector.</p>	<p>4.1 Service Provider agreements designed and endorsed by July 2008</p> <p>4.2 Service provider agreements operational by July 2009</p>	<ul style="list-style-type: none"> <li>• EDP/MoH records</li> <li>• EDP/MoH records</li> </ul>	
<p><b>Activities</b> As defined in Annual Work Plans and Budgets</p>			

## Logical Framework for NHSP-IP Output 4: Sector Management

### THIS LOGFRAME TO BE MANAGED BY THE CHIEF SPECIALIST, PPICD, MOH

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Assumptions
<p><b>Goal:</b> Increase the coverage and raise the quality of Essential Health Care Services (EHCS) with a special emphasis on improved access for poor and vulnerable groups through an efficient sector wide health management system developed with provision of adequate financial resources</p>	<p>1.1 Proportion of the population with access to responsive EHCS</p> <p>1.2 Proportion of population utilising prioritized EHCS services.</p> <p>1.3 Decentralisation of facility management</p> <p>1.4 No of service delivery contracts with NGO and private sector</p> <p>1.5 Percentage of expenditure born by locally generated resources.</p> <p>1.6 Increased commitment of HMGN budget.</p>	<ul style="list-style-type: none"> <li>• DHS Annual Reports</li> <li>• NDHS</li> <li>• Service Delivery Survey</li> <li>• HEFU Reports</li> <li>• HSRU Reports</li> <li>• Annual Accounts</li> </ul>	<ul style="list-style-type: none"> <li>• Overall environment (social, political, economic) is stable</li> <li>• Strong political commitment</li> <li>• PRSP implemented</li> <li>• HMGN implements Decentralization</li> <li>• Senior management capacity and overall skill mix and staffing levels improve</li> <li>• Performance management effective.</li> </ul>
<p><b>Purpose</b> Coordinated and consistent Sector Management (planning, programming, budgeting, financing and performance management) in place within the MoH supported by the EDPs, to support decentralised service delivery with the involvement of the NGO and private sectors <i>(Responsibility: Chief Specialist, PPICD, MoH)</i></p>	<ul style="list-style-type: none"> <li>• Partnership policy and framework document.</li> <li>• Number of joint annual planning and review.</li> </ul>	<ul style="list-style-type: none"> <li>• Partnership policy document</li> <li>• Joint Annual Review Reports</li> </ul>	<ul style="list-style-type: none"> <li>• Cooperation between MoH and EDPs maintained.</li> <li>• Cooperation between EDPs maintained and improved</li> </ul>

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Assumptions
<p><b>Output 1</b> A clear locus of responsibility for cross-cutting sector management issues identified within MoH.</p>	<ul style="list-style-type: none"> <li>Responsibility assigned by June 2004.</li> </ul>	<ul style="list-style-type: none"> <li>MoH meeting minutes</li> </ul>	
<p><b>Output 2</b> Health Sector Reform Unit terms of reference and organisational position finalised</p>	<ul style="list-style-type: none"> <li>ToRs approved by MoH</li> </ul>	<ul style="list-style-type: none"> <li>MoH records</li> </ul>	
<p><b>Output 3</b> A detailed organisational analysis of MoH, including Human Resource systems (output 7 logframe), information systems and partnerships at all levels.</p>	<ul style="list-style-type: none"> <li>Scope of analysis agreed with MoH and stakeholders, divided appropriately and studies commissioned by July 2005.</li> </ul>	<ul style="list-style-type: none"> <li>Terms of reference for contracting agency finalised</li> <li>Contract</li> </ul>	
<p><b>Output 4</b> A plan and timescale for restructuring to ensure strengthened planning, programming, budgeting, monitoring and decentralised management.</p>	<ul style="list-style-type: none"> <li>Restructuring plan and timescale produced and endorsed by MoH by July 2006</li> <li>Phase 1 of plan implemented by July 2007.</li> </ul>	<ul style="list-style-type: none"> <li>MoH records</li> </ul>	
<p><b>Output 5</b> Efficiency savings identified and factored into future projections of resource envelope (see output 5 logframe)</p>	<ul style="list-style-type: none"> <li>MTEF includes projected efficiency savings in resource envelope by July 2005</li> </ul>	<ul style="list-style-type: none"> <li>MTEF</li> </ul>	
<p><b>Activities</b> As defined in Annual Work Plan and Budgets</p>			

## Logical Framework for NHSP-IP Output 5: Health Financing and Resource Allocation.

### THIS LOGFRAME TO BE MANAGED BY HEAD OF HEFU, MOH

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Assumptions
<p><b>Goal:</b> Increase the coverage and raise the quality of Essential Health Care Services (EHCS) with a special emphasis on improved access for poor and vulnerable groups through an efficient sector wide health management system developed with provision of adequate financial resources</p>	<p>1.1 Proportion of the population with access to responsive EHCS 1.2 Proportion of population utilising prioritized EHCS services. 1.3 Decentralisation of facility management 1.4 No of service delivery contracts with NGO and private sector 1.5 Percentage of expenditure born by locally generated resources. 1.6 Increased commitment of HMGN budget.</p>	<ul style="list-style-type: none"> <li>• DHS Annual Reports</li> <li>• NDHS</li> <li>• Service Delivery Survey</li> <li>• HEFU Reports</li> <li>• HSRU Reports</li> <li>• Annual Accounts</li> </ul>	<ul style="list-style-type: none"> <li>• Overall environment (social, political, economic) is stable</li> <li>• Strong political commitment</li> <li>• PRSP implemented</li> <li>• HMGN implements Decentralization</li> <li>• Senior management capacity and overall skill mix and staffing levels improve</li> <li>• Performance management effective.</li> </ul>
<p><b>Purpose</b> Sustainable development of health financing and resource allocation across the whole sector, including alternative financing schemes in place. <i>(Responsibility: Head of HEFU, MoH)</i></p>	<ul style="list-style-type: none"> <li>• At least 10% of health expenditure borne by elected local bodies e.g. DDC, VDC, Municipalities in public health facilities by 2006/7;</li> <li>• At least 5% of health expenditure borne by local community in public health facilities by 2006/7 e.g. CDP, CHI</li> <li>• X % of contribution from private sector</li> <li>• X% of target population served under alternative health financing schemes</li> <li>• X% of the target population access to affordable and quality care</li> </ul>	<ul style="list-style-type: none"> <li>• Annual budget of the government</li> <li>• Local bodies plan and Financial Reports</li> <li>• Community Survey</li> <li>• Health institution records</li> <li>• National health account estimates</li> </ul>	<ul style="list-style-type: none"> <li>• Govt. gives priority to health sector programs</li> <li>• Local bodies are functional and districts plans prepared, implemented</li> <li>• Alternative financing schemes are acceptable to the community</li> <li>• Conducive environment is created for the participation of the private sector</li> </ul>
<p><b>Output 1</b> An MTEF extended to include projections for year 2005/06</p>	<ul style="list-style-type: none"> <li>• MTEF revised to include projections for year 2005/6 by July 2004</li> </ul>	<ul style="list-style-type: none"> <li>• MoH, Min of Finance, EDPs</li> </ul>	
<p><b>Output 2</b> An MTEF that includes projections of future efficiency savings identified by organisational review <i>(see Output 4 logframe)</i></p>	<ul style="list-style-type: none"> <li>• Efficiency savings projections factored into MTEF by July 2005</li> </ul>	<ul style="list-style-type: none"> <li>• MoH, EDPs</li> </ul>	
<p><b>Output 3</b> Increased proportion of resources allocated to ECHS and away from secondary and tertiary care.</p>	<ul style="list-style-type: none"> <li>• Tertiary spend proportion frozen from 2006</li> <li>• Resources allocated to ECHS rise</li> </ul>	<ul style="list-style-type: none"> <li>• MoH budget and Min of Fin records</li> </ul>	
<p><b>Output 4</b> MoH resource allocation formulae redesigned to be based more on need and addressing equity of access rather than historical patterns</p>	<ul style="list-style-type: none"> <li>• A resource allocation system designed and piloted by 2008</li> </ul>	<ul style="list-style-type: none"> <li>• MoH finance records</li> <li>• DHO and District Hospital records</li> </ul>	

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Assumptions
<b>Output 5</b> Alternative financing and safety net arrangements to protect the most vulnerable.	<ul style="list-style-type: none"> <li>Alternative financing and safety net arrangements piloted by 2007</li> </ul>	<ul style="list-style-type: none"> <li>MoH records</li> </ul>	
<b>Output 6</b> National guidelines for user fee practices	<ul style="list-style-type: none"> <li>National guidelines produced and adopted by MoH by 2007</li> </ul>	<ul style="list-style-type: none"> <li>MoH records</li> </ul>	
<b>Output 7</b> Social and community health insurance schemes.	<ul style="list-style-type: none"> <li>Different models of social and community health insurance schemes designed and piloted by 2007</li> </ul>	<ul style="list-style-type: none"> <li>MoH records</li> <li>Community surveys</li> </ul>	
<b>Activities</b> As defined in Annual Work Plan and Budgets			

## Logical Framework for NHSP-IP Output 6: Physical Asset and Procurement Management.

### THIS LOGFRAME TO BE MANAGED BY DG, DOHS AND REGIONAL HEALTH DIRECTORATES

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Assumptions
<b>Goal:</b> Increase the coverage and raise the quality of Essential Health Care Services (EHCS) with a special emphasis on improved access for poor and vulnerable groups through an efficient sector wide health management system developed with provision of adequate financial resources	1.1 Proportion of the population with access to responsive EHCS 1.2 Proportion of population utilising prioritized EHCS services. 1.3 Decentralisation of facility management 1.4 No of service delivery contracts with NGO and private sector 1.5 Percentage of expenditure born by locally generated resources. 1.6 Increased commitment of HMGN budget.	<ul style="list-style-type: none"> <li>DHS Annual Reports</li> <li>NDHS</li> <li>Service Delivery Survey</li> <li>HEFU Reports</li> <li>HSRU Reports</li> <li>Annual Accounts</li> </ul>	<ul style="list-style-type: none"> <li>Overall environment (social, political, economic) is stable</li> <li>Strong political commitment</li> <li>PRSP implemented</li> <li>HMGN implements Decentralization</li> <li>Senior management capacity and overall skill mix and staffing levels improve</li> <li>Performance management effective.</li> </ul>
<b>Purpose</b> Structure and systems established and resources allocated within the MoH for the effective management of physical assets and procurement, distribution and rational use of drugs, supplies, and equipment to ensure continuous availability of essential drugs, equipment and medical supplies in all health facilities maintained to MoH norms and standards. (Responsibility: DG, DoHS and Regional Directorates)	<ul style="list-style-type: none"> <li>Stock outs of ECHS indicator health commodities fall</li> <li>Drug Financing Schemes are implemented in at least 50% districts by 2006/7</li> <li>Procurement decisions are made based on information generated by LMIS by 2006/7</li> </ul>	<ul style="list-style-type: none"> <li>Facilities' reports and inspections</li> <li>Maintenance records kept at facilities</li> <li>LMIS generated procurement document</li> </ul>	<ul style="list-style-type: none"> <li>Political stability</li> <li>Adequate health budget is available</li> </ul>

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Assumptions
<p><b>Output 1</b> Effective, efficient and transparent procurement policies and capacities at central and local levels.</p>	<ul style="list-style-type: none"> <li>• Present systems reformed by 2008</li> </ul>	<ul style="list-style-type: none"> <li>• MoH records</li> <li>• LMD records</li> </ul>	
<p><b>Output 2</b> A responsive and decentralised commodity distribution system</p>	<ul style="list-style-type: none"> <li>• Annual indent essential drug procurement system converted from a "push" to a "pull" system by 2006</li> </ul>	<ul style="list-style-type: none"> <li>• LMD and MoH records</li> <li>• Facility records</li> <li>• Surveys of target facilities</li> </ul>	
<p><b>Output 3</b> An efficient and effective drug financing mechanism</p>	<ul style="list-style-type: none"> <li>• Drug financing mechanisms implemented at central and peripheral levels by 2007.</li> </ul>	<ul style="list-style-type: none"> <li>• MoH records</li> <li>• DDA records</li> </ul>	
<p><b>Output 4</b> A National drug policy</p>	<ul style="list-style-type: none"> <li>• Drug policy developed and implemented by 2007</li> </ul>	<ul style="list-style-type: none"> <li>• MoH</li> </ul>	
<p><b>Output 5</b> A responsive and effective logistics and management system</p>	<ul style="list-style-type: none"> <li>• LMIS with decentralised data processing at district level implemented by 2008</li> </ul>	<ul style="list-style-type: none"> <li>• LMD, MoH and DDA records</li> </ul>	
<p><b>Output 6</b> A restructured LMD within present personnel ceiling.</p>	<ul style="list-style-type: none"> <li>• HR Review of LMD as part of overall HMG HR review by 2005 (see output 7 logframe)</li> <li>• LMD restructured to ensure an integrated logistics, HR and organisational structure to ensure commodity availability and rational drug use by 2006</li> </ul>	<ul style="list-style-type: none"> <li>• Review</li> <li>• LMD records</li> </ul>	
<p><b>Output 7</b> A responsive disaster relief commodities management system</p>	<ul style="list-style-type: none"> <li>• LMD given responsibility for disaster relief commodities and system integrated by 2007.</li> </ul>	<ul style="list-style-type: none"> <li>• MoH LMD</li> </ul>	
<p><b>Output 8</b> Quality and safety systems.</p>	<ul style="list-style-type: none"> <li>• Practical plans developed and implemented for the disposal of biomedical waste at all levels by 2008</li> </ul>	<ul style="list-style-type: none"> <li>• MoH</li> </ul>	
<p><b>Activities</b> As defined in Annual Work Plan and Budgets</p>			

**Logical Framework for NHSP-IP Output 7: Human Resource Policy and Management.**
**THIS LOGFRAME TO BE MANAGED BY CHIEF, HUMAN RESOURCE AND FINANCIAL MANAGEMENT DIVISION, MOH**

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Assumptions
<p><b>Goal:</b> Increase the coverage and raise the quality of Essential Health Care Services (EHCS) with a special emphasis on improved access for poor and vulnerable groups through an efficient sector wide health management system developed with provision of adequate financial resources</p>	<p>1.1 Proportion of the population with access to responsive EHCS 1.2 Proportion of population utilising prioritized EHCS services. 1.3 Decentralisation of facility management 1.4 No of service delivery contracts with NGO and private sector 1.5 Percentage of expenditure born by locally generated resources. 1.6 Increased commitment of HMGN budget.</p>	<ul style="list-style-type: none"> <li>• DHS Annual Reports</li> <li>• NDHS</li> <li>• Service Delivery Survey</li> <li>• HEFU Reports</li> <li>• HSRU Reports</li> <li>• Annual Accounts</li> </ul>	<ul style="list-style-type: none"> <li>• Overall environment (social, political, economic) is stable</li> <li>• Strong political commitment</li> <li>• PRSP implemented</li> <li>• HMGN implements Decentralization</li> <li>• Senior management capacity and overall skill mix and staffing levels improve</li> <li>• Performance management effective.</li> </ul>
<p><b>Purpose</b> Clear and effective Human Resource Development policies, planning systems, and programmes developed and functional. (Responsibility: Chief, Human Resources and Financial Management Division, MoH)</p>	<ul style="list-style-type: none"> <li>• % of public health facilities will have appropriate mix of HR by 2006/7</li> <li>• Staff available to provide services at any given time</li> <li>• HR Master plan updated and incorporated in HR management</li> </ul>	<ul style="list-style-type: none"> <li>• Personal record HuRDIS report</li> <li>• Periodic survey</li> <li>• HMC report on attendance verification</li> </ul>	<ul style="list-style-type: none"> <li>• Health service act reform is expedited</li> <li>• Health personnel willing to learn new skills and accept redefined roles</li> </ul>
<p><b>Output 1</b> See output 4 and 6 logframes A detailed organisational analysis of MoH (in combination with Human Resource systems, information systems and partnerships) at all levels.</p>	<ul style="list-style-type: none"> <li>• Scope of analysis agreed with MoH and stakeholders, divided appropriately and studies commissioned by July 2005.</li> </ul>	<ul style="list-style-type: none"> <li>• MoH</li> <li>• ToRs</li> <li>• Contract</li> </ul>	
<p><b>Output 2</b> A plan and timescale for restructuring HR systems.</p>	<ul style="list-style-type: none"> <li>• A restructuring HR master plan and timescale produced, endorsed by MoH and implemented by July 2006</li> </ul>	<ul style="list-style-type: none"> <li>• MoH</li> </ul>	
<p><b>Output 3</b> HRD unit reform and placement, (MD, HRD)</p>	<ul style="list-style-type: none"> <li>• HRD unit reformed and relocated within MoH by 2005</li> </ul>	<ul style="list-style-type: none"> <li>• MoH</li> <li>• ToRs for unit endorsed</li> </ul>	<ul style="list-style-type: none"> <li>• Significant HR restructuring is acceptable to MoH and possible within Civil Service regulations</li> </ul>
<p><b>Output 4</b> A functional Training Information Management System (HRD Unit/NHTC)</p>	<ul style="list-style-type: none"> <li>• TIMS redesigned to include all major training course data by 2005</li> </ul>	<ul style="list-style-type: none"> <li>• TIMS</li> </ul>	<ul style="list-style-type: none"> <li>• HRD unit reformed, functional and has sufficient authority</li> </ul>
<p><b>Output 5</b> Transparent and consistent application of personnel policies and rules (HRD unit)</p>	<ul style="list-style-type: none"> <li>• % of transfers and postings in line with published policies and rules</li> </ul>	<ul style="list-style-type: none"> <li>• Independent staff and personnel record surveys</li> </ul>	

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Assumptions
<p><b>Output 6</b> Training coordination and quality (HRD, NHTC)</p>	<ul style="list-style-type: none"> <li>• Medium term training strategies developed for AWPB by all Divisions and centres and reviewed by NHTC for consistency with HNRP-IP goals by 2005</li> </ul>	<ul style="list-style-type: none"> <li>• NHTC and HRD records</li> </ul>	
<p><b>Output 7</b> An integrated network established of appraised and accredited pre-service education resources covering MoH, CTEVT, NGOs and the Private Sector facilities. (MoE, CTVET, NGOs, CTVET)</p>	<ul style="list-style-type: none"> <li>• All training facilities appraised by 2006</li> <li>• A mechanism established to allow MoH, MoE, NGOs, CTVET and HRD Unit to respond to projected health personnel needs by 2007</li> </ul>	<ul style="list-style-type: none"> <li>• National training resource for health directory</li> <li>• MoH records</li> </ul>	
<p><b>Activities</b> As defined in Annual Work Plan and Budgets</p>			

## Logical Framework for NHSP-IP Output 8: Integrated MIS and QA

### THIS LOGFRAME TO BE MANAGED BY THE DIRECTOR, MANAGEMENT DIVISION, DOHS

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Assumptions
<p><b>Goal:</b> Increase the coverage and raise the quality of Essential Health Care Services (EHCS) with a special emphasis on improved access for poor and vulnerable groups through an efficient sector wide health management system developed with provision of adequate financial resources</p>	<ol style="list-style-type: none"> <li>1.1 Proportion of the population with access to responsive EHCS</li> <li>1.2 Proportion of population utilising prioritized EHCS services.</li> <li>1.3 Decentralisation of facility management</li> <li>1.4 No of service delivery contracts with NGO and private sector</li> <li>1.5 Percentage of expenditure born by locally generated resources.</li> <li>1.6 Increased commitment of HMGN budget.</li> </ol>	<ul style="list-style-type: none"> <li>• DHS Annual Reports</li> <li>• NDHS</li> <li>• Service Delivery Survey</li> <li>• HEFU Reports</li> <li>• HSRU Reports</li> <li>• Annual Accounts</li> </ul>	<ul style="list-style-type: none"> <li>• Overall environment (social, political, economic) is stable</li> <li>• Strong political commitment</li> <li>• PRSP implemented</li> <li>• HMGN implements Decentralization</li> <li>• Senior management capacity and overall skill mix and staffing levels improve</li> <li>• Performance management effective.</li> </ul>
<p><b>Purpose:</b> 1. Comprehensive and integrated management information system for the whole health sector designed and functional at all levels. 2. Quality Assurance (QA) operational across public and private sectors (Responsibility, Director Management Division, DoHS)</p>	<ol style="list-style-type: none"> <li>1. Comprehensive and integrated information system in place at all levels by 2007</li> <li>2. Quality Assurance Policy for public and private sectors created and implemented.</li> </ol>	<ul style="list-style-type: none"> <li>• Operational tool in place at all level</li> <li>• Annual performance document</li> <li>• QA Policy doc.</li> </ul>	<ul style="list-style-type: none"> <li>• Political stability</li> <li>• Adequate health budget is available</li> </ul>

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Assumptions
<p><b>Output 1:</b> Strengthened current HMIS and appropriate IT to establish a comprehensive health information system providing accurate, timely and relevant information that supports to decision making</p>	<ul style="list-style-type: none"> <li>• Information needs mapped and indicators finalised by July 2005</li> <li>• Existing HMIS strengthened and expanded to integrate all other MISs designed and piloted at central and district level July 2006.</li> <li>• Integrated HMIS adjusted in light of pilot field experience and rolling implementation plan started by July 2007.</li> <li>• Number of districts using integrated HMIS and IT for information management</li> </ul>	<ul style="list-style-type: none"> <li>• MD records</li> <li>• MD and district records and HMIS returns</li> <li>• HMIS</li> </ul>	<ul style="list-style-type: none"> <li>• Wholesale integration of MISs is feasible</li> <li>• There is a body that regularly reviews and recommends changes to HMIS</li> </ul>
<p><b>Output 2:</b> To ensure appropriate policies are in place and standards are practiced, a conducive working environment is created, and the client's needs for better health are satisfied.</p>	<ul style="list-style-type: none"> <li>• % of health facilities providing minimum level of acceptable standards of quality EHCS</li> </ul>	<ul style="list-style-type: none"> <li>• Facility records</li> <li>• Special community user and non user surveys</li> <li>• MoH Supervision records</li> </ul>	
<p><b>Activities:</b> As included in the Annual Work Plan and Budgets</p>			

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