Nepal Health Sector Support Programme (NHSSP 3) – No Cost Extension

ROLL-OUT STATUS ASSESSMENT OF FINANCIAL MANAGEMENT IMPROVEMENT PLAN AND PROCUREMENT IMPROVEMENT PLAN IN IMADHESH AND LUMBINI PROVINCES

CONTENTS

ABBREVIATIONS

ADRA	:	Adventist Development and Relief Agency
AMC	:	Annual Maintenance Contract
APP	:	Annual Procurement Plan
AWPB	:	Annual Work Plan and Budget
BEK	:	British Embassy in Kathmandu
BHS	:	Basic Health Service
BMET	:	Biomedical Equipment Technician
CAPP	:	Consolidated Annual Procurement Plan
CGAS	:	Computerised Government Accounting Software
CIPFA	:	Chartered Institute of Public Finance and Accountancy
CMC	:	Comprehensive Maintenance Contract
CMS	:	Contract Management System
CSD	:	Curative Service Division
DDA	:	Department of Drug Administration
DoHS	:	Department of Health Services
DTCO	:	District Treasury Controller's Office
DUDBC	:	Department of Urban Development and Building Construction
e-CAPP	:	Electronic Consolidated Annual Procurement Plan
EDP	:	External Development Partners
e-GP	:	Electronic Government Procurement
e-LMIS	:	Electronic Logistics Management Information System
EMR	:	Electronic Medical Record
F/PLG	:	Federal/Provincial and Local Government
F/PMoF	:	Federal/Provincial Ministry of Finance
FCGO	:	Financial Comptroller's General Office
FEFO	:	First Expiry First Out
FMIP	:	Financial Management Improvement Plan
FMoHP	:	Federal Ministry of Health and Population
FPA	:	Financial Procedure Act
FPFAA/R	:	Financial Procedure and Fiscal Accountability Act/Regulation
FY	:	Fiscal Year
GHRM	:	Grievance Handling and Redressal Mechanism
GIZ	:	Deutsche Gesellschaft für Internationale Zusammenarbeit
GoN	:	Government of Nepal
HF/I/O	:	Health Facility/Institution/Office
HMIS	:	Health Management Information System
ICT	:	Information and Communications Technology
IMF	:	International Monetary Fund

LMIS	:	Logistics Management Information System
LMS	:	Logistics Management Section
MD	:	Management Division
MOOC	:	Massive Open Online Course
MTEF	:	Medium-term Expenditure Framework
NHSSP	:	Nepal Health Sector Support Programme
NPR	:	Nepalese Rupees
OAGN	:	Office of the Auditor General Nepal
OCMCM	:	Office of the Chief Minister and Council of Ministers
PAC	:	Public Account Committee
PAMS	:	Public Asset Management System
PE	:	Procurement Entity
PEFA	:	Public Expenditure and Financial Accountability
PFM	:	Public Financial Management
PFMSF	:	Public Financial Management Strategic Framework
PHD	:	Provincial Health Directorate
PHLMC	:	Provincial Health Logistics Management Centre
PHTC	:	Provincial Health Training Centre
PIP	:	Procurement Improvement Plan for Medicine and Medical Goods
PLAMAHS	:	Planning and Management of Assets in Health Sector
PLG	:	Provincial and Local Governments
PLMBIS	:	Provincial Line Ministry Budget Information System
PMoH	:	Provincial Ministry of Health
PPA/R	:	Public Procurement Act/Regulation
PPFM	:	Procurement and Public Financial Management
PPHL	:	Provincial Public Health Laboratory
PPMD	:	Policy, Planning and Monitoring Division
PPMO	:	Public Procurement Monitoring Office
PPSF	:	Public Procurement Strategic Framework
PTCO	:	Provincial Treasury Controller Office
P-TSA	:	Provincial Treasury Single Account
SBD	:	Standard Bidding Document
SDG	:	Sustainable Development Goal
SuTRA	:	Sub-National Treasury Regulatory Application
TSB	:	Technical Specifications Bank
USAID	:	United States Agency for International Development
VfM	:	Value for Money
WB	:	World Bank
WHO	:	World Health Organization

EXECUTIVE SUMMARY

Introduction

A sound public financial management (PFM) system is vital for delivering public goods and services effectively. PFM helps governments plan, deploy, and evaluate financial resources to drive social and economic development programmes. Procurement in health refers to the process of acquiring medical supplies, construction works and services. The complex nature of public financing processes and procurement activities and their interaction with the political economy, can challenge even well-intentioned governments in having an effective Procurement and Public Financial Management (PPFM) system.

Strengthening PPFM in the health sector is crucial for effective health systems reforms in Nepal. Limited fiscal space and capacity constraints have made it challenging for provincial governments to shape their policies, programmes and institutions. To address this, provinces have developed the Financial Management Improvement Plan (FMIP), 2022/23-2026/27 and Procurement Improvement Plan (PIP), 2022/23-2026/27. These are basically roadmaps aim to improve financial management and procurement in various health spending units and facilitate coordination between all three tiers of governments, finance and health ministries, External Development Partners (EDPs) and citizens. These plans are anchored in a broader PFM cycle, and were formulated based on two important federal frameworks, viz. Public Financial Management Strategic Framework (PFMSF), 2020/21-2024/25 and Public Procurement Strategic Framework (PPSF), 2022/23-2026/27, which aim to improve broader budgetary governance in the health sector.

Provincial Ministries of Health (MoHs) need to track the rollout status of the FMIP and PIP, take stock of progress annually and undertake timely corrective measures in critical areas of concern. The UK funded Nepal Health Sector Support Programme (NHSSP), technical assistance team, embedded within the Ministry of Health & Population (MoHP) and Lumbini and Madhesh Provinces, has been supporting them to undertake this. This report is based on this support to monitoring of the implementation and presents the progress of FMIP and PIPs in Madhesh and Lumbini provinces, by assessing performance against the benchmarks within the plans, and by tracking the implementation of activities over the fiscal year 2022/23. The report also presents key issues and bottlenecks faced in executing the plans during the first fiscal year and recommends way ahead.

A qualitative approach was used to track, gather and analyse data on the roll-out of FMIP and PIPs in both Lumbini and Madhesh provinces. This included tracking of activity implementation frameworks using a colour coding scheme and rating; consultation with key government officials from finance and health ministries and several other stakeholders; interviews with a purposively selected sample of health sector officials and providers and financial officials; desk review of various federal, provincial, and local government documents; and a validation workshop and policy discussion at provincial levels.

FMIP progress

An analysis of the progress of the two provinces against the seven critical dimensions (also known as outputs) and key intervention areas/activities of the FMIP, shows mixed progress in both provinces. Colour codes were used to offer a quick snapshot of the status of various activities, with ‘Green’ indicating successful implementation, ‘Blue’ signifying ongoing efforts,

and ‘Red’ highlighting areas that still require attention (See Section 3.8 for the Table). The main outputs of FMIP are:

Output 1: Improvement in Budget and Programme Formulation
Output 2: Strengthen the Internal Control System
Output 3: Improvement in Financial and Management Accounting
Output 4: Improvement in Public Procurement Management
Output 5: Auditing and External Scrutiny
Output 6: Improvement in Asset Management System
Output 7: Improvement of Institutional and Human Resource Capacity.

In Output 1, both provinces show mixed progress, with similar number of activities across the three colour codes. This suggests that provincial MoHs have completed or are in process of implementing various activities related to policy-based budgeting, transparency, and budget release and authorisation. However, the reds show that provinces still need to implement various activities related to preparing health budgets based on business plans and budget analysis. There is room for significant improvement in this aspect. Outputs 2 and 5 which refer to internal controls and asset management are weak in both provinces. Many activities under these outputs are either incomplete or underway. Specifically, targets related to establishing an internal control and audit support committee, formulation of directives, and clearance of a higher volume of audit arrears have not been met. Output 5 in particular includes 24 different activities for audit and external scrutiny, and very few have been completed.

Output 3 has a large number of activities overall and reasonable progress is observed showing that various fundamental activities related to financial accounting, financial reporting, and procurement planning have been implemented. There are however a number of unimplemented activities, suggesting that there is room for improvement in the integration of reporting and transparency and accountability related measures in disclosure of health expenditure data. Lumbini Province has more activities underway than Madhesh. Output 4 has only one planned activity which is to develop the PIP, and both provinces have completed it.

Madhesh has not completed any activities in Output 6, while Lumbini has completed one. But many activities in both provinces are currently underway with regard to improving asset management systems. Human resources challenges are pervasive in the country and Madhesh and Lumbini province status also reflects this in Output 7. Both provinces are working on enhancing institutional and human resource capacity and while Lumbini has completed two activities, Madhesh has been unable to complete any.

Overall, the colour-coded system pinpoints areas that demand further development and improvement in these provinces. It would be inappropriate to prioritise the importance of one Output over the other, as all go hand-in-hand and influence each other. It is important to note that provinces have made a good start with several activities being completed or underway. The challenges in undertaking the ones that haven’t yet been initiated needs to be addressed. Ensuring robust internal control systems, strong fiduciary governance practices, increasing settlements of audit irregularities and proper accountability and transparency in managing healthcare resources are critical areas of concern that need a focus.Inter-governmental coordination also needs to be strengthened with regular dialogues and sharing of fiscal information.

PIP progress

As per the assessment tool designed, PIP activities were rated on five-point scale as poor, below average, average, above average and well implemented, based on the progress status observed. Average scoring was calculated for the key interventions within the eight key outputs. The PIPs in both provinces include eight key outputs or intervention areas as below:

Output-1: Institutionalisation of Pre-bid Information System
Output-2: Effective Implementation of Procurement Plan
Output-3: Implementation of Standard Procurement Process
Output-4: Improved Contract Management
Output-5: Strengthened Supply Chain Management
Output-6: Guaranteed Quality Assurance
Output-7: Enhanced Institutional Capacity
Output-8: Maintained Good Financial Governance

Lumbini province was found to score little higher above average than Madhesh in Output 1 which refers to institutionalising pre-bid information system as planning to prepare guidelines for budget forecasting and preparing a list of items procured in previous years. Both the provinces scored average for Outputs 2 and 3 on implementing procurement plan and standard procurement processes. Output 4 on contract management practice was the worst performing output where both provinces were below average, and Madhesh was further below Lumbini. In terms of Output 5, however, Madhesh province has begun drafting the SCM guideline and hence a pioneer in this regard, and Lumbini too has performed well. Quality assurance – Output 6 - in both the provinces however is weak, although Lumbini province has been practicing post-delivery testing in bulk procurement. Both the provinces have low average scores on Output 7 on institutional capacity indicating the lack of adequate competent staff in procurement and SCM. Lumbini province regularly has suppliers' meetings and publishes some procurement information on its website, show a better average score in governance practices – Output 8 - than Madhesh province. In summary, Lumbini has done marginally better in terms of implementation of the PIP than Madhesh, but both provinces have to undertake a number of other activities to be fully compliant with the requirements of their PIPs.

Conclusion

There is recognition of the need for sound financial management practices and accountability at the province level in both provinces. Despite efforts made against several core FMIP indicators over the short period over which it has been implemented, a number of areas face challenges. Effective financial monitoring, internal control strategies and sustained reductions in audit queries remain a major challenge for the health ministries and their spending units in both provinces. There are other challenges too with regard to availability of expertise and skills proficiency at the sub-national level, and awareness of financial management reforms. Detailed recommendations to help better implementation of the FMIP are provided in Section 6.1, which mainly emphasise that need for building capacities, strengthening monitoring, and strategic co-ordination.

Procurement of medical goods is key for provinces, as they are responsible for supplies to a number of provincial as well as local level facilities. There is commitment to improve health standards, and an effort to standardise medicine and medical goods procurement and supply chains. Progressively, the provincial MoH in both provinces have initiated steps

to enhance transparency, competitiveness, and effectiveness in health sector procurement. There have been advancements over the ten months following the introduction of provincial procurement improvement plans (PIPs) which range from standardised pre-bid information systems, refined contract management and enhanced supply chain management. However, a number of planned activities and expected outputs are yet to be realised. A number of areas (See Section 6.2) need to be improved for better procurement processes including strengthening information systems, timely preparation of the Annual Procurement Plans, introduction of quality assurance mechanisms for medical goods, and building capacities.

1 INTRODUCTION

This report documents the key findings of progress on the procurement and public financial management reform processes in two provinces of Nepal – Madhesh and Lumbini. The overall purpose of the document is to provide the required information to the Federal Ministry of Health and Population, and the respective health ministries of Madhesh and Lumbini provinces, progress, and bottlenecks in the execution of Financial Management Improvement Plan (FMIP) and Procurement Improvement Plan (PIP) against the strategic signposts and discuss their impact on the current and future programmatic work. The FMIPs and PIPs have been developed in line with the federal Public Financial Management Strategic Framework (PFMSF) and Public Procurement Strategic Framework (PPSF) for Management of Medicines and Medical Goods, which are overarching financial and procurement management plans, and guiding agendas for efficient management of health resources ,enhancing financial discipline and accountability and procurement reform among budget holders and service delivery managers in healthcare management systems in all spheres of Governments.

The UK funded Nepal Health Sector Support Programme (NHSSP) had supported the development of the FMIPs and PIPs of three provinces – Madhesh, Lumbini and Sudurpaschim in the previous years. During Jan-December 2023, NHSSP has supported Madhesh and Lumbini provinces to monitor and ensure that the plans were being effectively implemented.

This report includes six chapters. Chapter 1 provides the background on public financial management (PFM) and public procurement system and the details of the current assessment. Chapters 2 and 4 focus on the public financial management and procurement reform processes, and the findings from the tracking are presented in Chapters 3 and 5. Chapter 6 concludes the report and offers recommendations.

1.1 BACKGROUND AND RATIONALE

A sound public financial management (PFM) system is vital for delivering public goods and services effectively. PFM helps governments plan, deploy, and evaluate financial resources to drive social and economic development programmes[1]. Public finance has four main objectives: sustainable fiscal space, strategic allocation of resources, redistribution of fiscal resources, and effective service delivery[2]. Procurement in health refers to the process of acquiring medical supplies, construction works and services. The complex nature of public financing processes and procurement activities and their interaction with the political economy, can challenge even well-intentioned governments in having an effective Procurement and Public Financial Management (PPFM) system[3] .

Strengthening PPFM in the health sector is crucial for effective health systems reforms in Nepal. Limited fiscal space and capacity constraints have made it challenging for provincial governments to shape their policies, programmes and institutions. To address this, provinces have developed the Financial Management Improvement Plan (FMIP), 2022/23-

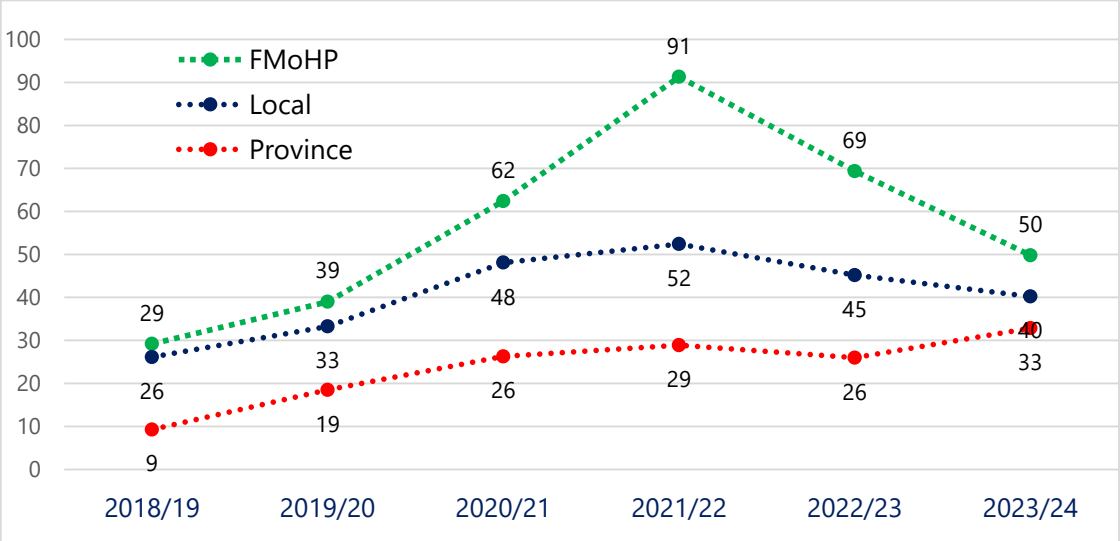
[1] PFM as defined by the Chartered Institute of Public Finance Accountancy (CIPFA), UK.
[2] Ihory (2016)
[3] PPFM system in wider sense also includes procurement, and hence the term procurement may not be used in all cases.

2026/27 and Procurement Improvement Plan (PIP), 2022/23-2026/27[4]. These plans are basically roadmaps aim to improve financial management and procurement in various health spending units and facilitate coordination between all three tiers of governments, finance and health ministries, External Development Partners (EDPs) and citizens. These plans are anchored in a broader PFM cycle, and were formulated based on two important federal frameworks, viz. Public Financial Management Strategic Framework (PFMSF), 2020/21-2024/25 and Public Procurement Strategic Framework (PPSF), 2022/23-2026/27, which aim to improve broader budgetary governance in the health sector.

1.2 PROVINCIAL GOVERNMENT ROLE IN PPFM

Provincial and Local Governments (PLGs) in Nepal have the authority to form their budget, buy and own assets, incur liabilities, procure necessary goods, services and works, and/or engage in transactions in their own right. They have autonomous and shared fiscal authority, can raise their Own Source Revenues (OSR), receive an intergovernmental fiscal transfer from the federal government (e.g., fiscal equalisation, and conditional grants), and bear increasing responsibility for health expenditure [(2.3% & 2.7% of GDP (2020) & (2021)][5]. Around 30% of the drug procurement budget is used for acquiring vaccines, syringes, and diluents in Nepal. Free healthcare and HIV//STI drugs make up 27% and 9%, respectively. Nearly 93% of the equipment purchasing budget remains in the pocket of the federal ministry, whereas provinces have a greater share in purchasing drugs related to basic health services (BHS), Ayurveda and homeopathy and supplements. The local level comprises 90% of the total health budget for purchasing medicines to provide free BHS (Transparency International, 2020).

Figure 1: Health Fiscal Space of Different Tiers of Government (Amount in billion NPR.)



Source: Budget Analysis Report, 2022, P-LMBIS and SuTRA estimate, 2023

[4] FMIP and PIP are approved by respective health ministries in Lumbini and Madhesh provinces during September 2022.
[5] Source: Health Sector Budget Analysis Report, 2022 and Nepal's GDP is ~ 4852 billion or 4.85 trillion (MoF, Nepal, website, 22, August 2023)

Thus, it is essential to effectively manage the PPFM systems of Provincial Health Ministries and associated offices to respond to any liabilities at the sub-national level[6]. The major hurdles in the effectiveness of PPFM in provinces are limited fiscal health space (Figure 1), weak enforcement of proper policies, plans and procurement rules and norms, ineffective intergovernmental fiscal coordination, and inadequately skilled staff, which have direct implications for equity and quality in healthcare delivery.

FMIP and PIP are designed as self-administered management tools both for provincial health and finance institutions, because health budget data, accountable entities, and programme activities and performance are all linked. These plans are an integral part of the provincial health ministry's regular work schedules and actions. FMIP includes seven and PIP includes eight critical dimensions, comprised of a number of indicators and activities of the PPFM cycle. Provincial MoHs must track the rollout status of the FMIP and PIP, take stock of progress annually and undertake timely corrective measures, and the NHSSP federal team has been supporting them to undertake this. This report is based on this support to monitoring of the implementation, and presents the progress of FMIP and PIPs in Madhesh and Lumbini, by assessing performance against the benchmarks within the plans, and by tracking the implementation of activities over the fiscal year 2022/23.

1.3 Purpose and Objectives

The main purpose of the technical support to provinces was to monitor the progress of FMIP and PIP implementation of the Lumbini and Madhesh provinces, in line with the federal Public Financial Management Strategic Framework (PFMSF) and Public Procurement Strategic Framework (PPSF) for Medicine and Medical Goods. The specific objectives were to:

- track the progress on various activities included in the plans and support provinces to enhance health sector financial management and procurement readiness and institutional capacities to implement plan,
- identify the strengths and opportunities that could enable better implementation of FMIP and PIP in the provinces,
- identify issues, challenges, and bottlenecks related to health sector fiscal governance and accountability at the subnational level, and
- provide recommendations to catalyse rollout of plans in the provinces, that can contribute towards achieving goals of the Nepal Health Sector Strategic Plan, 2023-2030.

Review of progress of the FMIP and PIP was important for provinces as the government stakeholders aimed to understand if the plans were working well, and ensure that resources were being used wisely and in line with policies and programmes. There was a need to take stock and reassess in case any changes and improvements had to be made.

1.4 Approach and Methods

A qualitative approach was used to track, gather and analyse data on the roll-out of FMIP and PIPs in both Lumbini and Madhesh provinces, as described below:

[6] Subnational level (also known as provincial level) and includes local level as well.

1. *Tracking of Activity Implementation Frameworks (Colour Coding and Rating Scales):* FMIPs and PIPs were examined, and tracking sheets were developed (in Nepali languages) as mentioned in the plans and adopted for progress tracking. Progress on each activity and indicator status was checked through discussions, document reviews, and visits to relevant sections responsible for implementing the activities. Progress on each activity under each output of the FMIP was assessed and assigned a specific colour code (Green, Blue and Red) (Annex-1) to indicate status/progress. PIP activities were rated on five-point scale based on status/progress (poor, below average, average, above average and well implemented) (Annex-2). The explanation of colour code and rating scale is given in the foot note of respective annexes.
2. *Consultations:* Key government officials from finance and health ministries (in both provinces) and donor agencies, including secretaries, public health directors, finance and planning officials, public health administrators, and health officials, doctors, nurses, technicians, procurement staff, and members of PFM and procurement-related committee members in various entities, were consulted through in-person meetings (Annex-3).
3. *Interviews:* Respondents for the interview were selected purposively to balance between health sector officials and providers and financial officials. A checklist along with open-ended questions (Annex 4 & 5) was used for interviewing key informants. Information on challenges, barriers to implementation, good practices, and adherence to financial and procurement regulations was gathered.
4. *Desk Reviews:* Desk reviews of various federal, provincial, and local government laws, policies, plans guidelines, national and international reports, budgets, and financial data were undertaken to track the progress of planned activities and to corroborate the information obtained from discussions and consultations. Other literature on PFM and procurement were also referred to analyse, triangulate, and substantiate findings and financial statistics. Reports and data were received from Provincial Treasury Comptroller Office (PTCO), respective account sections in spending units, and downloaded from the respective websites of PGs. The documents reviewed are listed in the bibliography at the end of the report.
5. *Validation Workshop and Policy Discussion:* The draft report was shared with relevant stakeholders (Annex 6) for review and final workshops were conducted in both provinces for validation of findings, where all the relevant stakeholders from provinces and FMoHP reviewed the findings and had a policy discussion. The feedback was incorporated, and the report was finalised.

Interviews were conducted in Nepali and notes were taken in writing, and the information was subsequently thematically categorised, synthesised, and organised for the final analysis, and interpretation. The modalities of the tracking were discussed in advance with the PFM committee[7], the federal and respective provincial MoHs.

[7] PFM Committee is chaired by Joint Secretary of Policy, Planning and Monitoring Division of FMoHP, formed during 2012 and comprises members from ministry and EDPs including BEK, USAID, WB, WHO, among others.

1.5 LIMITATIONS

This rollout status progress reporting is focused on tracking FMIP and PIP during the fiscal year 2022/23, as implemented by province MoH of Lumbini and Madhesh provinces, and their spending units. This exercise involves assessing achievements of the first year of their implementation plans, FY 2022/23. This is not necessarily representative or typical of all provinces, which may have their contextual influences on which aspects of an FMIP or PIP can be implemented or face challenges. This report does not aim to assess the impact of these plans on the delivery of care services and health policy goals of the provinces.

2 PFM REFORM IN THE HEALTH SECTOR

The PFM reform process is vital for driving health service delivery functions at all spheres of government, mainly in the federal context. This chapter explains PFM practices, issues and strengths in the health sector.

2.1 PFM LANDSCAPE IN THE FEDERAL HEALTH SECTOR

Nepal's transition to the federalism created the need for disbursement of fiscal resources to three tiers of government, which called for an accountability ecosystem that involved clear roles, responsibilities, and reporting requirements. The Constitution elaborates on financial powers and management authorities among various tiers of government and provides a clear direction to the financial systems and procedures[8] through the laws. PFM laws such as the Financial Procedure and Fiscal Accountability Acts (FPFAA), 2019, Financial Procedure and Fiscal Accountability Regulation (FPFAR), 2021, Public Procurement Act, 2007 and Public Procurement Regulation, 2007 (at the federal level), Financial Procedures Acts (at the provincial level), Local Governance Operations Act, 2017 (local government), Appropriation and Financial Acts (at each PG level), Good Governance Act & Regulations, among others are vital for a robust PFM landscape.

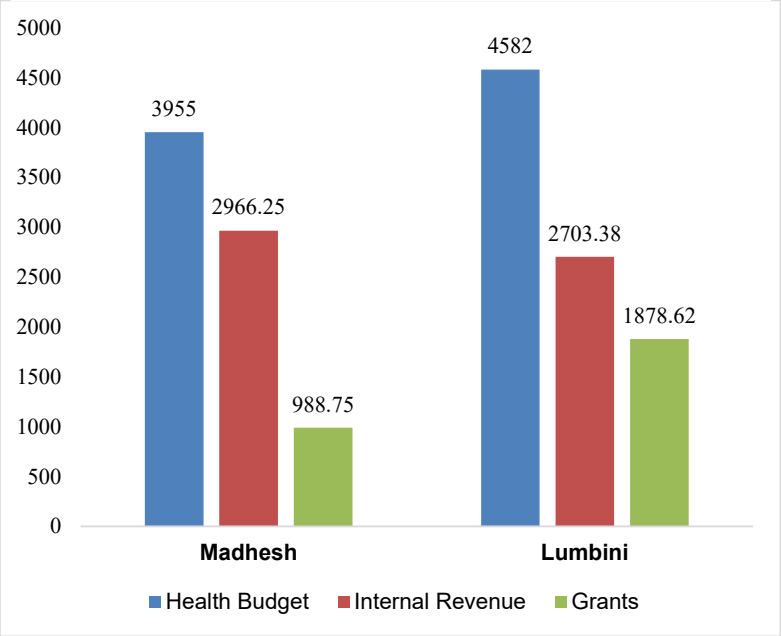
The PFM architecture across the three tiers of government, is connected and follows a coherent planning and budgeting process. All governments are mandated to follow norms and rules related to consolidated fund management, resource estimation, budget preparation, execution and financial reporting. Laws form the basis for maintaining fiscal transparency and discipline in expenditure management of social (e.g., health and education) services and economic and capital development programmes. The Nepal Public Sector Accounting (NPSAS) and audit compliance of the Office of the Auditor General (OAG)[9] in Nepal provide the oversight functions.

Effectiveness and performance of service delivery functions in a decentralised setting has to justify 'Finance Follows Functions[10]' and requires predictability of fiscal transfers, which is very complex and unclear in Nepal. In a context where PLGs do not have the right to collect enough revenues, nor are the fiscal transfers adequate to fund their expenditure responsibilities PFM efforts to enhance efficiencies can only yield limited results.

[8] Nepal's Constitution Part 10, 16 and 19 describes financial procedures of federal, provincial, and local level respectively.
[9] Constitution Part 23 provides authority to OAG to evaluate and conduct financial audit of each sphere of government.
[10] "Finance follows functions" means that all resources that are associated with delivering a service & associated with a function must be transferred if the function is shifted (i.e., shifting all resources, assets, budgets to the relevant entity in the appropriate governance level in a decentralised setting if the function is now the responsibility of the sub-national government). Devolving responsibilities to subnational governments without the appropriate resources may lead to challenges.

The National Natural Resources and Fiscal Commission (NNRFC)[11] has a pivotal role in driving fiscal federalism, and coordination of financial management across governments. The Intergovernmental Fiscal Management Act, of 2017 is the main legal instrument on the revenue sharing and intergovernmental fiscal transfers to the PLGs. NNRFC recommends fiscal equalisation and conditional grants as the major fiscal transfer mechanisms to sub-national governments, and these constitute the main funding mechanisms in the health sector too.

Figure 2: Composition of Health Budget in Mahesh and Lumbini Provinces, FY 2022/23 (Amount In million NPR)



Source: *Budget Analysis Report, 2022, MoHP/NHSSP*

Provinces therefore have their Own Source Revenue (OSR) [12], including revenue sharing, and allocations from federal fiscal equalisation grants and conditional health transfers, EDP contributions and internal debt, contributing to the overall fiscal space. MoHP health budget analysis of Nepal in 2022 shows an increasing share of internal revenues in provincial health budget allocation over the years, from 34% in FY 2018/19 to 65% in FY 2022/23. The health budget is a combination of the fiscal equalisation grant, OSR, and health conditional transfer (Figure 2),

For the local level governments, more than two-thirds (approx. 80%) of the local health budget comprises the grant transfers from the federal and provincial governments, the majority which is in the form of a federal conditional grant.

2.2 PFM INITIATIVES AND REFORMS

PFM reforms are needed in the new federal context to ensure the PFM architecture is fit for purpose in the country. Following the legal provisions, tools, guidance and institutional mechanisms to enable health spending units to effectively manage systems and processes are needed. Several technical and oversight committees at the federal and provincial level such as Health Coordination Committee, PFM Committee, Audit Committee, and Procurement Committee have been constituted. Various tools that measure institutional

[11] Constitution Part 26 provisioned of NNRFC for implementation of fiscal federalism in Nepal.
[12] OSR includes provincial taxes and fees and revenue sharing between different tiers of government as well. For e.g., VAT, vehicle tax, advertisement tax, land registration tax, among others.

capacity and undertake fiduciary risk assessment[13] support action plans development and implementation also exist. The Financial Management Information System (FMIS), Provincial Line Ministry Budget Information System (P-LMBIS) and Sub-National Treasury Regulatory Application (SUTRA), Public Asset Management Information System (PAMS) are the key systems through which PFM is conducted.

FMoHP has developed and implemented budgetary reform guidance through the Health Sector Planning and Budgeting Directive, 2019, the Internal Control Directive, 2021, Audit Clearance Directive, Gender Responsive Budgeting Guideline, Procurement Guidelines, and Chart of Activities in Health, 2019. A series of financial management strategic frameworks & plans, budgetary analysis, financial management and procurement training and assessment and supporting manuals, booklets and leaflets were developed and rolled-out. The Public Financial Management Strategic Framework (PFMSF), 2020/21-2024/25 is the main overarching document that brings together all this and is applicable nationwide. Provinces are expected to base their FMIPs on this overarching framework, for all planning, budgeting implementation and evaluation.

2.3 FINANCIAL MANAGEMENT IN PROVINCIAL HEALTH SECTOR

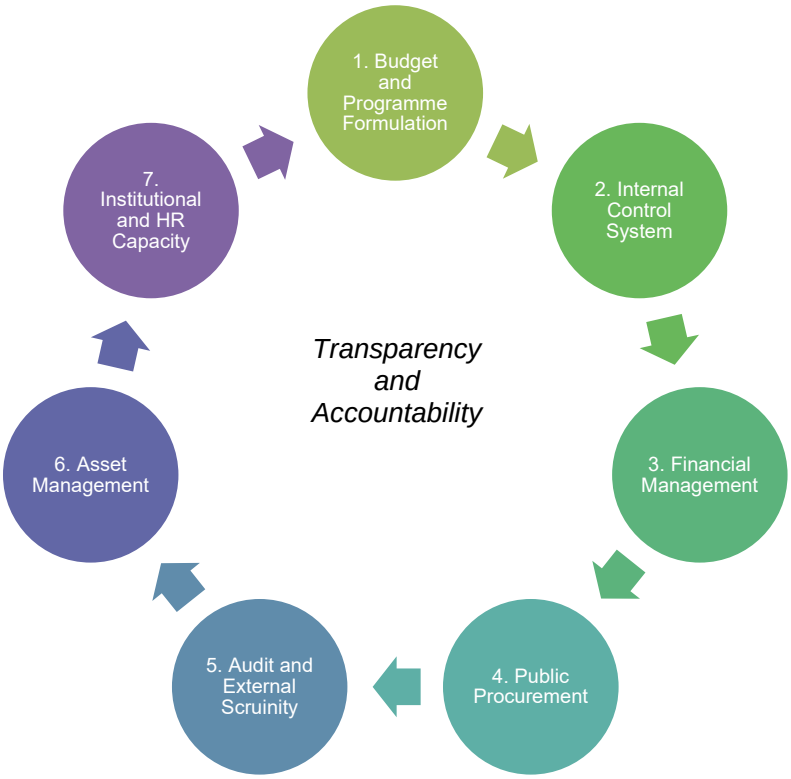
Three provincial ministries of health, viz, Madhesh and Lumbini and Sudurpaschim endorsed their respective FMIPs and PIPs for fiscal year 2022/23 that were based on the newly released federal PFMSF and PPSF and put them on the pathway to PFM reform. It is important to note that these plans are voluntary. As explained above these plans are the main instruments for the provinces which prescribe PFM actions, processes and practices in the health sector. These include a range of activities, indicators, and milestones to achieve health sector performance goals within specified timeframes. The FMIPs (2022/23-2027/28) in the health sector that were was introduced in the provinces were based on the PFMSF, which had been developed for the devolved context.

The FMIPs intends to strengthen PMoH's current practices on health budget cycle management including several new field-level initiatives such as the Provincial- Line Budget Management Information System (P-LMBIS), and adoption of a Provincial Computerised Government Accounting System (P-CGAS). These also focus on the medium-term allocation of budgetary resources, policy priorities, internal control, auditing compliances and submission of financial statements in the Nepal Audit Management Information portal, etc.

[13] Local Institutional Self-Assessment (LISA) and Fiduciary Governance Risk Assessment (FRA) Guideline are major tools developed by Ministry of Federal Affairs and General Administration (MoFAGA) and closely related to PFM reforms and capacity improvement at subnational level.

Overall, the FMIPs follow the PFM cycle[14] (Figure 3) with the main aim of reducing fiduciary risk, and improving financial accountability and discipline.

Figure 3: *FMIP Critical Areas/Expected Outputs*



Each FMIP has seven critical dimensions (also known as expected outputs) and key intervention areas/activities within it to be accomplished. The rollout status is assessed against the baseline and year-wise benchmark of the indicator, with specific responsibilities assigned to single or multiple spending units. The main outputs of FMIP are:

Output 1: Improvement in Budget and Programme Formulation
Output 2: Strengthen the Internal Control System
Output 3: Improvement in Financial and Management Accounting
Output 4: Improvement in Public Procurement Management
Output 5: Auditing and External Scrutiny
Output 6: Improvement in Asset Management System
Output 7: Improvement of Institutional and Human Resource Capacity.

This report presents an assessment of rollout progress against these various types of activities planned for each of these broad dimensions.

[14] PFM cycle components are aligned with International Monetary Fund (IMF) approach to PFM components.

3 KEY FINDINGS ON THE PROGRESS ON FMIPS

The FMIP covers the entire health budget cycle and is an overarching financial framework with numerous activities, baseline and target indicators, responsibilities, and timelines for multi-year PFM improvements. Hence, this chapter describes the implementation status of activities within the specific key areas and outputs. The findings below have been summarised based on interactions with stakeholders, examination of relevant documents, the rollout status progress in the FY 2022/23. The complete details of the activities and assessment against the colour coding is provided in Annex 1.

3.1 IMPROVEMENT IN BUDGET AND PROGRAMME

Credibility, comprehensiveness, transparency, and a policy-based budgeting process are the main aspects of a well-managed process. This involves planning a realistic budget, having minimum aggregate expenditure out-turns (i.e. minimum deviations from the original budget plan), relying on evidence-based planning and developing result-based policy and programmes. Under this output of the FMIP, four key intervention areas and 18 activities were planned related to policy and programmes. These broadly pertain to preparing a budget, reviewing past spending projections, medium-term projection of expenditure ceilings, allocation and approval of budgets, budget management, execution and analysis. Budget policies need to link with key service delivery goals and performance, to have a positive impact on the life of the population. The assessment found that the PMoHs in Lumbini had developed its health policy, and Madhesh is currently drafting one. An absence of a clear health policy and strategic directions there could result in fragmentation of health budget in the areas other than the priority health sector needs in the provinces.

The Health Budget Committee exists in both provinces, and the Secretary is the convenor. But the ministries are yet to develop a health strategic (results-based) framework to improve evidence-based budget planning and programming. Budget Guidance is provided to all spending entities, but access to the Provincial Line Ministry Budget Management Information System (P-LMBIS) is limited to their spending units, ultimately continuing traditional top-down budgeting practices in the provinces.

Health budgets are developed on the basis of provincial policies and programmes, any periodic development commitments, and aligning federal health priorities and charts of account in health including resources and revenue at hand[15]. These are all highly influenced by the extent of skills available in planning and budgeting in the provinces. In addition, the budget preparation process is led by the budgeting calendar, which generally starts in mid-January and ends in mid-July of the same year, with the legal provision to submit the budget proposal by mid-June, for legislative review and approval by the respective governance level. Both provinces submitted a budget proposal for FY 2023/24 on 16 June 2023. After discussion and debate in the unicameral provincial legislative assembly, the budget was approved and became a legally binding instrument that governs health resources available for care in the provinces. PMoH used P-LMBIS for entering the budget, later negotiated with

[15] The MoF and PPC are in-charges of planning and budgeting and have decision-making authority for sector funding that determines the government's annual and medium-term policy stance. They issue Budget Preparation Directory, Budget Ceilings and Budget Operations Manual to line ministries.

the P-MoF and Provincial Planning Commission (PPC) for the finalisation of the budget proposal (subsequently termed as a Red Book).

The health ministries (in both provinces) are currently in the process of including the fiscal tools and techniques into health sector management for achieving planned objectives and outputs of the FMIPs. In both provinces, PMoH have also been leading the preparation of the health budget, priority settings and coordinating with all spending units; and prepared a Medium-Term Expenditure Framework, 2080/81-2082/83 (MTEF)[16] along with multi-year health targets and resource projections which they submitted to the PPC in April 2023. But this process has not been without challenges. As reported by a respondent in PMoH, the sector MTEFs could not be made realistic due to unpredictable budget ceilings from the province government to line ministries, federal fiscal transfer from the central government, political reasons, and improper techniques to derive annual budget from medium-term estimates.

Analysis of expenditure data of FY 2022/23 from both provinces showed that budget absorption rates varied (Table 1). Madhesh province expended 90% of its adjusted health budget, although the overall budget reported only 57% expenditure. In Lumbini province the health budget absorption rate (63%) was lower than the overall budget expenditure (72%)[17]. Lower aggregate expenditure outturns could be the result of inappropriate priority allocation and miscalculation of inputs and could undermine health services delivery and budget credibility, particularly impacting the pro-poor targeted health programmes (PEFA, 2020).

Table 1: Budget vs. Expenditure in Madhesh and Lumbini province, 2022/23 (Amount in million NPR)

Description	Lumbini	Madhesh
Overall Adjusted Budget	42,635.70	47,024.15
Overall Expenditure	30,570.07	26,936.92
% Expenses of Overall Budget	*72%*	*57%*
Adjusted Health Budget	4,898.60	3,769.00
Health Expenditure	2,993.00	3,387.90
% Expenses of Health Budget	*63%*	*90%*
% of Health Budget in Overall Budget	*11.48%*	*8.01%*

Source: *Analysis of FMIS Reports, 2022, PTCO in Madhesh and Lumbini*

Positive budget virement[18] (Table 2) and reallocations in the health sector were noted in both provinces. In Lumbini and Madhesh, the budget was increased by 5% and 4% respectively after readjustment. However, the actual expenditure was less than the initial budget target in both provinces (as mentioned in Table 1), indicating that virements were

[16] MTEF is a rolling-multi-year budgeting plan-covering t-1, as a base budget year and t-2 & t-3 as a budget projection year. The framework is considered important, because it ensures resources for multi-year projects under implementation, although it is not clear whether these MTEFs align with annual budgets and link to broader medium-term development goals, match with P-LMBIS multi-year targets, considering health sector diseases data and based on actual projections of revenue and macroeconomic forecasting in the provinces (Allen, Hemming, & Potter, 2013).

[17] Minor change in data might be possible due to reconciliation and adjustment in expenditure.

[18] Virement refers to the process of transferring items from one financial account to another. For example, within the Government where one department underspends and another department needs more funding, the funds can be procured through virement.

also *ad hoc*. This impedes credibility due to unrealistic budget targets setting, weaker planning, allocation and expenditure inefficiency. Although, a certain percentage of virement (e.g., to a limit of 25%) could be acceptable/allowed within the same economic budget heading in an emergency situation or any other unavoidable circumstantial constraints, such virements if outside the legislative purview could be non-compliant with prevailing laws, weaken fiscal discipline, promotes fiduciary risk and weak institutional design.

Table 2: Health Budget Virement in Both the Provinces, FY 2022/23 (Amount in million NPR)

Province	Initial Budget	Virement (+)	Final Budget	% of Virement
Lumbini	4,660.54	238.06	4,898.60	5%
Madhesh	3,638.00	130.92	3,769.00	4%

Source: *Analysis of FMIS Reports, 2022, PTCO in Madhesh and Lumbini*

In summary, in both provinces, the health budgets were being prepared, financing from OSR was being done, data was being entered into P-LMBIS and was being authorised on time. The budget classification was based on Charts of Accounts (CoA) and is divided into economic head-wise, covering both recurrent and capital expenses, as well as health programmes and administrative budgets. While Lumbini has a detailed classification, Madhesh health budget classification was not. However, PFM performance on health sector needed to be improved, particularly in terms of setting appropriate budgets, programme and performance based budgeting.

3.2 Strengthen Internal Control

Internal control is the process of identifying, avoiding and managing operational risk in the public sector[19]. A flexible administrative framework, good financial management through ex-ante controls and risk-based control systems, with proper financial accounting, reporting and audits (FCGO, 2018) constitute a good internal control system.

OAG's audit findings of the 4th and 5th reports of FY 2020/21 and FY 2021/22 respectively show that the PMoH had not applied effective internal controls, and no instructions were provided to direct the spending units about operating daily expenditure and reporting to manage the healthcare services in both provinces. It is likely that healthcare services may require flexible financial methods (e.g., to respond to an emergency situation, a pandemic, etc.), which may bypass control procedures, and this increases the risk of poor legal and policy compliance in managing public funds. This assessment noted that PMoH and its spending units have had a minimal level of internal control procedures. Currently these are based on *ad hoc* and conventional bureaucratic administrative processes that are insufficient to identify all performance gaps or to communicate and monitor the procedures. The provinces do have internal controls for non-salary expenditure in health, for example, segregation of duties of providers and managers and monitoring of the quality of health purchasing, programmes and services, hospital care management, and service entities and standards, which provide partial assurance of efficient use of resources. Also, although both provincial governments have approved the Fiduciary Governance Risk Assessment (FGRA)

[19] According to Financial Procedures and Financial Responsibility Act 202 (Rule 81) and various financial laws and rules, public sector organisation, each public sector entity shall develop and execute its internal controls, and such a control mechanism should be formed based on international standards of the Committee of Sponsoring Organization of the Treadway Commission (COSO) framework.

Guideline to assess their institutional PFM capacity across their ministries, there is no evidence of this having been implemented.

Neither province has constituted an Internal Control Committee and Audit Committee, nor have they maintained a Risk Register as stipulated in the FMIP. Similarly, internal audit provisions are infrequent, and not happening each trimester as required. These are being conducted after the end of the year by the PTCO. All these gaps indicate further work needs to be done for accountability and financial disciplines in health expenditure management and reporting in both provinces.

Moreover, monitoring and feedback mechanisms are yet to be institutionalised in both provinces. Neither province has a concrete monitoring checklist, nor have they established any other monitoring mechanisms. While thy have been using indicative checklists, there is are no monitoring reports, and no discussions have taken place within the ministries and directorates. While both ministries have their own websites, financial reports were not uploaded or made available to the public. Also, although contracts need to be performance based as per plans this was not necessarily the case on all occasions in both provinces. In general, prevention, detection and control activities related operational management could be improved in the both provinces.

3.3 Improvement in Financial and Management Accounting

Financial and management accounting ensures the accurate recording and reporting of expenditure data against budgeted allocation, and fiscal transparency. In Nepal, provincial governments adhere to the Nepal Public Sector Accounting Standard (NPSAS) with a Cash based-Double Entry Accounting System, and use the Provincial Computerised Government Accounting System (P-CGAS).

The rollout of a customised CGAS across provinces, encompassing all health spending units has been a significant development post-federalisation. This is seamlessly linked to the P-LMBIS and the Provincial Treasury Single Account (P-TSA), facilitating streamlined budget authorisation, capturing fiscal transfer and reflective financial processes. The tailored P-TSA and P- LMBIS permit the synchronisation of the annual budget and expenditure in the health sector in both provinces.

The Financial Controller's General Office (FCGO) extends support through the PTCO by providing Financial Management Information Systems (FMIS) as a viewer software to all provinces. While MoH in Lumbini shows the integration of this system into their health operations, MoHP in Madhesh, has yet to engage in obtaining access credentials from PTCO. In tandem with revenue collection, the practice of channelling revenues into the government revenue account prevails. Notably, both provinces have adopted the Revenue Improvement Management System (RIMS) to effectively report revenue-related information. However, a gap persists in capturing internal revenues and expenditures within provincial hospitals and agencies. A lack of integration of proper mechanisms of reporting of internal revenue can create a financial risk and weak compliances in cash management system.

The lack of a system that integrates government revenue data system with expenditure accounting systems to generate real-time income-expenditure data, and effective cash management planning, is a drawback for the country in general. Despite some advancements, the reporting on Gender-Responsive Budgeting (GRB) and expenditure remains incomplete at the provincial level and opportunities for updating and mainstreaming GRB health budget component in the FMIP.

In both provinces, a pressing issue is the lack of dedicated Accounts Officers in the spending units, including the Provincial Health Directorates within ministries in both provinces. Human resource shortage means a single accountant is responsible for multiple entities thereby increasing workload pressures and the risk of inefficiencies. There are also some structural limitations to P-CGAS which makes accounting difficult in some circumstances (e.g., it does accept vouchers where there is insufficient balance in the corresponding expenditure category). In summary, therefore, as it is with the other dimensions of the FMIP, good structures and tools are available for the accounting dimension too, but some challenges exist which need to be addressed.

3.4 Improvement in Public Procurement Management

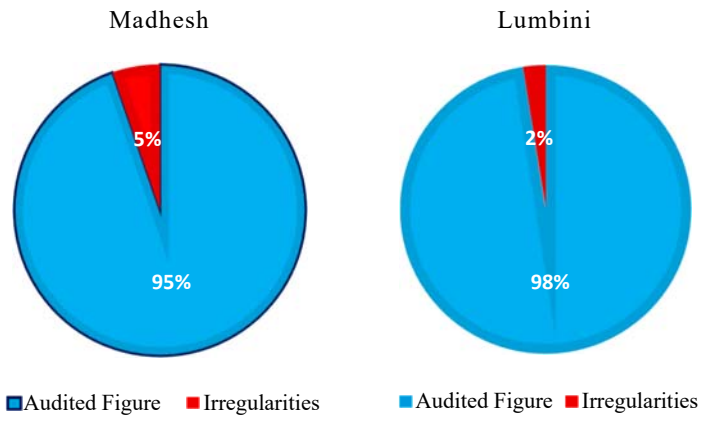
Public procurement is a crucial part of the budget execution process within the wider PFM cycle, and consumes a significant portion of taxpayer's money for the sourcing of public goods, services and works by governments. Because medical supplies, drugs and equipment are purchased more frequently in the health sector, procurement processes need more attention and constitutes a full topic of assessment. At the provincial level the FMIP lists the development of separate Procurement Improvement Plan as the main activity, which both provinces have complied with. Chapters 4 and 5 focus on the PIP.

3.5 Auditing and External Scrutiny

Audit as a process of independent review of financial records and related activities plays an important role in enhancing budgetary governance and financial accountability. The Office of the Auditor General Nepal (OAGN) has the responsibility to perform audits of all spheres of government including ministries, departments, divisions and sections and public hospitals.

While PMoH in both provinces are committed to resolving audit irregularities (or arrears) and maintaining good governance in the health sector, the pace of work has been slow. Of total cumulative outstanding irregularities of NPR 1.7 billion in Lumbini and 5.6 billion in Madhesh, only 8.5% and 1.5% irregularities were settled (up to FY 2022), far below the target (60%), in both provinces respectively. PMoH in both provinces were unable to provide data on integrated records of irregularities and clearance details up to the reporting period. The OAGN has been striving to keep audit irregularities at the lowest percentage of the total audited figure, and generally below 1% of audit arrears could be considered acceptable or under control.

Figure 4: Percentage of Irregularities of the Total Audited Amount



Source: *OAGN, 5th Audit Report, Madhesh and Lumbini Provinces*

Lumbini has maintained this at 2% below the OAG threshold during the FY 2022/23, but it is at 5% in Madhesh as shown in Figure 4. The Financial Accountability Officer (i.e., Chief of

the Spending Unit) is responsible for clearing the arrears or queries following the Financial Procedures Act in both provinces.

Likewise, the analysis of the audit reports[20] of the last two fiscal years 2021/22 and 2020/23 illustrates that health sector audit irregularities are a fairly high proportion of the irregularities reported at provincial level, particularly in Madhesh. It was19% of overall provincial irregularities in Lumbini and 43% in Madhesh province (Table 3).

Table 3: Comparison of Health Irregularities to PG Irregularities (Amount in million NPR)

Description	Lumbini		Madhesh	
	Audited Figure	*Irregularities*	*Audited Figure*	*Irregularities*
Province Government (A)	5,7081.26	1,488.88	4,3107.38	1,163.30
MoHP (B)	4,137.36	41.237	5,766.38	147.00
Hospitals/Committees (Non-Treasury) (C)	7,417.89	253.23	3,244.12	356.05
Health Sub-Total (D)=B+C	11,555.25	294.47	9,010.45	503.06
% of Total (D/A)	20.24%	19.78%	20.90%	43.24%

***Source:** 4th and 5th Audit Reports of OAGN*

Audit reports have also explicitly remarked on issues in financial management such as province ministries and agencies submitting reports on appropriation, revenue, bail, and assets to respective entities and explicitly focusing on improvement in PFM in health. The Nepal Audit Management System (NAMS) which was introduced last year is now being used by both provinces to upload documents and financial statements as requested by the OAG.

In summary, there was not adequate emphasis made on proper planning, documentation, recording of audit irregularities, against as required for the FMIP. A clear Action Plan to mitigate audit-related issues is absent which could lead to accumulation of health queries in the future. Besides, the records of Public Account Committee (PAC) committee decision are not updated indicating PAC decisions are not getting priority. This shows PAC enforcement in the province are weak to influence audit governance and oversight mechanism in the sector management.

3.6 Improvement in Asset Management

United Nations defines Asset Management as having the right assets, at the right place at the right time, managed by the right people with the right tools. In this context, the Public Asset Management System (PAMS) plays a crucial role in improving the government's balance sheet, particularly in the federal context. Use of PAMS and approval of assets register needs to be duly maintained and approved by respective officials as prevailing laws of recording and reporting of all capital, natural and official assets. The LGOA, 2017, FPFAA/R and various other laws provide a basis for managing public assets. Both PMoH and its entities are using PAMS to keep proper records of general health assets. Health commodities are recorded in e-Logistic Management Information Systems (e-LMIS). Discussions with various stakeholders revealed the need for the integration of both systems and the linking with and mainstreaming of local-level systems, to ensure all assets are

[20] OAGN 5th Audit report of Madhesh and Lumbini province published in www.oag.gov.np.

recorded. However, the practice of auction of the unused assets is not fully implemented as per the need.

3.7 Improvement of Institutional and Human Resource Capacity

A significant obstacle to the effective execution of the FMIP in provinces is limited capacities at sub-national levels. Unfortunately, the allocated budget for capacity enhancement is minimal within the province. In Lumbini, 0.45% of its budget was allocated for training purposes, whereas more than half of the total budget (57%) was allocated for strengthening and operations of provincial hospitals[21]. Data from Red Books were not available from P-MoF in Madhesh for further analysis on this issue. Discussions with training centres however, revealed that there has been no PFM-related training conducted within the province. PFM capacity-building initiatives for the health sector were not emphasised in the provinces. The shortage of trained personnel in financial management, coupled with inadequate orientation for service providers in effective PFM cycle management, is a major impediment. These factors collectively contribute to the barriers and weaken the implementation of plans and adherence to financial protocols. There are various external donor-supported PFM programmes in the provinces, such as the USAID PFM/*Digo Bitta*, and the Provincial and Local Governance Support Programme (PLGSP), among others. PMoH has the opportunity to coordinate with them, discuss strengthening institutional capacities of health ministries, and bring financial innovation to public health administration and management.

3.8 Overall Analysis

An analysis of the progress of the two provinces against the FMIP output areas is summarised in Table 4 below. The colour codes offer a quick snapshot of the status of various activities, with 'Green' indicating successful implementation, 'Blue' signifying ongoing efforts, and 'Red' highlighting areas that still require attention. The numbers within the boxes indicate the number of activities under each Output that were categorised under the particular colour code.

Table 4: Summary of Activity-wise Colour Coding

Output Description	No of Activities	Madhesh			Lumbini		
		Green	Blue	Red	Green	Blue	Red
Output 1: Improvement in Budget and Programme Formulation	18	6	6	6	5	6	7
Output 2: Strengthen the Internal Control System	9	0	2	7	0	2	7
Output 3: Improvement in Financial and Management Accounting	26	9	6	11	9	8	9
Output 4: Improvement in Public Procurement Management	1	1	0	0	1	0	0
Output 5: Auditing and External Scrutiny	24	3	10	11	3	12	9
Output 6: Improvement in Asset Management System	13	0	9	4	1	10	2

[21] Training budget is calculated from Red Book of Lumbini province, 2022/23. The initial health sector budget of Lumbini during FY 2022/23 is NPR. 4.72 billion.

Output 7: Improvement of Institutional and Human Resource Capacity	11	0	5	6	2	3	6
Total	**102**	**19**	**38**	**45**	**21**	**41**	**40**

For further details see Annex-1

In Output 1, both provinces show mixed progress, with similar number of activities across the three colour codes. This suggests that PMoHs have completed or are in process of implementing various activities related to policy-based budgeting, transparency, and budget release and authorisation. However, the reds show that provinces still need to implement various activities related to preparing strategic policy frameworks and comprehensive health budgets focused on improving efficiency, equity, quality, sustainability goals of health system strengthening. There is room for significant improvement in this aspect. Outputs 2 and 5 which refer to internal controls and asset management are weak in both provinces. Many activities under these outputs are either incomplete or underway specifying fiduciary risk concerns in health governance and administration. Specifically, targets related to establishing an internal control and audit support committee, formulation of directives, and clearance of a higher volume of audit arrears have not been met. Output 5 in particular includes 24 different activities for audit and external scrutiny, and very few have been completed.

Output 3 has a large number of activities overall and reasonable progress is observed showing that various fundamental activities related to financial accounting, financial reporting, and procurement planning have been implemented. There are however a number of unimplemented activities, suggesting that there is room for improvement in the integration of reporting and transparency and accountability related measures in disclosure of health expenditure data. Lumbini Province has more activities underway than that of Madhesh. Output 4 has only one planned activity which is to develop the PIP, and both provinces have completed it.

Madhesh has not completed any activities in Output 6, while Lumbini has completed one. Nonetheless, many activities in both provinces are currently underway with regard to improving asset management systems. Human resources challenges are pervasive in the country and Madhesh and Lumbini province status also reflects this in Output 7. Both provinces are working on enhancing institutional and human resource capacity and while Lumbini has completed two activities, Madhesh has been unable to complete any.

Overall, the colour-coded system pinpoints areas that demand further development and improvement in these provinces. Preparation of internal control guidelines, institutionalisation of monitoring and evaluation system in healthcare management, responding to audit queries, enforcing proper asset management, financial data governance are critical areas that must be strengthened to reduce the financial and fiduciary governance risk. Besides, increased dialogue and regular sharing among health service delivery technical persons, financial and planning officers is crucial. Evidence and result-based planning and program based budgeting must be gradually scaled up along with strengthening of sector-wise approach. It would be inappropriate to prioritise the importance of one Output over the other, as all go hand-in-hand and influence each other. It is important to note that provinces have made a good start with several activities being completed or underway. The challenges in undertaking the ones that haven't yet been initiated needs to be addressed and incentivised

4 PUBLIC PROCUREMENT REFORMS IN HEALTH SECTOR

4.1 PUBLIC PROCUREMENT IN THE FEDERAL CONTEXT

Procurement stands as a vital governance function, encompassing numerous operational endeavours, and should be acknowledged as an integral facet of any organisation's collective strategy. The alignment of procurement and supply chain operations holds particular significance in achieving the objectives of healthcare sector management. In Nepal, maintaining effective governance within the public procurement framework has been a challenge. A substantial portion of the national health budget in many developing countries (20-50%) is used for procurement of pharmaceutical products (MoHP, 2009). In Nepal around 6% of the national budget is used for the health sector, and out of this only 12% is expended in procurement of medical goods (MoHP, 2021). Improving procurement of medical goods is therefore an important area of work.

The Public Procurement Monitoring Office (PPMO) is the legislative body governing public procurement that has been mandated to formulate the procurement policy and oversee the execution of public procurement system/ laws and regulations. The updated Public Procurement Act, 2007, is the umbrella act to bring transparency, competitiveness, and efficiency in the federal procurement system. Nonetheless, provinces and local governments have the authority to form their procurement regulations based on the need. Various PLGs have endorsed such regulations but these are not elaborated and do not solve all procurement issues at the subnational level.

4.2 PROCUREMENT LANDSCAPE IN THE HEALTH SECTOR

In response to the federalised context, the FMoHP approved and rolled out the Public Procurement Strategic Framework (PPSF), 2022/23-2026/27 to improve procurement of medicines and medical goods in the country, and aims to enhance the effectiveness and efficiency of procurement and supply chain management. Other initiatives that FMoHP undertook to improve the efficiency and effectiveness of its Procuring Entities (PEs) focused on standardisation, system strengthening, and capacity building through knowledge transfer by coaching and mentoring. Various guidelines, booklets and manuals for the procurement process, were also made available on the MoHP and NHSSP websites[22]. Below are additional institutional and procurement mechanisms developed that demonstrate the improvements in reforming the procurement and supply chain of medicines and medical goods in the health sector.

4.2.1 Consolidated Annual Procurement Plan (CAPP)

As per the legal mandate of the Public Procurement Act (PPA) and Public Procurement Regulation (PPR), every PE needs to prepare its Annual Procurement Plan (APP) at the beginning of the fiscal year. In the health sector these plans are merged with updates and improvements to form a single CAPP to be used by respective units. The evolution of the CAPP has brought reforms in the monitoring of the procurement process, and the formation of the CAPP Monitoring Committee, established in FY 2017/18 with technical support from NHSSP. The CAPP preparation and execution can be tracked to date as presented in (Table 5). The timely finalisation of CAPP implies the timely publication of notices which

[22] MoHP website: www.mohp.gov.np and NHSSP website: https://www.nhssp.org.np/nhsp3.html

facilitates the timely procurement of medical goods and efficiency in procurement execution capacity (Table 6).

Table 5: Dates of CAPP Finalisation & First Bid Notice Published in the Respective FY

Fiscal Year	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
Date of CAPP Finalised	13 Oct	9 Sept	30 Aug	27 Aug	21 Aug	20 Aug	18 July	17 July	28 July
Date of First Bid Published	12 Dec	20 Nov	6 Sept	16 Aug	14 Aug	14 Aug	2 Aug	5 Aug	9 Sept

Source: *Records of LMD, MD and e-GP Portal of PPMO*[23]

Table 6: Efficiency of CAPP Execution (Amount in million NPR)

FY	2017/18		2018/19		2019/20		2020/21		2021/22		2022/23	
	Value	%	Value	%	Value	%	Value	%	Value	%	Value	%
Total Planned Budget	2,728		1,576		2,795		1,433		2,835		1,231	
Procurement Initiated against Planned Budget	2,367	86	1,565	99	2,497	89	1,373	95	2,835	100	1,230	99
Planned Budget of Contract Signed	2,156	79	1,411	89	1,967	70	1,057	73	2,453	86	1,143	92
Actual Value of Contract Signed	1,606	58	1,203	76	1,785	63	837	58	1,932	68	954	77

Source: *Annual Progress Report of CAPP Execution, DoHS*

4.2.2 Coding of Standard Technical Specification Bank

The Technical Specification Bank (TSB) is a legally mandated document for procurement management under PPA and PPR regulations. It's an IT-operated repository containing standardised technical specifications for pharmaceuticals and medical equipment. Initially launched in 2012/13 with the UK financed technical assistance to the health sector, TSB was updated in 2017/18 to include technical specifications of 108 pharmaceuticals and 1,089 equipment. This online resource streamlined specification development process. Previously, divisions crafted specifications, causing delays. TSB's introduction saved time, providing off-the-shelf standard specifications for quality procurement. Though not fully utilised initially, following the updates in October 2017 with unique codes for dynamic use, most medical goods specifications for Department of Health Services (DoHS) bidding are sourced from 1421 database of TSB. It remains a crucial aspect for maintaining, harmonising, and collaborating various spheres of procurement activities in the health sector.

4.2.3 Procurement Process through Electronic Government Procurement (e-GP)

Electronic bidding, known as e-GP, serves as the sole authorised platform for public procurement in Nepal, managed by the PPMO. The first use of e-GP took place in the health sector under NHSP-2 in its final year, with the initial e-GP bid by DoHS occurring on

[23] PPMO has webpage for e-GP: www.bolpatra.gov.np

March 6, 2015, for essential drugs. Consequently, about 83% of contract value bids were processed via e-GP in 2017/18, while the remaining 17% still followed manual bidding methods. The use of e-GP became a standardised practice at DoHS, which improved in recent years as shown in Table 7.

Table 7: Use of e-GP in Procurement (Value amount in million NPR.)

FY	2017/18		2018/19		2019/20		2020/21		2021/22		2022/23	
	Value	%	Value	%	Value	%	Value	%	Value	%	Value	%
Contract Value	1606	100	1203	100	1785	100	837	100	1932	100	954	100
Use of e-GP	1329	83	1176	98	1776	99	830	99	1913	99	857	90
Non-e-GP	276	17	26	2	9	1	6	1	19	1	97	10

Source: *Various Years CAPP Data of DoHS*

4.2.4 Grievance Handling and Redressal System

The Grievance Handling and Redressal System holds significance in managing procurement and supply chains, although it was overlooked in the health sector. Instances of grievances encompass shortages of free medicines, sub-par pharmaceutical quality, and inadequate equipment standards. Bidders and suppliers can also raise complaints about procurement procedures. Thus, an ICT-and web-based Grievance Handling and Redressal Mechanism (GHRM) concept gained approval in 2017/18, initiated by DoHS under FMoHP. The system effectively manages grievances across various categories and dates, generating reports based on specific criteria for DoHS management.

4.2.5 Operating Procedures and Guidelines

Standard Operating Procedures (SOPs) and Guidelines play a crucial role in enhancing procurement staff's understanding of fiduciary and compliance obligations. In FY 2017/18, two sets of SOPs were developed and endorsed for medical goods procurement and e-GP operations, and effectively implemented across governmental tiers. Procurement clinics at DoHS and FMoHP further supported their application. Recently, the COVID-19 Emergency Procurement SOP and revised Medical Goods Procurement SOP (with annexes including a checklist for bid document preparation) were prepared and rolled-out. Additional SOPs for pre-shipment and post-delivery inspection, along with quality assurance, were developed for subnational authorities to use in the health sector.

4.3 Procurement Improvement Plan for Medicine and Medical Goods in the Provinces

Madhesh and Lumbini provinces have endorsed the Procurement Improvement Plan (PIP) spanning from Nepali fiscal years 2022/23 to 2026/27, and it was officially approved it in September 2022 to improve the health sector procurement and supply chain process. The primary focus of the PIP is to elevate various aspects of procurement processes. This includes enhancing the procurement cycle activities and bolstering the capabilities of both health ministries and their spending units.

Moreover, PIPs emphasise on economy and timely availability of medicines and medical goods; ensuring the quality of procured goods and upholding financial governance. The objective of PIPs is to deliver quality health services to the people by strengthening procurement and supply chain management practices. Overall, the PIP serves as a comprehensive guide for provinces and local levels to align their procurement process

coherence with federal policies, plans and programmes. It is expected to ensure time and cost efficiencies, quality in the procurement, and continuous availability of medicines and medical goods at all levels. The PIPs in both provinces include eight key outputs or intervention areas as below:

Output-1: Institutionalisation of Pre-bid Information System

Output-2: Effective Implementation of Procurement Plan

Output-3: Implementation of Standard Procurement Process

Output-4: Improved Contract Management

Output-5: Strengthened Supply Chain Management

Output-6: Guaranteed Quality Assurance

Output-7: Enhanced Institutional Capacity

Output-8: Maintained Good Financial Governance

Outputs 1 to 5 above are principal outputs. The achievement of those outputs leads to the achievement of core outputs 6 to 8, which form the rationale of implementing the PIPs.

5 KEY FINDINGS ON THE PROGRESS ON PIPS

This chapter presents key findings on procurement practices, status, strength, and issues related to PIP in the provinces with emphasis on outputs planned. The activity-wise status findings and scoring against the five-point scale have been provided in Annex- 2.

5.1 INSTITUTIONALISATION OF PRE-BID INFORMATION SYSTEM:

Pre-procurement planning is crucial, which involves need identification, forecasting and quantification, market engagement, specification development, cost estimation, and budget forecasting. An efficient institutionalised information system is integral, and provinces are using various systems such as the Electronic Logistics Management Information System (e-LMIS), Health Management Information System (HMIS), Electronic Medical Records (EMR), PLMBIS, PAMS, CGAS, Subnational Treasury Regulation Application (SuTRA), and Technical Specification Bank (TSB) for financial management and facilitation of the procurement process. Madhesh province, with ADRA Nepal's support, is finalising a Supply Chain Management (SCM) Guideline, while Lumbini province is advancing e-LMIS, quantification, and forecasting through Provincial Health Directorate (PHD) and Provincial Health Logistics Management Center (PHLMC). Monthly e-LMIS reporting, has also been initiated in FY 2022-23 in both provinces. Lumbini province is planning to form guidelines for budget forecasting and appropriation of budget on medicines and medical goods based on PLMBIS, CGAS, and SuTRA for budget forecasting and allocation in the health sector.

The DoHS, representing MoHP, regularly updates the TSB, benefiting both provincial and local governments. The Curative Service Division (CSD) has finalised a BHS medicines list for all government tiers and is planning to endorse new BHS medicine specifications, which will be uploaded to the TSB and printed versions will be distributed to all health procuring entities. The system of ‘Planning and Management of Assets in Health Sector (PLAMAHS)’ is, being upgraded to manage equipment inventory and its condition but a system to record medical goods' unit prices over time is not available yet. Despite this, historic prices are retrievable for referencing in cost estimates. Access to all these data and information systems has been a positive feature in both provinces.

Despite this medical goods procurement duplication persists across government levels. The challenge lies in reconciling dual systems, for example, e-LMIS and PAMS are both mandated by FCGO for inventory recording. Integrating these systems is crucial to avoid confusion and work duplication.

5.2 EFFECTIVE IMPLEMENTATION OF PROCUREMENT PLAN

Procurement plans are indispensable for effective procurement activities and serve as a valuable tool for monitoring too. During the formulation and submission of AWPB, all PEs outline Annual Procurement Plans (APPs) for upcoming procurement activities, albeit without formal procurement plans at the budget proposal stage. Larger Procurement Entities (PEs) generally prepare APPs after the fiscal year commences and budget authorisation is obtained. Conversely, smaller PEs and local governments tend to create procurement plans just before executing procurement. Notably, PHLMC and PPHL in both provinces-initiated APPs at the start of the fiscal year, and many entities such as the provincial hospital in Lumbini responded during the discussion that they were unaware of preparing APPs. Procurement plan templates are available at the PPMO website and e-GP portal, which are in use.

5.3 Implementation of Standard Procurement Process:

Procurement standardisation involves establishing agreed-upon norms for procuring goods, services, and works to enhance efficiency, quality, and safety while driving down costs. Utilising the Standard Bidding Document (SBD) is a primary means to achieve effective public procurement. In the health sector across all government tiers, SBDs prescribed by the PPMO, and e-GP portal are prevalent. However, health-specific SBDs have not been endorsed yet by the PPMO for e-GP, limiting its utility in managing health sector procurement at the subnational level. PHLMCs in both provinces demonstrate a robust adoption of e-GP, with over 97% usage for contract amounts handled via bidding (Table 8). This reflects the alignment of e-procurement systems with PPA and PPR down to the local level.

Table 8: Total procurement in FY 2022/23 by PHLMC (Value in million NPR.)

Description	Madhesh		Lumbini	
	Value (Amount)	%	Value (Amount)	%
Total Contract Value	1,037.42	100	66.04	100
Use of e-GP	1,020.32	98	63.93	97
Non-e-GP	17.10	2	2.11	3

Source: *PHLMC data received during field visits from respective provinces*

The DoHS has developed a facilitation handbook for medical goods procurement, encompassing procurement method selection, supply-chain management, and emergency procurement. This has been disseminated to health sector entities across all three spheres of government and its use at provincial and local tiers has notably enhanced procurement efficiency and compliance with fiduciary regulations.

According to respondents, various purchasing units at provincial and local levels have led to varying unit prices and medical goods quality. The lack of proficient procurement personnel is evident. Respondents recommended a degree of harmonisation and consolidation in procurement through the Framework Arrangement, aiming to mitigate these challenges. In alignment with this, DoHS-MD developed a model SBD for medical goods procurement under the framework arrangement, which has been submitted to PPMO for review and endorsement.

5.4 Improved Contract Management

Effective contract management involves not only timely contract execution but also the seamless management of the procurement lifecycle and contract administration to maintain an unobstructed supply chain in procurement management. Successful procurement encompasses more than just signing contracts on time; it entails expert contract management that oversees the quality and quantity of medical goods, works, and services according to predefined criteria, along with punctual supplier/contractor payments. To enhance contract management effectiveness, a comprehensive system was envisioned to record procurement activities from planning to acquisition, ensuring quality adherence, acceptance, and payment to vendors or suppliers. Neither in Madhesh nor Lumbini has the provincial entity developed the Contract Management System (CMS) during this rollout period, and conventional methods for tracking contract progress post-signing persist. Local

levels in particular exhibit weaker contract management capacity and monitoring mechanisms compared to those other spheres of government in the health sector.

A provision mandates public disclosure of contract information within three days of contract signing by the PE for procurement via bidding. Despite no evidence of post-contract signing public notices, all PEs publish a 'Notice of Intention to Award' before the contract award decision and signing - a fiduciary requirement as per PPA and PPR. The latter practice facilitates transparency by sharing contract information with the public, aligning with the respective PE's procurement transparency obligations.

5.5 Strengthened Supply Chain Management

Effective management of the supply chain requires proper infrastructure, equipment, skilled human resources, and an information exchange system via e-LMIS and warehouse management among all tiers of government and federal entities. The all-in-one flow of goods, data, and finances from procurement to service delivery forms the backbone of supply chain management. DoHS, PHLMCs, and PHDs recognise the importance of e-LMIS rollout and real-time data entry. EDPs like ADRA Nepal, Save the Children, and FHI 360 support health procurement at all levels by offering guidelines, training, and data entry oversight. Real-time data entry has been successful up to PHLMCs and HO levels, but local levels face confusion between PAMS and e-LMIS.

Effective inventory management and supply chain are vital. However, Madhesh province currently relies on rented space as a medical store, lacking proper dry medical storage while a new medical store supervised by DUDBC is under construction. Both provinces established vaccine stores during the COVID-19 pandemic which continue to function. Lumbini province has a medical store but it requires expansion and upgrades. The stores are facing a shortage of skilled personnel.

Distribution systems follow the prevailing Basic Health Logistics Guidelines. ADRA Nepal is supporting P-MoHP to develop an SCM guideline and is at the final stage of being endorsed in Madhesh province. A Warehouse Management Handbook for Medical Goods and a Directive for Disposal of Expired Medicines, Chemicals, and Medical Waste have been distributed by the FMoHP. Both provinces are aware and know about the disposal process, but have not practiced it due to coordination issues, budget constraints, and technical knowledge gaps. Madhesh province employs reverse logistics for TB medicines.

Lumbini province established a workshop for medical equipment maintenance. Both provinces implement Annual Maintenance Contracts (AMC) and Comprehensive Maintenance Contracts (CMC) for costly equipment, yet some remain unused due to inadequate maintenance. The biomedical engineers available in the provinces for repair and maintenance is not sufficient. Nick Simons Institute (NSI) provides support for establishment of biomedical workshops at provinces and Biomedical Equipment Technician (BMET) trainings at hospitals.

5.6 Guaranteed Quality Assurance:

Securing medical goods' quality is vital for ensuring VfM in the procurement of medical supplies and for the safety of patients. Adequate infrastructure and skilled technical personnel for inspection and testing at provincial and local levels are imperative for this. A Facilitation Handbook for Pre-shipment and Post-delivery Inspection of Medicines and Medical Goods, prepared by DoHS-MD, is available to PEs. PEs in both provinces conduct

post-delivery physical inspections whenever possible, aligning with available technical resources, but not tracked effectively and planned.

While no formal quality assurance and monitoring system for medicines is currently in practice in any province, bidding documents incorporate quality assurance clauses to be complied with before awarding and shipment. Lumbini province has been conducting some laboratory testing, particularly for bulk procurement, however, no quality testing labs exist at the provincial level across any province. Provincial ministries in both provinces aim to establish provincial quality testing labs for medicines and medical goods, but they lack the technical know-how and budget deficit to run such labs.

5.7 Enhanced Institutional Capacity

Effective procurement management requires skilled and trained personnel and institutional capacity. Enhancing institutional capacity entails boosting staff capabilities through professional training, short courses, on-the-job learning, workshops, and more at federal, provincial, and local levels. This strategy, coupled with retaining institutional knowledge, forms the foundation of PIP implementation. Staff at PHLMC, PPHL, and PHD levels have been trained in procurement and e-GP. While local levels employ e-GP-trained human resources, many are not from the Health Section. PHLMC and PHD support hospitals and local levels in e-GP implementation and procurement facilitation. Basic Health Logistics Management and Public Procurement training manuals are utilised, providing fundamental training modules for health sector logistics management and procurement. There is a demand for advanced training in procurement, e-GP, and supply chain management. However, the capacity of the PHTC needs enhancement to effectively conduct such training within the province.

5.8 Maintained Good Financial Governance

Upholding sound financial governance in public procurement serves as an essential indicator of comprehensive public sector governance. Demonstrating good governance involves actions such as disclosing procurement details, adhering to a code of conduct for procurement officials, and establishing a system for addressing grievances. Among these measures, health entities primarily practice publishing a "Notice of Intention to Award" for the public and participating bidders, while other methods of sharing procurement information remain less utilised in provinces. In Lumbini province, there is a practice of organising suppliers' meetings prior to the tendering in specific cases, with pre-bid meetings more commonly organised for substantial procurements. Instances of grievances from bidders/suppliers are relatively infrequent, and PEs effectively manage and address these concerns promptly. Evaluation of procurement compliance involves assessing the volume of audit irregularities, which are minimal.

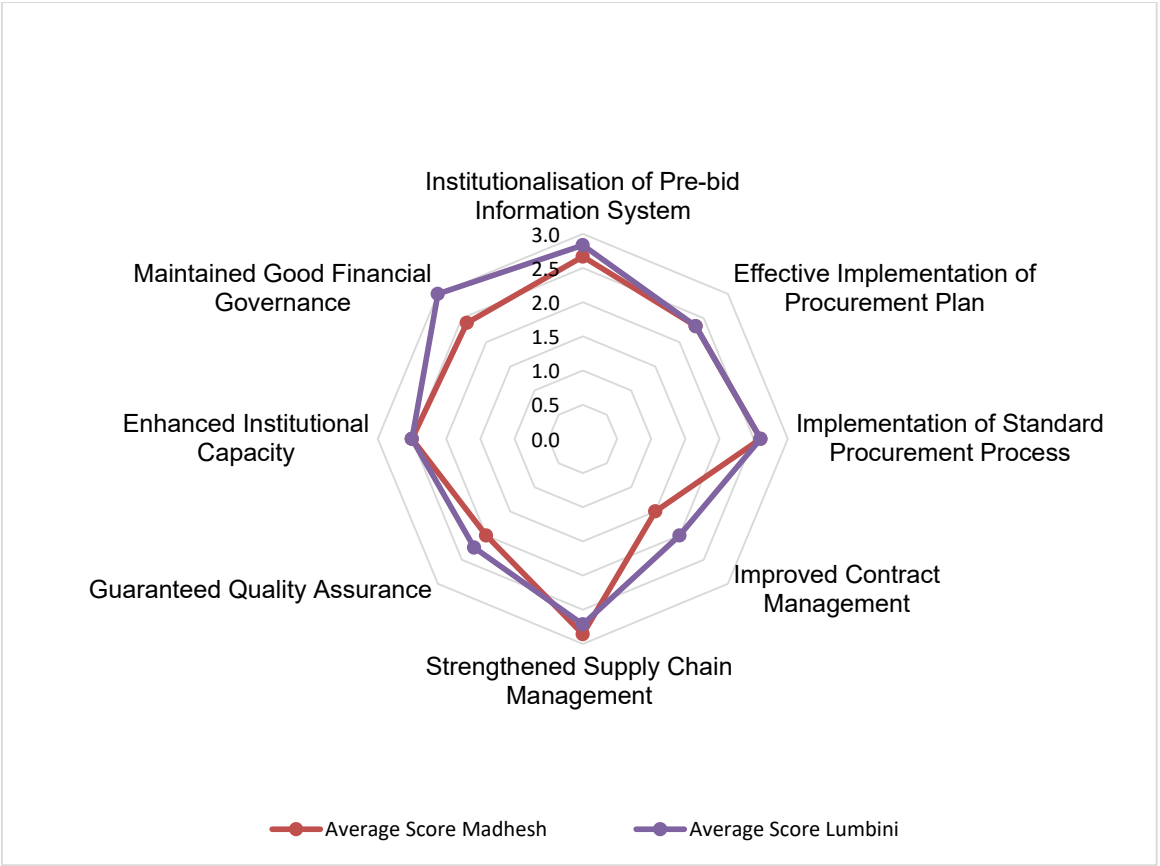
5.9 Overall Analysis

As per the assessment tool designed, PIP activities were rated on five-point scale as poor, below average, average, above average and well implemented, based on the progress status observed. Average scoring was calculated for the key interventions within the eight key outputs and is presented in the graph below (Figure 5).

Lumbini province was found to score little higher above average than Madhesh in Output 1 which refers to institutionalising pre-bid information system as planning to prepare guidelines for budget forecasting and preparing a list of items procured in previous years. Both the

provinces scored average for Outputs 2 and 3 on implementing procurement plan and standard procurement processes. Output 4 on contract management practice was the worst performing output where both provinces were below average, and Madhesh was further below Lumbini. In terms of Output 5 however Madhesh province has begun drafting the SCM guideline and hence a pioneer in this regard, and Lumbini too has performed well. Quality assurance – Output 6 - in both the provinces however is weak, although Lumbini province has been practicing post-delivery testing in bulk procurement. Both the provinces have low average scores on Output 7 on institutional capacity indicating the lack of adequate competent staff in procurement and SCM. Lumbini province regularly has suppliers' meetings and publishes some procurement information on its website, show a better average score in governance practices – Output 8 - than Madhesh province. In summary, Lumbini has done marginally better in terms of implementation of the PIP than Madhesh, but both provinces have to undertake a number of other activities to be fully compliant with the requirements of their PIPs.

Figure 5: PIP Progress of two Provinces in FY 2022/23



Source: Annex-2, Average score obtained from the activity wise rating point.

6 CONCLUSION AND RECOMMENDATIONS

6.1 FMIP

There is recognition of the need for sound financial management practices and accountability at the province level in both provinces. Despite efforts made against several core FMIP indicators over the short period over which it has been implemented, a number of areas face challenges. Effective financial monitoring, internal control strategies and sustained reductions in audit queries remain a major challenge for the health ministries and their spending units in both provinces.

There is dearth of expertise and skills proficiency at the sub-national level, and awareness of financial management reforms has been fairly basic, mainly in line ministries and agencies. In the context of limited capacities, implementation of a wide range of technical activities is challenging and the expectation of it only adds to the burden of an already constrained workforce in the provinces. Completion of tasks then becomes the goal, which do not necessarily lead to actual improvements. A focus on basic targeted improvements initially, could therefore be prudent before moving to more advanced reforms. The depth of provincial ownership and an enabling environment are crucial for the accomplishment of the FMIPs.

6.1.1 Recommendations for FMIP

Some practical recommendations to help better implementation of the FMIP are as follows:

Building capacities

- At the core of most challenges in the federal health system of Nepal currently are human resource issues. Ensuring availability of well trained and skilled staff at the provincial and local levels is essential at the very outset. The Organisation and Management (O & M) Survey and Public Service Commissions (PSCs) at the federal and provincial levels can accelerate efforts to fill-in already vacant positions.
- Robust in-service training of provincial stakeholders within the government is needed render financial management mechanisms are reliable and effective. Provincial Training Centres can step up efforts to improve PFM training capacities within their own institution.
- Elected representatives at the province level, the Public Account Committee, Secretaries and Provincial Social Committee and elected leaders, Hospital Management Committees have to be oriented on the FMIP outputs, the key intervention areas and activities, along effective oversight and coalition building.
- Financial and administrative staffs and healthcare managers particularly involved in planning, budgeting and decision making have to be made literate on service delivery needs and financial management practices respectively so that specific activities included in the FMIP are executed effectively.

Monitoring

- Monitoring of expenditures in provincial hospitals, PHLMC and PPHL has to be strengthened; and bottlenecks in financial management of services has to be addressed. PMoH officials will need to undertake these monitoring activities which in turn requires strong capacities within the ministries.

- Staff working in financial management in health ministries and public health entities could be incentivised to carry out analysis and clearance of irregularities and mitigating fiduciary risk.

Strategic coordination and mutual learning

- Healthcare providers, planning and procurement teams, and financial managers/officials have to be brought to a single platform for joint discussions and sharing. PMoH has to lead on this coordination and attention needs to be paid on both political economy factors, system design, technical operations, and fiscal accountability and transparency.
- A PFM advocacy and knowledge platform (learning and sharing, communities of practices, resource, exposure, technical assistance, and backstopping) has to be set up for enabling transparency in health spending and enhancing health fiscal space with the support of EDPs, CSOs and private sectors.
- To optimise PFM and health service delivery, it is recommended to develop a performance plan with strategies for each health entity including ministries with targets, allocated resources, and review yearly in the presence of wider stakeholders.

6.2 PIP

Procurement of medical goods is key for provinces, as they are responsible for supplies to a number of provincial as well as local level facilities. There is commitment to improve health standards, and an effort to standardise medicine and medical goods procurement and supply chains. Progressively, the PMoH in both provinces have initiated steps to enhance transparency, competitiveness, and effectiveness in health sector procurement. There have been advancements over the ten months following the introduction of provincial procurement improvement plans (PIPs) which range from standardised pre-bid information systems, refined contract management and enhanced supply chain management. However, a number of planned activities and expected outputs are yet to be realised.

6.2.1 Recommendations for PIP

Procurement planning and governance

- Information systems need to be integrated and made interoperable so that the linked procurement systems provide a more holistic picture. Systems such as the e-LMIS have to be expanded to all health institutions for real-time data entry, and Federal MoHP/DoHS needs to update guidelines for system usage and pre-procurement information.
- A market review on medical products should be conducted and keep TSB up to date, enhance PLAMAHS to cover equipment details, and provide historical procurement unit prices for cost estimation. This review should aim to understand current market trends within Nepal for medical products, identify potential supplies and their capabilities, and analyse the pricing structure, cost-effectiveness and innovation in medical supplies and technologies. This information would be helpful for strategic planning and setting realistic budgets and estimating costs. If resources allow this could be an annual review that PHLMC could lead on.
- Provinces have to prepare APP during AWPB preparation and revise as necessary after getting appropriation of budget, ensuring early execution and fiscal alignment.
- Three tiers of governments have to work together to create a contract management system more transparent and timely delivery medical goods and services.

Quality assurance and monitoring mechanism

- All three governments have to prioritise quality medicine procurement process by establishing quality assurance and monitoring mechanisms, ensuring Pre-Shipment Inspection and Post-Delivery Inspection as per the facilitation handbook, and setting-up medicines testing labs and inspection agencies across provinces.
- Federal and provinces have to develop an SBD for health sector goods and advocate for its endorsement by PPMO. Introducing Framework Arrangements would contribute to a smooth, quality-focused supply of goods. Compliance and acquisition of quality medicines enhances with the use of the procurement facilitation handbook for medical goods procurement .

Capacity building

- Continuously develop capacity through training, exposure, and experience sharing in procurement, e-GP, logistics, inventory, forecasting, and quantification. Align training with the PPMO manual and elaborate guidance for health procurement management.
- Developing a roster of certified and trained resource persons, Massive Online Open Courses (MOOCs) in procurement and supply chain methods, and peer-to-peer learning processes could foster procurement knowledge and skills among government staffs, procurement decision makers and suppliers.

Supply chain effectiveness

- Guidelines for supply chain management systems, inventory management and control, transportation, forecasting and quantification need to be updated at the provincial level. Warehouse infrastructure, equipment, and skilled technical human resources in the warehouses need to be improved, and distribution has to strengthened with defined ToRs and regular surveillance, inspection and supervision of storage and supply facilities.

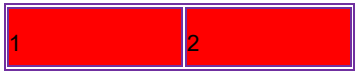
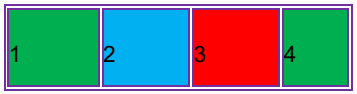
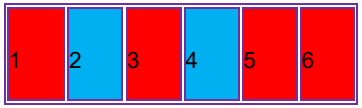
7 ANNEXES

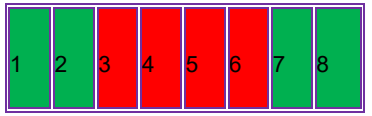
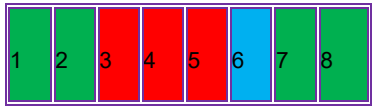
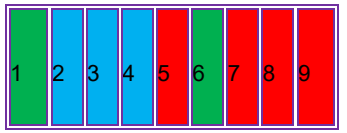
7.1 ANNEX—1: ACTIVITY STATUS TRACKING TABLE (FMIP):

Output/Objective/Key Intervention Area	Activity Implementation—Key Observations and Practices, FY 2022/23	Colour[24] Coding (Overall Status Rating)
4.1 Improvement on Budget and Programme (Budget Preparation – Credibility, Comprehensiveness, Transparency and Policy-based): *(Under this Output 4 Key Intervention Areas and 18 Activities were planned)*		
4.1.1 Policy-Based Budgeting	Six activities are planned to be implemented through PMoH's Policy and Planning Division (PPD), under this major intervention area, and a summary of the activities' implementation status has been depicted here. Both provinces prepared and submit MTEFs to P-MoF in March and April. Neither province has a health policy, strategy, nor result-based framework in place, but preparing budget guidance and sending it to municipalities (Madhesh). However, both provinces are in the process of drafting a health policy. The Madhesh province's Cabinet approved safe abortion, safe motherhood, and reproductive health guidelines, which could be served for budget allocation in such targeted programs. In the Lumbini, the budget absorption target was not met, although it was in Madhesh. A review of the health activities from the prior year is in place, but the pre-budget budget committees are not functioning in any provinces.	Madhesh 1 2 3 4 5 6[25] Lumbini 1 2 3 4 5 6
4.1.2 Comprehensive and Transparency	Under this main intervention area, six activities were intended to be executed by PMoH's PPD. A description of the activities' current state of execution is shown in the box. Approximately, more than 75% of the spending units under the Health Ministry could prepare their budgets within the permitted time after receiving budget circulars from the ministry in both provinces. However, it is unclear how wider stakeholders were included in the budget planning process, however, PGs are soliciting suggestions/input in policy and programme proposals from websites. The budget is comprehensive enough, it is allocated to various health programmes, and economic headings, such as recurrent and capital budgets. In Lumbini, budget meetings typically include discussions of donors, but not in Madhesh. Although P-LMBIS is fully operational, no spending units other than ministries have permission to enter budget proposals there.	Madhesh 1 2 3 4 5 6 Lumbini 1 2 3 4 5 6

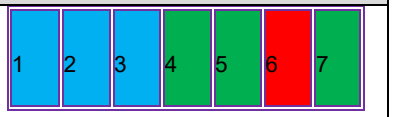
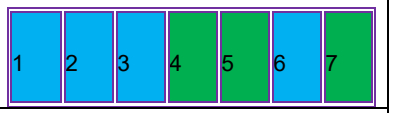
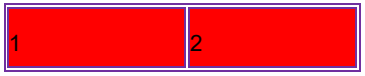
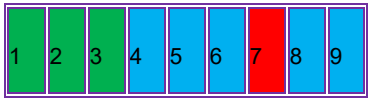
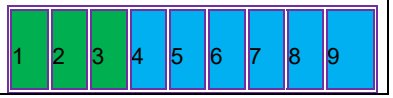
[24] Colour Code Definition: ***i) For single spending unit/entity responsible of activity implementation):*** **Green:** Completion (Implemented); **Blue:** Partially completion (In progress)**; Red:** Not complete (Late); and **ii) For multiple spending units responsible for activity implementation: Green**—Completion of activity by ≥4 entities; **Blue**—Completion of activity by < 4 but ≥2 entities; **Red** —Completion of activity by < 2 entities.

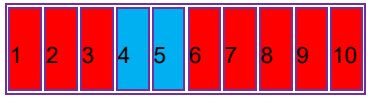
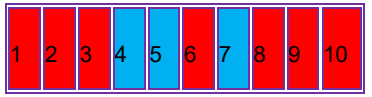
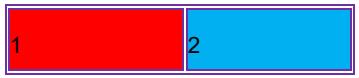
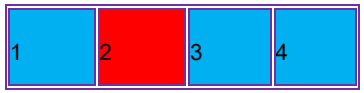
[25] Each numbers indicate respective activity under the specific Key Intervention Area in the Implementation Status Table within FMIP.

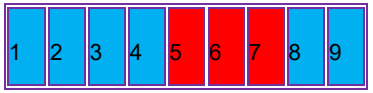
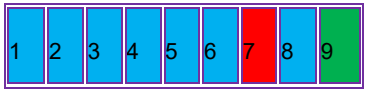
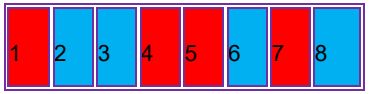
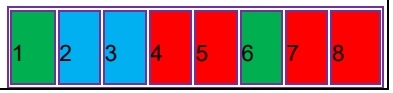
Output/Objective/Key Intervention Area	Activity Implementation—Key Observations and Practices, FY 2022/23	Colour[24] Coding (Overall Status Rating)
4.1.3 Budget Formulation Based on Business Plan	Two activities were planned under this intervention area to be implemented both from PMoH's PPD and spending units, but neither provinces nor any hospitals have developed Business Plan. Stakeholders have different views about business plans, some expressed government entities do not need business plans, but some agreed with developing such tools for generating income and being self-sustained.	Both 
4.1.4 Budget Release, Expenditure, Authorisation, Budget Surrender and Budget Analysis	Under this significant intervention, four activities were scheduled to be implemented by PMoH's PPD and various spending units. According to the Appropriation or Advance Expenditure Act, PLMBIS is approved within the given seven-day time frame in both provinces. With a few exceptions, most expenditure units prepare their annual action plans between July-August and proceed for implementation accordingly. But no provinces are performing budget analyses and budget surrender.	Both 
4.2 Strengthen the Internal Control: *(Under this Output 2 Key Intervention Areas and 9 Activities were planned)*		
4.2.1 Develop the Mechanism for Financial Management	Three actions were intended to be carried out through PMoH's Administrative and expenditure units under this important area of intervention. The Internal Control Guideline and any associated Internal Control Committee have not been created by any provincial PMoH. Furthermore, none of the proposed expenditure units have established Audit Support Committees.	Both 
4.2.2 Stimulation on Supervision, Monitoring and Feedback Mechanism	Six actions were scheduled to be implemented through PMoH's Medical Service and Monitoring Division and various expenditure units as part of this important intervention area. Ministries have not created any monitoring standards or checklists for monitoring. However, provincial centres, directorates, and ministries have been commissioning regular monitoring. Field visit reports are created for financial reasons, although OAG reporting forum no. 909 is not followed. Except in pressing and emergencies, field visit reports are neither regarded seriously nor compiled to make an integrated monitoring report to be available to the public. The health sector has not yet used performance contracts.	Both 
4.3 Improvement on Financial and Management Accounting: *(Under this Output 4 Key Intervention Areas and 26 Activities were planned)*		
4.3.1 Harmonised/ Uniformity of the Accounting Software	Eight actions encompassing all spending units were proposed under this important intervention area to be executed through Financial Administration Section (FAS) and various spending units. All entities use Cash Based-Double Entry Accounting Systems to keep accounting expenditures, receipts, and deposits while continuing to use CGAS for bookkeeping and financial reporting. Neither the ministries nor the hospitals are	

Output/Objective/Key Intervention Area	Activity Implementation—Key Observations and Practices, FY 2022/23	Colour[24] Coding (Overall Status Rating)
	coordinating with PTCO to develop software or upgrade features in CGAS to better track internal income in hospitals. There is currently no method in place to obtain approval from the concerned office or committee within the allotted time frame for validation and reporting on human resource payroll for both permanent and contracted workers. Furthermore, no ministries had coordinated the addition of menus to the CGAS for viewing anticipated physical progress (Lumbini: manually working to track physical progress). Even though all ministries/spending units could access the FMIS[26] software system, PTCO in Madhesh has not acknowledged providing users to sector ministries. Nevertheless, directorates in both provinces have done a good job of managing the records of individual field visits with reference numbers. In spending units, there were no problems with forward payments in both provinces.	Madhesh  Lumbini 
4.3.2 Strengthen the Internal Audit	Nine actions were slated to be implemented under this major intervention area for all spending units, including PMoH as a responsibility of a Chief and Head of FAS. Although it is not common practice to conduct quarterly internal audits of income-expenditure, revenue, and deposits in spending units, or organisations outside the purview of P/DTCO internal audit system, year-end internal audits are usually done within the two months of the fiscal year's end with the coordination of the relevant P/DTCO. In both, provinces, if a Chief or Account Officer is transferred while a monthly internal audit is being conducted, s/he has been taking the responsibility to clear all financial obligations. Similarly, the audit queries in the internal audit reports are only partially addressed by a few entities; the Directorate in Madhesh has the least amount of arrears, while the Directorate in Lumbini is working to resolve issues. Both provinces have a limited monitoring system in place without internal audit recording software. As such, there is no provision for compiling audit reports to make an integrated one. No Audit Committee, and system for review of such reports by the minister in both provinces.	Both 
4.3.3 Timely Preparation of Trimester and Annual Financial and Physical Progress	Under these key intervention areas, seven activities were planned to be conducted by the Chiefs and the Head of FAS in all entities. Interviewed all spending units said preparing details of resources and assets and commitments are not prepared monthly, however, this is in practice quarterly and systems such as CGAS and RIMS reflect these details. Further, these entities are preparing the statement of allocation, revenue collected, assets and guarantee annually, and submitting to PTCO or office assigned or OAG office, whereas	Madhesh

[26] FMIS is operated by FCGO/PTCO/DTCO and available to spending ministries to view the financial progress in all its spending units.

Output/Objective/Key Intervention Area	Activity Implementation—Key Observations and Practices, FY 2022/23	Colour[24] Coding (Overall Status Rating)
	ministries are further preparing centralised statements of such sources and reconciling as well, and these reports form the basis for OAG audit as well. Both MoHP is preparing physical and financial progress reports, however, time is not met as planned. No, ministries are involved in preparing and submitting Audited Financial Reports/Project Accounts to donors or EDPs. In MoHP in Lumbini, reporting on donor format for GFMAT as per need. Non-budgetary expenditures are made through miscellaneous accounts and reported to donors as deemed necessary.	 Lumbini 
4.3.4 Maintain the Financial Risk Register Framework and Implementation	Under this intervention area, two activities were planned for PMoH's Administrative Division and cost centres, though no activity is accomplished in any provinces. Directorate in Madhesh said, it has been reviewing the audit risk shown in the audit report but could clarify to the extent such risk mitigation practices are applied in financial transactions and expenditure management.	Both 
4.4 Improvement on Public Procurement: *(Under this Output 1 Key Intervention Areas with No Activity planned)*		
4.4.1 Procurement Improvement Plan	Procurement Improvement Plan in both provinces developed during September 2022, and under implementation. For performing this activity, the responsibility has been assigned to various divisions including PPD, Public Health Divisions and Administrative Division. A separate report has been prepared for this key intervention area with tracking of each activity.	Both 
4.5 Auditing and External Scrutiny: *(Under this Output 4 Key Intervention Areas and 24 Activities were planned)*		
4.5.1 Audit, Audit Response and Audit Queries Record	Nine activities were scheduled for this audit category of the intervention, with major responsibility assigned to the Chief and Head of FAS. Through the Nepal Audit Management System (NAMS), all spending units enter all financial data, audit clearance information, and pertinent statements available to the OAG team and reply to management feedback within 35 days. According to Annex 13 of the FPFAR, 2020, entities should further distinguish internal audit arrears from external audit arrears, but they were unable to do so within the permitted 15-day time frame. Additionally, ministries are not correctly accumulating information about all audit arrears from their cost centres. In addition, spending units are updating the status of audit arrears clearance, however, the process and rate at which audit backlog and irregularities are addressed is slow or not in practice.	Madhesh  Lumbini 

Output/Objective/Key Intervention Area	Activity Implementation—Key Observations and Practices, FY 2022/23	Colour[24] Coding (Overall Status Rating)
	Ministries occasionally organise meetings with PTCO and OAG, and Madhesh audit reports are reviewed by Public Account Committee in parliament as well.	
4.5.2 Achieving the Target of Audit Clearance	Ten activities were intended to be carried out across all PMoH expenditure units as a major intervention area, with major responsibility assigned to the Chief and Head of FAS. No entities are preparing an Audit Clearance Plan that falls short of the 60% goal for clearing arrears as targeted in the FMIP. Even though both ministries have a history of clearing and regularising previous audit arrears from the OAG team by giving proofs and appropriate papers at the time of the formal audit, there is no practice of delivering details of audit backlog (old arrears) to Kumari Chock Adda that could not be recovered. As such, nor monthly reporting in audit queries clearance, neither handover office clearance, nor reward and punishment for audit meeting audit clearance targets (at least 50% clearance of audit queries is a threshold set for reward) is in progress in any province.	Madhesh  Lumbini 
4.5.3 Reduced Arrears Percentage Against Audited Amount	Under this key intervention area for all spending units, targets of audit clearance (of the audited figure) did not meet, updated arrears piling and submission of proofs to clear arrears at the time of external audit is partially implemented in both provinces. During the past FY 2021/22, no arrears were recovered.	Both 
4.5.4 Discussion with Public Account Committee on OAG Report, Maintain Directives and Execute the Decision	Within this significant intervention area, three activities were planned, and the Secretary and Head of the Administrative Division and FAS are responsible to facilitate these activities. Although the rate of clearance is extremely low, audit clearance talks are routinely held. All entities in both provinces have been sent official letters from PMoH, and discussions regarding the audit backlogs of very previous years are still ongoing. Documentation and implementation of PAC decisions in both PMoH are insufficient.	Both 
4.6 Improvement on Assets Management: *(Under this Output 2 Key Intervention Areas and 13 Activities were planned)*		
4.6.1 Advance Management and Monitoring	Four activities were intended to be coordinated by all expenditure units under this core intervention area. Although directorates have a greater need for advances than ministries, hospitals and PHLMC does, the timely advance settlement has been given priority, and no staff is allowed an advance over another advance until the previous advance has been cleared in full. For training and orientations, direct payment is less common in practices. Neither advance mobilisation, nor concerns with advance forwarding and also, no guidelines are developed related to advance settlement and regulated in any province.	Both 

Output/Objective/Key Intervention Area	Activity Implementation—Key Observations and Practices, FY 2022/23	Colour[24] Coding (Overall Status Rating)
4.6.2 Inventory Accounting, Use, Safety and Handover-Takeover	Nine activities were planned to be implemented in this new area of intervention across all entities, with responsibilities primarily assigned to the Chief and Head of Store Section. PAMS has been implemented in ministries and directorates, although PHLMIS, PPHL, and hospitals employ two systems, i) e-LMIS for medical records and ii) PAMS for general goods recording, imposing burdens in both provinces. PAMS reports are generated, although it is unclear whether they were completed within the timeframe specified in the federal FPFAA, 2020. Last year, FCGO withheld payment from Siraha Hospital for failing to use PAMS. Hospital land and equipment records (including old and damaged and needed maintenance such as motorcycles, jeeps, cars, health equipment, furniture, and machinery tools, among others) have been partially put into the system. Both provinces have concerns with auctions, sales, and disposal. Handover is practised during transfer but is inadequately implemented. Madhesh province has allocated a budget for the disposal of useless and expiry commodities in hospitals.	Madhesh  Lumbini 
4.7 Improvement of Institutional and Human Resource Capacity: *(Under this Output 2 Key Intervention Areas and 11 Activities were planned)*		
4.7.1 Preparation of Directives, Update and Publication	Under this cross-cutting intervention, three activities were designed to be facilitated by PMoH. Three crucial guidelines on programme implementation, financial management, and audit clearance are intended to develop, but none have been formed. Various respondents stressed that financial capacity development is not getting priority in PMoH in both provinces and service providers and finance and administrative officers need rigorous training on preparation of financial strategies, documents, and their application.	Both 
4.7.2 Conducting Orientation/Workshop/ Training for Capacity Building	In this crucial intervention area involving the development of financial management competence, eight activities were planned. Despite some orientations and in-house discussions, none of the provinces has initiated any actual capacity-building initiatives. There are no scheduled or committed orientation sessions for financial management, budget analysis, or CGAS operation. The formulation of Business Plans and training to operate PAMS and NAMS were not organised to responsible staff. In the last year, neither province has scheduled any exposure or learning trips.	Madhesh  Lumbini 

7.2 ANNEX—2: ACTIVITY STATUS TRACKING TABLE (PIP):

S.N.	Key Outcomes/Key Interventions	Base Year Status 2021/22	Implementation Plan of 2022/23	Means of Verification	Rating[27]		Observations/Comments
					Madhesh	*Lumbini*	
1.	**Institutionalisation of Pre-bid Information System**						
1.1	Use of information from e-LMIS, HMIS, EMR, and PAMS in forecasting and quantification	Data entry in e-LMIS, HMIS by health institutions and in PAMS by local levels, but e-LMIS is not functional on all sites.	• Revision of guidelines for quantification by using e-LMIS, and HMIS and send to all PEs for implementation from this year Make PAMS and e-LMIS compatible	• Use of information from e-LMIS and HMIS in forecasting and quantification in procurement	4	3	• Monthly reporting of e-LMIS done for information. • Madhesh province has started to prepare a Supply Chain Management Guideline including forecasting, quantification and e-LMIS operation with the support of ADRA Nepal. • Discussion between FCGO and MoHP/DoHS-MD began for making interoperability of e-LMIS and PAMS.
1.2	Use of information from P/LMBIS, CGAS, and SuTRA in budget forecasting and preparation	Operational at all federal entities	• Preparation of guidelines for budget forecasting and appropriation on medicines and medical goods taking information from P/LMBIS, CGAS, SuTRA	• Use of P/LMBIS, CGAS, and SuTRA in budget forecasting	3	4	• Previous year data used for budget forecasting. • Lumbini province is planning to prepare guidelines for budget forecasting and appropriation of budget on medicines and medical goods taking information from PLMBIS, CGAS and SuTRA. • Training conducted at local levels on forecasting, quantification, and budgeting on medicines and medical goods.

[27] Rating is done on point scale 1-5 based on progress on activity completion such as, poor, below average, average, above average and very good.

S.N.	Key Outcomes/Key Interventions	Base Year Status 2021/22	Implementation Plan of 2022/23	Means of Verification	Rating[27]		Observations/Comments
					Madhesh	*Lumbini*	
1.3	Use of TSB in the procurement of medical goods	Technical Specifications of 121 medicines, 1114 instruments and 117 COVID-19-related items available in the TSB system with individual codes.	• Publication of specification booklet of BHS medicines and equipment by federal level • Circular for use of updated TSB sent to hospitals and health institutions	• Updated technical specifications available in TSB and its use by PEs in the Health Sector	2	2	• Available TSB is being used by the provincial and local governments. • Provinces have not initiated to prepare separate TSB. • CSD is planning to endorse new technical specifications of BHS medicines and upload them on the TSB as well as publication in a booklet and distribute to all the PEs of health.
1.4	Preparation of a list of medicines and medical goods to be procured by Federal, Provincial and Local Level	Standard Treatment Protocol (STP) for Basic Health Services approved	• Approval of list of medicines and medical goods to be procured from all three levels for basic and emergency health services	• List of medicines and medical goods available and monitored the procurement	5	5	• CSD has finalised the list of BHS medicines to be procured by the three levels of government and circulated to all the PEs. • The provinces and local levels are following the approved list of medicines to be procured by the respective levels of government.
1.5	Preparation of a list of medicines and medical goods purchased till last year with its current condition	A list of conditions of medicines and medical goods purchased till last year is not available	• Updating of the list of condition of medicines and medical goods purchased till the last year	• Updated list of condition of medicines and medical goods purchased till previous year available. • Update available on the website of the concerned entity	1	1	• PLAMAHS software is in the process of upgradation, which will record the inventory and conditions of medical equipment at all hospitals and HFs. • There is duplication of medical goods procurement at the federal, provincial, and local levels.
1.6	Preparation of unit price list of medicines and equipment procured till the previous year	Unit price list of medicines and equipment procured till previous year not available in computerised system	• Entering the unit price of medicines and equipment procured last year in computerised system and maintaining the average unit price	• The average unit price obtained from the unit price of medicines and equipment procured in previous years.	1	2	• The unit price list of medicines and equipment procured till the previous year is not available, but last year's price reference can be obtained when needed. • Lumbini Province is planning to prepare a list of items procured in previous years with unit prices.
2.	**Effective Implementation of Procurement Plan**						

S.N.	Key Outcomes/Key Interventions	Base Year Status 2021/22	Implementation Plan of 2022/23	Means of Verification	Rating[27]		Observations/Comments
					Madhesh	*Lumbini*	
2.1	PPSF for medicines and medical Goods preparation and execution by federal and PIPs by provinces	PIP exists at the federal level and draft PPSF for medicines and medical goods prepared	• Preparation and endorsement of PPSF at the federal level • Preparation of provincial PIP coherent with the federal PIP	• Federal PPSF endorsed. • PIP rolled out in provinces.	5	5	• PPSF endorsed at the federal level. • PIPs in Madhesh and Lumbini provinces were endorsed and rolled out.
2.2	Preparation of Annual Procurement Plan at the time of preparation of AWPB for the coming Fiscal Year and its implementation	The annual Procurement Plan is prepared partially along with the proposed AWPB for the fiscal year	• Preparation of Procurement Plan while proposing budget and update and revise Annual Procurement Plan as per the approved AWPB	• Procurement Plan prepared at the time of preparing AWPB. • Readiness of revised Annual Procurement Plan at the beginning of the fiscal year and implemented	1	1	• Only a tentative plan for expenditures was prepared at the time of preparing AWPB. • Procurement Plans are prepared after receiving the approved budget.
2.3	Preparation of Consolidated Annual Procurement Plan (CAPP) and monitoring	Consolidated Annual Procurement Plan (CAPP) prepared at federal MoHP and DoHS	• Sample CAPP will be made available on the website and monitoring of CAPP	• Practice of CAPP preparation and monitoring of its execution	1	1	• The practice of preparing APP at the beginning of F/Y was found in PHLMC and PPHL of both provinces. • There is no practice of preparing APP by other PEs. However, they prepare a procurement plan before procurement. • Procurement plan formats are available on the PPMO website and e-GP portal
3.	**Implementation of Standard Procurement Process**						
3.1	Standardisation and harmonisation of the procurement process with the use of e-GP	e-GP in use	• At least 80% of the annual contract value of bids done through e-GP at all levels	• Use of e-GP in all procurement done at all levels	3	3	• Large amounts of procurements are done through e-GP. • The use of e-GP by the PHLMCs in procurement is above 97% in terms of contract amount.

S.N.	Key Outcomes/Key Interventions	Base Year Status 2021/22	Implementation Plan of 2022/23	Means of Verification	Rating[27]		Observations/Comments
					Madhesh	*Lumbini*	
3.2	Preparation of Standard Bidding Document for procurement of medicines and medical goods	There is no separate Standard Bidding Document for procurement of medicines and medical goods	• Request PPMO for preparation and apply Standard Bidding Document for procurement of medicines and medical goods	• Standard Bidding Document for medicines and medical goods endorsed by PPMO	1	1	• Standard Bidding Document for medicines and medical goods is not available. • Support of PPMO is necessary for this intervention.
3.3	Preparation of Facilitation book for Selection of Procurement Methods	Not present	• Preparation of Facilitation Handbook for selection of appropriate procurement method of medicines and medical goods	• Facilitation Handbook for selection of appropriate procurement method of medicines and medical goods prepared and used	4	4	• A facilitation handbook for procurement of medical goods prepared by the DoHS and distributed to all the health sector PEs of three levels is in use.
3.4	Implementation of Framework Agreement	Not present.	• Preparation of draft Bidding Document for Framework Agreement and sent to PPMO for endorsement	• Execution of Framework Agreement in the procurement of medicines and medical goods	1	1	• A Framework Agreement is not executed in the procurement of medical goods. • DoHS-MD had prepared a model SBD for procurement of medical goods under framework arrangement and sent it to PPMO. • Support of PPMO is necessary for this intervention.
3.5	Preparation of Facilitation Handbook for procurement of medicines and medical goods in Special Circumstances (Emergency Procurement)	Not present	• Preparation of Facilitation Handbook for procurement of medical goods in Emergencies and its implementation	• Facilitation Handbook prepared. • Procurement in emergency monitored	4	4	• There is a guideline for emergency procurement too in the facilitation handbook prepared by DoHS. Which has been followed by the provinces.
4.	**Improved Contract Management**						

S.N.	Key Outcomes/Key Interventions	Base Year Status 2021/22	Implementation Plan of 2022/23	Means of Verification	Rating[27]		Observations/Comments
					Madhesh	*Lumbini*	
4.1	Update Contract Management System (CMS) and monitoring	Contract Management System is not in use	• Contract Management • System (CMS) Software prepared/ updated and implemented for managing contracts	• CMS implemented, fully executed, and monitored.	1	1	• No contract management system was prepared. • The traditional system of tracking the progress of contracts after contract signing is found in practice. • Contract management capacity and its monitoring mechanism are observed weak in local levels.
4.2	Publishing of contract management information	Not in practice	• Preparation of format for publishing contract management information and execution	• Information of contract available • Information available on an electronic platform	2	3	• Notice of Intention to Award before making the award decision and signing the contract is in practice as per law. • Lumbini province is preparing a format for publishing contract management information.
5.	**Strengthened Supply Chain Management**						
5.1	**Real-time** data **entry** of procurement and supply chain management in all levels and system developed for the exchange of information among the three levels	e-LMIS in operation	• Preparation of guidelines for e-LMIS operation in hospitals and implementation • Monitoring of Real-time data entry and system development for information exchange, and its implementation	• Real-time data entry applied • e-LMIS implemented	4	3	• Real-time data entry in the e-LMIS system has been satisfactory up to the PHLMC and HO levels. • The local levels have not been able to enter data in the e-LMIS due to the dilemma of PAMS vs. e-LMIS. • More than 85% of PEs of Madhesh enter data in e-LMIS. • The medicines sent from Central Medical Store or PHLMC and the medicines procured from conditional grants are entered in e-LMIS

S.N.	Key Outcomes/Key Interventions	Base Year Status 2021/22	Implementation Plan of 2022/23	Means of Verification	Rating[27]		Observations/Comments
					Madhesh	*Lumbini*	
5.2	Revision and updating of inventory management, forecasting and quantification guidelines for Federal, Provincial and Local Levels	Procurement and storage guidelines available	• Revision of inventory management, forecasting and quantification guideline	• Execution of revised guideline	3	2	• No new guideline for inventory management, forecasting and quantification developed by federal MoHP/DoHS. • Madhesh province is developing SCM guidelines and is in the process of endorsement. • For the time, the prevailing developed Basic Health Logistics Handbook is in use. • Forecasting and quantification in practice.
5.3	Strengthening of Inventory M**anagement** of medicines and medical goods	Storage guideline exists	• Identify required technical manpower in stores, • Management of store as per standard, • Feasibility study for warehouse infrastructure and capacity	• Stores are constructed as per the standards and stores are managed by skilled manpower	2	3	• Pharmacists are available at PHLMCs and technical manpower available at Health Offices, but not accessed at local levels. • The warehouse standard of Lumbini Province is not sufficient for Provincial capacity. Looking for more space and maintaining necessary standards. • Madhesh province is using the medical store as a rented infrastructure, but a new medical store, designed and supervised by DUBDC is in the final stage of construction.
5.4	Preparation of directive for the Distribution system of procured materials and its implementation	Not present	• Approval of directive for the Distribution system of level-wise procured materials will be prepared and its implementation. • Development of a distribution system based on requirement	• Directive for Distribution system of procured goods approved and implemented	3	3	• No directive for the distribution system of level-wise procured material developed. • A new SCM guideline developed by Madhesh province will address this. • Lumbini province is following the prevailing Basic Health Logistics guidelines.

S.N.	Key Outcomes/Key Interventions	Base Year Status 2021/22	Implementation Plan of 2022/23	Means of Verification	Rating[27]		Observations/Comments
					Madhesh	*Lumbini*	
5.5	Effective management of push/pull system including transportation facilities in the distribution of medicines and medical goods	Push/Pull system exists	• Preparation of guidelines for the Push/Pull method in the distribution of medicines and medical goods. • Develop and implement directives with technology for the systematic	• Effective transportation systems strengthened. • Effective transfer of medicines and medical goods strengthened	3	2	• The prevailing Basic Health Logistics Guideline in use. • There is a practice of reverse logistics for TB medicines in the Madhesh province. • Transportation of medicines and medical goods is not satisfactory at local levels.
5.6	Implementation of medicines and medical goods storage system improvement program	• FEFO system in use • Directive prepared for disposal of expired medicines	• Disposal of expired medicines as per the directive, • Strengthening of FEFO, Push/Pull, Stockout Monitoring systems	• Expired medicines disposed. • Warehouse management improved by executing the FEFO system	3	3	• Warehouse Management Handbook for Medical Goods and a Directive for Disposal of Expired Medicines, Chemicals and Medical Waste prepared by the FMoHP/DoHS and distributed to all HIs. • Push/Pull, FEFO and stock-out monitoring system used as per prevailing federal guidelines. • There is a lack of coordination, budget, and other logistics for disposal of expired medicines and medical waste.
5.7	Initiation of repair and maintenance of medical equipment and instruments	• Repair and maintenance done in some hospitals	• Preparation of directive and implementation • Management of necessary biomedical engineers for repair and maintenance	• In the use of usable medical equipment and instruments after maintenance	2	3	• No HR for repair and maintenance in Madhesh. The existing biomedical engineer is not sufficient. • The PLAMAHS is not in use but is in the process of updating. • Biomedical workshop at Lumbini • There is a practice of AMC and CMC of sophisticated equipment. • NSI is supporting for establishment of a Biomedical Workshop and providing BMET training in hospitals.
6.	**Guaranteed Quality Assurance**						

S.N.	Key Outcomes/Key Interventions	Base Year Status 2021/22	Implementation Plan of 2022/23	Means of Verification	Rating[27]		Observations/Comments
					Madhesh	*Lumbini*	
6.1	Preparation of directives for Quality Assurance and Preparation of a quality control system for medical goods through a Quality Assurance Plan	Not present	• Preparation, endorsement, and implementation of directive • Initiation of Quality Assurance Plan	• Directive prepared and in use. • Quality of procured medicines and medical goods assured	2	3	• No formal Quality Assurance and Quality Monitoring System of medicines found practiced, but quality assurance mechanisms are available in the PSI and PDI facilitation handbook. • Quality control clauses are mentioned in bidding documents. • Lumbini province has practiced laboratory testing in bulk procurement.
6.2	Preparation of directive for Pre-shipment inspection and Post-delivery inspection of medicines and medical goods	Facilitation Handbook for Pre-shipment inspection and Post-delivery inspection of medicines and	• Preparation of directive, endorsement, and implementation	• Strengthened Quality Assurance of medicines and medical goods	3	3	• The Facilitation Handbook for Pre-shipment Inspection and Post-delivery Inspection of Medicines and Medical Goods prepared by DoHS-MD is available at the PEs.
6.3	Develop a Quality Monitoring System for medicines	No quality assurance system at the province and local level	• Assure and monitor the quality of medicines procured by taking samples from the Department of Drug Administration	• Effective quality monitoring of medicines at all levels	1	1	• No Quality Monitoring System. • PDI is limited to physical inspection and verification.
6.4	Study on the need for laboratories at the provincial level for quality testing of medicines and medical goods	Study not done	• Study on the need for quality testing lab at the provincial level for quality testing of medicines and medical goods	• Initiation of quality testing of medicines and medical goods at the provincial level	2	2	• Advocacy has been initiated at the provincial ministerial level of both provinces for establishing quality testing labs at the provincial level.
7.	**Enhanced Institutional Capacity**						
7.1	Availability of trained manpower on procurement and implementation of e-GP	Less number of trained manpower available	• Development of useful training modules including basic e-GP and providing training	• Trained manpower on procurement available and execution of e-GP	4	4	• PHLMC, PPHL and PHD level staff are found trained in procurement and e-GP. • PPMO has developed a Training Module and Session Plan on Public Procurement. • Local levels have also used e-GP-trained human resources in procurement.

S.N.	Key Outcomes/Key Interventions	Base Year Status 2021/22	Implementation Plan of 2022/23	Means of Verification	Rating[27]		Observations/Comments
					Madhesh	*Lumbini*	
7.2	Develop and update integrated training module on procurement, enhance the capacity of personnel and managers involved in procurement	Draft training module developed	• Initiate to establish resource centres in Health Training Centres, • Develop/update the integrated training module	• Efficient procurement through efficient operation • Define and follow a clear outline of the training series	3	3	• PPMO has developed a Training Module and Session Plan on Public Procurement. • There is no procurement training module in PHTC.
7.3	Availability of necessary skilled manpower for Supply Chain Management	Less number of trained manpower available	• Revise and use guidelines for logistics management, inventory management, forecasting and quantification	• Availability of trained human resources	4	4	• There is a Basic Health Logistics Training manual. • Trained facilitators for logistics management, inventory management, forecasting and quantification available in PHLMC and PHD of both provinces. • Still, there is a smaller number of trained staff in the stores. • Hospitals are not practicing forecasting and quantification techniques.
7.4	Prepare a Roster of trainers and experts trained in procurement and supply chain management.	No procurement trainers familiar with the health sector	• Initiate preparation trainer	• Availability of trainers and experts in the health sector to provide procurement and logistics management training	2	2	• A virtual knowledge bank on health sector procurement experts developed at the Management Division of DoHS. • No procurement trainers are available in provinces. However, PHLMC and PHD are facilitation hospitals and local levels for procurement.
7.5	Sharing procurement experiences and spreading good learning ideas	Not exercised	• Enhance skills in Framework Agreement, LMIS, TSB, e-GP, and supply chain management through training, exposure visits, among others	• Expansion of exposure visits and learnings	1	1	• Not practiced.

S.N.	Key Outcomes/Key Interventions	Base Year Status 2021/22	Implementation Plan of 2022/23	Means of Verification	Rating[27]		Observations/Comments
					Madhesh	*Lumbini*	
7.6	Develop web-based training materials and keep training materials in the bank	Not present	• Develop concept notes on the training material bank and prepare guidelines for uploading developed training materials on the web	• Uniformity and effectiveness in training provided by trainers and experts at province and local levels	1	1	• Basic Health Logistics Management and Public Procurement training manual in use.
8.	**Maintained Good Financial Governance**						
8.1	Make the information public after the completion of the procurement process	Not present	• Preparation of format for publishing procurement information	• Procurement information published in the approved format	1	2	• Only publication of notice of intention to award. • Lumbini province has published some procurement information on its website.
8.2	Organisation of Suppliers' Conference	Practiced in DoHS	• The organisation of meetings with potential suppliers and at least one annual suppliers' conference will be	• Suppliers are updated about the procurement in the health sector and queries of suppliers on	2	3	• There are practices for organizing pre-bid meetings. • Lumbini province had practiced organisation of suppliers' meetings before tendering in special cases.
8.3	Preparation of a code of conduct for the officers involved in procurement	No separate code of conduct	• Preparation of a code of conduct for the officers involved in procurement and use	• Code of conduct in use	4	4	• A separate code of conduct was not prepared. • The code of conduct mentioned in the PPA followed.
8.4	Establishment of Grievance Handling Redressal Mechanism (GHRM) and increase citizen engagement	Web-based GHRM system established in DoHS/LMS	• Enhance the effectiveness of the present GHRM system	• GHRM system in use at all levels	2	3	• Grievances are addressed by the PEs, and they have been redressed in time. • Some grievances are addressed in the pre-bid meeting also. • Grievances from the bidders/suppliers are less observed. • Web-based system for citizen engagement has not been established. Conceptual discussion is done in Lumbini province.

S.N.	Key Outcomes/Key Interventions	Base Year Status 2021/22	Implementation Plan of 2022/23	Means of Verification	Rating[27]		Observations/Comments
					Madhesh	*Lumbini*	
8.5	Procurement Compliance System developed in health sector and preparation of its guideline	Not present	• Preparation of concept note, System design, and endorsement by MoHP	• Good Procurement practices established	3	3	• A procurement Compliance System has not been developed, but the Bid Evaluation Committee checks the procurement compliances in Lumbini province. • Procurement compliances measured in terms of the volume of audit irregularities are normal.

7.3 ANNEX—3: ORGANISATIONS AND OFFICIALS CONSULTED AND INTERVIEWED:

Organisation (Address) (Madhesh and Lumbini Provinces)	**Number of Officials (With Designations)**
Ministry of Finances and Provincial Treasury Controller's Offices (both provinces)	10 (Ministers, Secretaries, Planning and Budgeting Officers, IT Officers, Internal Auditors)
Ministry of Health and Population (in Madhesh) and Ministry of Health (in Lumbini)	10 (Secretaries, Consultant Senior Consultant Medical Directors, Nursing Officers, Account Officers, Administrative Officer)
Public Health Directorates in both provinces	7 (Directors, Account Officers, Statistician, Senior Public Health and Statistician, MSS Officers)
Provincial Health Logistics Management Centres (both provinces)	6 (Directors, Account Officers, Procurement Committee Members, Donor Staff)
Provincial Public Health Laboratories (both provinces)	5 (Directors, Administrative Officers, Lab Technicians, Cold Chain Officers, and Procurement Consultants)
Provincial Health Training Centre (Lumbini)	3(Director, Training Coordinator, Account Officer)
Provincial Hospitals (one in each province)	9 (Medical Superintendents/Directors, Medical Officers, Accountants, Medical Recorders, Storekeepers, Nursing In-charges)
Ayurbeda Aushadhalaya (in Lumbini)	1 (Chief of Ayurbeda Aushadhalaya)
Municipality Officials (7 municipalities both provinces)	20 (Mayors, Chief Administrative Officers, Account Officers, Health Section Chiefs, Health Officials)
NHSSP Province (both provinces)	6 (Provincial Lead & Coordinators)
PFM USAID and ADRA Nepal (Madhesh)	2 (Province Team Leads)
Office of the Chief Minister and Council of Ministers (OCMCM) Province and Local Governance Support Program (both provinces)	3 (Governance and Legal Expert, PFM Expert, Monitoring and Reporting Expert)
Total	**87 Officials (30 Females and 57 Males)**
Also, interacted by telephone with various other officials working on PFM and procurement management in respective provinces.	

7.4 ANNEX—4: FMIP STATUS ASSESSMENT-DISCUSSION QUESTIONNAIRE:

- How does the linkage of health policies and priorities with budget policy and program and the government's long-term social and development vision?
- How do you manage the overall health budget cycle and planning functions?
- How has FMIP helped to prepare a budget and how its activities are implemented in spending units?
- Does FMIP help in understanding the budget process?
- What are the laws and guidelines related to planning and budgeting? How are they implemented? Does the budget calendar follow?
- Who leads the budget preparation, and how priorities are set? and how negotiations happened with spending units and MoF.
- How does MTEF form and submit and are linkages developed with periodic plans and annual plans?
- How budget executed and expenditures monitored? What are internal practices and internal control systems applied?
- What are major financial issues in hospital management and recording, reporting and audit of internal revenue of hospitals?
- How is the internal control system and intern audit procedure adopted in PMoH and spending units?
- Which software is used for financial reporting, is there any issues related to the operations of software and management information system used for financial management?
- How are fiscal transfers in health managed and are they adequate, timely and effective?
- Does timing of financial reporting, assets verification and audit feedback are maintained?
- What are training needs related to FMIP implementation and budgeting?
- What is the status of the budget planned vs. expenditure and virement?
- What are the major issues and barriers in planning, budgeting, and expenditure management?
- What measures could be applied for effective implementation and improvement of the financial system of PMoH?
- What are the strengths, and opportunities in health service delivery in the provinces?
- Any additional remarks or opinions regarding the health sector PFM reforms?

Note: FMIP Activity Status Tracking Sheet (Nepali) is also part of this checklist.

7.5 ANNEX—5: PIP STATUS ASSESSMENT-DISCUSSION QUESTIONNAIRE:

- How the Forecasting and Quantification of medicines, equipment and other goods are being done? When do you do it?
- Is there any procurement guideline developed or updated?
- Do you use both e-GP, e-LMIS and PAMS? How are they used and any difficulties?
- How the budget for procurement is forecasted? What basis are being considered?
- How the specifications are being prepared? Are the SBD and TSB being in use?
- How is the list of medicines and equipment prepared for procurement?
- How the cost estimates and APP are being prepared?
- Is there a Contract Management System used and publicise the contract information?
- Is the warehouse/store as per the required standard? Is there any standard requirement, design and drawing available for the warehouse/store?
- Is there any guideline for Inventory management, quantification, and forecasting?
- Is there proper infrastructure and human resources in stores as needed? Is there any standard of human resources defined?
- Are there any guidelines for distribution, disposal, and waste systems? Do they follow them?
- Are there proper human resources for the repair and maintenance of the equipment? Are there any guidelines?
- Is there practice of PSI, PDI and Lab tests?
- What provisions and facilities are available for testing?
- Are there trained staff in Procurement and eGP?
- Are there practices of sending staff for training in Procurement and Logistics Management?
- Are the exposure visits to other procuring entities practiced?
- Is the procurement information being published for public notice?
- Do you have practice in interacting with prospective suppliers before procurement? Do you organise suppliers' meetings?
- Is there any code of ethics for employees working in procurement?
- How often are the grievances in procurement being faced? Do they are redressed in time and a proper manner?
- Any other concerns, issues, and remarks/ comments in PIP implementation.

Note: PIP Activity Status Tracking Sheet (Nepali) is also part of this checklist.

7.6 ANNEX—6: PARTICIPANTS OF VALIDATION WORKSHOP AND POLICY DISCUSSION:

6.1 Province: Madhesh **Date: September 15, 2023** **Venue: Janakpur**

S.N.	Name of Participant	Designation	Organisation
1	Dr. Pawan Kumar Yadav	Secretary	P-MoHP
2	Dr. Shrawan Kumar Mishra	Director	PPHL
3	Dr. Ram Naresh Pandit	Medical Director	Provincial Hospital
4	Dr. Indrajeet Kumar Rajak	Senior Medical Director	P-MoHP
5	Laxmi Prasad Joshi	Under Secretary	F-MoHP
6	Satish Kumar Shah	Medical Officer	PHD
7	Dr. Sachit Kumar Sharma	Division Chief	P-MoHP
8	Ram Naresh Shah	Accountant	PHD
9	Vijaya Kumar Gupta	PHO	P-MoHP
10	Nirbhaya Shankar Jha	PHO	P-MoHP
11	Ashok Kumar Yadav	Pharmacy Inspector	PHLMC
12	Vijaya Kumar Chaudhary	Account Officer	P-MoF
13	Dinesh Chaudhary	Accountant	Janakpur SMC
14	Navin Kumar Mishra	PHO	Janakpur SMC
15	Shaligram Chaudhary	Account Officer	F-MoHP
16	Sanjiv Kumar Paswan	Asst. Accountant	P-MoHP
17	Sunita Gupta	Chief	HO, Mahottari
18	Dipendra Kumar Yadav	PLMBIS Specialist	P-MoF
19	Arati Sharma	H.N.S.	Provincial Hospital
20	Laxmeswar Kamati	Na. Su.	P-MoHP
21	Nanulal Mahatto	A.C.O.	P-MoF
22	Sirjana Gyawali	Program Officer	F-MoHP
23	Ramesh Kumar Yadav	Provincial Health Officer	WHO
24	Sagar Dahal	G&A Lead	NHSSP
25	Ram Kaji Bhomi	Procurement Advisor	NHSSP
26	Krishna Prasad Awasthi	PFM Expert	NHSSP
27	Jeetendra Nayak	PHSS Lead	NHSSP

6.2 Province: Lumbini Date: September 24, 2023 Venue: Butwal

S.N.	Name of Participant	Designation	Organisation
1	Dr. Janardhan Panthi	Secretary	MoH
2	Dr. Binod Kumar Giri	Director	PHD
3	Dr. Puspa Raj Poudel	Division Chief	MoH
4	Roshan Lal Chaudhary	Director	PHLMC
5	Deepak Gyawali	Chief	PTCO
6	Nod Narayan Chaudhary	Act. Director	PHTC
7	Deepak Adhikari	SPHO	F-MoHP/DoHS
8	Gaurav Dhakal	SPHO	HO, Rupandehi
9	Dr. Savyata Panthi	Ayurvedha Physician	MoH
10	Hari Prasad Acharya	Cold Chain Inspector	PHLMC
11	Ram Prasad Bhattarai	PHI	PHD
12	Dol Bahadur Raj	Pharmacy Inspector	PHLMC
13	Bikram Aryal	Medical Lab Technologist	PPHL
14	Hum Prasad Khanal	Lab Technologist	PPHL
15	Yubaraj Pandey	PHO	Butwal SMC
16	Basanta Khawas	Accountant	Butwal SMC
17	Durga Prasad Poudel	Accountant	MoH
18	Sambhu Ghimire	Officer	MoH
19	Shaligram Chaudhary	Account Officer	F-MoHP
20	Saugat Sambahangphe	Section Officer	F-MoHP
21	Ranjana Prajapati	Computer Officer	F-MoHP
22	Krishna Prasad Awasthi	PFM Expert	NHSSP
23	Ram Kaji Bhomi	Procurement Advisor	NHSSP
24	Deepak Chhetri	PHSS Lead	NHSSP
25	Tara Nath yogi	Q&C PC	NHSSP
26	Alok Nath Jha	EBP PC	NHSSP
27	Sanjeev Sapkota	FO	NHSSP

7.7 ANNEX—7: A FEW PHOTOGRAPHS AND SCREENSHOTS OF DOCUMENTS:

Interview of Health Minister in Madhesh

Interview with Secretary of Madhesh

Discussion with P-Hospital team

After Discussion in PPHL in Lumbini

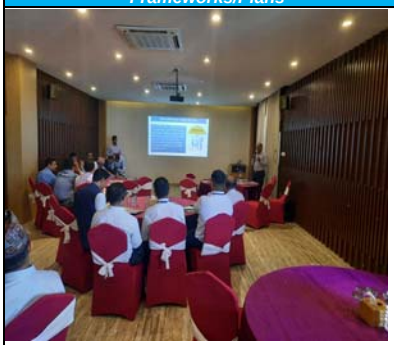
After Discussion in PHTC in Lumbini

Discussion with PHD Official in Lumbini

Financial and Procurement Strategic Frameworks/Plans

Procurement Facilitation Manuals

Classification of BHS Medicines



Policy Dialogue and Validation Workshop (Lumbini)

Policy Dialogue and Validation Workshop (Madhesh)

Presentation Slide

7.8 ANNEX—8: BUDGET AND EXPENDITURE DATA (ADDITIONAL):

Province Government, Provincial Treasury Controller's Office, **Lumbini Province**										
Overall Budget Vs. Expenditure (Amount in NPR.) (FY 2022/23)										
SN	**Ministry/Central Agency**	**Recurrent**			**Capital**			**Total**		
		Budget	**Expenditure**	**%**	**Budget**	**Expenditure**	**%**	**Budget**	**Expenditure**	**%**
1	Provincial Assembly	226,410,000.00	139,261,696.27	61.51	117,356,000.00	84,719,548.84	72.19	343,766,000.00	223,981,245.11	65.16
2	State Public Service Commission	37,200,000.00	77,506,354.22	208.35	14,800,000.00	14,384,996.00	97.20	52,000,000.00	91,891,350.22	176.71
3	Office of the Attorney General	14,500,000.00	11,102,062.13	76.57	500,000.00	1,061,509.00	212.30	15,000,000.00	12,163,571.13	81.09
4	Office of the Chief Minister and Council of Ministers	914,445,000.00	606,827,556.49	66.36	66,750,000.00	75,935,829.02	113.76	981,195,000.00	682,763,385.51	69.58
5	Ministry of Economic Affairs	363,777,000.00	112,283,390.97	30.87	46,840,000.00	17,137,651.60	36.59	410,617,000.00	129,421,042.57	31.52
6	Ministry of Industry, Tourism and Transport	727,391,000.00	422,744,269.86	58.12	364,550,000.00	269,057,202.69	73.81	1,091,941,000.00	691,801,472.55	63.36
7	Ministry of Agriculture and Land Management	2,330,350,000.00	1,410,615,546.45	60.53	149,150,000.00	56,645,213.95	37.98	2,479,500,000.00	1,467,260,760.40	59.18
8	Ministry of Home Affairs, Law, and Communications	222,996,000.00	147,957,552.95	66.35	407,215,000.00	266,827,533.00	65.52	630,211,000.00	414,785,085.95	65.82
9	Ministry of Forests and Environment	905,571,000.00	768,881,920.96	84.91	1,115,129,000.00	770,646,020.81	69.11	2,020,700,000.00	1,539,527,941.77	76.19
10	Ministry of Physical Infrastructure Development	521,136,000.00	331,512,772.32	63.61	13,220,472,000.00	10,115,085,832.09	76.51	13,741,608,000.00	10,446,598,604.41	76.02
11	Ministry of Water Supply, Rural and Urban Development	434,774,000.00	200,450,706.53	46.10	6,487,826,000.00	5,148,801,669.45	79.36	6,922,600,000.00	5,349,252,375.98	77.27

12	**Ministry of Social Development**	**2,290,856,000.00**	**1,595,635,149.48**	**69.65**	**782,650,000.00**	**504,031,691.03**	**64.40**	**3,073,506,000.00**	**2,099,666,840.51**	**68.32**
13	**Ministry of Health**	**3,080,799,000.00**	**2,586,698,245.05**	**83.96**	**1,500,860,000.00**	**409,756,370.43**	**27.30**	**4898656000.00**	**2992997045.00**	**63.40**
14	Provincial Planning Commission	26,504,000.00	14,525,519.30	54.81	12,950,000.00	6,594,158.00	50.92	39,454,000.00	21,119,677.30	53.53
15	Finance- Miscellaneous	1230943000	1,758,000.00		190000000	0.00	0.00	1,420,943,000.00	1,758,000.00	
	Sub-Total	*13,327,652,000.00*	*8,427,760,742.98*	*63.24*	*24,477,048,000.00*	*17,740,685,225.91*	*72.48*	*37,804,700,000.00*	*26,168,445,968.89*	*69.22*
16	Local level Transfer	4,831,000,000.00	4,401,628,785.00	91.11	0	0.0	0.00	4,831,000,000.00	4,401,628,785.00	91.11
	Grand Total	**18,158,652,000.00**	**12,829,389,527.98**	**70.65**	**24,477,048,000.00**	**17,740,685,225.91**	**72.48**	**42,635,700,000.00**	**30,570,074,753.89**	**71.70**

Expenditure of immediate past ministries are shown in new ministries. Expenditure data are initial estimate from website of PTCO, Lumbini as of July 10, 2023.

Province Government, Province Treasury Controller's Office, **Madhesh Province**

Overall Budget Vs. Expenditure Details (Amount in NPR.) (FY, 2022/23)

SN	Ministry	Final Budget (NPR.)			Expenditure (NPR.)			Remaining	Progress		
		Recurrent	Capital	Total	Recurrent	Capital	Total		Recurrent	Capital	Total (%)
1	Province Parliament	369684000	21063000	390747000	245158392	19585539	264743931	126003069	66.32	92.99	67.75
2	Province Civil Service Commission	77042000	15110000	92152000	49551600	3351877	52903477	39248523	64.32	22.18	57.41
3	Principal Attorney General Office	38282920	1920000	40202920	29448249	1141865	30590114	9612806	76.92	59.47	76.09
4	Office of the Chief Minister and Council of Ministers	781245319	135727000	916972319	234448208.9	22382538	256830746.9	660141572.1	30.01	16.49	28.01
5	Ministry of Finance	228698918	19826483	248525401	100035234	11648330.5	111683564.5	136841836.5	43.74	58.75	44.94
6	Ministry Industry, Tourism and Forest	2346575007	2248113710	4594688717	984582199	1415038164	2399620363	2195068354	41.96	62.94	52.23
7	Ministry of Law, Justice and Province Assembly	50058500	4655000	54713500	23240020	2698767	25938787	28774713	46.43	57.98	47.41
8	Ministry for Land Management, Agriculture and Cooperative	1590017000	853490000	2443507000	645484749.4	428118887.9	1073603637	1369903363	40.6	50.16	43.94

9	Ministry of Water Supply and Energy	163731000	1696853000	1860584000	104708027.9	1096608183	1201316211	659267789	63.95	64.63	64.57
10	Ministry of Home Affairs and Communication	300191000	270100000	570291000	227143723	64138146	291281869	279009131	75.67	23.75	51.08
11	Ministry of Commerce, Supply and Science and Technology	34204852	7559000	41763852	13510479	4310054	17820533	23943319	39.5	57.02	42.67
12	Ministry Physical Infrastructure Development	1748893799	16905745000	18654638799	736946102.1	10036673141	10773619244	7881019556	42.14	59.37	57.75
13	Ministry Women, Children and Youth and Sports	247309000	328225000	575534000	107595465	185114682	292710147	282823853	43.51	56.4	50.86
14	**Ministry of Social Development[28]**	**4743771700**	**3399278490**	**8143050190**	**3587731926**	**2772578448**	**6360310374**	**1782739816**	**75.63**	**81.56**	**78.11**
15	Provincial Policy and Planning Commission	65395000	5000000	70395000	11477158	624155	12101313	58293687	17.55	12.48	17.19
16	Finance-Internal Debt Servicing/Payment	166456000	0	166456000	0	0	0	166456000	0	0	0
17	Finance-Miscellaneous	3539110392	361820027	3900930419	0	150000000	150000000	3750930419	0	41.46	3.85
18	Local Level (Fiscal Transfer)	4259000000	0	4259000000	3621843291	0	3621843291	637156709.3	85.04	0	85.04
	Total	**20749666407**	**26274485710**	**47024152117**	**10722904824**	**16214012777**	**26936917602**	**20087234515**			

Province Government

Province Treasury Controller's Office, **Lumbini Province**

Expenditure Details (Health Ministry/Service/Program) (Amount in NPR.) (FY 2022/23)

SN	Ministry/Service/Programme	Budget			Expenditure		
		Recurrent	Capital	Total	Recurrent	Capital	Total
1	Disability and Leprosy Control Programme	10100000	0	10100000	5594632	0	5594632
2	Ayurbeda (Federal Conditional)	88500000	0	88500000	86822779.5	0	86822779.5
3	Ayurbeda Health Offices	107500921	2430090	109931011	77709771.37	2411420	80121191.37

[28] Ministry of Social Development includes Ministry of Health and Ministry of Education

4	Treatment Service Programme	57000000	0	57000000	32023186	0	32023186
5	Integrated Health and Sanitation Programme	407043506	65997173	473040679	354387898.2	25361499.58	379749397.8
6	AIDS and Sexually Transmitted Disease Control (Union Conditional Grant)	25600000	0	25600000	19145608.4	0	19145608.4
7	Tuberculosis Control (Federal Conditional Grant)	53700000	0	53700000	25744070	0	25744070
8	Nursing and Social Security Services Program (Federal Conditional Grant)	94900000	0	94900000	69280577.17	0	69280577.17
9	Family Welfare Program (Union Conditional Grant)	653050000	2000000	655050000	469643357.7	1553908	471197265.7
10	State Public Health Laboratory	15248533	542054	15790587	9984962.6	459605	10444567.6
11	Provincial Health Supply Management Centre	20025550	80000	20105550	12850202.9	8501	12858703.9
12	Regional Hospital Strengthening Programme	458901162	1421563667	1880464829	395952665.9	363896862	759849527.9
13	Provincial hospitals	827750464	3116166	830866630	714982025.4	3006206.49	717988231.9
14	Epidemic Disease Control Program (Federal Conditional Grant)	107237000	0	107237000	83224449.55	0	83224449.55
15	National Health Training Centre (Federal Conditional Grant)	7800000	0	7800000	4944094	0	4944094
16	National Centre for Health Education, Information and Communication (Federal Conditional Grant)	7500000	0	7500000	4703625	0	4703625
17	Health offices	159701269	9513584	169214853	135408602.5	9285504	144694106.5
18	Health Training Centre	13423554	61977	13485531	10311880.9	61977	10373857.9
19	Directorate of Health	25951027	720182	26671209	19477732	476522	19954254
SN	**Ministry/Service/Programme**	**Recurrent**	**Capital**	**Total**	**Recurrent**	**Capital**	**Total**
20	Health Management Program (Federal Conditional Grant)	33300000	0	33300000	25133536	0	25133536
21	Ministry of Health, Population and Family Welfare	40595671	3157920	43753591	24045981.83	2797264	26843245.83

22	Others	174644530		174644530	1087554.17	1218583	2306137.17
	Grand Total	**3389473187**	**1509182813**	**4898656000**	**2582459193**	**4105378521**	**2992997045**

	Province Government				
	Province Treasury Controller's Office, **Madhesh Province**				
	Expenditure Details (Health Ministry/Service/Program) (Amount in NPR.) (FY 2022/23)				
SN	**Ministry/Service/Program**	**Initial Budget**	**Virement**	**Final Budget**	**Expenditure**
1	Medicine Production, Tools, and Equipment	1,117,400,000.00		1,088,589,000.00	1,056,627,896.92
2	Outpatient Services	108,300,000.00		108,300,000.00	93,933,634.00
3	Hospital Services	1,225,248,000.00		1,321,856,000.00	1,114,101,078.69
4	Public Health Service	1,052,064,000.00		1,108,724,000.00	1,000,132,489.80
5	Research Service	41,442,000.00		41,442,000.00	36,162,732.00
6	Health-Not Classified	93,628,000.00		100,098,000.00	86,944,244.00
	Total	**3,638,082,000.00**	**130927,000.00**	**3,769,009,000.00**	**3,387,902,075.41**

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