14th May 2012

Minutes of Consultative Meeting on Regional Health System Strengthening

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Ministry of Health & Population

NHSSP Nepal Health Sector Support Programme

Strengthening Health Systems-Improving Services

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ACRONYMS

AIPF	Annual Indicative Planning Figure
ANM	Auxiliary Nurse Midwife
ASRH	Adolescent Reproductive and Sexual Health
DFID	UK Department for International Development
DHSSP	District Health Sector Strategy and Periodic Plan
DoA	Department of Ayurveda
DDA	Department of Drug Administration
DP/HOs	District Public Health Offices
EDP	External Development Partner
EPI	Expanded Programme of Immunisation
FP	Family Planning
GESI	Gender Equality and Social Inclusion
GiZ	Deutsche Gesellschaft für Internationale Zusammenarbeit
HMIS	Health Management Information System
HR	Human Resources
INGO	International Non-Governmental Organisation
IUCD	Intrauterine Contraceptive Device
LHGSP	Local Health Governance Strengthening Programme
MDGs	Millennium Development Goals
MoHP	Ministry of Health and Population
NHSSP	Nepal Health Sector Support Programme
PNC	Postnatal Care
PPICD	Policy Planning and International Cooperation Division
PPP	Public Private Partnerships
RHCC	Regional Health Coordination Committee
RHCT	Regional Health Coordination Team
RHD	Regional Health Directorate
RHSSPP	Regional Health Sector Strategy and Periodic Plan
RHIB	Regional Health Information Bank
TA	Technical Assistance
WHO	World Health Organisation

INTRODUCTION

A consultative meeting on Regional Health System Strengthening was organised jointly by the Ministry of Health and Population (MoHP) and the Nepal Health Sector Support Programme (NHSSP) on 14th May 2012 at the Hotel Everest, New Baneshwor, Kathmandu, Nepal.The 53 participants included the Secretary and Director General of MoHP, MoHP Divisional Directors and other senior MoHP officials, UK Department for International Development(DFID) Health Advisors, NHSSP Advisors and Specialists working in MoHP, DoHS and Regional Health Directorates(RHDs), External Development Partner(EDP) representatives [World Health Organisation(WHO) and Deutsche Gesellschaft für Internationale Zusammenarbeit (GiZ)](See Annex I for the Participants List).

1. WELCOME REMARKS AND OBJECTIVES OF THE MEETING

Dr.Padam Bahadur Chand, Chief of the Policy Planning and International Cooperation Division (PPICD) of MoHP welcomed all the participants and highlighted the key objectives of this consultative meeting. The key objectives were:

- to review the mandate, achievements and challenges of the Regional Health Directorates (RHDs);
- to discuss the Regional Health System Strengthening programme, activities, and technical assistance (TA) inputs; and
- to agree the way forward to ensure investments in regional support and to obtain the maximum benefits.

He added that MoHP is seriously committed to address the needs of RHDs in order to achieve the objectives set out when the RHDs were established in 1985 (Annex II). He added that MoHP is working towards decentralising more authority to RHDs and making them accountable for the delivery of responsive services through monitoring and back-stopping to the districts.

2. STRUCTURE, ROLES AND RESPONSIBILITIES OF THE REGIONAL HEALTH DIRECTORATES

Dr. Baburam Marasini, Coordinator of the Health Sector Reform Unit, MoHP, briefly presented the objectives of establishing RHDs, their institutional structure, roles and responsibilities. He explained that the DoHS was abolished in 2042 (1985) and RHDs were established in five regions. RHDs were mandated to carry out MoHP's functions i.e. the programmes and activities of the three departments. The organisational structure of the RHD was developed accordingly. Each RHD is headed by a Director (11th level, equivalent to Gazetted First Class Officer). However, the DoHS was re-established in 2051 (1994) with necessary changes in the RHD mandates. The National Health Policy of 2048 (1991), and the Decentralisation Act and Regulations are the main bases for the establishment of the RHDs.

The role of the RHDs is to carry out the following:

- Strengthen the district public health system by providing technical and administrative support;

- Supervise and monitor the health services available in the regional, zonal and district level health facilities and ensure that districts do the same in peripheral level health facilities; and
- Decentralise implementation of the DoHS, Department of Drug Administration (DDA) and Department of Ayurveda (DoA) activities.

He also discussed the overall roles, functions and institutional structure of RHDs (Annex III). The major responsibilities of the RHDs that he highlighted were:

- Administrative and financial management;
- procurement of essential drugs and supplies;
- assisting implementation of national policy by analysing regional health services;
- regional planning and programming;
- supervision and M&E of DoHS, DDA and DoA activities;
- inter, intra and external coordination;
- management of epidemics and disasters;
- recommendations for scholarships/foreign tours/ observation tours etc. using MoHP criteria;
- identifying basic and refresher training needs and recommending appropriate human resources (HR) to the centres;
- collecting and compiling monthly progress reports from district public health offices (DP/HOs);
- following up with districts that fail to send monthly reports on time;
- reporting to the central level and carrying out action research for programme improvement.

Dr. Marasini also pointed out certain critical bottlenecks that seriously impact the effective functioning of RHDs. These include the following:

- insufficient physical facilities, furniture, equipment and office supplies;
- inadequate transportation; regional variations in staffing structure, job titles and numbers of approved posts;
- unclear roles and responsibilities of senior staff and out-dated job descriptions;
- almost 50% vacancies in officer posts (statistical officer, planning officer, public health nursing officer and health education officer);
- lack of grading differentials between regional and district level staff causing management difficulties and incompatibility;
- frequent staff transfers; high turnover in leadership posts;
- low motivation level among staff;
- lack of management guidelines;
- insignificant staff development budget;
- information flows from the centre bypassing regional offices;
- DP/HOs tending to report to MoHP/DoHS rather than to RHDs;
- RHD authority being undermined in two ways, both from the centre and the district;
- sub-optimal district monitoring that is unlikely to yield consistent data quality;

- RHD district data frequently not being edited and analysed before being forwarded to the HMIS section;
- monitoring checklists not being adapted to track local health concerns;
- planning remaining the responsibility of DoHS and MoHP with regional and district health plans being simply aggregations of centrally sanctioned budgets;
- regional and district health offices not being involved in priority setting;
- budget inadequate to respond to emergencies and natural disasters;
- poorly developed intra, inter, and external coordination systems;
- limited capacity to coordinate with regional offices of other line ministries and EDPs/INGOs;
- most EDPs/INGOs implementing vertical district level programmes with few links to RHDs.

In this context, Dr. Marasini urged EDPs to provide technical assistance to RHDs for overall health system strengthening with a particular emphasis on four major areas: health planning, monitoring and evaluation (M&E), health sector information system (HSIS) and coordination (inter, intra, and external).

3. REGIONAL PRESENTATIONS

All five Regional Health Directors gave brief presentations on their experiences of regional health system strengthening. They discussed the changes observed since the second half of 2011, after the introduction of technical assistance from NHSSP). They focused on the major challenges and way forward to strengthen the RHDs (See Annex IV to VIII).

3.1 MAJOR CHANGES

The major changes described by the Regional Health Directors are described briefly below.

3.1.1 Health Planning

- All RHDs developed an annual calendar of operations with staff job responsibilities, disclosure of allocated budget and implementation time/month. Some districts have rolled out this practice.
- An integrated plan has been developed that combines all programme activities approved by MoHP, DoHS and other different Divisions and Centres.
- Selected staff members working at RHDs and districts have been trained on the planning process and preparation of the annual work programme and budget.
- Staff members working at RHDs and districts are sensitised to gender equality and social inclusion (GESI) in health planning and service delivery.
- A GESI Technical Working Group has been formed in all RHDs and is gradually being rolled out in the districts.
- The concept and process of identifying hard-to-reach areas and populations for focused programme intervention has been introduced.
- One-stop Crisis Management Centres have been established in selected district and zonal hospitals.

- The Mid-western Regional Health Directorate has developed a District Strategic Plan and this process has been initiated in other RHDs.
- The Local Health Governance Strengthening Programme has been initiated in Myagdi district of western region on a pilot basis.

3.1.2 Health Sector Information Management System

- The HMIS report and the physical/financial report, preparation, analysis and utilisation has been regularised.
- Service statistics from NGOs and private health institutions are collected to some extent.
- The technical skill of selected staff has been enhanced through TA on data management, including analysis and interpretation.

3.1.3 Monitoring and Evaluation

- The process of annual, half yearly and trimester review meetings has been improved, and report writing and presentation skills have improved through on-going discussion, mentoring and support.
- Routine internal review and planning meetings are regularised within RHD.
- A supervision plan has been developed; a logbook has been maintained; and a feedback and follow-up system has been introduced.
- A joint monitoring plan with EDPs and GoN is in place and made functional by using an improved monitoring and supervision checklist which includes a GESI perspective.
- Step by step report writing guidelines for public health professionals have been developed in the Western Region and used to train public health professionals. It will be rolled out in other regions.

3.1.4 *Coordination*

- Regional Health Coordination Committees (RHCTs) have been established/reactivated in all RHDs with specific TORs.
- Coordination and cooperation with other EDPs working in the region has improved.

3.2 MAJOR CHALLENGES

The major challenges highlighted by the Regional Directors are described briefly in the following section.

3.2.1 Human Resources

- High turnover of leadership at the regional and district levels.
- Karnali zone has no provision for ANM.

- Key posts within the RHD including mid-level officials (like Statistical Officer, Public Health Officers, Public Health Nursing Officer) have been vacant for a long time, and retention is very poor among those that are filled.
- Poor attitude and behavior of staff, poor commitment towards service delivery.

3.2.2 Planning

- Top down planning approach, with RHDs having little say in the planning process
- Limited opportunities for process planning and preparation of annual work programme and budget due to centralised planning system.
- Uncoordinated central planning leading to frequent absenteeism of district managers and key programme focal persons. The region often has to call district managers to fulfill requests from the centre to organise different reviews, orientation and training programmes.
- Reaching the unreached areas and populations in order to reduce disparities of access and utilisation of essential health care services is difficult.
- The geographical location is not favorable, especially for the Far-Western, Mid-Western and Eastern regional offices, to run large planning workshops and training. Most of the time the staff of those regional offices must go to Dhangadi, Nepalgunj and Biratnagar respectively.

3.2.3 Monitoring and Evaluation

- Region has limited skills and capacity to produce reports from facility level data, or to analyse and utilise the disaggregated service data for planning purposes.
- Supervisors have very limited skills and capacity, and limited financial and physical resources including vehicles for effective monitoring and supervision.
- Physical infrastructure is very poor (especially in the Far-west and Central regions) and budget is insufficient for physical facilities such as regular supplies, internet and communication facilities, computer and accessories.
- Some staff are reluctant to use the supervision guideline and checklist prepared by DoHS.

3.2.4 Limited Authority

- Authority is centralised.
- RHDs do not have programme budgets. Nor do they have any authority to revise and adjust to the existing budgets.
- Due to poor governance and the delegation of authority to the districts, financial and physical reporting from districts to the RHD and higher level is weak. This is not a priority for most of the districts.

3.2.5 Coordination

- Functional system to sustain collaboration and partnership with various non-state actors in the region is being developed.

3.2.6 Information Management

- Relatively weak software, hardware and human resources for health sector information management.
- Irregular reporting from NGOs and the private sector.
- Collection, analysis and use of GESI data was very weak, and is now improving.

3.2.7 Service Delivery

- Difficult to establish referral linkages from hilly and mountainous districts.
- Difficult to sustain Caesarean Section (CS) services in the districts.
- Difficult to maintain well-functioning Social Service Units and One-stop Crisis Management Centres in hospitals.
- Poor quality of buildings constructed by DUDBC

3.3 THE WAY FORWARD

The Regional Directors also suggested the way forward to overcome the challenges mentioned in previous section (See Annexes III to VII). The suggestions are listed below:

- Continuous advocacy for delegation of authority from MoHP to strengthen the RHD.
- Enhance RHD capacity, especially by filling vacant positions, providing programme resources and enhancing effective planning and monitoring skills and resources for monitoring and supervision.
- Make RHDs more visible, responsible and accountable in the annual planning process; the RHD should have full ownership of district and central level planning, in order to later carry out the plans.
- Sustain functional mechanisms for collaboration and partnership with GOs, I/NGOs, EDPs and the private sector to coordinate programmes and better utilise resources in the region.
- Link GESI in health sector programming and planning at all levels.
- Develop and implement GESI sensitive recording and reporting tools for the collection and analysis of disaggregated service data at the health facility level.
- Strengthen strong communication within the regional team and with central, district and related stakeholders and organisations at the regional level. Strengthen existing coordination and partnership concepts through effective facilitation of RHCT and District RHCC.
- Have a performance based reward and punishment system, with appropriate capacity enhancement for health professionals.
- Strengthen integrated joint monitoring and supervision with a comprehensive checklist and feedback mechanism.
- Strengthen the M&E framework at the regional level to improve the reporting mechanism of the public, private and I/NGO sectors

4. SHARING FROM GIZ ON REGIONAL STRENGTHENING

From GiZ, Mr. Tej Prasad Ojha made a brief presentation on GiZ experiences of in regional strengthening, especially in the Far and Mid-western RHDs. He stressed that GiZ support concentrates on decentralisation, good governance and social inclusion. Furthermore, GiZ promotes a single plan, a coordinating body and a monitoring system in the regions and districts; leadership, harmonisation, alignment, mutual accountability, and result management; integration of state and non-state sector actors; health management reform, particularly through M&E; and emergency health preparedness and response (Annex IX).

Mr. Ojha emphasised that the GiZ support has improved coordination, participation and collaboration of the sector actors at the regional and district level.

5. SHARING FROM NHSSP

Nancy Gerein, NHSSP international Lead, shared the findings of a regional assessment done by Professor Andrew Green in 2012. The presentation highlighted the following:

- formal powers delegated to RHD and their current level of practice;
- challenges for regions and capacity enhancement efforts; and
- key recommendations to government, EDPs and NHSSP

She stressed the key findings of the regional assessment on the current formal powers and actual practice of the RHDs. The formal powers RHDs practice consistently include: approval of small private facilities of fewer than 15 beds; development of the regional plan; coordination of district planning; management of resources at lower levels; coordination of training; technical and management support to lower levels; monitoring of district performance including finance; monitoring of district audit reports implementation; liaison with I/NGOs, EDPs and other government agencies and provide HMIS data, reports and research.

Similarly, she noted that the formal powers not practiced by RHDs include dissemination and contextualisation of National Policy; construction and repair of facilities; purchase of essential drugs and supervision and monitoring of the activities of the DDA and Ayurveda Department.

She also elaborated on key recommendations to government, EDPs and NHSSP based on the findings of the regional assessment. These are to decide upon a strategic approach; advocate for changes to regions; strengthen current regional institutions; strengthen districts; support the preparation for federalism; document the capacity enhancement work on systems and structure development (as a feed-in to future provincial health departments); consider the role of the regions in all NHSSP/EDP work at district and national levels; advocate for the role of the regions and the disadvantages of ignoring them; and building inter-regional collaboration and learning (Annex X).

6. PLENARY DISCUSSION

After the presentation, a plenary discussion session was held. The following major issues were discussed:

Dr. Frank Paulin, WHO: Dr Frank raised issues concerning Public Private Partnerships (PPP), specifically private medical practitioners and school health programmes.

Ghana Shyam Pokharel, RD Midwestern Development Region requested GiZ to provide an update on GiZ support to the Local Health Governance Strengthening Programme (LHGSP). He also mentioned that the procurement and distribution of commodities is important for regional strengthening.

Dr. Gerein agreed to update Andrew's report based on the comments raised. She also requested GiZ to share how they have been monitoring the results of their inputs. Dr. L. R.Pathak further clarified the questions raised by Dr. Frank , Suzanne Grimm (GIZ) and Ghana Shyam Pokharel.

Dr. Mingmar Gyalsen Sherpa, Director General of DoHS, commented that issues such as food, water and sanitation must be addressed through a variety of mechanisms. He spoke of how in India the need for food quality is being addressed by placing food inspectors under the health system.

Finally, Dr. Chand concluded the plenary session with the following comment: "When we are posted to a district we want district to be strengthened and when we are posted to a regional health office we want RHD to be strengthened, but when we are posted at the centre, we forget the district and region and undermine them by saying that they are weak." He emphasises the need to strengthen the districts and regions and stated they should be given skills, power and authority for programme planning, implementation and budgeting.

In addition, Dr. Chand noted that the region, through the regional directors,should be vocal and strong enough to take leadership on issues of regional strengthening. Weak leadership in the region has sometimes been a means for the centre to undermine the regions.

6.1 GROUP WORK RECOMMENDATIONS

The participants had worked in two groups and shared their outcomes in the plenary (See Annexes XI and XII). The group work was consolidated and shared with the Health Secretary (See Annex XIII). The key recommendations of the consultative meeting are presented below:

6.1.1MoHP and DoHS should delegate more authority to the RHDs

- Authorise RHDs and districts to prepare the AWPB with an annual indicative planning figure (AIPF) or budget ceiling in advance. This will help RHDs and districts to prepare the AWPB to respond to their local needs.
- In addition, MoHP and DoHS should authorise RHDs to send the budget approval (Budget Akhtiari) to the districts so the districts will be accountable towards the RHDs.

6.1.2. Improve the Human Resource situation in the RHDs

- Immediately fill all sanctioned vacant posts in all RHDs. Alternatively authorise the RHDs to fill all sanctioned vacant posts on a contract basis.
- Authorise RHDs for the transfer and deputation of human resources up to grade seven in the regions and for performance evaluations of DP/HOs.

6.1.3. Physical Infrastructure

- Make necessary budgetary provision for owned building with basic physical facilities including accessories like computers, furniture and other logistical support.

6.1.4. Financial Management

- Authorise RHDs to clear up audit irregularities (Beruju) to some extent, the amount to be decided by DoHS and MoHP.
- Ensure RHDs' role in the procurement of drugs, commodities and services through a multi-year contracting system.

6.1.5. Monitoring and Evaluation

- Strengthen the RHDs' capacity for effective supervision and monitoring to the districts and provide sufficient budget allocation for this purpose.

6.1.6. Regulation and Management of Health Institutions

- Assign regulatory functions for the approval and monitoring of the private sector e.g. hospitals, nursing home, polyclinics, medical shops, medical college, community hospitals etc.
- Assign RHDs with authority to ensure safe/hygienic food in the market. Since the existing HR is not sufficient to take on this responsibility, provide additional HR to RHDs to work in this area.
- Strengthen RHDs' capacity to respond to different types of epidemics and disasters.

6.1.7. EDPs' support to RHD

- EDPs should support RHDs to introduce an effective M&E mechanism.
- EDPs should support RHDs in strengthening the process of infrastructure development, e.g. update national standards, designs, estimates and quality assurance.
- EDPs should develop the capacity of key HR working in the RHD.
- EDPs should support the policy of effective, functioning RHCTs and RHCCs, by assuring the representation of EDPs, INGOs and Government.

6.2 CLOSING REMARKS

Dr. Gerein, International Lead, NHSSP, requested effective implementation of the recommendations made at this meeting. She thanked all participants for their efforts to make themeeting effective and productive.

Dr. Chand, Chief, PPICD, MoHP, made the following remarks. He said that MoHP is definitely interested in delegating authority to RHDs, minimising duplication from the central level, and making a more accountable and responsive health system. Concerning bottom-up planning, he said the implications for the over-all planning process must be discussed. He emphasised the need for infrastructure development and for working closely with partners to regularise the private sector.He stated that MoHP is very clear on the need for and is committed to strengthening the RHDs, and that the way to achieve this would largely depend on our commitment and leadership. He also stressed the need for willpower on the part of the RHDs to take the leadership role to strengthen the regional health system.

Dr. Sherpa, Director General, DoHS, said that improvement of district health service delivery through RHD strengthening is important. While providing authority and resources is easy, fulfilling the responsibility is more challenging. Thus, we must be clear about what we are going to achieve after providing all the inputs for system strengthening. The RHDs should be aware of the inputs to the system and its achievement.

Dr.Pravin Mishra, Health Secretary, MoHP, following the presentation from the five Regional Directors and the recommendations made by the group, shared his vision, saying that MoHP is looking for an opportunity to explore the way forward to strengthen the RHDs. He thanked the organiser for arranging such an important event. He noted that in the past the exchange of roles and responsibilities of the two Secretaries had negatively affected the effectiveness of programmes, monitoring, and delegating the power/authority to Regional Health Directorates.

He said that this consultative meeting could help address the regional needs. In the absence of local government, MoHP needs clear guidance to strengthen the monitoring and evaluation system. He stressed strengthening coordination and collaboration between the public and private sectors, and with EDPs, to achieve the expected results. Strengthening E-governance is another important area through which we can communicate effectively. He also emphasised that the MoHP cannot achieve the Millennium Development Goals (MDGs), especially reaching unreached population/areas, without effective and efficient inputs. The need for more budget is a priority, but building the capacity for effective utilisation of the available resources as important as increasing the human resources themselves, including the skills for effective service delivery.

Sharing power and authority and increasing resources are important aspects of RHD strengthening, but this will depend on our commitment, enthusiasm, active leadership and proper utilisation of available resources. The RHDs also should have strong commitment and leadership to bring better outputs from the health system by utilising the delegation of authority along with the available resources.

Dr. Mishra concluded as follows, “I am much happy to see the list of the recommendations. I think they could be relevant and actionable. In this connection, we have to develop programmatic linkages between the DoHS Divisions and the RHDs. Based on the outcome of this crucial meeting, I now suggest we discuss the modality of planning, implementation, monitoring and evaluation. As we all know, our basket is small and our needs are large, so we must carefully consider the mobilisation of local resources, including our partners, along with cost effective programming. Health goes beyond simply health issues; health falls not only under the jurisdiction of MoHP, but results from the work of many

different stakeholders. For this purpose, coordination and networking are very important and an essential part of the MoHP at all levels." He assured the group that he would respond to the recommendations on the basis of priority.

Finally, he thanked everyone for their active participation. He also thanked partners for their continued support and NHSSP for providing assistance with this important consultative meeting.

ANNEXES

Annex I: List of Participants

SN	Name	Organisation	Post	Contact No
1	Nancy Gerein	NHSSP, MoHP	International Lead	
2	Dr. L. R. Pathak	NHSSP, DoHS	National Lead	
3	R. D. Mehta	ERHD	Regional Director	9842031233
4	Suman Gurung	NHSSP/ERHD	PMSS Specialist	9849302578
5	Basanta Thapa	NHSSP/ERHD	MNCH Specialist	9851062068
6	Basanta Shah	NHSSP/WRHD	MNCH Specialist	9848020302
7	Min Raj Gyanwali	NHSSP/CRHD	MNCH Specialist	9851115225
8	Eman B. Sunar	NHSSP/FWRHD	GESI Specialist	9848056557
9	Suzanne Grimm	GiZ	DPM	
10	Dr. F. Siddiqui	NHSSP/MWRHD	GESI Specialist	9858022662
11	Bimba Bhattarai	NHSSP/ERHD	GESI Specialist	9840068860
12	Dr.Giridhari S. Paudel	NHSSP/WRHD	PMSS Specialist	9841417776
13	Ghana ShyamPokhrel	MWRHD	Regional Director	9841685763
14	R. M. Singh	NHSSP/MoHP	Advisor	
15	Dr. Rajendra Pant	CRHD	Regional Director	9851046646
16	D. K. Chapagain	Management Division	Sr. PHA	9851129595
17	K.K. Singh	GiZ	Regional Manager	9858020260
18	Dr. Saroj Rajendra	Management Division	Director	
19	Ramadhin Yadav	MoHP	Under Secretary	9853023489
20	Dr. Sainendra Upreti	FHD/DoHS	Director	9851079724
21	Dr. Bikash Lamichhane	FWRHD	Regional Director	9851136766

22	Dr. Anand Shrestha	PHC Division	Director	9851121266
23	Dr. M. G Sherpa	DoHS	Director General	
24	Rajendra Basnet	NHSSP/MWRHD	PMSS Specialist	9848026486
25	Dr. P. B. Chand	PPICD/MoHP	Director	
26	Dr. S.R. Upreti	CHD/HOHS	Director	9851088382
27	Kamala Shrestha	NHSSP/MWRHD	MNCH Specialist	9848305284
28	Lila Raj Paudel	MoHP	Section Officer	9851134375
29	Dr. Suresh Mehta	NHSSP/DoHS	Research Associate	9842036595
30	Tej Raj Ojha	HSSP-GiZ	Senior PO	9851041455
31	Dr. Laxmi Bilas Acharya	NHSSP/MoHP	Sr. R. Associate	9851064579
32	Hom Nath Subedi	NHSSP/DoHS	EAP Advisor	9851092214
33	Rita Joshi	NHSSP/CRHD	PMSS Specialist	9841292095
34	Dr. Baburam Marasini	MoHP	SHA	
35	Dr. Maureen Dariang	NHSSP/DoHS	Advisor	
36	Sushila Pandey	NHSSP/CRHD	GESI Specialist	9841271492
37	Louise Hulton	Option/EHCS		
39	Krishna Sharma	NHSSP/DoHS	Head of Finance	
40	Dr. Suresh Tiwari	NHSSP/MoHP	H.F. Advisor	
41	Dr. Praveen Mishra	MoHP	Secretary	
42	Matt Gordon	DFID	Health Advisor	9801075601
43	Sitaram Prasai	NHSSP/MoHP		9841446315
44	Himalaya Sigdel	NHSSP/FWRHD	PMSS Specialist	9846024430
45	Shankar Poudel	NHSSP/WRHD	GESI Specialist	9851117529
46	Durga Upreti	NHSSP/FWRHD	MNCH Specialist	9851063561

47	Dr. G. D. Thakur	DoHS/EDCD	Director	
48	Dr. Ganga Shakya	NHSSP/DoHS	MNH Advisor	
49	Dr.Amit Bhandari	DFID	Health Advisor	
50	Dr. Bhim Acharya	WRHD	Regional Director	
51	Pradeep Poudel	NHSSP/DoHS	M&E Advisor	
52	Dr.Chhaya Jha	NHSSP/MoHP	GESI Advisor	9841226584
53	Dr. Frank Paulin	WHO		

Annex II: Roles and Responsibility of RHDs:

Unofficial Translation of pages 116 and 117 of the "Operating Manual for the Department of Health Services"

b) Objectives

As per the policy set by the Ministry of health and Population (MoHP), preventive, curative and promotional health services are delivered through various health delivery outlets operational at various levels. Such services are aimed at bringing the services to the very doorsteps of the general population. Monitoring and supervision of the services is essential for ensuring that all the services provided from the region or development zonal, and specifically from the district or lower levels are being implemented smoothly and effectively. To achieve this objective and to decentralise implementation of the activities, Regional Health Directorates (RHDs) are established.

c) Working Area

As per the decentralisation policy of the Government of Nepal, local organisations are being provided greater authority. Under this policy all five Regional Health Directorates are given the responsibility of monitoring, evaluation and quality control of allopathic, alternative and ayurvedic treatments, drug management as well as all health services provided, and all activities conducted by health institutions run by governmental and private sectors in the regions. All regional, sub-regional, zonal, district, Ilaka, and village level health organisations under the three divisions of MoHP will come under the Regional Health Directorate.

d) Activities

1. Develop annual work plans following the policy directions of MoHP.
2. Assist to implement national policy by analysing the available health services in the region.
3. Develop the regional level programmes considering the district level programmes and report to the central authority.
4. Conduct necessary monitoring and supervision of district level programmes and provide feedback.
5. Collect and compile monthly progress reports of the health programmes from all district public health offices. Follow up with the districts that do not send monthly progress reports on time and report to the central level.
6. Consult and coordinate with all private and non-governmental organisations in the region and provide them support. Monitor and supervise existing programmes in the region.
7. Develop working relationships with national and international organisations and coordinate with DoHS if formal agreements are to be made with the organisations consulted.
8. Identify basic and refresher training needs for various level health workers in the region and consult with the relevant training division at the centre to arrange training from the Regional Health Training Centre or the National Health Training Centre.
9. Regarding the construction and repair of physical facilities, coordinate with the district health offices, prepare budget estimates and make requests to the central office.

10. Maintain personal records of the staff within the region. Manage staff transfers in the region following the existing policy of MoHP.
11. Manage leave applications of all office heads from the region except for special leaves and study leaves. For these two types of leave make recommendations to the related divisions in the centre.
12. Provide incentives and/or penalise staff of the sixth level and below within the region as per the health service laws and regulations and inform DoHS of the action.
13. In the case of regional officer level staff, make recommendations to the central divisions for incentives or penalties. If necessary make recommendations for transfer as well.
14. Maintain and update the leave record of all staff within the region.
15. Recommend for scholarships/foreign tours/observation tours etc. using the criteria set by MoHP.
16. Monitor and control the district level financial transactions as per need. Enforce the implementation of audit reports; take action against those who do not clear their advances and audit their findings according to existing financial rules or make recommendations for necessary action to the centre.
17. Purchase essential drugs and supplies for regional health institutions through medical stores.
18. Print and distribute to district health offices the forms provided by "Supply Management Division".
19. Appoint non-officer level staff to vacant positions if the Public Service Commission transfers this authority.
20. Similarly, if non-officer level staff positions are vacant or if new positions are created, and if the Public Service Commission transfers the authority, promote qualified staff to these vacant positions.
21. Provide administrative leadership to all health offices under the regional health secretariat.
22. Monitor and supervise the health organisations under the Drug Management Division and the Ayurvedic Division as per the authority provided by respective divisions. Send the M&E report to respective divisions.

NOTE: *This was developed in 2000, with the first edition printed in 2004 and the second edition printed in 2008.*

Annex III: Structures, Role and Functions of Regional Health Directorates

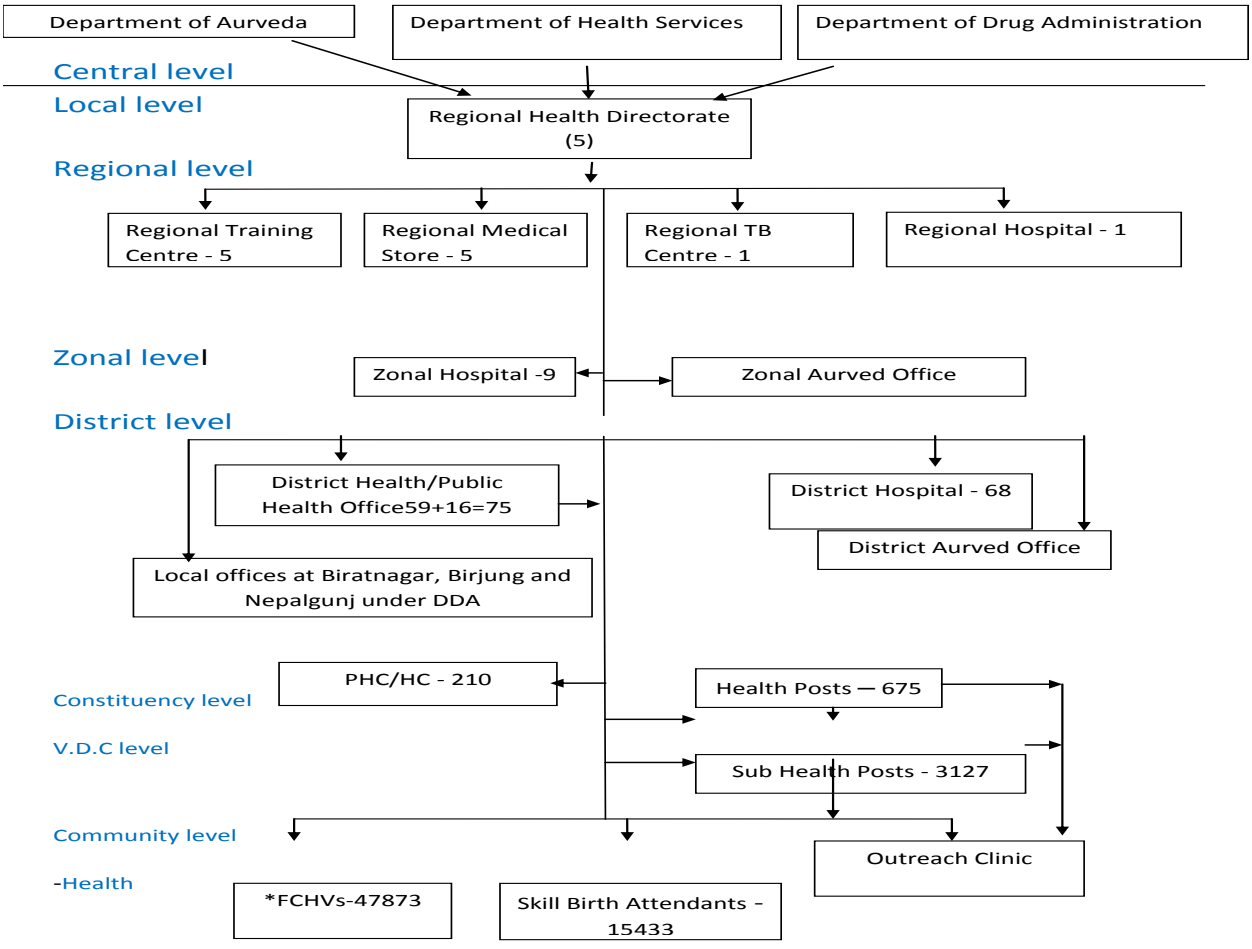
By Dr. Baburam Marasini

Chief, Health Sector Reform Unit, MoHP

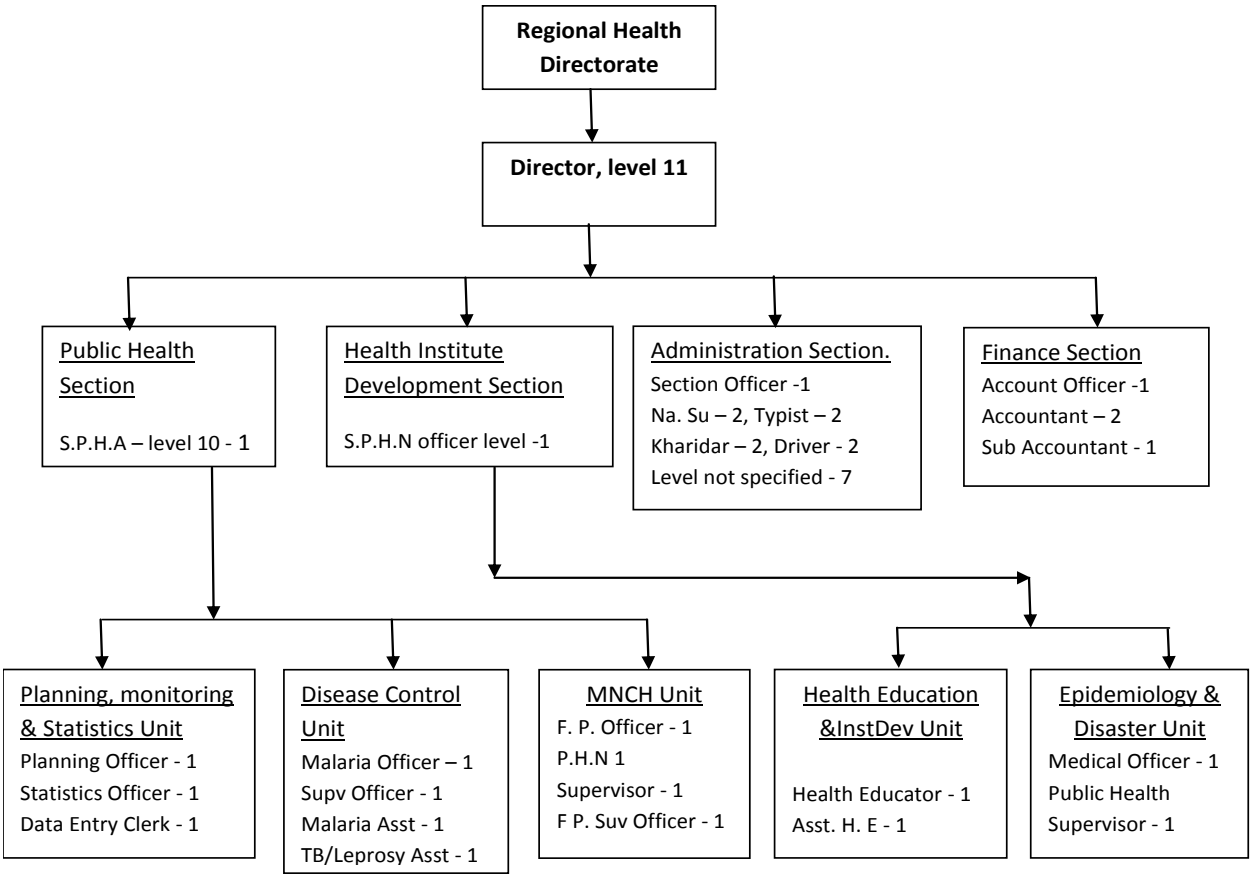
Highlights of the Presentations

- In 2042 (1985): DoHS was abolished and RHDs were established in five regions.
- RHDs were mandated to provide MoHP's functions i.e. the programmes and activities of threedepartments.
- Organisational structure was developed accordingly.
- Each RHD is headed by a Director (11th level equivalent to Gazetted First Class Officer).
- DoHS re-established (in 1994) with necessary changes in the RHD mandates.
- RHDs authority derives from the National Health Policy 2048 (1991), the Decentralisation Act and Regulations.

Organisational structure of health service delivery:



a) Organizational structure with sanctioned post.



Objectives of the RHDs

1. Strengthen the district public health system by providing technical and administrative support.
2. Monitor and supervise services from regional and zonal levels to districts and from districts to lower levels.
3. Decentralise implementation of DoHS, DDA and DoA activities.

Working Areas

1. M&E and quality control of allopathic, alternative and ayurvedic services, including drug management.
2. All services and activities of public health institutions and selected private sector health facilities.
3. All regional, sub-regional, zonal, district, Ilaka, and village level health organisations under the three divisions.

Responsibilities

1. Administrative and financial management
2. Procurement of essential drugs and supplies

3. Assist implementation of national policy by analysing regional health services
4. Regional planning and programming
5. Supervision and M&E of DoHS, DDA and DoA activities
6. Inter, intra-and external coordination
7. Management of epidemics and disasters
8. Make recommendations for scholarships/foreign tours/observation tours etc. using MoHP criteria
9. Identify basic or refresher training needs and recommend appropriate HR to the centre
10. Collect and compile monthly progress reports from district public health offices
11. Follow up with districts that fail to send monthly reports on time and report to central level.
12. Research and studies

Strengths of RHDs

1. The structure is seen to be fit for its purpose.
2. Regional officials are committed to their technical roles.
3. The number of sanctioned posts appears appropriate.
4. Most regional supervisor posts are filled.
5. EDPs and INGOs are willing to help RHDs improve planning, monitoring and coordination.
6. Good potential is found for regional cross-sectoral working and coordination with other Ministries.

Constraints of RHDs

1. **Offices**: Inadequate physical facilities, furniture, equipment, office supplies
2. **Mobility**: RHD staff lack adequate transportation
3. **Human Resources**: Staffing structure, job titles and numbers of approved posts vary by region
4. **Job-description**: Roles and responsibilities of senior staff are unclear - job descriptions need updating
5. **Under Staffing:** Nearly half of officer posts are vacant, including statistical officer, planning officer, public health nursing officer and health education officer
6. **Staff Grading**: Lack of grading differentials between regional and district staff causes management difficulties and incompatibility
7. **Staff Transfers:** Frequent staff transfers and high turnover of leadership posts
8. **Staff Management:**
    - Motivation levels low
    - No management guidelines
    - Job descriptions out-dated
    - No staff development budget.
9. **Communications:**
    - Information flows from the centre bypass regional offices.
    - DP/HOs tend to report to MoHP/DoHS rather than to RHDs.
    - RHD authority is undermined in both ways.

10. **Monitoring:**
    - District monitoring is sub-optimal - unlikely to yield consistent data quality.
    - District data at RHDs are frequently not edited and analysed before being forwarded to HMIS section.
    - Monitoring checklists not adapted to track local health concerns.

11. **Planning:**
    - Remains the responsibility of DoHS and MoHP.
    - Regional and district health plans are simply aggregations of centrally sanctioned budgets.
    - Regional and district health offices are not involved in priority setting.
    - Budgets are inadequate to respond to emergencies and natural disasters.

12. **Coordination:**

    - Inter, intra and external coordination systems poorly developed.
    - Limited capacity to coordinate with regional offices of other line ministries and EDPs/INGOs.
    - Most EDPs/INGOs implement vertical district level programmes with few links to RHDs.

TA (NHSSP) Support to RHDs

1. Capacity enhancement of RHDs.
    - Skills transfer
2. Regional health system strengthening based on regional assessments
    - Planning
    - Monitoring and Evaluation (M&E)
    - Health Sector Information System (HSIS)
    - Coordination (inter-, intra- and external)

3. The following staff are assigned to support regional system functioning:

    - Planning Monitoring and System Strengthening Specialist (PMSSS)
    - Maternal Neonatal and Child Health Specialist (MNCHS)/EHCS
    - Gender Equality and Social Inclusion Specialist (GESIS)

All of the specialists are embedded with the RHD.

Annex IV: Highlights of the Far Western Regional Presentation
Regional Director-Dr. Bikash Lamichhane

- Regional Health Directorate was established by MoHP in 1985.
- Far-western region has 514 health facilities with 18 hospitals serving to population of 25, 43,000.
- Access to drinking water is 83% and sanitation coverage is 29%.
- 10% of national population lives in this region
- Only 6% of the total (national) health budget is allocated to this region
- The health institutions & facilities are not in proportion to population

System strengthening efforts made since the presence of NHSSP specialist in July 2011 are as follows:

Area	Changes made/seen so far…
Health planning	• The calendar of operation is developed and displayed. • District strategic planning system is in place and functional. • The concept and importance of GESI is delivered to all concerned. *"One stop crisis centres"* have been established in Doti and Mahakali hospitals. • Districts have started identifying hard to reach areas and populations. • CEONC service has been started in one private hospital in Doti district. • The governance and accountability is expected to increase due to the recent leadership and governance training. • Bottom-up planning guidelines have been prepared.
Health sector information management	• Private hospital information is upcoming in district HMIS. • The periodic review meetings have improved the programme sharing and transparency within RHD. • The quality of report writing and presentation skill has improved through discussion and support. Last year's annual review presentation was an example.
Monitoring and evaluation	• A joint monitoring plan is in place and functional. • A supervision and monitoring checklist has been developed for GESI.
Coordination	• Coordination strategies and guidelines developed at different levels, i.e. inter, intra and multi-sectoral. The TOR is in place. • Coordination and cooperation with other EDPs working in the region has increased substantially and has become functional through the RHTC regular meetings and discussions. • Regular staff meeting in the regional office has increased understanding among

	the Government and NHSSP staff members.

Challenges

- Authority of Regional Director is limited in practice.
- Financial resources are inadequate.
- Poor motivation and absenteeism of staff.
- Some important posts are vacant because of low retention and frequent transfer.
- The office space in RHDs is inadequate to accommodate all easily.
- Information management is relatively weak.

Way forward

- Develop periodic plans based on all districts periodic plans.
- Replace vacant post in the regional office.
- Strengthen the existing information system.
- Activate the regional website.
- Establish performance based reward and appropriate capacity enhancement.
- Strengthen integrated joint monitoring and supervision with a revised supervision checklist.
- Regional level operating guidelines are required to improve coordination with EDPs.
- A fact finding study on barriers to MNCH service utilisation is needed.
- Initiate GESI reporting system in HMIS.
- Increase meetings and interactions with private sector so that they come under mainstreaming.
- Strengthen region through increased resources, improved communication and delegation of authority.

Annex V: Highlights of Mid-Western Regional Presentation
Regional Director-Ghana Shyam Pokhrel

- No. of districts: 15
- Total area: 42,378 sq. km
- Total population: 37,03,639
- Population under 1 year: 88,657
- Expected pregnancy: 1,03,857
- Population density/ square km: 5 (Dolpa) -- 209 (Banke)
- Human Development Index: 0.402
- Proportion of dalit population: 14.88 (MWR): 10.35 (national)
- Literacy rate: 62%
- Safe drinking water; 22.5%
- Exclusive breastfeeding: 79.5%
- Not accessible motor road: Dolpa, Humla, Mugu
- Seasonable motor road: Kalikot, Jumla, Rukum, Jajarkot
- Out of 2527 sanctioned posts in the region 2113 are filled and 414 (16%) are vacant

System strengthening efforts made since the arrival of NHSSP specialist in July 2011 are as follows:

Area	Changes made/seen so far…
Health planning	• Developed action plan of RHD and districts • Initiated strategic plan in low performing districts: Salyan • Context specific planning in selected districts : Kalikot, Banke, Jajarkot • Monthly plan of individual staff is initiated. • Action plan of client centre quality care in regional hospital is ready
Health sector information management	• Monitored reporting status of HMIS report from public and private sectors • Regularised HMIS report and physical/financial report, analyses and utilisation • Initiated Regional Health Information Bank (RHIB): developed ToR, formed health information committee
Monitoring and evaluation	• Standard and uniform reporting template for field report is in practice • Regular monitoring system of district health status and provide feedback • Sharing of major findings of field trips among concerned staff of RHD • Capacitated RHD and DP/HOs team in M&E • Internalised the practice of joint supervision in RHD • Updated monitoring and supervision tools • Introduced operational research in the region

	• Regularised routine internal review and planning meetings within RHD • Initiated half yearly report at regional level • Increased report writing skills of RHD staff
Coordination	• Profile of EDPs is available at region • Harmonised relationship between RHD and EDPs • Joint supervision with EDPs
Institutional strengthening	• Continue education sessions started for enhancing the capacity of the RHD staff • Functional internet system and computer training to RHD staff • Routine staff meeting and record minute (first Sunday of each month) • AI training for RHD and DHO staff • Establishment of display board of staff movement of RHD • Identified and prioritised establishment and construction of birthing centres • One Stop Crisis Management Centre (OCMC) started to deliver services in Bardiya

Challenges

- Top down (blanket) planning
- No provision for ANM in Karnali region
- Poor staff retention
- Vacant posts of key human resources including specialised doctors
- Irregular reporting from private sector
- No linkages are available from hilly and mountainous districts when referrals are made
- CS services in the districts
- Functioning of Social Service Unit in hospitals
- Quality of buildings constructed by DUDBC

Way forward

- Establish Health Information Bank in region and districts
- Establish Health Information Committee in districts
- Conduct data quality survey in selected districts
- Engage in operational research: free health services, integration of Family Planning (FP) and Expanded Programme of Immunisation (EPI) services, Postnatal Care, and PNC job-aid
- Establish documentation/resource centre
- GESI orientation to women cell of police personnel
- Electronic medical record system at regional hospital
- Analyse disaggregated data with GESI perspective and use for planning
- Form of GESI Technical Working Groups and provide orientation in the districts

- Strengthen the M&E framework at the regional level to improve the reporting mechanism of private and I/NGOS sectors
- Fill the vacant posts in regional and district levels
- Improve logistic support for institutional development of RHD
- Support regional AWPB and bottom up planning system
- Sustainable CS services in mountain and hilly districts
- Develop a multi-year contracting system for human resources
- Develop a refer system strategy for hill and mountain districts
- Strengthen the Social Security Unit
- Strengthen the curative division to support central, regional and district hospitals
- Based on the retirement plans of current staff allocate budget for contracting drivers and office support staff

Annex VI: Highlights of Western Regional Presentations
Regional Director-Dr. Bhim Acharya

- Total population of the region (HMIS) = 54,78,835
- Under 1 year population = 1,30,532
- Expected live births = 1,36,987
- Doctor and population ratio (public sector)= 1 : 30,438
- Nurse and population ratio (public sector)= 1 : 9,446
- Population per primary level of health care institutions (SHP, HP, PHC) = 6,226
- Population per secondary level of health care institutions (District Hospitals = 3,42,427
- Population per bed at secondary level of health care institutions = 19,090
- Population per tertiary level of health care Institutions = 18,26,278
- Population per bed in tertiary level of health care institutions= 9,131
  (Regional and Zonal Hospitals)
- Population per bed in all level of hospitals (Public and Private)= 1,669
- Of 4204 sanctioned posts in the region, 3638 are filled; 566 posts (13%) are vacant
- Eight key positions at RHD including PHN, Planning and Monitoring Officers are vacant
- The region has one Regional TB Centre, One Regional Training Centre, One Regional Medical Store, one Regional Hospital, two zonal Hospitals, twelve District Health Offices, four District Public Health Offices, sixteen government owned District Hospitals, nine Community Hospitals, three Ayurveda Zonal Centers, thirteen District Ayurveda Centers, 64 Ayurveda Centers, 42 PHCs, 173 HPs, 665 SHPs, 2527 PHC/ORCs, 3455 EPI Clinics and 11086 FCHVs.
- WRHD received technical assistance from NHSSP since August 2011 is in health planning, monitoring and evaluation, health information management and coordination

System strengthening efforts made since the arrival of the NHSSP specialist in August 2011 are as follows:

Area	Changes made/seen so far…
Health planning	RHD • Annual calendar of operation has been developed and is displayed • Integrated annual work plan and budget has been prepared • Staff members are sensitised to identify hard to reach area and populations for planning. • Orientation on GESI to key staff at RHD and D(P)HO has been completed. • GESI technical working group is formed at RHD • One Stop Crises Management Centre established in Dhaulagiri Zonal Hospital • Annual and half yearly review meeting reports are written in detail with recommend actions • Follow up to the districts on the implementation of review meeting recommendations has begun • Selected staff of the RHD and the districts are trained in the bottom up planning process **Districts** • 50 % of districts within the region have developed annual calendar of operation similar to the RHD • 50 % of districts of the region have prepared integrated AWPBs • Selected programme supervisors of the districts are trained in bottom up planning process
Health sector information management	• Email and internet (for key staff at RHD) is connected and functional • Quality of annual report prepared by the districts was reviewed. • A Step by Step Report Writing Guideline to Public Health Professionals was Developed • 28 programme supervisors and statistics officers are trained in report writing • Contributions of key I/NGOs and EDPs were collected and published in the RHD annual report 2011 • 16 statistics officers of the districts were trained in data management through peer review • Monthly reports of the districts are now received before 20th of next month at RHD. • RHD and district staff now internalise the need for disaggregated service information.

Monitoring and evaluation	• RHD revised the supervision checklist and the commitment of each thematic supervisor in DHO is sought during RHD integrated supervision and monitoring. • A practice of preparing the supervision report by all integrated supervision team and submission to RD has been instigated. Each team sends the recommendation sheet to districts after RD signature. • Monthly review of service statistics of each district of the region has begun at RHD. • A large key indicator monitoring board is installed at RHD meeting hall. • Key indicators are updated in this board and programme staff review the performance on a monthly basis and send feedback to the districts. • RHD staff members are trained on key programme indicators and their use during integrated supervision and monitoring • A MNCH service tracking checklist was developed and is used by RHD. • A guideline to train the FCHV for referral services with focus on IUCDsis developed and used in Arghakhanchi and Baglungdistricts.
Coordination	• Regional Health Net has been reformed for coordination between RHD and non-state actors in the region. • A ToR for the Regional Health Net has been developed. • Preparation of EDPs and other non-state health actors profile is in process. Meetings are scheduled for the RSCT on the 20th of each month.

Challenges

- Budget- No flexibility to revise and adjust the budget
- Human Resources – filling vacant sanctioned posts, insufficient skills and knowledge of staff, no population based staffing pattern
- Authority- Centralised system
- Attitude and behavior of staff - commitment towards service delivery
- Logistics – Erratic central supply- quality of supply
- Competition with private facilities regarding the quality of service

Way forward

- Develop district level periodic plan.
- Collect monthly service statistics from all partners.
- Map hard to reach areas and population.
- Pilot local health governance in Myagdi and replicate in other districts based on the experience.
- Develop Regional Health Profile and website of RH.

- Harmonise efforts between I/NGO, EDPs and the private sector to improve the weaker programme areas and increase access and utilisation of basic health services by all people in the region.
- Strengthen multi-sectoral coordination (Education, Agriculture, WASH, DDC and VDC).

Annex VII: Highlights of Central Regional Presentation
Regional Director- Dr. Rajendra Pant

- Total population of the region (HMIS) = 99,37,326
- Population under one year old = 2 21 186
- WRA 15-49 258356
- Expected pregnancies = 258257
- Out of 4964 sanctioned posts in the region, 3838 are filled, 1126 posts (22.68%) are vacant.
- The region has 30 hospitals, 69 PHCC, 172 HPs, 999SHPs, 4060 PHC/ORCs, 5185EPI Clinics and 13960 FCHVs.

System strengthening efforts made since the arrival of the NHSSP specialist in August 2011 are as follows:

Area	Changes made/seen so far…
Health planning	• Calendar of operations prepared and displayed • Regional Health Profile prepared • Annual planning process improved • Use of information in planning improved
Health sector information management	• CRHD website launched and information uploaded • Consistency in reporting especially in Aama programme: update specific information • Improved reporting on physical outputs and financial outlays • Resource centre established • Use of various socio-demographic information for Equity and Access Programme (EAP) planning and implementation
Coordination	• RHCT has been formed and is functional with TOR: regular meeting • Regularised RHD staff meeting • Regularised RHCC meetings with agenda at the district level • Joint monitoring and progress review
Others	• GESI perspective / lens: sensitising the programme operation and review • Use of Integrated Management of Childhood Illnesses protocol strengthened in some districts • CRHD space management: positive and comfortable working environment

Qualitative Changes Seen

- Regional Office staff are positive towards the support they are receiving
- Enabling working environment (they are working with the team and are interested in learning new things)
- Strengthened / encouraged TEAM Building
- Expressed positive things while working together

Challenges

- Leadership turnover at regional and district levels
- Vacant key positions at RHD and in the DP/HOs include Statistical Officer, Public Health Officers, Public Health Nursing Officer
- Reluctant use of supervision guidelines and checklists prepared by DoHS; more effort needed
- Financial and physical reporting (annex-2) is still not regular and is not a priority in most districts
- Start-up, initiation and implementation of programmes(especially joint and partnership activities like EAP and Social Audit)has been slow
- Physical infrastructure of the office (limited space and delay in maintenance)- in initial period

Way forward

- Advocacy for filling key positions
- Capacity building in supervision and monitoring of ongoing programmes and specific activities (Appreciative Inquiry based)
- Strengthen RHCT and District RHCC
- Encourage mid-level managers and district heads to use the available tools for monitoring programmes for improvement
- Joint Review of priority programmes and activities
- Strengthen strong communication within the team and with the related organisations at the regional and district levels

Annex VIII: Highlights of Eastern Regional Presentation
Regional Director- Ram Dhan Mehata

Total Population	6547126
Female Pop 15-44 Yrs	1620786
Female Pop 15-49 Yrs	1770393
Married Female Pop 15-49	1327779
Adolescent Pop 10-19 Yrs	1410545
Expected Pregnancy	180701
Expected Live Births	162616
Primary Health Center	49
Health Post	142
Sub Health Post	722
CEOC Site	26
BEOC Site	37
Birthing Centers	214
Total FCHVs	10818
Total no. of PHC/ORC	2933
EPI Clinics	3541
IUCD Site	151
Implant Site	124
VSC Site	15
VDC	892
Municipality	14
Zonal Hospital	3

District Hospital	13
Hospital (Rangeli, Lahan, Katari)	3
Primary Health Care Centers (PHCCs)	49
Health Post (HPs)	142
Sub-Health Posts (SHPs)	722
PHC-ORCs	2933
EPI-Clinics	3541
FCHVs	10818
NGOs/INGOs	67
Private Health Institutes	103

- Out of 44 sanctioned posts in ERHD, 27 are filled, 17 posts are vacant.
- Out of total employed health HR in ERHD, 39 percent are members of upper caste groups, 27 percent are disadvantaged Non Dalit Terai Janajatis, 24 percent are Janajatis, seven percent relatively disadvantaged Janajatis and one percent each are Hill Dalits and Religious Minorities.
- Out of the total staff 71 percent are men and 29 percent are women.

System strengthening efforts made since the arrival of the NHSSP specialist in August 2011 are as follows:

Area	**Changes made/seen so far…**
Health planning	• Developed Annual Calendar of Operation, annual supervision plan and quarterly work plan of the region for FY 2068/069 and it is being implemented • Annual Calendar developed and followed in some selected districts only. • Guidelines developed for strengthening quality CEONC service in two CEONC sites (Khotang and Taplejung • Initiated documentation system at RHD • Documentation system begun in all programme review and planning meetings to offset district/programme specific gaps
Health sector information management	• Updated HR inventory of the region and districts by sex, caste & ethnicity • Identified unreached areas/population in eight districts of the region through participatory vulnerability mapping • Developed a participatory tool for mapping unreached areas/groups • Analysed sample of disaggregated data of service receivers (collected from

	MZH) by sex and ethnicity • Updated profile information of the region and districts including status of service centers/sites
Monitoring and evaluation	• Initiated a written feedback system from RHD to the districts after supervision and monitoring visits • Developed monitoring profile for the regional and district focal persons • Joint integrated supervision in the low performing districts initiated through collaboration with EDPs • Initiated collecting and analysing service data by caste and ethnicity
Coordination	• Developed profile of GOs, I/NGOs and EDPs of the region and districts • Formed functional Regional Health Coordination Team (RHCT) with a defined TOR • Task Force Committee was formed and works to outline the role and future direction of the RHCT. • Monthly coordination meeting at RHD is functional with defined agenda • Coordination meetings with EDPs and government line agencies initiated and functional with defined agenda

Challenges

- Reaching unreached areas and populations in order to reduce disparities in terms of accessing and utilising of EHCs
- Collection, analysis and utilisation of disaggregated service data for planning purposes
- Sustaining collaboration and partnership with various non-state actors in the region
- Filling key vacant positions in the region and districts
- Initiating/accelerating GESI responsive programming and planning at various levels

Way forward

- Enhance the capacity of the regional and district team on using vulnerability mapping tools to reach unreached areas and populations to initiate
- Link Gender Equality & Social Inclusion (GESI) with health sector programming and planning at all levels
- Sustain functional mechanism for collaboration and partnership with the GOs, I/NGOs, EDPs and the private sector for coordinating programmes and better utilisation of resources in the region
- Accelerate effective implementation of HRH Strategic Plan (2011-2015) including actual performance based evaluation system
- Develop/implement GESI sensitive recording and reporting tools for the collection and analysis of disaggregated service data at the health facility level

Annex IX: Regional Health System Strengthening GiZ HSSP Technical Assistance

GiZ-Tej Prasad Ojha

Highlights of Presentation

Outline

- GIZ Cooperation approach in HSSP
- TA support to Regions:
- Regions at a glance
- Conceptual framework
- Areas of support
- Produced outputs/outcomes
- Outlook

GIZ cooperation approach in HSSP

- Programme-based approach within SWAP
- Capacity development
- Integration into partner systems–harmonisation with EDPs
- Joint responsibility and accountability
- Change management / change processes as continuous learning
- Multilevel approach
- Framework- NHSP II

TA support to Regions

- Mid-west region
- Far-west region

Support to Regions: Conceptual framework

- Decentralisation, good governance, social inclusion
- Single plan, coordinating body and monitoring system at regions and districts.
- Leadership, harmonisation, alignment, mutual accountability, result management
- Integration- (state & non-state sector actors)
- Health management reform particularly M&E
- Emergency health preparedness and response

TA support to Regions: Areas of support

- Health system decentralisation
- Quality improvement in health services
    - Adolescent sexual and reproductive health (ASRH)

Outputs:

- **Regional Health Coordination Team (RHCT)**

Objective: to bring government and non-government, including development actors, together to coordinate their programmes and resources for better results in terms of maximising coverage and improving access to quality health care services

- **Regional Health Resource Map**

Objective: to map the available resources for the health sector of regions provided through different state and non-state actors

- **Regional Health Sector Strategy and Periodic Plan(RHSSPP)**

- **District Health Sector Strategy and Periodic Plan (DHSSP)**

Objective: to identify and prioritise health needs and set strategic directions by identifying resource gaps and steps for resource mobilisationso that access and coverage in health services, particularly for the marginalised and underprivileged population, is increased

- **ASRH scaled up in 10 districts (MWR+FWR)**

Outcomes so far:

- Improved coordination, participation and collaboration of sector actors at regional and district levels
- Functional website at RHDs
- Increased local resource mobilisation
- Health seeking behavior of adolescents increased (observation)

Outlook

- Reflection of RHSSPP and DHSSP in respective annual plans of regions and districts
- Linkage/ integration of the R/DHSSPP with central level planning
- Simultaneous process for decentralising functions (for effectiveness, efficiency) and capacity development at regional, district and community levels
- Allocation of financial resources to RHDs, DHOs and HFs for effective implementation of annual, strategic and periodic plans in order to increase the effectiveness and efficiency of health services
- System strengthening for monitoring and coordination at RHD in particular and DHO and HFMC in general

Future status of regions in restructuring of country remains a major question.

Annex X: Findings of Professor Andrew Green's 2012 Regional Assessment
Presented by NHSSP International Lead - Nancy Gerein

Highlights of Presentation

Questions

- How should NHSSP focus its work at the RHD level to fit within the current strategic priorities of Government of Nepal and EDPs?
- What could be feasible objectives for NHSSP regional support assuming no moves to federalism within the next two years?
- In light of current progress on federalism, what direction could RHD development take that NHSSP might support?

Findings: Current formal powers and actual practice of RHDS

Formal powers practiced consistently: approval of small facilities <15 beds

Formal powers practiced to varying degrees:

- Development of regional plan
- Coordination of district planning
- Management of resources at lower levels
- Coordination of training
- Technical and management support to lower levels
- Monitoring of district performance including finance
- Monitoring of district audit report implementation
- Liaison with I/NGOs, EDPs and other govt. agencies
- HMIS and research

Formal powers not practiced:

- Dissemination and contextualisation of National Policy,
- Construction and repair of facilities
- Purchase of essential drugs
- Supervision and monitoring of activities re DDA and Ayurveda

Findings: Typical decentralised powerswhich are not part of Nepal's RHDs….

- Setting of regional policies
- Resource allocation and budgeting approval for lower levels
- Public health functions e.g. control of epidemics, coordination of emergencies (this is being practiced, along with health camps)
- Direct management of logistics
- Direct management of services

Challenges for regions and CE efforts

- Uncertainty re federalism – 'planning paralysis'
- Limited formal authority
- Limited practice of formal authorities
- Inadequate budgets for authorised activities
- Staff vacancies and absenteeism
- Bypassing by centre and districts

Key recommendations to government, EDPs and NHSSP

- Decide balance of strategic approach to regional CE:
  - Advocate for changes to regions
  - Strengthen current regional institutions
  - Strengthen districts
  - Support the preparation for federalism
  - Document CE work on systems and structure development (as feed-in to future provincial health departments)
  - Consider role of regions in all NHSSP/EDP work at district and national levels
  - Advocate for a role for the regions and the disadvantages of ignoring them
  - Build inter-regional collaboration and learning

Annex XI: Group Work

Group 1 Key Issues and Recommendations

Issues	Recommendations
Annual Work Plan and Budget (AWPB)	• Authorise RHDs to prepare annual work programme and budget • Allocate indicative planning figure (IPF) or budget celling to RHDs for AWPB • Authorise RHDs to compile districts' AWPBs and submit them to DoHS
Human Resources	• Fill all sanctioned posts urgently • Authorise RHDs to fill all vacant posts on a contract basis • Authorise RHDs to depute medical officers from scholarship programmes as required • Authorise RHDs to transfer HR up to grade seven • Ensure retention of high level positions at RHDs for at least 2two years • Authorise RHDs to recommend for capacity building training of different levels of staff within and outside the country
Physical Facility—Infrastructure and Logistic	• Provide necessary authority to RHDs in infrastructure development (planning, monitoring and releasing of payments). Provision of one technical personnel to monitor the infrastructure development work • Physical facilities (its own well-equipped office building) forall RHDs
Financial Management	• Provide authority to RHDs for financial and programme management • Authorise RHDs to clear up audited irregularities to some extent • Ensure RHDs' role in procurement of drugs/commodities and multiyear contract
Monitoring and Evaluation	• Strengthen RHDs' capacity to prepare periodic reports • Strengthen RHDs' capacity to ensure the quality of HMIS data • Empower HRDs to ensure programme quality through effective monitoring • Empower RHDs to ensure timely physical and financial reporting from all districts
Regulate private health institutions	• Strengthen RHD capacity to respond to different types of epidemiological outbreaks and natural disaster s • Carry out regulatory functions for approval and monitoring of the private sector, e.g. hospitals, nursing homes, poly clinics, medical shops, etc. • Authorise RHDs to ensure safe and hygienic food • Approve new posts to monitor the hygienic quality of food and beverages in the market
EDPs Support to RHD	• Support RHD to introduce an effective M&E system • Support the strengthening of infrastructure • Support updating the national quality care protocols and service delivery

	guidelines for quality assurance • Develop the capacity of key HR working in the RHD

Group 2Key Issues and Recommendations

Issues	Recommendations
Regulate the private sector	Provide budget for skilled HR to regulate the private health facilities in the region.
Planning, budgeting and management	**RHD** - Provide annual budget celling for regional programming - Provide a regional annual work plan with specific events, programme and budget (AWPB) - Grant authority to revise, adjust and transfer budget in special conditions **District** - Provide an annual indicative planning figure (IPF) for the district. - Develop a mechanism for regional involvement and participation in decision making in district planning and budgeting - Expedite regional leadership and facilitate for district planning - Arrange that the financial authority (Akhtiyari) letter goes through the RHD, with facilitating power. - Provide authority to oversee and govern the overall functions of the DP/HOs, so that RHD can better respond to problems and issues emerging in the regions (Currently, RHDs lack knowledge of district programmes and budgets but if problems arise, the RHD should take responsibility) - A mechanism should be created to allow the DP/HOs to exercise effective governance through the RHD, for example: give RHD authority to approve of leave, Kaj, deputation and national/international visits
Monitoring and evaluation	- Provide a suitable vehicle and budget for effective monitoring at the district level, based on the availability of appropriate HR with technical capacity and at a compatible level at the RHDs). - Provide budget and skills for action research to develop context specific planning for targeted community. - Provide a district focal person for physical, financial and general reporting to RHD (eg. periodic reporting on the condition of physical infrastructure)
Physical infrastructure	Assess the availability of the existing physical infrastructure and facilities for this fiscal year and make necessary budgetary provision from the next year onwards, at least providing for wholly-owned buildings with basic facilities and accessories

Linkage with Sub and Regional and Zonal Hospitals	- Clarify the coordination mechanism between RHD and Zonal, Community, Sub -regional and Regional Hospitals - Identify technical assistance from RHD to Community, Zonal, Sub-regional and Regional Hospitals
Personnel **Vacant posts** **Training and capacity building**	- At least fill all vacant posts in the RHD immediately - Review the current level of functions and restructure RHD to make necessary adjustment of positions - Maintain compatible levels of HR between divisions at the centre and region, and at the district and region - Provision for regional posting of up to level 7 - Provide flexibility and autonomy to mobilise a doctor on contract working at the district and other health facilities
Institution	- Review and revise the job description of the RHD and its staff - Revise the organogram of RHD considering its role in regulating public and private sector health institutions as well as its role in monitoring the DDA and Ayurveda Departments' programme activities - Provide incremental learning and on the job training - Arrange for only one trade union to represent the public sector staff - Create a clear distinction between high and low Beruju (irregularity) clearances in performance evaluation of the districts.
Coordination/collaboration among EDP programmes	- RHDs should be the first contact point of EDPs/INGOs working within the region and a mechanism should be developed for them to wpork through RHDs in the regions. - EDPs/INGOs should undertake the regional level planning (e.g. district selection, programme planning and budgeting) based on regional needs and priorities - Promote transparency of EDPs/INGOs programmes and budgets in the region. - As a policy, provide for authentic RHCTs and RHCCs with representation of EDPs, I/NGOs and Government, including representatives of regional and zonal hospitals - TA from EDPs to RHD
Decentralisation	- Focus on decentralisation of authority rather than decentralisation of problem solving. - Settle conflicts in the exercise of power - particularly concerning staff management (RHD should have fixed authority for personnel management – transfer, deputation, leave and so on and this authority should not be violated by DoHS or the Ministry.) - Make DP/HO accountable to RHD – do not limit on only for a performance evaluation. Maintain confidentiality regarding recommendations or

	performance evaluations done by the RHD for the district level staff - Though RHD is representative of three Departments (DoHS, Ayurveda and Drug Administration) it can only carry out its function as a health directorate partially, since the departments of Ayurveda and Drug Administration do not share their programmes and functions.
Logistic management	- Functionalise E-bidding immediately - Decentralise procurement authority to RHD and provide technical and financial capacity

Group 1 and Group 2
Key Issues and Recommendations

Issues	Recommendations	Expected outputs
Authority	• Authorise RHDs and districts to prepare the annual work programme and budget (AWPB) with annual indicative planning figures (IPF) or a budget ceiling • Authorise RHDs to send budget approval (budget Akhatiari) to districts	Improvements in the following: • Budget flow • MoHP budget absorption capacity • Service delivery • Utilisation of health services by people • Accountability of district level staff
Human resources management	• Immediately fill all sanctioned vacant posts in all RHDs or authorise RHDs to fill all vacant posts on a contract basis • Authorise RHDs for transfer and deputation of HR up to grade seven and performance evaluation of DP/HOs	Improved : • Work efficiency and quality of services • Efficiency in service delivery
Infrastruc-tures for RHDs	• Make necessary budgetary provision, for RHD's own building with basic physical facilities and including accessories like computer, furniture and other logistics	Improved : • Friendly working environment at RHDs
Financial Management	• Authorise RHDs to clear up audit irregularities to some extent (the amount to be decided) • Ensure RHDs' role in the procurement of drugs, commodities and services through a multi-year contract system	Decreased: • Irregularity • Minimise stock out situation in the districts and health institutions
Monitoring and	• Strengthen RHDs' capacity for effective M&E to	Improved: • Work efficiency of the districts

evaluation	districts with sufficient budget allocations	• Quality of recording and reporting • Timely reporting by districts
Regulation and management of private health institutions	• Strengthen RHD capacity to respond to different types of epidemiological outbreaks and natural disasters • Authorise the regulatory function of approving and monitoring of the private sector, e.g. hospitals, nursing homes, poly clinics, medical shops, technical hospitals, community hospitals etc. • Authorise RHDs to ensure safe and hygienic food and provide required human resources	Improved: • RHDs 'capacity to respond to epidemiological disease outbreaks and disaster management • Coordination between public and private sector s • Food safety of the population
EDP support	• Ensure EDP support to RHD to introduce effective M&E systems • EDPs should support strengthening physical infrastructure, updating national service delivery guidelines and quality care protocols for quality assurance • EDPs should develop the capacity of key HR working at the RHD, considering its role and the functions assigned by MoHP • EDPs should develop a policy provision on the authenticity of RHCT and RHCC with representation of EDPs, INGOs and Government	Improved: • Coordination between EDPs and public health institutions to minimise duplication of resources • Allocation of resources in area of need • Service delivery system