NHSSP Nepal Health Sector Support Programme

Nepal Health Sector Support Programme

Report of Internal Stocktake of NHSSP Support to MoHP, DoHS and Regions

July 2012

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Acknowledgements

Sincere thanks extend to all those who kindly gave time to contribute towards this review by taking part in interviews.

Acronyms and Abbreviations

AusAid	Australian Agency for International Development
CB-IMCI	Community-based Integrated Management of Childhood Illnesses
CE	Capacity Enhancement
CHD	Child Health Division
CV	Curriculum Vitae
DFID	UK Department for International Development
DoHS	Department of Health Services
DSA	Daily Subsistence Allowance
DSF	Demand-side Financing
DUDBC	Department of Urban Development and Building Construction
e-AWPB	Electronic Work Plan and Budget
EAP	Equity and Access Programme
EDP	External Development Partner
FHD	Family Health Division
FM	Financial Management
GAAP	Governance Accountability Action Plan
GESI	Gender, Equality and Social Inclusion
GIS	Geographic Information System
GoN	Government of Nepal
HEFU	Health Economics and Financing Unit
HMIS	Health Management Information System
HR	Human Resources

HRFMD	Human Resources and Financial Management Division
IP	Implementation Plan
JAR	Joint Annual Review
JCM	Joint Consultative Meeting
JTAA	Joint Technical Assistance Agreement
LMD	Logistics Management Division
M&E	Monitoring and Evaluation
MD	Management Division
MNCH	Maternal Newborn and Child Health
MoF	Ministry of Finance
MoHP	Ministry of Health and Population
NGO	Non-governmental Organisation
NHSP-2	Second Nepal Health Sector Programme
NHSSP	Nepal Health Sector Support Programme
OCMC	One-stop Crisis Management Centre
PHCRD	Primary Health Care Revitalisation Division
PPICD	Policy Planning and International Cooperation Division
RHD	Regional Health Director
RTI	Research Triangle International
SC	Steering Committee
SSU	Social Service Unit
SWAp	Sector-wide Approach
TA	Technical Assistance
TABUCS	Transaction Accounting and Budgeting Control System
TC	Technical Committee
TOR	Terms of Reference
USAID	U.S. Agency for International Development

WB	World Bank
WHO	World Health Organization

Executive Summary

As part of an internal stocktake of how the Nepal Health Sector Support Programme (NHSSP) is performing at the midpoint of its contract, the NHSSP Senior Management Team and Options were keen to elicit the views of the Government of Nepal (GoN) (Ministry of Health and Population (MoHP), Department of Health Services (DoHS), and Regional Health Directorates) and pooled donors on the support provided by NHSSP to date. Meetings were held with key stakeholders both centrally and in two of the regions.

The overall view expressed by MoHP/DoHS officials met was that there is great appreciation of NHSSP and of the volume of work being supported by Advisors. From the start of NHSSP 18 months ago to now, there appears to have been a noticeable change in government perception of the value of Technical Assistance (TA) with an increasing understanding of the model of TA employed by NHSSP.

NHSSP support is valued by Departmental and Divisional Heads, although some expressed the view that TA is still being under-utilised by government. The overall view of government is that TA should ultimately be a support, and that TA should not take a leading role in the work of Divisions and Departments, but that sometimes government does ask TA to do work that government should be doing itself. It was noted also that a certain amount of flexibility in TA is required and appreciated, so that TA can respond to unpredictable situations.

There was a view at the beginning of NHSSP that some of the areas of focus of the TA to the GoN were identified by NHSSP, rather than responding to an observed need by government. A point was also raised regarding whether international consultants are contracted in response to a need identified by NHSSP or one observed by government. Now the view is that TA needs are identified through close working and joint work-planning between Advisors and Counterparts, according to the needs of the government work plan.

There is a widespread perception among GoN that one of the most effective ways of bringing about skills transfer is through overseas learning and observation visits. As such, a common observation was that international exposure visits would be appreciated, although informants acknowledged that it was not currently in NHSSP's scope.

There are some key areas where NHSSP could develop its support to the GoN. Firstly, through increasing consultation and engagement with not only counterparts but also Heads of Departments/Divisions and Counterparts in the development of initial Terms of Reference (TOR) for consultants. Secondly, by increasing on-going dialogue with key stakeholders in government. This could be achieved through regular meetings disseminating the quarterly report in addition to future stocktake meetings. Thirdly, reviewing the options for international exposure visits and exploring potential scope for including these. Finally, by reaffirming that the NHSSP approach is to use a national consultant wherever possible and to only contract an international where a local consultant is not available continues.

1. Introduction

As part of an internal stocktake of how the Nepal Health Sector Support Programme (NHSSP) is performing at the midpoint of its contract, the NHSSP Senior Management Team and Options are very keen to elicit the views of the Government of Nepal (GoN) (Ministry of Health and Population (MoHP), Department of Health Services (DoHS), and Regional Directorates) and pooled donors on the support provided by NHSSP to date.

In order to gain the perspectives of key government officials and Counterparts, a series of meetings were held between members of the NHSSP Senior Management Team (Dr. Nancy Gerein, NHSSP International Lead), Mr. Ramchandra Singh, Health Systems Advisor), Options Senior Management (Dr. Kirstan Hawkins, Technical Director), and Divisional and Departmental Heads in the MoHP and DoHS (see Annex 1 for a list of people met).

In addition, a rapid stocktake of support to the regions was undertaken by NHSSP Senior Management (Krishna Sharma, Head of Finance and Administration) and Options Senior Management (Sarah Hepworth, Assistant Director of Programmes), who visited Western and Central Regions (Annex 1).

Key questions explored in the interviews were:

- What is GoN's view of how NHSSP Advisors are working with Counterparts? Is the way of working satisfactory and meeting GoN needs?
- Are there ways of working that could be done differently – or that could be improved upon?
- Does GoN appreciate the Capacity Enhancement (CE) approach taken by NHSSP? Is CE happening and how can it be improved?
- How effective is NHSSP communication/dialogue with government and how could it be improved upon?
- Does NHSSP have the right areas of focus – for example, is the regional focus valuable?

This report presents a summary of key findings of those meetings. Some meetings were held with the Head of a Division alone, while in others, the Head of the Division invited several senior staff to participate. It was not possible to meet with all Counterparts within the time-frame for the exercise: this report does not present a comprehensive overview of the perspectives of all GoN Counterparts involved in implementing the Second Nepal Health Sector Programme (NHSP-2). Nevertheless, it does give the views of a substantial number of our key Counterparts.

2. Key Findings

2.1 Government Perceptions of Overall Value of Technical Assistance

The overall view expressed by MoHP/DoHS officials met was that there is a tremendous appreciation of NHSSP and of the volume of work being supported by Advisors. From the start of NHSSP 18 months ago to now, there appears to have been a noticeable change in government perception of the value of Technical Assistance (TA). One GoN Counterpart said:

> 'At the JAR [Joint Annual Review] I said that this TA was not needed. Now I think my Division could not exist without it.'

MoHP officials who were involved in NHSSP at the start explained that there had been some confusion around or differences between MoHP expectations of TA and the NHSSP model of support. In particular there was an expectation that NHSSP would supply Human Resources (HR) to support Divisional and Departmental Heads and have funds to finance overseas learning visits (both provided by the previous TA programme managed by Research Triangle International.

At the midpoint of the programme there is now a much clearer understanding by GoN of the NHSSP model of working. TA from NHSSP is generally seen as having a special and defined role with clear accountability to the pooled donors. NHSSP is also perceived as being flexible and responsive to GoN requests; this aspect of NHSSP mode of working is clearly greatly valued by Counterparts. A turning point for the visibility and appreciation of NHSSP support appears to have been the JAR, in which the value of NHSSP support in preparation of data and reports became apparent. While coordination between NHSSP and GoN is perceived as working well (although there are criticisms of communication relating to identification of need for international consultants), coordination of TA by External Development Partners (EDPs) across the sector is perceived by GoN as problematic and in need of better harmonisation.

NHSSP support is valued by Departmental and Divisional Heads, although some expressed the view that TA is still being under-utilised by government. The overall view of government is that TA should ultimately be a support, and that TA should not take a leading role in the work of Divisions and Departments, but that sometimes government does ask TA to do work that government should be doing itself. NHSSP appreciated the recognition by GoN that there is a dual responsibility for CE. There is recognition by GoN that lack of HR within Divisions and Departments and frequent staff transfers act as major impediments to skills development. The GoN expressed the view that ultimately the role of TA is to put government in the driving seat, but that CE and systems building happen over time. Several senior officials made clear that they would like to see NHSSP continue in order to maximise the benefits of CE for the long term.

2.2 Modes of Working with Divisions and Departments

The View of MoHP

Population Division

NHSSP is providing support to Population Division in Gender, Equality and Social Inclusion (GESI) mainstreaming, including: development of an Implementation Plan (IP) and of Operational Guidelines for implementing the GESI Strategy; and establishment, strengthening, monitoring, and scale-up of One-stop Crisis Management Centres (OCMCs) and Social Service Units (SSUs). GESI is a new field for Population Division, and central to implementation of NHSP-2. At the start of NHSP-2, divisional staff had not had any exposure to GESI mainstreaming and concepts. The Head of Population Division expressed satisfaction with the mode of working of NHSSP, saying: 'What we seek, they provide.' Through working closely with NHSSP Advisors it is now considered that skills in GESI analysis are being developed within the Division, and that this is a process that needs to continue. The Head of Population Division suggested that it would be very helpful for divisional staff to be able to learn from visiting OCMCs in Bangladesh, but recognised that this is something that NHSSP is unable to support at present.

Human Resources and Financial Management Division (HRFMD)

The view of the Joint Secretary is that a good relationship has been formed between government and NHSSP Advisors, and that HR and Health Financing (HF) are receiving appropriate support. The development of the HR Strategic Plan is seen as being a major achievement, with the Head of HRFMD commenting: 'After the development of the HR Strategic Plan my people are being very much engaged.' The plan is in the process of being discussed with Ministry of Finance (MoF), after which it will be passed to Cabinet for approval. Nonetheless, legal challenges still remain in the implementation of the strategy.

He noted that revised governance indicators of the Governance Accountability Action Plan (GAAP) have been developed, although the view of HRFMD is that the GAAP does not cover all governance issues and an action plan needs to be developed by GoN which goes beyond the GAAP. He welcomed NHSSP involvement in this process.

In HF, he recognised that progress has been made in implementation of the Electronic Work Plan and Budget (e-AWPB), but felt that capacity gaps still exist within GoN in HF, with the Health Economics and Financing Unit (HEFU) being understaffed and poorly managed. Priority areas for HRFMD in the coming year are: the piloting and rolling-out of the Transaction Accounting and Budgeting Control System (TABUCS); moving forward with the implementation of the HR Strategy; the development of a HF Strategy; and the formulation of a health insurance policy.

Policy Planning and International Cooperation Division (PPICD)

The views from this Division were that NHSSP is doing well, and that it has a special role, unlike TA from other EDPs such as the World Health Organization (WHO) and the U.S. Agency for International Development (USAID), in that it is considered to be accountable to not just the UK Department for International Development (DFID), but also the MoHP. The TA programme was set up in order to provide MoHP with the capacity to implement the Sector-wide Approach (SWAp) (starting 2004),

and one interviewee felt that since then, the performance of the MoHP in budgeting and Financial Management (FM), Monitoring and Evaluation (M&E), and planning has deteriorated, although this comment did not appear to be directed towards the TA. There is sometimes a problem created by other TA programmes in terms of the competition that develops (as in health insurance), but NHSSP was not viewed as part of that problem.

PPICD appreciated the support from NHSSP in a number of key areas: specifically mentioned were the Joint Annual Review (JAR), Joint Consultative Meetings (JCMs), e-AWPB, on-going activities on health policy review, and the NHSP-2 IP. It was noted also that a certain amount of flexibility in TA is required and appreciated, so that TA can respond to unpredictable situations. A suggestion was made that the current lack of provision within NHSSP to support exposure visits could be raised with DFID and the pooled donors.

The View of DoHS

Logistics Management Division (LMD)

Government Counterparts in LMD expressed a very strong appreciation of TA provided by Advisors, to the extent that the Head of LMD suggested that 'if NHSSP consultants were to leave LMD, then procurement would currently be impossible.' It is recognised by LMD that systems building and CE have been constrained by a lack of HR within the Division, resulting in the need for executive TA in procurement. The head of LMD expressed the view that there is evidence of staff teaching taking place in some areas such as development of bid documents and computer skills. The introduction of framework contracts has also increased efficiency. The production of the consolidated procurement plan early in this financial year is seen as a very positive development, providing LMD with a tool for monitoring. LMD would value more training to be provided to staff by Advisors, but also recognises that current workloads in supporting executive procurement and the lack of HR in LMD make the training/skills building aspect of TA very difficult.

The lack of Biomedical Engineers has been felt as a limitation both by LMD and the World Bank (WB). NHSSP is cognisant of this and three Biomedical Engineers are being recruited.

Child Health Division (CHD) and Family Health Division (FHD)

Within CHD and FHD, TA is perceived to have been of great value, and again the view was expressed that 'if the TA were not here where would we be?' TA is particularly valued in CHD and FHD as a technical back-up to staff. TA is seen to be supporting CHD in core strategic areas. Of particular value is support to the Community-based Integrated Management of Childhood Illnesses (CB-IMCI) Maintenance Strategy and the Maternal Nutrition Strategy, which is only the second example in the world of a national Maternal Nutrition Strategy. CHD was one of the few to say that all partners work together to fill gaps and coordinate their inputs – this may be seen as a testimony to the management skills of the Director, as much as EDP cooperativeness.

While Advisors' TA is greatly appreciated and seen as vital to the day-to-day work of FHD (a number of specific examples were cited showing their detailed knowledge of the work being supported), several officials expressed the view that skills building of individual Counterparts in FHD has been slow. This statement was balanced by the recognition that not all government staff are interested in

capacity development, and some are less willing to pick up and use new skills. A view was expressed that at the start of NHSSP there was more of a ‘business as usual’ approach to the work of FHD, and that it was not immediately evident how consultants were contributing to CE. There was also a view at the beginning of NHSSP that some of the areas of focus of the TA to FHD were identified by NHSSP, rather than responding to an observed need by government. Now TA needs are identified through close working and joint work-planning between Advisors and Counterparts, according to the needs of the FHD work plan. However, an observation was made that ultimately TA should focus more on enabling the Counterparts to do the job themselves and it may be important for NHSSP and FHD to jointly look at ways to help improve the transfer of skills. NHSSP’s view is that this may require addressing the vacancies in FHD and the general issue of personnel management – both areas where NHSSP has little control – as well as a review of our approach.

Primary Health Care Revitalisation Division (PHCRD)

PHCRD is very satisfied with the TA being provided by NHSSP and considers that the arrangement of an Advisor being embedded within PHCRD works extremely well. The major constraints identified by PHCRD are that as a new Division it has many new projects and lacks the HR needed to oversee a diverse range of programmes. Currently there are few staff with the appropriate technical skills with whom to build capacity. The Head of PHCRD stressed how much he valued the support provided by NHSSP on Social Audit, the Equity and Access Programme (EAP) and the Urban Health Policy, as well as support provided from Advisors in LMD on procurement of drugs. Again the statement was made that without NHSSP it would be difficult to go forward with these programmes. The issue of multi-year contracts of Non-governmental Organisations (NGOs) for EAP was discussed and the view was given by PHCRD (as well as PPICD) that there is no obstacle to multi-year contracting of NGOs by the districts and this has been agreed by the MoF. This is an issue which NHSSP continues to raise, but it is felt by PPICD that it may not be possible to act definitively until there is greater clarity about the budget, which is an ordinance budget, and not the regular, full budget. There will be an opportunity to disseminate information to districts and regions about multi-year contracting in the regional and annual reviews in the September to December period.

Management Division (MD) and Department of Urban Development and Building Construction (DUDBC)

MD and DUDBC Counterparts expressed a strong appreciation of TA being provided by NHSSP. MD considered that given weak capacity within MD the most effective mode of skills transfer is for staff to ‘learn by doing’ with Advisors. This mode of working seems to be happening effectively. Work now being done with NHSSP Advisors on Health Management Information System (HMIS) tools is seen as very valuable. There is a major skills gap within GoN in data analysis and the capacity to use data for decision-making. An example was given of Geographic Information System (GIS) mapping of facilities and that support is needed to look at how these data can be used for planning and decision-making. NHSSP pointed out that MD has a person with a PhD in GIS, and is therefore better placed than NHSSP to address this issue. MD requested support in a number of other areas, such as improving the quality of services and facilities and dealing with medical waste, MD’s role in construction of facilities with DUDBC, equipment maintenance, and others, which can be seen as a vote of confidence.

2.3 The CE Approach

The CE approach appears to be both understood and valued by GoN. The two important aspects of CE that GoN emphasised were institutional strengthening and individual skills transfer/development. It is felt by some that NHSSP is doing better on the institutional/systems aspects of CE than on skills transfer to individuals. Others recognised that individuals are gaining skills by learning to use new systems and processes.

It is recognised by government that systems building is central to the NHSSP approach. There is evidence at this point that systems development is happening in some core areas of NHSP-2 as a result of support from NHSSP. Examples include: e-AWPB, business plans, Maternal Nutrition Strategy, IMCI multi-year plan of action, Social Audit, EAP, HMIS, Demand-side Financing (DSF), and GESI.

The view that NHSSP is better at systems development than individual capacity building appeared to be related to the almost universal perception among GoN that one of the most effective ways of bringing about skills transfer is through overseas learning and observation visits. All GoN senior officials expressed their desire or expectation that NHSSP would support individual skills building through overseas exposure visits and study tours. The expectation that a TA programme would support such learning was a major factor which contributed to a view at the start of NHSSP that the TA support was not as responsive to GoN needs as it could have been. By mid-programme, there now appears to be an understanding among most GoN Counterparts that funding of overseas exposure visits is not within the mandate and budget of NHSSP. Nonetheless this is perceived as a limitation of the TA programme.

GoN officials recognised that there is a dual responsibility of GoN and NHSSP to ensure that conditions are right for skills transfers to take place between Advisors and Counterparts. It is recognised by GoN that there are a number of factors which may act as constraints to skills transfer. These include:

- Advisors being engaged in day-to-day technical support of activities and workloads preventing more strategic approach to building skills of Counterparts to do the job (this is the case, for example, in LMD);
- Counterparts requesting Advisors to support them in completing their day-to-day activities, which does not enable Advisors to focus on the systems development aspects of individuals' skills building. This is the case, for example, in FHD.
- Lack of receptiveness of staff to having their skills built: a comment was made by a Divisional Head that 'you can take a horse to water but you can't make it drink.'
- Lack of HR with whom to transfer skills (such as in LMD, PHCRD, and regions)
- Frequent transfers limit the effectiveness of individual skills building so that the momentum and consistency of skills development is lost, hence the need to focus on tools and systems (this is a constraint across MoHP and DoHS).

It is important to keep dialogue open between NHSSP and GoN regarding mutual roles and responsibilities of Advisors and Counterparts where skills transfer is seen to be slow. A more open dialogue may be possible about the relative focus on CE vs. transactional TA, if a Director seems willing.

2.4 Use of Consultants

Overall there is a perception that skills transfer from international consultants to government counterparts is not taking place as effectively as it could. This perception is related to a concern of GoN Counterparts that there is insufficient dialogue with government before the need for an international consultant is identified. A question was raised on a number of occasions as to whether international consultants are contracted in response to a need identified by NHSSP or one observed by government. GoN is very keen to ensure that a national consultant is used wherever this capacity exists and that international consultants are contracted only where the skills are not available on the local market. More consultation would also be appreciated by Heads of Departments/Divisions and Counterparts in the development of initial Terms of Reference (TOR) for consultants.

NHSSP is entirely supportive of this view. The NHSSP approach is to use a national consultant wherever possible and to only contract an international where a local consultant is not available, and the need for an international has been identified with the Counterpart. An international consultant is almost always paired with a national consultant, as NHSSP also sees part of its CE mandate as building capacity in the private sector.

However, it appears that while the need for a consultant is agreed between the Advisor and their direct Counterpart, this information may not be communicated effectively to Department or Divisional Heads (where the Counterpart is not a Division Head). Clearly dialogue can be improved by NHSSP with GoN to ensure that the appropriate Divisional and Departmental Heads are involved in the identification of the need for a consultant, and that Counterparts are involved in the drafting of TOR, see the CVs of consultants, and know the dates and plan of work. NHSSP will work to improve this dialogue with GoN.

2.5 Communication/Dialogue with Government

The joint governance structures of the Steering Committee (SC) and Technical Committee (TC) are the appropriate mechanisms through which to ensure effective dialogue between NHSSP and GoN. The SC and TC were slow to get going in the first year of implementation, and some of the differences in expectations of TA and modes of working would have been managed more effectively had these structures been fully functional. Now that the SC and TC are functional, the mechanism for effective communication between NHSSP and government is established, and communication is perceived to be happening effectively.

It is clear from our meetings that GoN officials welcome the opportunity for informal communication with the NHSSP Senior Management Team. All senior officials met were extremely accommodating with their time and welcomed the opportunity to give feedback and engage in dialogue with NHSSP.

The quarterly report presentation was well attended, and NHSSP greatly appreciated the time given by GoN to attend the presentation following a heavy day of meetings. Feedback from those attending suggests that GoN would welcome the continuation of the quarterly report presentations, as they will provide an opportunity for dialogue and engagement around quarterly plans and progress. We recommend that NHSSP continue with these presentation meetings with GoN on a quarterly basis.

2.6 The Regions

View of MoHP/DoHS

It was noted that at this point there are a number of different views regarding the value of support provided in the regions, so at this stage it is difficult to assess the performance of NHSSP.

A view was expressed by several Counterparts that better use could be made of resources at the regional level, although no specifics were offered. There appears to be limited awareness of the role of NHSSP Regional Specialists and how they can be drawn on as a resource. A request was made for clarity on the line management structure of the regions so that it is made clear to whom NHSSP Regional Specialists are accountable.

View of Regional Health Directors

There was a generally positive attitude towards the NHSSP teams at regional level from the Regional Health Directors (RHDs). They felt that there had been some high quality support, that the teams were of a high technical quality, and that they could see progress in the strengthening of some systems. For example, they cited the development of an annual operational plan (Western Region) and the support to improved coordination amongst EDPs and NGOs (Central Region). In the Western Region the RHD also appreciated the opportunity for his staff to receive training on computer skills (he is hoping that within the next three months everything will be computerised), report writing, and effective communication and management. Communication channels between the RHD and the NHSSP team are good, although because the NHSSP team are not government staff, the RHDs are unsure of their authority regarding the NHSSP Regional Specialists.

A fundamental question was raised over how much it is possible for the NHSSP teams at regional level to achieve, given the lack of HR available for them to work with. For example, in the Central Region, while the RHD is a level 11, the next members of staff available are levels 7 and below, largely low-level technical or administrative staff. The perception is that the NHSSP team can therefore only achieve fairly low-level changes, which do not sufficiently draw on their skills or expertise. The perception is therefore that they could be utilised more effectively.

The workshop on the role of the Regions held in May 2012 in Kathmandu was attended by the RHDs from all Regions. However, both questioned the effectiveness of the workshop to prompt action. The perception was that it was a talking shop which repeated discussions that had been held on numerous occasions over a period of many years and that there needed to be greater continued advocacy at the central level to really effect change and ensure that money, resources, and responsibility were devolved to the regions. The comment made by Dr. Chand at the regional workshop was repeated, that when government officials are posted to the regions they want to strengthen them, but as soon as they are posted to the central level then they forget about them. This was acknowledged as true, and a cycle that is likely to continue.

Looking forward, there was a divergence of views on how NHSSP should continue support to the regions. In the Western Region the RHD wanted to see the scope of support widened and for the team to be in place longer term, continuing to be flexible in their response to various Regional Health Directorate programmes and in working with the districts. However, in the Central Region the RHD felt that there should be a greater emphasis at Kathmandu level in advocacy for building up the role and resources of the regions, and that only once that had been achieved should technical resources be placed in the regions. The suggestion was that greater advocacy was needed centrally to prompt the ministry to think seriously about strengthening the Regional Health Directorates, and that pre-conditions should be set with the MoHP for placing TA. For example, only once a certain percentage of positions were filled at all levels within the Regional Health Directorates should TA be forthcoming. One area where the RHDs did converge was on increasing access to NHSSP resources, particularly the vehicle (which was raised on several occasions), but also on support for buying computers and improving the office environment.

View of Regional Counterparts

The Counterparts in both regions appreciated the support provided by the NHSSP teams. They felt that there were some good improvements in relation to: the development of annual operational plans and calendars of events; improvements in coordination between EDPs and NGOs; improved structure around field visits and improved reporting times following monitoring visits; more detailed and analytical information available for the annual report; and the development of a regional profile. Counterparts have also appreciated the opportunity to build their computer and report writing skills. In the Central Region, in particular, the Counterparts were appreciative of the NHSSP team's technical expertise in filling the vacuum left by the significant vacancies of technical-level staff in the Directorate.

Both teams wanted to be able to use the car more freely and be able to use it on weekends. They felt that the rules surrounding the use of the vehicle were too restrictive. There had been misconceptions at the beginning of the programme over their access to the vehicle and this was still a point of contention. In the Western Region, they would also like to receive a daily subsistence allowance (DSA) from NHSSP and/or see a reward scheme for well-performing government staff. In the Central Region they would like a generator, computers[1] and a printer, and support to improve the network system which is currently very poor.

Changes within GESI were slow, although it was acknowledged that this was partly due to there being no-one with specific GESI responsibilities at the Directorate level. For example, in the Central Region, the GESI focal person was an administrative staff member who had to fit in GESI work around his normal workload. Overall, in line with the RHDs, the Counterparts also questioned their ability to fully utilise the expertise of the NHSSP staff, partly as a result of the lack of motivation of government staff and lack of accountability. However, communication channels were generally seen as good – particularly for the M&E Advisor in the Western Region who is sitting with the statistics team.

[1] In the Central Region they do have computers but they are very old and therefore unused. However, because they do have them, despite them being defunct, central government will not let them buy any more.

2.7 View of the Pooled Donors

We were able to meet with the WB and the Australian Agency for International Development (AusAid) to gain their overall view of the progress of NHSSP towards meeting its objectives. The WB said that there is now a realisation among EDPs of the value and 'tremendous' volume of work being supported by NHSSP, and that in the coming years it may be necessary to look at narrowing its scope slightly. There are some areas in which it is difficult to know what is happening; the example given was progress on TABUCS, which is largely an issue of communication and the scale of the programme. From the WB perspective, progress in fiduciary oversight has been slow. While the WB considers that progress is beginning to be seen in FM, they are less optimistic about progress in procurement. Questions were raised regarding whether the focus of the TA in procurement (as defined within the current TORs of NHSSP) is now the right focus.

AusAid expressed the view that there has been a change in responsiveness of GoN towards NHSSP over the first 18 months of implementation. At the design stage (prior to implementation) there was some resistance from government towards a TA programme which was perceived to be dominated by international consultants. The TA is now perceived by GoN and EDPs as extremely helpful. Examples of good progress include: timely completion of the AWPB; development of the business plans; support to GESI and Maternal Newborn and Child Health (MNCH), which has been effective at policy level; and integration of GESI into the AWPB. Governance support provided by NHSSP has been very beneficial, including support to FM. The finalisation of the M&E framework is also beneficial, although late in the implementation of NHSP-2.

AusAid also raised the question of whether the focus of support to the regions is the right approach given questions over the mandate of the regions and their capacity to perform a monitoring function. It was suggested that the regions and procurement may be core issues that will be considered during the mid-term review.

AusAid suggested that while government responsiveness to NHSSP is changing, the overall ownership of TA by government across the sector is still limited. A major constraint to CE is the limited HR within government (this is also related to the out-of-date structure of MoHP) and frequent staff transfers. In some instances NHSSP Advisors do not have effective Counterparts to whom to transfer skills. Another recognised constraint on GoN taking ownership of TA is the lack of coordination of TA by EDPs across the sector. The Joint Technical Assistance Agreement (JTAA) should help facilitate better coordination between EDPS and GoN and enable GoN to have more oversight, ensuring that TA is in line with GoN priorities. It is anticipated that by January 2013 the JTAA will be in place. More needs to be done going forward to build the stewardship of the MoHP and put government in the driving seat.

Annex 1

People Met in MoHP

Mr. Padam Raj Bhatta	(Joint Secretary, Population Division)
Mr. Surya Prasad Acharya	(Joint Secretary, HRFMD)
Dr. P.B. Chand	(Chief, PPICD)
Dr. B.K. Subedi	(MoHP)
Dr. B.R. Marasini	(Chief, Health Sector Reform Unit)

People Met in DoHS

Dr. Mingmar Sherpa	(Director-General, DoHS)
Mr. Padam Raj Bhatta	(Joint Secretary, Population Division)
Dr. Naresh Pratap K.C.	(Director, LMD)
Dr. Saroj Prasad Rajendra	(Director, MD)
Dr. Shyam Raj Upreti	(Director, CHD)
Dr. Senedra Uprety	(Director, FHD)
Mr. Shyam Kishore Singh	(Chief, Health Building Unit, DUDBC)
Mr. Dinesh Chapagain	(Senior PHA , MD)

Pooled Donors

Dr. Albertus (Bert) Voetberg	(Lead Health Specialist, World Bank)
Ms. Latika Pradhan	(Programme Manager, AusAid)

People Met in Regions

Pokhara: Western Region

Dr. Bhim Acharya	(Regional Health Director)
Madhav Thapalaya	(Public Health Officer (MNCH Counterpart))
Raju Raman Neupane	(Immunization Supervisor (Child Health))
Nil Kantha Sharma	(IRC/B CC Officer (GESI Counterpart))
Rabindra Ghimire	(Computer Officer (supporting planning/monitoring))

Hetauda: Central Region

Dr. Rajendra Pant	(Regional Health Director)
Narayan Shrestha	(Health Education Officer (planning/monitoring))
Uttam Pakurel	(Vector Control Officer (working on MNCH))
Chandra Man Tamang	(Immunization Officer (MNCH Counterpart))
Raj Mani Niraula	(Section Officer (GESI Focal Person))