Background thematic report no. 6

Progress Report on

Partnership, Alignment and Harmonisation in the Health Sector

2012/13

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EXECUTIVE SUMMARY

Progress report on partnership, alignment and harmonisation in the health sector

This report highlights the progress made and the challenges and ways forward on partnership working, alignment and harmonisation by the Government of Nepal and its partners in Nepal's health sector in 2012/13.

A. Progress

Nepal's sector wide approach (SWAp) to the development of its health sector is maturing as evident from the fewer independent projects, less fragmented aid and more external development partner (EDP) programmes and resources linked to government mechanism and strategies. This is resulting in reduced transaction costs for MoHP and improved MoHP budget absorption capacity.

The major mechanisms that are strengthening donor harmonisation and alignment, and fostering partnerships are the joint annual reviews (JARs), joint consultative meetings (JCM), technical working groups, the regular meetings of health sector EDPs and the health sub-group of the Association of INGOs in Nepal, and the Joint Financing Arrangement (JFA) of harmonised procedures.

Efforts are underway to improve the coordination and implementation of technical assistance through a Joint Technical Assistance Arrangement (JTAA). Progress was also made on setting up a TA/TC Coordination Committee for Nepal Health Sector Programme (NHSP) and by establishing a Technical Assistance Response Fund (TARF).

EDPs operating at the district level have made good progress on finding their comparative advantages. However, differing modus operandi of development partners often create difficulties for coordination at the district level.

The Aid Management Platform (AMP) now encompasses 4,654 programmes and projects with total disbursements for 2011/12 of $1.04 billion. In 2013/14, AMP was rolled out to all local development partners and all line ministries and progress was made on bringing INGOs on to the platform.

The main progress on state–non state partnerships was the inclusion of the importance of partnerships in the draft revised National Health Policy, and progress on finalising the State Non-state Partnership Policy for the Health Sector.

The main progress in 2012/13 on multi-sectoral collaboration was the signing of a collaborative framework between MoHP and MoFALD to strengthen local health governance.

B. The Way Forward

The principal ways forward for developing partnership working, alignment and harmonisation in the health sector are to:

1. expand the SWAp to bring in major donors such as India and China;
2. make further progress on a joint agreement on technical assistance;
3. put more of a focus on partnership working and harmonisation at district and regional levels;
4. the official approval of the State–Non-state Partnership Policy;
5. minimise duplication and improve efficacy of the health sector's many committees and technical working groups; and
6. strengthen multi-sectoral collaboration in new thematic areas.

CONTENTS

ACRONYMS

AUSAID	Australian Agency for International Development
AIN	Association of INGOs in Nepal
AMP	Aid Management Platform
AWPB	annual workplan and budget
DFID	Department for International Development (UK Aid
EDP	external development partner
FMT	Fund Management Team
FMIP	Financial Management Improvement Plan
GAVI HSS	The Global Alliance for Vaccines and Immunisation's Health System Strengthening Support
IHP+	International Health Partnership
INGO	international non-government organisation
JAR	joint annual review
JCM	joint consultative meetings
JFA	Joint Financing Arrangement
JTAA	Joint Technical Assistance Arrangement
KfW	German Development Ban
LHGSP	Local Health Governance Strengthening Programme
MoF	Ministry of Finance
MoFALD	Ministry of Federal Affairs and Local Government
MoHP	Ministry of Health and Population
MSNP	Multi Sector Nutrition Plan
NHSP	Nepal Health Sector Programme
NTC	National Tuberculosis Centre
SWAp	Sector Wide Approach
TA	technical assistance
TARF	Technical Assistance Response Fund
TC	technical cooperation
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
USAID	United States Agency for International Development
WHO	World Health Organisation

1 INTRODUCTION

1.1 Background

The 2004 *Health Sector Reform Strategy: An Agenda for Change* envisaged a government led health sector, with increased harmonisation and alignment of partners. A sector wide approach (SWAp) was initiated under the auspices of the Paris Declaration of Aid Effectiveness (2005), (to which Nepal is a signatory), and was formally endorsed and supported by 11 health sector donors. To tackle challenges in areas such as sector coordination, harmonisation, performance monitoring and health care financing, and to further strengthen the SWAp, Nepal became one of the first waves of countries to join the International Health Partnership (IHP+) in 2007.

The Nepal Health Sector Programme 2010-2015 (NHSP-2), aims to widen and strengthen partnerships in the health sector, espousing core values that reflect the current socio-political and socioeconomic paradigm of the country.

Some initiatives planned for 2013, such as the implementation of the state non-state partnership policy for the health sector (MoHP 2012a) have not progressed as anticipated. However, there are other policy areas relevant to partnership harmonisation and alignment where progress has been made. A new National Health Policy has been drafted in 2013 with wide consultation, and MoHP and the Ministry of Federal Affairs and Local Development (MoFALD) have signed a memorandum of understanding (MoU) to improve collaboration between the health and local governance sectors to improve health governance.

1.2 Objective

The objective of this report is to highlight progress, challenges, and ways forward on partnership, alignment and harmonisation in the health sector.

2 PROGRESS AND ACHIEVEMENTS

2.1 Improved Partnership Environment Supports Improved MoHP Performance

Partnership harmonisation and alignment continues to improve in the health sector leading to more equitable access to health services for citizens, particularly women, children, and poor and the marginalised populations. The health SWAp, as a funding modality as well as a partnership continues to be one of the most significant methods of aid alignment and harmonisation. In 2013 the Mid-term Review (MTR) of NHSP-2 referred to the health sector SWAp as a 'mature' arrangement.

As the 2004 SWAp continues to mature, there have been substantial improvements in health sector management through partnership. There are fewer independent projects as more partners adopt a programme approach. The resulting reduced overall transaction costs for MoHP have contributed to a steady improvement in MoHP's budget absorption capacity — from 69% in 2004/05 to 94% in 2012/13.[1] Aid fragmentation has also been reduced by better partnership working and aid harmonisation (MoF 2011).

Since 2005, there has been good progress on the formulation and implementation of clear result oriented strategies in the health sector. Both NHSP-1 and NHSP-2 were developed with the joint participation of external development partners (EDP) and other state and non-state stakeholders, indicating a greater focus on partnership in the health sector. Many EDP programmes and resources, including those of non-pool fund partners, are now linked to government health sector results and strategies. This is a substantial improvement, achieved through joint commitments and better partnership working over the years.

2.2 Mechanisms That Have Strengthened Partnerships

Mechanisms have been developed to further strengthen donor harmonisation and alignment and foster partnership in the health sector. MoHP, EDPs and an increasing numbers of non-state actors including NGOs, INGOs and other civil society organisations, discuss and review national health strategies and programmes at forums such as the Joint Annual Review (JAR) and Joint Consultative Meetings (JCM). The government has endeavoured to bring different actors into the JAR. The efficacy of the JAR as a platform for reviewing progress against results and instruments like Governance and Accountability Action Plan (GAAP) and IHP+ has improved over the years. However, there may be a need to adjust the mechanism for the government to engage more fully with partners in productive policy dialogue. At the implementation level, technical working groups have proved effective in harmonising activities among different actors, but there exists room for improvement in terms of the government exercising better leadership over these working groups.

Since 2004, the 11 health sector EDPs have met fortnightly as a formal group, with annual rotation of the chair and co-chair positions. This has contributed to improved harmonisation among these EDPs and a more coordinated approach to interactions with the government. The Association of INGOs in Nepal (AIN) also has a sub-group of agencies working on health, who meet regularly to coordinate their activities. However, there appears to be no interaction between the AIN health group and the EDP group, which leaves a disconnect between two important sets of partners operating in the health sector. It may be argued that INGOs working in the health sector are primarily funded by the EDPs, and

[1] As quoted in MoHP's Financial Management Improvement Plan (FMIP) (MoHP 2012b).

so their activities are naturally reflected through EDPs. However, this is not always the case and many INGOs operate with their own financial resources or those obtained from donors who are not based in Nepal, implementing programmes under agreements with the Social Welfare Council. These mostly remain outside the purview of the EDPs and MoHP.

More EDPs have become interested to pool their funds in the health sector. In 2012, the German Development Bank KfW formally entered into the pooled funding arrangement.

The Joint Financing Arrangement (JFA) for health between MoF and EDPs (all pool fund partners — DFID, AUSAID, World Bank, GAVI HSS, KfW *plus* four non-pool partners: USAID, UNFPA, UNICEF, WHO) clearly sets out harmonised procedures for performance reviews, financial management, and coordinating planning, monitoring and review exercises. The government considers this a positive step in fortifying partnership for improving overall sector management (MoF 2012). The JFA also encourages all development partners to better align their contributions by using MoHP's annual work plan and budget (AWPB) framework.

2.3 Improved Effectiveness of Technical Assistance

The effective coordination and implementation of technical assistance (TA) has been a subject of much discourse in the health sector. Under the auspices of the SWAp, the government and EDPs have made earnest efforts to improve the utilisation of technical assistance; but gaps remain. Issues include the alignment of technical assistance with Nepal's priorities, technical assistance cost effectiveness, the proper utilisation of technical assistance, the duplication of technical assistance activities, and the under-utilisation of national knowledge and resources. To address these shortcomings and improve the efficacy of technical assistance, the government and EDPs started working together to draft and endorse a Joint Technical Assistance Arrangement (JTAA); but as of December 2013, it had yet to be signed. The Mid-Term Review (MTR) mission of NHSP-2 felt that the JTAA needs to be replaced or revised with more pragmatic clauses. Nevertheless, both MoHP and EDPs continue to recognise that an agreement (JTAA or otherwise) is necessary to ensure that the government and EDPs commit to using technical assistance to support specific result areas of NHSP-2, thus avoiding duplication. Such an agreement would also help identify areas of comparative advantage among the EDPs, thus creating synergy in the sector.

In 2012/13, the ToR of the TA/TC Coordination Committee[2] for NHSP in MoHP has been revised to oversee all technical assistance in the health sector. However, the committee has not been meeting regularly and in fact has only met once since the revision of its ToR.

For some time the government has felt a need to set up a quick and responsive technical assistance mechanism to address unanticipated important issues. Responding to this need, DFID has funded the Nepal Health Sector Support Programme (NHSSP) to establish a Technical Assistance Response Fund (TARF). The main purpose of the fund is to provide technical assistance to MoHP quickly and responsively, as needs arise. Not all needs can be predicted in advance and the fund is designed to complement the more long term, planned provisions of technical assistance that makes up the majority of support from NHSSP and other EDPs. Work funded by the TARF must be aligned to the objectives of NHSP-2 and the preparation of NHSP-3. MoHP has developed guidelines for its departments, divisions and centres to access the fund. A Fund Management Team (FMT), led by MoHP, reviews and decides on TARF proposals sent by departments, divisions and centres.

[2] The Technical Assistance/Technical Cooperation Coordination Committee

2.4 Improved Coordination at Regional and District Levels

The participation of local stakeholders and communities in health programmes has greatly improved over the years, although some mixed feelings prevail at regional and district levels about partnership, harmonisation and alignment. The absence of locally elected representatives since 2002 undermines downward accountability and has adversely affected multi-stakeholder partnership and harmonisation in the sector (Ghimire et al. 2010). The EDPs operating at district level seem to have been better at finding their comparative advantage than at the central level, and a 2010 survey showed minimal duplication in most programmatic areas, with the exception of HIV/AIDS. On the other hand, differing modus operandi of development partners often creates difficulties for the district government institutions responsible for coordinating activities. Agency-specific reporting requirements can also tax the limited capacity of local government institutions. Some efforts have been made in the past by the regional directorates of the Mid and Far West Development Regions to foster better partnerships between actors engaged in the health sector in their regions by setting up regional health coordination teams and by starting to develop integrated district health planning to bring state and non-state health sector actors together. However, these initiatives have not been institutionalised.

The Local Health Governance Strengthening Programme (LHGSP), a collaborative programme of MoHP) and MoFALD was piloted initially in four districts and later on in one more district. One of the intended result areas of LHGSP was "strengthened collaboration among local level institutions… in managing health services effectively, efficiently and equitably." District technical teams, comprising district health office personnel, local development office personnel, TA/TC representatives, and representatives of INGOs and NGOs, were setup as a partnership forum to identify local health priorities and promote health as a development agenda. Although active in the initial stages of the pilot, the teams only met irregularly in subsequent months, producing less than optimum results.

2.5 Mapping Support

An Aid Management Platform (AMP) was established in the Ministry of Finance (MoF) in 2009 to map support provided by development partners and monitor aid flow. The AMP is a web-based tool that government institutions and development partners can use to plan, monitor, coordinate, track, and report on foreign aid flows and funded programmes and activities. The effective use of this tool by MoHP and EDPs will improve alignment and harmonisation. The implementation progress of AMP is steady. Currently the AMP encompasses 4,654 programmes and projects with a total disbursement for FY 2011/12 amounting to USD 1.04 billion (MoF 2013). In fiscal year 2013/14, AMP has been rolled out to all local development partners and all line ministries.

Despite the progress made on mapping support, an Achilles' heel of MoHP is mapping INGOs' actual support for health[3]. Starting from 2012, MoF has started to roll-the out AMP to INGOs as well. As of December 2013, 13 INGOs report their support to the AMP and this number is expected to increase. This will provide a better picture of INGOs' support for the government as and EDPs.

2.6 IHP+ Country Compact as Instrument to Foster Partnership

The IHP+ Country Compact, locally dubbed *Nepal Health Development Partnership*, signed in February 2009 has reinforced earlier commitments to partnerships and aid effectiveness, contributing to

[3] INGOs do not report their support to the health sector to MoHP. They are only mandated to report to the Social Welfare Council.

continuing improvements in this area (IHP 2010). This was helpful in the design of NHSP-2, on which EDPs and Government worked together. The Country Compact has also contributed to an increase in the role of civil society in the health sector, as during development phase of the Country Compact discussions of the IHP+ draft were led by civil society in all five regions (Pokharel 2009).

The 2012 Annual Performance Report of IHP+ has shown good progress for Nepal against most of its indicators (Taylor et al. 2012).

2.7 State–Non state Partnership

In 2013/14, the drafting process of the National Health Policy proceeded with extensive consultations, with more than 60 experts working through about 15 thematic working groups and a technical group that is guiding the consolidation of suggested inputs. This policy, in line with the World Health Organisation's (WHO) assertion of the importance of partnerships to bridge the gap between state and non-state efforts to achieve health for all, highlights the importance of state–non-state partnerships.

In 2012, MoHP produced a draft 'State non-state Partnership Policy for the Health Sector in Nepal'. The objective of the policy is to:

> *"achieve equitable access to quality health care for all citizens of Nepal, by promoting and facilitating a synergistic relationship between state and non-state health care providers in the country."* (MoHP 2012a)

The draft policy has been sent to MoF for comments; but no response has been received so far.

In 2013, MoHP embarked on an initiative to strengthen district health care systems through partnerships with academic institutions. This initiative aims to improve clinical care at district hospitals by posting senior resident doctors and specialised faculties (e.g. doctors and specialists of paediatrics, internal medicine, dentistry, surgery, and anaesthesiology) from academic institutions. Field visits have been completed in health facilities in three districts for taking forwards these partnerships. The ToR for these partnerships has been approved by MoHP and negotiations with individual academic institutions are planned for 2014.

The following are few illustrative examples of on-going state–non state partnerships:

- MoHP is embarking on developing a universal health coverage/health insurance policy and to design suitable schemes for this through broad partnership with non-state actors and EDPs.
- For safe motherhood, the Aama Programme has partnered with registered private health care service providers to provide delivery care, giving pregnant women the choice of opting for public or approved commercial or non-profit service providers for free delivery care. The government compensates private providers on a unit cost basis (cost depending upon the complexity of deliveries).
- For the treatment of uterine prolapse, regional health directorates assess and select service providers who express interest, and treatment is provided free of cost to patients, with the provider compensated by the government. As of 2012, more than 11,000 women have been treated for uterine prolapse and among them more than 95% of them have been treated by the private sector.[4]

[4] As reported by personnel from the Family Health Division of the Department of Health Services (DoHS).

- For specific family planning services, the government provides the private sector with contraceptive commodities, and private providers reciprocate by providing expenditure for service delivery and logistics to certain public health facilities.
- The National Tuberculosis Centre (NTC) frequently orientates and trains private health facilities to identify TB cases and private service providers routinely refer cases to NTC.
- Public-private partnerships are on-going for eye care and kidney treatment.

2.8 Multi-sectoral Collaboration

Even though there are examples of efforts from the past on multi-sectoral engagement including the school health programme with the education sector and urban health with the local governance sector, there has been renewed interest in the last couple of years on multi-sectoral collaboration for health.

In 2012, the National Planning Commission (NPC) launched a five-year Multi Sector Nutrition Plan (MSNP, 2013-2017) (NPC 2012). The plan brings together seven government line agencies to tackle maternal and child under-nutrition in the country. In a similar way, in 2013 a multi-sectoral framework was put in place for the water, sanitation, and hygiene (WaSH) sector.

Multi-sectoral collaboration between MoHP and MoFALD has also progressed on strengthening local health governance and on civil registration and vital statistics. Furthermore, a collaborative framework was signed between MoHP and MoFALD in December 2013 to strengthen local health governance. Both the ministries see the framework as a milestone reform step in terms of establishing more responsive and accountable health systems at local level.

3 LESSONS LEARNED

Partnership mechanisms such as the SWAp, the IHP+ Country Compact and the JAR have created greater harmonisation among some of the major donors and better collaboration with government, thus resulting in reduced overhead costs for both EDPs and MoHP, and contributing substantially to the steady improvements seen in the effectiveness of MoHP planning and spending. Aid fragmentation and duplication have been comparatively reduced but it is clear that more partners should be encouraged to participate in harmonisation efforts. However, MoF continues to flag the health sector as a sector with fragmented aid. MoF's Development Cooperation Report 2011-12 cites that "The health sector is…fragmented despite adoption of SWAps" and "the Ministry of Health and Population has the highest number of projects (83)" (MoF 2013). However, it is not immediately clear to MoHP and EDPs what these projects are. A more harmonised approach towards technical assistance is needed through joint agreement between the MoHP and the EDPs.

The role of national personnel working for EDPs and other international partners in fostering better partnerships in the health sector is often overlooked, but is significant. They often act as conduits between their employers and counterpart government institutions to better coordinate each other's efforts and improve communications in the cross-cultural setting of multi-agency partnership.

4 KEY CHALLENGES

4.1 EDP Technical Contributions Not Fully Harmonised

Despite improvements in harmonisation through the JAR and JCM, it appears that some EDPs have not fully entered into the spirit of harmonisation as outlined in the Paris principles. For example, despite the government's regular requests, some EDPs have not consolidated and presented the details of their technical contribution to the health sector (MoHP 2009 and 2010a). However, the technical assistance matrix produced by the EDPs during the 2012 JAR can be further refined as a viable tool to showcase their contributions. Similarly, EDPs largely continue to use separate monitoring and evaluation missions which, among other things, increases the transaction costs for both them and the government. Currently the AIN health group and EDPs do not interact enough to harmonise their support and some form of formal interaction mechanism needs to be established.

4.2 Poor Alignment With Government Institutions

While there has been a steady improvement in alignment of the EDPs with health sector policy and strategies, and aid flows are increasingly aligned to national priorities, alignment with the government's institutional system remains weak (MoF 2011). This is mostly due to the large number of non-pool EDPs operating in the country, who make little use of GoN systems. Although the number of EDPs providing pooled funding has increased, as has the amount of total pooled funds, many projects and programmes are still funded by individual EDPs. Currently there are only five pool partners (The World Bank, DFID, AusAID GAVI-HSS and KfW). In FY 2010/11, the total contribution of pooled funds was 63% of total EDPs contributions to the health sector (Tiwari et al. 2011). Even pooled funding at times imposes too stringent procurement and financial management requirements that stretch the government's capacities (MoHP 2010b), thus warranting external support.

4.3 Unpredictability of Aid Funding

Although the predictability of funds has improved over the years, with some EDPs making multi-year estimates, most are still not able to do this, and this is an area for further improvement and in particular for INGO support channelled directly through the Social Welfare Council. On the other hand, due to the lack of institutional capacity and resources, the government's financial system remains weak which may increase fiduciary risk for partners. Not all EDP planning cycles are aligned with the government, which further adds to the complications of mobilising resources and aligning support. More effort is needed on the part of EDPs towards making multi-year commitments to improve the predictability of aid.

4.4 Human Resource Constraints

The frequent transfer of human resources and problems with the retention of government staff hampers effective partnerships. In addition, many government staff (especially those working at the implementation level) are not adequately aware of the aid effectiveness agenda, including concepts of partnership, harmonisation and alignment. Comprehensive capacity development is needed in this regard. Although MoF, through its Aid Effectiveness project, has recently begun training officials of different ministries on aid effectiveness, the scope of the project is limited, with only a few participants.

4.5 Lack of Process for Change Management

Despite knowing that most IHP+ partner institutions around the world did not have adequate capacity for embarking on the change management process inherent to IHP+ (Conway et al. 2008), when the Country Compact was developed in Nepal, there was no explicit statement about how change management would happen. The tendency to conduct business as usual still persists among both the government and EDPs, thus undermining the efficacy of IHP+ as a partnership instrument.

4.6 Lack of Focus on IHP+

Although the IHP+ steering group — the Scaling-up Reference Group (SuRG) — recognises that:

> *"better communication, particularly at country level, is urgently needed so that all stakeholders better understand the objectives of the IHP+ and its relationship to similar initiatives" (IHP+ 2008),*

many government and EDP officials and stakeholders either do not fully understand the scope of IHP+ or are oblivious of it. The Country Compact is rarely discussed, or even referred to, during JAR meetings. For example, apart from the JAR meeting of January 2010, when 30 minutes were allocated to a presentation on IHP+ (by the international IHP+ core team visiting Nepal) and a brief discussion during the January 2011 JAR, dedicated space has not been provided for specific discussions on IHP+ or the Country Compact.[5]

4.7 Mapping of Technical Assistance

The overview (mapping) of technical assistance provided by the EDPs remains sketchy. It is not clear how the technical contributions are made for achieving specific NHSP-2. Despite the efforts to include INGOs support in AMP, a challenge still remains to map the support provided through INGOs.

[5] Agendas of JAR Meetings from 2009, 2010, and 2011

5 WAY FORWARD

1 ***Expanding the SWAp****:* Although all 11 original signatories have remained within the SWAp, no new partners have entered, and some major donors such as India and China still operate outside the agreement. Further efforts should be made to bring more partners into this agreement in order to further improve coordination and reduce MoHP transaction costs.

2 ***Joint technical assistance****:* In 2011, EDPs developed a joint technical assistance matrix to highlight their joint contributions to the health sector. A joint (EDP/MoHP) field monitoring visit also took place in early 2012 prior to the JAR of that year. Both these initiatives need to be further developed and institutionalised. Among other things, these initiatives can help in better aligning the technical assistance towards national strategies and make contributions explicit in achieving specific NHSP-2 objectives.

3 ***Technical assistance arrangement****:* A joint agreement between MoHP and EDP is needed to better align and harmonise technical assistance in the health sector. The recently formed TA/TC Coordination Committee needs better functioning with regular meetings.

4 ***District and regional level harmonisation****:* There needs to be a greater focus on improving partnership and harmonisation at district and regional levels, to better coordinate activities and help the authorities manage the multiple projects and different actors in their areas. Mechanisms for bringing state and non-state health sector actors together, such as regional health coordination teams and the development of integrated district health planning in the Mid-West and Far Western regions, should be studied, and their feasibility replicated in other regions in appropriate ways. The findings and recommendations from the assessments of LHGSP should be taken into account to further strengthen partnership and collaboration at sub-national levels.

5 ***State non-state partnership****:* MoHP needs to follow up with MoF and get this policy approved so that strategies and structures can be put in place to implement it.

6 ***Technical working groups****:* NHSSP has recently mapped the various committees and technical working groups of the health sector. Lessons from this mapping exercise need to be adopted to minimise duplication and improve the efficacy of these groups and committees. There is also a need for the government to exercise better ownership and leadership over the many technical working groups to which it is part of.

7 ***Strengthening multi-sector collaboration***: Following the good example of the Multi Sector Nutrition Plan, the government should explore other potential thematic areas (such as water, sanitation and hygiene) where multi-sectoral collaboration could be fostered.

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