Background thematic report no. 7

Progress Report on

Opportunities, Challenges, Lessons Learned and Strategic Directions

for the Implementation of the Nepal Health Sector Programme-2

2012/13

Report Prepared for Joint Annual Review (JAR)

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Government of Nepal (GoN)
Ministry of Health and Population (MoHP)
Ramshah Path, Kathmandu, Nepal

EXECUTIVE SUMMARY

Progress Report on Opportunities, Challenges, Lessons Learned and Strategic Directions for the Implementation of the Nepal Health Sector Programme-2, 2012/13

A. Opportunities for improved health services include:

1. The progress on producing a new National Health Policy will provide a more coherent and up-to date policy focus in the health sector.
2. The preparation of a draft National Health Insurance Policy (NHIP) and its implementation should extend access to health services to NHSP-2's target groups.
3. MoHP's newly endorsed Audit Clearance and Internal Control Guidelines will help improve financial management practices.
4. The implementation of the Revised Financial Management Improvement Plan should improve the efficiency of resource allocation and use of services in the health sector.
5. The progress on introducing a Contract Management System and Technical Specifications Databank will improve efficiency and value-for-money in health-related procurement.
6. The introduction of guidelines on the social auditing of the performance of health facilities should improve health service delivery.
7. The signing of the Collaborative Framework between MoHP and MoFALD opens the way for improved health sector governance at the local level.
8. An enhanced annual work plan and budget for the health sector, with a structured business plan, is an essential foundation for more effective and efficient health service provision.

B. Challenges to the development of Nepal's health sector include:

1. The delayed approval of the budget was the major challenge for the proper execution of health related activities in 2012/13.
2. Adequate financial reporting is hindered by the lack of timely reporting of expenditure against budgets and the lack of a means of compiling and consolidating budgets against expenditure.
3. The procurement of drugs and health commodities is hindered by the weak implementation of procurement regulations and oversight functions and the need to build the capacity of Logistics Management Division staff.
4. The achievement of some major health indicators including the neonatal mortality ratio (NMR) the contraceptive prevalence rate, and the nutritional status of children are substantial challenges as is the lack of clear indicators for some targets.
5. Other challenges include:
    - increased interest in the direct funding of programmes by some partners;
    - weak reporting to MoHP of funds generated at the local level by health institutions; and
    - the implementation of gender equality and social inclusion (GESI) across the health system, including the need for multi-sectoral coordination on this issue.

C. Lessons learned by MoHP in 2012/13 include:

1. The need for consistent objectives and indicators across policies, strategies and plans related to the health sector.

2. The need to incorporate more evidence into policy making.
3. The need to bring more external development partners into the sector wide approach (SWAp).
4. The need to strengthen programme implementation based on actual experience.
5. The importance of improving policy level understanding of health financing.

D. MoHP strategic directions for 2013/14 include:

1. More dialogue on the shape of health system functions and structures.
2. The finalisation of the draft new National Health Policy and National Health Insurance Policy.
3. To continue the focus on achieving universal health coverage.
4. Preparing NHSP-3 with the wide consultation of stakeholders.
5. Implementing the many recently endorsed guidelines, plans, systems and frameworks.
6. Implementing the human resources for health (HRH) strategy.
7. Making progress on integrating the separate health information systems.

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ACRONYMS

AWPB	annual work plan and budget
CB-NCP	Community Based Newborn Care Programme
DDC	district development committee
DFID	Department for International Development (UK Aid)
eAWPB	electronic annual work plan and budget
EDP	external development partner
EHCS	essential health care services
FCGO	Financial Comptroller General's Office
FMIP	Financial Management Improvement Plan
FMRs	financial monitoring reports
FY	fiscal year
GAAP	Governance and Accountability Action Plan
GAVI HSS	The Global Alliance for Vaccines and Immunisation's Health System Strengthening Support
GESI	gender equality and social inclusion
GoN	Government of Nepal
HEFU	Health Economics and Financing Unit
HFOMC	health facility and operation management committees
HIIS	Health Infrastructure Information System
HR	human resources
JCM	joint consultative meeting
KfW	German Development Bank
LMIS	Logistics Management Information System
M&E	monitoring and evaluation
MDGP	Doctor of Medicine in General Practice
MoFALD	Ministry of Federal Affairs and Local Development
MoHP	Ministry of Health and Population
MTEF	Medium Term Expenditure Framework
NHA	National Health Accounts
NHIP	National Health Insurance Policy
NHSP	Nepal Health Sector Programme
OAG	Office of Auditor General
Ob/Gyns	obstetric and gynaecological (doctor)
PFM	public financial management
PHCC	primary health care centre
PIP	Procurement Improvement Plan
PPICD	Policy Planning and International Cooperation Division
SBA	skilled birth attendant
SBA	skilled birth attendant
SHP	sub-health post
STS	Service Tracking Survey
TABUCS	Transaction Accounting and Budget Control System
TSA	Treasury Single Account
TWG	technical working groups
UHC	universal health coverage
VDC	village development committee

1 INTRODUCTION

1.1 Background

The overarching vision articulated in the Nepal Health Sector Programme-2 (NHSP-2) is to scale up the government's free essential health care policy to achieve universal coverage of health services. In this regard NHSP-2's results framework gives clear targets for the improved coverage of priority health care services and target groups. To monitor the targeting of inputs many NHSP-2 indicators are broken down by wealth quintiles and some by gender, age and ethnic group. Targets are also set for the use of community based emergency funds by the poor, as well as for the proportion of MoHP's budget that is spent and the proportion of the budget that is allocated for essential health care services (EHCS).

The sector wide approach (SWAp) in Nepal's health sector, which began in 2004, continues and the essential health care services package (that account for more than 75% of MoHP's budget) has been expanded to address the needs of oral health, mental health, environmental health and hygiene, emergency and disaster management and the primary prevention and management of non-communicable diseases.

Alongside the SWAp, an increasing numbers of development partners are directing their funding support through the Red Book, while non-pool partners have signed the Joint Financing Arrangement (JFA), which supports the functional implementation of NHSP-2. In the initial three years of NHSP-2, the weaknesses related to health system functions and inequities were addressed by scaling up programmes for governance and accountability, gender equality and social inclusion (GESI), revising the Financial Management Improvement Plan (FMIP), preparing a draft Procurement Improvement Plan (PIP), and improving the implementation of joint consultative meeting.

The main policy documents and international commitments that provide overall guidance for MoHP's work are:

- Nepal's commitments to achieving the Millennium Development Goals (MDGs) and Universal Health Coverage (UHC);
- the Nepal Health Sector Programme-2 (2010-2015);
- the Second Long Term Health Plan (1997–2017);
- the National Health Policy, 1991 and the 2013 draft of the new National Health Policy; and
- the government's Medium Term Expenditure Framework (MTEF) (that provides the strategic direction for the health sector's annual work plan and budgets [AWPB]).

1.2 Objective

The objective of this report is to document the opportunities, challenges and lessons learned in the implementation of NHSP-2 by MoHP. It also explains MoHP's planned strategic direction for fiscal year 2013/14.

2 OPPORTUNITIES

This chapter explains the recent developments that have strengthened the national health system and that provide opportunities for improved health services and better health for all.

2.1 Draft National Health Policy

The main official framework document that describes the policy directions for Nepal's health sector is the 1991 National Health Policy (NHP, MoHP 1991). In December 2013, MoHP finalised the consultative processes to prepare a new health policy. The draft new policy encompasses the visions included in different sub-sector policies, strategies, and plans endorsed by MoHP. Importantly, it also enshrines the overarching principles of universal health coverage (UHC). MoHP needs to take some additional steps to endorse the draft new national health policy. A new policy, prepared 20 years after the previous one, will provide a more coherent and up-to date policy focus in the health sector.

2.2 Draft National Health Insurance Policy

MoHP, in consultation with respective ministries, responsible government officials, international experts and national experts prepared a draft National Health Insurance Policy (NHIP). This policy aims to reduce out-of-pocket expenditure for accessing and using health services. MoHP formed a steering committee, a technical committee, a national health insurance unit and a task force to provide policy level and implementation level support on the production of the NHIP. MoHP is implementing the first phase of NHIP in Kailali, Baglung and Ilam districts.

2.3 Audit Clearance and Internal Control Guidelines

MoHP has prepared and endorsed its audit clearance guidelines. The audit committee under the leadership of the health secretary took a lead role in finalising them. Their implementation will improve practices related to the timely submission of audit queries and should reduce audit backlogs. Similarly, MoHP has prepared and endorsed internal control guidelines. Their use will help improve fund flow, fund use and internal auditing to improve financial discipline in health sector finances.

2.4 Revised Financial Management Improvement Plan

In 2011/12, a Financial Management Improvement Plan (FMIP) was prepared for 2012/13 to 2015/16 and endorsed by MoHP. The thrust of the revised FMIP is to reduce fiduciary risk and improve overall financial accountability in the health sector. The latest revision includes the major recommendations of the fiduciary risk assessments (FRAs) conducted by the World Bank and DFID in 2013. The implementation of this plan should improve the efficiency of resource allocation and use of health services in line with government priorities.

2.5 Contract Management System and Technical Specifications Databank

The following two initiatives should improve efficiency and value-for-money in health-related procurement:

- A Contract Management Database System (CMS) has been designed, and is being developed and taken into use by the Logistics Management Division (LMD) for procuring drugs and health

commodities. This should improve the information flow to prevent late payments to contractors and should facilitate coordination between LMD's Contract Management Section, its warehouses and DoHS's Finance Section.

- By the end of December 2013, over 800 technical specifications for medical equipment, surgical instruments, drugs and hospital furniture had been drafted and uploaded to a databank on LMD's website. The databank provides LMD with standard agreed technical specifications that are available with open access to all and especially to district health offices, district public health offices (DHOs and DPHOs) and potential bidders. This should make procurement more efficient and should improve transparency including by giving all interested parties the opportunity to comment on the specifications. The databank has yet to receive DoHS approval.

2.6 Social Auditing Guidelines

In 2012, comprehensive social audit guidelines for health facilities and district hospitals were developed and implemented in 21 districts. The guidelines were approved by MoHP in June 2013 incorporating feedback from districts where social audits have taken place. Technical support from many development partners at central and local levels has been important, feeding into the design and implementation of social auditing programmes. Social auditing is enabling many women and people from excluded groups to participate in social audits for a more thorough and inclusive auditing process and in turn to improve health service provision.

2.7 Collaborative Framework with MoFALD

In December 2013, an agreement was reached between MoHP and MoFALD on a 'collaborative framework' to strengthen local health governance in the country. The major objectives of the framework are:

- increasing access to and the use of quality health care services for poor and disadvantaged people;
- encouraging a participatory approach in health and community development programmes at the local level; and
- multisectoral coordination under the umbrella of local government bodies.

The agreement on this framework proves these two ministries' commitment to practicing health as an important development agenda. Its implementation will improved health sector governance at the local level.

2.8 Improved Annual Planning

An enhanced annual work plan and budget for the health sector with a structured business plan is an essential foundation for more effective and efficient health service delivery. In 2013, MoHP prepared a business plan and a consolidated annual procurement plan (CAPP), which were discussed with the external development partners (EDPs) at joint consultative meetings.[1]

[1] More details on are available on AWPBs at (www.nhssp.org.np)

2.9 Improved Health Management Information System

The Health Management Information System (HMIS) is the main information technology (IT) hub of the health sector, which compiles and analyses progress on indicators related to Nepal's health care delivery system. Over the years HMIS has gained a reputation for maintaining data quality. In 2013, the HMIS section, which is located in the Management Division, took a lead role in improving health recording and reporting indicators. The HMIS Section, with support from NHSSP, is planning to train planning officers and data entry personnel on the revised HMIS. More accurate and extensive performance data is crucial to provide evidence for improving the provision of health services.[2]

2.10 TABUCS Pilot Completed and Roll-Out Started

MoHP took a lead role in introducing a Transaction Accounting and Budget Control System (TABUCS), with the Nepal Health Sector Support Programme (NHSSP) providing technical assistance and the UK's Department for International Development (DFID) financial support for this initiative.[3]

MoHP has made good progress on introducing TABUCS as a key means of improving MoHP financial management. In In 2012/13 MoHP:

- completed the piloting of TABUCS in 11 MoHP cost centres;
- finalised and printed all technical documents to rollout the system in all 278 cost centres;
- sent the invitation letters for training on TABUCS to all cost centres and supported the improved availability of computers and internet connectivity;
- completed the training of TABUCS trainers (in mid-December 2013); and
- finalised the rollout plan including a plan for user training.

2.11 Improved Governance and Accountability Practices

MoHP has made good progress on implementing the Governance and Accountability Action Plan (GAAP) at all levels of the health system.[4] This provides an opportunity for the health sector to strengthen and expand local health governance and improve the transparency and accountability of service delivery. One important achievement has been the availability of policies, strategies, plans and budget through the websites of MoHP and concerned departments, centres and divisions.

2.12 State–non State Partnerships

In 2012/13 MoHP drafted a State Non-State Partnership Policy for the Health Sector. Although some progress has been made in purchasing public services from the private sector, for example the Aama Programme and treatment of uterine prolapse, a proper institutional mechanism and legal framework is needed for smooth implementation and expansion. Once finalised and officially endorsed the new policy will enable a better synchronicity between public and private health service providers and to make more of the private sector's potential.

[2] More details are available in the 2014 JAR report on progress against the logical framework.

[3] More details are available on the TABUCS at www.mohp.gov.np and www.nhssp.org.np

[4] See details in the GAAP background thematic report for the 2014 JAR.

2.13 Improved Inter-sectoral Coordination

The following progress in 2013 and recent years on intersectoral coordination are opportunities for improving health service delivery:

- MoHP organised several meetings of its Public Financial Management (PFM) Committee with the participation of pool and non-pool partners.
- The Reproductive Health (RH) Coordination Committee is coordinating the reproductive health activities of DoHS's various divisions.
- The sub-committees for safe motherhood and newborn health, adolescent health, and family planning have all been more active in recent years.
- In response to the increasing interest in multi-sectoral coordination in health, the Government of Nepal (GoN) endorsed a Multi-Sector Nutrition Plan (MSNP, 2013-2017), which is housed at the National Planning Commission.[5]

2.14 Improved Health Service Delivery

Improved health service delivery in many areas provides large opportunities for improving health; for example:

- Nepal has demonstrated that an integrated health care delivery system can successfully control and eliminate communicable diseases. This has happened for leprosy and polio, which have been eliminated in Nepal and for Kala-azar, which is well on the way to elimination and malaria, which is in the pre-elimination phase. The National TB Control Programme has made substantial progress on reducing the burden of tuberculosis. The Child Health Division and NGOs have also been active in distributing zinc tablets to reduce the incidence of childhood diarrhoea.
- Nepal has made large progress on safe motherhood with many more deliveries taking place in health institutions. While significant progress has been made in the training of skilled birth attendants (SBAs), with 3,637 trained so far by the National Health Training Centre, achieving the target of 7,000 SBAs trained by 2015 will require major efforts.[6]

2.15 Funding Assured through the Medium Term Expenditure Framework

The Government of Nepal, the National Planning Commission and the Ministry of Finance (MoF) provide budget ceilings to government sub-sectors through medium term expenditure frameworks (MTEF). This has been useful in strengthening MoHP's planning process. MTEFs provides the total budget ceiling for periods of three fiscal years, which is instrumental for making decisions about health interventions that require a time frame. These frameworks importantly help to ensure the predictability of external funds.[7] More predictable funding will result in the improved implementation of AWPBs.

[5] More information on MSNP is available in the 2014 JAR background report on partnership, alignment and harmonisation in the health sector.

[6] More information on improved service delivery is available in the JAR background report on the results against the logical framework.

[7] More information on MTEFs in relation to health sector funding is available at www.mof.gov.np

2.16 Improved Recruitment of Human Resources for Health

The Health Services Act (1997) was amended in 2013, including for ensuring inclusive recruitment. Following the coming into force of this amendment, recruitment restarted and most vacancies are being filled and forthcoming vacancies will be filled on a regular basis. Also, a number of health workers have been recruited locally on contracts and on a temporary basis. The process has also been started to create additional sanctioned posts as articulated in MoHP's HRH Strategy 2011–2015. This strategy was endorsed by the Council of Ministers to guide the production, deployment, distribution and retention of health care providers. The improved availability of appropriate HRH will have a large positive impact on health service delivery.

2.17 Improved Procurement and Infrastructure Management

The following initiatives will facilitate the smooth functioning and consistency of procurement processes:

- the production of consolidated annual procurement plans (CAPPs);
- the production of an operational manual on procurement procedures; and
- institutionalising evidence-based planning for the construction, operation and maintenance of health buildings and the suitable locating of sites for new health facilities (see next point).

2.18 Web-based Health Infrastructure Information System (HIIS) Endorsed

Considerable progress has been made on improving systems for infrastructure planning and management to support improved health care service provision. A web-based Health Infrastructure Information System (HIIS) has been completed, endorsed and adopted with much data uploaded into the system. This system allows policymakers and planners to more systematically plan the location of new health buildings and to know the condition of existing buildings. Technical personnel from 35 districts have been trained on using and updating the database.[8]

2.19 Increased Contributions from Local Authorities

The annual Service Tracking Surveys (STS) of health service provision have identified MoHP as the main financer for all levels of health facilities. For sub-health posts (SHPs), village development committees (VDCs) are the second largest source of income. The surveys found that SHPs have the most diverse income sources, with international donor agencies providing almost a fifth of incomes. Salaries were the main expenditure item for all the facilities, representing between a third and a half of facilities' budgets.[9] Funding by local government is an opportunity for enhancing health service delivery.

2.20 Implementation of Hospital Performance-Based Grants

As a part of the implementation of the FMIP, MoHP has finalised performance based grant agreements with Nyaya Health (Bayalpata hospital, Achham), Bhaktapur Cancer Hospital, Nepal Netra Jyoti Sangh, the Nepal Eye Hospital, the Suresh Wagle Memorial Cancer Hospital, the National Kidney Centre and the BP Koirala Lions Center for Ophthalmic Studies. This way of administering grants should improve the performance of these hospitals.

[8] More information on HIIS is available in the 2014 JAR report on procurement and at www.nhssp.org.np

[9] For detailed information visit www.nhssp.org.np and see the Service Tracking Surveys.

2.21 GESI Mainstreaming

The 'Operational Guidelines for GESI Mainstreaming in the Health Sector' were developed and approved by MoHP this year. The GESI Institutional Structure Guidelines were also approved to specify the location of GESI responsibilities in the government's health structure. Up to the end of 2013, GESI technical working groups (TWGs) have been formed in almost all districts (71 out of 75) and GESI focal persons nominated in all regional health directorates (RHDs) and in 75 district health office/district public health offices (DHOs and DPHOs).[10] The mainstreaming of GESI in the health sector provides opportunities to better reach women and social excluded groups with health services.

[10] More information is available in the 2014 JAR background report on GESI.

3 CHALLENGES

MoHP understands that despite the improvements and opportunities a number of challenges need to be addressed for the development of Nepal's health sector. Many of the challenges can be addressed through increased financial resources and improved partnerships with external and local development partners.

3.1 Delays in Budget Approval Process

FY 2012/13 has been a typical year in terms of having a complete annual work plan and budget (AWPB) and MoHP ensuring its proper implementation. MoHP was instructed by the Ministry of Finance to adhere to less than last year's expenditure of NPR 16.58 billion. The subsequent lack of a complete budget and the priority given to recurrent expenditure meant that inadequate funding was available for construction related works.

The delayed approval of the 2012/13 budget was the major challenge for the proper execution of both priority activities and other activities. This delay also directly contributed to some cost centres violating the financial rules and regulations, specifically concerning procurement and the payment of incentives to clients.

There are about 1,900 official programme activities defined by MoHP. The preparation and consolidation of performance information on all these activities requires considerable time and effort. The issue is exacerbated by the lack of a technology-based system for recording and monitoring these activities at the level of the spending units. Additionally, under decentralised mechanisms the funds are routed to the spending units through the DDC, creating another layer in the fund flow.

3.2 Weak Financial Reporting

The main challenges that result in weak financial reporting are:

- All cost centres do not send accurate expenditure reports on time to MoHP or DoHS.
- MoHP does not have any technology based solution to compile and consolidate budgets against actual expenditure.
- The Financial Comptroller General's Office (FCGO) provides budget vs actual reports on a periodic basis to MoHP; but these reports are based on particular account heads and are not broken down by programmes.

It is important to note that resources are also being generated at the local level. However, in the absence of financial reporting MoHP cannot give the total health expenditure (THE).[11]

3.3 Delayed Procurement

The main challenge to the procurement of drugs and health commodities has been the weak and inconsistent implementation of procurement regulations and oversight functions. These include timely preparation of procurement plans, and free and fair participation in the bidding process, with good specifications, bidding and evaluation processes. Procurement plans also tend to be fragmented. There has been some improvement due to the tightening of the mandatory requirement

[11] More information on financial reporting challenges is available at www.nhssp.org.np and the 2014 background JAR report on financial management.

for the timely presentation of consolidated annual procurement plans. The Integration of the procurement of construction, drugs and equipment, and services is needed to harmonise these procurement plans.

District level procurement is a major concern, and the Logistics Management Division is providing procurement training to district officers, accountants and storekeepers.

It is evident that due to the varied nature of goods being procured, procurement cannot be accomplished with only one or two specialists or experts providing technical support. Provision needs making to hire experts as per need while training the existing staff.[12]

3.4 Reaching Targets and Indicators

Challenges remain in relation to the three main health indicators:

- Despite government and development partner efforts, Nepal's neonatal mortality rate (NMR) has remained at 33 deaths per 1,000 children since 2006. This is a prime concern of MoHP, donors and technical support groups. The Community Based Newborn Care Programme (CB-NCP) has achieved only limited coverage and has little overall impact.
- The infant mortality rate (IMR) has only decreased slightly, from 48 deaths per 1,000 infants in 2006 to 46 in 2011, and this is to be expected since neonatal mortality accounts for 71% of infant mortality.
- The reduction of the maternal mortality ratio (MMR) from 539 per 100,000 live births in 1996 to 229 in 2009 has been one of Nepal's major health successes. However, achieving the MDG target of 134 per 100,000 by 2015 remains a major challenge.

The unmet need for family planning is nearly 27% and increasing coverage is another challenge.

The Contraceptive Prevalence Rate (CPR) fell to 43.1% in 2011 from 47% percent in 2006.

Overall, the nutritional status of children in Nepal has slightly improved over the last decade. In 2006, 49% of children were stunted and 39% were underweight, and this decreased to 41% and 29% respectively in 2011. However, the proportion of children who are wasted declined only slightly, from 13% in 2006 to 11% in 2011. Improving the nutritional status of children is one of the biggest challenges to the health sector.[13]

An additional challenge is that a number of GAAP indicators are unclear and difficult to measure. Many provide additional detail on activities, rather than defining what is required to demonstrate evidence of progress.

3.5 Increased Interest in Direct Funding

Although the predictability of funds is improving as some EDPs make multi-year funding commitments, most EDPs cannot make multi-year funding commitments. In particular, INGO support channelled through the Social Welfare Council is not reflected in AWPBs. This hampers the predictability of support and weakens partnership-working in the health sector.

On the other hand, due to the lack of capacity and resources, the government's financial system remains weak, which may increase the fiduciary risk for partners. Also, not all EDP planning cycles are

[12] More information is available on procurement challenges in the 2014 JAR report on procurement.

[13] More information on the achievement of health indicators are contained in the 2014 JAR report on the logical framework.

aligned with the government's cycle (Nepali fiscal years of mid-July to mid-July), which adds to the complications of mobilising resources and aligning support. More effort is needed by EDPs to make multi-year commitments to improve the predictability of aid.[14]

3.6 Weak Reporting of Funds Generated at Local Level

Currently, there is no national mechanism to capture the local revenues and related expenditures of health facilities. This indicates that MoHP lacks an institutional mechanism to report the total health expenditure that takes place under its umbrella.[15]

3.7 The Effective Implementation of GESI Provisions

A key challenge is to ensure the implementation of the GESI-related plans that are included in the AWPBs and annual business plans of the different divisions and centres. Effectively implementing the GESI operational guidelines, the social audit guidelines, and the Equity and Access Programme (EAP), and ensuring that the institutional structures for GESI are functional require dedicated attention.

3.8 Multi-sectoral Coordination to Address Issues of Women, Poor and Excluded People

A major challenge is developing a coordination and collaboration mechanism between ministries to address the complex issues that impact access to and use of health services by women and poor and excluded people. Service provision by one stop crisis management centres (OCMCs) in particular needs to be better coordinated. The challenge is to convince different actors to work in a holistic way.

3.9 The System-wide Implementation of GESI

The main challenges to implementing GESI across the health system are:

- to ensure the implementation of plans included by different divisions and centres in their AWPBs and annual business plans;
- budget cuts which have affected planned GESI-sensitive interventions; and
- effectively implementing the social audit guidelines, the GESI operational guidelines and the Equity and Access Programme, and
- ensuring that the institutional structures for GESI are functional.[16]

3.10 Quality Assurance

Increasing the use of health services may not improve health outcomes unless there is high quality service delivery along with benchmarks for good quality. Quality care can greatly influence clients' health seeking behaviour in a positive direction as it can result in the greater use of health facilities, the better uptake of health programmes by individuals and communities, all leading to better health outcomes for the population. Despite assertions about the importance of quality, this remains one of the most challenging areas for health policy makers (WHO 2006).[17]

[14] More detailed information is available in the 2014 JAR report on partnership working.
[15] For more detailed information please see the 2014 JAR report on financial management.
[16] For more detailed information please see the 2014 JAR report on GESI.
[17] For more information on quality assurance consult the 2014 JAR report on logical framework and visit www.nhssp.org.np.

4 LESSONS LEARNED

In fiscal year 2012/13, MoHP learned a number of lessons that are useful for improved programme planning and implementation.

4.1 Consistent Objectives and Indicators in Policy Documents

A fundamental concern is to ensure consistent objectives and indicators across policies, strategies and plans related to the health sector. MoHP has learned the need for consistent indicators in policies, strategies and plans and MoHP is committed to preparing all its documents in line with the overarching principles of the forthcoming new National Health Policy.

4.2 Incorporating Evidence into Policy

The lesson of the need to incorporate evidence into policies is being applied in the following two cases:

- MoHP has made a significant move in incorporating evidence into policy by integrating the Aama and 4ANC programmes. A number of studies suggested that the integration of these two programmes would increase efficiency by reducing the costs required for administration, monitoring, human resources and other costs.
- MoHP is recently using evidence from the Nepal Demographic and Health Survey (NDHS), the Nepal Living Standards Survey (NLSS), and the Service Tracking Survey (STS) and the household surveys (HHS) to report progress against its frameworks including its monitoring and evaluation framework.

MoHP will continue and expand this practice in other programme interventions.

4.3 The Health Sector SWAp

A sector wide approach (SWAp) was endorsed and supported by 11 health sector donors in 2004. In 2007, to tackle the challenges of sectoral coordination, harmonisation, performance monitoring and health care financing, and to further strengthen the SWAp, Nepal became one of the first wave of countries to join the International Health Partnership (IHP+). There are currently five pooled funding partners (DFID, the World Bank, AusAID, GAVI HSS, and KfW) supporting the implementation of NHSP-2 and more EDPs are interested in joining. However, only AusAID has entered the SWAp since 2004 and important donors like India and China operate outside. There has also been much discussion about pooling technical assistance to address concerns over the alignment of technical assistance with national priorities.[18] The lesson here is the need to bring more EDPs into the SWAp and the pooled fund.

4.4 Health System Strengthening

Expanding programmes and implementing them well sets a positive example across the health system:

- The Aama Programme has directly contributed to the expansion of delivery services by peripheral level health institutions and private sector hospitals. Most health posts and SHPs are now providing delivery services. Almost all medical colleges across the country are

[18] For more detailed information please see the 2014 JAR report on partnership.

implementing the Aama Programme of free delivery services. This has contributed to increasing the coverage and more people are using the services. This has contributed to larger caseloads at higher level health facilities and many hospitals are expanding their services by using unused space allocated for other services or departments.

- In another area, the Public Procurement Management Office has instructed line ministries to initiate the e-submission of bids. LMD has started e-bidding, which is having a positive impact in terms of value for money. Some hospitals have successfully implemented the e-submission of procurement bids and others are moving towards full e-bidding.

4.5 Revisions to Aama Programme based on Evidence

Considering implementation experiences and feedback from hospital staff, MoHP revised the Aama Programme guidelines for incentives to cover the actual costs of providing free institutional delivery and to clarify several components related to free delivery services. The Aama guidelines were then published to specify the services to be funded, the tariffs for reimbursement and the system for health facilities and hospitals to claim and report on the free deliveries they undertook each month.

The need for integrating the Aama Programme with the four antenatal care (4ANC) visits programme was felt necessary to ease implementation of the programme and reduce administrative costs. Thus, a second revision of the Aama Programme guidelines was carried out mainly to incorporate guidelines on providing the 4ANC incentive and to address other programmatic issues.

4.6 Policy Level Understanding of Health Financing

The following initiatives have helped increase policy level understanding on health financing:

- MoHP's Health Economics and Financing Unit (HEFU) was established in 2002, staffed by health economists, and statistical and administrative officers. Close interactions with the Finance Section meant that the staff were able to use information provided through the Financial Management Information System (FMIS) of the Financial Comptroller General's Office (FCGO) through an electronic link. Products initiated by HEFU have been the regular Health Public Expenditure Review (HPER) and National Health Accounts (NHA) surveys. The first NHA was produced in 2005 (Prasai et al. 2006).
- In recent years Nepal has initiated innovative health financing policies and programmes such as free delivery, free health care, community health insurance, incentives to women for four antenatal check-ups, and the female community health volunteer (FCHV) incentive model. The proper implementation of these policies and programmes will ultimately improve the health status of the Nepalese people.

4.7 Documenting Locally Generated Revenues and Related Expenditure

MoHP's annual work plan and budget does not capture some locally generated revenues and their related expenditure with potentially far-reaching consequences for the way in which the health system is managed towards outputs and outcomes. The government therefore has only limited information on what these other sources of income are spent on and the extent to which their allocation contributes to achieving health sector goals. Furthermore, international agencies sometimes provide funding to health facility and operation management committees (HFOMC) directly. MoHP has learned the lesson that these revenues and expenditures need to be captured.

4.8 Improving the Quality of Care

MoHP understands the importance of quality of care for health care delivery. Quality of care depends on clinical, management, governance and other factors. A number of studies have pointed out that quality can be ensured with the provision of enough physical space and proper referral mechanisms. MoHP has learned that a comprehensive, clear and consistent national quality control framework can improve the quality of care in Nepal.

4.9 Regularising the Reporting System from Health Facilities

The reporting of service statistics and financial data is generally weak. The failure to capture the service statistics from higher level hospitals leads to lack of knowledge at MoHP central level on their actual (higher) caseloads. This suggests the need to act to ensure timely quality services and financial reporting.

4.10 Integrating GESI into all Health System Components

MoHP has learned that working on only one or two elements of GESI mainstreaming is insufficient for the effective and in-depth integration of GESI into the health sector. Full integration needs a comprehensive and systematic approach. The entry points for GESI in the planning, budgeting and programming cycle and across the various technical divisions are fluid and can be unpredictable and opportunities need to be seized and built upon as they emerge.

5 STRATEGIC DIRECTIONS

Although the final structure of the federal system of government has yet to be agreed, it is likely that it will comprise local, provincial and central levels of government. The design of health systems and defining the functions of the various levels will present a significant challenge for MoHP. MoHP therefore needs to prepare to encompass the likely new system of government.

The following are the main strategic directions of MoHP for fiscal year 2013/14.

5.1 Dialogue on Health System Functions and Structures

GoN has agreed to achieve universal health coverage. The achievement of this means not only having more resources in the health sector, but also demands a dialogue on redefining health system functions and structures. More specifically, MoHP needs to identify the different functions related to health service providers and purchasers (clients). The separation of purchaser and provider functions would be a significant paradigm shift in the Nepalese health system. While discussing these issues MoHP also needs to give space for the probable introduction of a federal system of government. Health system functions and structures will probably need to be revised in the context of the federal structure and the rights and responsibilities given to local governments.

5.2 Finalise Draft National Health Policy

MoHP has finalised a draft new national health policy. In order to endorse it, MoHP may need to take some additional steps including discussions with political parties, the forums of external and local partners and with parliamentarians for their acceptance and ownership of the new policy.

5.3 Finalise Draft National Health Insurance Policy

MoHP understands that the National Health Insurance Programme (NHIP) requires comprehensive discussion and debate before its implementation. MoHP believes that NHIP will help reduce out-of-pocket expenditure by patients and facilitate more equitable health service delivery. MoHP has prepared a draft NHIP that is awaiting final approval. In order to gain more practical experiences MoHP has recently implementing a first phase of the programme in three districts. Political acceptance, reliable evidence, and appropriate fiscal space analysis are the key areas that considering while implementing the national health insurance policy.

5.4 Achieving Universal Health Coverage

The government has committed to achieving universal health coverage. MoHP understand that this is interlinked will existing and upcoming initiatives. Technical discussions are needed to outline the framework and plan for achieving UHC.

5.5 Preparing NHSP-3 with Wider Consultations

NHSP-2 (2010-2015) will end in July 2015. MoHP has started discussions and completed a stakeholder workshop to prepare the broad framework of NHSP-3. MoHP believes that the preparation of NHSP-3 requires engaging with different levels of institutions and individuals. Political consensus is also needed before the endorsement of the document.

5.6 Implementing Guidelines and Plans

In FY 2012/13 MoHP made significant headway on introducing important new policies and plans. The proper implementation of the following strategies and plans is strategically very important in FY 2013/14:

- Implement the integrated Aama–4ANC Programme in all health facilities implementing the Aama Programme.
- Implement TABUCS at the national level.
- Implement the audit clearance guidelines.
- Implement the internal control system and the procurement guidelines.
- Implement the HIIS.
- Ensure the proper implementation of the M&E framework.
- Ensure the implementation of FMIP.
- Mainstream the GESI while preparing AWPBs.
- Finalise and implement the procurement implementation plan (PIP) for FY 2014/15.

5.7 Implementing the HRH strategy

In 2012, MoHP prepared a costed human resource for health (HRH) strategy that prioritises the production, deployment and retention of critical human resources (MDGPs, Ob/Gyn doctors, advanced SBAs and anaesthesia assistants). The retention of human resources for health, did, however not improve in FY 2012/13. The models in use for improving the retention of HRH include scholarships for health workers bonded for three to five years' work in Nepal (the Nick Simons Institute model), and retention and performance-based incentives.

A retention and performance based incentive package has been developed for medical doctors and nurses and awaits implementation. Other options include creating more opportunities for medical doctors and nurses who work in remote areas, with complementary schemes such as career advancement, education, national and international exposure visits. The issues of the broader working environment and skill mix of HRH need to be addressed in this regard. MoHP will explore more models for retention and pilot them. The implementation of strategies and prioritised activities on HRH is a priority for MoHP.

5.8 Integrating the Separate Information Systems

In recent years the vertical programme-wise reporting of service provision and other results is receiving more preference, thus bypassing the regular HMIS. In addition MoHP has other information systems. In a first attempt at integrating these separate systems, MoHP plans to strengthen them, make them compatible with each other and identify the institutional home to manage the integration process. The information systems include the core HMIS, the Logistics Management Information System (LMIS), the Human Resources Management Information System (HuRIS), eAWPB, TABUCS and HIIS. These function independently. It will take some time to integrate these systems. Policy level guidance is required to formalise this task.

5.9 Endorsing and Implementing the Technical Specifications Databank

The endorsement and subsequent implementation of LMD's Technical Specifications Databank should make the procurement of drugs and medical commodities more efficient and should improve transparency including by giving all interested parties the opportunity to comment on the standard specifications. The databank has yet to receive DoHS approval and be formally launched.

5.10 Partnerships with Private Medical Colleges

There are 18 private medical colleges in Nepal with more than 6,000 hospital beds and a wide range of curative care that are generally underused. Unused beds, facilities, skills and expertise at private medical colleges could be used for public service delivery. At present the Aama and uterine prolapse programmes are the only major examples of public funding for private care provision.

5.11 Strengthening and Implementing the M&E Framework

MoHP recently revised the monitoring and evaluation framework for the national health system and will report its progress based on this framework. In this particular context, the capacity of the responsible entities and their staff need strengthening. This is particularly important as the framework needs to cover changing health needs and their reporting through the proper information systems.

5.12 Developing a Health Financing Strategy

Some analyses have been completed to inform the government's health financing strategy. These include: benefit incidence analysis, fiscal space analysis, budget and expenditure analysis, national health accounts, the Service Tracking Surveys and demand-side financing. Studies need carrying out to identify policy options for developing benefit packages and social health protection interventions, and a review of the benefit packages and purchase of services. The development of a health financing strategy will be completed and endorsed by the end of 2014.

5.13 Expanding EHCS Services Towards Universal Health Coverage

MoHP will act as follows to expand EHCS services for achieving universal health coverage:

- Reducing the neonatal mortality rate is one of the most challenging problems faced by Nepal's health sector. It requires the rapid scaling up of the Community Based Newborn Care Programme (CB-NCP) with institutional back-up.
- More resources are needed to provide quality service in higher level health facilities and technical advancement (at comprehensive emergency obstetric and neonatal care [CEONC] sites), and advanced training for SBAs to achieve the MDG targets.
- More attention is needed to extend the provision of family planning, especially in safe motherhood and adolescent health programmes. The increasing demand for long acting contraception, such as IUCDs and implants, needs to be addressed to widen the choice of methods available for women, especially in hard-to-reach areas. In addition, a targeted programme needs developing to reach under-served populations, such as Muslims and people living in remote areas.
- Necessary resources will be allocated to strengthen the essential health care programme, towards universal coverage.

5.14 Integrating Demand Side Financing Schemes

Learning from the integration of the Aama and 4ANC programmes, MoHP will take steps to integrate the demand side financing schemes under the wider framework of social health protection.

5.15 Implementing Performance Based Grants for Hospitals

In order to strengthen capacity and ensure timely reporting from hospitals, MoHP has started implementing performance based grants in the seven non-state hospitals. MoHP is currently reviewing the process of the grants agreement with the seven hospitals. Learning from the initial experiences, this approach will gradually be expanded to all hospitals.

5.16 Strengthening the GESI Institutional Structure

The Population Division needs strengthening to work as an effective GESI Secretariat. Also, the GESI Committee, GESI technical working groups (TWGs) and HFOMCs need to be made functional and the skills of their members need strengthening.

Support from external development partners is needed to support the integration of GESI in health in the districts where they are operational, including strengthening GESI TWGs.

5.17 Integrating GESI in AWPBs and Annual Business Plans

The good practice initiated this year of integrating GESI into MoHP's AWPB and Business Plan should continue. GESI focal persons in all divisions and centres will work to ensure that the activities on reaching underserved areas and unreached groups are identified and costed. TWGs at all levels need to ensure that these aspects are well addressed in their plans and programmes.

For further information related to this report please contact Mr Kabi Raj Khanal (krk.moha@gmail.com) or Dr Suresh Tiwari suresh.tiwari@opml.co.uk

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