Background thematic report no. 7

Progress Report on Opportunities, Challenges and Strategic Directions for the Implementation of the Nepal Health Sector Programme-2 2013/14

Report Prepared for Joint Annual Review (JAR)

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Ministry of Health and Population (MoHP)
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EXECUTIVE SUMMARY

Progress Report on Opportunities, Challenges, and Strategic Directions for the Implementation of the Nepal Health Sector Programme-2, 2013/14

A. Opportunities for improved health services:

1. *Overall strategic direction in place* — The recently endorsed National Health Policy, 2014 articulates the overall strategic direction for the development of Nepal's health sector while the draft Nepal Health Sector Programme-3 has been prepared as the Government of Nepal's health sector strategy for 2015-2020. NHSP-3 consists of a strategy document, an implementation plan and result framework. The 14 main policy elements of NHP-2014 form the overall strategic framework of NHSP-3.
2. *Structure for introducing health insurance* in place — The basis for introducing a nationwide scheme to reduce financial barriers to accessing health care were put in place with the official approval of the National Social Health Insurance Policy, 2014, the establishment of a Social Health Protection Development Board and the preparation of a draft National Social Health Insurance Act.
3. *Financial planning frameworks in place* — The official approval and bringing into use of MoHP's Audit Clearance Guidelines and Internal Control Guidelines should improve financial discipline in health sector finances. And the Financial Management Improvement Plan for 2012/13 to 2015/16 was revised and subsequently endorsed. Its implementation should improve the efficiency of resource allocation in the health sector.
4. *Strategy and legislation for human resource improvements in place* — The amended Health Services Act (2013) and MoHP's Human Resources for Health Strategy, 2011–2015 provide the basis for improving the production, deployment, distribution and retention of health care human resources.
5. *Opportunities for improved procurement* — The Procurement Improvement Plan (PIP) for 2013/14 to 2015/16 addresses the strengthening of procurement management practices across MoHP. Good progress was made on instituting systems for more efficient procurement with:
   - Development of consolidated annual procurement plan for 2013/14 and 2014/15
   - the piloting of LMD's Contract Management System and links established between this system and DoHS's Finance Section on payments, and with warehouses on stock control; and
   - the expansion of LMD's Technical Specifications Bank (it now has 1,050 specifications of drugs and health commodities, especially for use by DoHS divisions, district health offices and potential bidders.
6. *Opportunities for improved infrastructure planning* — The improved web-based Health Infrastructure Information System (HIIS) provides the information base for strengthening health infrastructure planning and management. The official approval of the criteria to identify health facilities for upgrading and land selection guidelines for new health facilities should make health facilities more fit-for-purpose.
7. *Opportunities for improved gender equity and social inclusion* — The Population Division's annual workplans and budgets (AWPBs) now provide funds for biannual reviews of gender GESI mainstreaming at the district level and meetings of district GESI technical working groups while the 'Operational Guidelines for GESI Mainstreaming in the Health Sector' were approved by MoHP. The 15 one-stop crisis management centres for victims of gender-based violence were strengthened and

social auditing for the improved governance of health services was carried out in 45 districts in 2013/14, covering 602 health facilities.

8. *Systems for improved aid* — A Technical Assistance Response Fund (TARF) was established in 2013 to more quickly and responsively meet MoHP's unanticipated technical assistance needs while the expansion of the Aid Management Platform to include all local development partners and line ministries provides more comprehensive information on aid flows and programmes.
9. *For improved local health governance* — In December 2013 a collaborative framework was signed by MoHP and the Ministry of Federal Affairs and Local Development (MoFALD) to strengthen local health governance. Related activities have begun.
10. *Improved financial management systems* — Improved financial control should result from installing the Transaction Accounting and Budget Control System (TABUCS) in all MoHP cost centres and the electronic annual work plan and budget (eAWPB) being integrated with the TABUCS.
11. *Improved funding mechanisms* —The testing of performance-based grants for seven health institutions should show the way for the widespread implementation of such agreements to promote the improved provision of health care at hospitals. Local government funding is an opportunity for enhancing health service delivery as such funding can be more responsive to local needs.
12. *Improved monitoring system* —The revision of the Health Management Information System (HMIS), including to capture more disaggregated data, and the harmonization of health facility and population based surveys will make more relevant and useful data available.

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

1. Implementing the National Health Policy, 2014, the National Social Health Insurance Policy, and the Governance and Accountability Action Plan (GAAP)
2. The availability of adequate funds to implement the government's health policies especially to fund basic health services and the proposed national health insurance scheme.
3. The absence of a legal framework to guide the government's essential health care services (EHCS) package including a standard definition of basic health.
4. Other system-wide challenges include the predominant top-down approach in health planning and budgeting, the delayed approval of annual budgets, a range of human resources for health related issues and the lack of regulation of private sector health care
5. Ensuring that sufficient government staff are available to conduct LMD's procurement responsibilities and the institutionalisation of the new guidelines, strategies and documents for health infrastructure development.
6. Service delivery challenges include inequalities in access to health care, inadequate referral systems and instituting mechanisms to improve and assure quality health care and meeting the health care needs of the urban poor. Specific challenges are to reduce the neonatal mortality rate and the maternal mortality rate.
7. The inadequate use of data and other information in health-related decision-making.
8. The lack of any clear mechanism or unified procedures to map support to the health sector.
9. The absence of any national mechanism to record health facilities' local revenues and related expenditure.

10. Ensuring the implementation of the GESI-related activities in the AWPBs and annual business plans of DoHS divisions and centres and multi-sectoral coordination on issues of women and poor and excluded people.

C. MoHP's strategic directions for the short to medium term:

1. Policy and planning:
   - Implement the National Health Policy, 2014 through MoHP's regular planning and budgeting process.
   - Endorse and implement NHSP-3.
   - Promote the inclusion of health issues in other ministries' policies.
   - Form a committee to define MoHP's package of basic health services.
   - Implement the HRH Strategy by exploring more models for retaining qualified and experienced health workers.
2. System strengthening and reform:
   - Implement the integrated Aama–4ANC Programme, the Financial Management Improvement Plan, the collaborative framework between MoHP and MoFALD and other plans, guidelines and revised and new systems.
   - Build the capacity of the National Social Health Protection Development Board to implement the National Social Health Insurance Policy. Recruit and train human resources to implement the proposed scheme.
   - Introduce more output-based decision-making and decentralised needs-based planning, budgeting and implementation.
   - Strengthen quality assurance and improvement systems
   - MoHP to initiate a dialogue on redefining health system functions and structures, especially to identify the different functions related to health service providers and purchasers.
   - Prepare for health system restructuring in line with state restructuring after the likely introduction of a federal system of government.
   - Examine the feasibility of partnerships with private medical colleges for public health service provision
3. Health financing and support:
   - Start formulating a Health Financing Strategy, especially to address the challenges of financing subsidised and free health care.
   - Integrate more demand side financing schemes learning from the integration of the Aama and 4ANC programmes.
   - Implement performance based grants for hospitals.
   - Improve the effectiveness of technical assistance.
4. Strengthen health procurement:
   - Improve the procurement of goods and services by the timely preparation of the consolidated annual procurement plan (CAPP) and training MoHP district level staff on procurement.
   - Build the capacity of MoHP and DoHS officials on planning and implementing health infrastructure projects and build the capacity of Department of Urban Development and Building Construction (DUDBC) technical personnel on designing and building health facilities.

- Expand the Technical Specifications Databank update it at regular intervals

5. GESI: Strengthen the GESI institutional structure and integrate GESI in AWPBs and annual business plans
6. Disaster preparedness: Strengthen the readiness of health facilities to respond to natural disasters and other emergencies
7. M&E:
   - Strengthen and implement the M&E framework.
   - Integrate health-related Information systems.
   - Carry out more research on neglected areas of concern

CONTENTS

ACRONYMS

AMP	Aid Management Platform
AWPB	annual work plan and budget
CMS	Contract Management System
DFID	Department for International Development (UK Aid)
DHO	district health office
DoHS	Department of Health Services
DPHO	district public health offices
eAWPB	electronic annual work plan and budget
EDP	external development partner
EHCS	essential health care services
FMIP	Financial Management Improvement Plan
FY	fiscal year
GAAP	Governance and Accountability Action Plan
GESI	gender equality and social inclusion
GoN	Government of Nepal
HEFU	Health Economics and Financing Unit
HFOMC	health facility and operation management committee
HIIS	Health Infrastructure Information System
HMIS	Health Management Information System (
HRH	human resources for health
LMD	Logistics Management Division
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
NHIP	National Health Insurance Policy
NHSP	Nepal Health Sector Programme
NHSSP	Nepal Health Sector Support Programme
NSHI	National Social Health Insurance
OCMC	one stop crisis management centre
PHCC	primary health care centre
PHCRD	Primary Health Care Revitalisation Division
SBA	skilled birth attendant
SHP	sub-health post
STS	Service Tracking Survey
TA	technical assistance
TABUCS	Transaction Accounting and Budget Control System
TARF	Technical Assistance Response Fund
TC	technical cooperation
TIU	TABUCS Implementation Unit
TWG	technical working groups

1 INTRODUCTION

1.1 Background

The Nepal Health Sector Programme-2 (NHSP-2, 2010-2015) is being implemented to scale up the provision of free essential health care services towards achieving universal health service coverage. NHSP-2's Results Framework therefore includes indicators on the improved coverage of priority health care services. To monitor the targeting of inputs, NHSP-2's indicators are broken down by wealth quintiles, gender, age and ethnic group in NHSP-2's M&E framework.

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

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

The main policy documents and international commitments that guide MoHP's work during the NHSP2 period are:

- National Health Policy 1991;
- The National Health Policy 2014;
- Nepal's commitments to achieving the Millennium Development Goals (MDGs) and universal health coverage;
- the Nepal Health Sector Programme-2 (2010-2015);
- the Second Long Term Health Plan (1997–2017); and
- the government's Medium Term Expenditure Framework (MTEF), which 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 and challenges in the implementation of Nepal Health Sector Program-2. It also intends to explain the MoHP's strategic directions for the short to medium term.

2 OPPORTUNITIES

The current Interim Constitution of Nepal (2007) enshrines health as a fundamental right of every citizen. The National Health Policy, 2014, which comes under the overarching framework of the Interim Constitution, aims to realise this right by ensuring equitable access to quality health care services for all. 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 National Health Policy, 2014

The main official framework document that describes the policy directions for Nepal's health sector is the National Health Policy-2071 (NHP-2014). The recently endorsed NHP-2014 replaces NHP-1991. This was one of MoHP's biggest achievements in FY 2013/14. The new policy's envisions , "All Nepali citizens have the physical, mental, social and spiritual health to lead productive and quality lives." The goal is to "Provide health services through equitable and accountable health system while increasing access of every citizen to quality health services to ensure health as a fundamental right of every citizen." NHP-2014 aims to improve the health and well-being of all Nepal's citizens, including the elderly, the disabled, single women, poor people, and marginalised and at-risk communities. It calls for a people-centred approach to health service provision that is accountable to the people it is meant to serve. It seeks to put health as a central component of the country's overall development, to build partnerships and to establish multi-sectoral working. The policy recognises the importance of creating a healthy environment and promoting healthy lifestyle choices, especially by young people, as well as taking an inclusive approach other complementary medicine systems. The 14 policy elements of NHP-2014 form the overall strategic framework of NHSP-3.[1]

2.2 National Social Health Insurance Policy-2014

The National Social Health Insurance Policy (NSHIP) was recently issued by MoHP. It aims to:

1. ensure additional financial protection through the implementation of national health insurance in an inclusive manner;
2. improve access and utilization of quality health services by reducing financial barriers;
3. generate financial resources for health service delivery; and
4. promote efficiency, effectiveness and accountability in health service delivery.

The policy includes the provision of a National Social Health Insurance Fund, which will be in charge of pooling and allocating funds, listing and accrediting providers, managing contractual agreements with providers, monitoring and paying providers, and settling complaints. The household will be the unit for enrolment. Arrangements will be made for accrediting all types of health facilities based on certain criteria. The benefits package will include health services that are currently provided for free plus other defined services. MoHP is implementing the first phase of the NSHI Programme in Kailali, Baglung and Ilam districts to test implementation modalities.

[1] A copy of NHP-2014 is available on MoHP's website.

2.3 Social Health Protection Development Board established

On 9 February 2015, the government of Nepal established the semi-autonomous authority, the Social Health Protection Development Board, to implement the National Social Health Insurance (NSHI) Policy. The board was established under the leadership of the Health Secretary. The board will take ownership of all the progress made so far and will prepare a strategic plan to implement the NSHI Programme.

2.4 Draft National Social Health Insurance Act

In 2012/2013, MoHP formed a committee under the chairmanship of Joint Secretary to prepare a draft National Social Health Insurance Act. The committee has held a series of meetings, discussion and consultations. As a part of the consultation process, committee members and experts visited Thailand, Philippines and Indonesia to acquire knowledge and see experiences with social health insurance schemes. The committee has submitted the draft act to MoHP.

2.5 Draft Nepal Health Sector Programme-3

The draft Nepal Health Sector Programme-3 (NHSP 3) is the Government of Nepal's health sector strategy for 2015-2020. NHSP-3 was drafted in 2014/15 under the leadership of a High-level Committee chaired by the health minister and under the guidance of the Steering Committee, chaired by the health secretary. The Programme Development Team of government and development partner officials put together the draft strategy based on technical inputs from subject-wise thematic working groups. The overall framework of NHSP-3 is built upon the premise that health is an integral part of the country's socioeconomic development. NHSP-3 therefore considers the concerns of the health sector to be beyond the exclusive domain of the Ministry of Health and Population (MoHP) and recognises that other government line agencies and non-state actors work on areas of social and economic development that influence health. NHSP-3 therefore has a strategic reach beyond MoHP that places health as a prominent development agenda across sectors and provides opportunities for line agencies and non-state actors to engage in collective efforts to develop the health of the nation. NHSP-3 consists of a set of complimentary documents:

- The Strategy Document provides the strategic direction and an overview of objectives.
- The Implementation Plan provides detailed action plan and gives indicative costings
- The Result Framework is the framework for tracking progress and performance with indicators.[2]

2.6 Audit Clearance and Internal Control Guidelines

In 2012/13, MoHP prepared its Audit Clearance Guidelines. These guidelines were officially endorsed on 13 February 2014 and MoHP's Finance Section is taking the lead to implement it. MoHP has suggested that the Department of Health Services (DoHS) builds the capacity of its finance officers on public financial management, and especially on audit clearance, internal control and financial governance. DoHS subsequently prepared a proposal for the same. The new MoHP Internal Control Guidelines were also officially endorsed (on 15 March 2014). MoHP has circulated the two guidelines to all its cost centres and all 75 district treasury comptroller offices. Their use will improve fund flows, fund use and internal auditing for improved financial discipline in health sector finances. [3]

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[2] See the draft NHSP-3 documents for more detailed information on NHSP-3 (available from MoHP).

[3] *See JAR 2015 financial management report for more detailed information.*

2.7 Revised Financial Management Improvement Plan

The Financial Management Improvement Plan (FMIP) was prepared for the period 2012/13 to 2015/16 and endorsed by MoHP. Noting the findings of the fiduciary risk assessments of the World Bank and DFID in 2013, MoHP revised the FMIP in 2014 and subsequently endorsed the revised version. The revised FMIP has been circulated to all MoHP cost centres and uploaded on MoHP's website. Its implementation should improve the efficiency of resource allocation and the use of health services in line with the government's priorities.[4]

2.8 Procurement Improvement Plan

A Procurement Improvement Plan (PIP) for FY 2013/14 to 2015/16 was developed to strengthen procurement management practices across MoHP. Related procurement achievements have been as follows:

- Approval of the Logistics Management Division's (LMD's) consolidated annual procurement plan for 2014/15.
- The training of LMD's central level staff on procurement and related disciplines.
- The introduction of an operating manual to standardize LMD procurement procedures.
- Where appropriate, the introduction of multi-year framework contracts for the supply of health commodities.
- The preparation of a draft amendment of the current Drug Act.

2.9 Consolidated Annual Procurement Planning

The pooling by all DoHS's divisions of their procurement requirements in early 2013 led to the production of a consolidated annual procurement plan (CAPP) for 2013/14. Advice and suggestions from DoHS's Finance Section and divisions and technical assistance were incorporated in the plan. A final no objection letter to the CAPP was received from the World Bank on 25 September 2013. Similarly, a conditional no objection letter was issued for the 2014/15 procurement plan in September 2014.[5]

2.10 Contract Management System

Considerable work went into developing the Contract Management System (CMS), which was introduced in 2012/13. The CMS was piloted in three districts and two DoHS divisions to test its linking with other government agencies' information systems. Links have been instituted with DoHS's Finance Section on payment and other financial matters, and with central and regional warehouses on supply chains and stock control.

2.11 Technical Specifications Bank

By the end of June 2014, 1,050 technical specifications had been prepared for medical equipment, surgical instruments, drugs and hospital furniture and uploaded to the Technical Specifications Bank. The databank is housed on LMD's website (www.dohslmd.gov.np). It provides standard agreed technical specifications that are available with open access to all and especially to DoHS divisions, district health

[4] *See JAR 2015 financial management report for more detailed information.*

[5] The World Bank is responsible for monitoring and signing off on expenditure from the Pooled Fund, which covers many health procurement costs.

offices and potential bidders. This databank is being continuously updated, improved and quality assured.

2.12 Health Infrastructure Information System

The web-based Health Infrastructure Information System (HIIS) was completed, officially approved and adopted in 2012/13. Good progress was made in 2014 on developing the system as the information base for strengthening health infrastructure planning and management, on training staff on its use and on bringing it into use. The HIIS is open access and can be located via a link on MoHP's homepage.

2.13 Criteria for Upgrading Health Facilities

The criteria to identify health facilities for upgrading were further developed in 2013/14. The criteria are for geographical location, accessibility and districts' health status as per the district health index level of the latest Human Development Report. These criteria were subsequently endorsed by the health minister in 2 August 2014.

2.14 Land Selection Criteria

The selection of suitable sites and land is one of the most important steps in health building construction. Up to now most delays and high costs of health facility building construction have been due to inappropriate land selection. With the initiative of the Management Division, land selection guidelines were developed and then circulated to DUDBC's district offices in 2012/13 as part of the Management Division's guidelines for programme implementation. These criteria were endorsed by the health minister on 7 May 2014.[6]

2.15 GESI Institutional Structure Guidelines

The GESI Institutional Structure Guidelines were approved in 2012. To the end of 2014, GESI technical working groups (TWGs) have been formed in all Nepal's districts and GESI focal persons nominated in all regional health directorates and all district health office/district public health offices (DHOs/DPHOs). From 2013/14 the Population Division's AWPBs have provided budgets for biannual (6-monthly) reviews of GESI mainstreaming at the district level and quarterly meetings of district GESI TWGs. The 'Operational Guidelines for Gender Equality and Social Inclusion Mainstreaming in the Health Sector' (MoHP 2013) were developed and approved by MoHP in December 2013. These guide all levels of health service providers and managers on mainstreaming GESI in their regular work streams. GESI mainstreaming training for health facility in-charges and district supervisors was initiated in 13 districts in 2013/14 and is planned for a further 16 districts in 2014/15.[7]

2.16 Addressing Gender-Based Violence

One new one-stop crisis management centre (OCMC) was established in 2014 (in Jumla). Substantial progress was also made on strengthening the existing 15 centres while several related publications were produced in 2013/14 on the roles of OCMCs.[8]

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[6] *See JAR 2015 procurement report for more details on achievements 2.8 to 2.14.*

[7] *See more details in 2015 GESI JAR report.*

[8] *See more details in 2015 GESI JAR report.*

2.17 Social Auditing Guidelines

Comprehensive social auditing guidelines were approved by MoHP in June 2013. With AWPB funding, the Primary Health Care Revitalisation Division (PHCRD) conducted the social auditing of health services in 45 districts in 2013/14, covering 602 health facilities, including 50 Health for Life (H4L)-supported facilities in an additional five districts. Orientation programmes about social auditing were also carried out. In February 2014, PHCRD and seven external development partners signed a MoU establishing a collaborative framework for the social auditing of health service provision. The external development partners have since been providing technical assistance to PHCRD and the DHOs and DPHOs in their programmes' districts. Technical support from the development partners has been important, feeding into the design and implementation of social auditing.[9]

2.18 Effectiveness of Technical Assistance

In 2013, the ToRs of the TA/TC Coordination Committee for NHSP-2 in MoHP were revised to oversee all technical assistance in the health sector. However, the committee remains inactive — in fact it has only met once since its ToRs were revised. 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, DFID is funding NHSSP to run a Technical Assistance Response Fund (TARF). The fund is quickly and responsively providing technical assistance to MoHP, 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 make up the majority of support from NHSSP and other EDPs. Work funded by the TARF must be aligned to NHSP-2's objectives and the preparation of NHSP-3. MoHP has developed guidelines for its departments, divisions and centres to access the fund.

2.19 Aid Management Platform

The Aid Management Platform (AMP) was established in the Ministry of Finance (MoF) in 2009 to map support provided by development partners and to monitor aid flows. It 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. Its use by MoHP and EDPs is improving alignment and harmonisation. The AMP encompasses 4,654 programmes and projects that disbursed USD 1.04 billion for FY 2011/12. In FY 2013/14, AMP was rolled out to all local development partners and line ministries.

2.20 Collaborative Framework

In December 2013, MoHP and the Ministry of Federal Affairs and Local Development (MoFALD) agreed on a collaborative framework to strengthen local health governance. Its objectives 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.

Related initiatives will improve health sector governance at the local level.

[9] *See more details in 2015 GESI JAR report.*

2.21 Transaction Accounting and Budget Control System

The Transaction Accounting and Budget Control System (TABUCS) is a simple accounting system that allows for the capture of basic accounting transactions on a real time basis at source level, and enforces budgetary control procedures so that no expenditure can take place without an approved budget and activity. In 2013, MoHP established a TABUCS Implementation Unit (TIU) to implement TABUCS across the country and a help desk to resolve technical issues and implement TIU decisions. Planning and finance officers have been trained on using the TABUCS, which was installed in all MoHP cost centres by April 2014.

2.22 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 EDPs at joint consultative meetings.[10] In 2014, the electronic annual work plan and budget (eAWPB) was integrated with the TABUCS.

2.23 State–non State Partnership

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

2.24 Health Service Delivery

The improved delivery of health services provides large opportunities for improving health. Nepal has demonstrated that an integrated health care delivery system can successfully control and help eliminate communicable diseases. This has happened for leprosy and polio, which have been eliminated in Nepal, for Kala-azar, which is well on the way to elimination, and for malaria, which is in the pre-elimination phase. The National TB Control Programme has made large 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 impressive progress on safe motherhood with many more deliveries now taking place in health institutions. While good progress has been made on training 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 requires major efforts.[11]

2.25 Recruitment of Human Resources for Health

The Health Services Act (1997) was amended in 2013, including on ensuring inclusive recruitment. Following the coming into force of the amended act, the recruitment of health personnel restarted and

[10] More details are available on AWPBs at www.nhssp.org.np

[11] More information on improved service delivery is available in the 2015 JAR background report on the results against the logical framework.

most vacancies are being filled, while forthcoming vacancies will be filled regularly. Also, a number of health workers are being recruited locally on contracts and temporarily. The process has also been started to create additional sanctioned posts, as articulated in MoHP's Human Resources for Health (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 should have a large positive impact on health service delivery.

2.26 Contributions from Local Authorities

The Service Tracking Surveys (STS) of health service provision have identified MoHP as the main financer of all levels of health facilities. Village development committees (VDCs) are the second largest source of income for sub-health posts (SHPs). The surveys found that SHPs have the most diverse sources of income, with international donor agencies providing a fifth of their incomes. Salaries were the main expenditure item for all types of facilities.[12] Local government funding is an opportunity for enhancing health service delivery as such funding should be more responsive to local needs.

2.27 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 is expected to improve the performance of these hospitals.

2.28 Health Management Information System

The Health Management Information System (HMIS) is the main information technology hub of the health sector, which collects, 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 the lead in improving health recording and reporting indicators. This included identifying 11 standard indicators for which disaggregated reporting is now required. The HMIS Section is training 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.[13]

2.29 Monitoring and Evaluation

There has been continuous progress on monitoring and evaluation during the NHSP-2 period. A results framework was developed in NHSP-2's second year to monitor the progress of NHSP-2. The revision of HMIS to address data needs, particularly for disaggregated data, of NHSP-2, NHSP-3 and programme divisions and centres; the harmonization of health facility and population based surveys; the annual monitoring of NHSP-2's Results Framework indicators during DoHS/MoHP annual reviews and Joint Annual Reviews (JAR) are examples of the M&E progress made by MoHP. Considerable data is already produced by MoHP's and other relevant management information systems and by studies and surveys.

[12] See copies of the Service Tracking Surveys on NHSSP's website.

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

3 CHALLENGES

MoHP understands that a number of challenges need to be addressed for the development of Nepal's health sector.

3.1 Implementation of National Health Policy

In NHP-2014 the government envision to improving the health and well-being of all its citizens. It calls for a people-centred approach to quality health service provision that is accountable to the people it is meant to serve. The new policy seeks to place health as a central component of overall development, building partnerships and establishing multi-sectoral networking. To ensure the full implementation of these commitments MoHP needs to strengthen and reform the existing service delivery mechanism, human resources, medical equipment and drug supply system, information systems, governance, and the modalities of preventive and promotive health. In this context, MoHP needs to take a holistic approach to strengthening and reforming existing health systems.

3.2 Defining Basic Health

The Interim Constitution, 2007 guarantees 'basic health' as a fundamental human right, but to date there is no legal framework on the implementation of this right. This leads to ambiguities between the interpretation of the term 'basic health' as per the constitution and as per the government's essential health care services (EHCS) package. EHCS, in effect, has no legal framework and also does not necessarily cover the range of services that may come under the scope of 'basic health'. MoHP also needs to define 'universal health coverage' and ensure that it can report its progress on its achievement in international forums. MoHP needs to clarify these ambiguities and endorse a nationally accepted package of basic health services.

3.3 Implementation of National Social Health Insurance Policy

The Government of Nepal has endorsed a National Social Health Insurance Policy (NSHIP), which is designed to reduce out-of-pocket expenditure, protect people from falling into poverty and ensure equity in the health system. The government established the Social Health Protection Development Board towards fulfilling these commitments. MoHP believes that this is the right approach as long as the institution has well-defined functions and proper structures. However, it is not known to what extent the board will be able to raise substantial additional resources for the health sector. Therefore, the main issues here are:

- how will this new health financing system facilitate efficiency gains in the health sector (complementing other reforms such as decentralisation and public-private partnerships); and
- how to avoid the risk that its implementation jeopardises the relatively good results achieved through existing social health protection interventions (such as the Aama Programme).

3.4 Planning and Budgeting Approaches

A top-down approach has predominated in health planning and budgeting. Matters of procurement, resource allocation, transfers and staff leave are dealt with at the central level. However, a bottom-up process functions at the district level. HFOMCs and sub-health post and health post personnel represent local communities' needs in VDC level planning, with the resulting plans transmitted to the district level. The two processes (top-down and bottom-up) result in different priorities, needs and demands that

usually have to be compromised at the district level, where there is varying capacity for such planning and coordination. Some districts have, drawn up strategic health plans that are costed and have disaggregated indicators and log frames. Although other districts lack the capacity to do this, the issue here is about the appropriate level of functional authority. Even if district health authorities are able to plan and coordinate programmes, the overall planning process and the control of resources favour the top-down approach, resulting in pre-determined budgets and plans being given to districts that often do not reflect local needs. This is a major cause of low budget absorption capacity.

3.5 Financing the Health Sector

The availability of adequate funds for implementing the government's health policies is a major cross-cutting challenge and a key obstacle to implementing NHP-2014:

- An important question for MoHP is whether Nepal can afford to provide the free basic health services that are enshrined in the Constitution. There is an urgent need to look at government policy in terms of citizens' rights and entitlements to health and the approach to financing these. This challenge is very important as the proportion of the national budget allocated for health has always been less than 7% of the national budget, below the national target of achieving 10%.
- The lack of a health financing strategy and slow progress on priority areas such as introducing social health insurance challenge MoHP's budget absorption capacity.
- The current range of initiatives to ensure adequate funding in the health sector, (each with related strategy documents, pilot activities and, in some cases, planned national roll-out), is insufficient.
- There is a lack of good analysis on how available resources are spent and what outcomes result from them. The better use of resources is growing in importance in the increasingly constrained fiscal environment.

3.6 Implementation of the GAAP

MoHP has taken several initiatives to improve health sector governance and accountability, but the following challenges remain for implementing the Governance and Accountability Action Plan (GAAP):

1. The cross cutting nature of the GAAP requires collaboration between different ministries and organisations for the smooth implementation of related activities. In some cases, progress is affected by difficulties in getting adequate and timely support from concerned agencies.
2. The cross-cutting nature of the GAAP and the involvement of many agencies, means that progress information is needed from a range of sources, which can be difficult to collect.
3. A number of GAAP indicators are difficult to measure. Many indicators provide additional detail on activities rather than defining what is required to demonstrate evidence of progress.

3.7 Delays in Budget Approval Process

The delayed approval of annual budgets has been the major challenge for the proper execution of priority activities and other activities across the NHSP-2 period. These delays have also directly contributed to some cost centres violating the financial rules and regulations, specifically those concerning procurement and the payment of incentives to clients.

MoHP has about 2,000 official programme activities. 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 spending unit level. Additionally, under decentralised mechanisms some funds are routed to spending units through district development committees, creating another layer of fund flows.

3.8 Procurement of Goods and Services

The main challenges facing the timely, efficient and proper procurement of goods and services are:

- ensuring sufficient government staff are available to conduct LMD's procurement responsibilities in an efficient and timely manner; and
- delays in LMD-related procurement due to delays in the approval of budgets and procurement plans and the production of no objection letters (by the World Bank).
- The approval of the technical specifications databank by DoHS.

3.9 Infrastructure Development

The main challenges facing the rational and efficient planning, procurement and implementation of health infrastructure building works are as follows:

- The institutionalisation of the new guidelines, strategies and documents.
- Direct grant budgets to zonal and higher level hospitals for construction works and part of the construction being directly implemented through district health offices (DHOs). These need to be regularly included in the regular reporting system as prescribed in the Joint Financing Arrangement. At present there is no procurement plan or progress reporting on these types of projects.

3.10 Implementation of HRH strategy

The HRH Strategic Plan, 2011–2015 identified the following key HRH problems and issues:

- The shortage of HRH as a result of imbalances between supply and demand.
- The misdistribution of staff, especially in remote and rural areas.
- Poor staff performance, especially concerning productivity, quality and availability.
- Fragmented approaches to human resource planning, management and development.
- HRH financing.

These continue to be the key issues. Recruitment hindrances and ad hoc transfers are other major obstacles to proper human resources management.

3.11 Ensuring Access and Equity

The wide variations in health service availability, use and health status across Nepal's different socioeconomic and geographical population groups indicate the challenges of access and equity:

- According to the Nepal Living Standards Survey (2010/11), more than 60% of people across the country had problems accessing basic health care. More than 70% of people in mountain areas 62% in the hills and 57% in the Tarai region reported access problems.[14]

[14] Central Bureau of Statistics and National Planning Commission, Nepal Living Standard Survey 2010/11 Volume 1. 2011, CBS: Kathmandu.

- 35% of households in rural areas (in mid and far western hill areas) reported less than adequate availability of health care facilities in their areas.[15]
- Health status is generally better in urban than rural areas; but in the absence of disaggregated data for the urban poor, this could be masking the poor health status of the urban poor.
- Poor people report a greater incidence of illness and use less health services due to social, economic and geographical barriers.[16]
- Another source reports a lower use of health services among Dalits, ethnic and religious minorities and people in remote areas due to the high costs of care and transport, and the non-availability of staff and drugs in public health facilities[17].

3.12 Referral Services

A key challenge is ensuring effective linkages between the various components of the health system. Since district health offices generally oversee district hospitals, PHCCs, health posts and SHPs, this provides a natural starting point for developing and monitoring an effective referral system. However, there is evidence that the system is not well structured and institutional linkages have not been developed. A 2010 study[18], found that, although all surveyed health facilities contained DoHS's standard referral form (HMIS 8), its use was limited. The same study found that 19% of hospital outpatients, 32% of PHCC patients, and 38% of health post patients were referred to other facilities. From hospitals it took a maximum of six hours to reach the nearest referral facility, while for PHCCs and health posts it took up to two days. These long transfers can prove fatal and costly for clients.

3.13 Standards and Quality of Health Care

NHSP-2 calls for improving the quality of health care. The recently developed guidelines for Health Facility Quality Management (QM), a Performance Based Management System and Integrated Supervision have all been approved by MoHP. These provide the basis of a quality management system for district level and below health facilities[19]. A 2009 Quality Assurance Policy lays down several levels of indicators; although in practice quality assurance mechanisms are weak. This policy aims to ensure the quality of health services provided by public, private and NGO health institutions. It calls for establishing an autonomous body (a quality assurance mechanism), quality assurance committees at various levels, and the development of quality and safety guidelines. However, no resources have been made available to functionalise these mechanisms.[20]

3.14 Reaching Targets and Indicators

Challenges remain in relation to the following three major health indicators, which are also MDGs:

- 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

[15] Central Bureau of Statistics and National Planning Commission, Nepal Living Standards Survey, 2010/11, Volume 2. 2011, CBS: Kathmandu.

[16] RTI International, Health System Performance. May 2010: Research Triangle Park, NC, USA.

[17] MoHP (2013). Strategic Plan for Human Resource for Health, 2013 to 2017. 2013: Kathmandu, Nepal

[18] Quality and Accessibility of RH services in Nepal 2010. Published by South Asian Institute of Policy, Analysis and Leadership (SAIPAL) Anamnagar and Family Health Division, Department of Health Services Kathmandu, Nepal

[19] NHSSP Essential Health Care Capacity Assessment, 2010

[20] NHSSP State Non State Partnership in Health Sector in Nepal: A Diagnostic Report. MoHP, September 2012

Newborn Care Programme (CB-NCP) has not been able to reduce the new-born death demanding more intensive and concerted effort in this area.

- The infant mortality rate (IMR) has only decreased slightly — from 48 deaths per 1,000 infants in 2006 to 46 in 2011. This is as expected given that 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 is one of Nepal's major health successes. WHO estimate shows even better progress (down to 190 in 2013). 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 (modern methods) prevalence rate (CPR) has been stalled at around 43 to 44% in two consecutive DHS surveys 2006 and 2011.

The nutritional status of children in Nepal has slightly improved over the last decade. In 2006, 49% of children were stunted and 39% underweight, decreasing 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.[21]

3.15 Use of Information in Decision-Making

Good information provided on time is crucial to enable good planning and decision-making. There has been good progress in establishing an M&E Framework under NHSP-2 and the efforts to put this in place are commendable. Similarly the health sector has many initiatives for collecting data and much data is being generated through routine systems and studies and surveys. The priority now is the better integration of the different systems. MoHP has proposed creating a unified coding system linking all nine relevant MISs (not all of which come under MoHP). This should include broad stakeholder engagement to ensure buy-in from the managers and users of all nine systems.

3.16 Lack of Private Sector Regulation

Nepal's private health sector has grown since 1991 but remained largely unregulated however introduction of standards guideline for Establishing, Operating and upgrading of the health institution in 2014 has laid down the foundation for the same. . The most recent data from the National Health Accounts suggests that the government contributes less than a quarter of total health spending (24%), while 21% comes from external development partners (EDPs) and 56% from the private sector. However, there is little empirical information available on the size, composition, distribution and characteristics of Nepal's private health sector. The lack of data on the non-state health sector, and especially the private-for-profit sector, is mainly due to the fact that different kinds of hospitals register with different government institutions:

- companies register with the Office of the Company Registrar of the Ministry of Industry under the Company Registration Act;
- NGOs register at district administrative offices and with the Social Welfare Council; and
- Cooperative hospitals register under the Department of Cooperatives of the Ministry of Agricultural Development.

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

This has led to non-state health care providers growing without adequate physical or clinical standards, accreditation, and quality norms or protocols. This is compounded by the fact that there is no legal framework or institutional structure nor resources to supervise, monitor or regulate the non-state and especially the for-profit private sector.

3.17 Mapping Health Sector Support

Progress has been made on mapping support to the health sector, especially through the Aid Management Platform (AMP). However, there is no clear mechanism nor any unified procedures to map support to the health sector. From 2012, the Ministry of Finance started to roll-out the AMP to INGOs. As of March 2014, 80 INGOs were reporting their support to the AMP and this number is expected to increase to provide a better picture of INGOs' health support.

3.18 Increased Interest in Direct Funding

Although the predictability of funds is improving as some EDPs make multi-year funding commitments, most EDPs are not able to make such commitments. And 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 fiduciary risk for partners. Also, not all EDP planning cycles are 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.[22]

3.19 Reporting of Funds Generated at the Local Level

There is no national mechanism to record health facilities' local revenues and related expenditure. This indicates that MoHP lacks an institutional mechanism to report the total health expenditure that takes place under its umbrella.[23]

3.20 The 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 different divisions and centres. Dedicated attention is needed to implement the GESI operational guidelines, the social audit guidelines, and the Equity and Access Programme (EAP), and to ensure that the institutional structures for GESI are functional.

3.21 Multi-sectoral Coordination on 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 the 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 by convincing different actors to work in a holistic way.

[22] More detailed information is available in the 2014 JAR report on partnership working.

[23] For more detailed information please see the 2014 JAR report on financial management.

3.22 System-wide Implementation of GESI

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

- to ensure the implementation of GESI related activities in the AWPBs and annual business plans of different divisions and centres;
- budget cuts that have affected planned GESI-sensitive interventions;
- 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.[24]

3.23 Urban Health

In recent years there has been rapid urbanization in Nepal. The high level of migration to the towns and cities has led to crowded and unregulated settlements. This urban population growth largely comprises the urban poor, who mostly live in unsanitary conditions and poor and overcrowded housing. Slum-dwellers face greater health risks, especially mothers and children. The draft National Urban Health Policy, and the Strategy and Action Plan on Primary Health Service Delivery System in the Municipalities of Nepal (2010–2014), report that the health of municipal slum dwellers is worse than the rural poor in some areas. Health care facilities for primary health care services in town and cities also tend to be located in less accessible places, are overcrowded, and there is a lack of effective outreach and referral systems.

[24] For more detailed information please see the 2014 JAR report on GESI.

4 STRATEGIC DIRECTIONS

MoHP has made significant headway in developing health policies, plans, guidelines and frameworks. Their proper implementation will go a long way towards addressing the challenges outlined in Chapter 3. The following are the main strategic directions of MoHP for the short to medium term.

4.1 Implement National Health Policy, 2014

MoHP needs to inform its entities, partners and the general public about the policy directions of NHP-2014. The commitment reflected in the policy needs to be translated into action through the periodic and annual plans. All planning and budgeting units need to incorporate the priority areas of NHP-2014 in their annual work plans and budgets.

4.2 Define and Deliver Basic Health Services

It is important to clear up the ambiguities on what 'basic health services' entail in relation to the basic health services and essential health care services packages. Also, the government has committed to achieving universal health coverage and MoHP understands that basic health services and the achievement of universal health care are closely interlinked. Technical discussions are needed to outline the framework and plan for achieving universal health coverage.

4.3 Build NSHI Board's Capacity

The capacity of the newly established Social Health Protection Development Board and its members need building to implement the National Social Health Insurance Policy. This board needs to be empowered to prepare the guidelines, generate the resources, use the resources, scale-up the related programme and ensure its good governance. Competent human resources need to be recruited and trained to implement the NSHI policy.

4.4 Initiate a Dialogue to Reflect Health in All Policies

As articulated in the new National Health Policy, improved health outcomes will require efforts across sectors other than health. The importance to health of clean/safe water, good sanitation, education, infrastructure, good quality food, road safety and ending harmful cultural practices is well known. NHP-2014 emphasises the importance of multi-sectoral working. Building partnerships between the public and private (for profit and not-for-profit) sectors will be expanded under NHSP-3 for improved access and quality of health services in remote and underserved areas, including urban areas.

4.5 Endorse and Implement NHSP-3

NHSP-3 (2015-2020) is designed to achieve the goals, objectives and priorities of NHP-2014. MoHP expects that the Council of Ministers will endorse NHSP-3 in June 2015. Its timely endorsement will help MoHP secure the resources from its external development partners. MoHP also needs to prepare NHSP-3's implementation plan.

4.6 Start Formulating a Health Financing Strategy

Several initiatives are underway to enhance access to health care (free EHCS at SHPs, health posts and PHCCs; free essential medicines at SHPs, health posts, PHCCs and district hospitals; free services at

district hospitals for poor and disadvantaged people; and free institutional deliveries). However, the free care policy faces many challenges including a lack of mechanisms to identify the poor; lack of contracting policy; efficiency concerns with respect to both government and household resources; lack of appropriate provider payment mechanisms; and out-of-pocket payments for free care services. MoHP is formulating a health financing strategy that will detail how the necessary funds will be acquired and efficiency gains made to address these challenges.

4.7 The Quality Assurance of Systems and Services

Health service coverage has tended to be the major focus with quality of care getting less attention. NHSP-3 will have quality of care as a central priority. This will include instituting quality systems and services as well as a renewed focus on quality of services in progress monitoring. The reforms on procurement, supply chain management, human resource management, and sector financing are being driven by the goal of improving quality of services. Nevertheless, it is essential to emphasise specific strategic directions on improving the quality of care provided by health facilities. MoHP will soon initiate dialogue and discussions to ensure the quality of health services.

4.8 Implement Guidelines and Plans

The proper implementation of the following strategies and plans is very important for the development of Nepal's health sector:

- Implement the integrated Aama–4ANC Programme in health facilities that are implementing the Aama Programme.
- Ensure the implementation of FMIP.
- Implement the collaborative framework between MoHP and MoFALD.
- Implement TABUCS at the national level.
- Implement the audit clearance guidelines.
- Implement the internal control system and the procurement guidelines.
- Use the Health Infrastructure Information System (HIIS) for planning purposes.
- Mainstream GESI in AWPBs.
- Ensure the proper implementation of NHSP-2's M&E framework.
- Implement the Procurement Implementation Plan (PIP).

4.9 Implement the HRH Strategy

The implementation of strategies and prioritised activities on HRH is a priority for MoHP. In 2012, MoHP prepared a strategy on the production, deployment and retention of critical human resources for health (HRH). Models in use for improving HRH retention include scholarships for health workers bonded to work in Nepal for several years, and retention and performance-based incentives. A retention and performance based incentive package has been developed for doctors and nurses and awaits implementation. Other options include creating more opportunities for doctors and nurses who work in remote areas. The issues of the broader working environment and skill mix of HRH need to be addressed in this regard. MoHP plans to explore more models for the retention of HRH and pilot them.

4.10 Improve the Procurement of Goods and Services

The following are the ways forward for improving the procurement of goods and services:

1. The timely preparation of the consolidated annual procurement plan (CAPP).
2. Procurement training for MoHP district level staff.
3. The continued development and promotion of the Technical Specifications Bank.
4. The continued development and implementation of the Contract Management System.

4.11 Develop the Health Infrastructure

The following are the ways forward for developing the health infrastructure:

1. Build the capacity of MoHP and DoHS officials and other staff on planning and implementing health infrastructure projects.
2. Build the capacity of Department of Urban Development and Building Construction (DUDBC) technical personnel on designing and building health facilities.
3. Train DHO, DPHO and DUDBC division office officials on the web-based HIIS, ensure the regular updating of the information in the system and enter details of all upgraded sub-health posts.
4. Publish the standard designs, drawings and implementation guidelines and develop typical sanitary and electrical drawings and other details for these designs.
5. Complete the needs assessment reports of the building works at Bheri and Seti Zonal Hospitals and the Mid-Western Development Region Hospital and initiate tendering for this work.

4.12 Dialogue on Health System Functions and Structures

The government aims to achieve universal health coverage. Its achievement entails not only having more resources in the health sector, but also a dialogue on redefining health system functions and structures. MoHP specifically 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 for the Nepalese health system. While discussing these issues MoHP also needs to account 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 a federal structure and the expanded rights and responsibilities that will likely go to local governments.

4.13 Move to Decentralised and Output-Based Planning

The lessons of the last decade point to the need for more output-based decision-making and for the more effective use of available resources through decentralised needs-based planning, budgeting and implementation. MoHP is promoting decentralisation and the strengthening of local health governance through the SWAp. Decentralisation will also require an organisational review of the structure and functioning of MoHP and its entities. MoHP will soon initiate technical discussions on this approach.

4.14 Integrate Information Systems

In recent years the vertical programme-wise reporting of health service provision and other results is becoming more prominent, bypassing the regular HMIS. MoHP has other information systems — the core HMIS, the Logistics Management Information System (LMIS), the Human Resources Management Information System (HuRIS), eAWPB, TABUCS and HIIS. These function independently. In a first attempt

at integrating these systems, MoHP plans to make them compatible and identify the institutional home to manage their integration. This will take time and policy level guidance is needed on this task.

4.15 Implement the Technical Specifications Databank

The use of the specifications in LMD's Technical Specifications Databank for procuring drugs and health commodities should make procurement more efficient and improve transparency, including by giving all interested parties the opportunity to comment on the standard specifications. The need is to continue adding quality approved specifications and to encourage their use for health sector procurement.

4.16 The Health System in State Restructuring

It is anticipated that during future state restructuring, responsibilities for the health sector will be divided between the three tiers of government, with national, state and local level bodies replacing the present centrally controlled system. The sharing of resources and the organisation of government depends upon how responsibilities related to health service provision are divided. Resources from the centre will likely be provided to the states through block grants, conditional grants and equalization funds. The states will in turn provide resources to the local bodies. MoHP will take a lead role in defining the structure, functions and responsibilities of the various political entities.

4.17 Effective Technical Assistance

MoHP intends to improve the efficiency, effectiveness and added value of the technical assistance it receives. The first challenge is to identify the scale and scope of technical assistance, the second is to see how far technical assistance is aligned with the government's plan. The TA Matrix is a useful addition to the documentation and highlights the large range of support provided by EDPs. The need now is to develop this further, to make it more user-friendly and to keep it up to date.

4.18 Partnerships with Private Medical Colleges

The 6,000 hospital beds and the wide range of curative care facilities at Nepal's 18 private medical colleges are generally underused. The Aama and uterine prolapse programmes are the only major examples of public funding for private care provision. MoHP is looking at how to make more use of these unused beds, facilities, skills and expertise for public service delivery.

4.19 Strengthen and Implement the M&E Framework

MoHP recently revised its M&E framework for the national health system and will now report progress based on this framework. The capacity of the responsible entities and staff needs strengthening to use the revised framework. This is particularly important as the framework needs to cover changing health needs and their reporting through appropriate information systems.

4.20 Integrate Demand Side Financing Schemes

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

4.21 Implement Performance Based Grants for Hospitals

To strengthen the capacity of hospitals and ensure timely reporting by them, MoHP has started implementing performance based grants in seven non-state health institutions. MoHP is currently reviewing the process of these grant agreements. Learning from the initial experiences, MoHP plans to extend this approach to all hospitals.

4.22 Strengthen the GESI Institutional Structure

The Population Division needs strengthening to work as the GESI Secretariat. Also, the GESI Committee, GESI technical working groups and HFOMCs need to be made functional and the skills of their members strengthened on GESI. Support from external development partners is needed to support the integration of GESI in health at the district level, including strengthening GESI TWGs.

4.23 Integrate GESI in AWPBs and Annual Business Plans

The good practices initiated in 2013/14 of integrating GESI into AWPBs and business plans should continue. GESI focal persons in all divisions and centres will work to ensure that activities for reaching underserved areas and unreached groups are identified and costed. All levels of TWGs need to ensure that these aspects are well addressed in health sector plans and programmes across the board.

4.24 Emergency Preparedness

Emergency preparedness is a priority of the government as many of its populated areas are at a high risk to natural disasters. However, while WHO is leading several interventions including for hospital and school safety, health facility mapping, and rapid response training, overall progress has been slow. According to the STS 2011, about half of all hospitals and PHCCs and a lower proportion of health posts and SHPs had emergency contingency plans. Of facilities with plans, only a quarter of hospitals and fewer lower level facilities reported that a budget had been allocated to implement these plans.

4.25 More Research

Sufficient evidence has been produced by studies to enable clear and systematic planning and action to improve EHCS health indicators, including reproductive, maternal and child health services. However, other areas, including nutrition, mental health, oral health, non-communicable diseases, need more research to generate necessary information. MoHP will soon start discussions to prioritise the research interventions that are needed.