Progress Report on Partnership, Alignment and Harmonisation in the Health Sector 2011/12

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EXECUTIVE SUMMARY

The endorsement of the Health Sector Reform Strategy (2004) and the subsequent advent of a sector wide approach (SWAp) in the health sector in the same year marked the beginning of an improved partnership between the government and its external development partners (EDPs). Despite substantial challenges, partnership, harmonization and alignment have improved in the health sector.

The first and second Nepal Health Sector Programmes (NHSP 1, 2004–10 and NHSP 2, 2010–15) were developed with the joint participation of external development partners (EDPs). The EDPs have largely aligned their programmes and resources with the policies and strategies of the national health sector. This has, among other things, reduced aid fragmentation and led to a better budget absorption capacity in the Ministry of Health and Population (MoHP).

The harmonization of activities within the EDPs has also improved over the years. They regularly interact with one another in a formal group. The INGOs working in the health sector have also organized themselves in a formal group. However, there is insufficient interaction between INGOs and the EDPs. Progress has been made on mapping the support provided by EDPs, mainly the Aid Management Platform (AMP) and the Technical Assistance Matrix. However, more efforts are needed, especially for mapping the support provided by INGOs.

There are currently five pooled funding partners (DFID, World Bank, AusAid, GAVI HSS, and KfW) supporting the implementation of NHSP 2 and more EDPs are interested in joining. However, no new partners have entered the SWAp since 2004 and important donors like India and China operate outside of it. There has been much discussion about pooling technical assistance (TA) to address concerns over the alignment of technical assistance with national priorities.

In 2012, MoHP drafted a 'State Non-State Partnership Policy for the Health Sector in Nepal'. This policy should be endorsed soon. The strengthening of district health systems by partnering with medical colleges is another partnership initiative, which MoHP embarked on in 2012. Other state to non-state partnership schemes are for the treatment of uterine prolapse, the provision of family planning commodities, in the Aama programme and in other areas.

There is also a growing interest in multi-sectoral collaboration in the health sector, underscored by the Multi-Sector Nutrition Plan (MSNP, 2013-2017), which was recently launched by the National Planning Commission.

The major challenges that remain include improving the efficacy of technical assistance, further improving the predictability of aid, improving human resources and instigating further change to improve and strengthen partnership working in the health sector.

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ACRONYMS

AIN	Association of INGOs in Nepal
AMP	Aid Management Platform
AusAid	The Australian Government's Overseas Aid Programme
DFID	Department for International Development
EDP	external development partner
GAVI HSS	The Global Alliance for Vaccines and Immunisation's Health System Strengthening Support
IHP+	International Health Partnership
INGO	international non-government organisation
JAR	Joint Annual Review
JCM	joint consultative meetings
JTAA	Joint Technical Assistance Agreement
KfW	German Development Bank
NHSP	Nepal Health Sector Programme
NTC	National Tuberculosis Centre
PHCC	primary health care centre
TA	technical assistance

1 INTRODUCTION

1.1 Background

The 'Health Sector Reform Strategy: An Agenda for Change' (2004) envisaged a government-led health sector, with increased harmonisation, the alignment of partners and strong government stewardship. A sector wide approach (SWAp) was initiated under the auspices of the Paris Declaration on Aid Effectiveness (2006), to which Nepal is a signatory. The SWAp was formally endorsed and supported by 11 health sector donors (see Table 1). 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+).

The Nepal Health Sector Programme (NHSP 2, 2010–2015) aims to widen and strengthen partnerships in the health sector. It also espouses the core values that reflect the country's current socio-political and socio-economic paradigm by aiming to improve the health and nutritional status of the Nepali population with a special focus on poor and excluded groups.

Table 1: Pooled funding and non-pooled funding SWAp EDPs for NHSP 2

Pooled funding (and SWAp) EDPs	Non-pooled funding SWAp EDPs
DFID	USAID
World Bank	UNFPA
AusAid	UNICEF
GAVI HSS	WHO
KfW	GIZ
	UNAIDS

1.2 Objective and rationale

The objective of this report is to highlight progress, challenges and ways forward on partnership, alignment and harmonisation in the health sector. This report is intended to inform the Joint Annual Review (JAR) process of 2013.

2 PROGRESS AND ACHIEVEMENTS

2.1 An improved partnership environment is supporting MoHP's performance

As the 2004 SWAp continues to mature there have been substantial improvements in the partnership for health sector management. More partners are directly supporting the government's programme and there are fewer independent projects. The consequent reduced overall transaction costs for MoHP has contributed to a steady improvement in MoHP's budget absorptive capacity: from 69% in 2004/05 to 80% in 2011/12 (Shimkhada et al. 2012). Note that the figure for 2011/12 is less than the absorption rate for 2009/10 (89%) with the delayed approval of the national budget cited as the reason for the lower absorption rates in 2011/12 (and 2010/11). The better partnership working and aid harmonisation has reduced aid fragmentation (MoF 2011).

Since 2005, there has been good progress in the formulation and implementation of result-oriented strategies in the health sector. The fact that NHSP 1 and NHSP 2 were developed with the joint participation of external development partners (EDP) and other state and non-state stakeholders, indicates the increased partnership working in the health sector. Many EDP programmes and resources, including those of non-pooled funding partners, are now linked to health sector results and strategies. This is a substantial improvement achieved through joint commitments and more partnership working.

2.2 The mechanisms that have strengthened partnerships

Mechanisms have been developed to strengthen donor harmonisation and alignment and foster partnerships in the health sector. MoHP, EDPs and an increasing numbers of non-state actors including INGOs and Nepalese civil society organisations, are now regularly discussing and reviewing national health strategies and programmes at forums such as the joint annual reviews (JAR) and joint consultative meetings (JCM). The government's endeavours have brought more actors into the JAR process thus increasing and diversifying participation. The efficacy of JARs for reviewing progress against results and instruments like the Governance and Accountability Action Plan (GAAP) and IHP+ has improved over the years. However, there may be a need to adjust these mechanisms in order for the government to engage more fully with partners in productive policy dialogue. At the implementation level, technical working groups have helped harmonise activities among different actors; but there is room for the government to exercise better leadership over these working groups.

Since 2004, the health sector EDPs that have been signed up to the SWAp have met every two weeks with the chair and co-chair positions rotating annually. This has contributed to improved harmonisation among them and a more coordinated approach to government interactions. The Association of INGOs in Nepal's (AIN) health sub-group also meets regularly to coordinate activities. However, there appears to be no formal interaction between the AIN and the EDP health groups, which leaves a disconnect between the two most important sets of partners operating in the health sector. It may be argued that, as most INGO health activities are funded by the EDPs, their activities will naturally be reflected through EDPs viewpoints. However, this is not always the case as many INGOs roll out activities using their own financial resources or those from donors not based in Nepal in programmes under agreements with the Social Welfare Council (and not MoHP). These remain outside the purview of the EDPs and MoHP.

More EDPs have become interested in pooling their health sector support funds. In 2012, the German Development Bank (KfW) formally entered into the pooled funding arrangement and committed 10 million euros for fiscal year 2011/12 to 2014/15.

All the pooled funding partners: DFID, AusAID, World Bank, GAVI HSS, KfW plus four non-pool partners: USAID, UNFPA, UNICEF, WHO have signed a Joint Financing Arrangement (JFA) with MoHP. This agreement sets out harmonised procedures for performance reviews, financial management, and coordinating planning, monitoring and review exercises. The government considers this a positive step to fortify partnership working in the health sector (MoHP 2012). The government also sees the Joint Financing Arrangement and the pending Joint Technical Assistance Agreement (JTAA) as instruments to encourage all development partners to align their contributions through MoHP's annual work plan and budget (AWPB) framework. These instruments are also important steps towards the establishment and use of a single monitoring and evaluation framework in the health sector.

2.3 Improving the impact of technical assistance

The effective coordination and implementation of technical assistance in the health sector has been a subject of much discussion. Under the SWAp, the government and EDPs have endeavoured to improve the utilisation of technical assistance. But challenges remain including alignment with national priorities, cost effectiveness, proper utilisation, duplication and the under-utilisation of national knowledge and resources. To address these challenges and improve the efficacy of technical assistance, the government and EDPs are working together to draft and endorse a Joint Technical Assistance Agreement (JTAA). As of December 2012, this agreement had yet to be signed. Some feel that the draft JTAA needs to be revised or replaced with a more pragmatic agreement. Nevertheless, both MoHP and EDPs continue to recognize that some kind of agreement is necessary to assist the government and EDPs to provide more focussed and harmonised and less overlapping technical assistance to support NHSP 2 result areas. Such an agreement would also help identify areas of comparative advantage among EDPs, thus creating more synergy in the sector.

In fiscal year 2012/13, MoHP proposed that a single steering committee be set up to oversee all technical assistance for the health sector. This proposal has been generally well recognized by the EDPs as a way to improve the alignment and harmonization of technical assistance in the sector.

2.4 Improving coordination at regional and district levels

The participation of local stakeholders and communities in health programmes has greatly improved over the years, although there are some mixed feelings at regional and district levels about partnership working, harmonisation and alignment. The continued absence of locally elected representatives undermines downward accountability and adversely affects multi-stakeholder partnership and harmonisation in the sector (Ghimire et al. 2010).

The EDPs operating at district levels seem to have been better at finding their comparative advantage compared to EDP's work at the national level, and a 2011 survey (MoF 2011) found minimal duplication in most programmatic areas, with the exception of HIV/AIDS. On the other hand, the differing ways of working of development partners often creates difficulties for district government institutions to coordinate activities. Agency specific reporting requirements may also tax the limited capacity of local government institutions. Some efforts have been made by the regional health directorates of the mid and far western regions to foster partnerships between health sector actors in

their regions, by setting up mechanisms such as regional health coordination teams and by starting to develop integrated district health planning. The latter attempts to bring state and non-state health sector actors together.

The Local Health Governance Strengthening Programme (LHGSP) is a collaborative programme of MoHP and the Ministry of Federal Affairs and Local Development (MoFALD). It is on-going as a pilot programme in four districts. One of the result areas of this programme is: "… strengthened collaboration among local level institutions… in managing health services effectively, efficiently and equitably." However, as the impact of this programme is yet to be measured, it is not possible to comment on whether or not pilot initiative is strengthening collaboration at the sub-national levels.

2.5 Mapping support

The Aid Management Platform (AMP) was established in 2009 in the Ministry of Finance to map donor support and 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. The effective use of this tool by MoHP and EDPs should contribute to better alignment and harmonisation. The platform now encompasses 462 programmes and projects that in fiscal year 2010/11 disbursed USD 1.08 billion (MoF 2012). It is being rolled out to all local development partners and line ministries in fiscal year 2012/13.

It has proved difficult for MoHP to map all the support provided by INGOs to the health sector. This is largely due to the fact that many INGOs do not report to MoHP on their support to the health sector and are only obliged to report to the Social Welfare Council. From 2012/13 MoF has started to roll-out AMP to the INGOs and as of December 2012, 13 INGOs are reporting their support to AMP and this number is expected to increase to give a better picture of INGO support to the government and the EDPs.

2.6 The IHP+ Country Compact to foster partnership

In 2007, Nepal became one of the first wave countries to sign the International Health Partnership (IHP+). IHP+ aims to strengthen health aid-effectiveness and the health partnership agenda at global and country levels. The IHP+ Country Compact, locally known as the Nepal Health Development Partnership, was signed in February 2009 between the EDPs and the government. This compact has reinforced earlier commitments to partnership and aid effectiveness, and is contributing to improvements in this area (IHP+ 2010). It proved helpful when EDPs and the government worked together to design NHSP 2. The compact has also contributed to an increasing role for civil society in the health sector as the five regional discussions on developing the compact were led by civil society (Pokharel 2009). Nepal has made good progress implementing the compact (Taylor et al. 2012).

2.7 State to non-state partnerships

In fiscal year 2012/13, MoHP drafted a 'State Non-state Partnership Policy for the Health Sector in Nepal'. The overall objective of this policy is to "achieve equitable access to quality health care for all citizens of Nepal by promoting and facilitating a synergistic relationship between state and non-state health care providers" (MoHP 2012). A draft policy has been circulated and it is expected to be endorsed in 2013.

In 2012, MoHP embarked on an initiative to strengthen district health care systems by partnering them with academic institutions such as the Institute of Medicine. This initiative aims to improve the clinical care at district hospitals and primary health care centres (PHCCs) by assigning senior residents and specialized faculties (e.g. in paediatrics, internal medicine, dentistry, surgery and anaesthesiology) from the academic institutions. Health facilities in three districts have been identified to introduce this initiative. Field visits to these sites have been undertaken and memoranda of understanding are expected to be signed between the academic institutions and MoHP in 2013.

Below are a few examples of on-going state to non-state partnership schemes:

- For safer motherhood, the Aama programme has partnered with registered private health care service providers to provide delivery care, thus giving pregnant women the choice of opting for public or approved commercial and non-profit service providers for free delivery care. The government compensates private providers on a unit cost basis, with the cost depending upon the complexity of deliveries.
- For treating uterine prolapses, regional health directorates are assessing and selecting interested service providers, with treatment provided free of cost with the government compensating the provider. As of 2012, more than 11,000 women have been treated for this condition with 95% treated by the private sector1.
- For specific family planning services, the government provides the private sector with contraceptive commodities while private providers reciprocate by meeting the costs of service delivery and logistics at certain public health facilities.
- The National Tuberculosis Centre (NTC) frequently orientates and trains the staff of private health facilities to identify tuberculosis cases while private service providers routinely refer cases to the NTC.
- Public-private partnerships are on-going for eye care and treating kidney ailments.

2.8 Multi-sectoral collaboration

Efforts have been made in the past for collaboration with other sectors including the school health programme with the education sector and urban health with the local governance sector. In recent years there has been renewed interest in promoting multi-sectoral collaboration.

In 2012, the National Planning Commission (NPC) launched a Multi-Sector Nutrition Plan (MSNP, 2013-2017). This plan aims to bring together seven government line agencies (NPC, MoHP, MoF, MoFALD, Ministry of Education, Ministry of Agriculture and Cooperatives, and Ministry of Physical Planning and Works) to tackle maternal and child under-nutrition. The plan was developed through consultations between the seven lines agencies, their development partners and civil society organizations. A High Level Food and Nutrition Steering Committee has been set up to oversee implementation of the plan.

Multi-sectoral collaboration between MoHP and MoFALD has also progressed in 2012 in strengthening local health governance and on civil registration and vital statistics.

[1] As reported by Family Health Division of the Department of Health Services to the author.

3 KEY CHALLENGES

3.1 EDP technical contributions not fully harmonised

Despite improvements in harmonisation through the JARs and joint consultative meetings (JCM), EDPs have yet to fully enter into the spirit of harmonisation as outlined in the Paris Principles. For example, despite the government's regular requests, EDPs have not consolidated and presented the details of their technical contributions to the health sector (MoHP 2009 and 2010a). However, the Technical Assistance Matrix (TA matrix) produced by EDPs during the 2012 JAR can be further refined as a viable tool to showcase their contributions. Similarly, EDPs largely continue to use separate monitoring and evaluation missions which, among other effects, increases transaction costs for EDPs and the government and the government. Currently the AIN INGO health group and EDPs do not interact enough to harmonise their support, and some form of formal interaction mechanism needs to be established.

3.2 Poor alignment with government institutions

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

3.3 Unpredictability of aid funding

Although the predictability of funds is improving as some EDPs make multi-year estimates, most EDPs are not able to do this. It is particularly INGO support channelled directly through the Social Welfare Council that by-passes MoHP. This hampers the predictability of support and weakens partnership working in the 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 cycle, 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.

3.4 Human resource constraints

The frequent transfer of human resources and difficulties retaining government staff has hampered effective partnership. In addition, many government staff (especially those working at the implementation level) are not adequately aware of the aid effectiveness agenda, including concepts of partnership, harmonisation and alignment. Comprehensive capacity development is needed in this regard. MoF's aid effectiveness project has begun training officials of different ministries on aid effectiveness, although only a few officials have been trained.

3.5 Lack of a process for change management

At the time of the development of Nepal's Country Compact it was well known that most IHP+ partner institutions around the world had not made adequate provisions for embarking on the change management process inherent to IHP+ (Conway et al. 2008). In spite of this, Nepal's compact contained no explicit statement about how change management could be influenced. The tendency to conduct business as usual persists among government and the EDPs, thus undermining the efficacy of IHP+ as a partnership instrument.

3.6 Lack of focus on IHP+

IHP+'s Scaling-up Reference Group (its steering group) recognises that "better communication, particularly at country level, is urgently needed so that all stakeholders better understand the objectives of the IHP+ and its relationship to similar initiatives" (IHP+ SuRG 2008). However, many government and EDP officials and stakeholders either do not fully understand the scope of IHP+ or have no knowledge of it. Nepal's compact is rarely discussed or referred to at JAR meetings. For example, apart from the JAR meeting of January 2010 when 30 minutes were allocated to the presentation on IHP+ as the international IHP+ core team was visiting Nepal, and a brief discussion during the January 2011 JAR, no space has been dedicated for specific discussions on IHP+ and the country compact.

3.7 Mapping technical assistance

The overview (mapping) of technical assistance provided by the EDPs remains sketchy. It is not clear how their technical assistance contributions are made for achieving specific NHSP 2 result areas. Despite the efforts to include INGOs support in the Aid Management Platform it remains a challenge to map all the support to the health sector provided by INGOs.

4 LESSONS LEARNED

Partnership mechanisms such as the SWAp, the IHP+ Country Compact and the JARs have created greater harmonisation among many of the major development partners and better collaboration of the EDPs with the government. This has resulted in reduced overhead costs for EDPs and MoHP and has contributed to steady improvements in the effectiveness of MoHP planning and spending. Aid fragmentation and duplication has been reduced although more partners need to be encouraged to participate in harmonisation efforts. The success of these efforts rests on the commitment of all partners and the establishment of effective coordination mechanisms. A more harmonized approach towards technical assistance is needed through joint agreements between MoHP and the EDPs.

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

5 THE WAY FORWARD

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

***Joint technical assistance**:* In 2011, EDPs developed a joint technical assistance matrix to highlight their joint contributions to the health sector and a joint EDP–MoHP field monitoring visit also took place in early 2012 prior to the JAR for 2012. These initiatives need to be developed and institutionalized. Among other things, they can help in better aligning the technical assistance towards national strategies and to make contributions explicitly address specific NHSP 2 objectives.

***District and regional level harmonisation**:* A greater focus is needed on improving partnership and harmonisation at district and regional levels to better coordinate activities and help local authorities manage the multiple projects and actors in their areas. Mechanisms for bringing state and non-state health sector actors together, such as the regional health coordination teams and integrated district health planning in the mid and far western regions, should be assessed, and where feasible replicated in other regions. The progress made by the Local Health Governance Strengthening Programme and the potential contribution of such programmes to strengthening partnership and collaboration at the sub-national level should also be assessed.

***State to non-state partnerships**:* The draft State to Non-state Partnership Policy needs to be endorsed and strategies put in place to implement it.

Technical working groups and committees: The Nepal Health Sector Support Programme (NHSSP) has recently supported the mapping of the many committees, technical working groups and other entities that exist in the health sector (Dixit and Karn 2012). The lessons drawn from this exercise need to be addressed to minimize duplication and improve the efficacy of these committees and groups. There is also a need for the government to exercise better ownership and leadership over the many groups and committees to which it belongs.

Technical assistance agreement: A joint agreement between MoHP and the government is needed to better align and harmonize technical assistance in the health sector.

Expanding multi-sectoral collaboration: Following the example of the Multi-Sector Nutrition Plan, the government should explore other areas, such as water, sanitation and hygiene, where multi-sectoral collaboration can be fostered.

Interaction with INGOs: Regular interactions between the EDPs and the INGOs need to occur. One way of doing this would be to invite representatives from AIN's Health Task Group every three months to the EDP's regular meeting.

Mutual accountability scorecard: A Mutual Accountability Score Card exercise from both MOHP and EDPs need to be institutionalized. It will help in tracking the commitments made by both partners'.

REFERENCES

Conway, Shaun; Andrew Harmer and Neil Spicer (2008). International Health Partnership: 2008 External Review. London: London School of Hygiene and Tropical Medicine.

Dixit Devkota, Madhu and Sumit Karn (2012). Review of Committees, Working Groups and other Entities under the Ministry of Health and Population, Nepal. Kathmandu: MoHP and NHSSP.

Ghimire, Kapil Dev; Bal Gopal Baidya and Paul Thornton (2010). Joint Evaluation of the Paris Declaration Phase II: Nepal Country Evaluation 2010. Kathmandu.

IHP+ SuRG (2008). Response to the 2008 Short Term External Review. IHP+ Scaling-up Reference Group.

IHP+ (2010). IHP+ Results 2010 Performance Report. International Health Partnership.

MoF (2011). 2011 Survey on Monitoring the Paris Declaration: Nepal Country Report. Kathmandu: Ministry of Finance.

MoF (2012). Development Cooperation Report: Fiscal Year 2010/11. Kathmandu, Ministry of Finance.

MoHP (2009). Ninth Joint Annual Review: Summary. Kathmandu: Ministry of Health and Population.

MoHP (2010a). Tenth Joint Annual Review: Summary. Kathmandu: Ministry of Health and Population.

MoHP (2010b). Nepal Health Sector Programme II (2010-2015): Final Draft. Kathmandu: Ministry of Health and Population.

MoHP (2012). State Non-State Partnership Policy for the Health Sector in Nepal: Final Draft. Kathmandu, Ministry of Health and Population.

Pokharel, Girirajmani (2009). Delivering on Commitments of IHP+: The Challenges and Opportunities. Paper presented at the high level meeting on International Health Partnership, Geneva, 4 February 2009 by Minister for Health and Population Pokharel, Girirajmani Pokharel.

Shimkhada, Shiva; Mohan Thapa; Suresh Tiwari and Shiva Pandit (2012). Progress Report on Financial Management — 2011/12. Kathmandu: Ministry of Health and Population.

Taylor, Martin; Louisiana Lush; Shaun Conway; Nicole Neumeister; Mialy Dermish; Alice Schmidt; Adi Eyal and Etienne Kruger (2012). Progress in the International Health Partnership and Related Initiatives: 2012 Annual Performance Report. IHP+.

Tiwari, Suresh; Susheel Chandra Lekhak; Prabha Baral; Rajan Adhikari; Lila Raj Poudel; Mohan Bahadur Thapa and Tomas Lievens (2011). Budget Analysis 2011/12. Kathmandu.