Nepal Health Sector Support Programme III

(NHSSP – III)

Strengthening local planning and budgeting to deliver Basic Health Care Services: lessons from selected local governments

Table of Contents

ABBREVIATIONS 4
Executive Summary 5
1. Introduction 8
1.1 Background 8
1.2 Scope and Objectives 8
1.3 Analysis approach 8
1.4 Limitations 9
2. Framework for planning and budgeting at local level 9
2.1 Shift in planning process: from unitary to federalism 9
2.2 Seven steps for planning and budgeting at local level 9
2.3 Components governing planning and budgeting at local level 10
3. Planning and budgeting practices in LL Sites 12
3.1 Federal and provincial roles in local planning 13
3.2 Governance structure for planning at local level 14
3.3 Use of available evidence in the planning process 16
3.4 New initiatives addressing local level needs 20
4. Flow of funds and budgetary patterns 21
4.1 Mechanisms of fiscal transfer 21
4.2 Composition of fiscal transfer and resource base at subnational level 21
4.3 Analysis of local level budget as per functions 23
4.4 Analysis of local level budget as per LNOB 24
5. Key Findings and policy implications 26
References 28
Appendices 29
Annex 1: Details on LL Planning and Budgeting Process 29
Annex 2: Interrelationship and sequencing towards annual development plan 30
Annex 3: AWPB Implementation Framework 30
Annex 4: Policy and Programmes of LGs aligned with their respective AWPBs 31
Annex 5: The decision-making process for health budget allocation in Pokhara 32
Annex 6: Ajaymeru Weightage Calculations for Programme Prioritisation 32
Annex 7: Planning in Kharpunath Rural Municipality (KRM) 33
Annex 8: Kharpunath Health Facilities MSS Scores, and Resource Allocations 34
Annex 9: OCA lessons 34

Annex 10: Workload re-adjustment case study 35
Annex 11: Sources of revenue and mechanisms of fiscal transfer 36
Annex 12: Composition of intergovernmental fiscal transfer for province and local level, 2018/19 36
Annex 13: Local level equalisation and conditional grants, in million NPR 36
Annex 14: Number of budget heads in health sector conditional grants, LL sites .. 37
Annex 15: Composition of health sector conditional grants in LL sites, 2020/21 ... 37
Annex 16: Comparative Scenario of Annual Budget in LL sites 38

ABBREVIATIONS

ANC	Ante Natal Care
ARM	Ajaymeru Rural Municipality
AWPB	Annual Work Plan and Budget
BHS	Basic Health Services
CAO	Chief Administrative Officer
COVID-19	Coronavirus Disease 2019
DCC	District Coordination Committee
DHIS 2	District Health Information Software 2
DM	Dhangadhimai Municipality
FCHV	Female Community Health Volunteers
FY	Fiscal Year
GoN	Government of Nepal
HF	Health Facility
HFOMC	Health Facility Operation and Management Committee
HMIS	Health Management Information System
ISC	Itahari Sub-metropolitan City
LG	Local Government
LGOA	Local Government Operation Act (2017)
LL	Learning Lab
LMIS	Logistics Management Information System
LNOB	Leave No One Behind
M&E	Monitoring and Evaluation
MoF	Ministry of Finance
MoFAGA	Ministry of Federal Affairs and General Administration
MoH	Ministry of Health
MoHP	Ministry of Health and Population
MSS	Minimum Service Standards
MTEF	Medium Term Expenditure Framework
NHSSP 3	Nepal Health Sector Support Programme 3
NNRFC	National Natural Resources and Fiscal Commission
NPC	National Planning Commission
NPR	Nepalese Rupee
OCA	Organisational Capacity Assessment
PMC	Pokhara Metropolitan CIty
RDQA	Routine Data Quality Assessment

EXECUTIVE SUMMARY

The UK aid-funded Nepal Health Sector Support Programme 3 (NHSSP) is supporting Nepal's Ministry of Health and Population (MoHP) in implementing the Learning Lab (LL) approach, with the primary objective of strengthening health systems at the local level. The overall scope of this report is to document the ongoing approaches and lessons to strengthening planning and budgeting at the local level for the delivery of basic health services. Existing provisions, practices, and lessons in planning and budgeting at LL sites were reviewed and analysed. It is expected that lessons from the selected Local Governments (LGs) will contribute for strengthening planning and budgeting in the local levels beyond the LL sites. The specific objectives are:

- Describe the existing framework for planning and budgeting at the local level;
- Summarise the planning and budgeting practices happening in LL sites;
- Draw lessons from the experiences and initiatives taken in the LL sites which can contribute to evidence-based decision making at all levels; and
- Provide recommendations for the strengthening of planning and budgeting at the local level.

Local level planning and budgeting: the framework

LGs are the administrative units on the frontline that provide public services in the federal structure, and are held accountable and responsible for addressing basic human rights including delivering health services. This is a fundamental departure from the highly centralized "unitary" governance system in the past. Federal and provincial legal and policy documents and guidelines provide the general framework for local governments to prepare their Annual Work Plan and Budget (AWPB). Based on these Acts and regulations, local governments develop their own laws, including their Finance Act and Appropriation Act. The major components governing planning and budgeting at the local level include constitutional provisions; policies, laws, and plans; Medium term expenditure framework (MTEF); Annual Planning and Programmes; Framework for Fiscal Transfer; Programme/Project Banks; Municipal Challenges and Prospects; and finally, the programme implementation framework.

There are seven steps in local level planning and budgeting, and all are detailed below. This AWPB cycle begins in February and ends in July every year, and requires harmonisation and coordination across the three tiers of government. Besides the AWPB cycle, some level of program planning is continuous throughout the year, especially to address issues arising during program implementation and during the monthly and quarterly reviews.

Financial authorities are exercised by elected representatives and the Chief Administrative Officer (CAO). The Local Government Operations Act 2017 (LGOA) defines the executive roles of the Mayor/Chairperson, Deputy Mayor/Vice-Chairperson, Ward Chairpersons and all members of the Municipal Council; the functions, duties and rights of the CAO; and establishes several committees that are key to the budget planning and allocation processes. These are defined further below.

Local level planning and budgeting: in practice

The realities of planning and budgeting were examined in the selected LL sites supported by NHSSP. The insights are grouped in four parts: (1) federal and provincial roles in local planning, (2) governance structure for planning at local level, (3) use of available evidence in the planning process, and (4) new initiatives addressing contextual needs. Several specific examples from LL sites are included. Key insights include the following:

Federal and provincial roles in local planning

- Local levels do strive to align with federal and provincial level policies and programmes, but there are examples still of similar activities being funded by different levels;
- There are still too many budget heads under the Federal conditional grants, reducing flexibility to address local needs.
- Delays in sending the budget and the implementation guidelines from the federal and provincial level is (still) not uncommon;
- "Policy and programme" documents usually precede the AWPB and therefore set the priorities for the AWPB;

Governance structure for planning at local level

- The Budget Formulation Committee and Sectoral Committees are mainly responsible in the planning and budgeting process;
- There is increasing clarity on the local level role in health sector management;
- Local Level planning and budgeting includes sectoral planning at the municipal (palika) level and area-focused planning at the ward level;
- Budgets were found to be divided equally between wards despite unequal needs.
- Prioritisation of the program and activities proposed for AWPB varies across LGs;
- Different factors have contributed to gradually prioritising the health sector in the local level planning and budgeting;
- Budget proposals from divisions and sectoral committees usually exceed the ceilings and are adjusted in the finalization process;

Use of available evidence in the planning process

- Local levels are expected to develop a Master Plan, Periodic Plan, and Medium Term Expenditure Framework (MTEF) to feed into the planning process. Some LGs develop them, some do not;
- The programme bank, Municipal profiles, case studies, and learning briefs were found to be instrumental in the planning process particularly to prioritise resources;
- There are multiple tools to support evidence-based decision making and planning at the local level, including: information system reports; checklists; sector profiles; review meeting and committee minutes; cross-sectoral and cross-municipality meetings; public statements from political leaders; and capacity enhancement tools (such as Minimum Service Standards [MSS], Routine Data Quality Assessment [RDQA], and Organisational Capacity Assessment [OCA]). These are described in detail at #3.3.4.

New initiatives addressing local level needs

- Focus on both supply and demand: performance-based incentives;
- Nutrition allowances targeting marginalised communities;
- Workload-based readjustment of the health workers.

<u>Flow of funds and budgetary patterns</u>

There are three major categories of revenue for the local level: (1) distribution of revenue and royalty, (2) federal and provincial grants, and (3) revenue internally generated by respective local levels. Grants are the most significant source and include conditional grants, equalisation grants, complementary grants, and special grants. The MoHP prepares implementation guidelines for conditional grants setting the terms and conditions for how activities should be operationalised, and there is little flexibility to adapt locally. Funds are not necessarily provided for all the local level functions outlined in the LGOA. Evidence was varied in terms of the Leave No One Behind (LNOB) and gender responsiveness of local

budgets: 77% was directly or indirectly gender responsive but only 49% was directly or indirectly LNOB responsive.

Lessons and recommendations

Several lessons are drawn, with the following recommendations:

Planning alignment

1. While making Federal conditional grant provisions, areas of additional financing from provinces or local levels should be indicated to avoid duplication and enhance alignment across all three levels;
2. Either the activities in Conditional Grants should be further merged, with specific guidelines on what they should be spent for, or more flexibility should be provided to partially switch budget from one activity head to another;
3. Local level performance should be also be analysed at district level. Monthly review meetings at the district level are found to be effective;
4. Support more effective procurement coordination to ensure continuous availability of medicines at the health facility level;
5. The budget and implementation guidelines need to be sent out in a timely manner from the federal and provincial levels;

Generating evidence through management tools

6. Introduce and maintain the OCA, MSS, and RDQA tools in each LG;
7. Develop a separate MSS tool for those Primary Health Care Centres which are not to be upgraded to primary hospital but need to function at higher capacity than a Health Post.
8. Ensure that local levels develop MTEF during the planning process;
9. Establish a programme bank at each LG site;
10. Support LGs to prepare municipal profiles and fact sheets and institutionalize in the sites where this has been started;
11. Update the health facility registry so that the database in the Health Management Information System can also be corrected and maintained;
12. Work with MoHP to standardize health facility nomenclature. After this standardization, ensure appropriate MSS tools exist for all levels;

Coordination and meetings

13. Organise monthly health sector review meetings, perhaps rotating between different health facilities;
14. Ensure regular monitoring and documentation of progress at the local level and feed results into the decision-making process at the higher level;

Human resources

15. Support the practice of assigning focal persons for thematic areas at local level.

1. INTRODUCTION

1.1 Background

Under federalism, the governance structure in Nepal includes the federal government, seven provinces, and 753 units of local government (LG). Local governments are of four types, namely metropolitan cities (6), Sub metropolitan cities (11), Municipalities (276) and Rural Municipalities (460). Functions of different levels of governance were analysed and assigned[1] and the institutional structures were re-organised across the three levels. While federalism provides for more responsive planning and budgeting, challenges remain to systematically connect health system functions across the three levels to ensure quality basic health services (BHS). The District Coordination Committee (DCC) exists in the new structure with very limited role. The major role of the DCC is to coordinate with the government agencies within the district as required. However, they do not have roles and authority in service delivery and the development.

The Local Government Operation Act (LGOA) defines legal provisions for local government operations, roles, and responsibilities. Like federal and provincial levels, local levels have mandates to develop policies and legal frameworks, and to conduct planning and budgeting exercises. Hence, the health programme content at local level must combine plans and budgets from all three levels. Funds are primarily provided via conditional grants, mainly from the federal level. Besides conditional grants, local levels pool resources from equalisation, special, and complementary grants (from federal and provincial levels), revenue distribution, and from local taxes and other revenue streams. All these resources can be used to support BHS.

The UK aid-funded Nepal Health Sector Support Programme 3 (NHSSP3) supports the MoHP in the implementation of the Learning Lab (LL) approach, with the primary objective of strengthening health systems at the local level. The LL approach originally aimed to strengthen planning and budgeting through evidence-based decision making, but its scope evolved to strengthen local health systems, particularly BHS, with a focus on capacity enhancement.

1.2 Scope and Objectives

The overall scope of this report is to document the LL approaches and identify key lessons. Existing planning and budgeting provisions, practices, and lessons from the LL sites were analysed. It is expected that lessons from the LL sites will contribute to strengthening planning and budgeting in other LGs. The specific objectives are:

- Describe the existing framework for planning and budgeting at the local level;
- Summarise the planning and budgeting practices and experiences in LL sites;
- Draw lessons that can contribute to evidence-based decision making at all levels; and
- Provide recommendations for the strengthening of planning and budgeting at the local level.

1.3 Analysis approach

The following outlines the approach to the analysis:

- Desk review of the existing provisions for planning and budgeting, particularly at the local level;

[1] Functional Analysis and Assignments, Government of Nepal. Local Government Operation Act.

- Analysis of budget data including conditional grants and internal allocation of the health sector budget at the local level;
- Review of the periodic progress reports of the LL sites internally produced by NHSSP;
- Consultation within the NHSSP team, with Health Coordinators at the local level, and with other stakeholders;
- Analysis of specific cases and contextual factors that were found effective towards strengthening planning and budgeting, prioritizing “leave no one behind” (LNOB); and
- Review of budgeting practices of the conditional grant and implementation guidelines over the last few years to assess gaps and draw lessons.

1.4 Limitations

This report is mainly based on the implementation experiences and lessons from the LL sites, and hence is not necessarily representative of the country. However, to the extent possible, and based on the available literature, the situation is analysed within the wider context of the country, and lessons are drawn that could potentially be replicated in other local levels.

2. FRAMEWORK FOR PLANNING AND BUDGETING AT LOCAL LEVEL

2.1 Shift in planning process: from unitary to federalism

Before the federal structure, there was 14-step planning process that district level authorities followed to formulate their Annual Work Plan and Budget (AWPB). In that “unitary” system, the District Development Committee (DDC) and Village Deveopment Committee played pivotal roles in the planning and implementation processes. district level offices of the Ministry of Health (MoH), i.e., District [Public] Health Offices, were responsbile for sectoral planning in coordination with the MoH, peripheral health facilities (HF), and with the DDC. Under the current federal structure, a seven-step planning process was defined for the preparation of local level AWPBs. In this structure, municipal (palika) and ward offices play crucial roles in the planning process, coordinated by Sectoral Committees and responsible Divisions or Sections.

Various national-level documents provide the legal and operational frameworks for local level planning and budgeting. Important documents include:

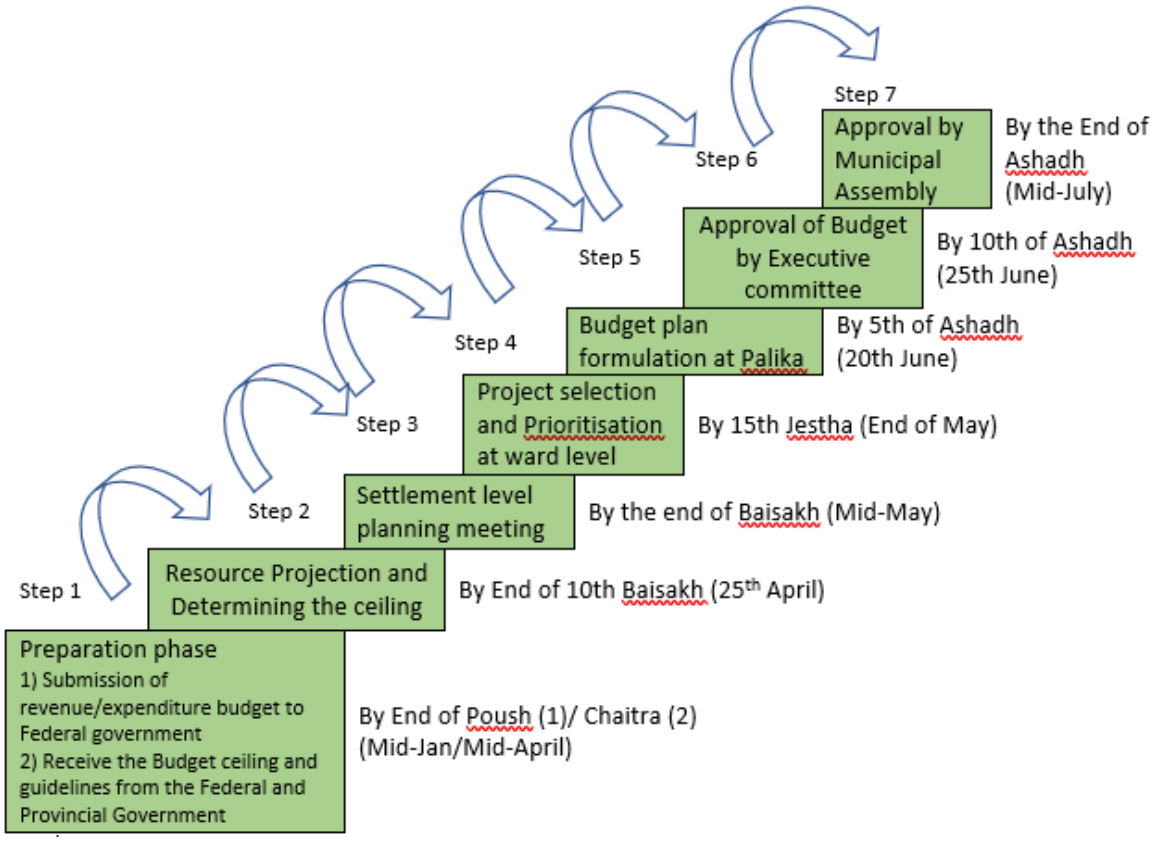
- Local Government Operation Act, 2074 [2017]
- Intergovernmental Fiscal Transfer Act, 2074 [2017]
- Reference guidelines for Local Level Planning and Budgeting, 2017 (MoFAGA)
- Handbook for Local Level Planning and Budgeting, 2020 (MoFAGA)
- Planning and Budgeting Guidelines for the Local Level (National Planning Commission)
- Planning and Budgeting Guidelines for the Health Sector, 2018 (MoHP)
- Programme Implementation Guidelines, various years (MoHP)

2.2 Seven steps for planning and budgeting at local level

Guidelines developed after the federal structure mandate the seven-step planning process for local levels. The LGOA outlines the framework and process of planning and budgeting. In 2017, the Ministry of Federal Affairs and General Administration (MoFAGA) endorsed a

guideline that elaborates the planning process for the local level. The seven-step planning process is shown in Figure 1, with major highlights detailed in Annex 1:

Figure 1: Timeframe for Formulation of Annual Work Plan and Budget at the Local Level



2.3 Components governing planning and budgeting at local level

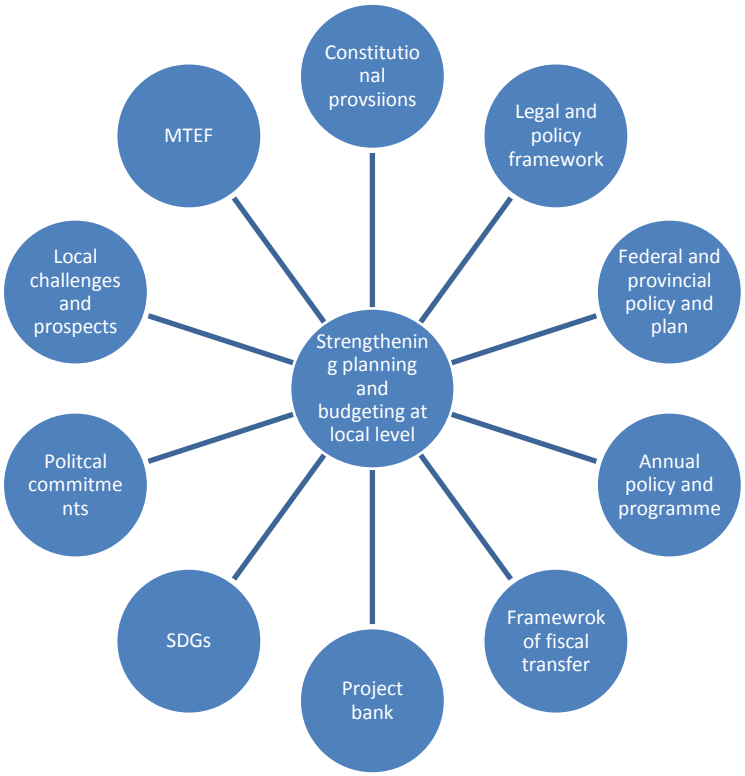
Other laws and guidelines developed by the federal parliament and concerned sectoral ministries also provide directives for local level planning and budgeting:

- The National Planning Commission (NPC) developed a guideline to facilitate the formulation of development plans in light of resource availability, institutional capacity, and local needs. This guideline aims to align the national and provincial level visions and strategies with the local level plan, bring uniformity in the management of development plans across local levels, and facilitate the fulfilment of international commitments. The interrelationship and sequencing for the preparation of the annual plan is presented in Annex 2.
- The LGOA includes a section on “planning and implementation” and makes the following important provisions for local level planning and budgeting:
  - Local levels should prepare periodic and annual plans;
  - Plans should be compatible with provincial and federal policies, targets, objectives, timeframe, and procedures;
  - Estimates of revenue, prioritization of projects, an execution plan, and a monitoring and evaluation (M&E) plan should also be included in local level plans;
  - For special programs, implementation should be as per the specific procedure defined by provincial and federal government.

- The MoHP also developed two sets of guidelines: (1) the 2018 health sector annual planning and budgeting guidelines for the local level, and (2) annual health sector programme implementation guidelines and operational procedures for activities included in federal conditional grants.

Taken all together, the major policy and legal framework tools for local level AWPB are shown in Figure 3, and summarised below:

Figure 3: Crucial components contributing towards strengthening planning and budgeting process



Source: Based on MOFAGA (2020) and NPC (2019)

Constitutional provisions: Local level health sector management is linked to the Constitution which establishes the right to 'free' basic health services, mandating delivery by LGs.

Policies, laws, and plans: Each of the three government levels is mandated to develop their own policy and legal framework, sequenced to ensure alignment of programme design and implementation, and a master plan, strategic plan and periodic plan:

- The **master plan** may be sector-specific but usually includes multisectoral aspects to ensure the integrated development plan is aligned with achieving the broader development goals.
- The **periodic plan** is a shorter-term strategic plan formulated to cover three to seven years period and developed based on meeting the overarching goals of development framework of master plan. Periodic plans are usually comprehensive plans based on the local socio-economic context.
- The **strategic plan** is the result-oriented short-term plan to achieve the aim of the master and periodic plans. They are usually sector specific and account for the

strategic direction to achieve the goals directed by the periodic plan. These plans support the effective execution of the development plan with specified targets and results along with the investment of resources over the time period.

Medium term expenditure framework: The MTEF is the structural framework forecasting sectoral expenses with respect to the sources of revenues, sectoral goals, and key result indicators, summary of prioritised programmes and activities, and sources of grants to cover those expenses for three consecutive fiscal years.

Annual Policy and Programmes: The LG Budget and Programme Formulation Committee develop their annual policy and programme, before the announcement of the annual budget, based on the periodic plan, sectoral policy decisions, investment priorities, contextual needs, and resource capacity. Annual policy and programmes are guiding documents to frame the AWPB for the upcoming fiscal year (FY).

Framework of Fiscal Transfer: The federal "Intergovernmental Fiscal Arrangement Act (2017)" defines the fiscal arrangement across the three tiers of government. According to this Act, all three levels of government are authorised to levy Tax, Non-tax and Royalty within their tax and non-tax jurisdiction. The Act also refers to revenue sharing of such income from the value added tax and excise duty, and royalty income reserved to a consolidated fund to share among the three levels. Furthermore, the Government of Nepal (GoN) has provided for various grants, including (1) Conditional grants for implementation of the programs which are prioritised at national level with some conditions of execution, (2) Equalisation grants as per the expenditure needs and capacity of revenue collection, (3) Special grants, and (4) Complementary grants. The different sources of revenue including the mechanism of fiscal transfer is presented in Section 5 below.

Formulation of Programme/Project Bank: The "Programme bank" is the collective plans and programmes formulated at ward or municipal level that lists out the candidate project and programme to address the real and perceived gaps identified during program implementation. The programme bank should back up the periodic and strategic plans, and identify priorities to feed into the AWPB.

Municipal challenges and prospects: As a part of budget preparation (Step 1, Figure 1), the LGs review progress on the key indicators of the development plan, and sectoral progress. Local levels are also expected to develop a municipal level profile and factsheets depicting the existing situation including challenges and prospects. The key issues and gaps are identified for the priority programme of LGs to facilitate the AWPB process.

Programme implementation framework

After the approval of the AWPB and Appropriation Act from the local municipal assembly, the implementation of AWPB begins. The implementation of AWPB is guided by the fiscal and appropriations Act, Local Acts, and guidelines. The AWPB implementation process is detailed in Annex 3.

3. PLANNING AND BUDGETING PRACTICES IN LL SITES

Where Section 2 outlined the theory of how local level planning and budgeting *should* happen, Section 3 offers insights into how planning and budgeting is done in practice in the select LL sites supported by NHSSP. The insights are grouped into four buckets: (1) federal

and provincial roles in local planning, (2) governance structure for planning at local level, (3) use of available evidence in the planning process, and (4) new initiatives addressing contextual needs. Several specific examples from LL sites are included. Several insights are drawn from experiences of using planning tools to better inform the local level AWPB cycle.

3.1 Federal and provincial roles in local planning

3.1.1 There are two insights related to Federal-Provincial-Local level alignment:

- **Local levels do strive to align AWPB with federal and provincial level policies and programmes.** In line with the federal level policy and plan, activities proposed for LGs included establishing a Primary Hospital at each LG, strengthening the basic healthcare service package, establishing a COVID-19 temporary hospital, and expanding the health Insurance program. In Itahari, Dhangadhimai, and Kharpunath, for example, all three of these activities were included in their AWPB, and some LGs added their own additional resources as well.
- **There are examples of similar activities being funded from different levels requiring effective alignment in the planning process.** Provinces have also started providing conditional grants to the local level which include health sector activities. But in the absence of a clear financing model for health sector programmes there are instances of similar activities being financed from the federal and provincial grants and from local internal revenues. For example, in 2020/21, communication expenses for the Female Community Health Volunteers (FCHVs) and improvements to the MSS are among the most common health sector activities provisioned by Bagmati province for the local levels. These are also the areas for which conditional grants have been provided from the federal level and many of the local levels have also allocated additional budget. This may indicate duplication in budgeting.

3.1.2 There are still too many budget heads under the conditional grants, reducing flexibility to address local needs. Health sector conditional grants to the local level are broken down into multiple activities, with operational procedures detailed through implementation guidelines. Although the number of budget headings in conditional grants has reduced since 2017/18, there are still many, and that limits the scope for flexibility to readjust the plan and budget from what has been provided centrally.

3.1.3 There are still delays in sending the budget and the implementation guidelines from the federal and provincial levels. For AWPB implementation, the Ministry of Finance (MoF) made a provision to develop or revise necessary working procedures and guidelines by the end of Shrawan (mid-August) and to develop or revise regulations by mid-Bhadra (early September)[2]. However, in practice, there are challenges in ensuring timely availability of the implementation guidelines from the MoHP.

3.1.4 "Policy and programme" usually precede the AWPB and therefore set the priorities for the AWPB. LGs should develop a "Policy and programme" document for the next fiscal year which covers the major prioritised plans and activities that have significant impact, and therefore should form part of the AWPB. Some LGs published the Policy and programme separately before the AWPB was endorsement by LG council, and some published along with the budget speech (along with publishing of the Redbook). Examples of the Policy and Programme in LL sites that influenced their AWPBs are presented in Annex 4.

[2] MoF (2019), Budget implementation related Guidelines (Margadarshan) for the fiscal year 2019/20.

3.2 Governance structure for planning at local level

3.2.1 There is increasing clarity on the role of the local level for health sector management. Recently in September 2020, the GoN published the package of basic health services as an internal part of the Public Health Services Regulations[3]. This has brought much clarity in terms of what specific responsibilities local levels for the provision of health services. The National Health Policy, 2019[4] has stated that provinces and local levels can add on services in the list of BHS package as necessary, subject to funding from the respective level. Many of the local levels have prioritised ensuring the availability of the minimum services in line with the MSS which is in accordance to the federal policy.

3.2.2 The Budget Formulation Committee and Sectoral Committees are mainly responsible in the planning and budgeting process. LGOA created two high-level Committees in relation to the AWPB cycle: the Resources Estimates and Budget Ceiling Determination Committee (Coordinator: Municipal Chair), and the Budget and Programme Formulation Committee (Coordinator: Deputy Chair)**.** As per federal guidelines, the overall development sector has been categorised into five sub-sectors for planning and management purposes: infrastructure development, social development, organizational development (including governance), economic development; and environmental and disaster management[5]. A majority of the LGs have established all five thematic sectors, though some LGs have merged some sectors. The LG budget ceiling is calculated by pooling the funds that local levels receive from different sources which mainly include different types of grants from federal and provincial levels, revenue transfers from federal and provincial levels, and administration tax and non-tax measures at the local level. Budget ceilings are then allocated by the Budget and Programme Formulation Committee to the sectoral committees (further split for concerned divisions/sections) and ward committees.

3.2.3 Local Level planning and budgeting includes sectoral planning at the municipal level and area-focused planning at the ward level. Based on the available resource envelope, budget is provisioned for administrative expenses (e.g., salary of the municipal staff and other non-programmatic obligations). After that, the budget ceiling is divided into two components: a) budget for sector planning at the municipal level, and b) budget for ward level planning. Separate planning teams are formed for each sector at the municipal level, led by elected representatives and consisting of relevant municipal staff. At Ward level, Ward Chairs and Ward Secretaries are key planning actors who coordinate with people from different sectors and communities. These two components of the plan are compiled back at the municipal level and finalized for the submission in the executive council for the endorsement. The decision-making authority to finalise the AWPB remains with the Budget Planning and Formulation Committee. An illustrative example of this from Pokhara Metropolitan City (PMC) is provided in Annex 5.

3.2.4 Budgets were found to be divided equally between wards despite unequal needs, and political influence is strong. Given variation in population and other needs, ward level ceilings can be expected to vary from one to another. Even guidelines from the NPC (2020) state that the budget should not just be uniformly divided across the wards. However, in practice, many of the local levels tend to allocate the same budget ceiling to their wards. Among the LL sites of Dhangadhimai, Itahari, and Kharpunath, the ward-level

[3] GoN (2020), Public Health Service Regulations, The Nepal Gazette, Government of Nepal.
[4] GoN (2019), National Health Policy 2076 (2019), Ministry of Health and Population, Government of Nepal.
[5] Handbook of annual planning and budgeting at Local Government, Government of Nepal, MoFAGA, 2077

total budget allocations differed. But in Yasodhara, Ajayameru, Pokhara, and Madhyapur Thimi the ward-level budgets were uniformly allocated. Nevertheless, additional needs of the wards are addressed by incorporating relevant activities at the municipal level planning. Community engagement varies across local levels, but the Health Facility Operation and Management Committee (HFOMC) has a pivotal role to identify key agenda points for the AWPB[6], prioritise activities, and advocate to incorporate the prioritized activities in the health sector AWPB process. But in the end the key decision makers are the ward committee members (elected representatives) and ward secretary. Therefore, the ward-level AWPB is mainly influenced by political mandates, and the chances for evidence-based plans to be included in the AWPB depends on how strongly health facility (HF) staff and other stakeholders can justify their need.

3.2.5 Prioritisation of programmes and activities for AWPB varies across LGs. As per the LGOA, prioritization of the projects and programmes should be based on seven pre-defined criteria: (a) directly contributes to economic development and poverty alleviation; (b) could bring production-oriented and quick outcomes; (c) uplifts the living standard, income and employment; (d) ensures maximum participation of the local people, could mobilize volunteers and costs less; (e) leads to maximum use of local resources and skills; (f) directly benefits the backward class, region and community; (g) enhances gender equality and social inclusion; (h) supports protection and promotion of sustainable development and environment preservation and promotion; and (g) preserves language and cultural aspects, and supports enhancement of social harmony and solidarity. In some LGs (e.g., Ajayameru) prioritization was done through weightage calculations on each of the criteria (See Annex 6 for details). At other LGs, the listing of activities was done at ward level, mainly led by the HF in-charges then discussed and agreed in the HFOMC meeting, with the final draft submitted to the ward committee for the approval. However, for the municipal level programme activities, health section or division prepares the draft with inputs from the respective health facilities and submits to Social Development Committees for approval.

3.2.6 Budget proposals from divisions and sectoral committees usually exceed the ceilings and are adjusted in the finalization process. After the compilation of the plan and budget from ward level, the draft municipal budget is developed based on the ceiling provided, and the prioritized activities are sorted out to fit into the criteria and scope of the AWPB guidelines. The Social Development Committee has the authority to compile the plan from different sectors, harmonise the proposed activities and budget to be aligned as per the guidelines, and ensure the removal of budget duplication. At this stage, the budget may still be adjusted, such as (in case of Kharpunath) where the budget allocation for Education sector generally exceeded the health sector. The prioritisation of sector could happen at this stage based on context and influence from the leadership of the chair of Social Development Committee (e.g., in Dhangadhimai). Similarly, all the sectoral committees submit their draft AWPB to the Planning and Budget Formulation Committee which again reviews the AWPB before submission to the municipal executive council for the approval. The Planning and Budgeting Formulation Committee has the authority to adjust the budget as per the priority of the Metropolitan City or other LG.

[6] In some rural municipalities (e.g., Kharpunath), the health facility in-charge (who is the ex-officio Member Secretary of the HFOMC) was observed to take the overall lead in prioritizing the health sector AWPB process at ward level.

3.2.7 Multiple factors have contributed to gradual prioritization of the health sector in the local level planning and budgeting. In the first couple of years of local level planning, the health sector was less prioritized; the focus was more on infrastructure and other developmental needs. However, based on experience from LL sites, the situation has changed and health has increasingly been prioritized in both the municipal and ward level planning. Important factors contributing towards this include: HFOMC reformation under the leadership of elected representatives and orientation to them; government policy to ensure health facilities in each of the wards, assessment of the health facilities using MSS depicting the critical gaps to improve quality of care, and an increasing understanding that conditional grants do not suffice to address local health sector needs.

3.3 Use of available evidence in the planning process

3.3.1 Local levels are expected to develop a Master Plan, Periodic Plan, and MTEF to feed into the planning process.

- Itahari, Dhangadhimai, Yasodhara, and Kharpunath developed their own Health Acts. Pokhara and Kharpunath developed their Health Policy, and in Ajaymeru this is being drafted. LGs developed their AWPB based on the mandate of these documents aligned with the respective LG's policy and acts.
- Among the LL sites, Kharpunath (rural municipality) is one of the LGs that developed a five-year village development periodic plan that also includes the health sector development plan and is aligned with their Health and Sanitation Act. Further, the municipality developed a separate three-year periodic health sector development plan to prioritise health system functions at Kharpunath. See Annex 7 for details. Following the master plan and periodic plan, a short-term strategic plan shall be developed based on the LG context, however such strategic plans were not developed in many of the LGs.
- The MTEF is yet to be developed by many of the local levels.

3.3.2 Preparation of "programme bank": Pokhara and Kharpunath are examples of where they developed a programme bank from which the list of activities for AWPB were selected.

3.3.3 Municipal profiles, case studies, and learning briefs: Kharpunath, Itahari, and Dhangadhimai have developed their own municipal profiles while other selected LGs were supported to develop them by NHSSP. The key health indicators at the population level were monitored and gaps identified. Frequently the lessons were captured as learning briefs or cases studies with the support from NHSSP. Some case studies describing good practices and approaches were already published, and these documents served as the reference documents in the LG setting. These were found to be instrumental in the planning process particularly to demand financial resources for the sector and allocate for the priority activities.

3.3.4 Lessons based on the tools for evidence-informed decision making and planning process. Several tools provided the evidence-base to feed into the Local level AWPB and the routine health sector program implementation. Based on these sources, information was analysed and need-based activities prioritized in subsequent discussions. The key sources of evidence to feed in AWPB for health sector are as follows, with examples of strengths and weaknesses:

(1) **Periodic Health Management Information System (HMIS) and Logistics Management Information System (LMIS) reports**: Most LL sites prepare HMIS and LMIS reports on a periodic basis which provide health service utilisation status and help to identify gaps to be addressed in the AWPB. For example, to ensure the institutional delivery "No More Home Delivery" initiative was started in some LGs (Ajayameru, Dhangadhimai, Kharpunath) and is monitored under the maternal and neonatal health program. Various interventions were devised such as incentive-based FCHV program and free distribution of in-kind materials to pregnant/postnatal mothers. Table 1 below presents some safe motherhood-related indicators in these three sites. There is a general trend of improvement, though COVID-19 appears to have affected utilisation in FY 2076/77 in two sites. Electronic Logistics Management Information System (LMIS) was also established in four of the LL sites to better manage the supply chain of the medicines within the local context.

Table 1: Comparative situation of select safe motherhood indicators in three local levels

Local levels	FY	ANC 1st visit Total	ANC 4th visit Total	Percentage of women who had 3 PNC check-ups as per protocol	Percentage of pregnant women who had four ANC checkups as per protocol	Percentage of pregnant women who had First ANC checkup as protocol	Percentage of institutional deliveries
Dhangadhimai Municipality	2073/74	579	369	5.3	31.8	50	5.4
	2074/75	656	308	2.2	26.5	56.6	6.2
	2075/76	724	346	7.1	30	62.7	10.5
	2076/77	684	294	1.6	25.5	59.3	11
Ajayameru Rural Municipality	2073/74	257	236	19.2	55.3	60.2	34
	2074/75	269	228	9.1	53.1	62.9	30.4
	2075/76	302	261	30.1	61.4	71.1	36.7
	2076/77	269	232	37.3	54.7	63.4	36.1
Kharpunath Rural Municipality	2073/74	106	68	28.4	48.2	75.2	43.3
	2074/75	152	106	19.9	75	107.8	66.7
	2075/76	123	81	41.1	57.4	87.2	83
	2076/77	178	124	75	88.6	127.1	110

Data Source: HMIS Report extracted from District Health Information Software 2 on 5th Nov 2020

(2) **Health facility self-assessment checklists**: Before the introduction of the MSS, use of self-assessment checklists was recommended to assess the readiness of the health facilities to deliver health facilities. However, after the endorsement of the MSS, budget has been provisioned for all the local levels nationwide for self-assessment of the health facilities and to address the identified gaps.

(3) **Supportive supervision and monitoring checklists/reports:** These are also important tools to monitor the status of routine service delivery at HF level by monitoring team. Any major issues observed during field visits are discussed at the HF level and followed up in the monthly meetings. It is also locally perceived that involvement of elective representatives in field monitoring has made concerned staff more accountable. The establishment of a monitoring evaluation and supervision team at LG level would help to closely monitor the health sector performance at municipal level. At HF level, the progress on health sector performance has been

regularly updated to the municipal health section and presented to the monthly review meeting for the way forward on crucial issues.

(4) Development of Health sector profiles and factsheets, and sharing with municipal team: The health sector profiles and factsheets are key documents that provide evidence on the strengths and weaknesses of the health sector programmes. For example, the health sector profile of Dhangadhimai Municipality was developed and shared with municipal authorities before the AWPB process began, and posted at the website for public use[7].

(5) Meeting Minutes at ward/community level: The regular HFOMC meeting held at ward level is the platform where the ward level health sector issues are most often discussed and prioritised for immediate action. Small-scale activities are planned through the ward level budget, however the activities which need a large budget are notified to the municipal authority through formal communication channels or noted in the 'programme bank' for the next AWPB prioritisation.

(6) Monthly health sector review meetings are routinely organised to report service statistics and other associated data, review the utilisation status and possible errors in reporting, and discuss key issues and challenges. Such reviews also provide feedback to the management authority in terms of what they should prioritise in the next months and jointly prepare operational plans and supervision as necessary. One important task during the monthly meeting is to review and verify reports. The issues and challenges identified through the analysis of health service utilisation data in HMIS reporting (both for completeness and timeliness) has been improved across all LL sites compared to the previous years. During the routine review, it was also found that the HF "functionality status" was not up-to-date in the HMIS in a few LL sites which was misleading the overall reporting status, and hence health facility registry was also updated. Such routine meetings were however affected in few of the LL sites due to the COVID-19 pandemic.

(7) Quarterly and Annual review of health programs: These are regular events conducted at LGs. The health sector progress for the immediate last quarter (Quarterly Review) and last FY (Annual Review) is reviewed, including the successes and challenges. The consequent action plans are formulated during the review meeting, and progress against these plans are measured in next quarter/year. Quarterly review meetings are regularly organised by district-based Provincial Health Offices; Annual review meetings are organised at LGs, PHO, and the Provinces.

(8) Monthly/bi-monthly LG meeting with all sectors – Key points, issues, and challenges in the health sector, and the interrelationship with other sectors, are discussed. Governance issues and other relevant issues were discussed in a multidisciplinary environment. Decisions were made by the municipal executive to improve the health sector performance. However, there is no uniform practise across the LL sites for such meetings.

(9) Cross-municipality meeting: Some of the LGs have started the culture of cross-sharing by visiting another LG site through mutual planning. For example, the

[7] https://www.dhangadhimaimun.gov.np/sites/dhangadhimaimun.gov.np/files/documents.pdf

municipal team organised such sharing events in Humla and Dadeldhura which enabled cross learning and helped in adopting good practices and lessons in the planning process. In another example, officials from the Pokhara Metropolitan City, including the health division team, visited Bharatpur Metropolitan City for this approach, and exchanged management experiences. Furthermore, monthly/quarterly Provincial Health Coordination Team meetings were held in Dadeldhura and Sunsari. The review and update on the health sector progress in these meetings created a cross-sharing and learning environment that helped in synergized efforts such as health disaster and emergency responses.

(10) Public commitments from political leaders: Public leaders announce ambitious plans from time to time, and as part of the political commitments made during the local election (including mandates of the LGOA). For example, one of the remote municipalities in the mountains, Kharpunath, made a commitment to subsidize premiums for enrolment in the Health Insurance Program and accordingly has allocated budget to cover the insurance premium partially. The amount proposed was NPR 1000 out of NPR 3,500 per annum per household and the total budget with the amount of NPR 1.4 Million has been allocated for FY 2020/21 for this purpose, which is adequate to cover all the families of the rural municipality.

(11) Coordination and review platform created at the district level found effective in progress monitoring and cross exchange of the initiatives: Regular health sector review meetings at municipality and district level have been effective for discussing progress, issues and challenges, and developing action plans to improve health system functions. At municipal level, monthly review meetings help to measure the progress against the operational calendar, collect and review the HMIS report, discuss ad-hoc issues and challenges, and plan for the next month's programme implementation. Some of the districts have been regularly organizing the district level review meetings on a monthly basis. For example, the District Health Coordination Team has been established at Dadeldhura district and meetings have been organized on a regular basis to discuss issues, share and update the progress by LGs, plan for the capacity building events including organizing the integrated health camps, coordination with development partners and consensus building, and developing the action plan for common issues and challenges such as logistics supply at district level. Thus, health sector review meetings have been effective in management and coordination at subnational level.

(12) Capacity enhancement tools: Tools such as Minimum Service Standards (MSS), Routine Data Quality Assessment (RDQA), and Organisational Capacity Assessment (OCA) were rolled out in the LL sites to enhance the capacity of health facilities and municipal-level health system functions, and to improve health service quality. These tools not only helped to identify gaps but also sensitised key actors during the assessment process as they were involved in the assessment process.

- **Lessons from MSS:** The MSS assessment helped to identify the health facility-related gaps in health services. The MSS score and relative gaps were presented in municipal-level discussions and those gaps were advocated for addressing in review meetings, HFOMC meetings, key stakeholder discussions, and key decision-making forums in AWPB preparation. And it worked: LGs allocated budget to address the gaps in the next AWPB; in some cases, within same fiscal year to address critical

gaps. For example, in Kharpunath significant budget was allocated to address the MSS gaps identified through the MSS assessment. Details are presented in Annex 8.

- **Lessons from OCA:** OCA helped to identify key capacity gaps at LGs. OCA has seven domains (building blocks of the health system) that provide the platform to identify gaps, and those gaps were addressed through the AWPB planning process. After addressing the gaps, the OCA scores improved. See the details in Annex 9.

3.4 New initiatives addressing local level needs

3.4.1 Focus on both supply and demand: performance-based incentives. Since its establishment, Ajayameru Rural Municipality (ARM) has prioritized both supply and demand sides to ensure access to BHS. As a community-based approach tailored to the local context, from the fiscal year 2017/18 onwards, budget was allocated from internal resources of the municipality to strengthen the FCHV program through the provision of performance-based incentives. To increase the utilisation of health services, FCHVs were assigned to promote health services at the community level. FCHVs could accumulate their points by ensuring the utilisation of targeted services from the nearby health facilities. Points ranging from 1 to 4 were assigned for different services as presented in this table. From the incentive side, each point is equivalent to NPR 50, meaning that FCHVs can claim that amount for each point gained, of which respective health facilities keep records. They then coordinate with the municipal office for the payment, which takes place on a monthly basis. Kharpunath also reformed the FCHV program and revitalized their role aiming to achieve the zero home delivery.

Table no. 1. Contribution based FCHV program

Per point NRs.50.00		
S.N.	**Subject**	**Point**
1	1st ANC as per protocol	2
2	2nd ANC as per protocol	1
3	3rd ANC as per protocol	1
4	4th ANC as per protocol	1
5	Institutional delivery	4
6	BCG vaccine	1
7	GMP for 7th month	2
8	1st Measeals vaccine at 9 month	1
9	JE vaccine	1
10	MR second and GMP for other month	1

3.4.2 Dhangadhimai Municipality implements nutrition allowances targeting marginalised communities. Dhangadhimai Municipality initiated an incentivisation strategy during FY 2018/19 to strengthen the safer motherhood program. The incentive was provided to pregnant women to improve the Four-ANC visit protocol and encourage institutional delivery. The incentive of NPR 2,000 was provided to mothers for total 4-ANC (Ante Natal Care) visits (NPR 500 for each visit) and an additional NPR 1,000 for giving birth at the health facilities. In FY 2019/20, however, the incentivisation strategy was dropped as there were some disputes in its implementation approach. In its place, the municipality proposed a nutritional package program for the same initiatives. The nutritional package program has been more matured and through consensus building process, this activity was prioritised and included in the key policy and program of the municipality and budgeted as a part of “No More Home Delivery Initiative”.

3.4.3 Workload-based readjustment of the health workers can help better manage service delivery. The nationwide health staff adjustment process from 2019 did not fully address the needs for human resources for health at the local level. Under federalism, local levels have the authority to manage staffing structures beyond the federally-allocated sanctioned posts. Pokhara Metropolitan City (PMC) and DM offer two examples of innovations in further staff re-adjustments to meet local needs. Details are provided in Annex 10.

4. FLOW OF FUNDS AND BUDGETARY PATTERNS

This section provides an overview of the existing provisions for fiscal transfers, composition of local level resource base, and trends of fund flows. After providing the overall fiscal scenario within the local context, resources provisioned for health sector are assessed. A graph of the flow is provided in Annex 11.

4.1 Mechanisms of fiscal transfer

The three major categories of local level revenue are (1) distribution of revenue and royalty, (2) federal and provincial grants, and (3) revenue internally generated by respective local levels.

(1) Revenues collected in the form of value added tax and excise duty on domestic production will be accumulated in a Federal Distributive Fund which will be distributed across federal, provincial, and local levels at the proportion of 70:15:15. Similarly, royalties collected on natural resources will also be accumulated in a Federal Distributive Fund which will be distributed across federal (50%), concerned provinces (25%), and concerned local levels (25%).

(2) There is provision for different types of grants that federal government can provide to provinces and local levels, and provinces can provide to local levels. They include:

- **Conditional grant:** this grant is provided as per the basis set by the National Natural Resources and Fiscal Commission (NNRFC) for the implementation of the plan of GoN, province, or local levels;
- **Equalisation grant:** this is provided based on needs and the revenue raising capacity of the respective provinces and local levels in accordance to the recommendation of the NNRFC;
- **Complementary grant:** this grant is provided for the implementation of infrastructure development-related plans. Necessary arrangements for providing the complementary grant will be as per the procedure defined by the GoN;
- **Special grant:** this grant is provided for the implementation of special plans targeted for development and supply basic services, balanced development of provinces and local levels, and for the development and upliftment of deprived communities or groups.

(3) The third category of income is revenue internally generated from the administration of the tax and non-tax sources of revenue (just like federal and provincial governments). The Intergovernmental Fiscal Management Act, 2074 (2017), has defined the tax jurisdiction of federal, provincial, and local governments.

4.2 Composition of fiscal transfer and resource base at subnational level

Table 2 below shows the composition of national as well as health and population budgets across three levels. Over the last three years, the share of national budget allocated to national- or federal-level entities is above three-quarters while the share of average allocation to provinces and local levels has remained around 7.3% and 15.5%, respectively. In comparison to this, the health sector is more decentralised with more than 30% of the budget allocated to the local level. This is the reflection of the large number of frontline health facilities (Health Posts and Primary Health Care Centres) being managed at the local level. Besides direct allocation of budget to the local level, a substantial amount of budget is being topped up at the local level during the process of implementation. One of the latest

examples of this is the additional transfer of NPR 2.3 billion (3.8% of the budget allocated to MoHP) for the establishment of hospitals in 264 identified local levels.

Among the different components of fiscal transfers from the federal level, conditional grants constitute the single largest resource at the sub-national level, particularly at the local level for which 46% of the fiscal transfer is for the programmes conditioned by the federal level (See graph in Annex 12). Accordingly, the share of revenue transfer and equalisation grants, which are unconditional by nature, comprise a relatively higher proportion for the provincial level (62%) than that of the local level (52%). This implies relatively less planning flexibility at the

Table 2: Composition of national budget by level

Level	Composition of total budget, %				Composition of health and population budget, %			
	2018/19	2019/20	2020/21	Average	2018/19	2019/20	2020/21	Average
Federal	76.5	79.5	75.4	77.2	60.4	62.0	66.9	63.1
Province	8.6	6.5	6.8	7.3	7.4	7.1	5.1	6.5
Local	14.8	13.9	17.8	15.5	32.2	30.9	28.0	30.4
Total	1315.2	1533.0	1474.6	-	56.4	68.8	90.7	-

Source: MoF (2018, 2019, 2020), Estimates of the expenditure and revenue (Redbook)

local level. The shares of the conditional grant for the local level is mainly dominated by the education sector followed by the health sector.

In aggregate, the volume of conditional grants is higher than equalisation grants, and its share is increasing (56% in 2018/19, 58% in 2019/20, 64% in 2020/21). The equalisation grants have not only been reduced in proportion but also reduced in absolute amount for the latest year (2020/21), which may be an impact of COVID-19. On average and consistently over the last three years, a metropolitan city has received 5 to 6 times more under each of the equalisation and conditional grants as compared to a rural municipality. See graph in Annex 13.

Within the health sector conditional grants, there is gradual relaxation in the stringency of the conditions as reflected in the reduction of the number of budget heads for health programmes over a period of four years. In LL sites the number of budget heads has substaintially and consistently decreased in successive years, Pokhara being the exception for the latest year. The number of budget heads has decreased by more than two-thirds in three (Pokhara, Madhyapur Thimi and Kharpunath) out of the seven local levels. See Annex 14 for details.

To facilitate the implementation of the health sector grants, the MoHP prepares implementation guidelines[8] setting the terms and conditions describing how those activities should be operationalised. Although the number of budget heads have been reduced, indicating more flexibility in the budget, some of the budget heads were broken down into multiple activities in the implementation guidelines to ensure the implementation of the each of the prioirty activities. For example, the maternal and newborn programme, which forms 1.9% of the health sector grants for local level (based on data of seven LLs, Annex 15), consists of 13 different activities and budgets in the implementation guidelines, although the exact number of activities varies by local level.

[8] During the preparation of the implementation guidelines, concerned divisions and centres prepare draft for the respective programme which MoHP compiles, reviews, finalises and disseminates through the MoHP website.

Based on the data from LL sites (Annex 15), salary, allowances and other administrative expenses cover 57% of the health sector conditional grants. A total of eight budget heads including salary and administrative expenses add up to more than 90% of the health sector conditional grants at the local levels. The remaining small fraction of the budget is divided into multiple activities giving little flexibility at the operational level.

In comparison to FY 2018/19, the allocated annual health sector budget of each LL site for FY 2019/20 increased by 38%, on average, through allocations from LG internal revenues, while the conditional grants for the health sector and total municipal budget increased by 30% on average. The major incremental budget was allocated for health infrastructure (such as establishing hospitals), fulfilment of MSS-identified gaps, and strengthening of BHS delivery. This might be the impact of capacity enhancement and technical assistance to improve the health system functions at LGs. Details of the budgetary patterns over the last two fiscal years are given in Annex 16.

4.3 Analysis of local level budget as per functions

The Health sector budgets of the seven LL sites for FY 2020/21 were mapped and analysed by the functions assigned to the local level as defined in the LGOA. Among 29 statements of health sector functions defined for the local level, 12 statements were from the exclusive rights the rest concurrent rights. As per the Constitution and LGOA, functions originating from concurrent rights are to be accomplished in accordance to federal and provincial laws, hence proper coordination and alignment in planning and implementation is important. Some of the statements are quite broadly defined while others are specific to some technical areas. For example, 'operation of promotive, preventive, curative, rehabilitative and palliative health services at the local level' covers broader aspects of the services to be mananged by the local level. In contrast, there are statements focusing on specific areas such as basic health, maternal and newborn care, family planning, nutrition, Ayurveda and other traditional health care services, blood transfusion services, waste management, and antimicrobial resistence. Budget was allocated for most functions. Some of the functions for which budget was not exclusively provisioned in the seven LL sites include the following:

- Operation, licensing, monitoring and regulation of pharmacies;
- Coordination, collaboration and partnership with private and non-governmental organisations on the management of waste generated in sanitation and health sector;
- Production, processing and distribution of medicinal plants, herbs and other medicinal goods at the local level;
- Determining maximum price and regulation of medicines and other medical products at the local level;
- Control the use of tobacco, alcohol and narcotic substances and awareness raising.

For rural municipalities, regulation of pharmacies and medicines is of less relevance as there are hardly any pharmacies currently operational; however, these are important areas for metropolitan and submetropolitan cities to prioritise. Depending on the local context, processing of medicinal plants and goods, and control of tobacco, alcohol, and narcotic substances may need prioritisation.

Budgets of the seven LL sites were mapped by thematic areas, and their composition is presented in Table 4 below. As expected, “Salary, Allowances and other Administrative Expenses” is the dominant category comprising of almost 40% of the budget, followed by

Infrastructure, equipment and maintenance" (20.8%); and "Maternal and child health services" (11.4%). COVID-19 response management also attracted a substaintial share of the local level health sector budget. Other important areas where a relatively high share of budget was allcoated include prevention and community outreach activities, and procurement of medicines and supplies.

Thematic areas mostly financed by local level internal revenues include COVID-19 response management, infrastrucutre, equipment and maintence, review, monitoring and information management while other areas were mostly financed through conditional grants. There were certain areas where federal funds were complemented by local level internal allocation mainly in the areas of review and monitoring, outreach activities and FCHV mobilisation, strengthening of the health facilities and purchase of medicines and supplies. In some of the

Table 4: Composition of the budget in seven LL sites

SN	Thematic areas	% of budget provisioned
1	Salary, allowances and other administrative expenses	39.8
2	Infrastructure, equipment and maintenance	20.8
3	Maternal and child health services	11.4
4	Ayurveda/homeopathy/unani health services	1.6
5	Health promotion and nutrition	2.1
6	Health protection and insurance	1.3
7	Prevention and community outreach	4.9
8	Provision of other services	0.2
9	Medicine and supplies	4.4
10	Policy and legal arrangement	0.0
11	Review, monitoring and information management	1.2
12	Capacity strengthening (training/orientation/workshop)	1.1
13	COVID-19 response management	10.1
14	Epidemic management and disease control	0.9
15	Waste management	0.1
	Total	100.0

Source: Analysis of the local level budget

local levels such as Itahari, Dhangadhimai, and Kharpunath, existing health facilities were recently upgraded to municipal level hospitals by the local level itself, which demanded significent budget from the local level for salary and infrastructure since these hospitals were yet to be official listed as hospitals by the MoHP and hence federal budget was not provided.

4.4 Analysis of local level budget as per LNOB

The health sector budgets of the seven LL sites were also analysed by gender and LNOB responsiveness using the Gender Responsive Guidelines[9] and draft guidelines on LNOB budget marker for the health sector, respectively[10]. In terms of gender responsiveness, 20% of the budget was found to be directly responsive to gender, 57% was indirectly responsive, and the remaining 23% was considered gender neutral. Similarly, as per the draft LNOB budget guidelines, 16% of the local level health sector budget was found to be directly LNOB

[9] MoHP (2019) Gender Responsive Budgeting in the Health Sector 2076, Ministry of Health and Population.
[10] Draft guidelines of the MoHP for the LNOB budget marker in the health sector, 2020.

responsive, 33% of the budget was indirectly responsive to LNOB, and the remaining budget was neutral in terms of LNOB responsiveness.

Examples of the directly- LNOB-responsive budget provided at the local levels include: specific area- or health problem-targeted health camps and outreach clinics, treatment support for targeted groups, microplanning to reach previously unreached segments of the population, community surveliance to identify high risk groups, “zero home delivery” initiatives, and full immunisation campaigns. Activities planned through internal local level revenues varied across the local levels and were more LNOB responsive than the budget provisioned from the federal level. About one-quarter of the locally allocated budget was directly responsive to the LNOB. Although some of the locally initiated programmes are perceived to be effective to reach the target population, their scalability should be considered after careful assessment of the programmes.

5. KEY FINDINGS AND POLICY IMPLICATIONS

The following table summarizes the key findings and the related implications for policy and programming.

Findings	Implications for policy and programming
Planning alignment	
1. There are examples of similar local level activities being funded from multiple levels indicating potential duplication in activities and resources.	While making Federal conditional grant provisions, areas of additional financing from provinces or local levels should be indicated to reduce duplication and enhance alignment across the three levels.
2. Conditional grants specify budget heads for multiple activities. Though the number of budget heads is fewer, the grants remain fairly restrictive.	Either the activities in Conditional Grants should be further merged, with specific guidelines on what they should be spent for, or more flexibility should be provided to partially switch budget from one activity head to another without compromising the essence of the programme or activity.
3. The targets set in the HMIS do not match with the local level reality particularly in relation to maternal and child health services.	Local level performance should be analysed at district level. Monthly review meetings at the district level are found to be effective to better link the local levels and could be a platform to exchange issues as well as lessons within the district.
4. Drug stock outs still remain a periodic problem in the majority of LL sites. In contrast, the occasional oversupply of certain medicines, often near expiry, has also been reported.	Support more effective coordination to ensure continuous availability of medicines at the HF level. Specifically, more clarity on types of medical items, their quantity, and time of the delivery are needed from the provinces so that local levels can prioritise their budget for the local procurement.
5. There are still delays in sending the budget and implementation guidelines from the federal and provincial levels.	The budget and implementation guidelines need to be sent out in a timely manner from the federal and provincial levels.
Generating evidence through management tools	
1. The roll out of OCA, MSS, and RDQA created the opportunity for participation by elected representatives, senior officials, and health staff in a single platform to understand the complex health system functions and challenges. These tools sensitized decision makers to specific needs, and motivated them to make evidence-based plans and allocate budget accordingly.	• Introduce and maintain the OCA, MSS, and RDQA tools in each LG. • Develop a separate MSS tool for those PHCs which are not to be upgraded to primary hospital but need to function at higher capacity than a Health Post.
2. Currently, MSS is not available for health facilities below the Health Post level. But there are facilities functioning under different names such as Community Health Units, Urban Health Centres,	• Work with MoHP on the need to standardize HF nomenclature in terms of services they should deliver, human resources that should be provided, and other management aspects.

Urban Health Promotion Centres and, more recently, Basic Health Service Centres.	• Ensure appropriate MSS tools exist for all facility types.
3. Development of the local level MTEF is an important component of the planning process, but many local levels are yet to do this.	Enhance institutional capacity to ensure that local levels develop their MTEF during the planning process.
4. A programme bank consists of priority projects to be considered during AWPB. A programme bank can help to speed up the planning process at the local level. However, only a few of the local levels were found to have initiated it.	Establish a programme bank at each LG site.
5. Municipal profiles and fact sheets highlight major progress and challenges, feeding evidence into the planning process. Some municipalities produce comprehensive profiles, even conducting municipal level surveys, while others have done little.	Support LGs to prepare municipal profiles and fact sheets highlighting the progress, issues, challenges and priority areas to be addressed.
6. In some LL sites, the HF "functionality status" was not up-to-date in the health facility registry and hence in the HMIS. Issues like listing of non-functional health facilities and appearance of same health facilities more than once were identified.	Update the health facility registry so that the database of actual number of health facilities that are providing services can be corrected and maintained in the HMIS.
Coordination and meetings	
1. The practice of organising health sector monthly meetings ensured timely reporting from health facilities, enabled discussion on existing issues, and provided opportunities to engage senior municipal officials in progress monitoring.	Organise monthly health sector meetings, perhaps rotating between different health facilities to facilitate field monitoring, cross-learning, and mutual accountability.
2. Continuous coordination with the MoHP and Provincial Health Directorate, where feasible, has helped to harmonise support at the local level. Sharing lessons through case studies, process documentation, and comparative analyses can promote cross learning and strengthening of the system.	Ensure regular monitoring and documentation of progress at the local level and feed results into the decision-making process at the higher level. Continuous support can enhance the capacity of LG particularly in the implementation of action plans and programme activities to address identified gaps.
Human Resources	
1. Roles and responsibilities of individual staff in the local health sector were not clearly defined, causing confusion and even conflicts in programme implementation.	Support the practice of assigning focal persons for thematic areas. Such practice has not only helped in improving responsibility and accountability but also facilitated better planning and implementation.

REFERENCES

Government of Nepal (2017), Report on Functional Analysis and Assignments, Government of Nepal.

Government of Nepal (2018), Local Government Operation Act 2074 (2018), Government of Nepal.

Metropolitan Office (2018), Health Policy, 2074 (2018), Local Government, Pokhara Metropolitan City, Pokhara, Kaski.

Ministry of Finance, (various years), Estimates of the expenditure (Red Book), Ministry of Finance, Government of Nepal, Kathmandu, Nepal.

Ministry of Health and Population (2018), Guidelines for planning and budgeting for the health sector, Ministry of Health and Population, Government of Nepal, Kathmandu, Nepal.

Ministry of Health and Population (2018), Guidelines for the formulation of annual work plan and budgeting for the health sector at the local level, Ministry of Health and Population, Government of Nepal, Kathmandu, Nepal.

Ministry of Health and Population (2019), National Health Policy, 2076 (2019), Government of Nepal, Ministry of Health and Population, Kathmandu.

Ministry of Social Development (2019), National Health Policy, 2076 (2019), Ministry of Social Development, Provincial Government, Karnali Province, Birendranagar, Surkhet.

MoFAGA (2020), Annual plan and budget formulation of Local Governments: A handbook, Ministry of Federal Affairs and General Administration, Government of Nepal.

MoHP (2017, 2018, 2019, 2020), Programme implementation guideline for the operationalization of the health and population related programmes at the local level, Ministry of Health and Population, Government of Nepal.

Municipal Office (2019), Health and Sanitation Policy, 2076 (2020), Local Government, Kharpunath Rural Municipality, Kharpunath, Humla.

National Natural Resources and Fiscal Commission (2018), Basis for the allocation of the conditional grants, National Natural Resources and Fiscal Commission, Kathmandu Nepal.

National Planning Commission (2019), Plan formulation guidelines for local level 2075 (sample), National Planning Commission Secretariat, Government of Nepal, Kathmandu, Nepal.

National Planning Commission (2020), Budget formation guidelines and framework along with three-year expenditure framework for fiscal year 2077/78, National Planning Commission Secretariat, Government of Nepal, Kathmandu, Nepal.

National Planning Commission (2020), Fifteenth Plan (2076/77- 2080/81), National Planning Commission, Government of Nepal.

The Constitution of Nepal, 2072 (2015).

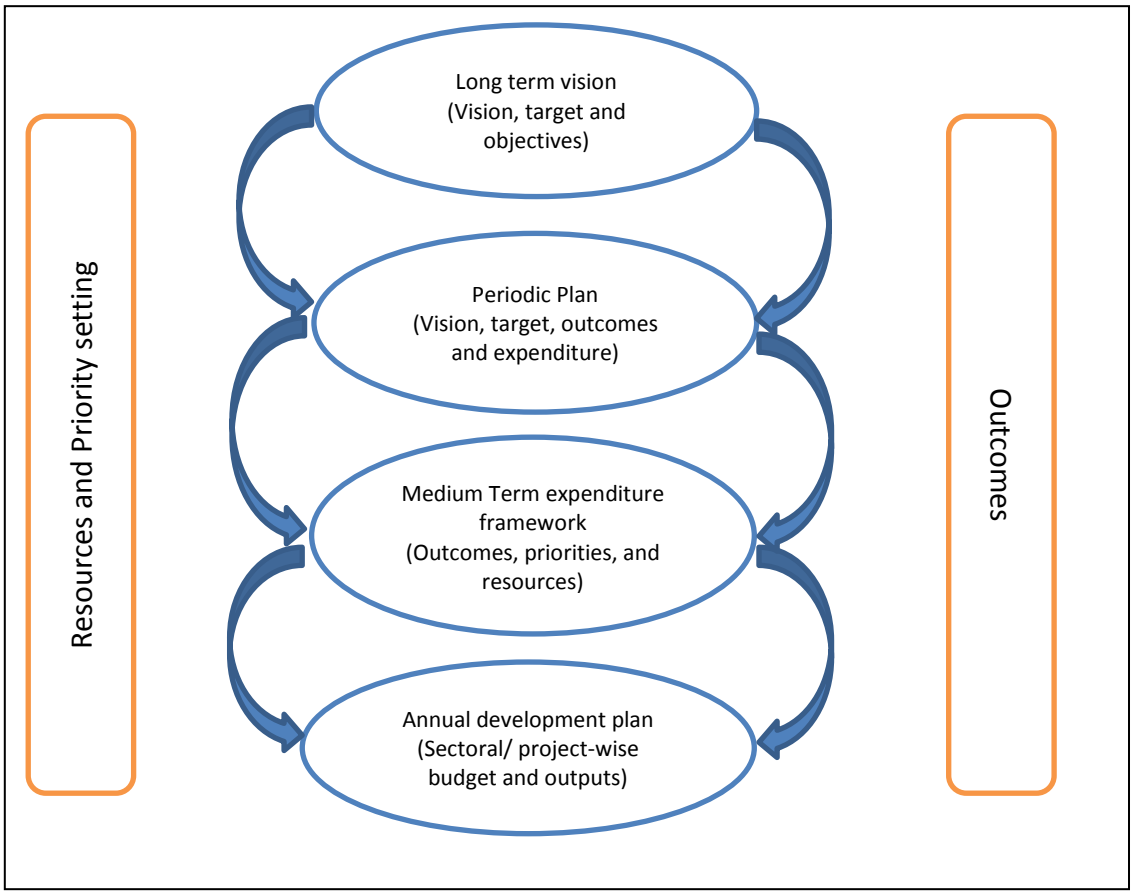
World Health Organization (2010), Monitoring the building blocks of health systems: a handbook of indicators and their measurement strategies, WHO Document Production Services, Geneva.

APPENDICES

Annex 1: Details on LL Planning and Budgeting Process

1st Step: Budget preparation stage	✓ Update the profile and situation analysis of LG ✓ Perform estimation of revenues at LGs ✓ Outline the Medium Term Expenditure Framework (MTEF) for three consecutive fiscal years (FYs) ✓ LGs submit the revenue forecast and estimation of expenditure to the Ministry of Finance (at Federal level) and relevant Province based on the revenue estimation and resource mapping ✓ Formation/Adjustment of Sectoral committees, allocate roles and responsibilities
2nd Step: Determination of budget ceiling and guidelines	✓ Receive the budget ceiling and guidelines from federal and provincial levels ✓ Determine budget ceilings and establish thematic committees for each sector ✓ Provide Guidelines for each sectoral committee ✓ Hold pre-budget session with stakeholders for budget discussion ✓ Prepare Policy and Programme then submit to Assembly
3rd Step: Selection of community level plan and program	✓ Selection of programme from community level from the meetings and discussion ✓ Submission of program to ward committee
4th Step: Ward level planning	✓ Collect plans (programme bank) from ward level along with programme and budget commitment from non-state development partners ✓ Submit to the municipal executive the programme that could not be covered through ward level budget allocation and inter-ward programmes of importance ✓ Prioritise the programme and submit to Budget and Programme Formulation Committee
5th Step: Consolidation of program from sectoral committees at municipal level	✓ Consolidate the programme submitted by different sectoral committees and prioritise programmes ✓ Conduct stakeholders' meeting to reprioritise the programme with each sectoral committee ✓ Integrate the program and budget committed by the non-state development partners ✓ Prepare the AWPB and fiscal and appropriation bill for submission to the municipal executive committee
6th step: approval of AWPB by the Municipal Executive Committee	✓ Approve the AWPB and Budget speech from municipal executive committee ✓ Approve the fiscal and appropriation bill by the municipal executive committee
7th Step: Approval of AWPB and fiscal and appropriation bill from local municipal assembly	✓ Endorse the AWPB and fiscal appropriation bills ✓ Verify and approve the endorsed documents from local municipal assembly ✓ Publish the documents in local government gazette

Annex 2: Interrelationship and sequencing towards annual development plan



Source: NPC (2019)

Annex 3: AWPB Implementation Framework

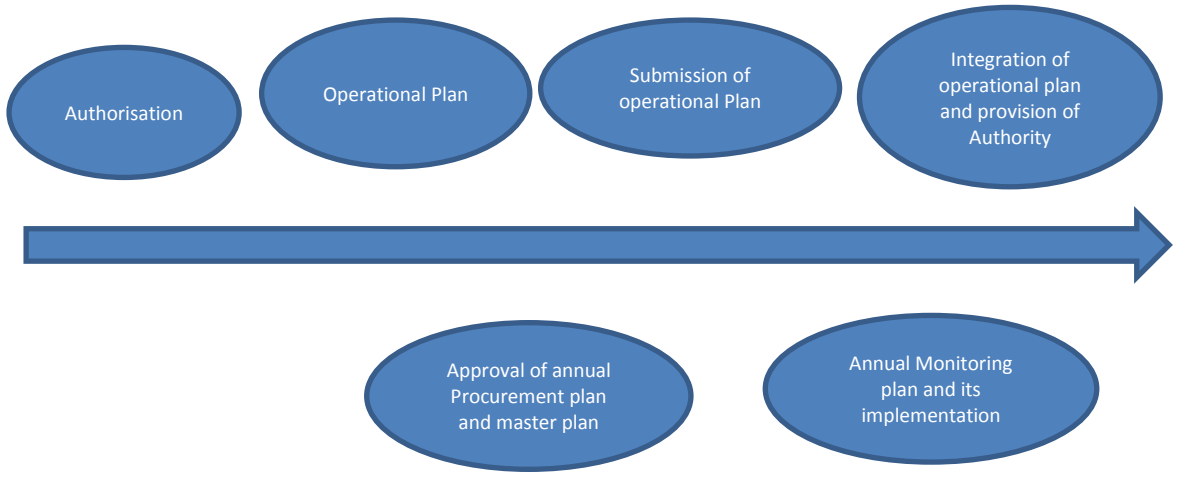
(1) Preparation: for effective AWPB implementation, the preparatory activities to be adopted are:

- ✓ Authorisation of budget expenditure to CAO
- ✓ Submission of final approved AWPB and annual operational plan by each thematic/subjective committee to CAO
- ✓ Submission of integrated annual operational plan to Municipal Executive committee by CAO
- ✓ Authorise AWPB implementation to ward secretary and subjective/thematic section by CAO
- ✓ Propose local rates (taxation and other income) and approval from municipality
- ✓ Preparation of procurement plan, approval and procurement management
- ✓ Preparation of Monitoring and Evaluation plan and its due implementation by monitoring committees and concerned subjective/thematic section

(2) Implementation: The AWPB implementation framework is presented in Diagram 1. AWPB implementation covers various tasks from the provision of authority to budget expenditure to ward committees and thematic sections, preparation of annual operational plan, preparation of annual procurement plan, preparing the estimates and proposals and approval. The other functions during this phase are formation of a users' committee and executing the operations at the respective sites. The LGOA

(2017) has provided the guidance on AWPB implementation such as implementation based on planning (section 24), coordination (section 25) and on being a partnership approach (section 26).

Diagram 1: AWPB implementation framework



(3) Monitoring and Evaluation (M&E): M&E is the key stage in the AWPB implementation process to ensure the quality of program implementation and the monitoring of the alignment and progress against the operational plan and target performance. The M&E consists of a set of activities such as data collection, tracking, analysis, evaluation and timely feedback for performance measurement on the AWPB implementation process. Monitoring is the continuous process to track the performance whereas evaluation measures the programme relevancy, effectiveness and sustainability of the plan on periodic basis such as monthly, quarterly and annually. The M&E is conducted through the Monitoring and Supervision Committee formed at municipal and ward level. The Reference guide for local level AWPB (2017) has envisioned the formation of a four-member municipal-level monitoring and supervision committee led by the Deputy Mayor (or Deputy Chairperson) and a three-member ward level monitoring committee led by respective ward chairpersons. The functions of these committees are guided by the LGOA (2017).

Annex 4: Policy and Programmes of LGs aligned with their respective AWPBs

- **Itahari**: Senior citizen health camp, Health insurance to marginalized community and strengthening ayurvedic health system, HF infrastructure management
- Ajayameru: lab facility, nutrition package program to the natal and postnatal women, Rural Ultrasound Program has been continued
- **Dhangadhimai**: Nutrition package (30 pieces eggs, Ghee, beans) is provided to Dalit and minority communities to promote the use of ANC services, institutional delivery, post delivery service and immunization and growth monitoring. Continuation of lab facility as part of the basic healthcare package and provided 50% special discount facilities to Dalit and minority communities. Cash incentive NPR 5000 given to Marginalised and disadvantaged people for transportation cost for treatments of severe eight diseases.
- **Pokhara**: Expansion of Health Insurance program to all wards of metropolitan city, provisions of adequate infrastructure and equipment for health facilities, strengthening the services from urban health centres and monitoring of private health service

providers.

- **Yasodhara**: Establishment of Birthing centre, Mobilisation of Mothers group and FCHVs, “No more home delivery” and Multisectoral nutrition program were included in the AWPB to strengthen the MCH program.
- **Kharpunath**: Capacity building of HWs and HFOMC, expansion of services (ultra sound, lab, x ray), health promotion (adolescent health and school health program), child and safe motherhood program and FCHV program, zero home delivery initiation through mobilizing FCHV and mothers group meeting, control of epidemic including Covid-19, health awareness, Quality improvement of HFs, door to door health services to the disabled and elderly people
- **Madhyapur Thimi**: Strengthening of the Hospital Services with expansion of modern facilities, strengthening of Health Insurance Program with subsidy on premium payment, COVID-19 response (testing and isolation services), subsidy in healthcare for ethnic minorities.

Annex 5: The decision-making process for health budget allocation in Pokhara

In Pokhara, along with the “Programme Bank”, proposed activities are provided in a written template distributed by the Health Division before the AWPB starts. The template was shared with the HF in-charges (or provided to the HFOMC or Ward chairperson where a HF does not exist). Data sources are mainly from the HFOMC meeting minutes, casual commitments made by the elected representative to ensure health service delivery, MSS gaps for service delivery from HF, etc. Interestingly, the gaps identified in the MSS action plan were the key points used to prioritize the budget for health facilities during the ward level planning process. From the meeting discussion and consultation, the list of the key activities was developed. The AWPB drafted from the ward level exercises were compiled and the health division prepared the initial draft of AWPB after discussion with the program focal persons. The draft was submitted to the Planning Committee, but they reformulated the Annual health plan and budget after consultation in the committee. The final AWPB was modified with an almost 25% lower budget compared to the proposed budget.

Annex 6: Ajaymeru Weightage Calculations for Programme Prioritisation

Weightage calculation for Prioritisation of the project at LG's AWPB process

Criteria	Weightage Score	Classification Criteria and Score
(a) That directly contributes to economic development and poverty alleviation	20	Directly contributing=20, Indirect Contribution=10, Neutral contribution=5
(b) That could bring production-oriented and quick outcomes	15	Accomplished within same FY=15, by Next FY=10, others=5
(c) That uplifts the living standard, income and employment	10	Directly contributing=10, Indirect Contribution=5, Neutral contribution=0
(d) That ensure maximum participation and budget contribution of the local people, could mobilize volunteers and cost less	15	>50% contribution=15, 20%-50% contribution=10, up to 20% contribution =5, No contribution=0
(e) That leads to maximum use of local resources and skills	10	All resources available locally=10, up to 50% resources available=7.5 and others=5
(f) That directly benefits the backward class, region and community, and (g) That enhances gender equality and social inclusion	15	Directly benefitted =15, Indirectly benefitted=7.5 and Neutral=0

(h) That supports protection and promotion of sustainable development and environment preservation and promotion	10	Directly contributing=10, Indirect Contribution=5, Neutral contribution=0
(g) That preserves lingual, cultural aspect, and supports enhancement of social harmony and solidarity	5	Directly contributing=5, Indirect Contribution=3, Neutral contribution=0
Total	100	

Annex 7: Planning in Kharpunath Rural Municipality (KRM)

KRM developed their three-year periodic health plan from 2020/21 to 2023/24 as the priority for health system strengthening. The periodic health plan is the part of Comprehensive Village Development Periodic Plan from 2020/21 to 2025/26 and acts as the key guiding document for the overall planning and budgeting process of the municipality including the health sector. The major areas of the periodic health plan include health infrastructure development, hospital service strengthening, procurement of equipment, expansion/strengthening of routine health services including outreach services, capacity development, health information management, and health sector governance mechanism.

These key areas are the KRM priorities and are also stated in the annual policy and program 2020/21. These areas were incorporated in the AWPB of the current fiscal year, and the required budget were ensured. The linkage of areas of the periodic plan and AWPB of the current fiscal year is compared in the following table:

Key areas (AWPB 2020/21)	**Budget Amount (in '000 NPR), FY 2020/21**	**Priority with Periodic health plan 2020/21 to 2022/23**
Health Infrastructure	223	Yes
Safer motherhood	520	Yes
FCHV program	1049.6	Yes
Medicine procurement	1100	Yes
Health Institution strengthening	575.6	Yes
Health education and Information	310	Yes
Health governance	245	Yes
Epidemic disease control including COVID-19	768	Yes
community health Program	906.4	Yes
Minimum Service standard	240	Yes
Quality Assurance	170	Yes
Nutrition program	516	Yes
Strengthening of Kharpunath Community Hospital (newly established in 2019/20)	4206.786	Yes
HR development	750.2	Yes
Health Information Management	739.4	Yes
Health risk management and health Insurance	1680	Yes
Total	**14000.0**	

Annex 8: Kharpunath Health Facilities MSS Scores, and Resource Allocations

MSS assessments helped to visualize issues at the HF and municipal level, drawing the attention of decision makers. Within a short period, the HFOMC and Municipality provided significant support to address gaps identified during the assessment held in April-May 2019. The Kharpunath Rural Municipality and HFOMC/ward committee arranged NPR 1.2 million from FY 2018/19 budget. The Rural Municipality allocated budget of NPR 10.53 million for the FY 2019/20, which is around 5 times more than the health sector budget of FY 2018/19. For the current FY (2020/21) the health sector budget is NPR 14 million, thus the figure has been continuously increasing. For the supply of commodities and equipment, the municipal authority provided logistics support to all 4 health posts and 1 CHU during FY 2019/20 to meet the MSS requirement as identified during the assessment.

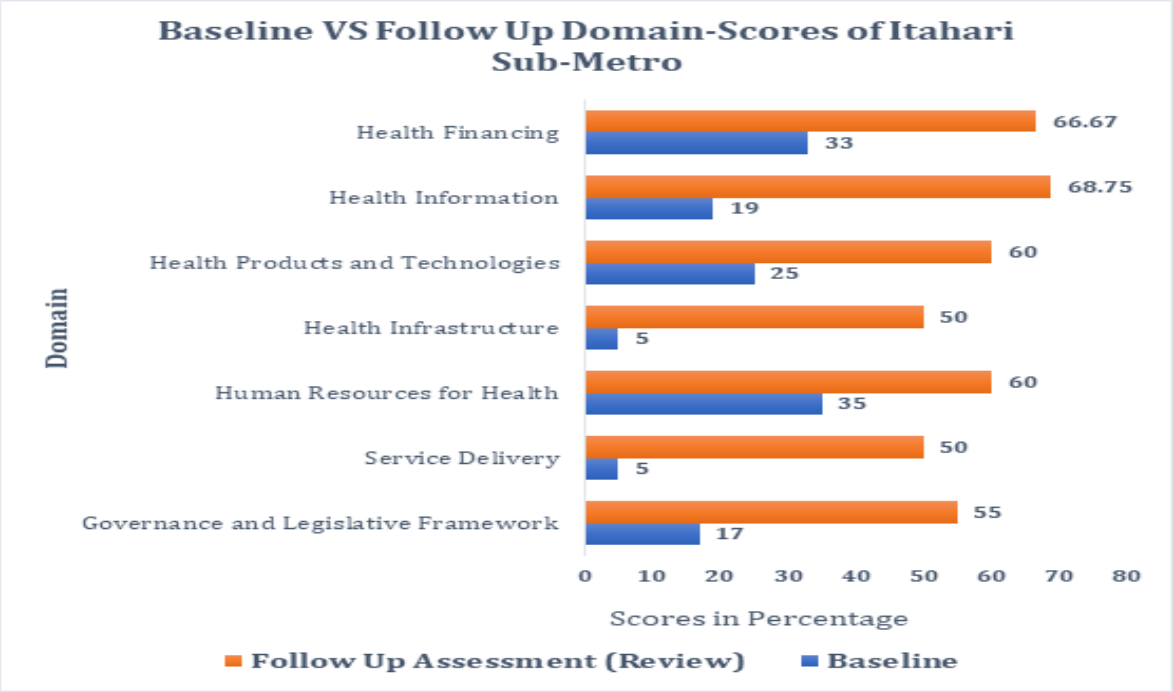
	Mar-19				Feb-20				Overall Change in MSS score
Health facility name	Domain 1	Domain 2	Domain 3	Overall MSS Score	Domain 1	Domain 2	Domain 3	Overall MSS Score	
Lali HP	48.0	20.7	33.2	29%	82.8	70.2	55.1	70%	143%
Raya HP	43.0	37.1	30.4	37%	60.8	65.3	49.7	61%	66%
Chhipra HP	39.7	31.1	27.3	32%	50.4	49.6	39.7	48%	49%
Kharpunath HP	28.1	31.7	16.5	28%	86.4	65.8	38.5	64%	130%
Kharpunath RM	***39.7***	***30.1***	***26.9***	31%	70.1	62.7	45.7	61%	94%

Annex 9: OCA lessons

The following examples show how the OCA led to strengthening of organisational capacity and hence (it is envisaged) the delivery of health services:

- Upgradation of existing health facilities into primary hospitals (Itahari, Dhangadhimai and Kharpunath). Planning is ongoing to establish the primary hospital at Ajayameru and Yasodhara;
- Developing local health acts;
- Establishment of municipal level health committee;
- Restructuring of HFOMC and the orientation program;
- Conducting regular health sector review meetings;
- Establish Citizen charter and service delivery dashboard at health facilities;
- Conducting social audit at health facilities;
- MSS roll out and the budget allocation for fulfilling the gaps from MSS assessment;
- RDQA roll out and budget allocation for data quality;
- Improved budget allocation for health sector from internal revenue;
- Regularization of supply of essential medicine and goods;
- Health insurance mechanism has been established at Kharpunath and Ajayameru.

Baseline versus follow up OCA scores in Itahari:

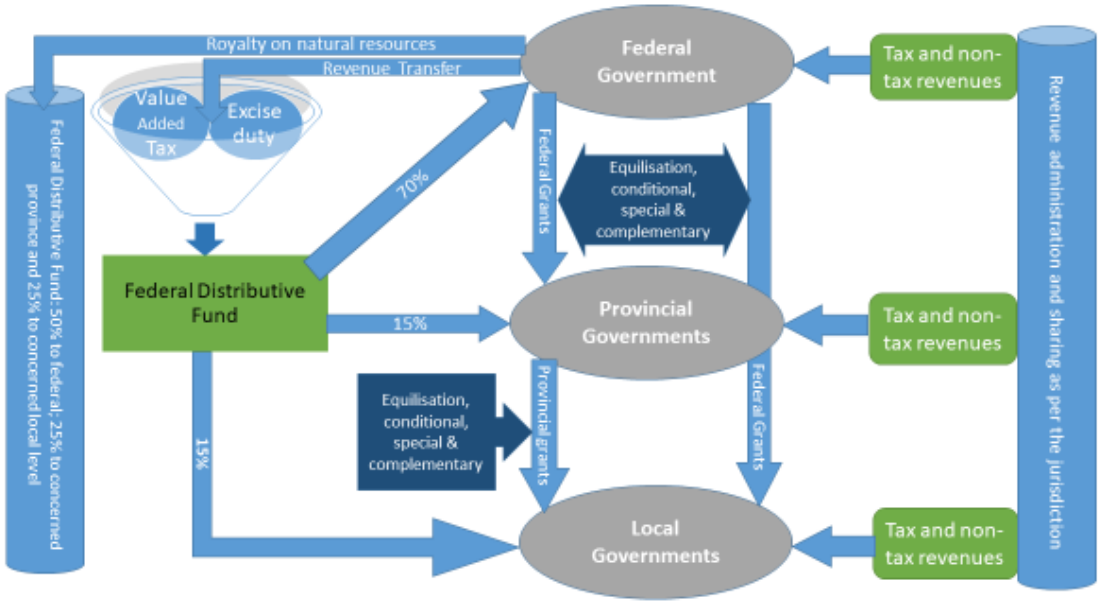


Annex 10: Workload re-adjustment case study

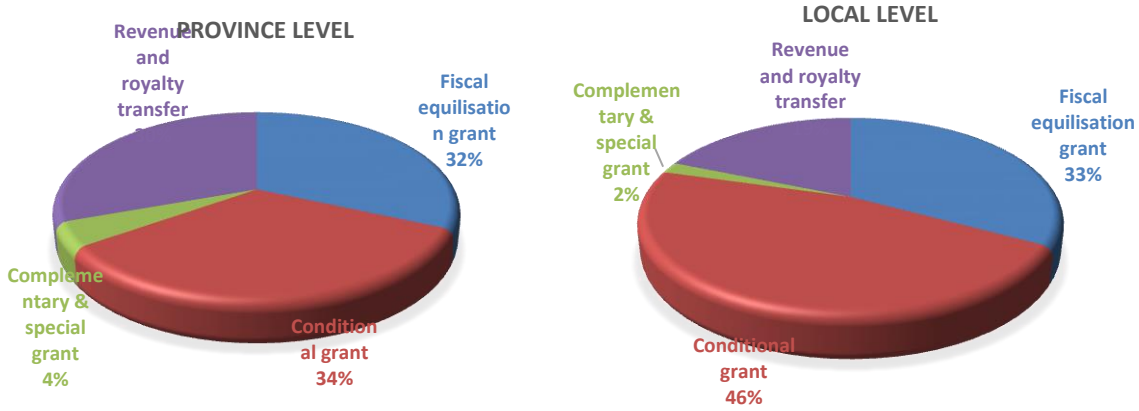
PMC has 43 health facilities yet the health division had only four sanctioned positions which is inadequate to manage the health programme. At HF level, the staff distribution pattern of MoHP is the same for both urban and rural settings, regardless of population size and needs. So, some health facilities, such as Urban Health Centres, are overburdened while others, such as rural Health Posts, remain under utilised. Given this, PMC conducted a workload analysis (Operations and Management Survey) of the health division and health facilities. Based on the results, PMC placed additional staff (now totaling 11 persons) at the Health Division. Then PMC reshuffled staff at the municipal and ward levels by pulling staff from low case load health Facilities and putting them into COVID-19 response management jobs such as Quarantine, Isolation, Contact Investigation and Contact Tracing. Staff from low caseload health facilities were also re-adjusted to Urban Health Centres where the caseload is high.

At the beginning of FY 2019/20, DM decided to upgrade a strategically located health post (Nayanpur HP), which is alongside the East-West highway, to a municipal-level primary hospital. New departments and services were started such as Indoor and Birthing ward along with 24-hour emergency and lab services. DM recruited a medical doctor and other staff using internal resources. This led to a gradual increase in patient flow and hence increased workload. The municipal office reviewed the patient flow and staffing pattern and decided to depute staff from the low-caseload health facilities to the upgraded hospital. Now the Nayanpur hospital serves as a referral facility within the municipality.

Annex 11: Sources of revenue and mechanisms of fiscal transfer

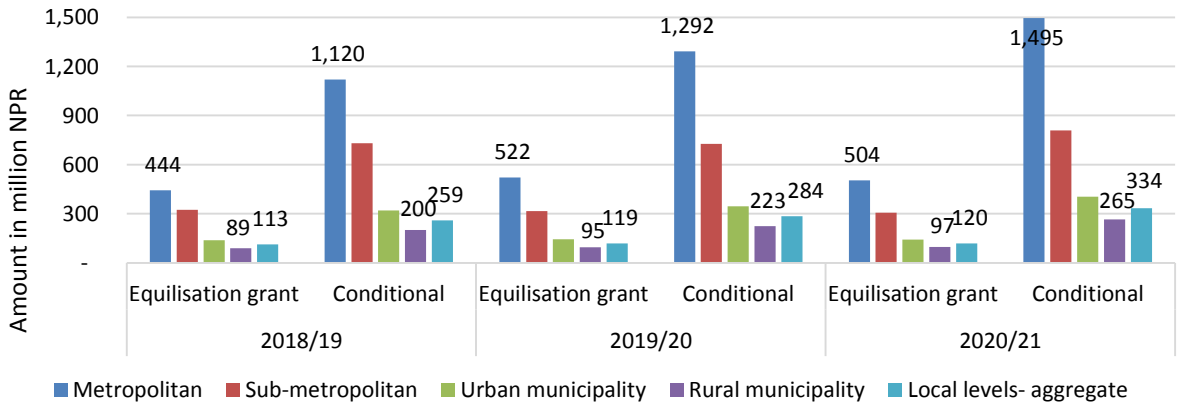


Annex 12: Composition of intergovernmental fiscal transfer for province and local level, 2018/19



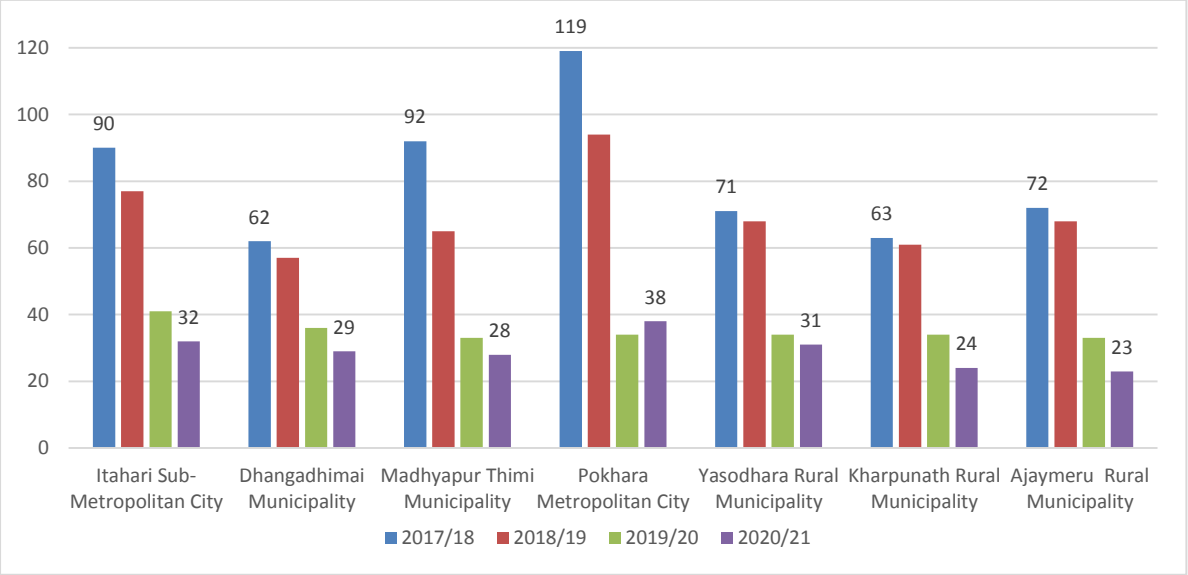
Source: MoF (2020), Economic Survey 2019/20.

Annex 13: Local level equalisation and conditional grants, in million NPR



Source: MoF (2018, 2019, 2020, 2021), Estimates of expenditure and revenues (Red book).

Annex 14: Number of budget heads in health sector conditional grants, LL sites



Source: Health sector conditional grants for the local levels, MoHP

Annex 15: Composition of health sector conditional grants in LL sites, 2020/21

(Amount in million NPR)

SN	Activity description	ARM	ISC	KRM	DM	PMC	MTM	YRM	Total	
									Amount	%
1	Salary and allowances for the staff working in HPs, PHCCs and hospitals of local levels including administrative expenses	19.7	18.8	15.8	24.1	97.6	20.2	30.8	227.0	57.0
2	Aama programme including incentives, baby bag and free abortion services	1.4	4.5	0.9	1.7	49.0	0.3	1.5	59.5	14.9
3	Operation of Basic Health Service Centres in the wards without health facilities	0.5	7.0	0.5	4.5	9.5	2.0	0.0	24.0	6.0
4	FCHV programme (dress allowances, transportation expenses, annual programme review and FCHV day celebration	1.1	2.0	0.5	0.8	9.4	0.7	1.5	16.0	4.0
5	Purchase of medicines and health safety materials (excluding PPE) for basic and emergency services including transportation, repackaging and distribution	1.5	1.8	1.2	1.2	3.0	0.8	1.2	10.8	2.7
6	Operational and programme budget for Ayurveda dispensaries	0.0	6.0	0.0	0.0	0.0	3.0	0.0	9.0	2.3
7	Maternal and newborn programme	1.1	1.1	1.0	0.7	2.7	0.2	0.8	7.4	1.9
8	Nutrition programme	1.1	1.7	0.5	1.2	1.6	0.5	0.6	7.1	1.8
9	Other programmes	1.2	2.4	1.3	1.9	20.6	7.1	2.9	37.6	9.4
10	Total	27.7	45.3	21.7	36.2	193.4	34.8	39.3	398.4	100

Source: Health sector conditional grants for the local levels, MoHP

Annex 16: Comparative Scenario of Annual Budget in LL sites

Total budget FY 2019/20						Total budget FY 2020/21					% change			
		Total health sector budget (in millions)					Total Health Budget in millions				Total Palika Budget	Conditional grant for Health	Internal health Budget	Total health budget
LL Site	Total Palika budget in millions	Federal Conditional	Palika total	Total	Budget Share for health %	Total Palika budget in millions	Federal Conditional	Palika total	Total	Budget Share for health %				
Itahari Submetropolitan City	1847.0	42.455	14	56.45	3%	**1780.00**	45.30	**25**	70.30	4%	-3.6	6.70	79%	19.7
Dhangadhimai	666.28	24.655	14	38.655	6%	**798.85**	36.20	**12.76**	48.96	6%	19.9	46.83	-9%	21.0
Madhyapur Thimi municipality	NA	24.679	1.25	25.93	NA	**1604.8**	34.80	**12.52**	47.32	3%	NA	41.01	902%	45.2
Pokhara Metropolitan City	5275.4	137.90	61.52	199.4	4%	**6197.2**	193.40	**85.6**	279.0	5%	17.5	40.24	39%	28.5
Yasodhara RM	394.80	34.456	15.39	49.851	13%	**550**	39.30	**9.78**	49.08	9%	39.3	14.06	-36%	-1.6
Kharpunath RM	323.76	19.62	10.53	30.151	9%	**338.88**	21.70	**14**	35.70	11%	4.7	10.60	33%	15.5
Ajayameru RM	426.03	22.987	5.546	28.533	7%	**472.8**	27.70	**9.315**	37.02	8%	11.0	20.50	68%	22.9
Total	**8933.26**	**306.76**	**122.24**	**429.00**	**4.8%**	**11742.53**	**398.40**	**168.98**	**567.38**	**4.8%**	**31.4**	**29.87**	**38%**	**24.4**