Annual Progress Report of Health Sector
Fiscal Year 2015/16
(For Joint Annual Review)

Government of Nepal
Ministry of Health
2017

Annual Progress Report of Health Sector

Fiscal Year 2015/16

(For Joint Annual Review)

Government of Nepal

Ministry of Health

2017

CONTENTS

ACRONYMS

AMP	Aid Management Platform
ANC	Ante Natal Care
AWPB	annual workplan and budget
BEONC	basic emergency obstetric and newborn (neonatal) care
BoD	burden of disease
CAPP	consolidated annual procurement plans
CEONC	comprehensive emergency obstetric and neonatal care
CLPIU	central level project implementation unit
CSD	Curative Services Division
DALY	disability adjusted life years
DDA	Department of Drug Administration
DDC	district development committee
DFID	Department for International Development
DHIS2	District Health Information System-2
DHO	district health office
DoDA	Department of Drug Administration
DoHS	Department of Health Services
DPHO	district public health office
DUDBC	Department of Urban Development and Building Construction
eAWPB	electronic annual workplan and budget
EDCD	Epidemiology and Disease Control Division
EDP	external development partners
EHCS	essential health care services
EWARS	Early Warning and Reporting System
FCGO	Financial Comptroller General's Office
FCHV	female community health volunteer
FHD	Family Health Division
FHD	Family Health Division
FMIP	Financial Management Improvement Plan

FMIS	Financial Management Information System
FMR	financial monitoring report
FY	financial year
GBV	gender based violence
GDP	gross domestic product
GESI	gender equality and social inclusion
GIS	geographic information system
GoN	Government of Nepal
HIIS	Health Infrastructure Information System
HMIS	Health Management Information System
HTC	HIV Testing and Council
HURIC	Human Resource Information Centre
ICB	international competitive bidding
ICD	International Classification of Diseases
ICT	information and communication technology
IHME	Institute for Health Metrics and Evaluation
IMNCI	integrated management of childhood illness
INGO	international non-governmental organisation
JAR	Joint Annual Review
JFA	Joint Financing Arrangement
JICA	Japan International Corporation Agency
KfW	German Development Bank
KOICA	Korea International Cooperation Agency
LMBIS	Line Ministry Budgetary Information System
LMD	Logistics Management Division
LMIS	Logistics Management Information System
M&E	monitoring and evaluation
MDGP	doctor of medicine in general practice
MIS	Management Information System
MMR	maternal mortality ratio
MoF	Ministry of Finance
MoH	Ministry of Health
MoUD	Ministry of Urban Development
MPDSR	maternal and perinatal death surveillance and response
MTR	Mid Term Review

NA	not available
NAC	Nepal Ayurved Council
NCB	national competitive bidding
NDHS	Nepal Demographic and Health Survey
NHFS	Nepal Health Facility Survey
NHPC	Nepal Health Professional Council
NHRC	Nepal Health Research Council
NHSP	Nepal Health Sector Programme
NHSS	Nepal Health Sector Strategy (2015-2020)
NHSS-IP	Nepal Health Sector Strategy Implementation Plan
NHSSP	Nepal Health Sector Support Programme
NHTC	National Health Training Centre
NMC	Nepal Medical Council
NMICS	Nepal Multiple Indicator Cluster Survey
NNC	Nepal Nursing Council
NPC	National Planning Commission or Nepal Pharmacy Council
NPHL	National Public Health Laboratory
OAG	Office of the Auditor General
OC	Outcome
OCMC	one-stop crisis management centres
ODA	official development assistance
OOP	out-of-pocket
OPMCM	Office of the Prime Minister and Council of Ministers
PBGAs	performance-based grant agreements
PFM	public financial management
PHAMED	Public Health Administration Monitoring and Evaluation Division
PHCC	primary health care centre
PHCRD	Primary Health Care Revitalization Division
PIU	project implementation unit
PPICD	Policy Planning and International Cooperation Division
QCBS	quality and cost based selection
RCC	reinforced cement concrete
RF	Results Framework
RHCC	Reproductive Health Coordinating Committee
SDG	Sustainable Development Goals

SHP	sub-health post
SOP	standard operating guidelines
SSU	social service units
SWAp	sector-wide approach
TABUCS	Transaction Accounting and Budget Control System
TARF	Technical Assistance Response Fund
TIU	TABUCS Implementation Unit
ToR	terms of reference
TWG	technical working group
UHC	Urban Health Clinic
USAID	United States Agency for International Development
WASH	water, sanitation and hygiene
WHO	World Health Organization

INTRODUCTION

Joint Annual Reviews (JARs) are carried out by the Ministry of Health (MoH) and its development partners to document progress in the health sector in the previous Nepali fiscal year. These reviews have been carried out every year since MoH adopt a pooled funding mechanism in 2003/04. The current report mainly covers the progress made in the previous fiscal year (mid-July 2015 to mid-July 2016), with progress also noted from the second half of 2016 and from previous years to elucidate the trends.

As decided at the previous JAR meeting in March 2016, the fiscal year covered by the 2017 JAR (FY 2015/16) is an extension of the Nepal Health Sector Support Programme-2 (NHSP-2). This decision was taken recognising the disruptions caused by the April and May 2015 earthquakes that put back the actual start date of NHSS to mid-July 2016. However, this reporting year is also a transitional period from NHSP-2 to NHSS and so it was agreed that the reporting against indicators at the 2017 JAR would be against the NHSS Results Framework to begin to focus on the NHSS and its indicators, which will be effective until 2020/21.

Following the previous JAR meeting, on 12 May 2016 an aide memoire was signed on behalf of the partners that committed to the actions in Table 1.1 in 2016. In addition, one of the main achievements in 2015/16 was the endorsement of the Nepal Health Sector Strategy (NHSS, 2015/2016–2020/2021), which will guide the work of the government and its development partners in the health sector over the next five years.

Table 1.1: Achievement of 2016 Aide Memoire points

S.N.	2016 Aide Memoire Points	Current Status
1	Extend the duration of NHSP-2 from July 2015 to a July 2016 finish date.	Agreed, and the actual start date of NHSS Implementation Plan was shifted to July 2016
2	Prepare the draft bill of the National Public Health Act	The draft bill of the National Public Health Act is under discussion at MoH in the context of federalization.
3	Revise the draft State Non-State Partnership Policy	The draft State Non-State Partnership Policy is under discussion at MoH in the context of federalization.
4	Finalize the Joint Financing Arrangement (JFA) for the NHSS period	The JFA to support the implementation of the NHSS was signed on 2 December 2016 with the agreement that its coming into effect was backdated to 15 July 2016. The JFA is the guiding document for implementation of the NHSS and monitoring its progress.
5	Form a task force to discuss audit queries	A task force has been formed and is working to address and reduce the number of audit queries. More than half (51.5%) of audit queries were cleared In the last fiscal year for which data is available (2014/15).
6	Mobilize and channel support by external development partners (EDPs) for implementing NHSS	The pooled and non-pooled arrangements are in place and channel funds through bilateral and multilateral agreements. The JFA provides a partnership framework.
7	Update and endorse the Financial Management Improvement Plan (FMIP)	The Financial Management Improvement Plan (FMIP) has been revised with inputs from EDPs to facilitate the implementation of NHSS
8	Provide adequate funding and mobilize technical assistance for implementing the procurement and supply chain management plan	Adequate funding has been allocated for procurement, supply chain management and the reconstruction of health facilities destroyed and damaged by the earthquakes.
9	Develop a Health Care Waste Management Plan	A Health Care Waste Management Plan is under discussion
10	Ensure quality of care including the minimization of overcrowding in referral hospitals	Quality of care is one of the four strategic directions of NHSS. More birthing centres and BEONC and CEONC centres have been established.
11	Review audit reports and resolve audit issues	The Audit Committee at MoH is active and more than a half of 2014/15 audit queries have been cleared.

Another achievement not covered in Table 1.1 is that discussions are ongoing to adjust the health sector under the new federal structure of government.

Chapter 2 of this report presents the results against the NHSS Results Framework and achievements on improving the availability of monitoring data, Chapters 3 to 8 present the main 2015/16 achievements related to improvements in the system of health care provision. Annex 1 gives three of the main areas of innovative health care delivery improvements. Box 1.1 presents the major highlights of 2015/16.

Box 1.1: Major health sector highlights of 2015/16

Law, policy and strategy related:

- An Immunisation Law and Immunization Fund were introduced to ensure sustainable funding
- Drafting of Integrated Public Health Act, Tuberculosis Act and Safe Motherhood Act started.
- The Urban Health Policy was endorsed.
- New procedures endorsed on health worker and other health sector employees responsibilities under MoH
- The Government of Nepal endorsed the Nepal Health Sector Strategy 2015/16–2020/21.
- Endorsed the "Reaching the Unreached Strategy".
- A Joint Financing Agreement was signed to support the implementation of the NHSS.
- The Leprosy Elimination Strategy (2017–2021) was developed to reduce new cases of leprosy-related disability to the zero level.
- A National Tuberculosis Strategy was developed to eliminate tuberculosis by 2050.
- National Malaria Strategic Plan (2014–2025) endorsed.
- Infant and Young Child Feeding Strategy (2016) developed.

Plan related:

- 67 Memoranda of Understanding were agreed with EDPs for the reconstruction of earthquake damaged facilities covering 359 buildings
- The National HIV Strategic Plan was developed and endorsed with the aim of ending the AIDS epidemic by 2030.
- A comprehensive multi-year plan (2017–2021) was developed for the National Immunization Programme with the target of eradicating polio and measles by 2019.
- National Family Planning Costed Implementation Plan, 2015-20 endorsed.
- Every Newborn Action Plan (ENAP, 2016) to reduce newborn morbidity and mortality was endorsed and is being implemented.
- Ten year action Plan on disability is under development.
- Five year action plan on Anaemia and Iodine Deficiency Control developed.

Other:

- The national Health Facility Survey was completed.
- Several studies, including the Nepal Demographic and Health Survey and the Nepal Nutrition Survey were started.
- More than 1,700 health facility based birthing units are now functional across the country.
- Social Health Insurance has been implemented in three districts.
- 18 out of 75 districts have been declared 'fully immunized districts'.
- The Integrated Management of Newborn and Childhood Illnesses (CB-IMNCI) programme has been implemented in 70 districts.
- Minimum standards are being developed for hospitals to improve quality of care.
- Maternal and Perinatal Death Surveillance and Response Initiatives instituted in 63 hospitals and 6 district health offices.
- Smart Health initiative started for improved e-governance.
- Coordinated health and nutrition response for recovery and reconstruction in post-earthquake situation.
- Large reduction in number of audit queries.

PROGRESS AGAINST NHSS RESULTS FRAMEWORK

2.1 Background

In 2015, the Ministry of Health (MoH) developed the Nepal Health Sector Strategy (NHSS), 2015/16–2020/21, which was endorsed by the Council of Ministers in 2016. This strategy will guide the work of Nepal's health sector over the next five years. The government and its partners have committed to align their efforts to NHSS priorities and are jointly accountable for achieving the results. Subsequent departmental and divisional annual workplans and budgets (AWPBs) will thus be aligned with the NHSS implementation plan (NHSS-IP) to translate the strategy into action.

Because of the disruptions caused by the 2015 earthquakes and the six month long fuel crisis (September 2015–February 2016) it was agreed at the 2016 Joint Annual Review that the NHSS-IP would be implemented a year later than planned — from fiscal year 2016/17 to 2020/2021. The progress of the health sector in the NHSP-2 period (2010-2015) in line with the NHSP-2 Results Framework was reviewed and discussed at the 2016 JAR and was well captured in the 2016 Aide Memoire. This chapter therefore presents the progress of Nepal's health sector in 2015/16 against the NHSS Results Framework indicators. And the results from the current reporting period (fiscal year 2015/16), are being taken as the baseline for NHSS implementation where data are available.

2.2 Monitoring Sector Performance

The NHSS document specifies that sector performance will be monitored over the next five years through its Results Framework, regular performance reviews and a mid-term review.

NHSS's Results Framework provides a broad strategic framework to monitor and guide the performance of the health sector over the next five years. The framework has 10 goal level indicators, 29 indicators to measure the 9 outcomes, and 56 indicators to measure the 26 outputs.

Towards achieving universal health coverage and leaving no one behind, the NHSS emphasises monitoring and reducing the equity gap in the health outcomes of different population sub-groups. The framework thus calls for the detailed disaggregation of data, and specifies regular monitoring, the means of verification and the responsible agencies for reporting on each indicator.

The national and sub-national performance reviews of the health sector will contribute to monitoring health sector performance under the NHSS. MoH and its partners aim to further harmonise these reviews at different levels and especially national annual reviews and joint annual reviews to extend functional linkages to the planning process.

A mid-term review of NHSS in 2018 will assess progress against its outcomes and results and review the sectoral management approach including the effectiveness of aid to the sector. This review will guide MoH and its development partners to make programmatic and systemic interventions to achieve NHSS's results in its remaining period.

2.3 Progress against NHSS Results Framework

The NHSS goal and outcome level indicators have targets (milestones) for 2017 and 2020 while there are annual targets for the output level indicators. MoH has developed a web-application for NHSS's Results Framework to house the latest results against indicators on MoH's website (www.mohp.gov.np)[1]. This portal includes an update of each indicator as per the monitoring frequency; a graph of the trend data with a focus

1 Note: The web portal with latest NHSS results Framework results is due to go live in the first week of February 2017 with a link to it on MoH's website's home page.

on equity (gaps) between different population sub-groups; the metadata related to the indicators; and the NHSS output specific key interventions defined in the NHSS-IP by each MoH agency. This application allows the compilation and analysis of indicators alongside the key interventions that contribute to achieving NHSS's outputs and outcomes by MoH departments, divisions and centres, and by the outcomes and outputs. This write-up presents highlights of the NHSS results Framework and progress against some tracer indicators.

Table 2.1 shows the 10 goal level indicators with their baseline data and defined targets. The Nepal Demographic and Health Survey (NDHS), 2016/17 will generate the population-based data to monitor 6 of the 10 goal level indicators.

Table 2.1: NHSS Results Framework goal level indicators

Code	Indicators	Baseline situation			Targets	
		Data	Year	Source	2017	2020
G1	Maternal mortality ratio (per 100,000 live births)*	190	2013	WHO	148	125
G2	Under five mortality rate (per 1,000 live births)	38	2014	NMICS	34	28
G3	Neonatal mortality rate (per 1,000 live births)	23	2014	NMICS	21	17.5
G4	Total fertility rate (births per 1,000 women aged 15–19 years)	2.3	2014	NMICS	2.2	2.1
G5	% of children under-5 years who are stunted	37.4	2014	NMICS	34	31
G6	% of women aged 15-49 years with body mass index less than 18.5	18.2	2011	NMICS	13	12
G7	Lives lost due to road traffic accidents per 100,000 population	34	2013	Nepal Police	23	17
G8	Suicide rate per 100,000 population	16.5	2014	Nepal Police	15	14.5
G9	Disability adjusted life years lost due to communicable, maternal & neonatal, non-communicable diseases and injuries	8,319,695	2013	BoD, IHME	7,487,726	6,738,953
G10	Incidence of impoverishment due to out-of-pocket expenditure in health	na			Reduce by 20%	
Note: * Nepal's MMR is reported at258 for 2015 (WHO estimates) Refer to full NHSS Results Framework for means of verification of the targets and required data disaggregation						

The estimated maternal mortality ratio (MMR) of 850 per 100,000 live births in 1990 declined to 281 in 2006 (Figure 1.1). The Maternal Mortality and Morbidity Study conducted in eight districts in 2008/09 (MoHP 2009) indicated that the MMR had further declined to 229. The UN global estimate of MMR for Nepal was 190 in 2013 and 258 in 2015 (WHO et al. 2015). Nepal aims to reduce the MMR further to 148 by 2017 and 125 by 2020. Realizing the importance of having a reliable source of data to estimate the MMR, priority is being given to strengthening and expanding the maternal and perinatal death surveillance and response system (MPDSR).

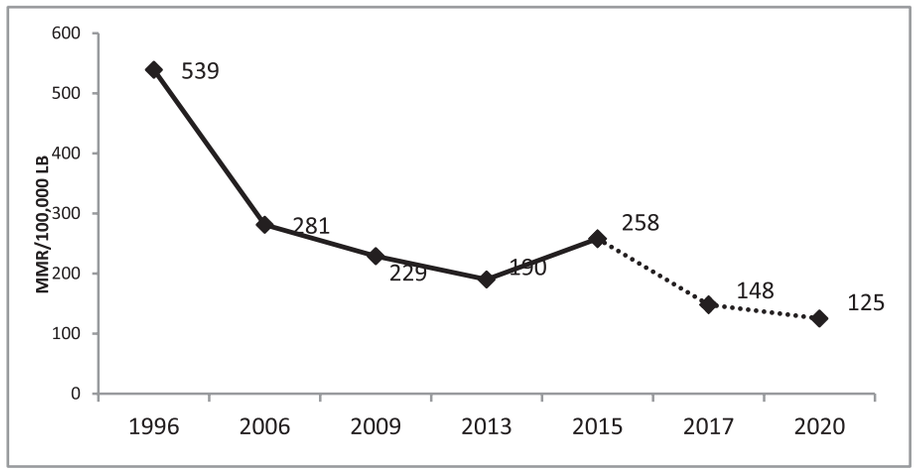

Figure 1.1: Maternal mortality ratio, Nepal, 1996 to 2020 (NHSS RF: G1)

There has been a large decline in child mortality (Figure 1.2). During the NHSP-2 period, under-five mortality declined from 54 per 1,000 live births (NDHS 2011) to 38 (NMICS 2014); and neonatal mortality from 33 per 1,000 live births (NDHS 2011) to 23 (NMICS 2014). The NHSS targets are to reduce under-five mortality to 34 by 2017 and 28 per 1,000 live births by 2020 and to reduce neonatal mortality to 21 per 1,000 live births by 2017 and to 17.5 by 2020. Also, stunting in children under five years has decreased from 60 per 1000 in 1990 (NPC 2005) to 37.4 in 2014 (NMICS 2014). The NHSS aims for a reduction to 34 by 2017 and 31 by 2020.

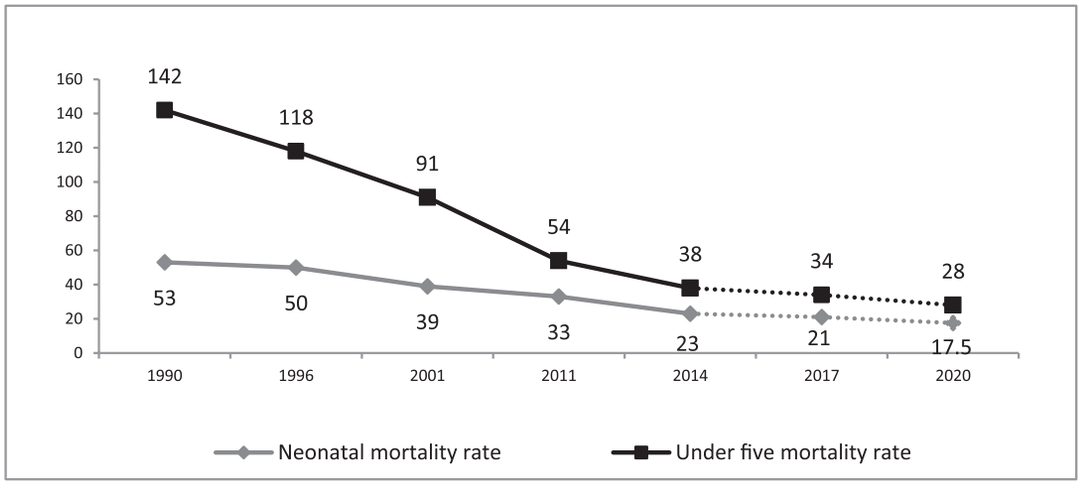

Figure 1.2: Childhood mortality per 1000 live births, Nepal, 1990 to 2020 (NHSS RF: G2 & G3)

2.3.1 Progress against outcome level indicators

The Results Framework has 29 outcome level indicators to monitor the achievement of NHSS's nine outcomes. NHSS has 2017 and 2020 targets for these indicators. This section presents progress of some of the outcome level indicators to 2015/16.

Institutional deliveries: There have been large improvements in the proportion of women delivering at health institutions (Figure 1.3). The proportion of women delivering at health institutions increased from 11 percent in 1996 (NFHS 2016) to 55 percent in 2014 (NMICS 2014. However, there is a wide variation between different population sub-groups with only 28 percent of lowest quintile women having institutional deliveries compared to 91 percent of highest economic quintile women (NMICS 2014). The Health Management Information System (HMIS), 2015/16, reports 55 percent of women delivering in health facilities. NHSS's target is to reach 65 percent by 2017 and 70 percent by 2020 with the focus on reducing the equity gap between sub-groups.

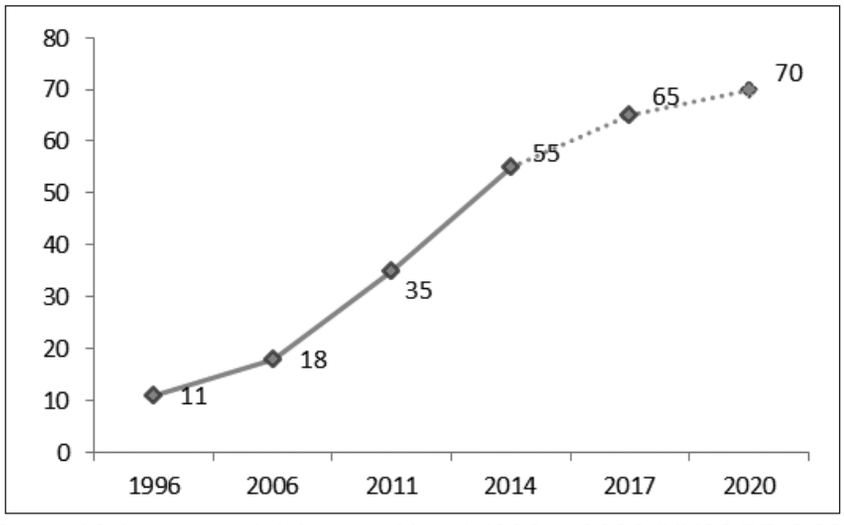

Figure 1.3: Institutional deliveries, Nepal, 1996 to 2020 (NHSS RF: OC3.3)

Quality of care: Improving the quality of care at the point of delivery is one of NHSS's four strategic directions. The Nepal Health Facility Survey (NHFS), 2015, for the first time in Nepal, collected information on quality of care at health facilities in terms of meeting minimum standards at the point of delivery; compliance with service delivery standards, protocols, and guidelines; and the quality of service provision. The NHFS's overall findings indicate that additional efforts are needed to improve the quality of health services. Table 2.2 presents findings of the NHFS on NHSS indicators.

Overall, 7 percent of zonal and above hospitals, 15 percent of district-level hospitals, 4 percent of PHCCs and less than 1 percent of health posts and urban health clinics (UHCs) stocked all 18 tracer medicines (selected for monitoring purpose covering different programmes) at time of monitoring.

When assessed, the minimum standard of quality of care at the point of delivery concerning the presence of nine tracer 'items', less than one percent of the surveyed facilities had all nine items. The nine items include soap and running water or alcohol-based hand disinfectant, safe final disposal of infectious waste, equipment and knowledge of processing time, trained staff, quality assurance guidelines, clinical protocol, availability of all four tracer amenities, waiting room, tracer medicines (amoxicillin or cotrimoxazole and gentamycin and oral rehydration solution and zinc and at least three family planning methods and iron and folic acid and albendazole).

Five percentage of observed antenatal care (ANC) clients were provided with quality services as per national standards against four tracer items (client received ANC services from an SBA, client reported being counselled on at least three danger signs, client recommended facility to others and client reported no problems regarding waiting time). Likewise, 24 percent of IMNCI clients and 10 percent of family planning clients were being provided with quality services as per the standards.

Table 2.2: Status of quality of care at point of delivery (Source: NHFS 2015)

	RF Code	Indicator	Facility type					Managing authority		14 earthquake affected districts	All
			Zonal & above hospital	District level hospital	PHCC	Health post	UHC	Public	Private		
1	OC1.4	% of health facilities with no stockouts of tracer drugs	6.8	14.5	4.4	0.2	0.0	0.72	1.2	0.6	0.8
2	OC2.1	% of health facilities meeting minimum standards of quality of care at point of delivery	0.0	3.9	0.5	0.7	0.0	0.7	0.0	0.0	0.7
3	OC2.2	% of clients provided with quality services as per national standards:									
		IMNCI services	7.7	13.2	29.3	30.7	13.7	26.2	10.9	22.5	24.0
		Antenatal care	0.3	5.4	6.8	7.4	0.0	5.8	3.3	2.8	5.3
		Family planning	23.6	7.7	18.6	7.6	18.9	10.1	4.3	8.2	9.9
4	OC3.1	% of clients who received basic health services free of cost:									
		Child treatment	na	24.9	81.3	97.2	98.9	na	na	71.7	85.9
		Antenatal care	na	65.1	85.6	97.9	100.0	na	na	88.7	87.9
		Family planning	na	81.5	92.3	99.4	100.0	na	na	98.4	97.1

na = not applicable, IMNCI = integrated management of childhood illness

Free services: Family planning, antenatal care, and services for sick children (IMNCI[2]) are provided free of cost in all public health facilities at the district level and below. The Nepal Health Facility Survey (2015) found that a greater proportion of family planning clients than antenatal and sick child clients received free services (Figure 1.4). Ninety-seven percent of family planning clients received services free of cost on the day of their visit as compared with 88 percent of ANC clients and 86 percent of sick children. For all three types of services, services are least likely to be actually provided free at district hospitals. The proportion of clients receiving free care at district hospitals was especially low for services for sick children (25 percent).

2 IMNCI = integrated management of childhood illness

2.3.2 Progress against outputs

There are 56 output level indicators to monitor the 26 NHSS outputs with annual targets and final 2020 targets. This section presents progress against some output level indicators.[3] Annex 2 shows the detailed progress and data availability on the NHSS outputs. The data for 2016 is available for 27 of the 56 indicators. The 2016 target have been met for 8, a medium level of progress (little progress) has been made for 10 indicators and there has been poor progress on 3 indicators while no target was set for 27 indicators. Note that the NHSS document mentions that data will be available for all indicators in 2017.

This section presents progress on some of the tracer output level indicators using NHFS 2015 data (see further details at www.mohp.gov.np). Note that Table 2.5 provides details on NHSS indicators that need additional efforts for data generation.

Positions filled: The NHFS 2015 found that overall 7 in 10 sanctioned posts in public health facilities were filled (Table 2.3). Primary health care centres (PHCCs) (78 percent) and health posts (72 percent) are more likely to have their sanctioned positions filled than district-level (64 percent) and zonal and above hospitals (69 percent). Urban health clinics (32 percent) are least likely to have their sanctioned posts filled.

In terms of the types of service providers, slightly more than half of doctor (MDGP) and medical officer posts and just under half of consultant positions are filled. Paramedic and nurse posts are more likely to be filled (74 percent and 72 percent, respectively) than the higher levels the health workforce cadres. Table 2.3 presents the current status on some related tracer output indicators.

Table 2.3: Progress against NHSS results Framework output indicators (Source NHFS 2015)

	RF Code	Indicator	Facility Type					Managing authority		14 EQ affected districts	All
			Zonal & above hospitals	District level hospitals	PHCC	Health post	UHC	Public	Private		
1	OP1b1.1	% of sanctioned posts filled:									
		Consultants	48.4	na	na	na	na	48.4	na	48.8	48.4
		MDGP	63.2	51.9	na	na	na	56.5	na	52.0	56.5
		Medical officer	57.6	57.6	50.7	na	na	55.9	na	61.3	55.9
		Nurse (staff nurse + ANM)	73.0	78.5	79.1	70.7	35.7	72.1	na	70.2	72.1
		Paramedics (HA + AHW)	80.6	80.5	83.0	73.1	28.6	74.3	na	64.8	74.3
2	OP1c2.1	% health facilities receiving tracer commodities within less than two weeks of placing orders	100.0	85.9	77.5	80.3	90.7	80.8	96.7	84.9	81.7
3	OP1c2.2	% of health facilities complying with good storage practices for medicines	75.8	71.1	75.6	63.2	70.7	64.3	62.0	60.0	64.1
4	OP2.1.1	% of providers complying with service delivery standard protocols/guidelines for tracer services:									
		IMNCI services	3.7	0.0	1.5	0.9	0.0	0.9	0.9	2.2	0.9
		Antenatal care	7.3	3.9	1.5	0.0	0.6	0.2	0.0	0.3	0.2
		Family planning	7.3	6.6	2.4	0.5	0.0	0.8	0.8	0.3	0.8
5	OP2.1.3	% of health facilities with capacity to provide selected laboratory services as per standards	30.7	21.1	3.4	na	na	10.3	14.8	12.2	12.6
6	OP2.3.1	% of health facilities segregating health care waste at time of collection	100.0	92.1	85.8	84.5	85.6	84.9	95.1	91.2	85.9
7	OP2.3.2	% of health facilities safely disposing health care waste	72.7	77.6	74.8	78.4	69.4	77.8	73.4	78.0	77.4
8	OP3.1.1	% of health facilities providing all basic health services by level	80.9	85.5	90.8	64.4	33.4	65.0	24.5	68.2	62.0
9	OP3.1.3	% districts with at least one CEONC site	na	na	na	na	na	na	na	42.9	40.0
10	OP5.1.2	% of health posts with laboratory services	na	na	na	13.4	na	na	na	3.6	13.4

3 See further details at www.mohp.gov.np

2.4 Initiatives to Improve Availability and Use of Evidence

Towards achieving NHSS Outcome 9, MoH is working to improve the availability and use of evidence in decision-making at all levels through the use of information and communication technology (ICT). This section highlights the key related initiatives in 2015/16.

Programme-specific results framework: All MoH's departments, divisions and centres have developed programme-specific results frameworks for monitoring their programmes and activities in line with the NHSS Implementation Plan. This should help them prepare their AWPBs for the next five years and regularly monitor progress.

Web-based monitoring of the Results Framework: To improve the availability and use of evidence in decision-making at all levels, the information on progress against the NHSS indicators and programme-specific results frameworks are being updated and are available on MoH's website (www.mohp.gov.np). The web application allows departments, divisions and centres to compile and analyse indicators and key interventions that contribute to achieving their outputs and outcomes.

Improving reviews and linking with planning process: Every year health programme performance reviews are carried out at facility, district, regional and central levels. The lower level reviews feed into the higher ones and on to the preparation of AWPBs. The annual regional health reviews of FY 2072/73 (2015/16) occurred in September and October 2016. Each review lasted three days with one more day spent on hospital-wise reviews. The national annual review took place 16–18 November 2016 in Kathmandu.

Migration of HMIS and EWARS into DHIS2 Platform: The Health Management Information System (HMIS) was recently 'migrated' to the District Health Information System-2 (DHIS-2) platform, to support online data entry from district health offices and facilities. The customised web-based application is supporting districts and facilities to implement DHIS-2. Its advanced analytical and data presentation features allow the better use of data and will help to improve data quality. HMIS is now gradually moving from paper-based to electronic reporting by health facilities. From now on HMIS data on the DHIS 2 platform will be used in all levels of reviews. In addition to monthly aggregate data reporting from health facilities, HMIS is moving towards an open source electronic health record system that not only captures case-based data with ICD-10[4] coded diagnosis (thus producing more accurate morbidity and mortality statistics), but will also help overcome the administrative, financial and data management issues associated with paper-based recording and reporting.

The Early Warning and Reporting System (EWARS) is also using the DHIS-2 platform. This enhances the capacity of the Epidemiology and Disease Control Division (EDCD) on data management and the use of surveillance data for rapid responses to epidemics.

Maternal and perinatal death surveillance and response: Towards improving the quality of care at the point of service delivery, MoH has initiated and expanded the community based maternal and perinatal death surveillance and response mechanism (MPDSR) in six districts and a health facility-based system in 63 hospitals in 2072/73. MoH is also focusing on revitalizing and strengthening the reporting by female community health volunteers (FCHVs) of pregnancy-related deaths and strengthening and expanding facility-based MPDSR.

The generation of evidence: The key surveys undertaken in 2015/16 include the following:

- The Nepal Health Facility Survey (NHFS), 2015 assessed health facilities in Nepal on their delivery of health care services and examined the preparedness of facilities to provide quality health services on child health, family planning, maternal and newborn care, HIV, sexually transmitted infections, non-communicable diseases and tuberculosis. Findings from this survey provide a baseline for NHSS. There is a need to develop a survey plan to ensure data availability at certain time intervals to monitor progress.
- The Nepal Demographic and Health Survey (NDHS) 2016 is underway and the final report is expected in October 2017. There is a recognised need to harmonize the NDHS and the Nepal Multiple Indicator Cluster Survey (NMIC) to meet the country's data needs, timing and resource mobilization.
- The Nepal Micronutrient Survey, 2016/17 is a cross-sectional population-based survey to provide region-wise information on nutritional status. The survey will also provide information on priority process and

4 3International Classification of Diseases

outcome indicators for national supplementation and fortification interventions and other key nutrition interventions.

- The Nepal Health Research Council (NHRC) published a number of reports in 2015/16 and its peer reviewed journal the Journal of Nepal Health Research Council (Table 2.4). These reports are available at http://nhrc.org.np/reports

Table 2.4: Nepal Health Research Council published report in 2015/16

	Publication
1	Translation of Health Research Evidence into Policy and Planning in Nepal: An Appraisal 2016
2	Situation Analysis of Ambient Air Pollution and Respiratory Effects in Kathmandu Valley, 2015
	Anaemia and its Determinants among Women of Reproductive Age in Mid-Western Tarai of Nepal, 2015
4	Knowledge Diversity and Healing Practices of Traditional Medicine in Nepal
5	Blood Lead Levels among Children Aged 6–36 Months in the Kathmandu Valley, 2015.
6	Evaluation of the Community-based Mental Health Programme in Selected Districts of Nepal, 2015
7	Health Effects of Pesticide among Vegetable Farmers and the Adaptation Level of Integrated Pest Management Programme in Nepal, 2014
8	Adolescent Nutrition Survey in Nepal, 2014
9	Outbreak Investigation of Influenza-like Illness in Jajarkot, Nepal 2015
10	Measles Outbreak in Kapilvastu, Nepal: An Outbreak Investigation, 2016
11	Proceedings of the First National Summit of Health and Population Scientists in Nepal: 11-12 April 2015, Kathmandu
12	Journal of Nepal Health Research Council, 2015, volume 13, Numbers 2 and, Issues 30 and 31 and volume 14, Number 1, Issue 32

2.5 Main challenges

Functional linkages between information systems: Progress has been slow on bringing about the more integrated information management system that was called for by NHSP-1 (2004–2010) and NHSP-2 (2010–2015). Information systems and e-Health solutions and initiatives are yet to be properly integrated within the national health system with the many systems developed in isolation. The lack of interoperability inhibits evidence-based timely decision making.

Data availability: The NHSS recognizes the need to strengthen information systems and establish new sources to meet the health sector's data needs. A number of sources of information need strengthening or establishing to meet data needs (see Table 2.5).

Harmonization of reviews: The mid-term reviews of NHSP-1 and NHSP-2 identified the need to review the review process possibly by combining Department of Health Service (DoHS) annual reviews and joint annual reviews (JARs). This is yet to happen.

Improving quality and use of data at different levels: There are concerns about the quality of data generated by routine information systems and the use of data for decision making. Data quality and use are interrelated as poor quality data will be used less, and so the data will remain poor quality while the greater use of data will help improve data quality, which will lead to more use of it. There is a need to improve both the quality and use of data.

2.6 Ways Forward

Improve the availability and use of quality data: Establish and strengthen routine information systems and harmonize surveys as per the (to-be-developed) survey plan to monitor the indicators of the Results Framework and the Sustainable Development Goals (SDGs). Actions that need taking to improve the availability of data are listed in Table 2.5.

Table 2.5: Action points for NHSS Results Framework indicators for which data sources need strengthening or establishing

NHSS Results Framework indicator		Action point & responsible agency
G7	Lives lost due to road traffic accidents per 100,000 population	PHAMED: Develop MIS/ mechanism to generate quality data G7 & G8: Collaborate with Nepal Police
G8	Suicide rate per 100,000 population	
G9	Disability adjusted life years (DALY) lost: Communicable, maternal, neonatal & nutritional disorders; non-communicable diseases; and injuries	
G10	Incidence of impoverishment due to out-of-pocket (OOP) health expenditure	
OC6.2	Incidence of catastrophic health expenditure	
OP6.2.1	% of OOP expenditure in total health expenditure	
OP5.2.1	% of private hospitals complying with MoH guidelines — by development region	
OP5.2.2	% of private hospitals accredited - by region	
OP6.2.2	% of population covered by social health protection schemes (free delivery, basic health service, insurance enrolment)	
OC9.3	Overall score of health information system performance index (%)	
OP9.3.1	% of result framework indicators reported on at specified frequency	
OP9.3.3	% of prioritized action points agreed during national review reflected in AWPBs	
OP4.1.2	% of grant receiving hospitals (above district hospitals) submitting progress reports to MoH	PPICD: Establish system to collect data
OP4.1.3	% of flexible budgets provided to districts (DPHO/DHO) in total district programme budgets	
OP6.1.3	% of districts receiving budget based on identified needs and output criteria	
OP9.3.2	% of programme budgets allocated for M&E	
OC4.2	Proportion of district development funds (DDF) allocated for health	
OC1.1	% of health facilities meeting MoH infrastructure standards by type of health facility	Management Division: Upgrade the HIIS
OP1a1.1	% of health institution buildings completed as planned for fiscal year (by type of facility)	
OP1a2.1	% of damaged health facilities rebuilt	
OP1a3.1	% of health buildings maintained annually as per maintenance plans (by type of facility)	
OC2.5	% of infection rates among surgical cases	Management Division: Upgrade the HMIS
OP3.1.1	% of health facilities providing all basic health services (by level)	
OP5.1.2	% of health posts with laboratory services	
OC4.1	% of MoH's district budgets disbursed as block grants	HRFMD: Establish a system to collect data
OP6.1.2	% of health budget in total budgets of local government	
OP1b1.1	% of sanctioned posts filled	
OP1b1.2	% of health workers working at their own deputed (*durbandi*) institution	
OP1b2.1	% of health academic institutions meeting minimum standards of respective councils	Councils (NMC, NNC, NPC, NHPC, NAC): Establish a system to collect data
OP1b2.2	Success rate of council examinations (examinees) in their first attempt (Medical and Nursing)	
OC2.4	% of tracer drugs meeting quality standard at different levels (at hospitals, PHCCs, health posts and district stores)	DDA: Establish a system to collect data
OP2.1.2	% of pharmaceutical companies with good laboratory practices (GLP) and good manufacturing practices (GMP)	
OP3.2.4	% of public hospitals with own pharmacy service (by level of facilities)	

NHSS Results Framework indicator		Action point & responsible agency
OP3.2.3	% of public health facilities providing both modern and Ayurveda services (by level of facilities)	DoHS: Establish a system to collect data
OP4.1.1	Number of districts (DHO & DPHO) submitting DDC approved annual plans to DoHS at specified time by development region	
OP5.4.1	% of districts with functional district health coordination committees	
OC8.1	Case fatality rate per 1,000 reported cases due to public health emergencies (natural disasters and disease outbreaks and events)	EDCD: Establish a system to collect data
OC8.2	% of natural disasters and disease outbreaks responded to within 48 hours (disasters and disease outbreaks)	
OP1c2.1	% of health facilities receiving tracer commodities within less than two weeks of placing orders	LMD: Upgrade the LMIS
OP3.2.2	% of referral hospitals providing fast track services for referred clients	CSD: Establish a system to collect data
OP2.2.1	% of hospital-based maternal deaths reviewed	FHD: Strengthen MPDSR
OP9.2.1	% of national level surveys and research producing policy briefs	NHRC: Establish system to collect data
OP2.2.2	% of registered laboratories accredited	NPHL: Establish system to collect data
OP3.2.1	Number of community health units	PHCRD: Establish system to collect data

Implement smart health initiatives: As warranted by the NHSS, there is a large need for MoH and its partners to implement the E-Health Strategy 2016/17 and capacitate institutional setups to operationalize it. This will help leverage the use of ICT in health service delivery and health sector information management.

Survey harmonization: Develop and implement a survey plan to harmonize population and facility-based surveys to meet national data needs.

PUBLIC FINANCIAL MANAGEMENT

3.1 Background

Public financial management is the capability of governments to plan in accordance with their national policy and fiscal frameworks, prepare budgets and ensure their timely release, carry out transparent and timely accounting, and provide financial and value for money audits of expenditure. Sound public financial management thus ensures that financial resources are used efficiently and effectively in line with government policies and priorities.

Substantial progress was made on strengthening MoH's public financial management system during NHSP-1 (2004–2010) and NHSP-2 (2010–2015). This contributed to the timelier authorisation of budgets, improved financial reporting (through the new Transaction Accounting and Budget Control System, TABUCS), improved capacity on audit clearance and improved decision making through regular meetings of MoH's Public Financial Management Committee.

This report summarises the progress on financial management in fiscal year 2015/16 and the overall progress made during NHSP-2. This report highlights progress on systems development, committee formation, expenditure patterns, financial auditing and the addressing of audit queries. It also describes the main challenges faced and the ways forward.

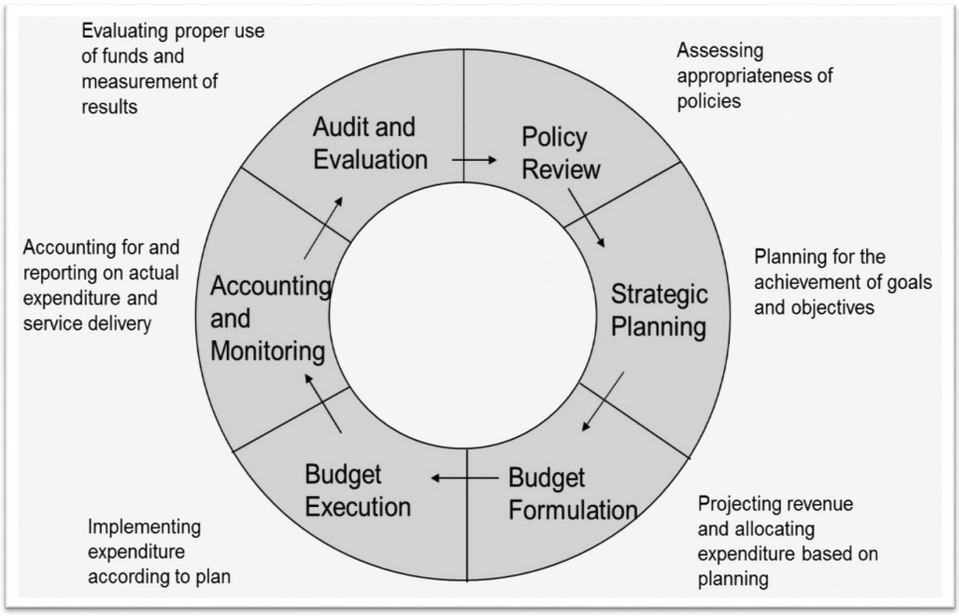

Figure 3.1: The public financial management cycle

3.2 Achievements

MoH made the following progress in 2015/16 on strengthening public financial management in Nepal's health sector across the PFM cycle (Figure 3.1):

1. Finalised the revision of the Financial Management Improvement Plan.
2. Analysed NHSP-2 budget allocations and expenditure.
3. Built the capacity of programme managers and finance officers on audit clearance.
4. Improved financial monitoring reports (FMR) templates.
5. The regularisation of the functioning of the Public Financial Management Committee.
6. Finalised performance-based grant agreements with seven major health institutions.
7. A more active audit committee.

Technical assistance contributed to these achievements by developing guidelines, frameworks, plans and information system and by building capacity.

As a result of the continuous efforts of MoH and its external development partners (EDPs), the latest International Health Partnership's (IHP's) country scorecard (2013 results) reported that Nepal's public financial management systems were of good quality.

3.2.1 Upgrading Transaction Accounting and Budget Control System (TABUCS)

Under NHSP-2, MoH designed, piloted, rolled out and upgraded the Transaction Accounting and Budget Control System (TABUCS). TABUCS is a simple accounting system to capture basic accounting transactions on a real time basis at source level, and enforces budgetary control procedures so that no expenditure can occur without an approved budget and activities. The basic functionality of TABUCS:

1. processes expenditures and payments
2. automatically posts payments to ledger accounts and summary accounts
3. processes cash, bank receipts and revenues
4. automatically posts receipts to ledger accounts and summary accounts
5. automatic posting in cash and bank books
6. generates financial monitoring reports (FMRs).

In 2013, MoH established its TABUCS Implementation Unit (TIU) and a help desk to resolve technical issues and implement TIU decisions. NHSSP provided technical support to design, pilot, build the capacity of planning and finance officers, install TABUCS in all cost centres and establish and run the help desk. TABUCS was rolled out across the country by April 2014.

The main progress in 2015/16 were the inclusion of the earthquake module and the upgrading of the eAWPB to allow district level planning and budgeting. Table 3.1 summarises the major milestones in the development of TABUCS.

TABUCS is now instrumental in capturing expenditure and aligning it against the budget by programme activities. Additionally, it provides a single tool to track budgets and prepare expenditure reports.

Table 3.1: Milestones in the development of TABUCS

Period	Milestone
July 2011	TABUCS concept note prepared
February 2012	MoH submitted a funding proposal for designing, piloting and implementation of TABUCS to DFID
February 2012	Selection of service provider
September 2012	TABUCS implementation plan submitted by service provider
November 2012	TABUCS specification and system design document prepared with the help of international PFM / ICT consultant
December 2012	Assessment of cost centres selected for piloting
January 2013	Selection of cost centres for piloting
March 2013	Training of the users from selected pilot cost centres
April 2013	Launching of TABUCS
May 2013	Installation of software and data entry in selected pilot cost centres
August 2013	Preparation of system manual, user manual, training manual, frequently asked questions, and situation analysis report
August 2013	Reflection workshop of piloted cost centres
October 2013	MoH decides to roll out MoH to all cost centres across the country
December 2013	Training of trainers for TABUCS completed
December 2015	Developed and integrated the earthquake module in TABUCS
December 2015	Upgraded eAWPB to allow the district level planning and budgeting
January 2016	Earthquake module functional in TABUCS
September 2016	Bottom up eAWPB included in TABUCS
December 2016	TABUCS user training of 607 participants from 274 cost centres are trained in 31 batches (Up to December 2016)
January 2017	Nepal Public Sector Accounting Standard (NPSAS) module included in TABUCS

3.2.2 Revised Financial Management Improvement Plan

In 2011/12, a Financial Management Improvement Plan (FMIP) was prepared for FY 2012/13 to 2015/16 and endorsed by MoH. The plan is in line with the government's Public Expenditure and Financial Accountability (PEFA) Framework (http://www.pefa.gov.np). The FMIP aims to extend good practices and implement new initiatives within MoH. It contains explicit indicators on MoH's practice of financial planning, accounting procedures, internal control, financial reporting, monitoring, auditing and transparency measures. The progress against these indicators is given in Table 3.2. The overall thrust of the FMIP is to reduce fiduciary risk and improve financial accountability in the health sector. Noting the findings of fiduciary risk assessments carried out by the World Bank and the Department for International Development (DFID) in 2013, MoH revised its FMIP in 2014 and endorsed the revised version.

FMIP was revised again in 2015/16 to facilitate the implementation of NHSS. MoH received inputs from The World Bank, DFID, USAID, KfW and the DFID supported PFMA programme to prepare and finalise the FMIP for 2016-2021 — the NHSS period. MoH actively engaged with its departments, centres, divisions and sections for producing it. The revised FMIP was finalised at a workshop on 5 December 2016 attended by representatives of the Office of the Auditor General (OAG), National Planning Commission (NPC), Ministry of Finance (MoF), EDPs, director generals of DoHS, Department of Ayurved (DoAY) and Department of Drug Administration (DDA), and division and department chiefs. In January 2017 MoH further revised the new FMIP and sent it to EDPs for their inputs.

Table 3.2: Progress against major FMIP indicators to mid-July 2016

	FMIP indicator	Achievements to end 2015/16
1	Audit queries in audit report cleared to about 35%	Achieved: 51.51%
2	Financial monitoring reports are prepared within 45 days of end of the trimester	Achieved
3	Audit reports are prepared and submitted within nine months of the end of the fiscal year	System is being established within TABUCS
4	Funds are disbursed to hospitals based on the performance	System has been established in 7 hospitals
5	Strengthening performance based audit	Performance audits have been conducted in Dhanusha, Kaski, Palpa, Jumla, Kailali DHOs/DPHOs and BP Koirala Memorial Cancer Hospital, Chitwan Performance audits completed of 187 GoN cost centres and 133 hospital development committees under MoH for 2014/15
Others achievements		
6	Maintain central records of audit queries	Managed and updated central records of audit queries covering 9 years (FY 2003/04-2011/12). Now every cost centre & concerned entities can see the total amount, categories of queries, queries description, etc. These will be uploaded in TABUCS.
7	Directives for audit clearance & compliance of rules	MoH has given directives to departments and concerned health entities to maintain financial discipline & follow audit report issues and suggestions.
8	Capacity building	TABUCS orientation programme organized to FCGO officers to harmonise TABUCS in others ministries on April 2016. TABUCS executive level workshop held in June 2016. Financial Management Handbook prepared and finalised at workshops.
9	Monitoring	Monitoring done time to time by MoH, departments, regional directorate offices on financial aspects. Monitoring formats incorporated in TABUCS.

3.2.3 Analysis of NHSP-2 Budget Allocation and Expenditure

In 2015, an extensive analysis of budget allocations and expenditure during the NHSP-1 and NHSP-2 periods (2005 to 2015) was carried out. These findings are presented in Annex 3.

3.2.4 Building the capacity of programme managers and finance officers on audit clearance

In 2012/13, MoH prepared its audit clearance guidelines. These guidelines were officially endorsed in February 2014 and MoH's Finance Section is leading their implementation. MoH suggested to DoHS that it needed to build the capacity of its finance officers on public financial management, and especially on audit

clearance, internal control and financial governance. Other new guidelines, MoH's internal control guidelines were officially endorsed in March 2014. MoH has circulated the two guidelines to all its cost centres and all 75 district treasury comptroller offices (DTCO).

In 2015 DoHS subsequently ran a training of trainers programme on delivering the 5 day audit clearance training for programme managers and finance officers in development regions. The training curriculum was endorsed by the technical committee. The training was run for 25 trainers in August 2015. In 2015/16, MoH conducted training workshops in the Eastern region and the Kathmandu Valley for 46 participants. DoHS also conducted a two days financial workshop in all five regions focusing on audit clearance. The Department of Ayurveda conducted three workshops across the country for office chiefs and planning officers on preparing budgets and on planning.

After the implementation of the guidelines audit queries against audited amount have reduced (from 13.8% in FY 2012/13 to 11.5% in FY 2013/14 and 9.44% in FY 2014/15). Also, the clearance of carried over and outstanding audit queries has increased. As of the end of 2015/16, MoH had exceeded the government's audit queries clearance target of 35% of queries cleared for the previous year (2014/15).

3.2.5 Improved financial monitoring reports

Financial monitoring reports (FMRs) need to be submitted within 45 days of the end of each trimester (four-monthly period) as the main basis for the disbursement of funds by Pooled Fund partners. The following important developments from the previous reporting period will enable the more timely submission of these reports:

- MoH, with consent from its external development partners, reduced the number of associated reporting templates from 33 to 8 to streamline reporting.
- In November 2013, MoH was connected with the financial management information system (FMIS) of the Financial Comptroller General's Office (FCGO). Since a major cause of delays in submitting FMRs has been the time consuming process of collecting and compiling reports from the FCGO, it is expected that this new connectivity and the inclusion of FMRs in the TABUCS will facilitate the more timely submission of FMRs.

The EDPs require reliable and regular financial reports from implementing ministries. The World Bank defines the production by entities of "audited cash receipts and payments financial statements and audited budget/actual comparative statements" as a main requirement.

Table 3.3: Number of days taken to produce FMRs by MoH (2012–2016)

Fiscal Year	FMR type	Period	Due Date	Prepared Date	Submission date compared to due date
2012/13	1st	July to Nov	12-Dec	15-Feb-13	76
	2nd	Nov to March	13-Apr	20-Sep-13	172
	3rd	March to July	13-Aug	26-Nov-13	117
2013/14	1st	July to Nov	13-Dec	7-Feb-14	68
	2nd	Nov to March	14-Apr	28-Jul-14	118
	3rd	March to July	14-Aug	10-Dec-14	131
2014/15	1st	July to Nov	14-Dec	14-Nov-14	17
	2nd	Nov to March	15-Apr	26-Mar-15	-6
	3rd	March to July	15-Aug	22-Aug-15	21
2015/16	1st	July to Nov	15-Dec	13-Jan-16	13
	2nd	Nov to March	16-Apr	3-Jun-16	37
	3rd	March to July	16-Aug	22-Aug-16	-7
2016/17	1st	July to Nov	16-Dec	6-Dec-2016	-24

The TABUCS is enabling MoH to produce these financial statements and significantly reduce the time required for producing financial monitoring reports. The number of days required to produce FMRs has reduced largely due to the introduction of TABUCS, with the last two reports being submitted well before the due dates (Table 3.3).

Also, MoH submitted its unaudited financial statements for 2015/16 to the Financial Comptroller General's Office (FCGO) on 29 November 2016 although a remaining challenge is that MoH still has to rely on the FCGO's Financial Management Information System (FMIS) data while preparing and finalising its FMRs.

3.2.6 Regularising the meetings of the Public Financial Management Committee

MoH formed a Public Financial Management Committee in 2012/13 to improve MoH financial management. The chief of the Policy Planning and International Cooperation Division (PPICD) chairs this committee with high level health officials and external development partner representatives as members (see Table 3.4). The committee leads the introduction and approval of the FMIP.

Table 3.4: Composition of PFM Committee (Source: MoH 2013)

	Members	Position		Members	Position
1	Chief, PPICD (MoH)	Chairperson	7	DFID	Member
2	Chief, Human Resources and Financial Resources Management Division (HR&FRM Division, MoH)	Member	8	World Bank	Member
3	Director, Logistics Management Division (DoHS)	Member	9	USAID	Member
4	Under-secretary, PPICD (MoH)	Member	10	KfW	Member
5	Chief, MoH Finance Section	Member	11	AusAID	Member
6	Chief, DoHS Finance Section	Member	12	NHSSP	Member

The several rounds of formal and informal meetings of the committee have focussed on revising the FMIP. The committee agreed to revise the FMIP, formed a working group and requested this group to finalise the plan. It agreed to include the recommendations of the World Bank and DFID's fiduciary risk assessments into the revised FMIP.

The committee held a PFM progress sharing meeting with the health secretary in April 2014 where officials discussed the proposed revision of the FMIP, the draft procurement improvement plan, and the major findings of the World Bank and DFID's fiduciary risk assessment. The meeting was attended by programme managers and finance section chiefs from most DoHS centres and divisions. In December 2015, a meeting was organised to revise the FMIP in line with the NHSS. A committee has decided to circulate the revised FMIP to the EDPs. The most recent meeting of the PFM Committee was held in August 2016.

3.2.7 Finalising performance-based grant agreements

Under NHSP-2, MoH improved financial management by implementing the actions specified in the governance and accountability action plan (GAAP). The GAAP calls for a shift towards output-based budgeting, timely fund release (including grants), the timely preparation and submission of trimesterly and annual financial reports, transparent operating procedures for non-state partners, periodic performance reviews and social audits, and taking prompt action on audit irregularities. In the previous year (2012/13), MoH had finalised the first performance-based grants agreements with the following seven health institutions, which are continuing in FY 2013/14:

1. Bayalpata Hospital, Achham (Nyaya Health)
2. Bhaktapur Cancer Hospital, Bhaktapur
3. Nepal Eye Hospital, Kathmandu
4. Nepal Netra Jyoti Sangh;
5. Suresh Wagle Memorial Cancer Hospital, Kathmandu (Tribhuvan University Teaching Hospital)
6. National Kidney Centre, Kathmandu; and
7. BP Koirala Lions Center for Ophthalmic Studies.

In 2012/13, MoH prepared a standard monitoring framework for these agreements. This framework was revised in October 2014 after testing it in the seven institutions with agreements and in eight without such agreements. The M&E framework was prepared for the seven health institutions using the generic performance objectives and outputs and the 12 indicators. In FY 2015/16 MoH has continued these agreements with the seven health institutions.

3.2.8 Audit Committee and status

Audit committee

MoH formed an Audit Committee in April 2012 with the objective of improving financial discipline. The secretary of MoH chairs the committee. The committee's role includes strengthening the internal control system, ensuring financial discipline, organising regular meetings and responding to audit queries. This committee has taken the lead in preparing and finalising MoH's audit clearance guidelines and internal control guidelines.

Table 3.5: Composition of MoH's Audit Committee

	Position and office	Committee position
1	MoH Secretary	Chairperson
2	Chief HR&FM Division (MoH)	Co-chairperson
3	DoHS Director General	Member
4	DoHS Finance Section Chief	Member
5	Health Sector Reform Unit (HeSRU) Chief	Member
6	MoH Finance Section Chief	Member Secretary

Source: MoH 2013. Decision of the Audit Committee

The committee recently instructed all concerned cost centres to clear their audit backlogs and also committed to build the capacity of finance officers on clearing audit backlogs. In FY 2015/16 the Audit Committee became more active on clearing audit backlogs, which helped accelerate the clearance of audit queries.

Status of audit queries

Figure 3.2 shows the progress on the annual clearance of audit queries concerning MoH's budget and expenditure. The trend shows that further work is needed in this area including to strengthen the capacity of MoH to prepare its audit status reports. A high level of commitment is needed to prevent irregularities and ensure the timely clearance of queries.

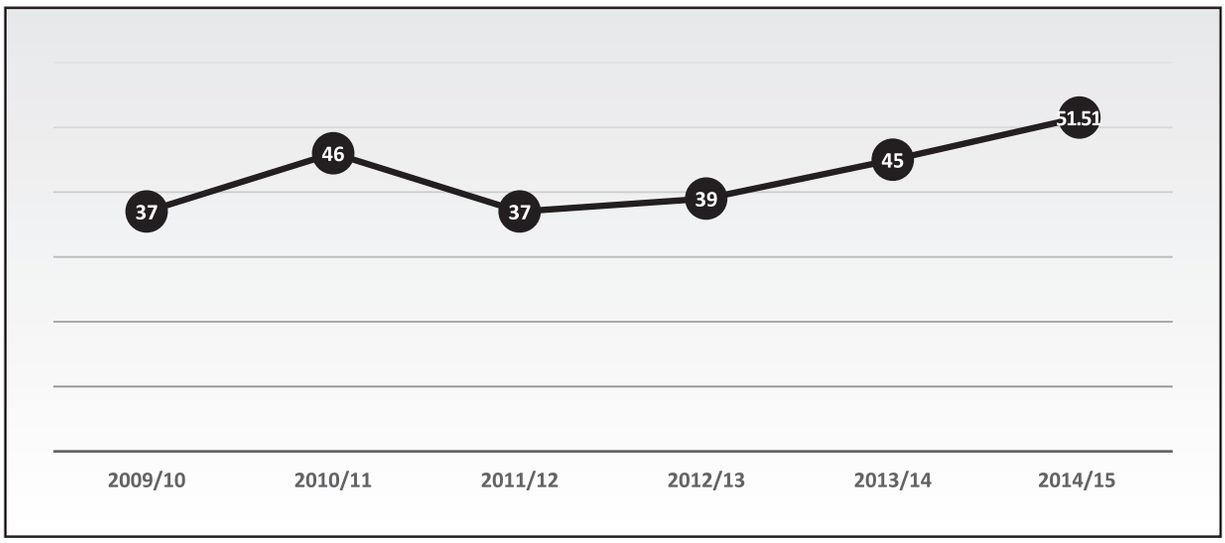

Figure 3.2: Trends in clearance of audit queries related to MoH's budget (%)

Source: MoH 2016

Most audit queries in the NHSP-2 period have been due to non-compliance with legal provisions, weak internal financial control and weak budget implementation. The cumulative amount of total irregularities concerning MoH's budget reported by the Office of the Auditor General (OAG) was NPR 4.3 billion in FY 2013/14. Forty five percent of these queries had been cleared by MoH as of the end of FY 2013/14. NPR 2.46 billion out of the NPR 4.77 billion of 2014/15 audit queries (51.5%) had been cleared by the end of FY 2015/16.

A significant proportion of audit queries across the NHSP-2 period have been due to unsettled advances. MoH believes that the proper implementation of its audit clearance guidelines, internal control guidelines and procurement implementation plan will reduce the proportion of audit queries in the coming years.

3.3 Major Challenges:

A number of challenges remain that need to be overcome for MoH to institute a fully functioning public financial management system.

Rolling out TABUCS — The major concern of MoH and the EDPs is the complete implementation of TABUCS by having all cost centres entering their financial data in the TABUCS.

Other TABUCS-related challenges include:

- the many responsibilities of cost centre accountants and account officers meaning that they are sometimes unavailable to prepare vouchers;
- the entering of data on a programmatic basis by DHOs and DPHOs as they have traditionally manually prepared vouchers against budget line items;
- motivating accountants and account officers to prepare vouchers in accordance with TABUCS instructions;
- the unavailability of electricity and internet connectivity due to load shedding meaning that some cost centres have to prepare expenditure vouchers manually; and
- weak follow-up from the monitoring level.

Budget preparation and execution — The following have been major issues affecting MoH budget preparation and execution in the NHSP-2 period:

- The frequently delayed approval of MoH's final annual budget has led to late fund release to spending units.
- FY 2012/13 was exceptional as the government made the budget based on the previous years' expenditure and the entire year passed without a full budget. This seriously impacted the absorption of EDP funds by MoH as less priority was given for programme implementation.
- The budget preparation process is insufficiently coordinated with the planning processes.
- The lack of formal involvement of MoH's and DoHS's Finance Section during budget preparation and progress monitoring.
- MoH lacks an investment strategy to guide decisions on the split between recurrent and capital allocations in its annual budgets.

Challenges beyond MoH's direct control — PFM structures and functions are designed at the sectoral macro level, which caters to the needs of all sub-sectors including MoH. This is a challenge for MoH as it has to comply with line item-based budgeting, which is not usually as flexible as performance or output-based budgeting.

The following implementation-level challenges are also mostly outside MoH's direct control:

- Macro-reconciliation on central financial statements: Due to delayed information from the Ministry of Finance (MoF) on virements, MoH sometimes faces difficulties reconciling its central financial statements. This is a key obstacle to finalising financial reports including third (final) trimester FMRs.
- Accounts not presented for auditing: Cost centres whose accounts are 'seized' by the Commission for Investigation of Abuse of Authority (CIAA) or district administration offices (DAO) for investigation are not able to present these accounts for auditing. In 2013/14 this led to such accounts being treated as queries because they were unavailable for checking, therefore increasing the volume of queries. This was recorded as an audit observation.
- Auditing issues: Direct expenditure by external development partners and their audit reports not being presented to the responsible government authorities are major public financial management concerns. Another challenge is that much EDP technical assistance expenditure is not submitted to the OAG during audits.

Recording, reporting and monitoring - Some MoH cost centres do not send timely budgets against actual expenditure to MoH and DoHS. Also, MoH does not have any technology-based solution to compile or consolidate budgets against actual expenditure reports. Although the FCGO provides budget versus actual expenditure reports to MoH; these are based on particular account heads and are not broken down programme-wise. The maintenance of the records on carried over (old) audit queries and the clearance process is a challenge under MoH. There is a lack of trained human resources and it is a huge task to monitor the status of the more than 300 cost centres.

Local revenues not recorded in MoH expenditure — There is currently no national mechanism to capture the local revenue and expenditure of health facilities. This may increase fiduciary risk at health facilities. MoH wants to introduce guidelines or a strategy to address this issue. Note that the TABUCS enables MoH to capture local revenues.

Implementation of PBGA monitoring system — The main challenges to implementing the performance-based grant agreements (PBGAs) between MoH and health institutions are:

- poor capacity of officials at MoH to manage the system;
- lack of knowledge of hospital administrators to adequately report against the PBGA monitoring framework; and
- delays in finalizing PBGA annual contracts and subsequent fund flow from MoH.

3.4 Ways Forward

a) Strengthening the TABUCs — The TABUCS has been rolled out to all cost centres and exceeded the ambitious target of making cost centres responsible for entering financial data, completing user training and ensuring that more than 90% of expenditure was entered into the system. During this previous reporting period, the TABUCS implementation committee realised the importance of adding an authorisation module which has been now incorporated within the system. The TABUCS is helping to track fund flows and increase MoH's absorptive capacity.

The following issues still, however, need to be addressed:

- First and foremost ensure the full functioning of the various TABUCS modules and use their findings in local planning processes.
- The Audit Committee and Public Financial Management Committee should meet more regularly and make discussions and decisions on TABUCS.
- Continuous technical inputs are needed to make TABUCS error free and to motivate users to enter data so that it can become fully functional in all MoH cost centres.

b) Implement more output-based decision making — MoH needs to carry out more output-based decision-making and make more effective use of available resources through decentralised needs-based planning, budgeting and implementation. There also the need to review the structure and functioning of MoH and its entities.

c) Capital expenditure and capturing local revenue — MoH needs to improve its planning, budgeting and spending capacity. MoH also needs to strengthen and institutionalise its purchasing function. The capacity of hospitals needs to be built to capture local revenues and local resources in the TABUCS to give a more comprehensive picture of income and expenditure.

d) Ensure the implementation of the audit clearance and internal control guidelines — The implementation of these guidelines should be a major reform agenda under NHSS. They need to be implemented through a dedicated entity with a strong monitoring framework that will help organisations under MoH respond to EDPs' queries and financial risk reviews. Also, audit queries records should be updated annually and old queries cleared on time.

e) Strengthen the system for performance based grant agreements:

- Establish a PBGA section within MoH with staff with accounting, MIS and hospital management expertise.
- Building MoH, DoHS and health institutions' capacity on performance-based grant management.
- Evaluate the reasons for delayed contracting and fund release, and then adapt future approaches.

PROCUREMENT OF GOODS AND SERVICES - INFRASTRUCTURE

Good quality infrastructure is needed to provide a safe enabling environment for the provision of quality health services and to ensure the retention of human resources. Hence the government has started institutionalizing evidence-based planning for the construction, operation, and maintenance of the health infrastructure. Appropriate and clear policies, strategies, plans, standards and guidelines have been developed and are in use. Assessment standards and guidelines are being continuously updated, upgraded and implemented.

4.1 Achievements

4.1.1 Web-based Health Infrastructure Information System (HIIS)

Under the leadership of the Management Division (DoHS) and with technical support from NHSSP, a web-based Health Infrastructure Information System (HIIS) has been prepared. The HIIS is a framework that accommodates different systems and databases to provide a consolidated information system. The HIIS was prepared in the course of equipping the planning authorities to carry out evidence based planning. The HIIS includes a geographic information system (GIS) database, a detailed infrastructure database, and an under-development monitoring and evaluation database. The HIIS's inventory management system enables the retrieval of current lists of health facilities and accommodates the procurement data on the construction of health facilities. The web-based HIIS was completed, officially approved, and adopted in 2012/13.

MoH and its departments are using the information in the HIIS in a number of ways:

- Inventory management— The HIIS contains data on all public health facility and administrative office buildings including most sub-health post that have been upgraded into health posts. The data includes information on accessibility, basic amenities and land along with photographs, architectural plans and location data. This information is being used by MoH and the Management Division for need assessments on the expansion and establishment of health facilities.
- Identifying catchments— The GIS-based information is being used to identify the catchment areas of facilities and their accessibility from surrounding settlements. The Management Division has used HIIS to select facilities for the construction of new buildings since FY 2014/15.
- Suitability analyses— MoH is developing a system to identify suitable locations for secondary and tertiary level health institutions using the GIS-based information in the HIIS to inform planning exercises to bring about a more equitable distribution of health facilities. Distance matrices and catchment areas have been analysed and suitability gauged for more than 4,000 health institutions to check their potential for upgrading to secondary or tertiary level institutions.
- Preliminary costing for repairs and maintenance— HIIS data is being used to help calculate repair and maintenance costs for health facility buildings. The updated HIIS allows for procurement plans and progress reports directly updated from the districts (DHOs and DPHOs).

The progress on the further development of the HIIS in FY year 2015/16 was as follows:

- System migration— The migration of the HIIS from a desktop based system to web-based system was completed. Previously, the web-based system was only used for the public dissemination of selected data while database administration was desktop-based. The new web-based system has administrative features such as the creation of users and the editing, deletion and creation of data. It also allows policymakers and planners to use the system to plan new health buildings and to know the condition of existing buildings from visual and written records. The HIIS is available at www.mohp.gov.np.
- Updated database —The database has been updated based on data collected by the post-disaster needs assessment and for upgrading SHPs. Data collection is ongoing in the 17 earthquake-affected districts for inclusion and substantial updates has been made on the road networks.
- Data verification and purification — Data verification and consistency checks are being carried out against historical and other data.

4.1.2 Standard designs and guidelines

The Management Division has been building health facilities as per standard designs and guidelines since FY 2005/06. The designs and guidelines are continuously evolving as per the needs of new policies and feedback from end users. The designs are in line with Nepal National Building Code and MoH's standards for health institutions. In 2015/16, multiple type designs were prepared for all facility types (hospitals, PHCCs and health posts) based on catchment populations (Table 4.1). Also, the designs have been updated for quarters, DHO offices, medical stores, separate parts of hospitals (in-patient, CEONC, BEONC and emergency units), and building services (placenta pits and septic tanks). EDPs are also using these standard designs and guidelines.

Table 4.1: Standard designs for health facilities

Building type	Design type	Bed capacity	Served population criteria	Total floor area (m^2)
Hospitals				
	Type 1	(51-70)	100,001 to 300,000	6,145.91
	Type 2	(26-50)	50,000 to 100,000	3,516.16
	Type 3	(15-25)	below 50,000	2,239.25
PHCCs				
	Type 1	(15)	above 20,000	2,046.73
	Type 2	(10)	15,000 to 20,000	1,014.53
	Type 3	(5)	below 15,000	808.43
Health posts				
	Type A		For populations above 12,000	537.57
	Type B		For populations of 7,001 to 12,000	348.58
	Type C		For populations of 3,000 to 7,000	302.47
	Type D		For populations below 3,000	218.11

It was previously commonplace for several building blocks to be arbitrarily built separately at different times in the same health facility. This resulted in high construction costs. At some older sites where buildings were laid out haphazardly, poor linkages between the different buildings have caused difficulties in efficiently providing services. This also caused some building blocks to remain unused. The current practice of using standard designs and guidelines promotes integrated designs which have led to considerable cost savings. The main features of the type design are as follows:

- They support the horizontal and vertical development of infrastructure, thus allowing for future expansion.
- They support well-designed linkages between units to facilitate efficient movement.
- They support integrated planning for including accommodation blocks and other supporting facilities at the same time as the construction of health service blocks to create better service delivery environments. A checklist is to be used of the components that each facility should have. These need to be included in designs and estimates.
- The planning of infection control with separate routes for the 'dirty out' and 'clean in' and specifications for finishing floors and walls that facilitate regular cleaning and the prevention of bacterial growth.

The development of facility designs for different sizes of catchment populations enables the better planning of health facility civil works. Up to the end of 2016 GIS analysis has been carried out that shows that according to their catchments 1,750 existing health posts are Type D health posts (smallest type with 218 m^2 built-up area), 380 are Type C, 72 are Type B and only 43 have catchments that need the largest type — health posts in Type A (see types and catchment sizes in Table 4.1). This analysis is serving as a very useful planning tool to save large amounts of financial resources by avoiding building too big health posts that will be under-used.

The updated standard designs and guidelines are in the process of endorsement by MoH.

4.1.3 More monitoring and supervision

In 2015/16, a joint monitoring team of officials from the Management Division, architects and engineers from the Department of Urban Development and Building Construction (DUDBC), the NHSSP infrastructure adviser, and local DUDBC and health sector officials made frequent visits to different 'delinquent' project sites to resolve delay issues.

4.1.4 Improved coordination with stakeholders

Need assessments and health facility designs were carried out for several hospitals in 2015/16 in coordination with stakeholders. Requirements and designs are being finalized based on the findings.

4.1.5 The single door and consolidated planning of civil works

As recommended by the 2014 JAR, starting in 2013/14, major building projects at Bheri and Seti Zonal Hospitals and Mid-Western Region Hospital (Surkhet Hospital) were planned in the Management Division's AWPB. In 2015/16 Narayani Sub-regional hospital and other zonal hospitals were planned in the division's AWPB together with other district level projects. Based on needs assessments, detailed designs have been prepared. Most new works have been planned based on the recommendations of the 2014 NHSSP supported study on the overcrowding of referral hospitals.

4.1.6 Improved bidding procedures and accelerating progress

The completion rate of building construction is improving and the number of sick projects is reducing (table 4.2). However, DUDBC still needs to pay more attention to projects that have been on-going for many years with 102 sick projects listed. It needs to be a priority to scrutinise the issues of individual projects to resolve them as soon as possible.

Table 4.2: Progress status of health infrastructure construction works planned in FY 2015/16 as of end 2016

Progress status	Ongoing (carried over from previous years)	New
Work completed (72 handed over)	131	-
Work in finishing, electrical and sanitary work stage	167	-
Worked upto reinforced cement concrete(RCC) on 3rd floor	3	-
Worked upto 2nd floor RCC	46	-
Worked upto 1st floor RCC/roofing	99	-
Worked upto sill level and walls	74	2
Worked upto foundation/damp proof course (DPC)	84	6
Work ordered	33	26
Work in designing / Cost Estimate	22	29
Tender called	17	57
Total	676	120
Total of ongoing and new projects	796	

4.1.7 Major challenges

Implementation of guidelines— The institutionalisation and strict implementation of the newly developed tools, guidelines, strategies and documents into the present system is a major challenge.

Land issues—More than 40% of upgraded SHPs do not own their land. Before upgradation, these SHPs were run in VDC or school buildings or on public land. Many facilities own land that is inadequate to accommodate the standard designs. In other cases the land they own is not in appropriate locations such as away from settlements or vulnerable to landslides. It is a major for MoH to acquire land to build health facilities.

4.2 Post-Disaster Reconstruction and Recovery Work

The April and May 2015 earthquakes destroyed or damaged many health facilities. With support from aid agencies MoH straightaway provided temporary shelters for facilities to operate from. Considering the urgency of resuming service provision, MoH adopted an intermediate strategy (2015–2016) to build semi-permanent pre-fabricated structures through the following activities.

The status of the 784 health facilities and their 1,301 building blocks is shown in Table 4.3.

Table 4.3: Damage to health facilities by April & May 2015 earthquakes in 14 most affected districts

Damage status	Number blocks/health facilities	Recommendation
Health facilities		
Completely damaged health facilities	358	
Partially damaged health facilities	311	
Undamaged health facilities	115	
Building blocks		
Completely collapsed	225	Reconstruction
Partially damaged — non repairable	249	Reconstruction
Partially damaged — repairable	195	Major repair
Superficial damage	265	Minor repair
No damage	367	No intervention
Total	1,301	

a) Committee formation — Immediately after the major earthquakes, MoH formed a Central Coordination Committee and 'MoU Proposal Review Sub-committee' to prepare and revise standard guidelines and to evaluate proposals, designs and make recommendations for memoranda of understanding (MoU).

b) Standard designs and guidelines —In 2015, soon after the major earthquakes, standard reconstruction guidelines were produced for health facilities using prefab materials and stakeholders orientated on them. The guidelines cover different designs by size of catchment population; typical construction details; electrical, sanitary, structural, and other details; lists of recommended prefab technologies and their specifications; construction and design guidelines; and lists of supplies and equipment for each level of health facility. The guidelines and other resource materials are available at www.nhsp.org.np

c) Detailed engineering assessments — Detailed physical and structural assessments were carried out of all health facilities in the 14 hardest hit districts. The results were uploaded to www.mohp.gov.np (HIIS link), the severity of structural damage was assessed, the type of intervention recommended (repair, retrofit or reconstruction), and costing completed. The data (including geo-spatial data, access to electricity and water, public access, availability and land type) were analysed and reports uploaded to www.nhsp.org.np. Detailed assessments of the 17 affected district were also completed.

4.2.1 Achievements and progress

The achievements of the post-disaster reconstruction and recovery work in 2015/16:

a) Signing of MoUs with NGOs and INGOs - Up to 15 December MoH signed MoUs for support on:

- demolition and debris removal
- the reconstruction of facilities, mainly with prefab semi-permanent and shelter structures
- the repair and retrofitting of facilities where reconstruction was not necessary
- the supply of emergency medicine and equipment
- health system strengthening, focusing on the health information system and emergency reproductive health.

- emergency surgical care for people in earthquake affected areas
- the establishment of a rehabilitation centre
- water, sanitation and hygiene (WASH), emergency nutrition, psychosocial services and capacity building for disaster risk reduction.

Afterwards, 17 tripartite MoUs were signed between MoH, the National Reconstruction Authority and supporting partners. MoH has altogether signed 67 such MoUs worth NPR 7.52 billion up to the end of 2016 of which 37 MoUs are related to infrastructure work worth NPR 1.92 billion in 356 health facilities. As of the beginning of 2017 the work has been completed in 137 facilities and is ongoing in 221 (Table 4.4).

Table 4.4: Progress status of works being carried out under MoUs signed in (to mid-January 2017)

	Health posts		PHCC		Hospitals	
	Completed	Ongoing	Completed	Ongoing	Completed	Ongoing
Bhaktapur	3					
Dhading	21	18		1		1
Dolakha	14	26		2	2	1
Gorkha	23	29	1			2
Kathmandu	1	1				2
Kavre Palanchok	9	28				
Lalitpur		6				
Makawanpur	4	3				
Nuwakot	15	31			1	1
Okhaldhunga		6				
Ramechhap		13		2	1	2
Rasuwa	3	13				2
Sindhuli						
Sindhupalchowk	36	19	1	2	2	2
Solukhumbu		6		2		1
Total	129	199	2	8	6	14
Total health facilities	**356**					
Completed	**137**					
Ongoing	**221**					

b) Reconstruction activities based on bilateral agreements: The reconstruction of several health facilities (mostly district hospitals) has been supported by six bilateral agencies. Table 4.5 gives the status of these works. MoH has coordinated with the bilateral agencies on these works. Regular consultations are being provided by the MoH infrastructure team across the construction process.

Table 4.5: Reconstruction of permanent health institution buildings as of late 2016

	Agency/nation	Work description	Progress
1	JICA	Bir Hospital and Paropakar Maternity Hospital Ampipal Hospital	Ready for tender Under construction
2	KOICA	Nuwakot District Hospital and prefab structures at 10 health posts	Designing
3	KFW	Reconstruction of Rasuwa, Dolakha, Gorkha and Ramechhap district hospitals	Consultant hiring underway
4	DFID	Health facilities in Sindhupalchok, Ramechhap and Dolakha	Ongoing
5	USAID	Bahrabise PHCC	Design phase
6	China	Chautara and Manang hospitals	Preparatory survey underway

c) Presentation at international seminar: A presentation was delivered at the International Seminar on Earthquake Risk Reduction held on the 23rd August, 2015, at Agartala, India on 'Uncertainty: Lives in Earthquake Zone'. It covered the impact and recovery strategies following the 2015 earthquakes. MoH's infrastructure planning adviser delivered this presentation.

d) Monitoring and quality control: An MoH engineering team, with technical assistance from EDPs, was deployed for the monitoring and quality control of reconstruction works starting from 2016 (when reconstruction works started). As per the standard guidelines, the team reviewed all the working drawings and designs. MoH provided approved the drawings based on the team's recommendation. Later on in 2016, the overall responsibility of verifying the detailed working drawings and designs submitted to MoH was given to the infrastructure team, which advised EDPs who had signed reconstruction MoUs with MoH on designs and suitable construction materials.

The team also visited construction sites to verify compliance with the approved designs. However, some partners didn't take part in the process of reviewing designs prior to construction and they were provided with post-construction reviews. Post-construction, a few works were found to be unsafe and the funding agencies were requested to rectify the defects. Some organizations even had to retrofit new prefab building due to them not abiding by the building code. Due to this tendency, at some sites, the overlapping of different works has created unnecessary conflicts.

e) Progress reviews: MoH held two review workshops in 2015/16 with MoU partners, DHOs/DHPOs, regional directors and government officials. These meetings reviewed the progress of works and partners were orientated on design requirements and guidelines and they were supported to meet Nepalese vendors of prefab and construction materials.

f) Damage of buildings construction as per seismic design: A number of health facilities, including Jalbire PHCC, Budhepa Health Post, Khopachagu Health Post, Dhuwakot Health Post, Khari Health Post and Chautara Hospital, were heavily damaged despite being designed to take seismic loads. Joint site visits were organized to document the damage, which was reported to the implementing agency (DUDBC). Several joint meetings were organized during which DUDBC committed to investigate the issue.

g) Preparation of AWPB: Based on the damage assessments, reconstruction plans were prepared for 31 districts in mid-2016. The plan includes 304 permanent constructions, 279 repair and retrofit works and 39 prefab construction works. MoH is deciding how to implement these approved plans.

h) Formation of project implementation unit: MoH is working to form a dedicated central level project implementation unit (CLPIU) for reconstruction activities. MoH envisages using the expertise of the Ministry of Urban Development's (MoUD's) district level PIUs. Several rounds of discussions have taken place to constitute a CLPIU and to delegate authority to DLPIUs under MoUD.

4.2.2 Ways forward

1. Provide regular refresher training to all DHO/DPHO and DUDBC Division Offices officials on the web based HIIS and start the direct updating of physical and financial progress of infrastructure works at the district level.
2. Facilitate the institutionalization and internalization of the HIIS system by:
    a. constituting a designated entity at MoH and department level to manage and control the HIIS.
    b. Assign focal persons in DHOs/DPHOs and DUDBC for HIIS system management.
    c. Develop a mechanism to interconnect the health sector information systems (including HMIS, LMBIS, HURIC, PLMAAS, TABUCS, DHIS2). MoH envisages establishing a central data centre to host all these systems in one place.
3. Carry out regular system upgrades and developments to accommodate the needs and requirements of new policies in close consultation with stakeholders.
4. Upgrade the GIS database for catchment boundaries considering accessibility friction costs.
5. Identify unserved populations and extend inter-sectoral coordination for developing accessibility by constructing new roads. Such coordination is also needed for upgrading the roads database and settlement data.
6. Pilot the newly developed M&E system of construction activities.
7. Rethink the procurement methods of works to expedite the completion of works. One such intervention could be the packaging of contracts of adjacent facilities. This will increase the size of contracts that will attract larger qualified contractors to bid. This should reduce the number of contracts and the administrative burden.
8. Build the capacity of DUDBC and DHO/DPHO staff on planning health infrastructure, using standard designs and guidelines, procurement works, design and implementation of sanitary and electrical works and quality construction management.
9. Develop typical working drawings for all standard designs and organize orientation programmes on them.
10. Develop a mechanism of joint peer reviewing of designs of selected construction works (together with DUDBC, Management Division and third party experts) before going to tender.
11. Review and revisit efforts and resources (procurement of consultant services) for preparing detailed engineering designs.
12. Give urgent attention to the unfinished projects that are more than four years old.
13. Monitor the implementation of the land selection criteria for new health facility construction.
14. Add a standard equipment list for each room in the HIIS standard designs.
15. Formally commission health facilities after construction work is over so that users are well acquainted with the use and function of facilities.

PROCUREMENT OF GOODS AND SERVICES - MEDICINE, LOGISTICS AND SUPPLY CHAIN MANAGEMENT

5.1 Background

Improving the efficiency, economy and transparency of procurement and the supply chain of drugs and medical equipment is a goal of the Government of Nepal and its EDPs. MoH and DoHS prepared a Procurement Improvement Plan in 2013 and the Logistics Management Division (LMD) is being supported to implement a 16 point Procurement Reform Plan (2015). LMD is implementing these plans including the formulation of consolidated annual procurement plans (CAPPs), and preparing bid documents, technical specifications and bid evaluations. The revised Programme Implementation Plan (PIP), 2016/17 is presented at Annex 4.

A team of procurement specialists, biomedical engineers and mechanical engineers provide day-to-day technical support. The progress and interventions are set against the considerable challenges and problems faced by LMD procurement.

5.2 Achievements

a) Timely preparation and improved implementation of the CAPP

The consolidated annual procurement plans(CAPP) have been prepared on time and progress has been monitored continuously by LMD since FY 2014/15. There has been significant progress on the implementation of the CAPPs. There has been good progress on the implementation of the 2016/17 CAPP with the bidding processes of more than 66 percent of international competitive bidding(ICB) contracts at the finalization stage (64/96) (Table 5.1) compared to only 3 percent in the previous CAPP (FY 2015/16) in the same period (Table 5.1).

Table 5.1: Comparative progress of 2016/17 CAPP and CAPP 2015/16 (both to 31 December 2015)

Procurement method	Number of contracts in CAPP		Number of contracts started bidding processes		Number of contracts signed or in process of signing	
	FY 2015/16	FY 2016/17	FY 2015/16	FY 2016/17	FY 2015/16	FY 2016/17
ICB	161	96	5	64		2 signed 2 in process
NCB (goods)	33	23	7	15	1 signed 1 in process	1 signed 8 in process
NCB (works)	0	4	0	0	0	0
NCB (non-consulting services	6	1	6	1	6 in process	1 signed
QCBS (consulting services)	3	2	0	1	0	0

b) Development of bidding document for framework agreement

A long term reform agenda in the Procurement Reform Plan is central bidding and local purchasing to address problems associated with long lead times for completing procurement processes and the frequent shortages of drugs. For this purpose, standard bidding documents (SBD) for the procurement of health sector goods using framework agreements have been drafted by LMD. The draft SBDs were discussed with MoH, DoHS and the Public Procurement Monitoring Office (PPMO) officials and other experts at a two day workshop in June 2016. The draft SBD document for framework agreements was then forwarded to the PPMO for

endorsement. An assigned PPMO committee has held several meetings that requested LMD to organise a discussion workshop involving experts and key stakeholders to finalise it in January 2017. The implementation of the framework agreement approach will help LMD with the timely procurement of essential medicines and the maintenance of minimum stock levels.

c) Standardization of medicine, medical equipment and goods

LMD's Technical Specification Bank contains 472 standard specifications of 70 essential drugs and 1,060 specifications of medical equipment, hospital furniture and cold-chain equipment. In 2015/16 a team of experts revisited the specifications and recommended improvements. LMD organized a workshop on September 14-15, 2016 involving LMD and DoHS professionals, pharmacists, DDA and Association of Pharmaceutical Producers of Nepal (APPON) representatives. The workshop recommended updating the specifications of 8 types of capsules, 16 external preparations, 4 oral liquids, 22 parenteral preparations and 36 tablets. Based on these recommendations, the specifications were updated with MoH approval. The updated specifications were used in the current ICB procurement process for 53 essential drugs.

LMD realized that some of the hospital equipment specifications had to be updated to address technological advances. LMD held a workshop on 1-2 July 2016 involving hospital biomedical engineers, practitioner physicians and technicians. The workshop assessed the 63 anaesthesia and operating theatre items, 45 radiology equipment, 7 ICU/CCU items and 17 cardiology and CTVS items and made recommendations for improvement.

d) Restructuring LMD

A long standing reform agenda is the establishment of a central health procurement unit for all health sector procurement. The issue of elevating the level of LMD to sit directly under MoH with full authority to oversee health sector procurement has been discussed at several forums. In this reporting period an organisation and management survey was carried out for restructuring LMD and providing more human resources. Its findings and recommendations were discussed with the Ministry of General Administration. However, the government's decision not to recruit new staff in the transition to federalization means that it is difficult to make recommended changes. MoH is working to support LMD human resource improvements through other mechanisms.

e) Capacity development

In 2015/16 LMD prepared draft SOPs for the pre-shipment inspection of medical goods and the ToR of a third party pre-shipment inspection agency. This work was taken forward at:

- a three day training workshop on procurement cycles on 20-22November 2016 for LMD procurement professionals and MoH, DoHS, PPMO and Auditor General's Office personnel; and
- a follow-on 23 November 2016 discussion workshop on the legal, operational and policy issues and challenges identified at the training workshop where MoH, Auditor General's Office, PPMO, EDP and other participants identified procurement processes, technical specifications, supply chain management, quality assurance, and management information system related issues

An outline SOP was then prepared and a national consultant appointed to draft it.

f) Other accomplishments

The followings activities were also accomplished in 2015/16:

- the Public Procurement Act was revised to facilitate the procurement of medicines;
- procurement training for MoHP district level staff;
- the continued development and implementation of the Contract Management System; and
- the continued implementation of e-procurement in LMD through the PPMO portal.

5.3 Challenges

- Procurement is a complex process that involves many steps, agencies, ministries, manufacturers and suppliers. Strong management is needed to improve the procurement of medical supplies.
- LMD is continuously challenged to keep the right amount of medical supplies and avoid running out of stocks. Supply chain management is weak as there are challenges in generating real time data on stocks and consumption.
- It is a challenging task to reorganize LMD as an independent procurement organization.
- Regional and district level facilities face problems in concluding procurement processes due to limited skills in preparing bid documents and resolving procurement issues; the limited use of e-procurement at field level; the lack of SOPs to guide bid documentation; and inadequate technical specifications, bid evaluations, stock management and contract management.
- Lead times for the completion of LMD procurement processes are often long and 'shaky'. LMD, itself, however is not in control of all decisions related to procurement as DoHS and its divisions are also involved. The average time to complete procurement processes and receive supplies is about one year.
- There are an inadequate number of skilled personnel and they are often transferred elsewhere. In the absence of standard operating guidelines, different personnel have different understandings on procurement procedures.
- Planning and management problems include the delayed endorsement of annual procurement plans, the weak linkages between LMIS and CAPP resulting in stock-outs of essential drugs at facilities. Stock balances are often below minimum levels while other items surpass maximum stock levels.

5.4 Ways Forward

a) More clearly define and assign accountability for procurement, supply chain and information management.

b) Build the capacity of regional and district health personnel who are involved on procurement.

c) In the context of a shift to a federal system of government, reorganize LMD so that accountability for procurement, supply chain and information management is precisely and independently defined.

d) Redefine the levels of safety stock of essential medicines and adopt strategic procurement practices such as framework agreements and direct shopping or emergency procurement to maintain these levels.

e) Link stock pipeline information with the current CAPP and adjust quantities and delivery schedules so that stock balances do not fall below safety levels or exceed maximum levels.

f) Prepare and adopt SOPs to improve LMD procurement and supply chain management including for shipment inspection and receiving goods.

PARTNERSHIP ARRANGEMENTS

6.1 Background

The Nepal Health Sector Programmes 1 and 2, the National Health Policy (2014), and the Nepal Health Sector Strategy (2015–2020) and its implementation plan call for strengthening partnerships across the health sector, building government leadership and ensuring the effective use of available resources.

A sector wide approach (SWAp) in line with the Paris Declaration on Aid Effectiveness (2005) was introduced by MoH in 2004 with the support of 11 health sector donors. In 2007, Nepal was selected as a first wave country under the International Health Partnership (IHP), which sought to tackle bottleneck issues such as inter-agency coordination, harmonisation, performance monitoring and health care financing in support of the SWAp.

The NHSS was endorsed by the Cabinet on 6 October 2015. It seeks to widen and strengthen partnerships for health with external development partners, indigenous state and non-state partners and communities. It espouses the four strategic directions of equitable access to health services, quality health services, health systems reform and a multi-sectoral approach to universal health coverage.

The Constitution of Nepal (2015) provides for a federal form of governance with a three tier structure. In the context of federalization it is evident that new partnerships and coordination and collaboration mechanisms are needed at federal, provincial and local government levels for the effective delivery of health services.

6.2 Progress and Achievements in 2015/2016

Progress and achievements for the main partnership modalities during the period are described below. These are partnerships between i) MoH and indigenous non state partners, and ii) MoH and external development partners including INGOs. Both have been influenced by a number of factors including the following:

6.2.1 Improved partnership environment

There have been important improvements in health sector management as a result of the improved environment for partnerships under the health SWAp in line with aid effectiveness principles. The mid-term review of NHSP-2 in 2013 referred to Nepal's health sector SWAp as a 'mature arrangement'.

EDPs and state and non-state stakeholders participated in the development of sector strategies and NHSP implementation plans. The introduction of participatory reviews of AWPBs at several levels helped translate strategies into programmes of coordinated action and encouraged pooled and non-pooled partners to align their inputs with sector priorities. As a result, relatively few EDP supported projects operated independently of MoH, particularly in NHSP-2's latter stages and, importantly, in the immediate aftermath of the April 2015 earthquake.

While a systematic review of the impact of the Nepal health SWAp has yet to be carried out, there is considerable anecdotal evidence to suggest that agency harmonisation under NHSP-2 has reduced aid fragmentation, limited duplication and lowered transaction costs for MoH. This marks a significant improvement on NHSP-1 efforts.

6.2.2 Mechanisms that have strengthened partnerships

Under NHSP-2, several mechanisms were used to strengthen donor harmonisation and foster effective partnerships:

Joint Financing Arrangement — The Joint Financing Arrangement (JFA) for health for the NHSS period (2015/16 to 2020/21) between the Ministry of Finance (MoF) and EDPs has been in place since mid-July 2016. The JFA sets out a framework of harmonised procedures designed to strengthen performance reviews,

financial management and advance coordinated planning, monitoring and reviews in the sector. The government views the JFA as an important instrument to fortify partnerships for improved sector management and the alignment of development partner inputs with MoH's AWPB. It also marks an important step in the development of a single sector monitoring and evaluation framework.

Health sector development partner forum — During NHSP-1 a health sector partnership forum was established to help coordinate and consolidate external partner inputs. This, however, remained dormant under most of NHSP-2, but it resumed in 2016.

Joint annual reviews — JARs have provided an important platform under NHSP-I, NHSP-2 and NHSS for annual progress reviews against targets and for increasing the number of state and non-state actors in discussions on key themes. The outcomes of these reviews are captured in the action points of the aide memoires signed by MoH and the EDPs.

Joint consultative meetings — A number of joint consultative meetings have provided an effective forum for updating, discussing and reviewing progress against key AWPB related targets. The main agenda items for such meetings have been the joint identification of priorities for forthcoming AWPBs, a mid-term review of progress and tracking progress against previous aide memoire commitments.

Technical working groups and committees — Several technical working groups (TWGs) and committees exist to carry forward specific activities related to key work streams. Several of them, including the M&E TWG, the PFM Committee and Reproductive Health Coordinating Committee (RHCC) continue to function at MoH and even at district level. These entities help track and harmonize the activities of various stakeholders. However, the RHCC and its sub-committees have been largely dormant since 2015 in the aftermath of the earthquakes, although the Reproductive Health sub-committee was reactivated in December 2016. NHSS looks forward to the formalization of these structures to create a solid base for strengthened partnership and collaboration.

External Development Partners Forum — Starting in 2004, Nepal's health sector EDPs have participated in an EDP forum, which is helping align EDP inputs more closely around NHSS priorities.

Association of INGOs in Nepal — The Association of INGOs in Nepal (AIN) has a sub-group of health agencies to coordinate INGO activities in the sector. This has reduced the duplication of inputs and serves as a platform for communicating with other stakeholders. However, there have been no formal interactions between the AIN health group and the EDP group, leading to a disconnect between the two types of key stakeholders.

6.2.3 Improved coordination at district and regional levels

The participation of local stakeholders and communities in district level health programmes has increased significantly over the years, although mixed feelings prevail at regional and district levels over the real extent of partnerships, harmonisation and alignment. The absence of locally elected government representatives since 2002 has undermined downward accountability and adversely affected multi-stakeholder partnerships and harmonisation in the sector.

Health specific arrangements such as district RHCCs, district, municipal and village WASH coordination committees and health and nutrition clusters have fostered district-level coordination. Organizations operating at district level seem to have been better at finding their comparative advantage in terms of synchronizing their interventions. However, the differing modus operandi of development partners has often created difficulties for district coordination efforts.

Institutionalised coordination arrangements for WASH, reproductive health and disaster relief have been established in all five regions. However efforts to create operational partnerships under these arrangements have generally been unsuccessful. Similarly, efforts under NHSP-2 in the Mid and Far West regional health directorates to create effective health partnerships between sector actors through regional health coordination teams, including the preparation of integrated district health plans, have not gained momentum during this reporting period.

6.2.4 Multi-sectoral coordination and collaboration

There are a number of examples of effective multi-sectoral collaboration in Nepal including the school health programme with the education sector and urban health programmes with municipal local governments. These initiatives are evidence of a growing interest in multi-sectoral collaboration for health. The Government of Nepal has produced several multi-sectoral plans and frameworks in recent years linked to health:

- National Action Plan Against Gender Based Violence, 2010.
- Multi-sectoral Nutrition Plan, 2013–2017
- Inter-sectoral Framework on Water and Sanitation for Health (WASH), 2013
- Nepal Road Safety Action Plan, 2013-2020
- Multi-sectoral Action Plan for the Prevention and Control of Non Communicable Diseases, 2014-2020

Apart from collaboration on human resource and infrastructure development, collaboration between MoH and MoFALD has also progressed on strengthening local health governance and on civil registration and vital statistics. Furthermore, the collaborative framework signed between MoH and MoFALD (2014) was a milestone for establishing more responsive and accountable health systems at the local level. In 2015/16 the two ministries continued to provide block grants to district health offices to plan and implement child and family health and family planning initiatives in six districts.

6.2.5 Mapping support

An Aid Management Platform (AMP) was established in the Ministry of Finance (MoF) in 2009 to track support provided by development partners and associated aid flows. The AMP is a web-based tool for use by government institutions and development partners to plan, monitor, coordinate, track and report on foreign aid funded programmes and activities. The effective use of this tool by MoH and EDPs improves alignment and harmonisation.

In fiscal year 2013/14, AMP was rolled out to all local development partners and line ministries. The implementation progress of AMP is steady and currently includes 1,487 programmes and projects with a combined disbursement in FY 2016/17 of USD 8,437 million. In FY 2014/15, the health sector became the largest sector receiving official development assistance (ODA), replacing education (FY 2013-14).

6.2.6 State non-state partnerships

The government recognises the importance of engaging non-state providers in the country's health system and has a long tradition of collaborating with non-state health care providers. Partnerships with non-profit NGOs, private-for-profit hospitals and medical colleges foster their participation in health care service delivery. These partnerships have expanded since 1991; but in the absence of uniformity in contract structures and effective supervision and monitoring, they are seen as innovative pilots but lack long term strategic commitments for their sustainability.

The draft health sector State Non-state Partnership Policy (2012) calls for improved partnerships between state and non-state actors and meaningful collaboration. Following the promulgation of the overall Public Private Partnership Policy by MoF in 2014, work began to review the 2012 draft policy in December 2016.

6.3 Lessons Learned

The partnership mechanisms developed within Nepal's health sector have improved the harmonisation of development partner inputs with MoH priorities. This, in turn, has enhanced operating efficiencies, reduced transaction costs for EDPs and MoH and contributed to improvements in planning, programming and spending. Although this has reduced aid fragmentation and duplication some agencies still need encouraging to work more closely and collaboratively with MoH.

As the multi-sectoral response to address the wider social determinants of health gains ground, the interests and perspectives of new non-health specialists must be accommodated. This represents both an additional opportunity for the sector and an additional management load.

Several partnership modalities are being practiced with non-state actors; but their efficacy has yet to be reviewed and the health sector State Non-state Partnership Policy needs to be finalised and implemented.

6.4 Ways Forward

As per the aspirations of NHSS, the government and EDPs should maintain efforts to strengthen Nepal's health SWAp to better align funding and technical support with strategy priorities. Government leadership in programme design, implementation and monitoring is also essential to maintain the gains made in health outcomes and health system strengthening under NHSP-2.

The mechanisms used to develop and help strengthen effective partnerships such as the JAR, JCM and technical working groups should also be maintained and further developed.

Some NHSS sector funding is likely to come through new types of partnerships with some EDPs opting for disbursement linked indicator milestones in addition to current financing arrangements. As policy directives to encourage private sector engagement in health service delivery already exist, including the draft State Non-State Partnership Policy, it is recommended that these be enhanced to accommodate new working partnerships.

Some efforts have been made to examine the implications of federalism on health sector funding and operational partnerships. This work should be developed further to identify appropriate modalities for partnerships under a federal decentralized political structure. The time has come to enhance MoH's stewardship function to leverage resources and expertise from multi-sector actors.

GENDER EQUALITY AND SOCIAL INCLUSION

7.1 Background

A National Action Plan on Gender Based Violence (GBV) has been implemented since November 2010. The plan's implementation is coordinated by the Office of the Prime Minister and Council of Ministers (OPMCM) and has the commitment of 12 ministries including the Ministry of Health (MoH) plus the National Planning Commission, the National Human Rights Commission and the National Women's Commission. MoH has responded to the national mandate and is addressing gender and social inclusion.

This progress report is compiled against the GESI Strategy Framework of NHSP-2 and objectives, indicators and activities undertaken as required by the NHSP-2 Results Framework. It provides an update on initiatives by MoH and its partners to mainstream gender equality and social inclusion (GESI) in the health sector and address the access of women, the poor and excluded people to health services in 2015/16. The latest results against the full NHSP-2 GESI Strategy Framework are given at Annex 5.

An important development in the reporting period was that MoH's GESI section was shifted from the Population Division to the Public Health Administration Monitoring and Evaluation Division (PHAMED). The GESI Section is responsible for mainstreaming GESI in the health sector and coordinating and implementing GESI-targeted interventions.

7.2 Progress and Achievements in 2015/16

7.2.1 Mainstreaming Gender Equality and Social Inclusion

a) MoH's GESI Steering Committee took decisions about mainstreaming GESI in planning, reviews and annual work plans and budgets (AWPBs), establishing one-stop crisis management centres (OCMCs), rolling out GESI institutional structures and establishing social service units (SSUs).

b) To the end of 2016, GESI technical working groups (TWGs) have been formed in all 75 districts and GESI focal persons nominated in all regional health directorates (RHDs) and all 75 district health office and district public health offices (DHOs and DPHOs).

c) The 'Operational Guidelines for Gender Equality and Social Inclusion Mainstreaming in the Health Sector' (MoH 2013) continue to guide all levels of health service providers and managers on mainstreaming GESI in their planning, programming, budgeting, service delivery, monitoring and reporting..

d) Orientations were conducted on overall GESI perspectives (concept, frameworks, mainstreaming, programmes, activities, achievements and ways forward) to PHAMED and the GESI Section. In 2016, 27 MoH GESI focal persons, and departmental and RHD representatives participated in a three-day GESI mainstreaming training and GESI orientations were conducted for health workers in several districts.

7.2.2 Addressing gender based violence

One-stop crisis management centres

a) Three new OCMCs were established in 2015/16 — at Chautara hospital (Sindhupalchowk), Charikot Hospital (Dolakha) and Manthali PHCC (Ramechhap). There are now 21 OCMCs in Nepalese health facilities.

a) b) The mid-2016 strategic review of OCMCs recommended a number of interventions to strengthen OCMCs including : (i)Make provision for single district-level GBV committees (instead of current six committees on GBV issues) to improve coordination and prevent duplication of activities (ii) Develop integrated district-wise work plans with all agencies working on GBV and get district coordination committees (DCC) to approve these plans(iii) Make women development officers (WDOs) the focal points for district-level coordination on GBV issues.

b) The 'Integrated National GBV Service Guidelines' for the effective delivery of services to survivors of GBV were finalised in 2016 by the multi-sectoral steering committee chaired by the secretary of the Ministry of Women, Children and Social Welfare's (MoWCSW's). They are ready to be submitted to the Cabinet for approval.

c) The GBV clinical protocol (2014) continued to be gradually introduced to all service providers at all levels to improve the overall quality and coverage of GBV. GBV clinical protocol training was conducted for health workers in the 14 most earthquake affected districts.

7.2.3 Social service units

a) In 2015/16, the SSU operational guidelines were revised based on lessons learned from the piloting of SSUs since 2013.

b) An evaluation of SSUs was carried out in 2015 to identify lessons and provide inputs to NHSS. It found that good progress had been made by the pilot SSUs in terms of (i) their capacity to identify and serve target groups) the improved governance of health facilities by increasing transparency and accountability, (iii) increasing the awareness of target groups on the availability of free and partially free health services,

c) A Roadmap prepared by MoH in late 2015 recommended i) replication of the SSU model in other referral hospitals; ii) capacity enhancement of SSUs; iii) standardising the benefits packages to target groups; and iv) earmarking budgets for free and partially free services.

d) Based on the Roadmap, in 2016 MoH established SSU in a further six referral hospitals: (Hetauda hospital, Gorkha hospital, Trishuli hospital (Nuwakot), Rapti sub-regional hospital (Dang), Dhaulagari Zonal Hospital (Baglung) and Lumbini Zonal Hospital (Butwal).

e) All 14 current SSU hospitals were trained on and helped to establish management information systems for online recording and reporting.

7.2.4 Social auditing guidelines

a) Social auditing of health facilities has rapidly progressed. Social audit was implemented across 55 districts in 1252 health facilities (district hospitals, primary health care centres, and health/sub-health posts) in 2015/16.

b) Social Audit Guidelines have been revised.

7.2.5 Other progress

a) Community health units (CHU) were established and are operational across 75 districts in 250 VDCs. The CHU guidelines were updated in the reporting period.

b) The essential drugs list was revised with the inclusion of second generation psycho-tropic drugs.

c) Mental health was included in the Package for Essential Non-Communicable Diseases (PEN) package in 10 districts in 2016/17.

7.3 Key Challenges

a) The inclusion and implementation of GESI provisions in government policies, programmes and guidelines requires further advocacy and influencing work.

b) The development of tools to accurately identify the income- poor people for the targeting of subsidised and free health services.

c) The provision of continuous interventions to improve the skills of service providers to recognise the barriers women, the poor and excluded people face accessing and using health services, and to identify what measures need to be taken to overcome these barriers.

7.4 Key Actions Going Forward

Policy level

a) Ensure all newly formulated, revised, updated and amended policies, including the NHSS Implementation Plan integrate GESI concerns. This requires further advocacy and influencing work.

b) Strengthen GESI training through NHTC and regional health directorate trainers for all levels of the system including induction training

One-stop crisis management centres

a) The Cabinet to approve the Integrated National Service Guidelines for GBV Survivors.

b) Establish new OCMCs in high GBV prevalence districts.

c) Roll out the GBV clinical protocol for frontline health workers (2014), and promote its use in health service delivery.

Social service units

a) Revise the SSU guidelines as per the recommendations of the 2015 SSU evaluation. Gradually establish SSUs in all referral hospitals including teaching, community and private hospitals.

b) Improve the budgeting system for free and partially free services so that the budget provided to SSUs is based on the local realities of hospitals including local poverty incidence, client loads, per-patient expenditure and prescribed benefit packages.

Social auditing

a) Review the modality of health service social audits.

b) Make social audits more effective by strengthening the capacity of DHOs, DPHOs and social auditors to carry out social audits as per the guidelines.

Mental health

a) Develop a new Mental Health Policy and its implementation plan.

b) Include revised second generation psychotropic drugs in the free drugs list.

c) Develop a training manual based on the revised standard treatment protocol and deliver capacity building training to prescribers in selected districts.

d) Produce a standardised psychosocial counselling training manual.

Health services for elderly and disabled persons

a) Develop a geriatric health care strategy and guidelines for elderly friendly services in hospitals.

b) Scale up geriatric-friendly health services in referral hospitals.

c) Develop guidelines for disabled friendly health services and related information, education and communication (IEC) materials.

d) Integrate disabled-friendly services in SSU based hospitals.

SELECTED REFERENCES

Adhikari, R; Adhikari, P; Tiwari, S; Thapa, M; Paudel, L; Pandit, S; Lamichane, P and Lievens, T (2011). Electronic Annual Work Plan and Budget (eAWPB) version 3. Kathmandu: Ministry of Health and Population.

CBS (2015). Nepal Multiple Indicator Cluster Survey 2014, Final Report. Kathmandu, Nepal: Central Bureau of Statistics and UNICEF Nepal

GIZ-HSSP and MoH (2011). Assessment of Government Health Financing System in Nepal: Suggestions for Reform. Kathmandu: Health Sector Support Programme and Ministry of Health and Population.

MoF (FYs 2011, 2012, 2013) . Budget Formulation Guidelines. Kathmandu: Ministry of Finance.

MoHP (2010a). MoU among Key Implementing Partners of the Local Health Governance Strengthening Programme. Kathmandu: Ministry of Health and Population.

MoHP (2010b). Nepal Health Sector Programme II, 2010/11-2014/15. Kathmandu: Ministry of Health and Population.

MoHP (2010c). Health Sector Gender Equality and Social Inclusion (GESI) Strategy, 2010. Kathmandu: Ministry of Health and Population.

MoHP (2010d). Hospital Based One-stop Crisis Management Centre (OCMC) Operational Manual 2010 (revised 2016). Kathmandu: Ministry of Health.

MoHP (2011). Gender Equality and Social Inclusion Institutional Structure Guidelines for Mainstreaming across the Ministry of Health and Population 2011. Kathmandu: Ministry of Health and Population.

MoHP (2012a and 2013a). Implementation Progress Report (IPR) and Financial Monitoring Report (FMR) of FY 2010/11. Kathmandu: Ministry of Health and Population.

MoHP (2012b). Directives of the Poor Citizen Medical Treatment Support Fund. Kathmandu: Ministry of Health and Population.

MoHP (2012c). Transaction accounting and budget control system. Kathmandu: Ministry of Health and Population.

MoHP (2013b). Operational Guidelines for Gender Equality and Social Inclusion Mainstreaming in the Health Sector. Kathmandu: Ministry of Health and Population.

MoHP (2013c). Spending Authorizations of concerned Health Institutions. Kathmandu: Ministry of Health and Population.

MoHP (2014a). First revision of Financial Management Improvement Plan. Kathmandu: Ministry of Health and Population.

MoHP (2014b). Social Service Unit Implementation Guidelines (revised) 2015. Kathmandu: Ministry of Health and Population.

MoHP and NHSSP (2013). GESI Mainstreaming in Nepal's Health Sector: Progress Review and Process Documentation. Kathmandu: Ministry of Health and Population.

MoHP, New ERA, and ICF International (2012). Nepal Demographic and Health Survey 2011. Kathmandu: Ministry of Health and Population, New ERA, ICF International Inc., 2012.

MoPPTM (2013). Nepal Road Safety Action Plan (2013-2020). Kathmandu: Government of Nepal: Ministry of Physical Planning and Transport Management.

OAG (2012, 2013, 2014 2015, 2016). Audit report submitted to President of Federal Republic of Nepal. Kathmandu: Office of the Auditor General.

OPMCM (2012). National Strategy and Action Plan for Gender Empowerment and to End Gender Based Violence (2012/13 to 2016/17). Kathmandu: Office of the Prime Minister and Council of Ministers.

PHCRD and NHSSP (2014 and 2015). Process Evaluation of Social Auditing in Ilam, Jhapa, Rupandehi and Palpa Districts. Kathmandu: Primary Health Care Revitalisation Division and NHSSP.

Population Division and NHSSP (2013) Progress Review of Pilot Social Service Units. August 2013 and Evaluations of Social Service Units 2015, Kathmandu: Population Division and Nepal Health Sector Support Programme.

Population Division and NHSSP (2014) Annual Progress Review and Future Direction of One-stop Crisis Management Centres. October 2014.

Population Division, UNFPA and NHSSP (2013) Assessment of the Performance of Hospital-Based One Stop Crisis Management Centres. October 2013. Kathmandu: Population Division, United Nations Population Fund and Nepal Health Sector Support Programme.

Subedi, BK, A Pradhan, S Barnett, M Puri, S Rai Chitrakar, P Poudel, S Sharma and L Hulton (2009). Nepal Maternal Mortality and Morbidity Study 2008/2009." Kathmandu: Ministry of Health and Population.

Tiwari S , Pandit S, Adhikari R, Timilisina B and Saxena S (2015). Transaction Accounting and Budget Control System (TABUCS). Kathmandu: MoH, NHSSP.

Tiwari S, Lievens T, Poudel LR, Gautam G, Bhatt H, Adhikari R, Chaulagain B and Pandit S. (2015). Budget Analysis of Nepal Health Sector Programme-2: FY 2010/11 to 2014/15. Ministry of Health

WHO, UNICEF, UNFPA, The World Bank, and UNPD (2014). Trends in Maternal Mortality: 1990 to 2013. Geneva: WHO, UNICEF, UNFPA, The World Bank, and United Nations Population Division.

ANNEX 1: INNOVATIVE SERVICE PROVISION ACHIEVEMENTS

The following write-ups summarise the achievements of three of Nepal's most innovative health programmes: the Aama Programme to improve access to safe childbirth, the National Immunisation Programme and the National Nutrition Programme.

A. The Aama Programme

Background — The 1987 safe motherhood initiative in Kenya put maternal health as an important public health agenda on the global forum. Many developing countries, including Nepal, subsequently announced safe motherhood as a national priority and institutionalized it into its primary care programme. The Government committed to achieve the maternal health MDG by strengthening the supply of maternal health services, investing in skilled birth attendant training, and expanding emergency obstetric services. The large investments on improving the supply side, however, only saw limited improvements in the use of services by the less reached sections of the population with a wide gap in service use between the rich and poor. Those in the richest quintile were almost 13 times more likely to use skilled delivery care than the poorest in 2014. The use of skilled delivery care services in Nepal was (and to an extent is) hindered by poor geographical access, socio-cultural factors, high rates of illiteracy, low actual and perceived quality of care and other factors. The Aama Programme was introduced to reduce the financial barriers to women seeking institutional delivery care to increase the proportion of institutional deliveries and thereby reduce maternal morbidity and mortality.

Evolution of the Aama Programme — The Maternity Incentive Scheme (MIS) was launched in 2005 following a study that suggested that the costs associated with delivery discouraged women from giving birth in health facilities as reaching a facility accounted for two-thirds of associated costs. The scheme introduced incentives whereby women were granted NPR 1,500 in the mountains, NPR 1,000 in the hills and NPR 500 in the Tarai. The scheme became the Safe Delivery Incentive Programme (SDIP) in 2006 with the addition of free institutional delivery services in 25 low Human Development Index districts. The SDIP became the Aama Programme in January 2009 with the removal of all user fees for all types of deliveries. In 2012, the 4 antenatal care (ANC) visits incentive programme was merged with the Aama Programme. In 2016, the free care of sick newborns was also incorporated into the Aama Programme making it the Aama and Newborn Care Programme.

The expansion of birthing centres and basic and emergency obstetric and neonatal care (BEONC and CEONC) nationwide from 2007 with the implementation of the SBA training strategy and the CEONC fund in 2008 have complemented the implementation of the Aama Programme. Table A1 shows expansion of service delivery sites since 2006/07.

Table A1: Expansion of delivery sites since 2006/07

Fiscal year	Birthing centres	BEONC	Districts with CEONC
2063/64 (2006/07)	199	29	33
2066/67 (2009/10)	543	58	39
2070/71 (2013/14)	1456	206	64
2071/72 (2014/15)	1621	166	68
2072/73 (2015/16)	1755	159	69

While access to maternal health care and especially institutional delivery has improved over the last decade with the implementation of the Aama programme and the expansion of service delivery sites, equity gaps remain especially in access to caesarean sections, which is much less in the mountain districts (Table A2).

Table A2: Trends of proportion of caesarean sections among total expected live births (Source: HMIS)

	2013/14	2014/15	2015/16
Mountain districts	0.7	1.0	1.7
Hill districts	8.3	9.3	8.9
Tarai districts	8.0	9.8	9.7

Challenges and way forward — The Aama Programme has had a positive impact on providing more women with birthing care and providing greater value for money to the government and its external development partners. An important challenge is now to finance the Aama Programme over the long run and to reach the unreached. And it will take time to properly integrate the newborn component into the Aama Programme. Technical discussions are needed to delineate how this integration contributes to strengthening the purchasing function of the Family Health Division and assuring allocative efficiency in the maternal health care delivery system. A clear programme implementation framework needs to be developed and implemented to plan and to report on progress. The continued development of the social security programme in-line with national social health protection programme is another important task. Technical and policy level discussions are needed to integrate the Aama Programme and newborn care with the National Social Health Insurance Programme, which would be an important step towards achieving universal health coverage in Nepal.

B. Immunization

The National Immunization Programme (NIP) is a government priority 1 (P1) programme. It is one of the best functioning systems as it reaches 97% of its target population and has the least equity gaps amongst the national health P1 programmes.

In 2011, the national coverage of BCG immunisation was the highest of all antigens with almost 94% of mothers being immunized, while DPT- HepB- Hib and OPV- 3 coverage is more than 90%. The coverage of measles/rubella vaccine coverage was 85% and Td2 and Td2+ 52%. The Japanese encephalitis coverage was 74% in the 32 target districts. New antigen PCV and MRS were introduced in all districts and 18 districts were declared as fully immunized districts.

The key successes and innovations in the National Immunisation Programme that have brought about these achievements are as follows:

- Smallpox eradicated in 1977
- Maternal and neonatal tetanus eliminated since 2005 and sustained
- Japanese encephalitis control began from 2006 and morbidity and mortality has significantly declined since then.
- Measles has been controlled and it is now targeted to eliminate it by 2019.
- Polio free status maintained since August 2010 and officially declared on 27 March 2014.
- MDG 4 target (Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate) exceeded three years early in 2012
- Electronic immunization registration system introduced in 5 districts (EIRS and Vaxtrax) in 2015/16.
- Switched from trivalent oral polio vaccine (tOPV) to bivalent oral polio vaccine (bOPV) in 2015/16.
- Immunization Law and Immunization Fund introduced in 2015/16.
- The electronic monitoring and GIS tracking of immunisation is being piloted.

Nepal's good achievements are evident from the fact that only 3 percent of children do not have access to life-saving immunization compared to 20 percent globally, although a considerable number of them do not complete the full immunization schedule (Figure A1).

Figure A1: Global and Nepal status of immunisation

Vaccine Coverage Status	
Global Scenarios	**Nepal Status**
⬇	⬇
 1 in 5 children do not have accessp to life-saving immunizations	3 in 100 do not have access to life saving immunizations
Vaccines prevent 2 to 3 million death per year globally	13 in 100 do not complete their NIP schedule (87% coverage of full immunization)
Over 22 million infants remain unimmunized in the world each year	Total 85800 children are not protected with life saving immunizations (Vaccines sav 25-30% death of the children thus 21450-25740 children's death could have been averted, Measles vaccines alone could avert 5000 deaths
$20 can fully vaccinate a child against pneumonia, diarrhea, polio and measles	1 child need $47 for full immunizations in NIP

C. National Nutrition Programme

The Government of Nepal (GoN) recognizes that the nutritional well-being of its population is crucial for enhancing human capital and overall socio-economic development. To fulfil these objectives, the GoN endorsed its National Nutrition Policy and Strategy in 2004 and has subsequently committed to global movements including Scaling up Nutrition (SUN). The government adopted the Multi-Sectoral Nutrition Plan (MSNP) in 2012.

Despite significant improvements in health and nutritional outcomes in recent years, Nepal still has a high rate of maternal and child malnutrition. The Department of Health Services and its Child Health Division have been coordinating efforts to improve nutritional programmes through facility and community level interventions. Major interventions such as growth monitoring and counselling; iron and folic acid supplementation, the prevention; control and treatment of Vitamin A deficiency; the prevention of iodine deficiency disorders; the control of parasitic infestation through deworming; flour fortification; Maternal, Infant and Young Child Nutrition (MIYCN), and the Nutrition in Emergency Programme are being implemented nationwide. Programmes implemented in some districts include the Integrated Management of Acute Malnutrition (IMAM in 16 districts), micro-nutrient powder distribution linked with the infant and young child feeding (IYCF) programme (15 districts), the School Health and Nutrition Programme (67 districts) along with Iron Folic Acid distribution to adolescents (10 districts), and the Multisectoral Nutrition Plan (16 districts). These programmes are being scaled up to other districts. Table A3 shows recent progress on nutrition-related issues.

Table A3: Nutrition related issues identified in 2014/15 and responses adopted in 2015/16

	Issues identified in 2014/15	Application adopted in 2015/16
1	Weak institutional and health worker capacity on nutrition at all levels	Capacity building activities run. Proposed institutional strengthening is under discussion
2	Resource gap to scale-up evidence-based and cost effective interventions of Infant and Young Child Feeding (IYCF), Integrated Management of Acute Malnutrition (IMAM), IYCF Micro Nutrient Powder (IYCF-MNP) and other programmes	Integrated Nutrition Package programme planned in all 75 districts within 3 years. In 2016/17, Multi-Sectoral Nutrition Programme (MSNP) planned to scale-up to additional 12 districts and IMAM in additional 8 districts
3	Poor dietary behaviour including low diversity of food	Changing behaviour to promote local and indigenous food diet diversity and nutrition rich foods: • SUAAHARA running in 40 districts, • Agricultural and Food Security Project in 19 hill and mountain districts of Far West and Mid-West Development Regions • Promotional activities under scaling-up including golden 1000 days
4	Less staff for nutrition under DoHS and no designated personnel for nutrition at regional and district level	MoH is deciding whether to place nutrition cadres at all levels of MoH
5	Quality of nutrition data i.e. under/over- reporting	A nutrition information management is being established process and data strengthening is being initiated in regular HMIS system
6	Delayed procurement of nutrition commodities	Increased frequent and regular coordination with LMD. Delegation of procurement authority to regional health directorate (i.e. baby weighing scale-Salter scale)

ANNEX 2: HEALTH SECTOR PROGRESS AND AVAILABILITY OF DATA AGAINST NHSS OUTPUTS (2015/16)

Code	Outcomes and Outputs	Overall progress	Data availability
OC1	Rebuilt and strengthened health systems: Infrastructure, HRH management, Procurement and Supply chain management		
OP1a1	Health infrastructure developed as per plan and standards	▪ Infrastructure standard building design and guideline developed; in the process of endorsement ▪ Greater realization of need of developing infrastructure development plan to complete all construction works in the next five years ▪ Need of assessing delayed (sick) and on-going projects realized and process initiated ▪ Infrastructure assessment survey is in progress (14 + 17 districts)	▪ Limited data available ▪ Health Infrastructure Information System (HIIS) needs to be updated ▪ Build interoperability with other MISs
OP1a2	Damaged health facilities are rebuilt	▪ Slow progress in reconstruction of damaged facilities	▪ Limited data available ▪ Health Infrastructure Information System (HIIS) needs to be updated ▪ Build interoperability with other MISs
OP1a3	Improved management of health infrastructure	▪ Limited initiatives to capacitate regional and district level staff to routinely monitor, supervise and support health infrastructure development and maintenance ▪ Same with the medical equipment ▪ Limited initiatives towards developing inventory and replacement plan of medical equipment	▪ Limited data available ▪ Health Infrastructure Information System (HIIS) needs to be updated ▪ Build interoperability with other MISs
OP1b1	Improved staff availability at all levels with focus on rural retention and enrolment	▪ HR registry development process in progress ▪ HR master plan to be developed ▪ Greater realization of the need of reviewing existing HR recruitment and deployment system; need to initiate the process ▪ Initiated e-attendance at PHCCs and above facilities as a HR management tools	▪ Limited data available ▪ Need to develop a routine MIS interoperable with other MISs ▪ Need to establish a system to track health workers working at their own deputed (Durbandi) institution
OP1b2	Improved human resource education and competencies	▪ Greater realization of need of establishing a joint mechanism among MoH, Ministry of Education and academic institutions to upgrade quality of pre-service education for health workers; need to initiate the process ▪ Partnership with academic institutions in progress	▪ Limited data available ▪ All five professional councils need to establish routine MISs to monitor academic institutions' compliance to respective council standards and students pass out rate at council examinations; and build functional linkage with MoH
OP1c1	Improved procurement system	▪ E-bidding process is in practice ▪ Central specification bank developed ▪ Limited initiatives towards: • Capacitating institutions in procurement and quality assurance • Central bidding and local purchasing • Laying foundations for the establishment of procurement centre	▪ Limited data available ▪ Need to establish system for effective monitoring
OP1c2	Improved supply chain management	▪ Expansion of warehouse capacities, including upgrading of storage facilities at regional and district levels is in progress ▪ On-line inventory management system initiated ▪ Redistribution of drugs within districts and region initiated ▪ Process of improving transportation of drugs and medical products below district initiated	▪ Limited data available ▪ Need to upgrade LMIS to monitor daily/ weekly/monthly stock status of drugs and functional status of equipment; and build interoperability with other MISs
OC2	Improved quality of care at point-of-delivery		
OP2.1	Health services delivered as per standards and protocols	▪ A number of initiatives being undertaken by different agencies. Need to consolidate and harmonize the efforts; and scale up the best practices. ▪ Quality improvement initiatives being planned based on the NHFS 2015 findings ▪ Initiatives are taken towards standardizing pre and in-service training for health workers and improve hospital management	▪ Limited data available ▪ Needs to strengthen routine MISs ▪ Initiated development of quality improvement management information system (QIMIS) aligned with the existing MISs

Code	Outcomes and Outputs	Overall progress	Data availability
OP2.2	Quality assurance system strengthened	▪ MPDSR is implemented in 63 hospitals and 6 districts; plan to scale up covering all hospitals	▪ Limited data available ▪ Needs to strengthen routine MISs ▪ Need to establish and operationalize the QMIS
OP2.3	Improved infection prevention and health care waste management	▪ Revision and enforcement of standards for infection prevention and health care waste management in progress ▪ Health care waste management at facility level improving (77% of facilities safely dispose health care waste: NHFS, 2015)	▪ Limited data available
OC3	Equitable utilization of health care services		
OP3.1	Improved access to health services, especially for unreached population	▪ Service hours extended from 10am to 5 pm ▪ Collaboration with Nepal Police Hospital and Nepal Army Hospital initiated for service expansion ▪ 21 OCMCs and 14 SSUs are in operation ▪ Process of monitoring and planning based on disaggregated data initiated to reduce the equity gap between different population sub groups	▪ Data available, need to improve quality
OP3.2	Health service networks including referral system strengthened	▪ Air lifting critical cases from remote districts initiated ▪ Referral guideline needs to be revised to include: • Make referring institutions responsible for cases in transit • Fast-track service delivery for referred cases	▪ Limited data available
OC4	Strengthened decentralized planning and budgeting		
OP4.1	Strategic planning and institutional capacity enhanced at all levels	▪ AWPB preparation guideline developed; ready to use for the next AWPB	▪ Limited data available
OC5	Improved sector management and governance		
OP5.1	Ministry of Health (MoH) structure is responsive to health sector needs	▪ Defining the structure and functions of MoH under federalism is in progress ▪ Public Health Act is in the process of development	▪ Limited data available
OP5.2	Improved governance and accountability	▪ Smart health initiatives initiated ▪ Extension of service hours from 10am to 5pm at health facilities ▪ Social audit was implemented in 1252 health facilities in 55 districts ▪ Grievance handling process strengthened; need further efforts	▪ Need to establish an effective system to monitor accreditation and compliance of private facilities
OP5.3	Development cooperation and aid effectiveness in the health sector improved	▪ Development Cooperation Policy (2014) is in place, needs further enforcement ▪ Need to establish an effective and transparent database of development assistance to the health sector, including off-budget funding ▪ Need to establish periodic review mechanism for INGOs	▪ Limited data available
OP5.4	Multi-sectoral coordination mechanisms strengthened	▪ Multi-sectoral nutrition interventions based on the multi-sectoral nutrition plan ▪ Water quality surveillance initiated in collaboration with WASH sector	▪ Limited data available
OP5.5	Improved public financial management	▪ TABUCS implemented in all cost centres. It captures expenditure against the budget by programme activities. It provides a single tool to track budgets and prepare expenditure reports. ▪ Efforts in progress to align with LMBIS.	▪ Limited data available ▪ Need to institutionalise on-budget and off-budget reporting mechanism
OC6	Improved sustainability of health sector financing		
OP6.1	Health financing system strengthened	▪ Financial Management Improvement Plan revised ▪ Built the capacity of program managers and finance officers on audit clearance ▪ Improved financial monitoring reports (FMR) templates ▪ Performance-based grant agreements done with seven health institutions	▪ Limited data available

Code	Outcomes and Outputs	Overall progress	Data availability
OP6.2	Social health protection mechanisms strengthened	▪ Health insurance started from 3 districts; scaled up to 8 with the plat to reach 25 this fiscal year ▪ Need to harmonize the social health protection schemes	▪ Limited data available, particularly related to basic health services
OC7	Improved healthy lifestyles and environment		
OP7.1	Healthy behaviours and practices promoted	▪ Package for Essential Non-Communicable Diseases (PEN) initiated in 10 districts	▪ Limited data available
OC8	Strengthened management of public health emergencies		
OP8.1	Improved preparedness for public health emergencies	▪ Health sector damage and lessons from health sector response documented for institutional memory and disaster preparedness	▪ Data available, need to improve quality
OP8.2	Strengthened response to public health emergencies	▪ Cluster approach in practice ▪ Rapid response team (RRT) active at different levels	▪ Data available, need to improve quality
OC9	Improved availability and use of evidence in decision-making processes at all levels		
OP9.1	Integrated information management approach practiced	▪ Program specific results framework developed in line with the NHSS RF ▪ E-health strategy developed; institutional home identified; needs to be capacitated and operationalized ▪ HMIS and EWARS functioning in DHIS2 platform ▪ Practice of sharing the data to larger audience/public initiated – e.g., smart health initiatives: performance monitoring, e-attendance, health facility registry ▪ E-reporting from facilities initiated ▪ Routine data quality assessment (RDQA) systems initiated	▪ Overall, limited data available for effective monitoring of NHSS RF, SDG and DLIs; and limited use of data in planning process ▪ Need to functionalize routine MIS and build interoperability with each other ▪ Need to collaborate with other sectors like Nepal Police, Road Department, MoFALD
OP9.2	Survey, research and studies conducted in priority areas; and results used	▪ Harmonization of surveys initiated, e.g., NHFS 2015 (combines SARA, SPA, STS; USAID, DFID, WHO, UNFPA) ▪ Preparation of policy briefs/implications based on the NHFS findings is in plan ▪ Survey plan development process in progress ▪ NDHS 2016 is in progress; discussion initiated for harmonization of NDHS and NMICS ▪ TB prevalence survey and micro-nutrient survey in progress ▪ M&E TWG at MoH has initiated responding to the national data needs based on NHSS RF, NPC 14th Plan, SDGs and DLIs ▪ Limited/no practice of evaluating priority programs ▪ Limited efforts in capacitating NHRC and M&E wings of MoH at different levels	▪ Limited data available on use of evidence in decision making process ▪ Need to systematize the system for providing grants to public health institutions for innovation
OP9.3	Improved health sector reviews with functional linkage to planning process	▪ Some initiatives taken (e.g., national review of 2016) but need additional efforts to improve further; and align JAR with national review	▪ Need to develop a mechanism to monitor the prioritized action points agreed during national review reflected in AWPB

ANNEX 3: ANALYSIS OF NHSP-2 BUDGET ALLOCATION AND EXPENDITURE

In 2015, an extensive analysis of budget allocations and expenditure during the two Nepal Health Sector Programme a and 2 periods (2005 to 2015) was carried out.

MoH's budget doubled in NHSP-2 period

Table 1 shows the trend of GDP, the national annual budget and MoH's annual budget and related expenditure levels.

Nepal's health budget more than doubled in the NHSP-1 period (from NPR 8 billion to NPR 18 billion) and in the NHSP-2 period (from NPR 18 billion to NPR 40.56 billion) and increased overall by more than five times. However, MoH's budget decreased from 6.29% of the national budget in 2005/06 to 3.87% in 2016/17, mainly because the government increased the budget for other sectors, especially reconstruction, infrastructure, education and social security. Except for FY 2012/13, MoH's absorption rate in the NHSP-1 and 2 periods was less than the average for the national budget. Note that 2012/13 was considered an expenditure year meaning that MoH received the amount it had spent in the previous year. This data suggests that MoH's budget absorption capacity needs to be improved.

Table 1: Trends of GDP, national and MoH budgets and expenditure (in NPR billion)

Categories	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
GDP	654	728	816	988	1,193	1,367	1,527	1,693	1,929	2,120	2,248	NA
National budget	127	144	169	236	286	338	385	405	517	618	819	1049
MoH budget	8	9	12	15	18	24	25	20	30	33.51	36.7	40.56
National expenditure	111	134	161	220	260	295	339	359	450	531	601	NA
MoH expenditure	6	7	10	13	16	18	20	19	23	24.53	29.2	NA
National absorption rate	87.4	92.8	95.5	93.1	90.8	87.4	88.1	88.6	87.0	85.92	73.34	NA
MoH absorption rate	76.0	80.6	81.4	84.9	89.2	76.3	81.2	94.1	75.1	73.9	79.6	NA

Source: GoN Red Book, 2006-2014. NA= not applicable

Budget and expenditure by source of funds

The government's Red Book mainly covers government funds and contributions from external development partners. The EDPs provide pooled and direct funding. The government increased its funding to MoH from NPR 13.9 billion in FY 2010/11 to NPR 35.1 billion in 2016/17 (Table 2). The same period saw only a small increase in pooled and direct funding. It is important to note that the reporting of expenditure under direct funding has been weak over the years.

Table 2: Budget (NPR) and expenditure (%) by sources of fund (NPR billion)

Source	2010/11		2011/12		2012/13		2013/14		2014/15		2015/16		2016/17
	NPR	%	NPR	%	NPR	%	NPR	%	NPR	%	NPR	%	NPR
GoN	13.9	85.4	15.2	90.8	11.7	105.7	35.1	76.5	22.0	48.41	28.89	81.61	35.1
Pooled funds	6.0	69.5	6.2	76.2	5.8	85.2	1	98.9	6.7	21.62	1.69	100	1
Direct funds	3.9	54.2	3.6	48.6	2.7	63.3	4.4	33.3	4.8	3.15	6.14	64.46	4.4
MoH total	23.8	76.3	24.9	81.2	20.2	94.1	40.5	75.1	33.5	73.18	36.72	79.6	40.5

Source: Red Book, 2010- 2014

Budget and expenditure at central and district levels

More than 50% of MoH's budget was allocated to the district level in the first four years of NHSP-2 (2010/11–2014/15) (Table 3). This could be due to weak central level procurement practices.

Table 3: MoH budget (NPR) and expenditure (%) by central and district levels (NPR billion)

Level	2009/10		2010/11		2011/12		2012/13		2013/14		2014/15		2015/16		2016/17	
	NPR	%	NPR	%	NPR	%	NPR	%	NPR	%	NPR	%	NPR	%	NPR	%
Budget:																
Central	8.3	46.8	11.4	48.0	11.6	46.4	9.1	44.9	21.08	51.97	17.0	50.6	19.78	53.85	21.08	51.97
District	9.5	53.2	12.4	52.0	13.4	53.6	11.2	55.1	19.48	48.03	16.6	49.4	16.95	46.15	19.48	48.03
Total	17.8	100	23.8	100	24.9	100	20.2	100	40.56	100	33.5	100	36.73	100.0	40.56	100
Expenditure:																
Central	6.4	40.5	8.0	43.8	8.1	40.0	8.6	45.1	NA	NA	NA	NA	14.22	48.67	NA	NA
District	9.5	59.5	10.2	56.2	12.1	60.0	10.5	54.9	NA	NA	NA	NA	15.0	51.33	NA	NA
Total	15.9	100	18.2	100	20.2	100	19	100	NA	NA	NA	NA	29.22	100	NA	NA

Source: MoH, 2010- 2016(FMR)

Budget and expenditure by organisational level

In the first four years of NHSP-2 (2010/11–2014/15), DoHS held between 74.1% and 91.6% of MoH's budget while the Department of Drug Administration (DDA) held the lowest proportion (Table 4). The data also shows a large increase in hospital funding in the NHSP-2 period in tandem with their good budget absorption capacity.

Table 4: Budget (NPR) and absorption (%) rate by MoH organisations (NPR billion)

Level	2009/10		2010/11		2011/12		2012/13		2013/14		2014/15		2015/16		2016/17
	NPR	%	NPR	%	NPR	%	NPR	NPR	NPR	%	NPR	%	NPR	%	NPR
MoH	1.3	71.5	1.9	70.6	2.1	68.6	1.7	5.7	2.6	77.7	4.2	41.55	4.3	49.8	5.7
DoHS	13.1	88.9	17.6	74.6	17.8	83.3	14.5	24.7	20.1	74.1	21.0	78.47	23.2	83.3	24.7
DDA	0.0	90.5	0.0	83.4	0.0	93.8	0.0	0.1	0.1	94.0	0.1	105.68	0.1	86.8	0.1
DoAY	0.4	98.4	0.5	91.5	0.5	98.8	0.5	1.3	1.1	65.2	0.9	76.92	1.1	65.4	1.3
Centres	1.1	84.9	1.4	80.2	2.3	57.4	1.7	2.7	3.5	46.0	3.2	38.62	2.6	26.7	2.7
Hospitals	1.8	105.0	2.3	88.0	2.3	95.7	1.8	6	3.2	114.9	4.0	106.8	5.4	115.5	6
Total	17.8	89.2	23.8	76.3	24.9	81.2	20.2	40.5	30.4	75.1	33.5	73.22	36.7	79.6	40.5

Source: MoH, 2010- 2016

Allocation and expenditure by EHCS, systems support and beyond EHCS

MoH has prioritised the essential health care services (EHCS) budget as it accounted for almost 80 percent of MoH's budget in the NHSP-2 period, which is in line with the NHSP-2 strategy. MoH has categorised the activities which come under EHCS and included it in the electronic annual work plan and budget (e-AWPB) system, which has made it easier to calculate the budget allocated to EHCS.

Table 5: Allocation (NPR) and expenditure (%) by EHCS, systems support and beyond EHCS (NPR billion)

Type	2010/11		2011/12		2012/13		2013/14		2014/15		2015/16		2016/17
	NPR	%	NPR	%	NPR	%	NPR	%	NPR	%	NPR	%	NPR
EHCS	16.6	78.6	18.6	81.9	15.1	90.7	21.2	73.2	22.5	71.3	25	80.64	26.6
Beyond EHCS	1.8	88.5	1.9	95.6	1.6	124.2	2.9	104.0	3.6	96.9	3.9	98.46	4.2
System components	5.4	65.3	4.4	71.9	3.6	95.5	6.3	68.2	7.4	67.43	7.8	67.05	9.7
Total	23.8	76.3	24.9	81.2	20.2	94.1	30.4	75.1	33.5	73.22	36.7	79.65	40.5

Source: MoH, 2010- 2016

The increased 'beyond EHCS' budget is due to the increased budgets to hospitals. The budget for system components, which includes decentralized service delivery, private and NGO sector development, sector management, health financing and resource management, logistics management, human resource development and information system management, increased from the first to the last years of NHSP-2. The amount spent on system components and beyond EHCS increased proportionately more than that spent on EHCS indicating that MoH has been increasingly prioritising these two service areas (Table 5).

ANNEX 4: IMPLEMENTATION STATUS OF REVISED PROCUREMENT IMPROVEMENT PLAN (PIP), 2015/16

	Activities	Current status	Remarks
1. Improved procurement guidelines, planning and procedures			
1.1	Standardization of specifications for drugs, vaccines and contraceptives • Ensure web security to prevent tampering. • Print handbooks on specifications and circulate to all stakeholders with unique code numbers.	Done Pending Pending	
1.2	Standardization of equipment specifications	Done, but errors need to be corrected and finalized soon	
1.3	Adopting the standards with unique code numbers in the bid document		
1.4	Assist in the timely preparation of CAPP	SOP has already been prepared	
1.5	Assist in the preparation of standard bid document (SBD)	SBD has been prepared for framework contracts and is under review by the PPMO	
1.6	Define list of drugs and equipment to be procured at different levels. Clearly specify the scope of work of the LMD and leave the rest to regions and districts	Limited achievements	Free drugs and other essential items plus equipment above a value alone may be procured by LMD
2. Improvement in procurement process including e-procurement			
2.1	Speed up the procurement process, cutting down delays at different levels	SOP is under preparation for which training workshop has been organised	
2.2	Implement first phase of e-procurement such as e-bidding	Most bids are now by e-submissions	
2.3	Operationalizing the e-procurement • Finalisation of the SBD • Training of staff and other stakeholders • Installing the software • Pilot testing • Making it operational	SBD has been submitted to PPMO Training will be organized in December	
3. Improvements in supply chain and monitoring			
3.1	Procurement monitoring system	No progress	This MIS can be generated with e-procurement
3.2	Build adequate capacity at warehouses to store desired levels of stock: • Desired stock levels at different levels to be decided • Capacity required for this to be estimated • Measures to fill the gap to be taken		Capacity assessment needs carrying out
3.3	Make LMIS online with quality and timely data inputs	Some progress made, but 100% reporting should be ensured in addition to data accuracy	

	Activities	Current status	Remarks
3.4	Generate necessary management information reports required at various levels from the LMIS • Reports to manage inventory to prevent stock outs and excesses at the district warehouses	None available	
3.5	Manage the supply chain with such online data: • Eliminate stock out at district warehouses • Eliminate excesses • Monitor delayed supplies • Monitor prompt payment	No monitoring because data not available in usable form	
4. General			
4.1	Post-delivery quality assurance to be put in place in addition to pre-shipment inspections		Could be in-house or out-sourced
4.2	Strengthen the organizational capacity of LMD	Many capacity building programmes have been organized and are on-going	Supply chain expert and quality assurance managers are needed
4.3	Introduce framework contract	SBD is under consideration by PPMO	
4.4	Establishment of a Central Procurement Agency		This is a long term goal of MoH

ANNEX 5: GESI STRATEGY FRAMEWORK OF NHSP-2

Strategy	Working policy	GESI related progress in 2015/16 against working policy
OBJECTIVE 1: DEVELOP POLICIES, STRATEGIES, PLANS AND PROGRAMMES THAT CREATE A FAVOURABLE ENVIRONMENT FOR INTEGRATING (MAINSTREAMING) GESI IN NEPAL'S HEALTH SECTOR.		
Strategy 1. Ensure inclusion of GESI in the development of policies, strategies, plans, setting standards, and budgeting, and advocate for use of such policies, standards and budget provisioning at the central level.		
Review the existing policy, law and guidelines to make them GESI inclusive	1. Integrate GESI in existing health policy, regulations and guidelines. 2. Advocate for health as a fundamental human right in the constitution. 3. Include the standards for integration of GESI in NHSP-2. 4. Develop mechanisms for regular policy feedback. 5. Revise HMIS to improve health monitoring on GESI. 6. Identify and recommend expansion of health facilities to locations with high concentrations of underserved poor and excluded groups.	1.1 Integrated GESI elements into New Health Policy 2014 and is now under implementation. 1.2 The 'Operational Guidelines for Gender Equality and Social Inclusion Mainstreaming in the Health Sector' approved by MoH in 2013 and are now under implementation. 1.3 'Gender Equality and Social Inclusion Institutional Structure Guidelines for Mainstreaming' across MoH approved by the Minister, MoH in 2013 and is now under implementation. 1.4 The Urban Health Policy approved in 2015 is in revision process. The revision has focused in further improving an access to health services for the urban poor. 1.5 Social Auditing was implemented across 55 districts in 1252 health facilities in 2015/16. PHCRD is conducting auditing across 70 districts in 1752 health facilities in 2016/17. 1.6 Social Audit Guidelines revised and approved by MoH. 1.7 The One-stop Crisis Management Centre (OCMC) operational guidelines was revised and approved after incorporating feedback as per the aspiration of new Constitution, district level feedback and recommendations from the OCMC national review 2016. 1.8 The revised Social Service Unit Operational Guideline was approved after incorporating inputs and feedback from SSU annual progress review and study of SSU piloted hospitals 2014/15. 1.9 Integrated GESI elements into Nepal Health Sector Strategy - Implementation Plan 2016-2021, which is in an approval process. 4. Provided feedback regularly on the revision of policies such as Health Facility Operation and Management Committee (HFOMC) guidelines, Urban Health Policy, operational guidelines related to marginalized, remote areas, referral for target group patients and deprived citizen medical treatment fund. 5. With HMIS Section identified indicators related to GESI to be disaggregated by sex, age, location, and caste/ethnicity. Among these, revised HMIS incorporating GESI related key 11 indicators in 2014/15. Also, improvements being made to hospital recording and reporting systems in revised HMIS to enable mortality and morbidity data to be generated by age, sex and cause. The revised HMIS reporting system and its new software will enable sub-district level data to be generated.

Strategy	Working policy	GESI related progress in 2015/16 against working policy
Make necessary policy provisions to include GESI related issues in plans, programmes, and budgeting	7. Develop policy for identification of poor and excluded groups. 8. Develop implementation guidelines and ensure implementation. 9. Develop policy measures to promote GESI in human resource management. 10. Develop provisions for poor and excluded groups to receive free secondary and tertiary health care services. 11. Formulate provisions for compulsory social auditing to make health services inclusive, transparent and accountable. 12. Incorporate GESI in e-AWPB programmes and MoH activities. 13. Advocate to MoF and NPC for regular budget provisioning of GESI in AWPB. 14. Formulate provision for health cooperatives for easier access of poor and excluded to health services. 15. Develop provision for health insurance to increase access to health services of poor and excluded. 16. Formulate provision for media to disseminate health care messages and inform about facilities for poor and excluded groups.	8a. Operational Guidelines for Mainstreaming GESI in the Health Sector approved by the health minister in December 2013. Guidelines implemented at all levels by health service providers and managers to mainstream GESI in planning, programming, budgeting, monitoring & reporting. 8b and 9. MoH has incorporated GESI targeted interventions (OCMCs, SSUs scaling up and strengthening, GESI TWGs, training of service providers and OCMC staffs of the hospitals on GBV and psychosocial counselling, GBV training to health staff in selected districts, GESI mainstreaming training to focal persons from MoH, DoHS and RHDs) into their programme planning, monitoring and implementation. 8c. GESI integrated into the programme implementation guidelines of Primary Health Care Revitalization Division (PHCRD) and Public Health Administration Monitoring and Evaluation Division (PHAMED). 9. A study "Assessment of Gender Equity and Social Inclusion Mainstreaming Training" conducted to assess the effectiveness of the GESI training. The study reflected that GESI trainings are largely a dynamic platform for sharing knowledge and experiences by service providers working at various levels. 10. SSUs have been established in 14 hospitals in 2015/16 to improve the access of poor and excluded groups; disaster survivors, GBV survivor to subsidised and free secondary and tertiary health care services. Evaluation of SSU pilot initiatives (2013-2015) completed in 2015 and scaled up of SSU in additional six hospitals in 2015. 11. Social Audit Guidelines revised and approved by MoH. Social Auditing implemented across 55 districts in 1252 health facilities in 2015/16. PHCRD is conducting auditing across 70 districts in 1752 health facilities in 2016/17. 12. GESI activities were discussed and identified with different divisions and centres since 2012/13 AWPB. For the PHAMED and PHCRD, detailed plans covering GESI activities were developed with relevant staff. Annual business plans were developed by different divisions and centres, which specify GESI related activities. 13. Successful advocacy and lobbying has been done to MoF for regular budget provisioning of GESI in AWPB. 16. At district level, dissemination of messages through various media (local FM radio, TV) on availability of service from SSU, OCMC for poor and excluded groups including GBV survivors and other target groups such as senior citizens, FCHVs, differently abled person. Additionally, each year 16 days activism against GBV is organized in which media is mobilised to inform general public on services to GBV survivors.
Strategy 2: Prioritise GESI in planning, programming, budgeting, monitoring and evaluation at local levels (DDC, DHO, DPHO and VDC) to ensure services are accessible and available to the poor, vulnerable and marginalised castes and ethnic groups.		

Strategy	Working policy	GESI related progress in 2015/16 against working policy
Create an environment whereby programme planners, managers and directors will include issues related to GESI in making plans, programmes, budgeting, monitoring and evaluation.	17. Address GESI issues in plans, programmes and budgets. 18. Develop GESI indicators as necessary, disaggregate the HMIS, monitor and report performance of target groups. 19. Define roles and responsibilities for monitoring and evaluating performance of target groups. 20. Develop mechanisms/ processes to review the progress from a GESI perspective periodically.	17. Inputs for including GESI related directives in the programme guidelines issued by divisions and centres for districts were provided as relevant for the preparation of AWPBs and the guidelines. 18. The HMIS has incorporated 11 key GESI-related indicators that are to be disaggregated by sex, age, location, and caste/ethnicity. This has been operationalized since 2014/15. Also, improvements are being made to hospital recording and reporting systems in the revised HMIS to enable mortality and morbidity data to be generated by age, sex and caste/ethnicity. The revised HMIS reporting system and its new software enables sub-district level data to be generated. 19. Annual district and regional health reviews were conducted from a GESI perspective on a regular basis. 20. The institutional structure for mainstreaming GESI, headed by the health Secretary as Chair of the GESI Steering Committee, and technical working groups at each level of the health system, provides the mechanism to regularly review progress on GESI in the health sector. MoH has allocated funds to support biannual reviews of GESI progress at MoH and district levels since 2013/14. However, for 2015/16 the annual review of GESI progress has been only conducted in selected districts with support from EDPs.
Include GESI related issues in programme implementation by health service providers.	21. Operationalise guidelines to facilitate access and utilisation of health services by the poor and excluded. 22. Ensure that the work of every health institution includes GESI.	21. The Operational Guidelines for Gender Equality and Social Inclusion Mainstreaming in the Health Sector approved by the health Minister in 2013 is regularly implemented. These guide all levels of health service providers and managers on mainstreaming GESI in their planning, programming, budgeting, service delivery and monitoring. 22. Training on GESI mainstreaming to focal persons from MoH, DoHS and RHDs conducted.
Coordination and participation among concerned organisations for GESI.	23. Coordinate with MLD, MoF and NPC to allocate more budget for GESI in DDCs, VDCs and Municipalities. 24. Coordinate and implement with DDCs, VDCs, and Municipalities to attract their social development budgets in the health sector. 25. Continue handover of health facilities at local level and make the HFOMCs inclusive. 26. Coordinate/partnership with district- and village-level NGOs working in the health sector. 27. Coordinate with Ministries, I/NGOs and local bodies to integrate GESI in their programmes. 28. Create trust between health care providers and communities. 29. Create policy provisions to make local bodies responsible to develop participatory inclusive plans, and to implement and monitor them. 30. Transfer knowledge, skills, resources and materials to local bodies to meet the needs of the target groups.	23. Lobbied with MoF for the allocation of more budget for GESI (OCMC, SSU), which resulted in increased budget for OCMC and SSU since 2013/14. 24. Social auditing process has supported health facilities to generate resources from VDC, DDC and other agencies (the action plan developed at the end of the social auditing process requires commitment from all and in many districts DDC, VDC and agencies have been contributing for the same). 26a. All the districts that implemented social audits used NGOs as third party social auditors and involved community based organisations in the audits. 26b. SSUs work in partnership with local NGOs and OCMCs coordinates with district level NGOs on the GBV agenda. 27. Many GESI related interventions are achieved through the partnership with UNFPA and EDPs like H4L, GiZ, TAF, JHPIEGO and larger level collaboration with MOWCSW, Police Head Quarter, Attorney's office, OPMCM and President's office. 28a. Social auditing seeks to foster partnerships for improving health services with communities, and through the very process of auditing generates greater communication and trust between service providers and communities. Similarly, OCMC, SSU, Mental health requires larger communication with community. 29. The Local Health Governance Strengthening Programme (LHGSP) is being implemented in 6 of Nepal's 75 districts to enable VDCs, including health facility management committees, to identify and address local health needs through local planning. These inputs also encourage the generation and mobilisation of local resources to implement local health planning. This programme is being implemented to operationalise the collaborative framework between MoH and MoFALD, which aims to improve local health governance. 30. Several rounds of meeting, orientation and training to local bodies (representatives) regarding the need of target groups of OCMC, SSU and mental health.

Strategy	Working policy	GESI related progress in 2015/16 against working policy
Strategy 3: Establish and institutionalise GESI unit/desk at the MOH, DOHS and divisions of the DOHS, regional directorates, and DHO/DPHO, and Social Service Units for GESI at central, regional, sub-regional, and zonal hospitals.		
a) Establish Social Service Units (SSU) in hospitals.	31. Establish and operationalise Social Service Units in central, regional, sub-regional, zonal, and district hospitals.	31.1 Fourteen SSUs were established in referral hospitals. On-going capacity building support is being provided to the SSUs through system building, training, mentoring and reviewing the performance. On-line reporting system of SSU services was established with on-site coaching in 2016 and functioning in 13 SSUs out of 14. Capacity building training to SSU staff on facilitation and communication skills was provided and workshop was organized on inspirational volunteerism and humanitarian approach in eight SSU based hospitals to improve service delivery to target group patients. 31.2 Annual progress review workshop on SSUs was held every year. The workshop reviewed the achievements, issues, lessons learned, recommendations for effective functioning of SSUs and areas of revision/improvement of guidelines. The SSU guidelines were revised and approved by the Minister MoH based on assessment findings, workshop inputs and feedback from SSU visits. MoH is organising monitoring and progress reviews of each SSU and making a capacity building plan considering the feedback from monitoring visits. 31.3 MoH with support from NHSSP, commissioned an independent SSU evaluation of the initiative to inform hospital management and MoH about the achievements, challenges and constraints, and lessons, and provided inputs to NHSS-IP. Based on the roadmap developed immediately after the SSU annual review 2015, MoH decided to scale up SSUs in all referral hospitals. Up to July 2016 the fourteen SSUs have served more than 200,000 target group clients who have received free or partially free services, with an almost equal number of male and female cases. Most of the cases have been either poor people or senior citizens.
b) Establish GESI Unit/Desk at different levels of the health sector.	32. Establish GESI and internalise a GESI unit within MoH, DoHS, RHDs, DPHOs and DHOs.	32.1 A GESI Steering Committee was formed in 2011 at MoH chaired by the secretary and regular meetings have been held. The Steering Committee has guided and given policy direction to address GESI related issues. By the end of 2014, GESI technical working groups (TWGs) have been formed in all districts. GESI focal persons have been nominated at MoH, DoHS and in all regional health directorates (RHDs) and in 75 DHOs/DPHOs. MoH has allocated funds to support biannual reviews of GESI progress at MoH and district levels since 2013/14. However, for 2015/16 the annual review of GESI progress has been only conducted in selected districts with support from EDPs. 32.2 In 2013 a GESI section was formed and began functioning in the Population Division. Currently GESI section restructured into Public Health Administration, Monitoring & Evaluation Division. 32.3 The PHAMED incorporated GESI targeted interventions (OCMCs, SSUs and geriatric health services), strengthening GESI TWGs and GBV orientation to health staff of the districts into their programme implementation guidelines since 2013/14 continuing in 2016/17.
OBJECTIVE 2: ENHANCE THE CAPACITY OF SERVICE PROVIDERS AND ENSURE EQUITABLE ACCESS AND USE OF HEALTH SERVICES BY THE POOR, VULNERABLE AND MARGINALISED CASTES AND ETHNIC GROUPS WITHIN A RIGHTS-BASED APPROACH.		
Strategy 4: Enhance the capacity of the service providers to deliver essential health care service to poor, vulnerable, marginalised castes and ethnic groups in an equitable manner and make service providers responsible and accountable.		

Strategy	Working policy	GESI related progress in 2015/16 against working policy
Improve service delivery mechanism by service providers for the poor, vulnerable and marginalised caste and ethnic groups.	33. Sensitise health workers, SSU and GESI focal points at all levels, FCHVs, and HFOMCs on GESI. 34. Implement behaviour change training for the health workers, FCHVs and local HFOMCs. 35. Strengthen capacity of FCHVs and NGOs to provide proper information to target groups on health services. 36. Include GESI content in the health sector education and training curricula.	33.1 To the end of 2015, GESI orientations were provided to the technical working groups and focal persons of all 5 regions and 75 districts, in 21 OCMC hospitals and the 14 hospital-based SSUs. GESI training (concept and its application in planning, programming and service delivery) was provided to supervisors and health facility in-charges of 31 districts. 34. Capacity building training to HFOMCs and FCHVs was provided in selected districts with support from EDPs (NHSSP, H4L, UNFPA, etc). 36.1 The National Health Training Centre reviewed 5 curricula from the GESI perspective (HFOMC, FCHV, behaviour change communication [BCC], upgrading assistant health worker [AHW] and skilled birth attendant [SBA]) and finalised materials of five curricula in 2013. The revised HFOMC, AHW and SBA revised curricula have been implemented since 2014. 36.2. GESI concepts and application has been integrated into the induction training package for new health sector personnel (officer and non-officer), and implemented by NHTC since 2013.
Strategy 5: Address GESI-related barriers by properly identifying target groups, ensuring remote communities are reached, and emphasising programmes to reduce morbidity and mortality of the poor, vulnerable and marginalised castes and ethnic groups.		
Increase access of the target groups to universal and targeted free care programmes.	37. Develop criteria to identify poor and excluded groups and provide them with "Free Health Check-up Cards" for secondary- and tertiary-level health care services and referrals. 38. Ensure equitable and meaningful participation of target groups and women in HFOMCs. 39. Ensure meaningful participation of poor and excluded groups in social audits of health services.	37. SSUs have been established in fourteen zonal, regional and central level hospitals and have been providing subsidies and free health care services to the poor, the helpless, the disabled, senior citizens, GBV survivors, disaster victims, mental health patients, etc. All established SSUs were provided with backstopping organisational and management support in 2016. 38. Ensured meaningful participation of target group representatives in HFOMC in selected districts with support from EDPs. 39. The social audit guidelines have provisions to include women, the poor and socially and geographically excluded people in consultation processes (patient exit interviews, interview with mothers and focus group discussions) during social auditing. The process has enabled many women and people from excluded groups to participate and raise their concerns in social audits for a more thorough and inclusive process.
Increase the use of Mother and Child Health and Free delivery services by the target group.	i) Develop special programmes for women, poor, and excluded groups (women and children) to increase their access to MCH services and free deliveries. 40. Support increasing use of neonatal and postnatal care services, institutional deliveries, nutrition, and childhood immunisation. 41. Mobilise and train/strengthen FCHVs and NGOs to increase target groups' access to services. 42. Provide assistance on awareness raising, IEC/BCC programmes, outreach services to pregnant women.	42. PHCRD added 110 new community health units in 2016/17. The total Units are so far 250 to provide services to underserved populations. Similarly, PHCRD added 50 Urban Health Centres in 2016/17 and total centres are so far 326 to provide services to urban poor population.
	ii) Address gender based discrimination which constrains access of women (of different social groups) to health care services, especially institutional deliveries. 43. Collaborate with women's CBOs /NGOs on gender and social based discrimination. 44. Conduct community and family counselling on GBV. 45. Promote regular work attendance of female health workers.	43. Awareness programmes, interviews and TV shows, radio jingles and rallies were organised at district levels during the 16 days of activism against GBV. This contributed to developing sensitivity about violence against women and girls and has improved understanding of the government services and plans in addressing GBV. 44. A total of 21 OCMCs have been established as of now. They are based in hospitals to support survivors of GBV where family counselling is also done. 44.1 Technical assistance support has been provided for the designing and development of GBV clinical protocol, which has been approved by the health Minister in 2015. The rollout of the training on protocol has been conducted in disaster affected and in few remote districts.

Strategy	Working policy	GESI related progress in 2015/16 against working policy
Conduct context specific analysis of current issues in the health sector and design and implement specific interventions for specific poor, vulnerable and marginalised caste and ethnic groups and areas (Regional and/ or District).	iii) Promote service expansion in geographically inaccessible/remote regions. 46. Conduct mapping of the areas and increase outreach and mobile health camps and community health clinic programmes for the target groups. 47. When establishing new HP/SHPs, select sites most appropriate for the target groups' access and use.	46a. PHCRD has organized integrated public health camps in 5 districts targeting remote areas, unreached areas where Dalit, Janajati and marginalised communities are living and earthquake affected areas. 46b. In 2015/16, PHCRD has been regularly organizing special health programme targeting geographically unreached and underserved communities-- Dalit, persons with disability and DAG VDCs in 10 districts.
	iv) Expand services in low HDI districts. 48. Focus on community and outreach programmes in the 35 low HDI districts. 49. Ensure programmes are focused at less populated areas to make the target groups feel health as their fundamental right.	
	v) Make provision for regional programmes to address unmet health issues and needs of women, poor and excluded groups. 50. Promote programmes like publicity campaigns, outreach services, counselling services and orientations to free care. 51. Conduct special activities to reach Dalits. 52. Implement special programmes such as providing monetary incentives to those using EHCS.	50. SSUs provide free services to certain target group that includes poor and vulnerable also .The NGOs (partner agency for SSU) also supports in publicity campaigns regarding the free care from SSU. Similarly, OCMC also provides services to GBV survivors. The preventive programmes such as publicity and campaigns against GBV and the availability free services from OCMC were also conducted by OCMCs.
Strategy 6: Enhance or modify services to be sensitive to GESI and ensure access is equitable and services are delivered uniformly without regard to social status.		
Give emphasis to special activities to provide adequate and quality services.	53. Ensure the presence of female doctors at all district hospitals. 54. Make a provision for local language speaking staff at service delivery sites. 55. Allow the district-level health organisation to adopt district-specific GESI policy, if needed. 56. Conduct social audits.	56. Social audits were conducted in 1252 health facilities of 55 districts in 2015/16 and will be completed in 1752 health facilities in 2016/17.
OBJECTIVE 3: IMPROVE HEALTH SEEKING BEHAVIOUR OF THE POOR, VULNERABLE AND MARGINALISED CASTES AND ETHNIC GROUPS WITHIN A RIGHTS-BASED APPROACH.		
Strategy 7: Develop and implement Information Education and Communication (IEC) programmes to improve health seeking behaviour of the poor, vulnerable and marginalised groups.		
Develop and disseminate targeted IEC materials that will bring changes in behaviour of target groups.	57. Prepare and distribute enough audio visual, pictorial, etc. information and publicity materials. 58. Include the target groups' programme in publicity and communication materials of MoH. 59. Develop skills at the local level for producing information materials, especially in remote areas.	57. The development, production & distribution of communication media materials continued including radio jingles, tele-serials & printed material. 58. The localisation of centrally developed media and materials on safer motherhood and newborn child health (SMNCH), family planning, and adolescent sexual and reproductive health (ASRH) BCC/IEC strategies continued. 21 OCMC districts developed and disseminated radio jingles, brochures on gender based violence and services from OCMC. SSUs printed information leaflets. 59. Capacity built of district BCC/IEC focal persons of all 75 districts focused on using local media and materials.
Increase the use of appropriate media.	60. All media allocate appropriate time for broadcasting health service news. 61. Emphasise use of effective media and local languages. 62. Increase information communication on GESI among health institutions. 63. Include appropriate media programming for low HDI districts and districts with diverse language. 64. Conduct regular monitoring on quality of communication services.	

Strategy	Working policy	GESI related progress in 2015/16 against working policy
Strategy 8: Empower the target groups to demand their rights and conduct their roles while realising their responsibilities.		
a) Increase the target groups' awareness of their health rights and of free health care services, and enhance their capacity to make the service providers accountable.	vi) Empowerment. 65. Conduct activities for the target groups to make them aware of their rights/responsibilities and capable of taking leadership roles. vii) Information, Education and Communication 66. Conduct publicity campaigns on how to access and properly utilise health services. 67. Create door-to-door consumer committees and orient them to conduct effective awareness and information dissemination to the target groups. 68. Develop and conduct orientation and awareness campaigns for change in health seeking behaviours. 69. Promote women's participation and conduct awareness on equal treatment of both male and female children. 70. Provide orientation on women's reproductive health rights.	65. Community awareness programme was implemented in selected districts by different EDPs to mobilise targeted communities (women, the poor and excluded people) by applying a rights-based social mobilisation approach. NGOs and FCHVs were mobilised to promote health rights, and they disseminated messages through mass communication, group facilitation, behaviour change communication and interpersonal communication.

Government of Nepal
Ministry of Health

Annual Progress Report of Health Sector

Fiscal Year 2015/16

(For Joint Annual Review)