

**Medium Term Expenditure Framework
(2002/3-2004/5)
Health Sector**

Nepal Development Forum-2002

**His Majesty's Government of Nepal
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ABBREVIATION

ARI	Acute Respiratory Infection
BCC	Behavioral Change Communication
CDD	Control of Diarrhoeal Diseases
CDP	Community Drug Program
DHO	District Health Office/Officer
DDC	District Development Committee
DoHS	Department of Health Services
EDPs	External Development Partners
EHCS	Essential Health Care Services
EPI	Expanded Program of Immunization
FCHVs	Female Community Health Volunteers
IEC	Information, Education and Communication
IMR	Infant Mortality Rate
IPR	International Patent Rights
JE	Japanese Encephalitis
MTSP	Medium Term Strategic Plan
MMR	Maternal Mortality Ratio
MoLD	Ministry of Local Development
NHA	National Health Account
NHTC	National Health Training Center
PERC	Public Expenditure Review Commission
PAF	Poverty Alleviation Fund
QA	Quality Assurance
SLTHP	Second Long Term Health Plan
TB	Tuberculosis
VDC	Village Development Committee

Executive Summary

Nepal has shown an improvement in some of the basic health indicators in the last few years. The Infant and Maternal deaths have been reduced remarkably. Similarly, contraceptive prevalence rates, child immunization, control of tuberculosis and leprosy, effective surveillance of malaria, Kala-azar and control of diarrhoeal diseases have been significantly improved.

In spite of some impressive improvements the health system is not adequately meeting the needs of most vulnerable groups, women and children, the rural population, the poor, the disadvantaged and marginalised population. Major constraints are seen in areas like human resources, inadequate staff motivation and low retention, insufficient community involvement, rapidly expanding private sector without adequate regulatory mechanisms. Similarly, weak referral system, weak monitoring and supervision in public and private sectors, unsatisfactory condition of physical facilities, insufficient quantity and quality of drugs, low awareness on health and low utilization of available health services, are some of the major challenges.

Similarly, insufficient clarity of organizational roles and responsibilities, over-centralization, resulting in lack of responsiveness to local needs, a shift in Government expenditure from primary to secondary/tertiary levels of care are some other major challenges that MOH has to deal with.

At the policy level efforts have been made to reform the national health system. Some of the major steps in this regard are development of National Health Policy, SLTHP, Health Act-1997/98, attempts in reorganizing the MoH, strategic analysis and preparation of Medium Term Strategic Plan as a road map to the 10th five year plan.

With regards to monitoring and evaluation a separate division for monitoring health programmes in the ministry of health is established. Curative Division in MoH will look after improvement of services including referral system in hospitals. This ensures the quality control in the services of public and private institutions. A separate Act is also submitted in the parliament with an objective to improve the quality of services particularly in private health facilities. The Regional Health Service Directorates will be responsible for implementing and monitoring the activities of all the three Departments of MoH.

The Ministry of Health through the Second Long-Term Health Plan and subsequent strategy discussions has reached a decision that first it will deal with the unfinished agenda of those health problems which are disproportionately and maximally contributing to the highest level of mortality and burden of disease. Hence, in the process of financial allocation, highest priority is accorded to these essential health care interventions.

Greater efficiency is accorded in the use of existing resources within the existing pattern of allocation. Although the allocation to the health sector has substantially increased over the years, there is a general belief that the efficiency in the use has remained low with low absorptive capacity of less than sixty eight percent. Therefore, financial management and tracking of expenditure will be given priority.

Similarly, cost effective management and quality options are being gradually implemented through decentralisation of the management of health facilities at the district level and below, for communities to own the service facilities and make service providers more accountable to them. Moreover, there are efforts ongoing for encouraging competitive and low-cost private sector services in urban areas for ancillary, treatment and diagnostic services in curative health care and for the production of human resources in health of various categories.

The MTEP and 10th plan will focus on provision of EHCS, decentralization, quality management of human, financial and physical resources and public private partnership.

The prioritization of the activities have been made on the basis of highest burden of diseases, implementation capability, equity consideration, programs directed to poor, marginalised, vulnerable and disadvantaged groups, programs contributing to poverty alleviation and availability of resources in the country. There is also a focus on the control of major communicable diseases, nutrition, and reproductive health and family planning services. The major reforms proposed are: handing over health institutions to VDC including their operational expenditures, review of programs which have got maximum expenses on allowances and administrative matters and enhance the capacity of the MOH Planning Division.

During MTEP and 10th five-year plan period the policies will ensure: control of communicable diseases, strengthening of safe motherhood and immunization programmes, efforts on production of quality drugs, drug regulatory mechanism and self reliance. Further development of alternative medicines and their integration in the general health system, expansion of CDP, initiation of the concept of cooperative and Health Insurance aiming providing services to poor and unserved population.

In achieving the above outcomes HMGN has adopted major strategies. These include: effective management of health services including fiscal management by both central and local institutions, transparent, efficient and effective personnel administration, quality production of HRH, initiation of PAF and micro-credit schemes for drug supply, adaptation of decentralized and need based approach and carry out operational research for indispensable part of the health services system.

The proposed policies, strategies and priority programs are consistent with the I-PRSP. Key programs and activities have been prioritized into three groups i.e. Priority 1 Programs - which have the highest burden of diseases and consist of Essential Health Care services interventions; Priority 2 and Priority 3 Programs consist of services beyond essential health care services, public-private-NGO partnership and issues related to sectoral management.

Arrangements for effective implementation, monitoring and accountability through use of existing resources and alternative financing are some of the major commitments of the HMGN in improving health services. These will be ensured through community participation, decentralization, Public-Private-NGO Mix and Strengthening Sectoral Management.

It is recommended that financing for priority 3 programs should be reduced or phased out in the coming five years period and priority 2 programs in the subsequent 10 years, where applicable.

For the implementation of priority health programs mentioned in the MTEP a commitment from the government and EDPs of **Rs. 16,676.3 million** is required. The estimated budget for the fiscal year 2002/2003 on the development side is based on the ceiling provided by the NPC, a modest of 15% annual increment is proposed for all the three years. The regular expenses have been kept constant.

Both MTEP and 10th five year plan will accord highest priority in the provision of Essential Health Care Services and other key programmes targeted to economically deprived population to ensure equity.

As MTEP is an austerity plan budget cut should be protected particularly in EHCS and an efficient and cost effective management approach should be explored. For this purpose optimization of financial allocation through PAF, effective mobilization of VDC contribution and Parliamentarian Fund and a move towards sector-wide approach will be some of the major steps in the plan period. It is believed that the MTEP can make a significant contribution to improving HMG's own processes of strategy formulation, implementation of development programs and public expenditure management and on "donor accountability".

1. Background

1.1 Present Status in the sector

Nepal has shown an impressive improvement of some of the important health indicators in the last few years. The Infant Mortality Rate (IMR) has remarkably reduced from a level of 107 per 1000 live births to 64 as of 2000, maternal mortality has come down from 850 to 539 and the contraceptive prevalence rate from a level of three in 1976 increased to 39 in the year 2001. However, these figures are still some of the highest in the world and even in the South East Asian Region.

Health infrastructural facilities have fairly increased, though people's access to institutional services has not improved accordingly. Also, quality of care remains uncertain in most cases. Significant progress has been achieved in child immunization, tuberculosis and leprosy control and in the effective surveillance of malaria, kala-azar and diarrhoea. However, Tetanus Toxoid immunization of pregnant women remains below the target.

1.2 Key Issues and Challenges

1.2.1 Key Issues

- HMG/N has a clear vision and health policy framework for health sector development as set out in the Second Long Term Health Plan (SLTHP) that is to be implemented through successive Five Year Development Plans. The Local Self-Governance Act (1999) establishes a framework for decentralization within which the SLTHP and Five Year Development Plan goals, objectives and targets should be reached.
- In addition to the need for a costed and financially viable medium term health sector strategy a number of connected issues as following must also be addressed :
 - Ways of working within government which reduce the efficiency and effectiveness of the public health sector, and which hinder necessary change.
 - Insufficient clarity of organizational roles and responsibilities.
 - Weak planning, limited financial and human resources, logistics and information management problems (which will have to be addressed within the context of civil service reform)
 - Inadequate monitoring of sector performance (availability, accessibility, affordability, acceptability of services, equity)
 - Inadequate staff motivation; deployment and retention problems
 - Over-centralisation and a resulting lack of responsiveness to local needs
 - A shift in Government expenditure from primary to secondary/tertiary levels of care

- Inputs not linked to outputs which makes it difficult to monitor whether the inputs are used efficiently, effectively and equitably
- Insufficient community involvement in planning, implementation and supervision of service delivery
- An ad hoc public/private NGO mix which has evolved in the absence of a public policy discussion that would have considered its implications for sustainable financing, availability, accessibility and equity of service provision
- A rapidly expanding private sector without adequate regulatory mechanisms
- No strategy for intersectoral collaboration
- Inadequate framework for and implementation of alternative financing schemes
- Sub-optimal and limited coordination of External Development Partners' (EDPs) investment leading to duplication of efforts and/or gaps in needed support
- Inappropriate or unrealistic assumptions on the part of some EDPs regarding the length of time required for projects to be sustainable in the public and NGO sectors

1.2.2 Challenges

- There has been significant investment within the public, private and NGO health sectors. This investment has focused on health system development (including policy development, capacity building and management strengthening etc), supporting service delivery and human resources development. However:
- Though health indicators have improved significantly, particularly in the past decade, they are still lower than might be expected by comparison with countries of a similar socio-economic profile and level of health funding. The health system is not adequately meeting the needs of the most vulnerable groups, women and children, the rural population, the poor, the disadvantaged and marginalized. This suggests that resources must be used more equitably and efficiently.
- The public health system is complex (eg. the existence of seven levels of service delivery and management) and highly centralised which reduces its ability to respond to local needs.
- Monitoring and supervision is weak in the public and the private sectors. This is reflected in inadequate performance, the inability to ensure quality of care and in the case of the public sector in low utilisation. Though monitoring and regulatory frameworks have been developed, they have not been effectively implemented nor adequately enforced.

- The low demand for government services is attributable in part to a lack of drugs and medical supplies, insufficient quantity and quality of staff as well as the unsatisfactory condition of buildings and equipment.
- Despite the significant investment in the health sector, the existing level of financing is insufficient to fund essential health care services. To address these limitations, various initiatives have been undertaken in the area of alternative financing and attempts made to define an appropriate public/private/NGO mix. However they have not achieved the success necessary to ensure that the needs of the most vulnerable groups are being met.
- A coordinated approach by EDPs to support the implementation of HMGs Five Year Development Plans has been hampered by the absence of a costed and financially viable Medium Term Strategic Plan which clearly outlines:
 - the targets;
 - the time bound steps necessary for their achievement;
 - the responsible officials; and
 - the required human resources and financial/material inputs,

Moreover, the absence of a costed Medium Term Strategic Plan has allowed development partners to invest in services which are not HMG/N priorities.

1.3 Review of Policy Reform

- National Health Policy 1991 was a turning point in delivery of primary health care services up to the grass-root level.
- Reorganization of the Ministry of Health with the integration of basic public health services was a major departure to match the service needs with the National Health Policy 1991.
- The Ministry of Health in collaboration with its national and external development partners developed a twenty years Second Long Term Health Plan (SLTHP) 1997-2017.
- The Health Act was enforced in 1997/98, in order to improve the quality of health services and to promote the professional standards and deployment of health care providers.
- Following to SLTHP, strategic analysis to operationalise the SLTHP was undertaken and a Medium Term Strategic Health Plan (MTSP) logical framework was prepared in the year 2000. The main components as identified in MTSP are adopted as the strategic policy and strategic reform measures for the Tenth Five-year Plan Program and Medium Term Expenditure Framework.

2. MTEF Focus and Health Sector Priorities and Programs

- Greater efficiency will be accorded in the use of existing resources within the existing pattern of allocation. Although the allocation to the health sector has substantially increased over the years, there is a general belief that the efficiency in the use has remained low with low absorptive capacity of less than sixty five percent. One of the important reasons of this problem is, most of the time district accountants cannot submit the statement of expenditures as required due to different formats as per the requirement of the donor agencies, leading to non-clearance of incurred expenditures and less disbursement from donor agencies. Therefore, financial management and tracking of expenditure will be given priority by necessary training provision and monitoring including the implementation of reforms in the areas of staff deployment, equipment, drugs and quality of care provisions in the peripheral health facilities.
- A more rational allocation of resources will be made by prioritising financing to those illnesses which contribute to a maximum burden of disease and mortality, such as immunization programs, safer motherhood, improved nutrition, programs to prevent and control major communicable diseases. It is reported that these interventions along with Malaria, Hepatitis B and HIV/AIDS, if well managed, would address 75 percent of the burden of disease in Nepal.
- The Ministry of Health through the Second Long Term Health Plan and subsequent strategy discussions has reached a decision that it will firstly deal with the unfinished agenda of those health problems which are disproportionately and maximally contributing to the highest level of mortality and burden of disease. Hence, in the process of financial allocation, highest priority will be accorded to these essential health care interventions.
- Cost sharing and cost recovery schemes are being increasingly implemented, tied with quality of health care tools for curative health services by establishing development committees in hospitals and allowing a more autonomous status to such health facilities.
- Similarly, cost effective management and quality options are being gradually implemented through decentralization of health facilities at the district level and below, for communities to own the service facilities and make service providers more accountable to them. Similarly, there are efforts ongoing for encouraging competitive and low-cost private sector services in urban areas for ancillary, treatment and diagnostic services in curative health care and for the production of human resources in health of various categories. Critical review is being made of those programs, which are longstanding and incur a substantial allocation each year. These institutions are under consideration for a change in management support approach or deletion, such as the senior citizen health program, 24-hour clinic and phasing out plan of support to institutions like cancer hospital, medical college etc.

3. Health Sector Strategy

3.1 Goal

His Majesty's Government of Nepal aims at improving the health status of the general population through equitable access to coordinated quality health care services that are characterized by full community participation, decentralization, gender sensitivity and effective and efficient management both in rural and urban areas, thereby contributing to poverty reduction through sustainable human development and increased productive labour force.

3.2 Objectives

- Essential Health Care Services* (EHCS) will be made available to all people giving special emphasis to rural, remote, poor, and disadvantaged population through the development of an effective and efficient health management system.
- The health system will be decentralized with a participatory approach at every level.
- Public – private – NGO partnership will be established in the delivery of health care services.
- The quality of health care provided by public / private / NGO partnership will be improved through total quality management of human, financial and physical resources.

3.3 Key reforms proposed

On the basis of the recommendations made by the Public Expenditure Review Commission (PERC), the following issues are proposed to be carefully reviewed and reform made accordingly in the MTEP and 10th Five Year Plan period:

- Health institutions (SHPs, HPs and Ayurvedic Dispensaries) at the village level will be handed over to the Village Development Committee and at the same time the operational expenditures of these institutions will be made available to the Village Development Committees through DDC.
- Critical review of the following four programmes is recommended:
 - Health Management Information System (HMIS) (70-4-740)
 - Senior Citizens' Treatment Support Programme (70-5-850)

* **The EHCS Package** is defined as priority public health and basic curative care based on the primary health care principles, economic efficiency and equity.

The criteria used to select the 20 interventions of EHCS package are :

- a) cost-effectiveness of the interventions against the most prevailing causes of death and burden of disease in the country;
- b) availability of limited resources which need to be invested in a way that assures equity and reduces unfair social gaps in health and health care among citizens, regardless of their socio-economic status, geographical location, sex and ethnicity;
- c) minimization of operational costs through the delivery of integrated services, and
- d) availability of resources by identifying and defining EHCS at each level of the health care system.

- Maternal and Child Health Programme (Ramechaap and Dolakha (70-5-455)
 - Bir Hospital (70-4-301)
- Review of the programs which have got maximum expenses on allowances and administrative matters is urgently needed. There are 12 such programs whose administrative and allowance expenses vary from 17-100 %.
 - It is necessary to initiate concrete steps to enhance the capacity of the MoH Planning Division in planning, management, implementation and coordination aspects.
 - Nepal's burden of disease study shows that 68% of the burden is due to communicable diseases, malnutrition and conditions related to maternal and perinatal disorders. Fifty percent of the total mortality is due to the above mentioned conditions. In this context, health sector programs in the coming years need to focus on the control of major communicable diseases, nutrition, reproductive health and family planning programs.
 - The Ministry of Health needs to specify the geographical areas and the areas of health care services to be provided by various NGOs.
 - The private sector's active involvement to maximize the participation in the provision of curative and specialised services will be more emphasized.
 - A regular monitoring and follow up of the programs receiving lump sum grants is necessary for the effective use of grant funds. Standard criteria need to be developed for the selection of health institutions/ programs to receive grants that are service and result oriented.
 - Reduce the existing sanctioned position of MoH by adopting an appropriate reform measures.

3.4 Relations to the Poverty Reduction Strategy and Tenth Plan

The proposed policies, strategies and priority programs are consistent with the I-PRSP strategy. The programs address the health care needs of the poor, vulnerable, marginalized population and contribute to the production of a healthy and productive work force, thereby contributing to the improvement of the national economy.

3.5 Key outputs/outcomes/services

No.	Indicators	Targets in percentage for planned period				
		9 th Plan	Present Status	MTEP	10 th	12 th
1.	Availability of essential health care services (in percentage)	70	70	82	90	100
2.	Availability of selected essential drugs/health commodities (Health Institutions in percentage)	-	80	86	90	100
3.	Essential health services provided from health institutions equipped with full human resources	-	60	72	80	100
4.	Women attending the antenatal care services 4 times during pregnancy period	50	16	20	25	90
5.	T.T. 2 doses available to 15 – 44 age group female	-	15	36	50	80
6.	Delivery conducted by trained health personnel	50	12.7	16	18	80
7.	CPR (contraceptive prevalence rate)	36.6	39.3	45	47	70
8.	Condom users for a safer sex by 14-35 years age group	-	-	25	35	80
9.	Total health expenditure as percentage of total HMG national budget	6.1	-	6.5	6.5	8
10.	Total fertility rate	4.2	4.1	3.8	3.5	2.5*
11.	Crude birth rate	33.1	-	-	30.1	26.6
12.	Crude death rate	9.6	-	-	7	6
13.	Infant mortality rate	61.5	64	50	45	34.4
14.	Neonatal death rate	-	39	35	32	15
15.	Child mortality rate	102.3	91	85	72	62
16.	Maternal mortality rate / 100,000 live birth	400	-	340	300	250
17.	Life expectancy	59.7	-	-	65	68.7

3.6 Policies and strategies in achieving the Indicators

3.6.1 Policies

The following policies have been identified taking into account the population growth, burden of disease in Nepal and the objective of protecting EHCS for whole population, particularly the poor, marginalized and women. The proposed policies cover the 10th five year plan period and are consistent with the 2nd LTHP.

- The Safer Motherhood programme will be further improved and expanded.
- Family planning services will be ensured, based on quality of care, informed choice and easy access at the community level.
- EPI and nutrition programmes will be strengthened and expanded.
- Disease specific measures will be taken against communicable diseases like TB, Malaria, Kala-Azar, JE and Rabies

* Long Term Health Plan target is 3.05. Since this program is a high priority program, the target should be more ambitious.

- Health care management will be further decentralized.
- Programmes on Oral health, School health, Environment and Occupational health, Injury Prevention, Mass Casualty Management, and Sanitation will be developed with intersectoral collaboration.
- Duplication of resources including services of hospitals will be avoided by improving coordination with NGO/INGO and private sector.
- Alternative medicine like Ayurveda, Unani, Homeopathy and Naturopathy will continue to be considered as complementary to the health care system.
- Drug regulatory mechanisms will be further strengthened aiming at the production of quality drugs for self reliance. There will be improved quality assurance for the imported drugs.
- Production of Ayurvedic Medicine shall be enhanced utilizing the locally available herbs. Patent rights and IPR of Nepal will be established wherever possible.
- Capacity building (continuing education) of health care professionals will be organized at all levels on a regular basis.
- Services provided by private sector, INGOs and NGOs will be made more equitable and service orientated by regularizing them according to medical standards and norms.
- The concept of Community Drug Program (CDP), cooperatives and health insurance schemes will be further expanded, promoted or initiated as applicable.
- Health promotional activities will be further improved and scaled up, also using distant radio and other communication/information systems.
- Quality Human Resources in health will be produced with effective involvement of private sectors.
- Hospital waste disposal will be organized with involvement of public, private, INGO/NGO hospitals and involvement of local municipalities.
- Surveillance of Non Communicable Disease (NCD) and other life style related problems will be carried out. Super specialized services shall be developed in collaboration with private sectors.
- Existing Acts and Regulations will be reviewed and revised to make the HC result orientated.
- Essential Health Research will be promoted as an important component of the national health care delivery system.

3.6.2 Strategies

- In line with the outgoing decentralization process, the role of central level will be policy formulation and the development of regulatory, mechanism to ensure quality of services through monitoring, supervision, training, coordination and technical and financial resources mobilization.
- Management of health services including fiscal management by central and local health institutions will be made effective and efficient by

appropriate planning and deployment of skilled and motivated human resources.

- The procurement and supply of drugs equipment and health commodities will be made available based on program priorities and equity consideration at local level with a decentralized management approach.
- The personnel administration in matter of recruitment, retainment, transfer and promotion of health personnel will be made more transparent, efficient and effective. At the same time, the terms and conditions of services will be reviewed and revised.
- Training and other skilled development opportunities and living facilities to the health personnel in remote areas will be given priority to promote and encourage them to work willingly in these areas.
 - Production of primary, middle and high level manpower inside the country for the delivery of health services will be maintained and enhanced.
 - Quality assurance by regular supervision will be made in all health institutions with an active involvement of professional bodies as required.
 - Competency based training will be organized in health programs.
- Mobilization of Poverty Alleviation Fund (PAF) and micro credit schemes will be initiated at the district level to sustain a continuous supply of drugs through the community drug program, health insurance schemes and health cooperatives, including essential curative services' provision from private agencies, especially for poor people.
- Present medico legal practices of the forensic medicine will be reviewed.
- Essential health care services at the district hospitals, primary health care centers, health posts and sub-health posts will be institutionalized and made affordable with the involvement of local level bodies (VDCs etc.). The provision of services by private and NGO Sector will be made effective by co-ordinating them at their respective levels.
- Essential Health research will be promoted to provide guidance to program planners and managers of health services, based on the country's needs.
- Health professional councils and associations will be encouraged to provide input in delivery and training to improve quality of services and human resource development.
- Essential facilities in some of the existing hospitals and Primary Health Centers (PHCs) will be upgraded in a phased manner to manage the increasing problem of accidents and injuries.
- Quality of care in Reproductive Health including family planning will be delivered as per local needs through counseling.
- Multi sectoral approaches in controlling HIV/AIDS will be developed at each level.

- The present status of the health service delivery system and management organization will be critically reviewed and analyzed for strengthening essential health services. An efficient and more flexible organization and management system will be established which will include provisions for planning and monitoring, capacity building, fiscal and personnel management, integrated information management and training system keeping in account the ongoing decentralization and public private partnership.

4. Priority Programs and Activities

Key programs and activities have been prioritized into the following three groups:

Priority 1 Programs - which have the largest number of activities include EPI, ARI/CDD, nutrition, family planning, safe motherhood, reproductive health, adolescent reproductive health, communicable disease control, Vector Borne Disease Regional Training Center (VBDRTC), emergency preparedness and disaster management, TB control, leprosy control, HIV/AIDS/STD control, district health institutions, information and education, health training, logistics management, including drugs, medical equipments and health commodity supplies, integrated supervision and monitoring, community drugs and health insurance, HMIS/ FMIS/ LMIS/ HuRDIS, FCHVs and health poverty alleviation fund.

Priority 2 Programs - on the other hand, include oral health, accident prevention, children hospital, maternity hospital, Ayurvedic department, Ayurvedic dispensaries, drug administration, health laboratory, non-communicable disease control, environmental and occupational health, health institutions renovation and maintenance, Ministry of Health with all departments and below.

Priority 3 Programs- include substance abuse, urban health, communicable disease hospital, Bir hospital, heart center, Patan hospital, mental hospital, regional hospitals, zonal hospitals, cancer hospital, BPKIHS, Dharan, BPK ophthalmic center, Netra Jyoti Sangh, Nardevi Ayurvedic hospital, Singh Durbar Baidyakhana, Homeopathy, Unani, PGMEC, development of health infrastructures (ambulance, PHCC/HP construction, hospital construction).

It is recommended that financing for priority 3 programs should be reduced or phased out in the coming five years period and priority 2 programs in the subsequent 10 years, where applicable.

5. Basis for prioritization of programs and projects

- Burden of disease
- Implementation capability
- Equity consideration
- Programs directed to poor, marginalized, vulnerable and disadvantaged groups
- Programs contributing to poverty alleviation
- Availability of resources

6. Programs/activities by objectives and outputs (Policy Matrix)

Goal:

Health status of the general population improved through equitable access to health care services contributing to poverty reduction increased.

Objective 1:

Availability of Health Care services to all people specifically living in rural, remote area, poor and disadvantaged population is sustained.

Output 1.1: The prioritized elements of Essential Health Care Services delivery ensured.

No	Program	Activities	Indicators/outputs
1.	Child Health	EPI	-Coverage of immunization increased to 90 % from present status
		ARI	Proportion of sever pneumonia reduced from 5.3 to 3.5 %
		CDD	Proportion of sever dehydration reduced from 5.4 to 3.5 %
2	Nutrition	Micro-nutrient and Vitamin A supplementation,	Proportion of malnourished children reduced from 20.9 to 15.5 %
3.	Family Health	Safe Motherhood	MMR reduced from 400 to 340
		Family Planning(Institution and mobile services)	CPR increased from 39 to 45%
		Adolescent RH	RH Services provided to 30% adolescent
4	Epidemiology and Disease Control	Vector Borne Disease control	Malaria incidence reduced from 0.56 to 0.1% Kala-azar incidence reduced from 0.29 to 0.1%
		Emergency Preparedness and Disaster Management	All 75 districts are prepared as per protocol
		TB	Case detection increased from 67 to 90%
		Leprosy	Prevalence rate reduced from 3.88 to .8%
		HIV/AIDS	Present awareness level of HIV/AIDS (52.5%) increased to 70%
5	Treatment of common illnesses and conditions	Essential curative services including eye care, accident prevention, deafness, mental etc.	80% of the population have access to treatment of common illnesses
6	Prevention of Non Communicable Diseases	screening and referral of Non communicable Disease cases	At least 50% of non communicable diseases screened and referred to appropriate facilities.
7	Information ,	IEC through electronic, print	Behavioral Change

	education and Communication (IEC)	and indigenous media on promotive, preventive and curative services	Communication (BCC) increased to 80% from present status
8	Health Promotion and rehabilitation	Community based Rehab: nutrition, eye care, substance abuse, mental, oral health, school, environmental & occupational, and	80% of population have sound health

Output 1.2:

Beyond EHCS service delivered through safety net provision

S.N	Program	Activities	Indicators/outputs
1	Curative services	General curative services ➤ Outdoor ➤ Indoor	80% zonal and above level hospitals provide specialized services
		Specialized service delivery	80% zonal and above level hospitals attend 60% referral cases (communicable and Non communicable) specialized services

Output 1.3

Access to and utilization of health services by the vulnerable population (poor, disadvantaged, women and children) improved.

S.N	Program	Activities	Indicators/outputs
	Health services for the vulnerable population	Access to EHCS	70% of vulnerable population residing within 30 minutes walk have access to EHCS.
		Access to specialized services	100% of Specialized services at Central, Regional and Zonal level hospitals are providing 50% off in regular cost for vulnerable population

Objective 2:

Public Private – NGO partnership in the delivery of health care established

Output 2.1:

Increased partnership of public/private /NGO providers in provision of health services

No.	Program	Activities	Indicators/outputs
1	Operational stakeholder's coordination mechanism	Define and operationalize roles and responsibilities of all stakeholders	100% of stakeholders are keen to their roles and responsibilities towards health services
2	Partnership of Public/private /NGO	Services - promotive, preventive, curative and rehabilitative	Sharing service delivery in districts increased by 75% Sharing service delivery in

	in service delivery		beyond EHCS increased by 50%
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Output 2.2

Increased Public/ Private/NGO sector collaborative investment in health care

S.N	Program	Activities	Indicators/outputs
1	Partnership management	Establish partnership mechanisms	Public/ Private/NGO partnership exist in each level
2	Collaborative investment for Health care	Develop and implement modalities (Partnership, regulatory framework, partnership management system, financial mechanisms)	Public/ Private/NGO sector collaborative investment in health care increased by 75% from the current level.

Objective 3

decentralization of health system at each level ensured

Output 3.1

Ensured and assured systematic planning and management of health services at all levels using qualifying factors.

No	Program	Activities	Indicators/outputs
1	Decentralized health planning and implementation	Development and implementation of decentralization policies and modalities.	Decentralization policies and modalities are 100% practiced
		Community initiated programs including Community Drug & Health Insurance	Increased numbers of decentralized/community initiated programs.

Output 3.2:

Participatory planning and management capabilities enhanced at all levels.

N	Program	Activities	Indicators/outputs
1	Participatory planning and management	Strengthening participatory planning and management capabilities of MoH network	-Each stakeholder explain their role and responsibility. -Stakeholders participation in planning health programs increased 75%
2	Functional Health Management committees (HMCs)	Establishment Health Management Committees at all levels of service management	HMC's at center and all districts, established and are functional.
3	Establishment of Health units	Establishment of health sectoral units/ sections	75 DDC health sectoral units established.

Objective 4:

Quality of health care provided by public/ private/NGO partnership is strengthened and improved.

Output 4.1:

Ensured and assured systematic planning at all levels using qualifying factors towards the development of an effective and efficient health management system.

N	Program	Activities	Indicators/outputs
1	Health Planning and Management	Development and implementation of policies and modalities.	Health system policies and modalities are 100% practiced.
		Information based planning	increased use of HMIS/FMIS/LMIS/HuRDIS by 80% in planning health programs
	Infrastructure	Development of Health Facilities including renovation and maintenance	At least 90% of infrastructure are in proper condition.

Output 4.2

Developed and deployed adequate and appropriate mix of HRH at all levels of health systems

N	Program	Activities	Indicators/outputs
1	Human Resource Development	Capacity Building including training and PGMEC/ health institute	At least 90% of personnel at job are trained.
2	Human Resource Deployment	Human Resource at health institutes	Atleast 80% of health institutions maintain 100% of qualified/competent/skilled health health resource.
		Deliver quality services	Reduced grievance of clients towards service providers

Output 4.3

Quality assurance mechanism is placed in public/Private/ NGO sectors for provision of quality services

S.N	Program	Activities	Indicators/outputs
1.	Quality assurance mechanism	EHCS and Service beyond EHCS delivery	Client satisfaction increased form current level by 75%.
2.	Integrated supervision /M&E	Supervision Monitoring Evaluation Research	100% of health facilities are visited for QA.
	Laboratory Support	Laboratory Supported diagnosis	At least 50% of disease diagnosis supported by laboratory investigation

Output 4.4

Adequate and reliable information available and used for planning and management decision making.

1	Documentation of informations	Documentation and use of informations - HMIS/FMIS/LMIS/HuRDIS in planning health programs	Documentation of informations (HMIS/FMIS/LMIS/HuRDIS) exists by 100%.
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Output 4.5

Availability and proper utilisation of financial resources to meet the requirements of national health delivery system ensured

N	Program	Activities	Indicators/outputs
1	Management of financial resources	Mobilize financial resources-Public, Grant and Loan	100% of programs satisfied with allocated budget
		Auditing/Monitoring utilization of finance.	Utilization of allocated budget is increased to 90% from existing status.

Output 4.6

Supply of drugs and medical consumables of approved quality assured throughout the year

S.N	Program	Activities	Indicators/outputs
1	Logistics management	Medicine, medical equipment & commodity including alternative medical supply	Atleast 80% of health institutions maintain 100% of Authorized Stock Level(ASL) of health logistics.

7. Total Budget estimation including annual cost

A three year commitment of **Rs. 16,676.3 million** is required in order to implement fully the above mentioned priority health programs. Regular budget constitutes about 40.4% of the estimated health budget which is maintained at the level of current fiscal year. The contribution of the government in the total budget (regular plus development) is estimated to be Rs. 12,044 million (72.2%); the remaining amount of Rs. 4,623.3 million (27.8%) to be borne by foreign grant. The development budget, however, amounts to Rs. 9,945.2 million (59.6% of total); with comparatively lower share (46.5%) of foreign grant as compared to that of government share((53.5%)). The year wise breakdown of the estimated budget is documented in the table below.

7.1 Estimates of Medium Term Health Expenditure by Sources of Funding
Rs. in million

Particulars	2002/2003	2003/2004	2004/2005	Total
Regular expenses (government)	2,243.70	2,243.70	2,243.70	6,731.10
Development expenses	2,864.00	3,293.60	3,787.60	9,945.20
Government source	1,530.00	1,759.50	2,023.40	5,312.90
Foreign aid (Grant)	1,334.00	1534.10	1,764.20	4,632.30
Total	5,107.70	5,537.30	6,031.30	16,676.30
Government share	3,773.70	4,003.20	4,267.10	12,044.00
Share of Foreign aid	1,334.00	1534.10	1,764.20	4,632.30

Note: This budget estimate for the fiscal year 2002/2003 is based on the ceiling provided by the NPC; for the subsequent two years the regular expenses have been kept constant and a modest of 15% annual increment in development budget is proposed.

The program wise allocation of the budget for each of the next three years is provided in the next table given below. According to this allocation the health programs under top priority (Priority One) constitutes over 72% of the total budget. The health programs under the second and third priorities have been allocated 17 % and 11 % of the total budget respectively.

It should also be mentioned that the health programs such as oral health, accidental prevention, environmental health, HIV AIDS, hospital waste management, preventive disease, NCD, surveillance, rehabilitation programs, post graduate grant are important intervention programs. These programs require an addition of 15% to the budget estimate outlined above. These are the areas where foreign assistance is specifically required.

7.2 Estimates of Health Budget for three years by Program Priorities

Rs. in Million

Program / Activities	Base Year 2001/2002	Budget Proposal			
		2002/2003	2003/2004	2004/2005	Total
PRIORITY ONE PROGRAMS	3309.8	3628.2	3984.1	4337.2	11949.5
Child health	262.8	305.7	320.3	336.0	962.0
EPI (Regular, Hepatitis B, MNT, NID)	201.1	204.6	213.1	222.1	639.8
ARI/CDD	25.9	50.7	54.5	58.7	163.9
Nutrition(PEM, Vitamin A & Micro-nutrient supplement	35.8	50.4	52.7	55.2	158.3
Family health	120.2	150.7	161.8	174.1	486.6
Family Planning					
Safe Motherhood /Reproductive health					
Adolescent Reproductive health					
FCHVs					
Epideomology & disease control	146.5	177.2	197.2	220.4	594.8
Communicable disease(kal-azaar, malaria)	108.9	150.3	170.3	193.5	514.1
Vector borne disease(research & training)	25.3	25.0	25.0	25.0	75.0
Emergency Preparedness and disaster mgt.	12.3	1.9	1.9	1.9	5.7
TB Control Program	122.9	148.6	159.6	171.4	479.6
Leprosy Program	28.0	37.1	27.6	11.1	75.8
HIV/AIDS/STD	183.3	183.3	210.8	242.4	636.5
District level health institutions	1790.2	1825.4	2070.7	2295.3	6191.4
District Hospitals	175.1	175.1	201.4	175.1	551.6
Primary health care center/health center	201.1	236.3	243.2	250.2	729.7
District Public Health Office, HPs, SHPs	1414.0	1414.0	1626.1	1870.0	4910.1
Information Education Communication	64.2	67.1	68.6	70.1	205.8
Health Training	97.9	161.2	161.2	161.2	483.6
Logistics Management including medicine, medical equipment & commodity supply	282.0	324.2	331.7	339.4	995.3
Integrated Supervision/ M & E	48.4	53.2	53.2	61.2	167.6
Health science research	2.0	2.2	2.2	2.2	6.6
Community Drug & Health Insurance	11.8	12.9	12.9	14.8	40.6
HMIS/FMIS/LMIS/HURDIS/ & planning	149.6	164.5	189.2	217.6	571.2
Health PAF (safety net)	0.0	2.0	2.0	2.5	6.5
PRIORITY TWO PROGRAMS	665.2	565.4	631.0	725.6	1922.0
Hospitals	142.2	120.9	132.9	152.9	406.7
Kanti Children's Hospital	60.5	51.4	56.6	65.1	173.0
Maternity Hospital	64.0	54.4	59.8	68.8	183.1
Ayurveda Chikitsala (dispensary)	10.7	9.1	10.0	11.5	30.6
E ye Hospital	7.0	6.0	6.5	7.5	20.0
Ministry of Health	15.6	13.3	14.6	16.8	44.6
Departments	189.9	161.4	177.6	204.2	543.2
Department of Drug Administration	26.8	22.8	25.1	28.8	76.7
Department of Health Services /regional directorates	105.9	90.0	99.0	113.9	302.9
Department of Ayurved	57.2	48.6	53.5	61.5	163.6
National Health Laboratory	22.8	19.4	21.3	24.5	65.2
Development of health facilities including renovation and maintenance	294.7	250.5	275.5	316.9	842.9
Non-communicable Disease Control	0.0	0.0	2.2	2.5	4.7
Environmental & Occupational Health	0.0	0.0	3.2	3.7	6.9
Hospital Waste Disposal					
Environmental Sanitation					
Occupational Health Hazard					
Oral Health	0.0	0.0	2.1	2.4	4.5

Accident Prevention	0.0	0.0	1.5	1.7	3.2
PRIORITY THREE PROGRAMS	1215.0	914.0	922.2	968.5	2804.8
Hospitals	1104.0	831.3	835.3	877.1	2543.3
Teku tropical hospital	6.5	4.9	4.9	5.1	14.9
Bir hospital	526.2	394.7	394.7	414.4	1203.7
Shahid Gangalal heart center	19.0	14.3	14.3	15.0	43.5
Patan hospital	1.3	1.0	1.0	1.0	3.0
Western Regional Hospital	13.0	9.8	10.8	11.3	31.9
Zonal Hospitals	80.0	63.0	63.0	66.2	192.2
BPKIHS Cancer Hospital Bharatpur	11.0	8.3	9.3	9.8	27.3
BPKIHS Dharan	400.0	300.0	300.0	315.2	915.2
Netra Jyoti Sangh (Eye Care Organization)/BP eye hospital	47.0	35.3	35.3	37.0	107.5
Mental hospital	0.0	0.0	0.0	0.0	0.0
BPK Ophthalmic Centre	0.0	0.0	2.0	2.1	4.1
Ayurved and traditional medicine	98.9	74.0	74.0	77.7	225.6
Naradevi Hospital	70.2	52.7	52.7	55.3	160.6
Singha Durbar Vaidhya Khana	26.3	19.7	19.7	20.7	60.2
Homeopathy	2.1	1.6	1.6	1.7	4.8
Unani	0.3	0.0	0.0	0.0	0.0
Urban Health	1.6	1.2	3.2	3.4	7.8
PGMEC/health institute grant	10.5	7.9	7.9	8.3	24.0
Substance Abuse	0.0	0.0	2.1	2.2	4.3
TOTAL (Rs. in Million)	5190.0	5107.7	5537.3	6031.3	16676.3

Note: The budget allocation for the priority one programs is based on the unit cost analysis (Unit Cost of Essential Health Care Services Package, May 2001, PP&FAD, MoH). The annual increments is recovered from some downward adjustments, deduction of 15% in first year and 5% in the second year and addition of 9% in the third year for priority II programmes. There is deduction of 20% -25% for priority III programmes.

8. Arrangements for effective implementation, monitoring and accountability

8.1 Determination of Financial Requirements for Service Delivery

Neither the SLTHP nor the 9th 5-Year Development Plan indicate financial requirements nor likely resource availability for service delivery. The inability to determine financial requirements is due in part to the limited availability of the necessary financial and costing information and inadequate capacity to effectively analysed the data that is available. The following actions are suggested to address these limitations:

Institutionalise the collection of financial data integrating HMGN Financial Expenditure data and non-“Red Book” expenditures of decentralised units (eg hospitals, VDCs, DDCs) as well as direct funding by various EDPs into existing MOH management information systems.

- Make a clear distinction between recurrent and capital expenditures; clarify the definition of primary and non- primary health service for financial and budgetary purposes; make information on central and district level expenditure more transparent.
- Institutionalize and update on a regular basis a “national health accounts” (NHA) covering public, private, NGO and EDP health sector expenditures

at all levels of the health system. The NHA will be used as an input for increasing the efficiency of health sector allocations and as a tool for monitoring and evaluating the effects of health reform.

- Establish/designate a “health economics body” outside the formal structure of the MOH to provide technical support to the health sector particularly the MOH, NPC, and DDC Association on key health financing issues. This will include access to TA as required.
- Develop and introduce a common financial reporting framework for all EDPs. The process could build on steps already taken to develop sub sector programmes eg TB, leprosy and reproductive health. It will require improvements in financial management capacity on the part of HMGN and a willingness of development partners to consider different ways of working.

8.2 Use of Existing Sources and Developing Alternative Sources of Finance

In making better use of existing sources of financing a balance must be struck between more effective/efficient use of existing funds to reduce unit costs and maximising revenues that can be generated from existing sources.

8.2.1 Effective exemption criteria

Despite the introduction of user fees, establishment of community financing schemes etc. the MoH/HMGN has had limited success in maximising the potential of existing sources of financing and exploiting opportunities to raise additional resources from new sources. There are further concerns that the ways in which resources are currently being raised may not be consistent with health sector goals (eg user fee exemption criteria may not be effective in reducing financial barriers limiting access to services).

8.2.2 The following alternatives are suggested

- Major emphasis to be placed on improving outcomes from out of pocket expenditures through improved household decision-making, consumer education, and improved quality of care in the public, private and NGO sectors.
- Encourage private and NGO financing and delivery of EHCS interventions as well as services beyond the EHCS
- MoH and EDPs to continue to advocate for additional resources given the relatively low allocation of HMGN resources to health
- A review of experience with current financing mechanisms to ensure they are in accordance with health policy goals and do not result in costs that are unduly high and unaffordable.. This will include a review of user fee and exemption criteria experience. It will also focus on the lessons learnt from community financing schemes including insurance/prepayments schemes and drug revolving funds and identify the barriers that have prevented the replication of successful approaches.

- MoH should encourage the MoF to look at alternative taxation mechanisms which might help serve health policy goals, as well as raise revenue
- The feasibility of alternative delivery mechanisms that make use of the public, private and NGO sectors should be explored. The alternative delivery mechanisms should allow for the necessary government oversight to ensure quality of care, and to maintain reasonable access to services, and to maintain a “safety net” to ensure that needy and underprivileged populations are not deprived of necessary health care services because of their inability to pay. Among the alternative delivery mechanisms to be explored are:
 - establishing private wings in government hospital facilities - eg arranging for private practice at government facilities
 - contracting with NGOs for provision of service and/or attachment of NGO staff to work in government facilities
 - contracting with private-for-profit clinics, private-nursing homes; contracting with hill shopkeepers (provision of drugs)
 - contracting for non-medical services (security, cleaning, and maintenance, laundry etc.)
 - contracts between the VDCs (responsible for essential health services) and others eg NGOs, private sector, etc.
 - health insurance
 - health cooperatives.

8.2.3 Improvement in Equity and Access to Services by the Poor

Government health policies have been consistent in confirming a commitment to equity of service delivery. Equity is defined in the SLTHP as: access and provision of services according to “demonstrable needs” rather than on the basis of political or socio-economic status or privilege. To ensure equity, the strategy must, therefore, take into consideration the different levels and characteristics of the health service users and providers if it is successfully to address the needs of the poor, men and women, the young and old, the disabled, different castes and ethnic groups, and vulnerable and marginalized groups.

8.3 HMGN’s commitment to equitable health services

The following actions are suggested to help realize:

- A better match between service users and providers (eg increasing the number of women in the health sector’s paid posts, at every level, to better reflect the number of women who come to use the service, etc.). Decisions about recruitment and selection of new staff should bear these issues in mind.
- Wider representation of service users in decision making: If equity is to become a reality in the health sector, mechanisms to include a wider representation of service users in decision making with regard to service delivery is to be promoted. The move towards decentralisation provides an excellent opportunity for this to happen.

- Development of national guidelines with respect to current user fee practices and other payments in public facilities particularly regarding exemptions for the poor and the provision of some form of safety net. Implementation of these guidelines at all levels of service delivery. The guidelines should ensure that practice is consistent with national health policies without stifling local initiative
- An Equity Assurance Steering Committee should be established at the highest levels within the MOH to develop and enforce a comprehensive policy aimed at ensuring equity is in place and ensure that the approaches being adopted are consistent.
- Establish a high-level forum of key players including Directors in the Department of Health Services, National Planning Commission, and major donors to discuss and draw attention to innovative approaches, national experience etc. in ensuring equity of service delivery.
- Integrate principles and best practices of equity into basic pre and in-service training curriculum.

8.4 Increasing appropriate community participation

Participation is a corner-stone of equity. Stronger community participation that is not limited to local elites but is representative of the broader population has the potential for improving equity and increasing access. To improve community participation, it is proposed that the MoH take the following steps:

- Conduct a comparative assessment of existing community participation models (eg drug schemes, community planning and mobilization etc.) identifying potentials and constraints. This should give guidance to the MOH, DDCs, and VDCs on appropriate approaches to community participation within the context of decentralisation.
- Create a context that encourages DDCs and VDC to establish District and Village Health Committees and allows them to identify and effectively carry out their roles and responsibilities.
- Develop guidelines to ensure that District and Village Health Committees have an appropriate gender mix and are fully representative of the communities they serve.
- Provide the necessary resources to ensure that these committees can undertake needs assessment, planning, implementing and monitoring of health services in their respective communities
- Assist the District and Village Health Committees to develop and implement communication strategies to inform communities about their rights, roles and responsibilities, and those of health workers, within the context of decentralisation.
- Inform health workers about their roles and responsibilities, and those of the community within the context of decentralisation.

8.5 Decentralisation

The 1999 Local Governance Act establishes a policy of decentralisation through which HMGN can achieve its strategic objectives. Decentralisation will require a careful balancing act between 1) devolution of authority and responsibility; 2) capacity building to exercise authority and take responsibility; and, 3) ensuring that the centre can ensure the implementation of national health policies.

Strategy for MoH to support decentralisation within the health system:

- Form a Health Decentralisation Steering Committee to facilitate the decentralisation process; it is proposed that this be chaired by the Minister of Health and includes all senior MoH staff (ie directors and above) and representatives of the MoF, NPC, the Social Welfare Council and MoLD.
- Review and clarify roles and responsibilities at all levels (central MoH, Regional Health Directorates, DDCs, VDCs, DHOs, facility support committees, hospital boards etc) ensuring that they are in accordance with the Local Governance Act and other relevant decentralisation policies as set out in the 9th Five Year Development Plan, SLTHP etc
- Ensure that definition of roles takes into account:
 - the service delivery and support responsibilities of each level (as identified in the EHCP)
 - appropriate integration of specific services (often described as “vertical programmes” e.g. tuberculosis, vitamin A etc.)
 - need for intersectoral coordination/collaboration (taking particular note of areas of concern such as water and sanitation, urban planning, HIV/AIDS, nutrition, production of medicinal plants)
 - the need for clarity between the strategic, management and operational functions at each level
- Conduct a ‘Capacity Appraisal’ of all levels of the health system to assess the extent to which the new roles can be fulfilled and identify where additional capacity building will be required
- Review the organisational structures at all levels; assess whether these need to be changed to enable new roles to be undertaken effectively; define which roles (eg policy making, scarce skills, performance management) are retained at the centre and which will be devolved
- Development of a phased plan for the appropriate integration of “vertical programmes” within a decentralising system. This would have to ensure efficiency and cost-effectiveness, that essential preventive and curative services would not be interrupted, and that specific services continue to receive necessary technical and managerial support.
- Develop plans for the sequenced devolution of the management and delivery of health services. The exact sequencing of devolution will have to take account of the required changes in legislation and regulations, and capacity building efforts.

8.6 Actions to Improve the Public-Private-NGO Mix

The following actions are proposed to encourage collaboration at the central level:

- Collection, analysis and synthesis of available information on the actual and potential contribution of the private/NGO sectors to the health system
- Formal recognition of the important contribution of the private/NGO sectors to the health care system (including development of a system of incentives to facilitate private/NGO sectors participation - such incentives should not outweigh the benefits derived)
- Strategies should be developed, with a determination of the resources necessary and available to ensure effective public/private/NGO collaboration and should not place excessive human resources demands and financial strains on the public health sector
- Develop, clarify and implement effective regulatory frameworks. Such frameworks can serve to strengthen mutual confidence and understanding between HMGN and private/NGO sectors.

8.7 Public/Private/NGO Collaboration at the District Level

There is an absence of knowledge and experience of innovative mechanisms to improve the effective provision of district health services through the private/NGO sectors such as: contracting, risk sharing schemes with providers, targeted subsidies (eg, seconded personnel, subsidised essential drugs & vaccines). In order to gain such experience the following actions are proposed:

- Identification and analysis of appropriate and effective strategies for effective public/private/NGO partnerships in each district (should include the identification of key partners, costs, resource availability and requirements, and coverage rates)
- Support willing districts to pilot one or more of the alternative service delivery modalities proposed in #7.4 (contracting with Private/NGO sector, establishing private wings in HMGN facilities, encouraging where possible voluntary consultations by doctors and specialists in government facilities etc). This will require mechanisms and tools to enable districts to monitor and regulate the activities of local private and NGO providers.

8.8 Strengthening Sectoral Management

8.8.1 Human Resource Management

This section makes recommendations to address the needs for both improved human resource planning, and for improved human resource management (particularly in the light of decentralisation). These two areas must be addressed jointly in order to integrate and rationalise the recruitment, retention, and deployment of all staff working in the sector, and to increase their effectiveness.

- Complete the identification of future requirements for different categories of health workers. This will cover all levels of service delivery for government, non-governmental and private sectors using a needs-based approach.

- Assess the capacity of training institutions to deliver the necessary quantity and quality of health workers and strengthen capacity as appropriate.
- Assess the feasibility of contracting with the private and NGO sectors for in-service clinical training of MoH personnel.
- Develop standards, criteria and the requisite compliance mechanisms governing establishment and operation of public and private medical schools.
- Develop mechanisms to ensure that medical students studying at private medical colleges under MOE quotas and those studying at the Institute of Medicine and B. P. Koirala Institute of Health Sciences serve in a public health facility for at least two years after qualification.
- Implement appropriate strategies to address staff deployment issues, particularly those that could be implemented with the strong participation of INGOs/NGOs/locally elected bodies.
- Devolve the responsibility, necessary authority and resources for human resource management-related tasks to the appropriate levels in line with roles and responsibilities as agreed under decentralization.
- Conduct appropriate human resource management development activities (including training placements, mentoring, study visits and group training) at all levels.
- Establish and disseminate: clear and explicit job descriptions, transparent performance based and result oriented incentive systems (which should have positive and negative incentives that also address the “push and pull factors” for filling remote postings), and integrated supportive supervision systems.

8.8.2 Financial Management

The following steps are proposed to strengthen the effectiveness of financial management in the sector:

- Conduct a “financial management capacity appraisal” to assess the structural and functional constraints to effective financial management at all levels (central MoH, district level, DDC and VDC health committees) and implement recommendations.
- Develop budgetary approaches that link budget to priorities, performance and outcomes.
- Strengthen the budgeting system with particular reference to decentralisation:
 - incorporate the principles and procedures of decentralization and “bottom-up budgeting” into the budget process.
 - establish integrated budgeting at the district level and below (to include all sources of available finance including locally generated funds).
- Establish specific chart(s) of accounts for health programmes, facilities and institutions
- Increase auditing capacity in the health sector.

8.9 Information Management

In order to provide accurate, reliable and timely information for planning and management at all levels the following steps should be taken:

- Integrate the different existing information systems
- Establish a system to monitor and improve the quality of data collected
- Institutionalise data collection and analysis (including provision of essential equipment, personnel and financial resources)
- Set up an information dissemination system
- Develop capacity to use information for policy and decision making

8.10 Quality Assurance

Assuring the quality of health services delivered in the public and private/NGO sectors requires a broad range of actions. The aim is to establish a quality improvement process.

Specific steps to be taken include:

- Develop and implement programs to build a concept of quality management in the health sector. This should involve politicians, health sector managers, care providers and the community. It should raise awareness of the cost and impact of poor quality
- The MoH should develop a policy for Quality Assurance (QA) which clearly defines the authority for development of an effective QA system in the public, INGO, NGO and private sectors
- A Quality Assurance Unit (QAU) should be established as the focal point for QA in the Ministry of Health. Though quality must be assured throughout the health sector, the emphasis should be on improving quality of services provided at the peripheral level where most primary health care takes place.
- MoH should establish minimum standards for physical infrastructure, amenities, equipment, instruments, and staffing levels, on the basis of which District Health Office will assess facilities annually. These standards should gradually be extended to cover private and NGO facilities.
- MoH should develop a system to ensure regular monitoring of diagnostic centres (laboratories, radio-diagnosis) to improve quality and reliability of results.
- Publicise and inform patients of their rights.
- Regular re-licensing / re-registration of health professionals/ paraprofessionals (eg. every 5 years) linked to evidence of technical competence.

8.11 Drugs and Medical Supplies Management / Logistics Management

In order to improve the supply of quality essential drugs and medical supplies the following actions are suggested:

- Strengthen the procurement system to ensure uninterrupted supply of quality products to health facilities; identify which items can be procured most effectively and efficiently at central and district level and follow a procurement policy accordingly.
- Strengthen capacity to forecast needs for all supplies (building upon the existing effective system for forecasting for some commodities - eg. contraceptives, TB drugs - and taking into account of private and NGO sector usage and supplies). This should be linked to efforts to combine the logistics management information system with the MoH's other health information systems.
- Ensure that appropriate levels of logistics support staff with clearly defined roles and responsibilities are available at all levels (Logistics Management Division, Regional and District Health Offices and Stores).

8.12 Physical Assets Management

There is a need for a comprehensive system for selection, standardisation, procurement, commissioning, user training, preventive maintenance and repair of buildings, equipment and vehicles. The establishment of such a system requires:

- A central level unit to coordinate the Physical Assets Management (PAM) functions
- Establishment of a technical environment in which a PAM system can function (e.g. standardisation of specifications for equipment; inventory of buildings and equipment; provision of spare parts, maintenance and repair budget, provision of workshop facilities at the district level)
- Development and clarification of responsibilities of health facility staff for first-line maintenance and repair
- Development of district maintenance and repair units
- Establishment of links with private/NGO sectors to benefit from their capacity either through training or making these services available through direct maintenance and repair service provision.

9. Implications for donor assistance and donor behavior.

For the past many years, donors in Nepal have been the main financier of the development expenditures of the Government of Nepal incurring about 50 percent of the total health expenditure. Donors can claim some credit for the significant progress in literacy, infant mortality and total fertility reduction, increase of contraceptive prevalence rate, reduced malarial morbidity, implying increased development efforts, such as access to safe drinking water, road infrastructure, etc., over this period. However, most donors share a sense that in the aggregate, the impact of the massive aid has been quite limited.

Money provided in development aid is money taken away from other priorities that the taxpayers in donor countries may have. Perhaps it is the right time for donor agencies to bring out issues of similar "hard budget constraint" also in the recipient country. The comfort feeling of that there is always going to be adequate money available from donors may have made counterpart agencies being more negligent in accountability and outcome matters. It has been mentioned many times that Nepal has a very strong goodwill from donor countries and lack of money is not the problem in Nepal. Access to easy money might in fact be part of the problem.

Donors should be ensuring that HMG fully implements its various programs through its own institutions (including NGOs). Donors should support those institutions rather than creating their own alternative structures.

Donors support a mixed bag, because of various shortcomings in the HMG institutions and the overall governance environment. It is perceived that donors have chosen to adopt very different approaches. While some specific donor-supported projects may have produced good results, more often than not they have not become sustainable. Therefore, donors find it difficult to change their approaches that often bypass HMG rather than work through it.

HMG should manage its expenditures effectively, and donors should provide their financial resources within the HMG expenditure framework, facilitating capacity for doing so.

How can HMG and donors move toward a better relationship? Hence, as HMG is preparing the Tenth Five-Year Plan, there is an increasing focus on the need to improve the effectiveness of its program. HMG's declaration to make the Tenth Plan as poverty reduction strategy plan underlines its commitment to reinforce poverty reduction in its development plan.

MTEF process in this regard lays the foundation for constructive discussions, both among donors and between the donor community and HMG/Nepali society, on how donors may modify their practices and behaviour so as to become better development partners of HMG and Nepal.

MTEF can make a significant contribution to improving HMG's own processes of strategy formulation, definition and implementation of development programs, and public expenditure management and on "donor accountability".

MTEF provides a forum for donors themselves to look critically at their approaches and practices as what are donor strategies/approaches, practices, and behaviour that may have contributed to undesirable outcomes, and desirable outcomes. Have donors coordinated effectively and delivered assistance in a consistent and coherent manner? What has characterized successful donor interventions? What has characterized the successes and failures?

It is visible that the distribution of health aid, as well as the public expenditures of HMG, seems to be very uneven across regions leading to varying overall patterns of aid and their impact on the society. It is high time to review critically how has

this come about, and what impact this has had on the overall economic and social development of Nepal.

MTEF augmented by Nepal Development Forum (NDF) is expected to pave a way how donors can modify their approach, practices, and behaviour to improve their effectiveness as development partners of Nepal.

10. Additional Programs / Projects subject to availability of additional funds

- Speed up priority 1 programs and, additionally, focus on priority 2 programs
- Preventive measures for non-communicable diseases, for example lifestyle related diseases
- Complimentary programs directed to poor, disadvantaged women and children
- Local level capacity building
- Geriatrics Health
- Emergency Preparedness and Disaster Management Programs (mass casualty)
- Urban health including hospital waste management
- Oral health.

11. Conclusions

- The present MTEP/F is an austerity plan. However, under PRSP, the health sector should be protected even under budget cuts, particularly the essential health care services.
- Policy implications – dealing with low priority activities:
Low priority activities or unproductive program activities can not be instantly discontinued. These programs should be revisited and assessed for revitalization or discontinuation. An efficient and cost effective management approach should be explored.

12. Recommendations

- Accord priority to key programs which include essential health care services and programs that are targeted to the economically deprived population to ensure equity.
- Enhance cost-effectiveness and management efficiency by decentralization and devolution of financial and human resources with an approach of public, private, NGO and community partnership.
- Optimize financial allocation in the health sector through the Poverty Alleviation Fund (PAF), VDC contribution and parliamentary fund.
- Encourage move towards a Sector Wide Approach in order to optimize available resources from EDPs.

