GAVI Health System Strengthening Support Evaluation

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Nepal Case Study

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Acronyms and Abbreviations

AHW	Auxiliary Health Worker
ANC	Ante Natal Care
ARI	Acute Respiratory Infection
CB-IMCI	Community Based Integrated Management of Childhood Illness
CMYPA	Comprehensive Multi-Year Plan of Action
(N) DHS	(Nepal) Demographic and Health Survey
DoHS	Department of Health Services
DOUDBC	Department of Urban Development and Building Construction
DTP	Diptheria, Tetanus, Pertussis (whooping cough)
EHCS	Essential Health Care Services
EmOC	Emergency Obstetric Care
EPI	Expended Programme of Immunisation
HMIS	Health Management Information System
HSS	Health System Strengthening
IHP	International Health Partnership
IRC	Independent Review Committee
JAPR	Joint Annual Review
M&E	Monitoring and Evaluation
MCH(W)	Maternal and Child Health (Worker)
MDG	Millennium Development Goal
MoHP	Ministry of Health and Population
MTEF	Medium Term Expenditure Framework
NCP	Newborn Care Package
NHSP	National Health Sector Programme
NGO	Non Government Organization
PHC	Primary Health Care
PIU	Project Implementation Unit
SBA	Skilled Birth Attendant
SLTHP	Second Long Term Health Plan
SWAp	Sector Wide Approach
TB	Tuberculosis
TWG	Technical Working Group
VHW	Village Health Worker

Summary of key findings, conclusions and recommendations

This summary of the Nepal case study answers the first two GAVI HSS evaluation questions, namely:

1. What has been the experience at country level with GAVI HSS in terms of each of the following aspects: design, implementation, monitoring, integration (harmonisation and alignment), management and outputs/outcomes;
2. What have been the main strengths and weaknesses of GAVI HSS at the country level, and what are the specific areas that require further improvement?

It also highlights some key issues related to how well the Nepal HSS intervention fits with GAVI's principles and values.

Despite the constraints it faces Nepal has made good progress towards the MDGs and, in the case of many essential services, improved equity in access; much of the credit for which must go to the effectiveness of public health services (Foster 2007). The fact that resource allocations to poorer districts are larger than those to the more developed ones (although human resources tend to be focused in the Kathmandu valley) further supports this. The free care policy which is gradually being expanded from primary care also represents an effort to address financial access barriers. Nepal is highly dependant on aid to fund its health sector but, as a first wave IHP country, it is taking steps to improve aid effectiveness.

GAVI HSS Proposal Design, Focus and Rationale

The proposal contains many "upstream" HSS activities; perhaps more so than for other GAVI HSS recipients. Support goes beyond the individual programmes; supporting issues such as micro planning, health management information system (HMIS), supporting the urban health sector, planning at district level. This being the case it will be a particular challenge to link inputs with outputs and outcomes. Only a modest share of the support is channelled through the Child Health Division; the Training Division, Management Division and Logistics Division are also involved. A large share of funding is channelled to the district level and other Ministries will also undertake activities on MoHP's behalf. The general consensus among those interviewed is that the proposal was addressing the key constraints. The lack of clarity on how HSS is defined presents some analytical problems. For example, although there are few doubts that expanded community based integrated management of child illness (CB-IMCI) is likely to get results, one could question whether simply expanding an existing programme could be classed as systems strengthening.

HSS application and approval

Nepal's initial HSS proposal was rejected. A second proposal was approved and covers a two-year period consistent with the Health Sector Strategy which has been extended to 2010. Transaction costs have been high to date given the short timescale of the funding and, in view of this some questioned whether the effort was worth it. The approach has become more complex as GAVI guidance has evolved through different versions of proposal preparation guidelines and is partly a reflection of the fact that GAVI itself was also going through a learning process. These high transaction costs and disproportionate level of effort are likely to decline; the next proposal should cover a five-year period and will involve less effort as HSS constraints are now well documented, articulated and design processes have been established and can possibly be streamlined.

GAVI, quite rightly, does not want to be too prescriptive as its flexibility is seen as a key strength. However, experience from the first proposal suggests greater direction and more explicit messages might be helpful. The Independent Review Committee (IRC) questioned certain activities e.g. the inclusion of an endowment fund for female volunteers and construction of storage facilities and requested further justification. Not surprisingly, rather than risk a second rejection the Ministry of Health and Population (MoHP) excluded these activities from the subsequent proposal (the endowment fund was subsequently funded through the donor pool). Some respondents complained about what were perceived as rather generic and subjective advice provided by the IRC and its lack of understanding the country context. This raises the question as to whether current IRC processes draw the right balance between independence and consistency with understanding of the local situation.

A Phase 2 proposal is being developed and a Technical Working Group (TWG) has been established. The aim is to submit this in September alongside a revised strategic health plan. Whilst this would suggest that the GAVI support is being catalytic in the sense of encouraging the development of such a plan, this review would question whether such a timetable is feasible or appropriate. The Ministry aims to submit its Annual Progress Report (APR) shortly after the end of the 2008/9 FY which was on July 15th. This does not fit within the GAVI timetable but we would support this approach as being more aligned with Government timetables.

HSS implementation

In terms of implementation of the GAVI HSS programme it is still early days and it is certainly too early to assess impact. The programme has faced delays due in large part to political turmoil but also due to the widespread use of Government systems which, for example, resulted in a significant delay in activities as the budget for the 2008/9 financial year was not approved until well into the financial year. As most activities were programmed in year 1 this has meant that some activities have been delayed and put back to year 2. However, the MoHP seem confident that most outputs will be delivered by July 2010. At the same time the political situation presents some risks and highlights the vulnerability of the programme to external events. Following the collapse of the Maoist-led Government no important decisions are being taken as there is no Minister in place and it is not clear how soon this situation will be resolved.

Implementation of the programme has also revealed some flaws in the programme design which may affect the delivery of outputs. As the support uses Government systems (and is included in the Red Book - which only contains programmes which fully follow Government procedures) taxes need to be paid on some inputs - a fact that was overlooked during the design process. It was quite interesting to note that some suggested this was down to the automatic, but obviously misplaced, perception that donor support follows separate procedures. In addition, Government rules state that funds are converted at the exchange rate in place on the day they are received in the country. At that date the rate was extremely unfavourable. It now seems unlikely that the budget will deliver the programme outputs in full. Extent to which outputs are delivered on time and within budget will be a good indicator of Government commitment and likely sustainability (through its willingness to cover any funding gaps).

Technical support to the HSS grant

The **process** has been increasingly led by Planning Division (the head of the Planning Division used to head the Child Health Division and is therefore well placed to lead). At the outset the immediate, and perhaps understandable, reaction was for the Department of Child Health to lead. In the initial proposal the WHO HSS staff had no involvement. For the second application and following constructive comments from GAVI, the **National Health Sector Coordinating Committee** (NHSCC) was revised / expanded to include more senior people. It tends to meet on an ad hoc basis suggesting it still isn't focusing on routine monitoring but responding instead to major events. Respondents did express some frustration with delays in decision processes resulting largely from the lack of a country presence and long gaps between Board meetings.

The programme has seen an extraordinary degree of **Government ownership**. The (now ex-) Minster was extremely engaged and knew all about the individual activities and targets and pushed strongly for rapid implementation and shown in the NHSCC meeting minutes. Following the demise of the Maoist-led Government it seems highly unlikely that such a level of support will be maintained. Even if there is support, momentum will need to be rebuilt and this will require time and effort. There has been increasing support from WHO and UNICEF.

How does HSS fit the GAVI principles and values?

Alignment: The programme is closely aligned with both policies and systems. The National Health Sector Programme (NHSP) 2004-9 is focused on delivery of a package of Essential Health Care Services. This package is prioritised and immunisation features prominently. Effectively GAVI HSS is providing earmarked budget support to NHSP. The GAVI support is included in the Red Book – activities are included in divisional work plans (with the GAVI line in most cases easily identifiable). The M&E framework is aligned – indicators are consistent with SWAP log frame and Annual Report targets (although Annual Reports tend to be seriously delayed – the 2007/8 report is still not published). Government has, quite reasonably, insisted on using its own reporting year (July to July) for the APR. GAVI needs to begin thinking about what steps might need to be taken and which conditions need to be met before the APR could be dropped. The programme is integrated – there is no Project Implementation Unit (PIU).

Harmonisation: GAVI is harmonised with the most aligned donors. A key question is whether GAVI should formally join the pool. Nepal's IHP status would suggest that it should. Some respondents suggested that such a move would reflect donor confidence in MoHP and a reflection of its good track record in increasing immunisation coverage. There is a lack of enthusiasm for this in the Ministry with concerns about the risk of diluting the effect of GAVI support, reducing the HSS profile it has succeeded to create and the highly visible results it has achieved. One option might be a dual approach – part pool, part earmarked – as many donors already do. The APR is an additional requirement and, as noted above, should ideally be dropped when some key conditions – which would need to be defined – are met.

Inclusive. The GAVI preparation grant funded a proposal process which appears to have been truly inclusive involving consultation with a wide range of stakeholders right down to the district level. The proposal also benefited from regional consultations as well as field visits. There is a risk that inclusive processes may result in a populist, unwieldy shopping list

of activities which tries to keep all stakeholders happy. A prioritisation exercise will, therefore, always be required to ensure any approach is streamlined and coherent. This seems to have taken place in Nepal.

Sustainability: The issue varies by component. The programme does support a lot of one-off activities – some will require follow on activities. According to the SWAp log frame, Government is committed to allocating 10% of its budget for health by the end of the programme. This being the case one might have less concern. However, although the share has been increasing it is unlikely it will reach such a high share in such a short period of time. At the same time Nepal does have a proven track record having taking over the costs of routine vaccines. The Financial Sustainability Plan is not being updated (as suggested in the proposal) but the CMYPA will be revised 2010 and 11 and extended to 2015. In terms of technical sustainability progress will depend on a number of factors – the quality of the training and the extent to which it changes behaviour. The relatively advanced age of those trained suggests that attrition might undermine some of the benefits – an issue which might usefully be tracked with between now and the 2012 evaluation.

Catalytic: The programme does contain a number of pilot programmes. Most notable is the implementation of pilot MCH strategies which might ultimately be expanded to all 54 municipalities. A number of respondents suggested that this is a particularly valid approach in Nepal as Government tends to be quite good at taking new ideas it likes and running with them once it is convinced they work. (This is less likely to be the case in many other settings.). This being the case, the challenge will be to ensure that the pilots are rigorously evaluated and action taken accordingly. Specific examples of changes to date include the change in Government policy on training allowances provoked by the GAVI HSS support. Effectively, new allowances introduced for GAVI HSS funded training has now been adopted across the Ministry. Although this approach is catalytic, this review did not address the question of whether or not this was a good thing (Isn't it better just to pay higher salaries?). Potential access to follow-on GAVI HSS support also appears to be pushing the NHSP process forward (as noted earlier). The GAVI support does appear to have raised the profile of HSS in Nepal – a Global Fund proposal incorporating elements of HSS is being currently being developed.

Results oriented The programme sets out a range of outputs, but given their upstream nature they are quite hard to track. There are problems with quality of data (e.g. immunisation coverage where there are reasonable concerns that the denominator - target population - is too high, resulting in an underestimation of the true coverage rates). This

issue was discussed widely in the Joint Annual Review (JAR); again reinforcing the importance of GAVI engaging in this process. There is no real tracking of progress against activity work plans at present. This is currently only done through specific exercises such as the Tracking Study and APR processes.

Predictability: This is *potentially* very high. Using the GAVI HSS resource allocation formula it is, in principle, possible for MoHP to know exactly how much it will get once approved (but not necessarily whether the proposal will be approved). Nepal's experience is that the risk of rejection might be reduced by greater clarity of guidelines – perhaps through expansion of an explicit negative list in the GAVI proposal preparation guidelines. GAVI, for understandable reasons would be reluctant to do this, but it should consider the possibility. The next proposal should provide MoHP with long term (5 year) predicable financing. The support is far more predictable than that of other SWAp donors who tend just to give indicative commitments. Though it will hopefully not be an issue, it is not clear how poor performance would need to be before support would be withheld.

Additionality: It seems likely that activities were, for the most part, additional. They would probably have happened anyway but more slowly. Additionality is significant. For example MoHP currently buys around 8-10 pick-ups per annum for the 75 districts, and 240 PHCs – the GAVI support proposes to purchase at least 37 immediately. Given the funds available are lower than originally anticipated (due to the inclusion of tax) and the loss of budget (due to exchange rate fluctuations), achieving the agreed outputs may require additional resources.

Impact: It is far too early to detect impact. Given the upstream nature of much of the support this will involve considerable challenges. Key issues that will need to be considered include the quality of the training, the extent to which training changes behaviour, the presence of complementary measures to improve productivity such as remuneration and supervision, and attrition rates. In terms of the infrastructure development one will need to ask whether quality services are being provided in birthing centres. One might also expect to see some evidence of improvement in performance in low performing districts (perhaps using Government performance index – set out in Annex 4 of the proposal) given that much of the support is focussed there. CB-IMCI is a proven approach with a relatively good evidence base; it is reasonable to expect that this will be repeated as the new districts seem to differ little from those already benefiting from the programme.

Inequality: The evidence suggests that current Government efforts are improving access to child health services as well as reducing inequalities (RTI 2008). In terms of the GAVI HSS proposal some of the components are specifically addressed at reducing inequalities. This is more explicit in some areas than others. Training of Health Facility Management Committees, for example, is concentrated in the poorest performing districts. In other areas the targeting is implicit. The assumption would be that as the needs of the better-off are better covered, efforts to expand access are likely to be focused on the better-off. A recent International Health Partnership (IHP) Mission commended the MOHP on the sector's emphasis on addressing equity which "was repeatedly evident during the JAR's deliberations".

Conclusions and Issues Raised

The experience of GAVI HSS in Nepal has been broadly positive. The welcome focus on alignment has served to highlight the weaknesses in, and drawback of using national health systems. Although activities were slow to start it appears likely that objectives will be achieved within the programme timeframe. The experience also illustrates the vulnerability of donor programmes (not just GAVI's) to changes in high level leadership and broader political developments.

The key **value added** of the GAVI HSS was seen as its **flexibility** - "simple, country driven, no strings attached, money up front, no intermediaries, no extra rules", and "GAVI is the easiest donor – others have their own agenda – country decides but we need to justify what we ask for" as two respondents put it. Whilst some complained about problems, these typically reflected the rigidities of the Government system and not necessarily the GAVI procedures which were trying to mirror them.

Specific Issues

Need for Strategic Health Plan Several discussions with respondents raised the question of the need for a current strategic health plan. What is important is evidence of Government commitment to further strengthening immunisation services and the health systems that support them, and a key question is whether the presence of a Strategic Health Plan is necessary to do this. Therefore alternatives might be worth considering. These might include a separate, but succinct statement of policy along the lines of a World Bank *Letter of Intent*. It is not immediately clear why the Long Term Health Plan 1997-2017 was not sufficient for GAVI's purposes. In practice many plans do not guide policy and are not necessarily a good indicator of Government commitment. In practice, many of the policies in place e.g. the free

health care policy are irreversible – it does not necessarily require a strategy document to do this.

Need for a balance between quantitative and qualitative measures of progress. A recurring them was the need for focus on **quality –** whether in terms of the quality of services or qualitative aspects of the M&E framework.

Key areas to focus on in the **2012 evaluation** might include the extent to which:

- There is a clear vision for how GAVI plans to take forward the harmonisation agenda. Will it join the pool? When, under what conditions?
- The more upstream investments are leading to changes in behaviour. This might include a review of the training programmes including a tracking study of a sample of the beneficiaries to see if they are still practising;
- there is evidence of integrated delivery of CB-IMCI, MCH and NCP (new born care package) – especially given that neo natal mortality accounts for over half of all child deaths;
- more uniform structure and approaches to MCH in urban areas;
- a clear way forward following rigorous assessments of pilot approaches to promoting new born care and integrated micro planning.

1 Scope, Approach and Methodology

1.1 Background

This report contains the findings of the case study conducted in Nepal between June 1st and 5th 2009 as part of the GAVI HSS Evaluation Study. This is one of 11 In-depth case studies that have been conducted in the following countries, all of them recipients of GAVI HSS grants: Burundi, Cambodia, Democratic Republic of Congo (DRC), Ethiopia, Kyrgyzstan, Liberia, Nepal, Pakistan, Rwanda, Vietnam and Zambia. An additional 10 countries were also studied that did not involve country visits but just review of available documentation combined with email/phone interviews by the study team. These countries were Bhutan, Honduras, Georgia, Ghana, Kenya, Nicaragua, Nigeria, Sierra Leone, Sri Lanka and Yemen.

Other issues relating to the overall study methodology (evaluation framework, key questions, study components, guidelines for data collection, sampling method, etc) are publicly available documents that can be requested from HLSP. To keep this report short these broader methodological issues are not be discussed here.

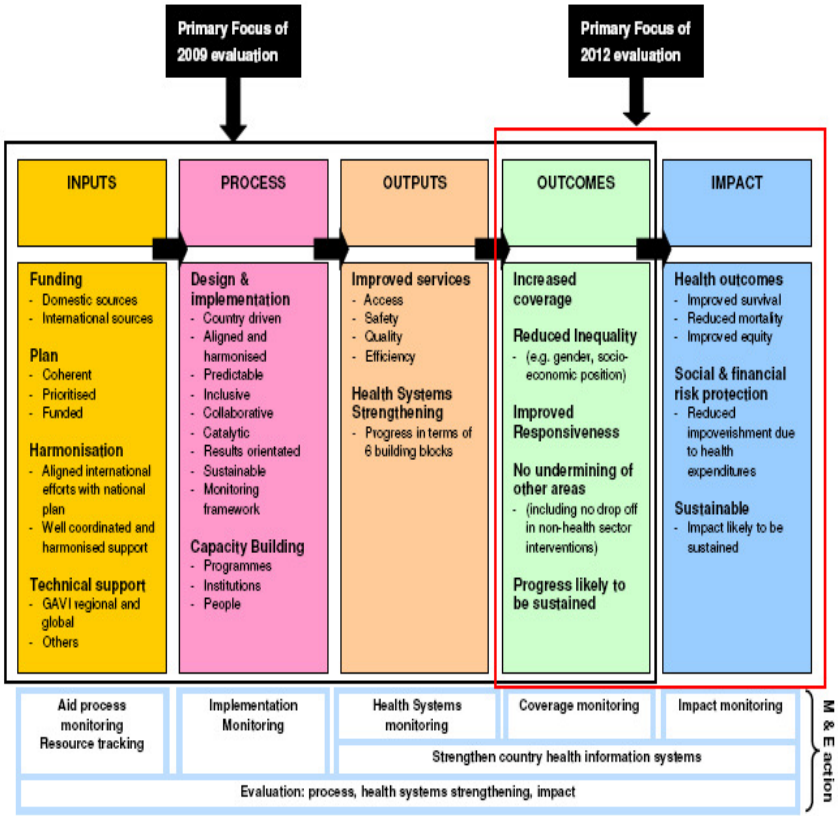
1.2 Brief conceptual framework of the Evaluation

This evaluation is being conducted to inform three areas of decision making:

1. The Board decision in 2010 about whether or not to increase the funding available to the GAVI HSS window
2. How to improve current and future implementation. (This is valid even if the window is not expanded, because there are considerable sums of money which have been awarded but not yet disbursed.)
3. To enhance the quality of the 2012 evaluation.

It is important to note that in view of the short time elapsed since the first HSS applications were approved in 2006 that this evaluation – the first one ever conducted on the GAVI HSS component - will focus primarily on issues linked to: proposal design; approval and review processes; early start up measures; nature of inputs, processes and outputs involved in grant implementation and annual performance review; and assessment of activity and outputs achieved to date. The study will also reflect on the nature and quality of global, regional and national technical support systems delivered by a range of stakeholders in support of HSS grants. The conceptual framework for this evaluation is shown in Figure 1.

Figure 1: The conceptual framework - logical progression from inputs to impact



The priority evaluation questions are summarised in Box 1 below.

Box 1: Examples of Questions for the HSS Evaluation Study

- Is GAVI HSS on track to achieve what it set out to (in general and in individual countries)? If not, why not? How might GAVI HSS be improved?
- What would have happened if GAVI HSS had not been created? Is it additional money and does it add value to existing ways of doing business?
- Are the "right" bottlenecks being identified – i.e. are they priorities and relevant to the desired outcomes?
- Are design and implementation processes consistent with GAVI principles?
- What factors can be linked to countries being on- or off-track?
- Are HSS-related monitoring frameworks well designed? Do they measure the right things? Are they being appropriately implemented? Do they take into account country capacity to deliver?
- Are they consistent with existing country monitoring frameworks? Where they differ, what value is added and at what expense in terms of extra transactions costs?
- What do we know about outputs and outcomes? How realistic is it to try and attribute improved outputs and outcomes to GAVI support? What are some of the key contextual factors which influence results?
- How sustainable are the results likely to be?
- What have regional and global support mechanisms delivered?
- What effect have they had – how could they have been improved?
- What should the 2012 evaluation cover and what need to be done now to support it?

1.3 Approach to the Country Case studies

All 11 in-depth review countries were visited by the HLSP country lead consultant assisted in some cases by one or more national consultants or national research institutions depending on the circumstances.[1] In the case of 6 countries (DRC, Ethiopia, Kyrgyzstan, Nepal, Vietnam and Zambia) the HSS evaluation team benefited from ongoing work by the so called GAVI HSS Tracking Study in those countries. The Tracking Study - led JSI/InDevelop-IPM - covers very similar areas (albeit from a different angle) to those of this HSS Evaluation study, so attempts were made to achieve synergies between the two studies.

In Nepal, as in other countries, the country case studies were triggered by a letter from the Executive Secretary of the GAVI Alliance Secretariat addressed to the Minister of Health and copied to the main stakeholders involved in follow up or implementation of GAVI grants at national or regional level, including the so-called "Focal Points" based at either the World Health Organisation (WHO) or UNICEF.

Once the letters had been sent the Country Lead Consultants began the process of documentation, and began preparing the country visits with country and regional stakeholders. In the case of Nepal the country visit took place between 1st June and 5th June. A list of people met for this evaluation is included in **Annex 1**. Meetings took place in Kathmandu supplemented with phone conversations with regional WHO contacts and the GAVI country contact. Key constraints included the short visit, access to key staff as well as logistical problems associated with a general strike. A list of documents reviewed is at **Annex 2.** A summarised description of the study approach is at **Annex 3**.

The Nepal case study was carried out in late May and early June by Mark Pearson. The study involved a series of meetings with key stakeholders - including the implementers of the Nepal Tracking Study - using structured questionnaires and teleconferences with other stakeholders at regional and global levels. Available literature was also reviewed (see Annex 1). Key constraints included the short nature of the visit, lack of an APR or the preliminary draft of the Tracking Study (still awaited) and access to key some key stakeholders due to other commitments. Nonetheless, it was still possible to get some impression of progress to date and of the emerging issues.

[1] The main circumstances that determined the kind of support required by the HLSP Country Lead consultants included the size of the country, the size and complexity of the HSS grants, whether the grants were targeting any specific geographical areas, etcetera.

1.4 Acknowledgements

We would like to thank the Ministry of Health in Nepal for facilitating this study and for those stakeholders who generously gave their time to contribute.

2 Overview of Nepal Context

2.1 Economic and Political Environment

Just as Nepal appeared to be emerging from conflict and instability, the 2006 peace agreement - which resulted in largely peaceful elections in 2008 and a Maoist level coalition with an agenda to deliver change - has broken down. In early May 2009 the Prime Minister resigned. A new prime Minister representing all parties except the Maoists was sworn in on May 25th and the process of Government formation is ongoing amidst considerable political uncertainty.

Nepal is one of the least developed countries with a population of around 28 million and a gross national income (GNI) per capita of $340 in 2007. Around 24% of the population live on less than a dollar a day.

2.2 Health Policy Environment

Nepal's Ministry of Health and Population's overall goal is to provide an equitable, high quality healthcare system The overarching framework for this is the **Second Long Term Health Plan (SLTHP) 1997 – 2017** which emphasises the importance of effective Child Survival, Safe Motherhood, and Essential Health h Care Services (EHCS). The 2003 ***Health Sector Strategy: An Agenda for Reform*** (HSRS9) aimed to move towards a sector-wide approach (SWAp) and encourage a more strategic approach to health planning. The 2004 ***Nepal Health Sector Program Implementation Plan 2004 - 2009*** (NHSP-IP) is the framework for taking this forward and was accompanied by a pooled financing agreement signed by the GoN, DFID and the World Bank. The plan has subsequently been extended to July 2010. Key components of the plan include:

- Provision of essential health care services (EHCS) **(Annex 4)**
- Decentralization of service delivery; and
- Implementation of Sector-Wide management and Public-private partnerships.

The new Government introduced a 10-point health policy guideline, Interim Constitution and Three Year Interim Plan which established a right-based approach to health. This built on the existing policy framework which included:

- An overarching PRSP;
- NHSP-IP 2004-9 which is currently being extended to 2010 to align it with the 3 Year Interim Health Plan;
- Long Term Health Strategy 1999-2017.

Key targets are set out in the NHSP logframe (**Annex 5**)

Nepal has been increasing its share of funding for the health sector as a means of expanding access to key services. The share of the Government budget going to health increased from 4.9% in 2003/4 to over 7% in 2007/8. According to the 2008/9 budget speech this may have fallen back a little – the NHSP log frame aims for a share of over 10% by July 2010. Around 70% of spending is on the Essential Health Care Package (in which immunisation and child health services play a prominent role). Low rates of budget execution - although they have risen to around 80% - represent an ongoing problem.

The Government has gradually been rolling out a free health care policy with all primary care services now provided free, and secondary level services provided free for specific target groups.

2.3 Sector Management Arrangements

Around half of Government spending on health is aid financed. There is a developing SWAp – the only one in Nepal if one excludes the sub sector Primary Education SWAp - with pooled funding provided by DFID, World Bank, and Ausaid with other donors considering joining the pool. Progress is monitored through:

- Semi-annual Joint Annual Reviews (JARs)[2]
- quarterly Health Sector Development Forum meetings;
- monthly implementation meetings.

Pooled funding partners have contributed around 20% of total public spend; the majority of which is from the World Bank. The share of support which is pooled is likely to increase.

2.4 Progress on Outcomes and Access to Services

The NHSP mid term review reports satisfactory progress and indicates that some targets had actually been achieved by 2006. Foster et al highlighted the key role of the public sector in providing essential services as a key factor in this.

Nepal is one of the seven first-wave International Health Partnership countries; the IHP compact was signed on February 1, 2009.

Health indicators have improved – and further analysis of Demographic and Health Survey (DHS) data suggests that inequalities in access have been reduced for many services,

[2] the October/November JAR reviews the past performance the May/June JAR reviews and agrees on the future work plan and budget

though there are exceptions such as ante natal care (ANC). Neonatal mortality now accounts for around 54% of total child mortality.

Table 1 Reductions in Mortality Rates 1996-2006

Year of survey	1996	2001	2006
Under five mortality rate (per 1000 births)	118	91	61
Under five mortality net of neonatal mortality (per 1000 births)	68	52	28
Maternal mortality rate (per 100,000 births)	539	-	281
Adult mortality (% who die from age 15-49)	11.5	-	7.9

Source: Demographic Health Surveys

Table 2 Access to Key Services

Overall Results Indicators	Baseline (DHS 2001)	Achievement in 2006	2007	2008	Target 2009	Target 2010
Contraceptive Prevalence Rate, modern method (%) Lowest income quintile	**35.4** **23.8**	**44.2** – *42.0* **30.3**	*42.1*	*41.4*	47	48 35
% of births attended by skilled birth attendants Lowest income quintile Attendance by trained health worker Lowest income quintile	**10.9** **2.5** **12.9** **3.6**	**18.7** **4.8** **25 –** *23.4* n.a.	*29.7*	*18**** *31.7*	22 35	26 10 39
% children immunized against DPT-3 Lowest income quintile DPT-3 % children immunized against measles	**72.1** **62.1** **70.6**	**88.6 -** *93* **75.2** **85 -** *88*	*84* *83*	*81.9* *79.0*	90	90 80 88
% Population with the knowledge of one correct method of preventing HIV infection**	F: **37.8** M: **66.9**	F: **64.6** M: **81.1**	n.a.	n.a.	n.a.	F: 75 M: 85

Foster et al (2007) suggest that the improvements in U5 mortality can be attributed to increased immunisation coverage (EPI & measles campaign) (36%), Vitamin A supplementation (39%) and CB-IMCI (24%).

Nepal seems on track to meet most of the MDGs – indeed it may achieve its MDG 4 goals well before 2015. However, despite this Nepalese citizens have the lowest life expectancy in Asia. Almost half of all children continue to be chronically malnourished and despite a halving of maternal mortality, only around 20% of births are attended by a skilled practitioner.

2.5 Sector Reforms

It terms of broader reforms the NHSP Mid Term Review noted that progress in terms of decentralisation had been slower than anticipated. A health sector decentralisation policy forum has been formed and has designed a pilot programme to strengthen local health governance,

Another significant policy move in 2007/08 was to dramatically increase the district budgets to procure drugs and equipment; key elements in supporting the free basic care policy. A public private partnership policy forum was established in 2007/08 and a workshop organised to share experiences and best practices in the sector; the private health sector assessment and legislative assessment were initiated and the report should be shared soon. In the next two years, MOHP plans to (i) develop or formalise a number of partnerships specifically to improve access to key services in underserved areas; and (ii) use these experiences to design a more ambitious strategy for NHSP 2.

2.6 Progress on immunisation coverage

According the 7th JAR HMIS data suggests that immunisation may have dropped slightly in 2008, though the programme is confident that it is still making progress. Despite the reported incidence of diarrhea increased significantly in 2007/08, the proportion of children severely dehydrated decreased, Similarly, the proportion with severe pneumonia among acute respiratory illness cases decreased, despite more reported infections.

2.7 Ongoing Systems Weaknesses

Systems weaknesses well elaborated as part of the HSS proposal development process (see **Box 1**)

Box 1: Key Health Systems Weaknesses

- Inability to retain and motivate health workers in remote districts
- Inadequate skilled levels at the health posts sub-health posts to deliver effective MCH and newborn care services
- Inequitable distribution of health services by ethnic groups, geographic regions with particular problems faced by internally displaced, marginalized and hard to reach populations.
- Particular weaknesses in public health services, especially MCH and immunization services, in municipality areas.
- Weak supervision at sub-district level
- inability to utilise HMS system fully in decision making processes
- Weak community-level capacity to carry out decentralized health management functions at sub-district level.
- Poor coordination between public and private sectors in relation to service
- Provision, human resources, quality and accountability
- Poor infrastructure and ineffective maintenance at sub-district level
- Managerial weaknesses at district and sub-district level
- Low levels of government funding for health especially for vaccine supply and destitution
- Lack of adequate transportation facilities to support logistic supply, supervision and monitoring, rapid response to outbreak and other emergencies
- Frequent stock outs of vaccine and other health commodities, due to inadequate transportation capacity.
- Outdated skills of key health workers (AHWs, VHWs and MCHWs)
- Failure to meet needs of internally displaced, marginalized and hard to reach populations. (DHS 2006; MTEF)

Other donors are involved in various aspects of the HSS agenda – as set out below - but such support has not been sufficient to accelerate progress:

- **Technical training in maternal and neonatal health**: USAID, UNFPA, UNICEF, JICA, GTZ
- **CB-IMCI:** USAID/JSI, UNICEF WHO NFHP, PLAN, CARE, ADRA, JICA, Save the Children (US), AusAID and UMN
- **Management training**: GTZ, DFID and WHO
- **HMIS**: UNFPA, UNICEF and WHO

Nepal was the first South Asian country to benefit from the **International Health Partnership** and related initiatives (IHP+). A compact was signed in February 2009 following extensive consultations (including with civil society).

3 GAVI HSS in Nepal

This section will review the main issues surrounding the GAVI HSS design and application processes and will attempt to summarise progress to date. It concludes with a reference to the issues that ought to be covered in the assessment of the HSS grant at completion in 2010. This section is intentionally mainly descriptive, while the assessment of the meaning of these findings in relation to GAVI principles and to the questions of the evaluation study will be done in section 4 in order to avoid repetition.

3.1 HSS proposal design

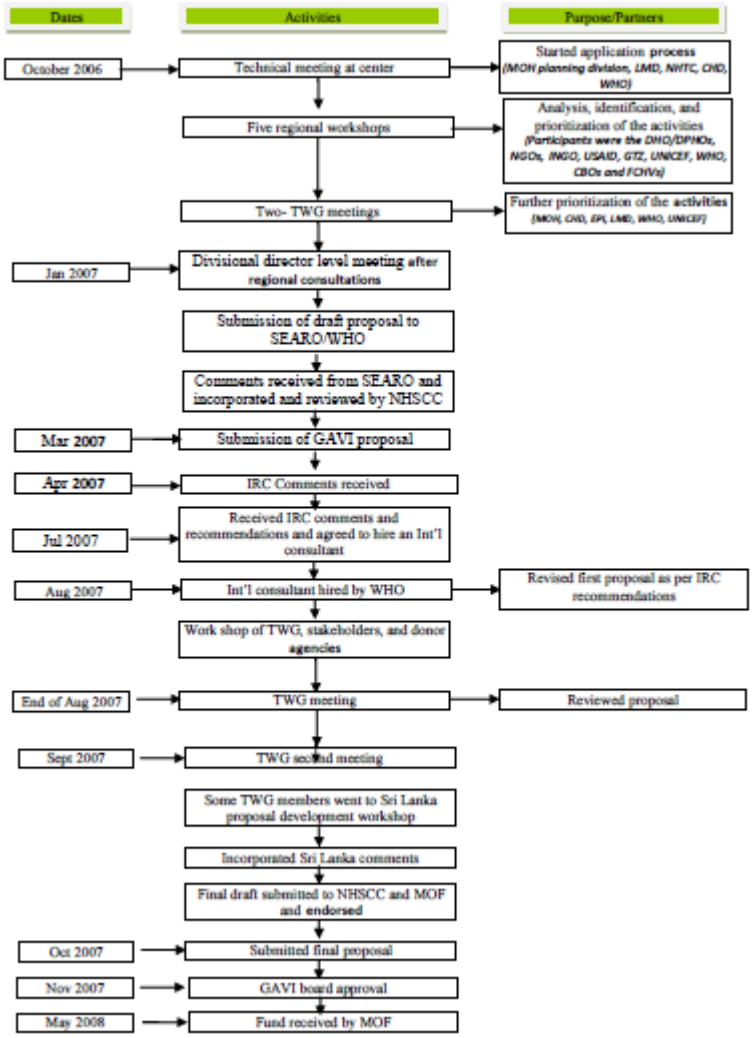
The process was led by the National Health Sector Coordinating Committee (NHSCC) which was established in November 2006 with the sole aim of taking forward the GAVI HSS proposal. The NHSCC is chaired by the Minister for Health and Population and supervises the activities of the Technical Working Group and external consultants and authorised consultative arrangements at central, regional and sub-district levels. Members of the NHSCC include senior officials from the MoHP, the MoF, and the National Planning Commission. The Chief Specialist, Policy, Planning and International Cooperation Division, MoHP, chairs the TWG with Child Health Division acting as the lead technical unit with support from external development partners. National and international consultants supported the situation analysis and application development. The TWG membership included partner agencies, such as UNICEF, WHO, other ministries and the Nepal Health Research Council. The process involved regional visits (to Sri Lanka) and a series of regional and central consultations within Nepal. An initial proposal was rejected with questions raised about some of the content (support for the establishment of an endowment fund for Female Community Health Volunteers and construction of regional storage facilities but also because of the composition of the NHSCC).

3.2 HSS application and approval process

Nepal's initial HSS proposal was rejected. A second proposal was approved and covers a two year period consistent with the Health Sector Strategy which has been extended to 2010. Transaction costs have been high to date given the short timescale of the funding and, in view of this some questioned whether the effort was worth it. The approach has become more complex as the GAVI approach has evolved through different versions of proposal preparation guidelines; partly a reflection of the fact that GAVI itself was also going through a learning process. These high transaction costs and disproportionate level of effort are likely

to decline: The next proposal should cover a 5-year period and will involve less effort as HSS constraints are now well documented, articulated and design processes have been established that can possibly be streamlined. Key milestones are shown in Figure 1 below:

Figure 1 Key Milestones in GAVH HSS Proposal Process



Source: Tracking Study

GAVI, quite rightly, does not want to be too prescriptive as its flexibility is seen as a key strength. However, experience from the first proposal suggests greater direction and more explicit messages might be helpful. The IRC questioned certain activities e.g. the inclusion of an endowment fund for female volunteers and construction of storage facilities and requested further justification. Not surprisingly, rather than risk a second rejection the MoHP excluded these activities from the subsequent proposal (the endowment fund was subsequently funded through the donor pool). Some respondents complained about what were perceived as rather generic and subjective advice provided by the IRC and its lack of understanding the country context. This raises the question as to whether current IRC

processes draw the right balance between independence and consistency with understanding of the local situation.

The approved Phase one proposal included a range of activities which most respondent felt fit well with the existing systems bottlenecks. On the other hand some aspects such as social inclusion, quality of care and demand side issues were not fully addressed in the proposal.

A Phase two proposal is being developed and a Technical Working Group has been established. The aim is to submit this in September alongside a revised strategic health plan. Whilst this would suggest that the GAVI support is being catalytic in the sense of encouraging the development of such a plan, this review would question whether such a timetable is feasible or appropriate. The Ministry aims to submit its APR shortly after the end of the 2008/9 FY on July 15th. This does not fit within the GAVI timetable but we would support this approach as being more aligned with Government timetables.

3.3 HSS Start-up measures

The programme has faced delays due in large part to political turmoil but also due to the widespread use of Government systems which, for example, resulted in a significant delay in activities as the budget for the 2008/9 financial year was not approved until well into the financial year. As most activities were programmed in year one this has meant that some activities have been delayed and put back to year two. However, the MoHP seem confident that most outputs will be delivered by July 2010. At the same time the political situation presents some risks and highlights the vulnerability of the programme to external events. Following the collapse of the Maoist-led Government no important decisions are being taken as there is no Minister in place and it is not clear how soon this situation will be resolved.

3.4 Annual Progress Reporting (APR) on HSS

The Government has, quite reasonably, insisted on using its own reporting year (July to July) for the APR. This means the 2008 APR has nothing on HSS – it is not clear what implications this will have for approval of funds given that the IRC reviews the APRs on fixed dates. MoHP plan to submit the APR shortly after the end of its fiscal year. Some of those interviewed favoured separate HSS and ISS APRs as different people are responsible for them. Another recommendation is to shift the APR deadline to X months (3 months??) after

the end of the FY rather than May 15th. This would be more aligned with country planning cycles and help spread the workload for GAVI and the IRC.

GAVI needs to begin thinking about what steps might need to be taken and which conditions need to be met before the APR could be dropped. There is potential, for example, for GAVI to join trimesterly SWAp reviews and Joint Annual Reviews (JAR). At present such fora do focus on HSS issues – financial management, procurement, human resources etc – and the JAR includes a budget analysis which should give GAVI some confidence about the degree of Government commitment (though as it is broken down by division it is hard to tell what is happening with HSS specifically). However, current reporting systems do not focus heavily on performance so APRs may be needed for some time to come.

3.5 HSS Progress to date

Nepal has received significant support from GAVI over the years as shown in **Table 3.**

Table 3 GAVI Support in Nepal

GAVI Channel	$m
Health system strengthening	6,165,500
Injection safety	1,426,017
Immunisation services	3,679,020
New & underused vaccines	16,611,852
Total (US$):	27,882,389

Source: GAVI website

The overarching purpose of the HSS proposal is "to reduce child mortality (MDG 4) and maternal mortality (MDG 5), by strengthening core components of the system to yield durable improvements in EHCS delivery, including immunization services" The main components of the HSS grant are summarised below in **Table 4**

Table 4 Overview of GAVI HSS Programme

Objective	Expected Outcomes	Budget 2008/9 and 2009/10
Community-based health workers are certified as having their skills formally updated to ensure the delivery of MCH and immunization services to achieve coverage targets by 2010.	By 2010, 2600 trained village health workers VHWs will be formally trained to provide high quality MCH services and manage effectively their health area.	$1.2m
	400 trained auxiliary health workers (AHWs) will be deployed and retained by the end of 2010 in health service posts	$0.49m
Rapidly expand CB-IMCI to the remaining 11 districts to achieve 100% national coverage by 2010.	CB-IMCI will be introduced in the 11 remaining districts by 2010; A newborn care component will be added to CB-IMCI in these 11 districts.	$2.06m
Implement pilot programs on district micro planning in 10 districts and urban maternal and child health in 5 municipalities by 2010.	Increased availability of MCH services measured by the number of pilot municipality areas achieving 90% DPT3 coverage, verified by surveys if indicated.	$0.21m
	405 health facility management committees (HFMCs) in the 10 lowest performing districts will be trained in financial resource, human resource, and operations management (including micro planning for delivering health services) through an already established national curriculum.	$0.04m
	Improved utilization of MCH services measured by achieving 90% DPT3 coverage, and 50% of pregnant women will receive a 4th antenatal care visit.	$0.15m
	42 health posts with birthing centres constructed at the sub-district level, to utilize available and already trained health workers by 2010.	$2.58m
Health information management and logistics improved in 75 districts by filling identified infrastructure, logistics and communication gaps by 2010.	50% of districts conduct all 12 monthly supervisory visits using the integrated supervision checklist by 2010. Improved communications measured by having 100% of district hospitals with internet connection, so as to report of outbreaks within 24 hours and increase	$1.48m
	Timeliness and completeness of weekly reporting by 2010.	$0.02m
	Procure and supply computers and maintain them in operation condition in the 50 districts for effective HMIS.	$0.31m
	Switch from manual to electronic data management (HMIS) to reduce inconsistency and reporting errors will be completed in all districts by 2010.	$0.11m

The approach is genuinely system wide with Child Health, Training, Management and Logistics divisions responsible for implementing the different components and it is a lot more

"upstream", for example, than the Cambodia HSS programme.

There has been some reprogramming due to late access to funds and due to additional cost pressures (tax and exchange rate changes) but on the whole the programmes seem on track to deliver the outputs set out in the proposal, although most activities will be undertaken in year two rather than in year one. This is being assessed in detail as part of the Tracking Study.

Nepal received HSS support in May 2008. As the support uses Government systems and approval of the budget was delayed activities did not begin until late 2008. As the Government financial year runs from 15th July no GAVI HSS activities took place in FY 2007/8. As a result the MoHP did not include HSS in its 2008 APR. It has just begun work on the APR which will cover 2008/9 FY and plans to submit this shortly.

Implementation of the programme has revealed some flaws in the programme design which may affect the delivery of outputs. As the support uses Government systems (and is included in the Red Book[3]) taxes need to be paid on some inputs - a fact that was overlooked during the design process. It was quite interesting to note that some suggested this was down to the automatic, but obviously misplaced, perception that donor support follows separate procedures. In addition, Government rules state that funds are converted at the exchange rate in place on the day they are received in the country. At that date the rate was extremely unfavourable. It now seems unlikely that the budget will deliver the programme outputs in full. The extent to which outputs are delivered on time and within budget will be a good indicator of Government commitment and likely sustainability (through its willingness to cover any funding gaps).

Table 5 below summarises the current state of play in terms of delivery of outputs:

[3] The Red Book includes all support – whether Government of donor funded - which fully utilises Government procedures

Table 5 Summary of Progress by Activity

GAVI HSS activities to be completed by July 2010	GAVI HSS inputs for the FY 2008/09 (US $)	GAVI HSS target set in AWPB for the FY 2008/09	Progress against the AWPB by the Q2-2008/09	Remarks
Activity 1.1: Upgrading skills of 2600 Village Health Workers (VHWs)	846154	1200	1200	All completed
Activity 1.2: Upgrading 400 Auxiliary Health Workers (AHWs) to Senior AHWs		200	On-going	Will be completed as per AWPB
Activity 2.1: Expansion and inclusion of newborn care in Community Based Integrated Management of Childhood Illness (CB-IMCI) in 11 remaining districts	2061538	11	11	Completed in all the districts
		2	2	Districts identified CB-NCP Reprogrammed for next FY
Activity 3.1: Develop and implement an urban MCH health plan in 5 major municipalities	83600	Development of Urban MCH Strategy	Strategy developed and finalized	Actual implementation shifted to the next fiscal year 2009/10.
		MCH clinic establishment	Not established	
Activity 3.2: Training of Health Facility Management Committees (HFMCs) in 10 lowest performing districts (405)	20769	HFMOC training	On going	District and facility level trainings will be completed as per AWPB
Activity 3.3: Micro-planning for effective delivery of MCH and newborn health (including immunization) in 10 lowest performing districts	76923	Development of micro planning guideline	Completed	Ongoing
		Integrated micro-planning in 5 districts	On going	
Activity 3.4: Establishing birthing centers in 42 districts	1292308	Begin construction of 42 health posts	3 tenders awarded 39 to be awarded by end of year	In 3 of the districts tender had been called Anticipated to start work by May/June 2009.
Activity 4.1: Providing 50 pick-up trucks and 100 motorcycles	1400000	Pick- up trucks- 37	Still in the process of tendering	The first tender for 37 pick-up trucks was cancelled since none of the bidders were qualified and a second tender has been called upon
		Motor-cycle- 100	Contract awarded	
Activity 4.2: Providing telephone lines to 50 DHOS, 11 districts hospitals, and 101 PHCs	24923	50 DHOs; 11 district hosp; 101 PHCs	Completed	Almost completed at the district level.
Activity 4.3: Providing computers and related equipments, and email/internet facilities to 50 DHOs & 71 District Hospitals	295384	50 DHOs & 71 District Hospitals	Contract awarded for computers.	E-mail/Internet connected in 20 districts.
Activity 4.4: Decentralizing the computerized Health Management Information System (HMIS) to 50 districts	64615	Numbers of districts targeted- 50	15 districts started electronic reporting HMIS software being installed in other districts.	Activity will be completed as per plan.

Source: Tracking Study

3.6 End of HSS Assessment

Key areas to focus on in the **2012 evaluation** might include the extent to which:

- There is a clear vision for how GAVI plans to take forward the harmonisation agenda. Will it join the pool? When, under what conditions?
- the more upstream investments are leading to changes in behaviour. This might include a review of the training programmes including a tracking study of a sample of the beneficiaries to see if they are still practising;
- there is evidence of integrated delivery of CB-IMCI, MCH and NCP (new born care package) – especially given that neo natal mortality accounts for over half of all child deaths;
- more uniform structure and approaches to MCH in urban areas;
- a clear way forward following rigorous assessments of pilot approaches to promoting new born care and integrated micro planning.

3.7 Support systems for GAVI HSS

3.7.1 Technical support for proposal design and approval

The **process** has been increasingly led by Planning Division (the head of the Planning Division used to head the Child Health Division and is therefore well placed to lead). At the outset the immediate, and perhaps understandable, reaction was for the Department of Child Health to lead. In the initial proposal the WHO HSS staff had no involvement. For the second application and following constructive comments from GAVI, the NHSCC was revised / expanded to include more senior people. *See 3.7.3 for comment on the NHSCC.*

3.7.2 Technical support to the APR

It was proposed that the WHO/GAVI in country immunisation officer would play a lead role in completing the APR. Given that no HSS APR has been submitted yet the process has not yet been tested.

3.7.3 Technical support for HSS implementation

The NHSCC tends to meet on an ad hoc basis suggesting it still isn't focusing on routine monitoring but responding to big events. Respondents did express some frustration with delays in decision processes resulting largely from the lack of a country presence and long gaps between Board meetings.

3.8 Monitoring

HMIS data suggest that the CPR and immunisation may have dropped slightly in 2008. This issue was discussed at length during the MOHP regional and central reviews and the consensus is that the core problem may be in the HMIS data itself[4] rather than a real worsening in service delivery performance. The denominators used to compute HMIS indicators are projections based on data which needs to be adjusted. These projections may not adequately reflect the decline in the number/age of marriage and fertility, which are believed to have been more rapid than anticipated[5] - not clear but discussed.

The GAVI HSS indicators are shown in **Table 6** below:

[4]

[5] The HMIS calculates expected pregnancy without adjusting for a declining Total Fertility Rate, more specifically NDHS 2006 reports a decrease in the TFR from 4.1 in 2001 to 3.1. The HMIS is based on the 2001 report.

Table 6 GAVI HSS Monitoring and Evaluation Framework

Indicator	Data Source	Baseline Value	Source	Date of Baseline	Target	Date for Target
1. National DTP3 coverage (%)	HMIS & Survey	93%	WHO/UNICEF Joint Reporting Form for 2006	2006	95%	Jul 14, 2010 (cMYP; 3YP p.30)
2. % of districts achieving =90% DTP3 coverage	HMIS & Survey	77%	WHO/UNICEF Joint Reporting Form for 2006	2006	100%	Jul 14, 2010 (cMYP)
3. Under five mortality rate (per 1000)*	Survey	61	NDHS 2006	2006	55	Jul 14, 2010 (3YP p. 7)
4. % pregnant women attending a minimum of four ANC visit	HMIS	44%	HMIS Annual Report 2006, DoHS	2006	50%	Jul 14, 2010 (3YP p.7; NHSP-IP p. 83)
5. % births delivered by SBA	HMIS	23%	HMIS Annual Report 2006, DoHS	2006	35%	Jul 14, 2010 (3YP p.30; NHSP-IP p. 83 NSMNHP p. 19)
6. % of children with pneumonia who receive appropriate treatment	HMIS	1.6%	HMIS Annual Report 2006, DoHS	2006	1.0%	Jul 14, 2010 (NHSP-IP p. 83)

There is some minor misalignment in the M&E framework. GAVI requires countries to collect data on the % of districts achieving over 80% DPT3 coverage – Nepal has included it but for a higher 90% target. The current donor log frame incorporates all of the above indicators except the % of districts covered. Instead, it aims to achieve 80% DPT3 coverage for the lowest quintile by 2015. Whilst this is more difficult to measure and is, in principle, a better indicator of progress in terms of equity it might make sense to replace the existing indicator with this one. The current log frame also included more disaggregated indicators on other core GAVI indicators e.g. Births attended by a skilled birth attendant (SBA), regardless of place, increased to 26% and 10% for lowest income quintile). Progress against such indicators might also usefully be reported in the APR. The indicator for acute respiratory infection (ARI) coverage and ANC are taken from the HMIS and not included in the SWAp logframe.

The indicators selected for each activity are measurable and are based upon data that is already regularly collected by the HMIS, NDHS or as part of routine administrative data. In terms of the needs of M&E for the GAVI HSS activities there is no need for additional assistance in the data collection and analysis for the listed indicators.

The HMIS Annual Report is prepared but with significant delays. Consideration should be given to changing the monitoring framework to include only those which are included in the log frame as these are reviewed on a regular basis. The log frame also includes a series of HSS indicators which also form a useful basis for assessing progress.

Table 7 Key Output Indicators

6.2: Output Indicators

Indicator	Numerator	Denominator	Data Source	Baseline Value	Source	Date of Baseline	Target	Date for Target
Objective 1: Community-based health workers are certified as having their skills formally updated to ensure the delivery of MCH and immunization services to achieve coverage targets by 2010.								
# CBHWs certified								
Objective 2: Rapidly expand CB-IMCI to the remaining 11 districts to achieve 100% national coverage by 2010.								
% districts implementing CB-IMCI	Number of districts implementing CB-IMCI	Total number of districts	Administrative	85%*	MoHP	2007	100%	14 July 2010
Objective 3: Implement pilot programs on district microplanning in 10 districts and urban maternal and child health in 5 municipalities by 2010.								
# districts with integrated MCH microplans according to new guidelines/criteria	Number of districts with microplans	N/A	Administrative	0	MoHP	2007	10	14 July 2010
Objective 4: Health information management and logistics improved in 75 districts by filling identified infrastructure, logistics and communication gaps by 2010.								
# districts having at least 1 vehicle for supervision and logistics management	Number of districts with at least 1 vehicle	N/A	Administrative	18	MoHP	2007	68	14 July 2010
# districts reporting HMIS data electronically	Number of districts reporting electronically	N/A	Administrative	0	MoHP	2007	75**	14 July 2010

*CB-IMCI has already been implemented in 48 districts. MoHP will implement in 16 districts in FY 2007/08.
**MoHP will implement electronic reporting in 25 districts in FY 2007/08.

4 Analysis of Progress against Key GAVI Principles

4.1 Country Driven

The programme has seen an extraordinary degree of **Government ownership**. The (now ex-) Minster was extremely engaged and knew all about the individual activities and targets and pushed strongly for rapid implementation and shown in the NHSCC meeting minutes. Following the demise of the Maoist-led Government it seems highly unlikely that such a level of support will be maintained. Even if there is support, momentum will need to be rebuilt and this will require time and effort.

4.2 Alignment with National Plans and Systems

GAVI HSS is well aligned with national health **policies** with immunisation playing a prominent role in the Essential Health Care Service (EHCS) package which is the focus of the strategy.

In terms of **systems,** the support is included in the Red Book (which contains programmes which follow Government procedures) and activities are captured in annual work plans. Neither the APR itself nor its timetable (calendar years) is aligned with Government systems or harmonised with other donor support. The M&E framework is largely aligned with the M&E framework used for the SWAps. Implementation is integrated into the MoHP structure – there is no PIU.

4.3 Harmonisation

The eighth and ninth Joint Annual Reviews (JAR) of the Nepal Health Sector Programme were held in December, 2008 and May 2009 respectively. There is generally wide participation from MoHP, the Department of Health Services (DOHS), the Ministry of Finance, the Office of the Auditor General, and the Department of Urban Development and Building Construction (DOUDBC), members of the High Level Health Policy advisory committee, external development partners representatives including: AusAID, UNICEF, GTZ, IDA, KFW, SDC, UNAIDS, UNFPA, USAID, and WHO. In December 2008, representatives of the IHP+ core team from UNICEF, the World Bank and WHO also participated in the Joint Annual Review and held separate discussions on the Nepal Compact. The JAR's main objective is to review the performance of Nepal Health Sector Programme (NHSP) in 2007/08 including progress on performance indicators, in the eight output areas, as well as on the implementation of key reforms such as the free care policy. In addition, the JAR monitored progress in implementation during the first half of the fiscal

year and was meant to review progress on actions agreed during the December 2007 JAR.

The Foster report (an independent review to feed into the JAR) suggests that "external commitments often come too late in budget preparation, are too short term for planning purposes, and too unreliable in converting promises to actual disbursements. This has serious consequences for the ability of MOHP to sustain and develop the critical public health programmes".

As an IHP country there might be some impetus for GAVI to join the pool as a signal of its confidence in Government systems. As most of the pool donors also provide discrete support some respondents felt that a mixed approach might make sense in Nepal (as an interim measure) to maintain the profile of HSS and ensure certain activities take place.

GAVI might also consider ways of providing more focused in country support by attending key meetings (the GAVI Country Officer did try and attend the last JAR but the dates changed). This would include the JAR meeting but also the trimesterly reporting system adopted by the SWAp donors. As discussed in other case studies funding more staff capacity at regional level to engage more regularly with Government might be a useful way forward.

4.4 Predictability of Funding

The IHP 'compact' commits external development partners to provide longer-term predictable financial support. In principle, GAVI HSS does provide highly predictable support. Once approval is received the country knows exactly how much it will receive. The only uncertainties relate to whether proposals will be approved, whether performance is sufficient to warrant continued support and whether GAVI itself has sufficient funds. Nepal only received two years funding given its NHSP is due to end in 2010. Future funding should be of a longer term nature. The recent Foster review set out a range of criteria to judge donor performance in terms of predictability. Table 8 shows how the GAVI HSS approach fares against these criteria.

Table 8 Predictability of GAVI HSS Support

Foster Criteria	GAVI HSS Performance
Wherever possible, external development partner (EDP) commitments or at least indications should be multi-year. Alterations to announced figures should be minimised.	Current proposal 2 years – next proposal should cover 5 years. Potentially YES
The date by which EDP estimates of their spending for the following year should be provided to MOHP should be advanced to January 15th, to give more time for a more participatory AWPB process.	YES – budget known at time of approval. Scope for viring between years at Government discretion
If EDPs have to adjust their spending, or feel compelled to do so because of concerns about performance, the sanctions should apply only from the next budget year, not the current one, and MOHP should be given clear guidance on whether previously indicated figures can be restored, and what actions are needed to secure this	Not tested. But suggest that if APR report for 2007/8 (received in 2008/9 does not demonstrate sufficient programmes but should be reduced in the following year)
All formalities for donor support should whenever possible be completed before the July start to the financial year in which it is to be provided, to ensure that late approval by EDPs does not become a cause of disruption in the NHSP programmes	Yes

4.5 Inclusive and Collaborative Processes

This has been a key strength of the proposal development process. Five regional meetings (2-day workshops at five Regional Headquarters) were conducted in late 2006 to identify the key health system barriers they faced. Sub-district staff were specifically asked to identify the type of activities that had been successful in removing constraints to higher coverage of MCH services. Participants included district public sector health workers, (health staff from all 75 districts were represented by Female Community Health Volunteers, vaccinators, Maternal and Child Health Workers, District Public Health Officers, and District supervisors), and civil society members (including Nepal Family Planning Association, Nepal Red Cross Society, NEPAS, Nepal Association of Obstetricians & Gynaecologists, Nursing Association of Nepal), municipality health staff, local NGOs, Plan International, USAID, CARE, CORE, GTZ, Red Cross, Family Planning Association, ADRA, UNICEF, and WHO.

4.6 Catalytic Effects

The approach does include a number of pilot programmes which will prove catalytic if they result in further expansion/modification of the programmes in question. The GAVI support has already proved to be catalytic in terms of provoking a discussion about changing (i.e. increasing) allowances for training attendances – now Rs 300 per day (taxed) plus Rs 35 per days for refreshments (exempt of tax). This is now being applied across the sector and will

serve to increase the funds available for some of the HSS components. Though catalytic it is far from clear that the change is appropriate. The potential for substantial GAVI support is also clearly creating a pressure to begin work on the next strategic plan – although it is not clear that the current timeframes being considered (by September) are realistic.

4.7 Results-oriented Approach

Given the rather upstream nature of much of the support it will not necessarily be difficult to measure outputs, but measuring results may be more problematic. For instance it may be possible to easily assess whether people have gone through training programme. However, key questions about the effectiveness of such programmes would depend on whether the right personnel were trained, how relevant the training was, whether it changed behaviour and whether people actually utilised the new skills and learning they acquired.

4.8 Sustainability

The sustainability implications vary by component. Many of the GAVI components involve one-off costs with no subsequent recurrent costs. Here the question is more around the sustainability of benefits. Some components will have ongoing recurrent implications (e.g. vehicles, maintenance of CB-IMCI). Others are one-off and have no long term recurrent implications (e.g. refresher training for AHWs and VHWs) so sustainability is less of a concern.

Nepal has a good track record as it is currently meeting the procurement costs for polio, BCG, measles and TT vaccines. It is committed to bridge financing the costs associated with pentavalent introduction. The ongoing SWAP also means that pooled funds are available to meet high priority interventions. As is the case in most countries the ongoing global financial crisis will present challenges. However the strengthening MTEF process - in which the Ministry of Finance reviews programmes closely in terms of financial sustainability - offers some degree of reassurance. The proposal does suggest that the MoHP planned to update its Financial Sustainability Plan in 2009. However it has dropped plans to do this but does plan to revise and extend its (costed) cMYPA.

In terms of technical sustainability the approach is aimed at motivating staff to improve retentions. It is also implemented through the existing system so offers the best chance of ensuring sustained results.

4.10 Impact and Inequity

The more downstream the interventions the more difficult it will be to trace possible impact. In the case of the expansion of CB-IMCI it would be reasonable to assume that the impact in the existing CB-IMCI districts (MoHP Annual Report 2006/7 page 65) will be repeated in the GAVI supported districts. For the more upstream activities assessing impact will be more challenging. For the VHWs there are questions about the quality of the training. Many of the beneficiaries are in the 45-55 age group and may not work much longer. The lack of effective supervision and the existence of other opportunities (e.g. in terms of private practice) do raise questions as to the likely impact of these activities. For the birthing centres there are questions as to whether or not they can be adequately staffed if current recruitment freezes remain in place. The evidence suggests that current Government efforts are improving access to child health services as well as reducing inequalities (RTI, 2008). In terms of the GAVI HSS proposal some of the components are specifically addressed at reducing inequalities. This is more explicit in some areas than others. For example:

- Training of VHWs is focused on 50 lowest performing districts;
- training of Health Facility Management Committees (HFMCs) – focused on 10 lowest performing districts;
- micro-planning for effective delivery of MCH and newborn health (including immunization) is focused in the 10 lowest performing districts.

In other areas the targeting is implicit The assumption would be that as the needs of the better-off are better covered (as suggested in the DHS), efforts to expand access are likely to be focused on the worse-off. For CB-IMCI the aim is to achieve more equitable access by using GAVI HSS funds to cover the outstanding 11 districts.

Urban MCH plan: Janakpur (population - 86,130), Lalitpur (189,744), Pokhara (182,709), Butawal (88,713), Nepalgunj 68,281.

For other activities support is national. In terms of provision of telephone lines and computers and decentralising HMIS all districts are covered (in the case of HMIS – GAVI is covering 50 districts, Government 25).

More broadly GoN's focus on equity is widely appreciated (earlier IHP comment) and there is evidence of successful impact. Analysis of consecutive DHSs suggests that "between 1996 and 2006, differences between castes, ethnicities, and wealth quintiles decreased in contraceptive use, childhood immunisation, diarrhoeal disease control, and treatment for acute respiratory infection. Differences in fewer than five and infant mortality rates between

castes, ethnic groups and wealth quintiles decreased. Disparities between castes, ethnic groups, and wealth quintiles in birth weight or size at birth have also diminished[6]" (RTI International, 2008. *Equity Analysis of Health Care Utilization and Outcomes,* Research Triangle Park, NC, USA). This is also reflected in terms of resource allocation with per capita allocation far higher in poorer areas (although human resources tend to be focused in and around the Kathmandu valley (Foster 2008). The free health care policy should also complement efforts to improve access to care by reducing financial barriers to access.

4.11 The Counterfactual and Additionality

Respondents generally agreed that the support, while consistent with national policies, would not have happened so quickly had GAVI support not been available. Many of the activities were receiving support form other donors, however, GAVI allowed more rapid scaling up, and in the case of CB-IMCI for example full national coverage.

[6] It did not however that "disparities increased in antenatal care and deliveries attended by skilled birth attendants. At the same time, differences in neonatal mortality rates between Brahmins/Chhetris and Dalits, and between Newars and Janajatis have increased".

Annex 1 List of People Consulted

Susan Clapham and Marilyn McDonagh Health Advisers DFID

Dr Pankaj Mehta – Chief, Health and Nutrition UNICEF

Dr Suniti Archaya and Pushkar Silwal Centre for Health Research and Dialogue (Tracker Study)

Dr Nastu Singh and Albert Voetberg Health Specialists, World Bank

Dr Gharti WHO/GAVI In Country Immunisation Officer

Dr Upreti: Director, Child Health, MoHP

Dr Pradhan: GAVI HSS Focal Point Chief Specialist Policy and Planning Division, MoHP

Dr Setaidi WHO HSS Tecnhcai Advisor

Mr Kadka HSS Focal Point Training Division, MoHP

Mr Sharma HSS Focal Point Management Division, MoHP

CARE

Plan Intl

RTI Health Sector Reform Programme

Ranjana Kumar GAVi Secretariat (by phone)

Annex 2 List of Documents Reviewed

NEPAL HEALTH DEVELOPMENT PARTNERSHIP IHP National 'Compact' between Ministry of Health and Population Federal Democratic Republic of Nepal and External Development Partners January 2009

SURVEY ON MONITORING THE PARIS DECLARATION EFFECTIVE AID BY

NEPAL: HEALTH SECTOR PROGRAMME Draft Aide Memoire Eighth Joint Annual Review (JAR) (December 11-12, 2008)

FIFTH MEDIUM TERM EXPENDITURE FRAMEWORK (Fiscal Year 2006/07 – 2008/09) (MAIN VOLUME) Government of Nepal National Planning Commission Singh Durbar, Kathmandu

Workshop Proceedings Role of Civil Society in IHP+ Initiatives 29th September 2008: Kathmandu

Nepal at a glance World Bank

Application for GAVI Alliance Health System Strengthening (HSS) by the Government of Nepal, Ministry of Health and Population Strengthening the Health System of Nepal 5 October 2007

Nepal Demographic and Health Survey 2006 Population Division Ministry of Health and Population Government of Nepal Kathmandu, Nepal

Ministry of Health and Population Health Sector Reform Unit International Health Partnership Secretariat Proposal for Strengthening Health Sector

IMPLEMENTATION COMPLETION REPORT (IDA-38300) ON A CREDIT IN THE AMOUNT OF SDR 51 MILLION (US$75 MILLION EQUIVALENT) TO THE KINGDOM OF NEPAL FOR THE FIRST POVERTY REDUCTION SUPPORT CREDIT March 28, 2006

Three Year Interim Plan (2007/08 – 2009/10) Government of Nepal National Planning Commission Singhadurbar, Kathmandu, Nepal December 2007

Annual Repprt Raw Data 2064/5

South Asia: Human Development Sector Attaining the Health and Education Report No. 12 Millennium Development Goals in Nepal World Bank February 2007

Budget Speech of Fiscal Year 2008-09 Government of Nepal Ministry of Finance 2008

MoHP Annual Progress Report 2008

Equity Analysis of Health Care Utilization and Outcomes August 2008 Health Sector Reform Support Programme RTI International

Review of Nepal Health Sector Programme: A Background Document for the Mid-Term Review Mick Foster, John Quinley, Raghav Regmi and Binjwala Shrestha

Final Report November 2007

Nepal Health Sector Programme -Plan (NHSP-IP) 2004-9 MoHP October 2004

Health Sector Strategy – An Agenda for Reform MoH October 2004

Nepal HSS Proposal Review November 2007

Annex 3 Summary of Methodology

The GAVI Alliance HSS Evaluation Study Approach

On February 2009 HLSP Ltd won the contract for the 2009 GAVI Health Systems Strengthening (HSS) support Evaluation. The expectation for this evaluation is to determine to what extent operations at country level and support from global and regional levels, as well as trends in health systems and immunization are heading in the right (positive) direction. Qualitative and quantitative information will be collected and analyzed both retrospectively as well as prospectively beginning from the time that the application process commenced in country throughout implementation and monitoring and evaluation of the project to date.
There are five main objectives and areas of evaluation:

1. What has been the experience at country level with GAVI HSS in terms of *each* of the following: design, implementation, monitoring, integration (harmonization and alignment), management, and outputs/outcomes?
2. What have been the main strengths of GAVI HSS at the country level, and what are specific areas that require further improvement?
3. How has GAVI HSS been supported at regional and global levels—what are the strengths of these processes and which areas require further improvement?
4. What has been the value-added of funding HSS through GAVI as compared to other ways of funding HSS?
5. What needs to be done, and by when, at country, regional, and global levels to prepare for a more in-depth evaluation of impact of GAVI HSS in 2012?

The GAVI HSS evaluation will develop **five In-depth country case studies**. These are structured in such as way that independent consultants teamed with local consultants spend time in countries documenting country experiences. We anticipate up to two visits to each in-depth country between the period of May and June 2009. The first visit will focus largely on interviewing key country stakeholders to map key areas of interest, information and gather initial data. This visit may also include engaging / commissioning a local research institution to conduct further research into particular districts/ activities. During the second visit we anticipate any outstanding stakeholder interviews being conducted, all data collated and subsequently presented to all key stakeholders. We will explore with national stakeholders the opportunity and convenience of conducting an end-of-mission 'validation workshop' in order to provide countries with feedback on the in-depth case studies, and seek validation of these.

In addition, the results from the in-depth case studies will be **complemented by the results of 6 on-going GAVI HSS Tracking Studies** being conducted by the JSI-InDevelop-IPM research group that will become fully fledged GAVI HSS Evaluation studies. Finally, the HSS Evaluation team will desk review all HSS application forms, HSS proposals and HSS Annual Progress Reports produced to date in order to **develop a database of HSS countries**. All these sources of information put together will aim to answer the five study questions mentioned above.

Annex 4 Essential Heath Care Package

The Second Long Term Health Plan indicated that priority be given to health promotion and prevention activities based on Primary Health Care principles. It identified Essential Health Care Services (EHCS) that address the most essential health needs of the population and that are highly cost-effective. EHCS are priority public health measures and are essential clinical and curative services for the appropriate treatment of common diseases.

Essential Care Services for the Modern System of Medicine	
Main Interventions*	**Health Problems Addressed**
Appropriate treatment of common diseases and injuries	Common Diseases and injuries
Reproductive health	Maternal and Peri-natal
The expanded programme on immunisation (EPI) and Hepatitis B Vaccine	**Diphtheria, Pertusis, TB, Measles, Polio, Neonatal Tetanus, Hepatitis B**
Condom promotion and distribution	STD/HIV, Hepatitis B, Cervical Cancer
Leprosy control	Leprosy
Tuberculosis control	Tuberculosis
Integrated Management of Childhood Illness (IMCI)	**Diarrhoeal Disease, Acute Respiratory Infection (ARI), Protein Energy Malnutrition (PEM)**
Nutritional supplementation, enrichment, nutrition education and rehabilitation	**PEM, Iodine Deficiency Disorders, Vitamin A Deficiency, Anaemia, Cardiovascular Disease Prevention, Diabetes, Rickets, Perinatal Mortality, Maternal Morbidity, Diarrhoeal Disease, ARI**
Prevention and control of blindness	Cataracts, Glaucoma, Pterygium, Refractive Error, and other Preventable Eye Infections
Environmental sanitation	Diarrhoeal Disease, Acute Respiratory Infection, Intestinal Helminthes, Vector Borne Diseases, Malnutrition
School health services	Diarrhoeal Disease, Helminthes, Oral Health, HIV, STDs, Malaria, Eye and Hearing Problems, Substance Abuse, Basic Trauma Care
Vector borne disease control	Malaria, Leishmaniasis, Japanese Encephalitis
Oral health services	Oral Health
Prevention of deafness	Hearing Problems
Substance abuse, including tobacco and alcohol control	Cancers, Chronic Respiratory Disease, Traffic Accidents
Mental health services	Mental Health Problems
Accident prevention and rehabilitation	Post Trauma Disabilities
Community-based rehabilitation	Leprosy, Congenital Disabilities, Post Trauma Disabilities, Blindness
Occupational health	Chronic Respiratory Disease, Accident, Cancers, Eye and Skin Diseases, Hearing Loss
Emergency preparedness and management	Natural and Man-made disasters.

Annex 5 NHSP Log Frame

Nepal Health Sector Programme – Implementation Plan (NHSP-IP)

23 January 2009

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Assumptions
Goal			
Achievement of the health sector Millennium Development Goals in Nepal with improved health sector outcomes for the poor and those living in remote areas and a consequent reduction in poverty.	By the end of 2015: Progress towards health related MDGs (1990 - 2015) – Proportion living on less than $1 a day halved (from 38% to 17%) – **Under-five mortality reduced by two thirds (from 161.6 per 1,000 in 1990 to 54 per 1,000)** – Maternal mortality ratio reduced by three quarters to 134 per 100,000 live births – Achieve universal access to reproductive health – Spread of HIV/AIDS halted and begun to reverse the trend – Incidence of malaria and other major diseases, including TB, halted and trend reversed By the end of July 2010: – Total Fertility Rate reduced from 3.1 to 3.0 – Maternal mortality ratio reduced from 281 per 100,000 live births to 250 – CPR increased to 54 percent	Nepal Demographic Health Survey (NDHS) National Livelihoods Survey and Poverty Monitoring and Analysis System (PMAS) Other poverty related surveys developed under GON HIV prevalence: IBBS and sentinel surveillance	Political Stability Economic growth continues NDHS 2011 to measure 2010 targets IBBS continued

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Assumptions
	– **Infant mortality reduced from 48 per 1,000 live births to 44** – **Under-five mortality reduced from 61 per 1,000 live births to 55** – **Neonatal mortality reduced from 34 per 1,000 live births to 30** – Prevalence of malaria reduced (78 per 100,000 in 2003) – Estimated Prevalence of all forms of TB reduced to 230 per 100,000 population (243 per 100,000 in 2006) – HIV prevalence among IDU and migrants reduced (IDU from 34% (2008) to 20%; migrants from 1.9% (2006) to 0.75%) – Proportion of government budget allocated to health sector increased to at least 10%		
Purpose			
To improve the health status of the Nepalese population through increased utilization of essential services delivered by a well managed health sector. "A health system in which there is equitable access to coordinated quality health care services in rural and urban areas, characterized by: self-reliance, full community participation, decentralisation, gender sensitivity, effective and efficient management, and private and NGO sector participation in the provision and financing of health services resulting in improved health status of the population"	– **88% of children 12-23 months immunized against measles, 90% DPT3, and 80% DPT3 for lowest income quintile (note: 3-year interim plan recommends measles, mumps, rubella vaccination to be piloted)** – Births attended by a SBA, regardless of place, increased to 26% and 10% for lowest income quintile – Births attended by a trained health worker increased to 39% – At least 48% Modern Contraceptive Prevalence and 35% for lowest quintile – Unmet need for family planning reduced to 21% (25% in 2006) – **Utilization of EHCS* at health and sub-health posts increases by 30% for 2 lowest wealth quintiles (*prevalence and treatment of fever for children under**	NDHS National Household Survey· National Livelihoods Survey Other poverty-related surveys developed by GON PMAS NASA	Strong political commitment Health continues as a GON priority Health budget will continue to increase EDPs' contributions continue to increase Government committed and reduced reliance on external funding

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Assumptions
	age five) – TB case detection rate increased to 80% (67% in 2006) – TB treatment success rate at least 90% (89% in 2006) – Percentage of young people who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV (by age and sex group) o Young female (15-24 years) knowledge about HIV/AIDS increases from 27% to 50% o Young male (15-24 years) knowledge about HIV/AIDS increase from 44% to 70% o FSW, IDU and MSM knowledge about HIV/AIDS increases to 80% – Proportion of government funds to HIV/AIDS increased to 15% (from 8% in 2007) – **Underweight children under five years of age reduced from 39% to 34%** – At least 80% of the planned health sector budget will be spent in 2010		

Outputs			
1. Essential Health Care Services: EHCS costed, allocated the necessary resources and implemented. Clear system in place to ensure that the poor and vulnerable have priority for access. HIV/AIDS awareness increased and services extended to high-risk populations.	By the end of July 2010: 1.2. 40% of pregnant women receive at least 4 antenatal visits **1.3. 75% of pregnant women receive TT immunization (at least 2)** 1.4. Identified evidence-based interventions to address underweight children 1.5. 30% of deliveries are in facilities, 20% for lowest income quintile 1.6. 25% increase in total number of clients attending health and sub-health posts 1.7. 100% of poor and destitute clients attended by social service staff 1.8. 50% of health facilities providing quality STI services 1.9. 50% of NGO health facility providing quality STI services 1.10. Percentage and number of people with advanced HIV infection receiving antiretroviral combination therapy (by age and sex) 1.11. Facility-level quality improvement system in place in 50% of facilities by 2010	HMIS/DHS Monitoring survey report	Peace continues and programme can be implemented as planned Strengthening of reproductive STI services prioritised by the government Sustained funding to existing NGO services
2. Decentralisation: Local responsible bodies are capable of managing health facilities in a participative, accountable and transparent way with effective support from the MOHP and its sector partners.	By the end of July 2010: 2.1. MoHP provides formula-based block grants to District Health Offices with five-year plans to supplement grants to DDCs from MoLD to address local health needs 2.2. At least 30% of districts with five-year plans hire staff to fill vacant positions at facilities and offices 2.3. At least 50% of MoHP budget is allocated directly to District-level programs where Districts have five-year plans to address local health needs	HMIS	Local bodies functional
3. Private/NGO sector development: The role of the private sector and NGOs in the delivery of health services is recognised and developed with participative representation at all levels which ensure consumers get access to cost-effective high quality services that offer value for money.	3.1. Completion of Private Health Sector Assessments and legislative assessment by December 31, 2008 3.2. State—non-state policy and strategy prepared by July 15, 2009 3.3. At least 3 state—non-state models piloted and evaluated by 2009 3.4. Contracts signed with non-state hospitals/clinics in 5 districts to provide CEOC by 2010	HMIS DOS Annual Report	Partners willing to cooperate

4.Coordinated and consistent sector management (planning, programming, budgeting, financing, and performance management) in place within MOHP supported by the EDPs, to support service delivery with the involvement of NGOs and private sector	4.1. Restructured MoHP as steward and to facilitate sector wide management by 2009/10 4.2. Ayurveda and alternative medical section in MoHP and Ayurveda units in 5 RHDs fully staffed by 2008/09 4.3. National Ayurveda Academy established by 2009 4.4 Ayurveda drug and medicinal plant policy formulated and programmes initiated for documentation, IPR protection, development and utilization by 2010 4.5. AWPB, inclusive of district, EDP, and civil society participation by 2009 4.6. Output-based AWPB initiated in 2008 and implemented by 2010 reflecting all known resources 4.7. End-year JAR combined with the MoHP regional and national review meetings by 2009 4.8. Nepal Health Sector Strategy II and NHSP II prepared by a participatory process in 2009 for implementation 4.9. IHP accord finalized and signed by July 31, 2008	HMIS/DHS MOHP Annual report	Harmonisation pursued by all partners.
5.Health financing resource management: Sustainable development of health financing and resource allocation across the whole sector including alternative financing schemes in place	5.1. At least 10% of local revenue allocated for health expenditures by 2009 5.2. CDP and CHI redesigned in compliance with free health care policy by 2008 5.3. Costing and budgeting of free care options for district facilities and below by 2008/09 5.4. Study on AHF started in 2008 5.5. Completion of improvement action plan of June 2007 JAR by December 2008 JAR	HMIS/DHS MOHP Annual Report DOHS Annual Report	Government priority on health sector continues.

6. Logistics management: Systems established and resources allocated within MOHP for the effective management of physical assets and procurement, distribution and rational use of drugs, supplies and equipment	6.1. Stockouts of 10 monitored drugs below 25% for all PHF (any stockout in any quarter; baseline FY06/07: only 3 drugs below 25% stockout) 6.2. National institutional pricing established for District-level procurement initiated 2008 and implemented by 2009 6.3. "Pull system" operating in 9 Districts in 2008 increased to 50 Districts and training completed by 2010 6.4. Essential drugs procured annually or more frequently by 25 Districts by 2010 6.5. Essential drugs available in 95% of designated health facilities by 2010 6.6. 20% of total construction budget of FY 2008/09 and 2009/10 spent on building maintenance following the building maintenance plan 6.7. 1,000 sub-health posts upgraded to health posts by 2010 6.8. Two regional Ayurveda hospitals, 90 Ayurveda dispensaries and 2 natural medicines centres established by 2010 6.9. Plans for management of health care waste developed and implemented in 2008	MOHP Annual Report HMIS/DHS DOHA Annual Report	
7. Human resource development: Clear and effective HRD policies, planning systems, and programs developed and functional	7.1. Enhance staff skill-mix by 10% at sub-health posts, 15% at health posts, 20% at PHCCs, and 25% at District hospitals where BEOC and CEOC are provided by 2010 7.2. At least 40% of health facilities (District and PHCC) fully staffed by SBAs (with skill mix, both number and types by 2010 7.3. Incentive package for doctors, nurses, paramedics, especially for remote areas designed in 2008 and implemented by 2009 7.4. Production of MDGP, DA, DGO, DCH and DCP for strengthening 30 district hospitals started from 2009 7.5. Strategic Plan for Human Resources for Health, 2003-2017 updated by 2009 including updating of strategic Plan for Human Resources for Maternal Health. 2003-2017 by 2008 7.6. HR flexible fund established for short-term contracting of critical medical staff by 2009 7.7. e-HuRDIS designed and implemented in 50% of health facilities by 2010	HMIS/DHS DOHS Annual Report MOHP Annual Report	Role shift accepted by all.

8. Integrated MIS: Comprehensive and integrated management information system for the whole health sector designed and functional at all levels as well as quality assurance mechanism in place for public and private sectors	8.1. Completed system integration study to establish linkages by 2008 8.2. Unified coding system for establishing linkages and standardizing database by 2008 8.3. Simplified reporting formats to make more user-friendly by 2008 8.4. Strengthened information dissemination and increased access for general public by 2008 8.5. Integrated program-specific health data at DDC Information Centre to support decentralized health planning and management, and forwarded subset of data to central level by 2008 8.6. Captured and integrated NGO/private sector data at DDC Information Centre for decentralized health planning and management and to promote PPP by 2009 8.7. Establish pro-poor monitoring system at sample of health facilities for quarterly or trimester data collection and analysis by 2008 8.8. Regulatory framework for NGO/private sector health providers established by 2009 and implemented by 2010 8.9. Quality assurance program and monitoring established and implemented by 2008	HMIS/DHS	Appropriate skills mix of MOHP management