



Taking Stock Report
Nepal

March 2008

International Health Partnership and Related Initiatives (IHP+)

'Stock Taking' Report

**Ministry of Health and Population
Government of Nepal
Ramshahpath, Kathmandu
Nepal**

1. Introduction

Health as a human right has been accepted in principle by many countries including Nepal since 1948. However, the Interim Constitution of Nepal 2063 v.s. (2007) has declared and enshrined the state's commitment and responsibility to people's health for the first time in the history of Nepal. The Interim Constitution is informed by a comprehensive vision of an inclusive society, where peoples of all ethnic groups, castes, religions, political persuasions, social and economic status, and genders live in peace and harmony, and, enjoy equal rights without discrimination. To ensure that the health sector actively and consistently contributes to realization of that vision is the guiding principle for the policies plans and programs of the Ministry of Health and Population (MoHP), Nepal.

Starting from 2004, and continuing for a period of 5 years, the Nepal Health Sector Program Strategy and Implementation Plan (NHSP-IP, 2004-2009) has been implemented by the Ministry of Health and Population (MOHP) and supported by 11 External Development Partners (EDPs). These same development partners are also the signatories to a Statement of Intent to guide the partnership for health sector development in Nepal.

Since the success of the pro-democratic movement of April 2006, important changes have taken place in the development of the health sector in Nepal. As part of the new government, MoHP has issued a 10 Point Policy Guideline (see •• below) emphasizing health as a fundamental human right of the Nepali people and setting out certain fundamental policy commitments. The interim constitution has ensured the right of Nepali citizens to have basic health service free of cost. A Three-year Interim Health Plan (2007/08 – 09/10) is in effect now. The Government of Nepal (GON) has started providing universal free essential health services at the health post and sub-health post levels, and targeted free health care in Primary Health Centers and District Hospitals, and plans to expand these programs up to higher levels. The targets and indicators of the NHSP-IP have also been aligned with those of Three-year Interim Health Plan.

In this context, Nepal has also become one of the first wave countries in the International Health Partnership. This partnership emphasizes the importance of strengthening the public health system in the country and of harmonization of donor aid with the health policy and plan priorities of the Ministry of Health and Population. A brief summary of those health policies, strategies and plans is presented below, beginning with some historical background.

2. Background

2.1 Nepal's Recent Health Plans and Policies

Since the People's Movement of 1990, there has been significant progress in the development of the public health system under the framework of long term health plans and policies. The Second Long Term Health Plan (1997-2017) had a vision of providing equitable access and encompasses principles of community participation, decentralization, gender equality, effective and efficient management, and public and private participation in health care. The SLTHP vision also emphasizes a healthcare system with equitable access and quality services in both rural and urban areas.

The Three-Year Interim Health Plan (2007/8-2009/10) in effect now brings health sector programs into alignment with the new Interim Constitution and with the policy commitments of the post-2006 government.

Under the guidance of these plans and policies, Nepal has made commendable progress in the health sector over the past decades despite formidable geographical and other constraints, such as persistent social and economic inequalities and high rates of poverty. Recent progress has been especially striking. For example, the DHS 2006 shows significant improvement in both the IMR and U5MR, from 64 and 91 per 1000 live births in 2001 to 48 and 61 per thousand live births respectively in 2006. The maternal mortality rate has also come down to 281 per 100,000 live births from 539 per 100,000 live births in 1996. Nepal is on target to meet MDG4 even before 2015 if present trends can be sustained.

However, significant challenges remain. Neo-natal mortality remains a particular challenge. Access to health services is not equitable. About twenty-two percent of the population still doesn't have access to even the basic health care services. Malnutrition is still prevalent, affecting over forty percent children under five. Nepal also faces the emerging threat of human Immunodeficiency Virus (HIV) /Acquired Immunodeficiency Syndrome (AIDS).

A significant level of inequity in health outcomes still exists in Nepal. Life expectancy is 74 years in the capital, but only 44 years in the remote mountainous district of Mugu. The life expectancy of *dalits* (the so-called untouchables of the caste system) wherever they may live, remains far below the national average. Marked differences have been seen in the IMR when the data is disaggregated geographical region, by economic status, and by educational level, as reflected in 2006 NDHS.

The public health sector service infrastructure in Nepal consists of preventive and curative health care facilities from the grassroots to central level: sub-health posts (SHPs), health posts (HPs), Primary Health Centers (PHCs), District hospitals, Zonal and Regional hospitals and Central level specialty hospitals. The public health work force consists of about 28,000 persons distributed across the country, though problems in adequately staffing remote posts persist. A unique feature of Nepal's public health system is that at the community level, in addition to the health workers, there is a strong force of about 50,000 Female Volunteer Health Workers who are providing a number of basic services, and are particularly active in preventive health services. Their role expanding access to basic maternal and child health is considered especially vital.

Over the last few decades there has also been significant growth in the private sector with the establishment of medical colleges, "nursing homes" (private clinics and small to medium size hospitals), and diagnostic imaging and laboratory services in various parts of the country. All these facilities have significantly increased the available services in the country, although real access is inequitable both geographically and by economic status, and the quality of private services also varies significantly. According to Health Management Information System (HMIS) data, currently 78% of people can access a health facility within half an hour travel time.

2.2 Current Political Context and Efforts for Health Development in the New Nepal

Since the People's Movement II of 2006, and the signing of a series of political accords, Nepal has entered a post-conflict period and a period of transitional government. The elections of April, 2008 have created a Constituent Assembly and given a mandate to form a new transitional government to see the country through to the promulgation of a new constitution in 2010. Until that time the Interim Constitution, which enshrines health care as a human right, basic free care as a right of all Nepalis, and reproductive rights for all Nepali women, is the supreme law of the country. To align the health sector with that law, the MoHP has produced its 10 Point Policy Guideline (see 3.1 below) and the current Interim 3 Year Health Plan (see 3.2 below), which will guide the health sector through 2010, the mandated period of the Constituent Assembly. In developing its Policy Guideline and Interim Plan, MoHP has shown a very high level of political commitment toward equitable healthcare delivery, and has moved effectively to create a sustained and sustainable health policy during the transitional period.

The Three Year Plan (2007/8-2009/10), has outlined objectives and strategies to operationalize the Ten Point Policy Guideline, and sets out strategies to implement 'Basic Health Care as a Human Right' as included in the Interim Constitution of Nepal, 2006. The present government has initiated important policies targeted towards increasing access to basic health services by the poor through its universal and targeted free care programs (see • below)

The Three Year Interim Plan has also provided continuity to the ongoing Health Sector Reform Strategy (HSRS) which was a move to take the health sector towards strategic planning and a Sector Wide Approach (SWAp) with eleven development partners supporting MoHP to design and implement the National Health Sector Plan (NHSP-IP) 2004- 2009. The

NHSP –IP has been extended to 2010 to bring it into alignment with the Interim 3 Year Plan and take it through to the end of the transitional period. It has given the highest priority to essential health interventions that will allow Nepal to achieve the MDGs.

While donor resources remain very important, due to the political commitment and policy initiatives of MoHP, the government has also increased investment of its own resource in health. A significant increase to over 7 percent of the national budget took place in 2007/08. However, this amount remains insufficient to meet the constitutional health mandate, and to meet all the health-related MDGs. MoHP is strongly advocating for 10 percent of the national budget to be devoted to health in 2008/09. Compared to other countries, Nepal's per capita health spending still remains low. The most recent National Health Account (2003-2004) shows that 62% of the expenditure comes from “out of pocket expenses “.

These facts indicate that though there is very high level of political commitment for pro-poor and equitable basic health care in Nepal, MoHP remains constrained by inadequate resources for the health sector, and poor people are suffering from the heavy burden of having to spend from out of pocket for their health care. The GON has tried to rectify this inequitable situation by bringing out the Free Health care Policy which needs support from all sectors of the government as well as from the International Development Partners .

In this context, Nepal joined the International Health Partnership as one of the seven countries in the first round of the programme. In keeping with IHP's concept of a national compact, Nepal aims to design and implement a country-led National Health Development Accord with cooperating EDPs, for the intensification of free health care, motivating and enabling the health workforce to scale up health services, and other initiatives in accord with NHSP, the 3 Year Interim Plan, and MoHP's policies. With such an accord in place, it is expected that IHP will act as a strong strategic partnership mechanism for further supporting health sector reform in Nepal through resource mobilization and donor harmonization in accord with the health policies and plans of the Ministry of Health and Population .

2.3 Summary information on current status of health plans and strategies

The remainder of this Stock Taking report provides summary information on the current status of health plans and strategies in the following areas:

- Existing national health policies and strategies, and the broader development context (PRSP, MTEF, etc.) as well as outputs defined in the national plan and level of achievements.
- Health sector reforms and investment plans, with financial requirement for national health plan implementation, and identification of funds available and financing gaps by source.
- Current composition and structure of coordination groups and mechanisms for health and HIV/AIDS, under the lead of the government.
- Summary of current domestic national health sector financing structures and budget by sources.
- Health systems and agency bottlenecks and constraints that have been identified as needing to be removed by inclusion in national plans and review mechanisms.
- Identification of required changes in process relationship with development partners and civil society as per Paris Declaration and Aid Effectiveness.
- Identification of technical assistance needs for preparing the National Health Development Accord [compact] and other sector instruments (e.g. plans, costing, MTEF, and implementation strategies)
- Time table of key events for 2008-9 (sector reviews, major evaluations etc.)
- Revised NHSP-IP Targets and Indicators (Appendix A)

3. Existing National Health Policies and Strategies, and the Broader Development Context

Over the past 17 years Nepal has seen sustained continuity in health policies together with important timely changes, refinements and advances. Some of these, such as the National Health Policy, 1991-2001, and the Second Long Term Health Plan have already been described, while other more recent policies and plans have also been mentioned. In this section the current guiding policy document is first reproduced in full, after which the other core documents guiding policy and programs are described in some detail:

3.1 Ten-point Policy Guideline of the Ministry of Health and Population (2007)

In accord with the spirit and essence of the People's Movement of 2006, the Nepal Government has issued the following policy guideline to direct the activities and conduct of the Ministry of Health and Population and its staff:

1. Expressing our commitment to the universal principle that "health is a fundamental human right", while ensuring that health care is available to all Nepalis, we will continue to give special priority to those persons, genders, castes and ethnic groups, communities and regions that are socio-economically disadvantaged.
2. It is our firm principle that it shall be the main responsibility of the state to deliver all types of health services—preventive, rehabilitative and curative—to socio-economically disadvantaged people. These services will be organized in accord with the principles of the Alma Alta Declaration regarding primary health care. Ayurvedic and other alternative medical systems will be conserved and promoted.
3. The present health budget will be increased to deliver the necessary resources for health care. Steps will be taken to make available to the health sector, as to other social welfare sectors, funds which are cut from the budgets of the royal palace and the army. The budget set aside for the health sector will be utilized in an effective manner, and the international donors will also be encouraged to provide assistance in accord with the essence and spirit of this policy guideline. Administrative and financial corruption and irregularities will not be allowed in the health sector. A reward and punishment policy will be responsibly implemented.
4. Special initiatives will be developed to create a proper working environment for doctors and health workers in rural and remote areas. Their financial advancement and opportunities for advanced study will be ensured. The two-way referral system will be activated.
5. In coordination with the Ministry of Education, universities, and other educational organizations, necessary steps will be taken to fulfill the responsibility of medical education to develop human resources in accord with Nepal's needs, and to involve educational centres in providing medical treatment to the people.
6. To ensure that the private sector is organized in a manner that is responsible toward the people, necessary assistance, policy directives and supervision will be provided. A Health Cooperatives policy that ensures people's participation and ownership will be put into practice.
7. Health work at the district level will be conducted in accord with the concepts of decentralization and an integrated approach. The people will be empowered through health related works by empowering the community health workers. Special steps will be taken to make effective use of the full inner potential of these health workers and volunteer health workers, who form the link between the people and the health facilities.
8. Realizing the integral relationship between health and development, continuous efforts will be made for effective inter-sectoral coordination.

9. The population policy of the nation will be closely linked to the aim of eradicating poverty and hunger.

10. The Ministry of Health and Population will take immediate steps to safeguard the health of those injured in the People's Movement (2006) and the families of those martyred in that movement.

3.2. Three-year Interim Health Plan

The Government of Nepal (GON) has designed a Three-year Interim Health Plan (2007/08 – 2009/10) to carry out development programmes in a planned manner until the new constitution is promulgated and a new elected government formed. The focus of the Plan is to create a foundation for building a country with economic prosperity, good governance, social justice and inclusive development processes, giving priority to reconstruction, rehabilitation and social reintegration, and the reduction of poverty through employment-oriented and inclusive economic growth. The health sector has developed and embraced this agenda, as set out in the Three-year Interim Plan, in line with the overall national agenda for development.

Objectives of the Three Year Interim Health Plan

1. Provide equal opportunity for health development to all with special emphasis on equity for the socially disadvantaged, the poor, women, and disabled people as per the provision of 'free basic health as a fundamental human right' as set out in the Interim Constitution of Nepal, 2063 vs. (2006).
2. Strengthen ongoing high priority EHCS and achieve MDGs in accordance with the principles of primary health care, equity and social justice.
3. Redesign the health system to make it people-oriented, efficient and effective through reform in institutional management and health professional education.
4. Ensure availability of good quality essential drugs to all at affordable prices through well-regulated pharmacy services.
5. Strengthen Public-Private Partnership in a manner that strengthens the overall public health system.
6. Improve hospital services and referrals through integrated management of the district health system.
7. Initiate important services such as urban healthcare focused programs, and targeted healthcare for the elderly which are not currently included in EHCS.
8. Promote health research and health research systems.
9. Further develop Ayurvedic and other alternative systems of medicine.
10. Align population policies and programs with the goal of poverty eradication.

Targets of the Three Year Interim Health Plan

S.N	Health Indicators	Situation up to 2006	Target till 2010
1	Access to Essential Health Care Service (%)	78.83**	90.0
2	Availability of Essential drugs in Health Institution (%)	93.3**	95.0
3	Women making 4 antenatal care visit (%)	29.4*	40.0
4	15-49 age group women receiving TT injection	63.0*	75.0
5	Delivery from health worker (%)	19.0*	35.0
6	Current user of Contraceptive (%)	44.2*	53.0
7	Use of Condom (14-35 years) (%)	77.0*	85.0
8	Total Fertility Rate (15-49 year women) (%)	3.1*	3.0
9	Neonatal Mortality Rate(Per 1000 live birth)	33.0**	31.0
10	Infant Mortality Rate(Per 1000 live birth)	48.0*	44.0
11	Maternal Mortality Rate (per 100000 live birth)	281.0*	270.0
12	Child Mortality Rate (Under-five) (per 1,000 live birth)	61.0*	55.0
12	Knowledge of Women (15-49) on ways to avoid AIDS (%)	65.0*	75.0

** DHS/MoHP

* NDHS. 2006

3.3. Policy on Free Essential Health Care Services

As per the spirit of the People's Movement of 2006 and the provisions of the Interim Constitution of Nepal, 2063 (2007), in which basic health care is defined as a fundamental right of the citizen, the Government of Nepal has taken the following decisions to provide free health care services.

On December 15, 2006 (2063-8-29), through a Cabinet decision, the Government of Nepal decided to provide the essential health care services (emergency and inpatient services) free of cost to poor, destitute, underserved, elderly, people living with physical and psychological disabilities, and women volunteers known as Female Community Health Volunteers (FCHVs) at district hospitals and Primary Health Care Centres. Through the same decision, outpatient care was also made free in 35 low HDI districts.

On October 7, 2007 (2064-6-21), through another Cabinet decision, the Government of Nepal decided to provide the essential health care services free of cost to all (universal free) at the health post and sub-health post levels.

MoHP is currently advocating for sufficient funds to implement universal free basic care at the PHC and District Hospital levels in 2008/09. According to current MoHP estimates, a relatively small investment from Pooled Funds or another suitable EDP source could cover the gap between possible government expenditure and the cost of this important expansion of services.

3.4 Nepal Health Sector Program- Implementation Plan

The Health Sector Reform Strategy: An Agenda for Change (2004) has set three program outputs and five sector management outputs. Nepal Health Sector Programme – Implementation Plan (NHSP-IP), (2007/08 – 09/10), prepared as per the provisions of *The Health Sector Reform Strategy: An Agenda for Change* (2004) facilitates implementation of the "Sector-Wide Approach (SWAp) which has been followed in Nepal since 2004.

The Nepal Health Sector Program (NHSP) is led by the Ministry of Health and Population (MOHP) and supported by 11 External Development Partners (EDP), who are signatories to a Statement of Intent to guide the partnership for health sector development in Nepal. DFID and the World Bank are pooled financiers. The other EDPs use parallel financing mechanisms under the umbrella of the NHSP-IP, based on a jointly developed Health Sector Strategy.

Overview of NHSP-IP:

NHSP-IP:

Goal	Achievement of the health sector Millennium Development Goals in Nepal with improved health outcomes for the poor and those living in remote areas and a consequent reduction in poverty
Purpose	To improve the health status of people 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, decentralization, 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.
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.
	2. Decentralization Local bodies are responsible and capable of managing health facilities in a participative, accountable, and transparent way with effective support from the MoHP and its sector partners.
	3. Private/NGO Sector Development The role of private sector and NGOs in delivering health services is recognized and developed with participative representation at all levels to ensure consumers have access to cost effective, high-quality services that offer value for money.
	4. Sector Management 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
	5. Health Financing and Resource Allocation Health financing resource management: Sustainable development of health financing and resource allocation across the whole sector including alternative financing schemes in place.
	6. Physical Assets and Procurement 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
	7. Human Resource Policy and Management Clear and effective HRD policies, planning systems, and programs developed and functional
	8. Integrated MIS and QA 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

The mid-term review of the NHSP-IP (NHSP, 2007, Progress Status Report, 6th JAR) found the overall progress achieved satisfactory, and also found that many of the targets of NHSP-IP had already been achieved by 2006. In order to give continuity to and complete the entire

NHSP-IP agenda, it has been agreed to extend the timeframe from 2009 to 2010. Alignment of NHSP-IP indicators with those of the Three-year Interim Health Plan has also been completed and is presented in the revised log-frame of NHSP-IP (Appendix1).

NHSP Targets and Achievements

Indicators	Targets 2006	Targets 2009	Achievements (Demographic and Health Survey, 2006)
Maternal mortality ratio	325	300	280/100,000 live births
Child mortality rate	70	65	61/1000 live births
Infant mortality rate	50	45	48/live births
Total fertility rate	3.8	3.5	3.1/women
Contraceptive prevalence rate	43%	50%	44% modern method 48% any method
Skilled birth attendance	22%	35%	22.45 -HMIS
Child Immunization-DPT3	78%	85%	85%
HIV knowledge		75% women 85% men	58% women 82% men

4. Health Sector Reforms and Investment Plans

(with financial requirements for national health plan implementation, and identification of funds available and financing gaps by source)

The new free health care policy adopted by the government demands an increased budget. MoHP has requested 10% of the total national budget for 2008/09 to meet its constitutionally mandated responsibilities to the people. Preliminary costing for universal free care at the PHC and District Hospital levels indicates a relatively small gap between possible government commitments and the total required for implementation.

A Financial Management Improvement Plan has been prepared and implemented.

A Procurement Law has been enforced from this year (2064/5 - 2008) that has made mandatory provisions for the preparation, implementation and monitoring of procurement plans.

4.1. Investment plans – MTEF and resource gaps

	2007/08			2008/0			2009/10		
	Govt	Donor	Total	Govt	Donor	Total	Govt	Donor	Total
Free essential health care services	30000.0	0.0	30000.0	725000.0	725000.0	1450000.0	904800.0	835200.0	1740000.0
MDGs related programme	2627681.0	4471602.0	7099283.0	4121922.8	5018652.5	9140575.3	5215632.0	7073914.3	12289546.3
Essential drugs	226054.0	1193055.0	1419109.0	114384.3	1700971.5	1815355.8	21001.3	2088714.4	2109715.7
Public Private Partnership	31200.0	0.0	31200.0	37215.0	0.0	37215.0	44399.3	0.0	44399.3
Integrated Management of District Health System.	2204236.0	0.0	2204236.0	2637883.2	1816140.0	4454023.2	3289391.7	255826.0	3545217.7
School health, urban health, oral health and mental health			0.0	153750.0	153750.0	307500.0	353250.0	169560.0	522810.0
Health Research Systems	4000.0	15000.0	19000.0	3300.0	19500.0	22800.0	2985.0	24375.0	27360.0
Ayurvedic and other alternative systems of Medicine	251613.2	40000.0	291613.2	293340.1	52000.0	345340.1	335754.0	65000.0	400754.0
Population programme	8608.0	1800.0	10408.0	10339.6	2160.0	12499.6	12143.5	2700.0	14843.5
Secondary and tertiary care hospitals	535530.0	485000.0	1020530.0	569676.0	356000.0	925676.0	511321.2	445000.0	956321.2
Total available	5918922.2	6183498.0	12102420.2	8666811.0	9844174.0	18510985.0	10690678.0	10960289.7	21650967.7
<i>Share</i>	<i>48.91</i>	<i>51.09</i>	<i>100.00</i>	<i>46.82</i>	<i>53.18</i>	<i>100.00</i>	<i>49.38</i>	<i>50.62</i>	<i>100.00</i>

Funding gap

	2007/08	2008/09	2009/10
Total budget requirement	12102420.2	18510985.0	21650967.7
USD	189100.3	289234.1	338296.4
Total commitment	10283795.6	14253458.2	16238225.8
USD	160684.3	222710.3	253722.3
Gap	1818624.6	4257526.8	5412741.9
USD	28416.0	66523.9	84574.1
Gap %	15.0	23.0	25.0

5. Current composition and structure of coordination groups and mechanisms for health and HIV/AIDS, under the lead of the government

MoHP has created a number of coordination groups and mechanisms to advance intra-health sector coordination within the government, between government and the private sector, and between government and EDPs, as well as necessary inter-sectoral governmental coordination. Some of the main bodies are the following:

High Level Advisory Committee: A technical assistance committee comprised of seniormost health professionals encompassing a wide range of sub-specialties, country-wide administrative and practical experience, and senior administrative experience at the central level. To advise the Minister and his senior staff, on request, on matters of policy and effective plan design and implementation.

EDP Forum: A small forum bringing together senior MoHP officials and the health officers of primary EDPs on a regular basis to ensure increased coordination and the alignment of EDP plans and programs with the policies of MoHP.

HIV/AIDS Control Board: A Semi-autonomous body created by the government to oversee, coordinate and administer funded initiatives in the HIV/AIDS sector. MoHP is actively working to develop this body into the PR for Global Fund financed HIV/AIDS work.

Inter-sectoral coordination mechanisms such as: Coordination with the Ministry Of Agriculture for prevention of Avian Influenza; coordination with the Ministry of Education on medical education; coordination with CTEVT; coordination with the Ministry of Industry & Commerce regarding the WTO, etc.

6. Summary of Current Domestic National Health Sector Financing Strategies and Structures

6.1 Health Financing Strategies

Policies governing health care financing have been covered in the Second Long-Term Health Plan (1997-2017). Sustainable development of health financing and resource allocation across the whole sector including putting in place an alternative financing scheme is one the sector management outputs addressing health care financing.

The current financing strategies are:

The government will allot a higher proportion of resources to make essential health Care Services (EHCS) available free or at subsidized cost in all levels, while also meeting the state's responsibility for providing secondary and tertiary care for needy population.

Alternative financing arrangements will be promoted, in particular for referral hospital and specialty care. However, appropriate mechanisms will be developed and tested for public sector financing of a safety net for the poor to access these services and to deal with catastrophic illness.

The Government has permitted the central, regional and zonal hospitals to charge user fees from well-off patients while providing subsidized or free care to the poor.

MOHP will investigate the viability and suitability of various alternative financing schemes such as community and social health insurance schemes in order to develop means to supplement the government health sector financing sources.

The drug financing mechanisms will be made consistent with universal and targeted free care policy of MOHP. The Community Drug Program (CDP) will be adapted according to the spirit of the interim constitution of Nepal.

6.2. Financing Structure

Health Sector Annual Budget (2007-2008)

An unprecedented growth in the health budget was achieved in 2007-8. The health budget as a percentage of the national budget increased from 6.4% in 2006-07 to 7.2% in 2007-08. The health budget increased by 31.1% in fiscal year 2007-8 to cover the scaling up of the existing programmes and provisions of new programmes and initiatives such as free medical care, maternity incentives schemes and construction of health facilities. While the national budget increased by 17.4 percent overall, the health budget increased by 31.1 percent due to the policy commitment of the MoHP and advocacy and lobbying efforts made by all concerned institutions.

Budget by Sources

The crucial issue of financing health services received the attention of the Government of Nepal in this fiscal year. The government fund increased 31 percent (from NRs. 4.51 in 2006-07 to 5.92 billion in 2007-08). This indicates the higher level commitment of the government in health care. Donor funding also increased from NRs. 4.71 billion in 2006-07 to 6.18 billion in 2007-08, a 31 percent increase. In fiscal year 2008-2009, the health budget is expected to increase further, as MoHP continues to work toward its NHSP-IP and Three-year Interim Plan targets, and the MDG goals.

Budget by Sources

Sources	2006-07		2007-08		Growth
	Share	Amount	Share	Amount	
GON	4.52	48.93	5.92	48.89	30.98
Donors	4.71	51.07	6.18	51.11	31.17
Total	9.23	100.00	12.10	100.00	31.08

Source: Ministry of Finance, 2007

The Ministry of Health and Population has encouraged External Development Partners (EDPs) to provide necessary assistance in line with NHSP- IP 2004-09 and the 10 Point Policy Guideline of MoHP. Nepal has been practicing the sector wide approach in health sector with pooled fund, and demonstrated increased government leadership and ownership. The pooled fund has been established with the assistance of the World Bank (IDA) and other bilateral and multilateral agencies and some of these are supporting it on a project basis but in the spirit of harmonization. In addition to significant pooled funding, DfID and WB (IDA) funds are available on a project basis as well, representing 3.51 and 2.31 percent respectively. Additionally, the World Bank (IDA) contributed NRs. 279 million for Avian Flu control and prevention and DfID contributed NRs. 4.25 million for safe motherhood and HIV/AIDS control and prevention. The share of Global Fund (GFATM and GAVI) financing is over 5.54 percent. Funds from WHO, UNICEF, and UNFPA account for 1.78, 2.9 and 0.39 percent respectively.

7. Health systems and agency bottlenecks and constraints that have already been identified as needing to be removed by inclusion in national plans and review mechanisms

Difficult and varied geographical terrain, from hot humid plains to high mountainous environments, over 100 ethnic groups and languages, many dialects and numerous religions are some of the features which characterize Nepal's diversity. Some of these differences present access challenges, whether geographical or cultural. One also finds inequitable distribution of health services in Nepal by geographical location. A history of systematic discrimination along ethnic and caste lines in the provision of state resources has also produced disparate outcomes in health as in other sectors (such as education). Despite a new level of political commitment to ending such discrimination, there remain significant

differences in mortality and health status, literacy, HDI, etc. among various caste, gender and ethnic groups. (NDHS 2006-2007)

In addition, there are several managerial weakness and challenges affecting the health system which contribute to inequitable health outcomes. Some important weaknesses include problems in the deployment and retention of healthworkers (particularly in remote regions), slow and inadequate decentralization, problems in supply and maintenance of equipment and physical infrastructure, unresponsive attitude of health provider to client needs and, last but not least, outdated and rigid rules and regulations which affect program implementation.

Though the resources for health have been increasing over the last few years, the available resources from the public sector remain inadequate to provide equitable access even to basic health service for all the people of Nepal.

The commission on Macroeconomics and Health recommends 24-34 dollars per capita health spending for developing countries. However the estimated health spending in Nepal is around 14 dollars. Out of the 14 dollars it is estimated that only around 7 dollars is spent from the public sector, while the rest is out of pocket expenses. The government as well as donor investment has been inequitable and inadequate to provide even EHCS to all.

In addition, increased demand on the health system due to epidemiological transition, conflict, increasing injuries and road traffic accidents, and, rising expectations of the people are some of the challenges which the health system of Nepal faces at the moment.

8. Identification of required changes in process relationship with development partners and civil society in order to prepare Paris Declaration and Aid Effectiveness

8.1. Existing partnership practices

NHSP-IP serves as an operational guideline for sector-wide planning, budgeting, management and monitoring for reaching the goals of the Health Sector Strategy. MOHP and EDPs have agreed to work together under a shared vision and on agreed-upon priorities. The EDPs will ensure that all the assistance made by them to the health sector will be consistent with the priorities of the new orientation in Nepal's health policy, as reflected in the Interim Constitution, 10 Point Policy Guideline and Three-year Interim Health Plan. Similarly, EDPs will harmonize their support in annual planning, joint reviews and reporting and they will maintain a climate of transparency and accountability and will share relevant information with all partners to facilitate their contributions to health sector development so as to strengthen the health system.

With the participation of all the partners, the MOHP conducts a joint review every six months (November and June). The review focuses on planning in June and programme review in November, to provide an ongoing assessment of the performance of the health sector. All the relevant development partners together with the health sector officials analyse and assess the progress made during the year and later develop an Aide Memoire for the next fiscal year in consultation with the MOHP. Partners prepare their organisational plans based on the government health sector plan. In the changed context, a recent Joint annual review meeting and the mid-term review of NHSP-IP suggested alignment of NHSP targets and indicators with those of Three Year Plan which has already been accomplished.

8.2 Time table of key events for 2008-9

Key events	Time frame
Preparation of National Health Development Accord (national compact)	Feb-Oct 2008
Creation of stakeholders' forums for health sector policy dialogue at national, regional and district level (GON, civil society and private sector).	Feb 2008 – March 2009
Development of coordination among the concerned ministries, universities and institutions and private sector to introduce appropriate skill mix.	Mar-July 2008
Building coordination capacity of MOHP, Regional Health Directorates, District Health Offices/ District Public Health Offices (DHO/DPHO), hospitals, civil society and Health Management Committees.	Apr-Nov 2008
Strengthening the newly adopted ministerial level sector co-ordination mechanism	Feb 2008 – March 2009
Conducting studies: To introduce local governance service systems in health sector to introduce subsidiary principles in health service delivery To examine role of Community Drug Programme after introduction of Free Care Policy To Conduct rapid assessment on implementation of free health care provisions all over the country To develop scaling-up strategy for free health services leading to universal health care To document learning form emerging experiences in universal free health care To examine existing facility usage and distribution together with road networks, and actual travel patterns of the population in order to provide a sound basis for revising the referral system and for determining location for upgrading and building of new facilities.	May-Nov 2008i
Updating National Health Policy and Health Sector Plan and Programmes	Mar 2008 to Feb 2009
Providing critical HR to critical locations for short-term deployment for uninterrupted service delivery owing country's overall transition context	June 2008 – March 2009
Introducing health work force motivation schemes in remote districts for the retention of staff in such areas.	Apr 2008 – March 2009
Organisational re-engineering of MOHP and capacity development.	Apr-Oct 2008
Implementing the performance based management system for organisational effectiveness.	July 2008 – March 2009
Providing piloting support to backup MOHP-initiated monitoring networks to make it functional down to the village level	Apr 2008 – March 2009

9. Conclusion

Despite its difficult terrain, significant socio-economic constraints, and a long period of conflict, Nepal is on track for MDG4 and impressive developments have been achieved in MDG5 and MDG6. With the support of global initiatives like IHP+, it is expected that Nepal's efforts to ensure basic health care as a fundamental right of Nepali citizens will continue to make steady and substantial progress.

Appendix: 1

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

Revised Log-Frame 8 June 2008

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Assumptions
<p>Goal</p> <p>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.</p>	<p>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) 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</p> <p>By the end of July 2010: Total Fertility Rate reduced from 3.1 to 3.0</p> <p>Maternal mortality ratio reduced from 281 per 100,000 live births to 270 ANC visits increased (at least one visit and at least 4 visits)</p> <p>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 Proportion of government budget allocated to health sector increased to 10%</p>	<p>Nepal Demographic Health Survey (NDHS) National Livelihoods Survey and Poverty Monitoring and Analysis System (PMAS) Other poverty related surveys developed under GON</p>	<p>Political Stability Economic growth continues NDHS 2011 to measure 2010 targets</p>

Purpose			
<p>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"</p>	<p>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 35% At least 53% Modern Contraceptive Prevalence and 35% for lowest quintile 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 age five) 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) Young female (15-24 years) knowledge about HIV/AIDS increases from 27% to 50% Underweight children under five years of age reduced from 39% to 34% Share of public expenditures increased from 17% in 2001—03 to 22% and out-of-pocket expenditures decreased from 62% in 2001 to 55%</p>	<p>NDHS National Household Survey National Livelihoods Survey Other poverty-related surveys developed by GON PMAS</p>	<p>Strong political commitment Health continues as a GON priority Health budget will continue to increase EDPs' contributions continue to increase</p>
Outputs			
<p>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.</p>	<p>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</p>	<p>HMIS/DHS Monitoring survey report</p>	<p>Peace continues and programme can be implemented as planned</p>

	<p>1.5 Facility-based safe abortion services available in all districts</p> <p>1.6. 25% of deliveries are in facilities, 10% from lowest income quintile</p> <p>1.7. 25% increase in total number of clients attending health and sub-health posts</p> <p>1.8. 100% of poor and destitute clients attended by social service staff</p> <p>1.9. 50% of health facilities providing quality STI services</p> <p>1.10. Facility-level quality improvement system in place in 50% of facilities by 2010</p>		

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:

	<p>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</p> <p>2.2. At least 30% of districts with five-year plans hire staff to fill vacant positions at facilities and offices</p> <p>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</p>	HMIS	Local bodies functional
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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

	<p>3.2. State—non-state policy and strategy prepared</p> <p>3.3. At least 3 state—non-state models piloted and evaluated by</p>	HMIS DOS Annual Report	Partners willing to cooperate
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	2009		
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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

	<p>4.2. Ayurveda and alternative medical section in MoHP and Ayurveda units in 5 RHDs fully staffed by 2008/09</p> <p>4.3. National Ayurveda Academy established by 2009</p> <p>4.4. Ayurveda drug and medicinal plant policy formulated and programmes initiated for documentation, IPR protection, development and utilization by 2010</p> <p>4.5. PB, inclusive of district, EDP, and civil society participation by 2009</p> <p>4.6. Output-based AWPB initiated in 2008 and implemented by 2010 reflecting all known resources</p> <p>4.7. End-year JAR combined with the MoHP regional and national review meetings by 2009</p> <p>4.8. Nepal Health Sector Strategy II and NHSP II prepared by a participatory process in 2009 for implementation</p> <p>4.9. IHP accord finalized and signed by 31 July, 2008</p>	HMIS/DHS MOHP Annual report	Harmonisation pursued by all partners.
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5. Health financing resource management: Sustainable development of health financing and resource allocation across the whole sector including alternative financing schemes in place

	<p>5.2. CDP and CHI redesigned in compliance with free health care policy by 2008</p> <p>5.3. Costing and budgeting of free care options for district facilities and below by 2008/09</p> <p>5.4. Study on AHF started in 2008</p>	<p>HMIS/DHS MOHP Annual Report</p> <p>DOHS Annual Report</p>	Government priority on health sector continues.
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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. Stock outs of essential drugs decreased based on tracer drugs list by 2010

	<p>6.2. National institutional pricing established for District-level procurement initiated 2008 and implemented by 2009</p> <p>6.3. "Pull system" operating in 9 Districts in 2008 increased to 50 Districts and training completed by 2010</p> <p>6.4. Essential drugs procured annually or more frequently by 25 Districts by 2010</p> <p>6.5. Essential drugs available in 95% of designated health facilities by 2010</p> <p>6.6. 20% of total construction budget of FY 2008/09 and 2009/10 spent on building maintenance following the building maintenance plan</p> <p>6.7. 1,000 sub-health posts upgraded to health posts by 2010</p> <p>6.8. Two regional Ayurveda hospitals, 90 Ayurveda dispensaries and 2 natural medicines centres established by 2010</p> <p>6.9. Plans for management of health care waste developed and implemented in 2008</p>	<p>MOHP Annual Report HMIS/DHS DOHA Annual Report</p>	
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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

	<p>7.2. At least 40% of health facilities (District and PHCC) fully staffed by SBAs (with skill mix, both number and types by 2010</p> <p>7.3. Incentive package for doctors, nurses, paramedics, especially for remote areas designed in 2008 and implemented by 2009</p> <p>7.4. Production of MDGP, DA, DGO, DCH and DCP for strengthening 30 district hospitals started from 2009</p> <p>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</p>	<p>HMIS/DHS DOHS Annual Report MOHP Annual Report</p>	<p>Role shift accepted by all.</p>
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	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		

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	HMIS/DHS	Appropriate skills mix of MOHP management
	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		

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