NEPAL COUNTRY REPORT

An assessment of the political economy factors that shape the prioritisation and allocation of resources for essential health services for women and children

Ian Anderson, David Hipgrave and Midori Sato
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Cover Picture
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Acronyms

ADB  Asian Development Bank
ANC  Antenatal Care
CA  Constituent Assembly
CPR  Contraceptive Prevalence Rate
DFID  Department for International Development (UK)
DFAT  Department of Foreign Affairs and Trade (Australia)
DHS  Demographic and Health Survey
EBPB  Evidence-based Planning and Budgeting
EDP  External Development Partners
EHCS  Essential Health Care Services
EPI  Expanded Programme on Immunization
GESI  Gender Equality and Social Inclusion
GIZ  Gesellschaft für Internationale Zusammenarbeit (GIZ)
HDR  Human Development Report
HMIS  Health Management Information System
JAR  Joint Annual Review
MOHP  Ministry of Health and Population
MMR  Maternal Mortality Ratio
MDGs  Millennium Development Goals
NCDs  Non-Communicable Diseases
NGO  Non-Governmental Organisation
NHSIP-IP  Nepal Health Sector Program Implementation Plan
NPC  National Planning Commission
ODA  Official Development Assistance
OOPE  Out of Pocket Expenditure
PEA  Political Economy Analysis
PPP  Purchasing Power Parity
RMNCH  Reproductive, Maternal, Neonatal and Child Health
SWAP  Sector Wide Approach
TFR  Total Fertility Rate
THE  Total Health Expenditure
UNICEF  United Nations Children’s Fund
UNDAF  United Nations Development Assistance Framework
USAID  United States Agency for International Development
UHC  Universal Health Coverage
VAT  Value Added Tax
VDC  Village Development Committee
WB  World Bank
WHO  World Health Organization

Currencies and exchange rates

All $ are current United States dollars unless otherwise specified.
1 Nepalese Rupee = $US 0.0100756 in November 2014
$US 1 = 99.25 NPR in November 2014

1 Executive summary

Background and methodology

How countries prioritise, plan, allocate, and use their own financial, human and natural resources has become increasingly important in international development. Moreover, the majority of the world’s poor now live in middle income countries that already have the means to promote growth and reduce poverty. As development funding decreases as a share of total public investment, development partners increasingly understand that effective, strategic and durable assistance should help developing countries use their own resources better. The ‘country-driven development’ vision of the Paris Declaration and Accra Agenda for Action points unmistakably to the importance of national planning and budgeting. However, decisions on the allocation of scarce resources are rarely made purely on the basis of technical criteria: political and other factors also shape decision-makers’ choices. It is therefore important for development partners to also understand how and why governments in developing countries prioritise and allocate their own resources (as well as those of development partners).

Since 2011, the Australian Government has been providing development assistance to improve reproductive, maternal, newborn and child health (RMNCH) outcomes in Bangladesh, Indonesia, the Philippines and Nepal. The approach focuses on improved use of local data in the prioritisation, planning and allocation of resources at district level. The main objective has been to develop, through district-level pilots, an ‘investment case’ to encourage sub-national governments to fund RMNCH as a key area of human development. Australian aid funding was channelled through UNICEF and other partners working with governments at national and district level in each country. To deepen its understanding of the political economy of health and RMNCH in these four countries, UNICEF undertook a related analysis during July-September 2014. A mixed methodology was used, drawing on expert recommendations from academia and development experts. A questionnaire was developed based on a review of the relevant peer-reviewed and grey literature. Local data was gathered and interviews conducted in-country. This report provides the findings for Nepal.

Situation analysis of Nepal

Nepal has achieved some dramatic and rapid improvements in RMNCH outcomes despite being a low income country with high levels of poverty, difficult geography, and conflict. It has already achieved the Millennium Development Goal (MDG) target on reducing maternal mortality by three quarters between 1990 and 2015. Reductions in fertility and public health interventions including the National Safe Motherhood Program have helped Nepal to rapidly reduce its maternal mortality ratio (MMR) from 850 maternal deaths per 100,000 live births in 1990 to just 281 in 2006. Nepal is also “on track” to achieve its child mortality targets before 2015. Indeed, the Malaria target of a under-five mortality rate (USMR) of 54 per 1,000 live births was achieved in 2011. As a result a new, more ambitious target of 38/1000 has been set. Similarly, a more ambitious infant mortality rate target has been set of 32/1000. Social capital in the form of a strong community-based volunteer movement, supported by development partners and an acquiescent government during conflict, helped to introduce evidence-based interventions such as Vitamin A supplementation to the poorest communities. Removal of user fees (including transport costs) and provision of free health care to users also contributed to an increase in access to essential care for RMNCH.

However, Nepal faces important challenges in terms of RMNCH and in the health sector more broadly. Under-nutrition and newborn deaths have been slower to improve. There are still important inequalities in terms of access to services and RMNCH outcomes, including between rural and urban areas. Non-communicable diseases, putting increasing pressures on household and government budgets. Universal Health Coverage (UHC) is needed to help further reduce out of pocket expenditures and expand access to essential services, but even expanding UHC involves significant policy, managerial, regulatory and financial challenges.

The political economy of the health sector and RMNCH in Nepal

Nepal has had a long, turbulent, political history which includes feudalism, monarchy, Maoist rebellion, and post-conflict democracy. The cessation of internal conflict, combined with poverty and important health challenges, has attracted strong technical and financial support from development partners.

The priorities and political importance attached to health are reflected in government decisions about health financing. As a low income country, Nepal has low absolute levels of health expenditure: just $35.8 per person in 2012. Given the high level of out of pocket expenditure, the government sector contributes less than a quarter of total health spending (23.7%). High levels of out of pocket expenditure act as a barrier to essential health care for the poor, and a source of impoverishment for many. On the other hand, Nepal does relatively well compared to other comparable countries on some other measures. For example Nepal Government of Nepal –
supported by development partners – allocated 10.4% of total government expenditure to the health sector in 2012. This is a measurably higher share than low income countries globally (8.8%) or South Asia regionally (8.7%) and strongly suggests a political commitment to the health sector.

Planning and priority setting is highly centralised in Kathmandu, despite some ‘bottom up’ local initiatives. Financial planning is complex, rigid, and centralised. There are an estimated 166 fixed budget lines, with little opportunity for reallocation between line items to meet emerging priorities. Interviews conducted during this analysis revealed that important priorities appeared with little advance notice or consultation, despite having major financial and resource implications. Important decisions about scaling up UHC were made in the budget but – again according to interviewees – did not involve detailed prior consultations with stakeholders (including development partners). Efforts at decentralisation, including the 1999 Local Self Government Act, have only been partially successful. The private sector is often overlooked in planning and priority setting, and the quality of private sector healthcare is not known, monitored or regulated in any systematic way.

The production, distribution and quality of human resources for health is key to the effective and efficient functioning of a health system. However, health worker promotions and placements in Nepal are the subject of patronage and power. Volunteer community associations have achieved significant outcomes in rural settings by being outside of that system.

Remittances from overseas Nepalese workers are a dominant part of the Nepal economy, and totalled $4.9 billion in 2013, more than 25% of GDP and exceeding both foreign aid and foreign direct investment by a considerable margin. Remittances significantly help to increase consumption – including for expenditure on RMNCH and other health needs – and reduce poverty. But remittances carry some economic, social and health outcome risks as well.

Analysis, summary and recommendations

This analysis yielded eight key findings. The first and most important is to recognise that Nepal’s recent political history has been has particularly turbulent; it is still addressing key issues that get to the very heart of what makes a modern nation state. A second key finding is that while there are promising developments in government planning and priority setting, much more needs to be done, especially if Nepal is to achieve UHC. Third, there are major challenges in the process of health financing, programming and budgeting. Fourth, there are important challenges in making UHC equitable and financially sustainable. Fifth, the relationship between government and the non-government/private sector in Nepal is very complex, again creating challenges for UHC. Sixth, there are challenges for development partners, with tensions and trade-offs between their role and need to achieve impact and “results” versus their influence on systems and institutional sustainability. A seventh finding is that overseas remittances have benefit and disadvantages with respect to poverty reduction, expenditure on RMNCH and health and reducing inequality. The last key finding, potentially affecting the future political economy of RMNCH in Nepal is the rise of NCDs, which will generate new and different challenges in terms of prioritisation, planning, resource allocation and healthcare services systems. Finally, reliable ‘evidence’ is difficult to obtain in Nepal, but its generation and presentation to the public and to development partners is particularly important as the nation emerges politically and economically, and as its health sector evolves.

Given this analysis, this report makes two very specific recommendations relevant to development partners. First, given Nepal’s turbulent political history, and current complex environment, development partners should not view interventions through a purely technical lens. Key aspects of the functioning of the state, including the form of the Constitution and the transition to a federal structure remain unresolved. Development partners in Nepal need to be fully aware of this troubled and complex situation, and that their assistance will not yield rapid results. They should use their technical expertise and bureaucratic political capital to explain to their own stakeholders the risks of short-termism and ‘announcables’, and commit to long term support.

Second, development partners can have an important role to play in moving away from traditional stand alone “projects” to helping make UHC effective, efficient, equitable, affordable and accountable at national level in the context of Nepal. All political parties in Nepal have committed to some form of health insurance: the challenge is to make UHC financially sustainable. This will require more ‘upstream’ dialogue about the design and implementation of UHC, as it is progressively rolled out. There will be good opportunities to support the design of Nepal’s health sector with a view to UHC, and also to conduct impact evaluation on what works, for whom, at what cost and under what circumstances. Development partners can be helpful in providing financial and technical support in these areas.
2 Background

Nepal offers an intriguing case study of the challenges of meeting development and public health goals in post-conflict countries. According to Claude Bruderlein, Director of the Humanitarian Policy and Conflict Research Center at Harvard University, “Nepal is not a standard case. In order to understand public health in Nepal it is important to stay above the cynical view of Nepal as a failed state and below the development discourse of the New Nepal. The truth is somewhere in between. The case of Nepal illustrates how political legacies and social forces mould the public health agenda. Most importantly, it shows that health is a transformative political issue and a cornerstone to successful peace building.”

2.1 Context

Social and economic development processes involve much more than technocratic approaches: “political economy” factors usually determine the fate of reforms. This finding is clear from the international literature (3-14). More specifically, how – and why – governments make and implement decisions; prioritise the allocation of scarce financial and human resources; resolve trade-offs; regulate the private sector; achieve accountability; and interact with civil society and development partners is an essential key to understanding the process of international development. Understanding how governments use – or don’t use – evidence to shape policies and prioritise the use of their own scarce resources is increasingly important. That is particularly true as more and more countries achieve middle income status1, albeit with large burdens of poverty (15) and aid programs become progressively smaller. The impact of political economy factors is particularly important to understand in post conflict situations (or “fragile” situations) as in the case of Nepal. That is because conflict directly affects health and RMNCH outcomes through the disruption of basic service delivery, and indirectly through disruption to economic growth. On the other hand, governments that effectively – and visibly – deliver essential health and other services can strengthen their political legitimacy (16-20).

Development partners need to increasingly understand the political economy of decision making and resource allocation if they are to have impact. Traditional forms of Overseas Development Assistance (ODA) have become relatively less important in much of Asia as those economies expand and some development partners withdraw. For example, total ODA in all sectors now constitutes less than one per cent of government expenditure in Indonesia. While ODA can be helpful and catalytic in supporting reforms, the key to improved outcomes will be how countries prioritise and use their own resources. The ‘country-driven development’ vision of the Paris Declaration and Accra Agenda for Action further point unmistakably to the importance of national planning and budgeting, however uncomfortable that may be for development partners increasingly seeking visibility, “quick wins” and avoidance of corruption from their own aid dollar. Development partners have their own political economy incentives and drivers. Those partners wishing to support more evidence-based priorities and resource allocation decisions by developing country governments must identify more sophisticated – but legitimate – entry points of influence.

Understanding the political economy of Reproductive, Maternal, Newborn and Child Health (RMNCH) is a particularly important issue. That is partly because there remains a large but preventable RMNCH burden globally, including in Asia and the Pacific: 2.5 million children under five died in this region in 2013, 41% of the global burden (21). Understanding the political economy of RMNCH is also important because proven, affordable, interventions that dramatically improve RMNCH outcomes have been successfully implemented at scale in some low income Asian countries decades ago (22). Yet if the scientific evidence base, cost-effectiveness and affordability for improving RMNCH have been so clear, for so long, why have so many countries failed to invest accordingly? Why, despite the political commitments and rhetoric, do several countries in Asia have the lowest absolute and relative levels of government expenditure going to health, and especially RMNCH? How can RMNCH be prioritised and resource allocated in countries where evidence demonstrates a political and economic decision making to sub-national districts and even to villages? Political economy analysis can help provide insights into these issues for the benefit of governments and their development partners.

This report builds on recent collaborative work between Australia and UNICEF aimed at improving the evidence base for investment decisions for RMNCH in Asia. More specifically, the Australian Government’s Aid program2 has been funding an initiative – known as the Investment Case Approach – in Bangladesh, Indonesia, Philippines and Nepal since June 2011. Led by UNICEF and its partners, the goal has been to demonstrate a new and innovative approach for securing the political support that enables policymakers and planners to: 1) assess the extent to which RMNCH services are equitably distributed, using locally gathered data; 2) identify the constraints hampering the scale-up of effective interventions that affect RMNCH; 3) design realistic strategies to address those constraints and 4) estimate the expected mortality and morbidity impact and costs associated with implementing the strategies proposed. The approach sought to influence national policymakers and other stakeholders, including development partners, by highlighting financing gaps within national health systems and in specific geographic areas, as well as gaps in governance of the health sector. By “proposing strategies on improving the evidence base for sub-national planning and budgeting. That is because some of the greatest RMNCH needs occur in geographically and economically disadvantaged areas, where the evidence and capacity for good decision making is weakest.

UNICEF commissioned this report to better understand the political economy of decision making in Nepal, with particular reference to RMNCH. This report responds to UNICEF’s and DFAT’s wish to better understand the overarching strategic factors that drive priority setting and resource allocations for RMNCH and the health sector more broadly. We reviewed and data and base analyses were then used to develop an inception report summarising the key political economy characteristics and RMNCH status of each country. The Inception Report also set out the proposed methodology and analytical approach, including ethical issues; a proposed standard questionnaire for interviews, and a recommended program of field level interviews, decided in collaboration with the UNICEF Country Office. The Inception Report for Nepal is available at Annex 3. Field level interviews were conducted involving one or two week visits to each of the four countries over 7 weeks during July – September 2014. In Nepal the two consultants interviewed 76 stakeholders from government, civic society including research institutions, and development partners over one week in country and during follow up by local UNICEF staff. A list of those interviewed by the authors in Nepal is appended as Annex 4.

2.2 Methodology, frameworks used and report structure

There are numerous analytical tools and approaches that could be drawn on to examine the political economy of health and RMNCH in developing countries, as they are reflected in priority setting, planning and budgeting by Governments. These include a “how to note” on political economy analysis by the UK Department for International Development (DFID) (23) and the World Bank (24); the approach by the Overseas Development Institute (25); and the World Bank’s “problem driven governance” framework presented by Fritz et al. (26). There are also numerous tools and approaches that can be applied to political economy analysis including the “Seven Canons of Change” “Most Significant Change”. All of these tools and approaches have something to offer, but because there is great variety between, and within, the four countries captured in this study, we have not attempted to one in particular. Indeed, it is possible that if any one analytical approach could be applied coherently and comprehensively to all four countries, especially given the focus of the work on sub-national level, which has not been analysed very widely, especially in Asia (27). Having said that, this analysis of the political economy of RMNCH in Nepal, and the other three countries, did draw on the methodological framework employed by DFID’s “How to note”, and Fritz’s “problem driven governance” approach as it had the most applicability to social sector situations. Further details, including a schematic overview of the approaches used by DFID, as well as Fritz et al, are in Annex 2.

The specific methodology used for each of the four countries was as follows. The two independent consultants1 first reviewed different approaches to political economy analysis, especially as it applies to the health and social sectors, in peer reviewed and grey literature. They then selected the peer reviewed and grey literature, and open access data bases to identify the main political economy characteristics of each country’s health and development sectors, their performance and challenges. The data and base analyses were then used to develop an inception report summarising the key political economy characteristics and RMNCH status of each country. The Inception Report also set out the proposed methodology and analytical approach, including ethical issues; a proposed standard questionnaire for interviews, and a recommended program of field level interviews, decided in collaboration with the UNICEF Country Office. The Inception Report for Nepal is available at Annex 3. Field level interviews were conducted involving one or two week visits to each of the four countries over 7 weeks during July – September 2014. In Nepal the two consultants interviewed 76 stakeholders from government, civic society including research institutions, and development partners over one week in country and during follow up by local UNICEF staff. A list of those interviewed by the authors in Nepal is appended as Annex 4.

The country level visits and interviews involved a mixed method approach. This involved:

a. Discussions with local staff on the findings of the desk review and exploring its implications for their local activities (in health and other sectors).

b. Interviewing experts from government (in the finance, planning, health and other social sectors, and the equivalent of the office of the prime minister or president)
c. Discussions with the major development partners and academics who have previously assessed the political economy of social sector issues

d. Gathering and analysing quantitative data on social sector spending, disbursement and sub-sectoral allocations (infrastructure, human resources, advocacy/communications), as well as local analysis on related policy direction

This report is structured as follows. Section 3 provides a summary and analysis of the RMNCH situation and development context of Nepal. Section 4 summarises the structure and function of the health sector and RMNCH at the national and sub-national level, and an appraisal of its performance. Section 5 provides analysis and recommendations. Section 6 provides a short conclusion.

3 RMNCH situation of the country

3.1 RMNCH achievements despite low income and high poverty.

Nepal is a low income country that, despite political instability and conflict, has made remarkable progress, including in reducing poverty. Nepal is a low income country with a Gross National Income (GNI) per capita of $730 in 2013: higher than the $663 per capita for low income countries globally but less than the $1473 per capita average for South Asia (28). Gross Domestic Product per capita (GDP) in Nepal is lower at $694 per capita in 2013 but does not capture overseas remittances, a major source of income for many in Nepal (Box 1). GDP growth is around 5%, and debt is considered manageable. Nepal has a total population of just over 27 million. Life expectancy has increased from 54 years in 1990 to 67 years in 2011 for males, and from 55 years to 69 years for females (29). The latest estimate is that one quarter of the population lived on less than the $1.25 a day (Purchasing Power Parity, or PPP) poverty line in 2012. This represents a major and rapid reduction from the situation where more than half (53%) of the population lived below the $1.25 a day poverty line as recently as 2003. Much of the poverty reduction has taken place in rural areas, partly assisted by remittances (Box 1).

Nepal is also making solid progress in achieving the Millennium Development Goals (MDGs). Indeed, it is one of only 15 countries globally, and the only country from South Asia, to be categorised as an “MDG Trailblazer”: a country exceeding its expected trajectory for achieving all the MDGs overall (30). The latest Government and UNDP report states Nepal has already achieved the targets for MDG 5a (reduce maternal mortality by three quarters between 1990 and 2015) and MDG 6c (halt and begin to reverse malaria). That report also states that Nepal is “likely” to achieve all the other MDGs, except for those MDGs related to employment, universal primary education and sanitation which are assessed as only “potentially likely”, and gender and women’s empowerment which is assessed as “unlikely” (31).

Nepal has made particularly good progress with respect to key RMNCH outcomes. Chart 1 below summarises progress in all the main RMNCH outcome indicators captured by MDGs 4, 5, and 6 during the mid-term review of the second donor-supported Nepal Health Sector Program (NHSP2) (32). Chart 1 shows Nepal has made particularly rapid progress in reducing the adolescent fertility rate and under 5 mortality rate. Good progress has been made in reducing the infant mortality rate, and relatively good progress in reducing the neonatal mortality rate, although progress in both has flattened out since 2006. The Contraceptive Prevalence Rate has similarly improved, but levelled out since 2006. The following paragraphs explore the trends in more detail.

Box 1: The importance of remittances


“Limited employment opportunities domestically mean that an estimated 4 million people work overseas, often as unskilled labourers, in India and the Middle East. World Bank analysis finds that “remittances totalled $4.9 billion in 2013, equivalent to over 29 percent of GDP—exceeding both foreign aid and foreign direct investment by a considerable margin. These inflows were mostly channeled to consumption, boosting aggregate demand, helping to lift household incomes, and driving expansion of services (albeit mostly basic services with low sophistication or growth potential) and they also contributed to a large current account surplus, despite a widening trade gap.” Remittances are also closely associated with reductions in poverty.”

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5 Using the standard World Bank classification system, all countries with a GNI per capita of less than $ 1045 are classified as low income. See http://data.worldbank.org/about/country-and-lending-groups.

6 Purchasing Power Parity is a measurement that seeks to avoid distortions caused by market fluctuations in exchange rates. PPP recognises that actual costs in a country may be lower than in another country, so that the actual purchasing power of the local currency may be higher than might otherwise be the case. PPP often uses a notional “international dollar” to distinguish it from US$.
Nepal has achieved important improvements in reducing fertility. The latest Demographic and Health Survey states that fertility declined from 4.6 births per woman in 1996 to 2.6 births per woman in 2011 - a drop of two births per woman in the past 15 years (33). The decline in fertility is most pronounced in the five years between 2001 and 2006 (a one-child decline). Fertility has declined in every age group over the past 15 years, with the largest decline seen among women 25-44 years. The DHS attributes this significant reduction in the total fertility rate to improved access to contraception. However the DHS also notes that "extended spousal separations due to migrants seeking work in foreign countries, especially in the Gulf countries and other Southeast Asian countries, may be another reason for the fertility decline." (33). Despite progress, the contraceptive prevalence rate in Nepal is just less than half (49.7%) (1). However, further progress is needed, with a high number of unwanted births, early childbearing (almost half of Nepalese women have given birth by age 20) and a static use of modern contraception between 2006 and 2011. The latest DHS concludes that Nepalese women have about one child more than their ideal number which in turn implies that "the total fertility rate of 2.6 children per woman is 44 per cent higher than it would be if unwanted births were avoided" (33). The DHS also notes that use of modern methods has increased by 66 per cent in the past 15 years. However, there has been little change in the last five years. It also notes that childbearing begins early in Nepal, with almost one quarter of women giving birth by age 18 and nearly half by age 20. Seventeen per cent of adolescent women age 15-19 are already mothers or pregnant with their first child (33).

Nepal has also achieved significant improvements in maternal health. Reducing fertility helps to reduce maternal mortality. Public health interventions including the National Safe Motherhood Program (Section 4.2) have also helped Nepal to rapidly reduce its maternal mortality ratio (MMR) from 850 maternal deaths per 100,000 live births in 1990 to just 281 in 2006 (33). Using different data sets, the Countdown to 2015 estimated the maternal mortality ratio fell from 770/100,000 live births to 170/100,000 between 1990 and 2010 (Chart 2). Indeed, progress was so dramatic that the Government was able to lower its MMR target to 134/100,000 live births (31). Box 2 describes initiatives to improve maternal care.

Nevertheless, challenges remain. Only 36% of births involve skilled birth attendants (1). Post-partum haemorrhage is the main cause of maternal death followed by pre-eclampsia/eclampsia, abortion complications, obstructed labour, other direct causes, and puerperal sepsis. The proportion of women who deliver with the help of a skilled birth attendant (SBA) has increased five-fold in the last two decades, from seven % in 1990 to 36 % in 2011 (31). While this is a big improvement it still means that around two thirds of women give birth without the assistance of a SBA. Around half of all births occur at home. Nepal has also rapidly reduced its under-five mortality rate, made good progress on reducing the infant mortality rate, and slower but steady progress on reducing the newborn mortality rate. Under-five mortality fell from 141 deaths per 1000 live births in 1990 to 50 such deaths in 2010 (34) (Chart 2). Infant mortality fell from 97/1000 live births in 1990 to 41 in 2010 (34) (Chart 3). The latest DHS concludes that infant mortality has declined by 42% over the last 15 years, and under-five mortality has declined by 54% over the same period (33). Childhood mortality is relatively higher in the mountain ecological zone than in the terai and hill zone and is highest in the Farwestern region. Neonatal mortality fell from 43 to 33/1000 live births between 2001 and 2006, but no further up to 2011. The perinatal mortality rate is 37 per 1,000 pregnancies (33).
Malnutrition rates vary geographically as well. Similarly, infant mortality is highest in the Far-western regions. Under-five mortality is higher in the Far-western ranging from 62 deaths per 1,000 live births in the terai to 44 deaths per 1,000 live births in the mountain zone. Under-five mortality is higher in the Far-western and Midwestern development regions than in the other regions. Similarly, infant mortality is highest in the Far-western development region (65 deaths per 1,000 live births) and lowest in the Eastern development region (47 deaths per 1,000 live births).

Malnutrition rates vary geographically as well. Government and UNDP reports state that there are more stunted children in rural areas (42%) than in urban ones (27%). Rates of stunting vary across ecological regions, too: the respective rates in the mountains, hills and Terai are 53, 42 and 37% (31). Inequalities in women’s education are also linked to inequities in children’s health. The latest DHS finds that under-five mortality among children born to mothers with no education (73 deaths per 1,000 live births) is more than double that of children born to mothers with a School Leaving Certificate or a higher level of education (32 deaths per 1,000 live births). The DHS also finds that the risk of dying among children below age five gradually decreases with increasing household wealth, from 78 deaths per 1,000 live births in the poorest households to 36 deaths per 1,000 live births in the wealthiest households (33).

Significant health challenges remain, including the ‘double burden’ of communicable and non-communicable diseases (NCDs). There is an unfinished agenda of strengthening RMNCH interventions and outcomes. For example, the contraceptive prevalence rate in Nepal is just less than half (49.7%) and only 36% of births involve skilled birth attendants (1). But Nepal is also facing a dramatic rise in NCDs. WHO estimates that NCDs – especially cardiovascular disease - already accounted for around 50% of all deaths of all ages in Nepal in 2008 (latest year available). Communicable, maternal, perinatal and nutritional conditions comprised around 47% of all deaths and injuries the balance (36). The WHO now identifies tobacco use as the highest risk factor for adult males, and the second highest risk factor for females after raised blood pressure (37). The recent Global Burden of Disease Study estimates that the three risk factors accounting for the most disease burden in Nepal are household air pollution from solid fuels, tobacco smoking, and dietary risks. The leading risk factor for children under 5 was overweight. The Global Burden of Disease study also finds that in Nepal the top three causes of Disability Adjusted Life Years (DALYs): a measure that combines premature death and disability in 2010 were lower respiratory infections, diarrheal diseases, and neonatal encephalopathy (birth asphyxia and birth trauma). NCDs – and HIV AIDS – are now the major driver of increased DALYs (38).

The rise of NCDs will put additional and different types of demands on the health system. NCDs are often chronic (long term or even lifelong) raising the cost of treatment to government and households. Cancer, stroke, and diabetes can be complex to treat, directly increasing the cost of health care and indirectly raising the cost of health care through the need for additional training and diagnostic equipment. NCDs can also increase the level of disabilities – including through stroke and diabetic amputations/blindness – which reduce the capacity to work for patients and their carers.

3.2 Political, economic and development context

3.2.1 Health-focused political, economic and administrative history

Nepal has had a long, turbulent, political history which includes feudalism, monarchy, Maoist rebellion, and post-conflict democracy. People have been living in Nepal for thousands of years, sometimes under feudal type arrangements. More recent history has included being a protectorate of China, and then Britain and, since the 20th century the autocratic Rana dynasty; a period of democratic politics under a constitutional monarchy; revolution and a king and dissolving of parliament; a Maoist rebellion from 1996-2006 and a massacre of the royal family in 2001. Cessation of the conflict with the Maoists in 2006 led to the establishment of a constituent assembly to write a new constitution. As noted by one analyst “Nepal’s political history since 1990 has been characterised by a turbulent transition to a more open and democratic system in which the hegemony of traditional elites has been challenged by the political mobilisation of groups that have historically been excluded from power and access to economic opportunities” (39).

Nepal is undertaking an historic, rapid, and radical transition to a more democratic and inclusive polity. The degree of political change cannot be exaggerated. Jones, for example, describes the historically centralised, elite, power structures as follows:

Since its political unification in the eighteenth century under the Gorkha rulers, Nepal has been dominated by Nepali-speaking high caste Hindus (Brahman and Chhetri) from the Hill areas, and by the Newars (the highly urbanised indigenous population of the Kathmandu Valley). The image of the Himalayan archipelago of high caste hill people have been particularly prominent in politics and the military. Excluded and disadvantage groups have included Janajatis (indigenous ethnic minorities), Dalits (untouchables), Muslims, and Hindu-speaking Hindus from the Terai plains along the Indian border” (39). This traditional and elite based polity was overturned by a Maoist uprising followed by successful participation by Maoists in elected government. The Maoist party was the largest party in the Constituent Assembly but subsequently lost significantly winning only 14% of seats in 2012 elections. The two other main parties—Nepali Congress and United Marxist-Leninists (UML)—won 34% and 30% of the vote, respectively, pitting ideologically different groups together. This has been reflected in debates about the right to free health care. On the one hand, the Communist Party of Nepal (Maoist) sought nationalisation of the private sector both in health and education, reflecting its rural and marginalised constituency and its commitment to free education and health care for all. On the other hand, the Nepali Congress and other groups have been concerned about the affordability, poverty targeting, and financial sustainability of such programs. More broadly, there remain fundamental differences about the nature and shape of the Constitution itself, and the nature of a possible federal system.

Efforts at decentralisation have only been partially successful. Decentralisation of decision making is, in principle, a natural response to the sharp ecological – mountains, hills, and terai (plains) - and cultural/political differences in the country. The Local Self-Governance Act (LSGA) of 1999 expanded the mandates of local bodies, devolving the powers, responsibilities and resources required to allow local governments to meet the basic infrastructure needs of the locality. It also
called for a greater role for civil society in the everyday functions of local bodies, emphasizing transparency, public accountability and popular participation. The Asia Foundation notes that:

“the LSGA unleashed unprecedented expectations and quickly faced difficulties in implementation, particularly due to the capacity crunch at the local level, disjointed planning, and the onset of conflict. As a result, the LSGA became a repository of unfunded mandates rather than an enabling instrument for local bodies to take control of their affairs. ... The LSGA unleashed unprecedented expectations on the local bodies from both the demand and the supply sides. On the supply side, local bodies often lacked the capacity to carry out the mandates of the LSGA for planning, budgeting, accounting, providing technical inputs to sectoral programs and competitively overseeing implementation. On the demand side, the gap between expectations and results was even wider in the areas of participation, accountability, transparency and delivery. ... The health sector was devolved through the LSGA in order to promote a more efficient and effective delivery system. Yet this sector remains highly centralized, such that the local units remain little more than ‘simple aggregations of centrally sanctioned budgets’.” (40).

During the field interviews conducted for this analysis there was a consistent and repeated view that policy and resource allocations were very much determined centrally. A commonly expressed view was that some bottom up district level planning occurred, but this was overwhelmed by centralised decision making in Kathmandu on actual budgets and resource allocations. Several of those interviewed said that even if there was devolved decision making under a future federal system, capacity and management constraints would arise, particularly in the more remote and poorer districts and villages most in need of improved health facilities and care.

3.2.2 Macroeconomic and fiscal context

Nepal has generally favourable macroeconomic indicators, but is vulnerable to some external and internal shocks. GDP growth in Nepal slowed to below 4% in 2012/13, largely due to a weather-related weakening in agricultural output. Delays in passing the budget resulted in low capital spending which further softened the economy. The 2014 International Monetary Fund Article IV consultations generally conclude that macroeconomic prospects appear stable. This reflects the fact that the overall fiscal position is deemed “solid”, with public debt projected to decline to 30.5% of GDP in 2013/14. Inflation is manageable. Revenue growth has remained strong due to high import growth which then generates customs and remittance receipts. GDP growth in Nepal slowed to below 4% in 2012/13, largely due to a weather-related weakening in agricultural output. Delays in passing the budget resulted in low capital spending which further softened the economy. The 2014 International Monetary Fund Article IV consultations generally conclude that macroeconomic prospects appear stable. This reflects the fact that the overall fiscal position is deemed “solid”, with public debt projected to decline to 30.5% of GDP in 2013/14. Inflation is manageable. Revenue growth has remained strong due to high import growth which then generates customs and remittance receipts. GDP growth in Nepal slowed to below 4% in 2012/13, largely due to a weather-related weakening in agricultural output. Delays in passing the budget resulted in low capital spending which further softened the economy. The 2014 International Monetary Fund Article IV consultations generally conclude that macroeconomic prospects appear stable. This reflects the fact that the overall fiscal position is deemed “solid”, with public debt projected to decline to 30.5% of GDP in 2013/14. Inflation is manageable. Revenue growth has remained strong due to high import growth which then generates customs and remittance receipts.

3.2.3 Social, cultural and other determinants relevant to health and MNCH

Demographic and social. Nepal had a population of 27.4 million in 2012. With a growth rate of 1.9% per annum over the period 1990-2012 (1), the population has more than doubled in the past 40 years (33). Life expectancy for males has increased from 54 years in 1990 to 67 years in 2011, and from 55 years to 69 years for females (29). Nepal has a young population: 11.6 million (42% of the total population) are aged under 18 years and 2.9 million (10.5% of the total population) are under 5 years of age (1). Nepal is ethnically diverse; the 2001 census identified 103 diverse ethniccaste groups, each with its own distinct language and culture, and 92 separate mother tongues (33). Ethnicity can be mapped to the three broad geographical ecosystems of Nepal – mountains, hills, and terai (plains) – with the unit costs of accessing ethnic communities in remote mountains higher than for those in the terai. Around 17% of the population live in urban settings, particularly Kathmandu (1). Around 81% of the population are Hindu, 9% are Buddhist and 4% Muslim.

Gender. The latest 2011 DHS survey found that “41% of women have never been to school, 23% have an incomplete primary education, 6% have completed primary school but not continued on to the next level of schooling, 25% have some secondary education or have completed secondary school and have not continued on, and about 5% have more than a secondary school education” (33). The female adult literacy rate is estimated to be less than two thirds (66.7%) of males over the period 2008 – 2012. Eighty-three percent of women residing in urban areas are literate, compared with 64% of rural women (1). Government is, however, committed to the Education for All program, partly to increase access and outcomes in terms of female education. Early Childhood Development centres are also being scaled up, with no gender bias detected (33). The increasing number of males working overseas to earn remittances has meant more female headed households in Nepal. The latest DHS estimates that more than one quarter (28%) of households are female headed (33). Three quarters of women are engaged in the agricultural sector (whether paid or not) compared to just over one third of men. As a result, women are disproportionately affected by crop failures, flooding, landslides and drought in the rural sector. The median age at first marriage among women age 25-49 is 17 years, falling to 16 years in the west of Nepal. Women lack power and authority. Only 46% of currently married women participate in decisions pertaining to their own health care, major household purchases, and visits to their family or relatives. Around 93% of women age 15-49 do not own a house and 90% do not own any land (33). Married daughters in Nepal are excluded from inheriting property from their parents (45).

NEPAL COUNTRY REPORT

NEPAL COUNTRY REPORT
4 Structure and function of the health sector and RMNCH at national and sub-national levels

4.1 Health systems

The Government’s strategy for health has three main goals. Government of Nepal documents (47) confirm that a results framework was developed and approved by the MoHP in 2010 to monitor the three objectives of second Nepal Health Sector Programme (NHSP2) namely:

1. To increase access to and utilisation of quality essential health care services.
2. To reduce cultural and economic barriers to accessing health care services and harmful cultural practices in partnership with non-state actors.
3. To improve the health system to achieve universal coverage of essential health services.

The public health system is centrally controlled but suffers from weak management. Although the central civil service apparatus proved robust during the conflict/civil war and remained largely intact, it suffers from a weak management structure, with limited delegation below the ministerial level; poor supervision and accountability; the dominance of personal networks operating in the main to serve narrow interests; and inappropriate skills. The ratio of managers and professionals to support staff is low; the wage structure is compressed; and there are other problems of incentives (42). The public health system has created a reasonable network of facilities across the country including 86 hospitals, 205 primary health centres, 822 health posts, and 2987 sub health posts. These facilities are supported by nearly 80,000 female community health volunteers including trained traditional birth attendants (48).

There have been some efforts at decentralised decision making but these have not been successful, partly due to lack of capacity at the periphery and partly through unwillingness to relinquish control (and patronage) by the centre. The authors’ field visits during August confirmed that initiatives aimed at local level planning are not influencing priority setting and resource allocation decisions made at the central level (see Annex five). Importantly, the strong centralised control of policy and resources does not necessarily equate to strong implementation. Several reports comment on the limitations in capacity at central (and devolved) levels. For example:

“The effective and responsive delivery of health services requires effective systems for procurement, human resources management, budgeting and the timely release and flow of funds, management and provision of drugs and equipment, and reporting and accountability relationships. All of these are affected by the interests and incentives facing key stakeholders, particularly those working within the public health system. Implementation problems … (relate) to the adverse effect of rent-seeking and the use of political influence in the operation of these key systems. Weak management and supervision through the still effectively centralised … management of health facilities has not yet been compensated for systematically by effective local supervision for instance through the Health Facility Management Committees. These generally lack the skills and influence to perform their role and may also be severely affected by local political conflicts that distract attention from management issues …”

A salient feature of the political economy of Nepal is the continuing highly centralised control of resources and decision-making. In the case of the health and agriculture sectors there have been some moves towards decentralisation of services through, in the former case, the establishment of Health Facility Management Committees and decentralisation of some procurement, and in the latter through the role of District Development Committees in setting agricultural service priorities. However, in both sectors accountability for service provision at the local level has generally remained weak with the centralised control of staffing and human resources decisions providing an important source of patronage that has been a focus of political competition and which strongly influences staff incentives and accountability relationships (39).

Such weaknesses should, however, be seen in context. The recent tumultuous political history of Nepal, including a ten year Maoist rebellion, would undermine the management effectiveness of any country. It also needs to be recognised that the Constituent Assembly has – despite many extensions – still been unable to yet agree on the constitutional format of a modern Nepal and how basic services such as health will be organised and delivered. Some analysts believe the health sector has, in fact, operated more successfully than other sectors. Jones for example notes that:

“Compared to some other sectors in Nepal (such as power and agriculture) that have been examined in political economy studies, the political and institutional context has not paralysed decision-making or the effectiveness of service delivery in the health sector. This reflects in part the high priority placed on health by politicians in response to the perceived electoral benefits of success in this area as well as strongly articulated ideological visions for health provision which the Left has made progress in bringing to fruition since 2006, and in part the existence of
a reasonably effective infrastructure and human resource base for service provision that has been able to make use of additional financial resources (39).

The private sector is large and important, but poorly monitored and regulated. The private sector is an important part of the health financing system in Nepal. Around half of all health care is paid for directly out of pocket by individual households; the vast majority of such payments do not involve government pooling of finances or reimbursement. The private sector is also important in terms of provision of services via private sector doctors and pharmacies, and private sector medical schools. However there is little real knowledge or understanding of the scale, scope and quality of the private sector. The authors’ interviews during August confirmed that the existing role of the private sector is rarely if ever taken into account in planning government expenditure on new facilities and staffing. The mid-term review of the NHSP2 notes that:

The non-State especially the private sector in Nepal has grown in an unorganized manner. Most recent data from the National Health Accounts suggests that the government sector contributes less than a quarter of total health spending (23.7%), 20.8% from external development partners and 55.6 % from the private sector. However, there is little empirical information available on the size, composition, distribution and characteristics of the private health sector in Nepal. Since hospital establishments are licensed and registered under various authorities, the non-State health care providers have grown without adequate physical/clinical standards, accreditation, quality norms or protocols. This is compounded by the fact that there is lack of legal framework or institutional structure or resources to supervise, monitor or regulate the non-State especially for-profit private sector. The private pharmacy sector is another area where regulation is lacking and outlets proliferating. Moreover, there is no evidence to suggest that the quality of care at the private sector is based on any clinical norms or standard protocols. Quality of care from individual providers is questionable. MoHP does not have sufficient infrastructure to monitor quality in the non-State especially forprofit private sector’ (32).

It is worth noting that the private, for-profit, sector can see political advantages to itself in the Maoist or communist government. The ADB DFID and ILO diagnostic study on Nepal makes the following interesting point:

That the present as well as previous governments were led by the two communist parties may not be a particular problem for the private sector, as so far both these parties’ actions and policies toward the private sector have not been significantly different from those of the other political parties or recent governments. Indeed, their policies may be more positive given that they (1) are committed to the notion of ending corrupt, feudal, privileged links between politics and business; and (2) will collect their funds from business centrally rather than through prominent individual politicians. However, their political ideologies have introduced ambiguities and uncertainties. (42).

4.1.2 Health financing

Nepal has low absolute levels of expenditure on health, but does relatively well compared to other comparable countries. Table 1 below shows the latest available (2012) statistics for key aspects of health financing in Nepal compared to other low income countries globally, and South Asia. It can be seen that Nepal has low absolute levels of health expenditure: just $35.8 per person in 2012. Even taking into account the lower cost of goods and services in Nepal and filtering out commercial exchange rate fluctuations only raises health expenditure to 80 international dollars in purchasing power parity (PPP) terms. Even in PPP terms, Nepal spends less per capita than other low income countries or South Asia. On the other hand, Nepal does relatively well compared to other comparable countries on some other measures. For example Nepal spends more on THE (public and private) as a share of GDP than other low income countries and significantly more than South Asia countries, many of which like India are middle income countries. While the public share of THE as a percentage of GDP is low at just 2.15%, it is nevertheless a higher share than for low income countries globally (2.0%) or South Asia regionally (1.3%). This can be taken as prima facie evidence of the priority that Government of Nepal – supported by development partners – places on health compared to other sectors. Similarly, Government of Nepal – supported by development partners – allocated 10.4% of total government expenditure to the health sector in 2012: a measurably higher share than low income countries globally (8.8%) or South Asia regionally (8.7%).

Longer term trends in health financing are generally favourable in Nepal, but have not increased as fast as in comparable countries. As shown in Chart 5, the per capita in real (adjusted for inflation) PPP terms has been increasing in Nepal, trebling since the mid-1990s. Nevertheless, Nepal is still spending less than half that

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8 Purchasing Power Parity is a measurement that seeks to avoid distortions caused by market fluctuations in exchange rates. PPP recognizes that actual costs in a country may be lower than in another country, so that the actual purchasing power of the local currency may be higher than might otherwise be the case. PPP often uses a notional “international dollar” to distinguish it from $US.
of low income countries globally, and much lower than South Asia generally, although still larger than that spent in Bangladesh. Chart 5 also shows that the rate of increase in expenditure on health in Nepal is lower than that of low income and South Asia countries. The MoHP budget more than doubled in nominal terms between 2007/8 and 2011/12, and the actual budget execution rate improved to 89%, but government contribution to the health sector subsequently fell (32). Interviews with the Ministry of Finance and other stakeholders suggest that allocation of resources to the health sector is an iterative annual process, involving negotiation between the Finance and Health ministries and the National Planning Commission, and guided by a three year National Action Plan and Medium Term Expenditure Framework. The annual budget ceiling for each line Ministry, including Health, depends on this Plan and Framework, previous budget expenditure and the forthcoming national projects and programs. For unforeseen crises, special emergency funds can be mobilised after approval has been obtained from Finance.

Importantly public expenditure on health is still well below what is needed to achieve Universal Health Coverage (UHC). Public expenditure on health – supported by development partners – was just 1.31% of GDP in 2012. This is important, given that the World Health Organization (WHO) finds that UHC* “usually is attained in countries where out of pocket payments are a large share of health expenditure, including Nepal (52, 53). An estimated 43% of the poorest in Nepal did not seek care for their last illness due to anticipated out-of-pocket expenses (32).

Table 1. Key health financing statistics for Nepal in 2012

<table>
<thead>
<tr>
<th>Health financing feature</th>
<th>Nepal</th>
<th>Low Income countries globally</th>
<th>South Asia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health expenditure per capita (current $US)</td>
<td>35.8</td>
<td>30.9</td>
<td>55.5</td>
</tr>
<tr>
<td>Health expenditure per capita (PPP constant 2005 International dollars)</td>
<td>80</td>
<td>69</td>
<td>138.5</td>
</tr>
<tr>
<td>THE (GDP)</td>
<td>5.46</td>
<td>5.36</td>
<td>3.96</td>
</tr>
<tr>
<td>Public health expenditure (% GDP)</td>
<td>2.15</td>
<td>2.04</td>
<td>1.31</td>
</tr>
<tr>
<td>Public health expenditure as a % total government expenditure</td>
<td>10.36</td>
<td>8.8 (2011)</td>
<td>8.69</td>
</tr>
<tr>
<td>Out of pocket expenditure as % total expenditure on health</td>
<td>49.23</td>
<td>48</td>
<td>58.17</td>
</tr>
<tr>
<td>Out of pocket expenditure as % private expenditure on health</td>
<td>81.3</td>
<td>71.8</td>
<td>88.91</td>
</tr>
</tbody>
</table>


The mid-term review of the NHSSP makes the important point that the government sector contributes less than a quarter of total health spending (23.7%), 20.8% from external development partners (EDPs) and 55.6% from the private sector (32). It is also clear from Chart 6 below that Nepal still has a long way to go in terms of getting the balance right between public expenditure on health and private, out of pocket, expenditure on health. Chart 6 shows that it is increasing government expenditure on health (supported by development partners) that is driving THE. Nevertheless, and while the gap is narrowing, household out of pocket expenditure on health has been consistently larger than government expenditure on health. High levels of household out of pocket expenditure on health is a key policy issue as even small – but unexpected – household payments can act as a barrier to accessing essential health care for the poor and / or a source of impoverishment and debt. This is particularly true in South Asia where out of pocket payments are a large share of health expenditure, including Nepal (52, 53). An estimated 43% of the poorest in Nepal did not seek care for their last illness due to anticipated out-of-pocket expenses (32).

Resources – supported by development partners – are increasingly being directed to Essential Health Care Services. A positive feature of health financing in Nepal is that financial resources are increasingly being allocated to Essential Health Care Services (EHCS). Chart 7 below shows that the budget for EHCS (the red line) has more than doubled from NPR 7.17 billion in 2007/8 to NPR 18.63 billion in 2012/13 and is a major share of the total MoHP budget. This is a positive development in that EHCS is aimed at responding to the essential health care needs of the population, including the poorest and most vulnerable. Of some concern however is the fact that actual expenditure on EHCS (purple line) is consistently below budgeted allocation.

Nepal continues to face challenges in terms of the quality of public expenditure. Increasing the budget allocation and amounts for EHCS is, in principle, a welcome development to the extent that such expenditure will meet the essential health needs of the poor and vulnerable. However increasing the budget says nothing in itself about the quality (and therefore impact) of that expenditure. The World Bank’s Country Policy and Institutional Assessment (CPIA) rating for the quality of budgetary and financial management for the country as a whole (i.e. not just the health sector) fell from 3.5 in 2007 to 2.5 in 2011 and had not improved in more recent years. A Public Expenditure and Financial Accountability (PEFA) assessment in 2007 found that while Nepal’s Public Financial Management and procurement systems

Chart 5. Total health expenditure in Nepal compared to other countries and regions

Chart 6. Sources of per capita expenditure (constant 2012 US dollars)

*N In essence, the goal of universal health coverage is to ensure that all people obtain the health services they need without suffering financial hardship when paying for them.
design. These issues came into greater prominence during the implementation of NHSP2, particularly with the extension of free services. NHSP2 is designed to focus from the start on improving the health of poor and marginalized groups. It also aims to reconsider how best to achieve improved efficiency and accountability in order to sustain government and external development partner support and make the best use of limited resources (39). The process of Gender Equality and Social Inclusion (GESI) institutionalisation was seen by some interviewees as creating parallel modalities and the process was seen as mechanistic. GESI institutionalisation has not reached the districts and health facilities fast enough and this has been a major shortcoming (32).

4.1.4 Service delivery and quality

Nepal has introduced policies to improve quality of care, however the quality remains patchy. These include the recently developed guidelines for Health Facility Quality Management (QFM), Performance Based Management System and Integrated Supervision. However the quality of medical staff and supervision is patchy. The Nick Simmons Institute (a Nepalese based institute focused on training and support for rural health workers in Nepal) conducted a 2007 study of the clinical skills of mid-level staff, who scored 28% in adult medicine, 35% in maternity care, 45% in orthopaedics, 46% in management, 56% in paediatrics, and 59% in procedures. Poor availability of pre service and in service training and poor supervision were identified as causal factors behind such poor results.

Increased training is only part of the solution to improved quality. Carlough and McCall found that a 15 week course for community health workers focusing on maternal and child health, and a 6 week refresher course, generated an acceptable level of knowledge and skill, demonstrated in a practice situation, to meet the definition of community level skilled birth attendants. However their study also makes the important point that “Competency alone will not necessarily improve the situation. To affect maternal mortality in Nepal, (maternal and child health workers) must be widely available, they must be allowed to do what they are trained to do, and they must have logistical and policy support” (57).

4.1.5 Human resources

The number, quality, and placement of human resources for health is one of the key binding constraints to better health care – and certainly to an effective UHC – in Nepal. Generating the right number of health workers, at the right cost, and deploying them to where they can do most good is a challenge for all countries, especially developing countries (58). Recent analysis shows that the 294 institutions training health workers in Nepal are, on average, neither efficient nor effective in producing graduates. For example, only 1451 staff nurses graduated in 2013, out of a capacity for producing 4017 per annum. Only 1074 medical doctors graduated out of a potential capacity of 1760 (59). Several major reports note the high level of staff turnover in the government health system and the likelihood that staff placement and promotions are based on patronage and personal networks rather than merit (32, 39, 42). The latest Joint Annual Review between government and development partners found that only 23% of sanctioned posts at primary health care clinics had a doctor; and less than half (47%) of sanctioned posts at hospitals had a doctor in 2013 (46). Only 39% and 55% of sanctioned posts for nurses at clinics and hospitals were filled. Not one district hospital had the required combined complement of a doctor, obstetrician, 5 nurses (ISBA trained) and an anaesthetist (48).

Placements and promotions tend to reflect patronage rather than merit. The authors’ interviews during field visits suggested that “pledges” (financial payments) were an important determinant of promotions and postings. Some interviewees suggested that Director Generals within the Ministry of Health tended to be at retirement age, and therefore reluctant to adopt new initiatives.

One report noted a worrying decline in the percentage of sanctioned positions - which are often professionally and politically influential in lobbying on behalf of health workers (32, 46). Placements and promotions tend to reflect patronage rather than merit. The authors’ interviews during field visits suggested that “pledges” (financial payments) were an important determinant of promotions and postings. Some interviewees suggested that Director Generals within the Ministry of Health tended to be at retirement age, and therefore reluctant to adopt new initiatives.

Other analysis (44) finds that trade unions and professional associations – which are often politically connected and even formally affiliated with political parties – are very influential in lobbying on behalf of the well-connected health staff to achieve postings in Kathmandu rather than remote rural settings. They note the interesting and important point that female community health volunteers – a locally employed position that sits outside of the government’s formal staff rotation scheme, “enabled policy makers to effectively bypass many of the problems” inherent in the subverted staffing rotation and placement scheme. In so doing, and by bypassing the formal system, community volunteers helped Nepal achieve its impressive reductions in MNCH mortality especially in rural areas (14).

4.1.6 Procurement and logistics

Procurement and logistics are a potentially large source of waste, inefficiency and corruption in many developing countries. The WHO estimates that...
between 20-40% of health expenditure is lost due to waste, corruption and inefficiency (60). This includes poor procurement choices of items that absorb large parts of the budget including pharmaceuticals. Mis-procurement can often be a major cause of financial delays and otherwise well-designed plans being abandoned. Yet implementation of plans, including procurement, is often neglected by managers and decision makers (12). Lack of funding for maintenance is a common source of waste and inefficiency. Counterfeit and sub-standard drugs are an increasing problem in South Asia and South East Asia, with Nepal particularly at risk due to imports of counterfeit drugs from neighbouring India and China (61-63). In 2012/13, the Logistics Management Division of the Ministry procured NPR2,362 million worth of goods and services out of the targeted NPR2,790 million. Problems in the past that are currently being addressed include the timely preparation of annual procurement plans; use of standardised bidding documents; improved communication between finance departments and procurement departments; and more vigilant supervision of implementation (64). The NHSP2 mid-term review found ‘poor progress’ in terms of reducing drug stock outs, with nearly one quarter of all facilities having a stock out of the free essential listed drugs at some point. Despite this, there was only ‘limited progress’ in terms of physical asset management, with little or no evidence of increased budget allocation to maintenance (32).

4.2 Appraisal of health sector performance in relation to RMNCH

The widespread application of several evidence based interventions helps to explain Nepal’s success in RMNCH. Nepal has seen significant reductions in maternal and under five mortality. There are several explanations (65-73). Several of these explanations point to developments within the health sector including expansion of a network of health facilities; elimination of user fees; increased coverage of midwives, and improved nutrition including widespread coverage of Vitamin A. Other explanations lay outside the health sector including increased female education and empowerment, and improved road transport links to remote hill and mountainous areas. Hussein and colleagues sought to estimate the combined effects of various influences between districts in Nepal. They concluded that “the reduction in fertility, changes in education and wealth, improvements in components of the human development index, gender empowerment and anaemia each explained more than 10% of the district variation in maternal mortality” (74). As part of the Lancet series on midwifery, Van Lerberghe and colleagues reviewed 21 developing countries, including Nepal, likely to achieve the MDG goal of reducing the maternal mortality ratio by 75% between 1990 and 2015. They make the interesting observation that in these countries: “The deployment of midwives in the countries reviewed has been the result of managerial choices to accelerate and operationalise universal access to care. Endorsement in the national political arena came only later in the process, once appreciation by the population of the successful deployment of midwives became apparent and civil society more vocal and assertive.”

Community based and participatory approaches were particularly important, especially when government was preoccupied with the civil war. Manandhar and colleagues (65) used a cluster randomised control trial in rural Nepal to demonstrate the importance of participatory interventions involving women’s groups. They found important improvements in birth outcomes, including a 30% reduction in newborn deaths, and significant reductions in maternal mortality. Actual interventions included awareness raising, community generated funds for maternal and newborn care, provision of clean birthing kits and home visits. The interventions were also judged to be cost-effective. Manandhar and colleagues emphasise that the nature of the women’s local community participation was important. Rather than use formal “instructors” or formal health workers, “facilitators” were identified from the local community and villages. The interventions were designed to make participation and active learning the primary intervention in its own right, rather than simply an adjunct to more traditional top down direction instruction and lecturing. The key was to encourage direct and active community participation and engagement of local women as a means of improving knowledge and practices relevant to women and their children.

60 More specifically: “From 2000 to 2003, the neonatal mortality rate was 26.2 per 1000 (76 deaths per 2899 live births) in intervention clusters compared with 36.8 per 1000 (118 deaths per 3226 live births) in controls (adjusted odds ratio 0.70 95% CI 0.53-0.94). Still birth rates were similar in both groups. The maternal mortality ratio was 69 per 100 000 (two deaths per 2899 live births) in intervention clusters compared with 36.9 per 1000 (119 deaths per 3226 live births) in controls (adjusted odds ratio 0.70 [95% CI 0.53–0.94]). Stillbirths were more likely to have antenatal care, institutional delivery, trained birth attendance, and hygienic care than were controls.”

61 The cost per newborn life saved was $3442 and per life year saved $111 ($142 including health-service strengthening costs).
5 Analysis and recommendations

The above analysis makes it possible to formulate an overall perspective on the political economy of health and RMNCH in Nepal. In turn, this enables the development of recommendations for DFAT and other development partners seeking guidance on their engagement with government and other stakeholders in Nepal’s health sector.

5.1 Analysis

The first and most important issue to recognise is that Nepal has emerged from a particularly turbulent political time and is still addressing key issues that get to the very heart of what makes a modern nation state. This is a country transitioning from effectively a feudal system to modern and more inclusive democracy. It is emerging from a ten year civil war. Far from being marginalised or ignored, improvement in health outcomes has actually been a central part of the post-conflict nation building agenda. One analyst notes, for example, that:

What Nepal illustrates is that fundamental to any definition of peace is good health. Achieving the MDGs has been the one policy objective that all political players in Nepal can agree on. In Nepal, promoting public health transcends linguistic divides, caste divisions, and ethnic factionalism. Perhaps that is why, despite being a country with a caste system, a 35% poverty rate, and a 48% literacy rate, the Supreme Court mandates explicit antidiscrimination laws for HIV/AIDS. In the political scenario in Nepal where garbage is collected in the streets of Kathmandu and a 16-hour per day blackout is the norm, the health system has been the last institution to break down (2).

But political challenges remain that can easily affect health outcomes including RMNCH. Negotiations on the form of the constitution and transition to a federal system remain in process. The ADB, DFID and ILO study on critical development constraints of 2009 is still relevant when it says:

Despite the weak and over-stretched capacities, the government faces a daunting number of major tasks: to agree on a new constitution; to deliver adequately on a very challenging and contentious commitment to introduce federalism; to discipline and control the Young Communist League and other youth wings of political parties; to alleviate major trade union militancy; to keep a lid on the smuggling, fragmented, and volatile politics of the Madhesh and terai areas; to deal with at least one armed secessionist movement on the eastern border; to resolve the problems of competing security forces; to handle the politically “hot” issue of land reform to deal with a large legislative backlog, and, in the face of a major downturn in the global economy, to deliver sufficient material benefits to the poor of Nepal that the parties do not split or leave the government. These tasks are straining the political system (42).

A related point is that development partners must be especially alert to the political complexity and challenges of Nepal and, as in all post-conflict and potentially fragile situations “do no harm.” Jones concludes that:

Political economy factors will continue to constitute the main binding constraint to growth at the macro level for the foreseeable future. Strengthening the political settlement and reducing conflict will therefore be central to Nepal’s growth and development prospects in the medium term. … Development agencies and the international community must learn to live with a highly ambiguous situation, and not exacerbate the challenge of effectively governing Nepal (39).

Amongst other things, this means development partners must get the balance right between supporting much needed reform and adhering to the maxim of post-conflict countries especially to “do no harm.” For example, while using financial and other leverage to counter political patronage in staff promotions in the health sector, development partners should avoid overloading the government with policy reform agendas. Development partners should “leave room for the necessary domestic political compromises and not push too hard for complex, interdependent programmes that are very vulnerable to failure at a few key points. While the political economy challenges can only be addressed internally within Nepal as part of evolving processes of state building and of political negotiation, development partners have a key role to play in ensuring their interventions are conflict-sensitive and do not inadvertently contribute to undermining this fragile political settlement” (39).

A second key finding is that while there are some good aspects of government planning and priority setting, much more needs to be done especially if Nepal is to achieve UHC. RMNCH has been a genuine priority for governments of all political persuasions including during the civil war. Expenditure on health has been increasing (supported by development partners) in absolute and 5.1 Analysis

The first and most important issue to recognise is that Nepal has emerged from a particularly turbulent political time and is still addressing key issues that get to the very heart of what makes a modern nation state. This is a country transitioning from effectively a feudal system to modern and more inclusive democracy. It is emerging from a ten year civil war. Far from being marginalised or ignored, improvement in health outcomes has actually been a central part of the post-conflict nation building agenda. One analyst notes, for example, that:

What Nepal illustrates is that fundamental to any definition of peace is good health. Achieving the MDGs has been the one policy objective that all political players in Nepal can agree on. In Nepal, promoting public health transcends linguistic divides, caste divisions, and ethnic factionalism. Perhaps that is why, despite being a country with a caste system, a 35% poverty rate, and a 48% literacy rate, the Supreme Court mandates explicit antidiscrimination laws for HIV/AIDS. In the political scenario in Nepal where garbage is collected in the streets of Kathmandu and a 16-hour per day blackout is the norm, the health system has been the last institution to break down (2).

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A second key finding is that while there are some good aspects of government planning and priority setting, much more needs to be done especially if Nepal is to achieve UHC. RMNCH has been a genuine priority for governments of all political persuasions including during the civil war. Expenditure on health has been increasing (supported by development partners) in absolute and relative terms, a tangible expression of political commitment. Funding for Essential Health Care Services increased from 59% to 75% from 2007/8 to 2011/12.

On the other hand, there are clearly important challenges remaining. The authors’ interviews confirmed that few if any stakeholders could explain how priorities were actually determined and if budgets were allocated accordingly. One stakeholder interviewed thought that priority setting was “too doctor-centric and disease focused.”

A fourth finding is that Government faces important challenges in making UHC equitable and financially sustainable. As noted earlier, the government sector contributes less than a quarter of total health spending (23.7%). High levels of out of pocket expenditure act as a barrier to essential health care for the poor, and a source of impoverishment for many. Achieving UHC is therefore an appropriate goal in such circumstances (75, 76). Government has made announcements about introducing Social Health Insurance, but interviews during the field visits confirmed few stakeholders knew any details of this. Whatever decision is made about UHC, a fundamental question then arises as to its affordability and financial sustainability in the context of Nepal. That is particularly so given the dominant role of out of pocket expenditures currently, the rising burden of NCDs (including chronic and complex diseases such as cancer, diabetes and stroke); the large informal sector (which makes collection of premiums difficult), and the management challenges of designing and implementing UHC in a mixed system where the private sector is largely unregulated and public system facing its own challenges. UHC involves, almost by definition, the pooling of financial risks and resources so as to expand coverage of services and reduce financial distress. Pooling of financial resources and risks in a sustainable way in Nepal will be particularly challenging given the fragmented financing at present, the low proportion of formal sector workers who can pay health insurance premiums and/or income tax, and dependence on external development partners for financing. Scaling up UHC involves complex policy and management challenges. Countries that have successfully scaled up UHC have been able to integrate the implications of economic growth, demographics, technology, politics and health spending (76).

Source: ADB, DFID and ILO (2009)

A comparison with India helps explain the poor performance of the agriculture sector. In adjacent states of North India, agriculture constitutes a powerful political interest group. Elections are partly fought over issues related to technology, politics and health spending (76).

Box 3: The political economy of agriculture in Nepal compared to India

Source: ADB, DFID and ILO (2009)

A comparison with India helps explain the poor performance of the agriculture sector. In adjacent states of North India, agriculture constitutes a powerful political interest group. Elections are partly fought over issues related to technology, politics and health spending (76).
A fifth finding is that the relationship between government and the non-government/private sector in Nepal is very complex. In many ways, part of the explanation for Nepal’s impressive improvements in RMNCH outcomes is due to “space” given (or forfeited) by government to community-based and often voluntary interventions. The international literature, and the authors’ field interviews confirm the importance of community interventions, especially those implemented by women’s groups, in providing essential primary level prevention and care in a range of areas such as nutrition, diagnosis and treatment of pneumonia (66, 77-78). However, such non-state actors’ performance in service delivery has not translated into influencing policy. (Box 3 provides another example). Another analysis reported, similarly: “…the general lack of significant influence of collective action by civil society over policy choices and government action. The strong interests of the business community in addressing the problems of power shortages, for instance, do not appear to have created effective political pressure for change. Farmers’ groups, NGOs involved in agricultural service provision, and private agro-industry have also lacked influence in encouraging a stronger government focus on improving agricultural services. In general, individual relationships appear to have been more important in determining influence than institutional relationships, and the ability of civil society organisations (such as the Safe Motherhood Network) to exert influence appears to have depended on the contacts and advocacy of politically well-connected individuals” (39).

Moreover, relations with the private sector are particularly complex. On the one hand, government would appear to have little control over this large and important part of the health system in Nepal. On the other hand, in the context of UHC it is likely that government will need to engage with, regulate and oversee the quality of care provided by private health practitioners of all kinds. This may involve financial mechanisms administered by State-controlled or affiliated insurers, but its design and financing is likely to require ongoing support from development partners in the medium-term.

The sixth finding concerns the role and influence of development partners. Development partners have clearly been significant in terms of providing additional financing, and technical advice, to Nepal, especially in the health and education sectors. Some development partners are more influential than others. The World Bank and DFID for example can be particularly influential in terms of shaping policy and programs because the funds they provide are not tied to specific, traditionally managed projects. That, in turn, means their financing is more flexible and responsive to changes in government priorities.

It is worth noting that DFID commissioned a series of political economy studies of policymaking during political transition in Nepal. On the basis of those studies one analyst notes “the studies suggest that donors may have an important role in acting as a counterweight to rent-seeking and short-term political pressures, for instance in attempting to ensure enforcement of rules on posting and transfers, and strengthening procurement systems” (39).

The Nepal National Vitamin A Program (NVAP) illustrates the potential tensions and trade-offs for development partners between achieving impact and “results”; versus institutional sustainability. This case is relevant and interesting because the benefits and value for money of the program were so clear (making it tempting for development partners to participate) yet institutional and political economy issues undermined sustainability. Results were impressive: it cost just $1.25 at the time to deliver two Vitamin A capsules; the cost per averted death was $327. Fielder reports that “the NVAP reduces the incidence and severity of diarrhoeal diseases and measles, which in turn reduces the need for Ministry of Health services thereby annually saving the Government of Nepal $1.5 million (80). But successes that could be claimed by the development partners were not institutionalised. Fiedler notes a common dilemma facing development partners:

The process of institutionalizing NVAP has confronted a chicken-egg type of problem. On the one hand the NVAP has not been institutionalized within the MOH, in part because the programme has been donor-driven, and organized and administered independent of the MOH. On the other hand, in the early stages of the development of NVAP the MoPH was undergoing major institutional changes and could not (or would not) provide the necessary cadre of programme coordinators…..The absence of an effective MOH-based supervisory system for community volunteers is a troubling aspect of the NVAP that raises concerns about the ability of the system to maintain its impressive performance to date and the sustainability of the system (80).

A seventh finding is the benefits, and disadvantages, of overseas remittances to poverty reduction and reducing inequality. As noted (Box one) remittances are a large part of the Nepalese economy, bringing in more financial resources than foreign aid and direct foreign investment combined. In many ways, remittances have had a particularly positive impact on Nepal’s economy, and society. Remittances increase the capacity for consumption and therefore to reduce income poverty. To the extent that remittances are spent by women, there is a tendency for the remittances to be spent on ‘merit goods’ such as education and health, and/or improved housing. The latest DHS also makes the observation that the large number of overseas workers may well have contributed to the ongoing reductions in total fertility (33).

On the other hand, remittances bring social, economic and policy challenges too, especially in the context of any scaling up to UHC. The inflow of remittances is dependent upon external economic conditions overseas: sudden downturns in the economic climate will create a large economic shock to Nepal’s overall economy and household budgets. It could be argued that dependence on remittances means households are more dependent and interested in the political and economic conditions in the overseas country than in their own country, thereby muting local pressure for reform. Inflow of remittances raises the exchange rate of Nepal, making it more expensive for Nepal to export goods and services, thereby further reducing the opportunities for local employment and creating a vicious cycle of exporting labour. Socially, families are disrupted. Having higher levels of disposable income through remittances is, of course, desirable, but poorer households could be vulnerable to exploitation in seeking health care. This would be particularly the case if expansion of UHC brought poorer communities into the formal health system, but they were then exploited by any fee for service payment systems in the private and public sectors, especially under any expanded UHC program that used fee for service and relied heavily on a largely unregulated private sector. Any fee structure associated with a UHC scheme would also need to acknowledge that not all households have access to remitted funds. At the most strategic level, the high level of overseas workers and remittances is a proxy indicator of the inability of governments in the past to generate a climate for private investment and productive employment.

An eighth finding potentially affecting the future political economy of RMNCH in Nepal is the rise of NCDs which will generate new and different challenges in terms of prioritisation, planning, resource allocation and health systems. Because NCDs are increasing in prevalence, and their cost of treatment is often chronic and expensive, there is a risk that NCDs could divert already limited public funding for unfinished priorities in RMNCH and under-nutrition. The rise of NCDs will also put new and additional demands on health worker skills and facilities, not just financing. While it may be possible for existing facilities and staff to do simple diagnosis and treatment, it is unlikely that they will be able to treat more complex later stages of these chronic illnesses at community level such as cancer treatment or dialysis for kidney failure. WHO finds that tobacco use is the leading risk factor for death and morbidity for males, and the second highest risk factor for females after raised blood pressure in Nepal (37). Reducing tobacco use is therefore a key strategic public health intervention to reducing NCDs and ill health (81). However tobacco companies will inevitably use political and other lobbying to resist tobacco control (82, 83). There may also be political and community pressure to provide curative treatment for clearly recognised and visible adverse health outcomes such as stroke and advanced cancer, as distinct from ‘invisible’ preventive and promotive interventions such as undernutrition and micronutrient deficiency. The introduction of a
Development assistance in Nepal will be relevant to Nepal. Transformational programs are the least measurable. This is least transformational, and those programs that are most precisely and easily measured are the least important (84). Andrew Natsios writes that “development programs that are subject to political pressures and where the state, including the form of the Constitution and a post-conflict government. Key aspects of the functioning of the state, including the form of the Constitution and a likely transition to a federal structure remain unresolved. First, and most obviously, Nepal is emerging from a particularly tumultuous political history that includes feudalism, dynasties, royal assassinations, a ten year civil war, and the incorporation of Maoists into democratic politics. Key aspects of the functioning of the state, including the form of the Constitution and a likely transition to a federal structure remain unresolved. Second, all political parties in Nepal have committed to some form of health insurance: the challenge is to make UHC financially sustainable. All development partners should be therefore actively engaged in the policy development and implementation of UHC. International development partners should engage in policy dialogue and advocacy on health financing, benefit packages, resource allocation, health governance, stewardship and regulation. As UHC is progressively rolled out there will be good opportunities to support impact evaluations on what works, for whom, at what cost and under what circumstances. Development partners can be helpful in providing financial and technical support. An equity focus is encouraged, as this will indicate the government’s commitment for fairness to an increasingly educated and informed population. Moreover, studies on the cost of prevention and treatment of key health burdens at different levels of the health system will inform the evidence-base for formulating UHC policy and implementation strategies. UNICEF itself should continue to move ‘upstream’ in terms of broader policy engagement, and away from activities that are viewed locally as stand-alone “UNICEF projects”.

5.2 Recommendations

The preceding analysis enables some suggestions for development partners working in Nepal. First, and most obviously, Nepal is emerging from a particularly tumultuous political history that includes feudalism, dynasties, royal assassinations, a ten year civil war, and the incorporation of Maoists into democratic politics. Key aspects of the functioning of the state, including the form of the Constitution and a likely transition to a federal structure remain unresolved. Development partners need to be fully aware of this troubled and complex situation and not view interventions through a purely technical lens. In this context, development partners should not expect “quick wins”. It is not just developing country institutions that are subject to political pressures and institutional incentives. Development partners are increasingly being told to demonstrate (early) results. While understandable, this can lead to perverse and unintended consequences. Former USAID Administrator Andrew Natsios writes “those development programs that are most precisely and easily measured are the least transformational, and those programs that are most transformational are the least measurable” (84). This is relevant to Nepal. Development assistance in Nepal will not yield rapid results; development partners should use their technical expertise and bureaucratic political capital to explain to their own stakeholders the risks of short-termism and ‘announcables’, and commit to long term support.

To conclude, Nepal has made important achievements, including in RMNCH, through a unique mix of widespread community health personnel supported by a very active NGO sector implementing a set of globally recommended preventive and public health interventions. Significant new challenges are emerging as the health program targets issues whose resolution demands more complex approaches including the prevention and management of NCDs, reduction of under-nutrition, reduction of newborn and maternal mortality and roll out of UHC. Development partners can play an important, albeit catalytic, role in helping Nepal position itself to respond in ways that are effective, efficient, equitable, affordable, and sustainable in financial, social and political terms. However, in many ways Nepal is a fragile state, politically, economically and socially. To maximise the likelihood of sustained and ultimately independent progress in Nepal, development partners must take this current context into account and commit to long-term support.
Political economy analysis is a powerful tool for improving development effectiveness:

Political economy analysis is a more powerful tool for improving the effectiveness of aid. Bridging the traditional concerns of politics and economics, it focuses on how power and resources are distributed and contested in different contexts, and the implications for development outcomes. It gets beneath the formal structures to reveal the underlying interests, incentives, rents/rent distribution, historical legacies, prior experiences with reforms, social trends, and how all of these factors effect or impede change.

What is political economy? Political economy (PE) is the study of both politics and economics, and specifically the interactions between them. It focuses on power and resources, how they are distributed and contested in different country and sector contexts, and the resulting implications for development outcomes. PE analysis involves more than a review of institutional and economic processes which involve several factors such as incentives, relationships, and the distribution of power between various interest groups in society, all of whom have an impact on development outcomes” (85).

There is no single, agreed definition of the term "political economy.” The OECD concisely says that: “Political economy analysis is concerned with the interaction of political and economic processes in a society: the distribution of power and wealth between different groups and individuals, and the processes that create, sustain and transform these relationships over time.” (23) Bueuran says “In its modern form, political economy studies refer to the study of the relations between political and economic processes which involve several factors such as incentives, relationships, and the distribution of power between various interest groups in society, all of whom have an impact on development outcomes.” (85).

DFID has a more expansive description, which highlights how political economy analysis can improve development effectiveness:

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Annex two: approach and methodology

The following is an extract on initial thinking about methodology and approaches written by Dr Midori Sato. The full text is available on request.

There are numerous analytical tools and approaches that could be used to examine governance and political economy of priority setting, planning and budgeting in the social sectors of developing countries. According to DFID’s “how to note” on political economy analysis\(12\), these tools are broadly divided into three types: 1) Macro-level country analysis (understanding how political and economic systems of a country enable or hold back overall development, and to identify strategic entry points for programming in a country); 2) Analysis focused on particular sectors (understanding the interests, incentives and institutions operating within a particular sector, to inform the design of a sector programme)\(13\); and 3) Problem-focused analysis (understanding and resolving a specific problem that may be encountered in a particular donor programme)\(14\).

For example, the analytical process proposed by DFID/ODI (Figure 1) broadly follows these three stages (including the above two levels of analysis at both country-level and sector/intra-sector level) and supports DFID’s “Drivers of Change”\(15\).

Another option is a problem-driven framework for political economy analysis (Figure 2)\(16\) which was informed by a review by Wild et al., (2012).\(17\) on governance and political factors affecting weak service delivery in three social sectors (education, health and water and sanitation) in multiple countries.

Mcloughlin (2012) maps technical characteristics of service provision in particular sectors and sub-sectors and identifies the political and governance implications of these characteristics for provision. These papers facilitate our understanding by providing an analytical toolbox to give shape to the complex web of incentive structures that affect sector performance. The problem-driven analysis framework (Figure 2) presents a way of thinking about governance and political economy and the interaction between the three sets of variables/factors and corresponding steps to analyse those variables:

(i) Identifying the problem, opportunity or vulnerability to be addressed,
(ii) Mapping out the institutional and governance arrangements and weaknesses, and
(iii) Drilling down to the political economy drivers, both to identify obstacles to successful and progressive change and to understand where a ‘drive’ for positive change could emerge from and likelyhood is of stakeholder support for various change options.

The second and third layers are differentiated in order to emphasize that institutional and governance dimensions as well as stakeholders and their interests, motivations, power and behavior will be explicitly considered in the second layer. The framework is useful in framing the concrete, problem-focused analysis and for structuring the inquiry process, yet it has limitation, such as difficulty in understanding linkages between wider country-level dynamics and specific problem analyzed within specific sector (Fritz et al., 2009).

Figure 1: Stages in political economy analysis (taken from Moncrieffe and Luttrell, 2005)

<table>
<thead>
<tr>
<th>STAGE 1</th>
<th>BASIC COUNTRY ANALYSIS</th>
<th>HISTORICAL / FOUNDATIONAL COUNTRY ANALYSIS</th>
</tr>
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<tbody>
<tr>
<td>STAGE 2</td>
<td>UNDERSTANDING ORGANISATIONS, INSTITUTIONS AND ACTORS</td>
<td></td>
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<tr>
<td>STAGE 2A</td>
<td>DEFINING THE SECTOR</td>
<td></td>
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<tr>
<td>STAGE 2B</td>
<td>INTRO-SECTOR ANALYSIS</td>
<td></td>
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<tr>
<td>STAGE 2C</td>
<td>RELATIONSHIP BETWEEN PLAYERS</td>
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<tr>
<td>STAGE 3</td>
<td>OPERATIONAL IMPLICATIONS</td>
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</tr>
<tr>
<td>STAGE 3A</td>
<td>DEFINING OBJECTIVES AND EXPECTATIONS</td>
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<tr>
<td>STAGE 3B</td>
<td>DETERMINING ENTRY POINTS</td>
<td></td>
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<tr>
<td>STAGE 3C</td>
<td>IDENTIFYING MODE OF SUPPORT</td>
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\(15\) A conceptual model that seeks to explain how pro-poor change arises as a result of the interaction between structures, institutions and agents; useful to identify drivers for change, but less useful for understanding how political systems operate in practice.


All of the tools and approaches described above have strengths and weaknesses. Considering that there is great variety between, and within, the four assessment countries (Bangladesh, Indonesia, the Philippines and Nepal), it might be difficult to apply any one analytical framework coherently and comprehensively across all four.

Other tools and approaches that can also be applied for political economy analysis include: “Power Analysis” by SIDA (Swedish), which focuses on the nature of power relations, distribution of power, and incentives for pro-poor reforms; “Strategic Governance and Corruption Analysis (SGACA)” developed by the Netherlands’ Ministry of Foreign Affairs, which is very similar to “Drivers of Change,” but with a more tightly structured process and heavily relying on secondary sources of data conducted within a short timeframe; other tools include, but are not limited to “Politics of Development” by DFID and “Addressing Governance in Sector Operations” by the European Commission (EC).

Annex three: Inception report for Nepal

Key political economy challenges identified in this note:

1) Despite significant progress in transitioning to a new political system and reducing extreme poverty in just 7 years, vulnerability remains high among the bottom 40% of the population with a continuous risk of political instability arising from continued disagreement among the major political parties over unsettled constitutional and governance issues (i.e. arrangements for fiscal flows, the role of district level government authorities. It is uncertain when and what federal system will be introduced, which will significantly affect all levels of the health sector.

2) Nepal’s government is already spending a relatively large share of its budget on health and the sector is already quite dependent on external resources. Additional sources of fiscal space for the health (and RMNCH) sector is likely to be created through improving efficiency in its health financing system (e.g. strategic purchasing, provider payment, results-based financing) and through introduction of earmarked taxes such as “sin taxes.” Considering the high level informal sector employment (73% of urban labour force), it is important to mobilize additional resources for the sector is likely to be limited.

The Political Environment: Nepal’s political conflicts originated in the caste and ethnic divisions of the early twentieth century. Multi-party democracy was only reinstated in the 1990s. However, continuous change and corruption in the political leadership prompted the 1994 formation of the Maoist people’s movement, which, over 15 years, led to over 10,000 deaths and a multitude of internally displaced persons. During the conflict, health services were affected in several ways: the distribution of medicines and essential commodities was interrupted by bandhs (local strikes) and insurgents’ harassment of health workers. In 2005, King Gyanendra announced his absolute royal rule, against which the second democratic people’s movement arose in April 2006, after the movement the monarchy was abolished, leading to the coalition government led by the Community Party of Nepal (Maoist) and the Suna Party Alliance. The Maoist leader seized the opportunity to establish the right of all Nepal citizens to free health and education services and to eliminate discrimination and inequity in its interim Constitution. Despite the end of the civil conflict, the shortage of basic human needs such as water, electricity, and petrol remains a significant problem, and political instabilities seem to never end. As of July 2014, Nepal’s second Constituent Assembly (ACA), elected in late 2013 under protest, fraud allegations, boycott by opposition parties and extensive violence of attacks and bombs, has only just started drafting a federal, republic and inclusive Constitution. There is continuing risk of political instability arising from disagreement among the major political parties over unsettled constitutional and governance issues (i.e. federalism, and the nature of parliament and the executive) and they may potentially create hurdles to draft Constitution. Long-term political uncertainties in the country since 2006 also provided the backdrop for attacks against journalists and media that had continued even after the peace initiatives. The main problems affecting the media in Nepal are insufficient legal framework and enforcement for press freedom and access to information; and persistent violence against journalists and failure to bring perpetrators to justice especially when it happens outside the capital. Influence of political parties and private media owners on media and media content is another big problem as well as lack of transparency in media ownership.

Geographic and Demographic Context: Nepal is a diverse country geographically, religiously, culturally, and ethnically, with numerous castes, tribes and ethnic groups. Nepal is a patriarchal society in which a large number of girls between 6 and 14 years of age are still deprived of basic social services. Despite high levels of poverty, geographical challenges, and the decades-long civil political conflict, Nepal’s health-related MDGs have been or are on track to be achieved; the rate of decline of the infant mortality rate (IMR) over the past 20 years has been impressive, decreasing by 57.4 percent and under-five mortality rate by 66.6 percent (INDHIS 2011). Nepal’s neonatal mortality rate (NMR) has made significant progress over the previous decade, due to the country’s policy and programme prioritization of newborn survival, reduction of the fertility rate, improvements in female education, increased coverage and rapid scale-up of skill attendance at birth and community-based neonatal and child health interventions. However, Nepal’s potential are hindered not just by persisting geographical inequalities but also by inequalities based on social groups, gender and household well-being. For example, the percentage of

NEPAL COUNTRY REPORT

NEPAL COUNTRY REPORT
births attended by skilled birth attendants (SBAs) almost doubled, from 19 percent in 2006 to 36 percent in 2011, but women’s access is higher in urban than rural areas and more prevalent near the border with India (Tara ecological zone) areas than the mountain districts. Infant mortality is highest in the Far-Western development region (85 deaths per 1,000 live births and the total birth rate was 7.3% with a literacy rate of 67%), and under-five mortality among children born to mothers with no education (73 deaths per 1,000 live births) is more than double that of children born to mothers with an School Leaving Certificate (SLC) or a higher level of education (32). Similarly, malnutrition rates among children whose mothers had no education are more likely to be higher than those whose mothers have attended school and married at an older age (rural 42 percent, urban 27 percent). The risk of dying among children below age five gradually decreases with increasing household wealth, from 75 deaths per 1,000 live births in the poorest households to 36 in the wealthiest households 14.

Macroeconomic and fiscal context: Nepal is still one of the poorest countries in the region, ranking 157 out of 187 countries in the Human Development Index (HDI) 2013. However, the country made remarkable progress in halving the percentage of people living on less than US$ 1.25 a day (international line for extreme poverty) within 7 years, from 53 percent in 2003/2004 to 25 percent in 2010/2011. Nepal’s GDP growth rate (3.4% in 2011, 4.9% in 2012 and 3.8% in 2013) with a projection of a recovery to 4.5% in 2014 due to increased agricultural production, business and service sector growth supported by strong remittance inflows (from its 4 million migrant workers) and Nepal’s inflation rate was close to 9% in Q1 2014 influenced heavily by food inflation 4. As for the macro-fiscal conditions, revenue reforms and strong political commitment by the government led to increased revenue share of GDP (174 percent of GDP, which is the highest in South Asia) some of the increase was the result of higher levels of grants), yet the economy is heavily import-based with expenditure increasing to 22.4 percent of GDP (from 172 percent in 2008). Public debt levels are declining with the overall government deficit projected to remain in the 3 percent of GDP range. From a macro-fiscal perspective, Nepal has fairly limited fiscal space to implement any medium-term, for the health sector 15. Sector-wise resource distribution of the FY2013-14 budget reflects the government commitment to prioritize the social sectors (mainly education, health and social security), which together accounted for 25 percent of the total budget while the macroeconomic sectors were allocated 15.7% (compared to the health sector allocation of 6.5%) as a share of the government budget, a significant increase from the previous year. On the other hand, actual expenditure on education as a proportion of total government expenditure was 23.2% in FY2010-11 and on education as a share of GDP was 4.7% (last measured in 2010 16), and for health these figures were 10.5% and 2.1%. This suggests that actual spending of the public budget tends to prioritise the social sector even more than what was intended at the time of budget planning, although health expenditure as a proportion of GDP remains low.

Health Financing: Nepal’s health financing system is characterized by passive purchasing of public health services resulting in inefficiencies in the health system; lack of incentives for quality service delivery; and increasing malnutrition and associated poverty (rural 42 percent, urban 27 percent). The risk of dying among children below age five gradually decreases with increasing household wealth, from 75 deaths per 1,000 live births in the poorest households to 36 in the wealthiest households 14.

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District Health Office (DHO), headed by District Health Officer(s), while the District Hospital (DH) provides curative health under the functional responsibility of the Medical Superintendent. At the community level, primary health care services are provided through fixed facilities, outreach clinics, and vaccination centres. The funds from the central DOHS-Management Division (MD) are allocated to the DPHO through the local sections of the Ministry of Finance. Allocation of funds to a particular facility is not pre-determined; the Director of the DHO/DPHO calculates and allocates according to service delivery with assistance from skilled health worker, later evolved into ‘Aama’ [Mother] programme made the immediate decision to make flexible pooled funds available for rapid scale-up nationwide. Another example was development, piloting and rapid scaling-up of the Community-Based Newborn Care Package (CB-NCP) through partnership among MoHP, UN, donor agencies, professional associations and NGOs. Further scale up in RMNCH service delivery has been hampered by various factors such as: limited local level autonomy and capacity in planning, budgeting and allocating resources; lack of mechanisms to support local-level managers to monitor, provide supportive supervision, and create incentives for health workers to improve quality of service delivery; weak financial management system which causes delays in the disbursement of funds; and insufficient and delayed disbursement of resources i.e. drugs, human resources, and finance.

Service delivery: Since 2004, Nepal joined IHP+ and it has facilitated aid effectiveness, strengthening partnership and donor support towards rapid scale up of RMNCH services. For example, with support from DFID, Free Delivery Programme (e.g. Safe Delivery Incentive Programme [SDIP] which provided cash incentives to women and service providers for facility delivery with assistance from skilled health worker, later evolved into ‘Aama’ [Mother] programme) made the immediate decision to make flexible pooled funds available for rapid scale-up nationwide. Another example was development, piloting and rapid scaling-up of the Community-Based Newborn Care Package (CB-NCP) through partnership among MoHP, UN, donor agencies, professional associations and NGOs. Further scale up in RMNCH service delivery has been hampered by various factors such as: limited local level autonomy and capacity in planning, budgeting and allocating resources; lack of mechanisms to support local-level managers to monitor, provide supportive supervision, and create incentives for health workers to improve quality of service delivery; weak financial management system which causes delays in the disbursement of funds; and insufficient and delayed disbursement of resources i.e. drugs, human resources, and finance.

Prepared by Midori Sato (July 12, 2014)

References

Annex four: List of those interviewed in Nepal

The following lists the people interviewed in Kathmandu during field interviews 11 – 16 August 2014.

People are listed in alphabetical order, by surname.

<table>
<thead>
<tr>
<th>NAME</th>
<th>ORGANISATION</th>
<th>TITLE</th>
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<tr>
<td>Bhim Acharya</td>
<td>Management Division</td>
<td>Director</td>
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<tr>
<td>Netra Prasad Acharya</td>
<td>District Health Office</td>
<td>Accountant</td>
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<td>Sharad Prasad Acharya</td>
<td>District Health Office</td>
<td>EPI Officer</td>
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<td>Apsana Adikari</td>
<td>Benighat HP</td>
<td>HFMOC member, FCHV</td>
</tr>
<tr>
<td>Rajan Adhikari</td>
<td>MOHP</td>
<td>Chief, Financing Unit</td>
</tr>
<tr>
<td>Rashila Armatya</td>
<td>District Hospital, Dhading</td>
<td>Medical Superintendent Gynecologist</td>
</tr>
<tr>
<td>Ramesh Aryal</td>
<td>Jogimara HP</td>
<td>Sr. AHW</td>
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<tr>
<td>Bikesh Bajracharya</td>
<td>GIZ</td>
<td>Programme Officer</td>
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<tr>
<td>Sita Bania</td>
<td>Jogimara Health Post (HP)</td>
<td>In-Charge (HA/HPI)</td>
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<tr>
<td>Sushil C Baral</td>
<td>Health Research and Social Development Forum (HERD)</td>
<td>Executive Director</td>
</tr>
<tr>
<td>Manav Bhattarai</td>
<td>World Bank</td>
<td>Health Specialist</td>
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<tr>
<td>Tylasa Bharati</td>
<td>GIZ</td>
<td>Senior Technical Advisor</td>
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<tr>
<td>Rita Bohota</td>
<td>District Hospital Dhading</td>
<td>Senior Staff Nurse</td>
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<td>Nar Badadur Buda</td>
<td>UNICEF</td>
<td>DIC Consultant</td>
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<tr>
<td>Padam Bahadur Chand</td>
<td>PPPCD, MOHP</td>
<td>Chief</td>
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<tr>
<td>Pramila Dallakoti</td>
<td>Jogimara HP</td>
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<tr>
<td>Mohammad Daud</td>
<td>DPHO</td>
<td>Director, DHO Senior Public Health Administrator</td>
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<tr>
<td>Franziska Fuerst</td>
<td>GIZ</td>
<td>Senior Advisor for health financing</td>
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<tr>
<td>Tara Gurung</td>
<td>DFAT Australia</td>
<td>Policy officer</td>
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<tr>
<td>Babu Ram Kaudel</td>
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<td>HFMO, member secretary</td>
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<td>Mon Ram Hari Kaudel</td>
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<td>Ram-hari Kadel</td>
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<td>HFMO Chairperson</td>
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<td>Yagyaw Bahadur Karki</td>
<td>NPC member</td>
<td>Commissioner for Health, Education, Youth</td>
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<tr>
<td>Hariram Khatiwda</td>
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<td>Shusila Khatiwda</td>
<td>Jogimara HP</td>
<td>HFMO, FCHV</td>
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Dukh Lal Sah DHO Statistical Assistant
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 Annex five: report from a district field visit

Report on a district field visit by Midori Sato

SUMMARY:
Feedback from field visits.

The study district, where the UNICEF-supported District Investment Case (DIC) approach has been implemented since 2010/11, was purposively selected to deepen our understanding about the local realities of evidence-based planning for RMNCH at the sub-national level, particularly in the context of devolution and the political economy around priority setting, planning, budgeting and resource allocation. The assessment drew insights from front-line health workers, facility managers, and Health Facility Management and Operation Committee (HFMOC) members in two facilities/VCDS, and compared those with views from district and central-level respondents.

In general, the field assessment found that the evidence-based local-level planning approach introduced by UNICEF in the health sector has been instrumental in strengthening local level capacities in planning. Communities were able to use evidence-based plans to mobilize local resources to address local needs. There appears to be some degree of integration between the ongoing, 14 step bottom-up planning process and the health sector specific DIC approach. Particularly in the most disadvantaged VDCs, where DIC principles were applied, sub-district level actors have seen improvements in the lives of mothers and children. The field visits found (and confirmed central-level findings) there are views among district and sub-district level actors that decentralized bottom-up plans were not considered/used sufficiently by the central level authorities in making budget allocations more “context-specific” (Senior district official.). However, the study also found evidence of local-level coping mechanisms, and the exercise of local level actors’ (district and facility-level managers) agency to make financial and other decisions to allocate resources, operational decisions about local-level recruitment of health providers and to do the best they could within a given budget, no matter how different it was from the plan they sent to the central level. These local level health managers live and operate within their local context.

Practical lessons and opportunities

The practical lesson for UNICEF is that no matter how “context-specific” and “evidence-based” the local or central-level plans might be, local and “street-level” actors (district and sub-district managers as political influencers) use their knowledge, skills, power, authorities, political will and local relationships to adopt to their local situations. In Nepal local-level planning starts at ward-level and at every level upwards, there is political influence.

UNICEF has worked in Nepal for over 45 years, supporting government to implement Decentralized Action for Women and Children (DACAW), an approach to improve access to social sector services (e.g., health, education, sanitation, hygiene, protection) in rural communities of over 23 districts in the past 15 or so years. UNICEF’s experience, long-term relationship at both downstream service delivery, as well as upstream policy advocacy has the potential to position UNICEF Nepal as a powerful advocate of evidence-based planning and budgeting for social and health sector in the Ministry of Federal Affairs and Local Development (MoFALD), former Ministry of Local Development (MLD).

In the health sector, Nepal is recognized as the global leader. It has successfully scaled up an evidence-based package of MNCAC interventions, including Birth preparedness Package and Community-based Newborn Care Programme. Large scale and alternative financing scheme (conditional cash transfer (maternity voucher) UNICEF may consider a strategic shift towards focusing on strengthening health systems governance and management such as planning, budgeting, resource allocation capacities at both central and district/sub-district level, while moving away from issue-based and geographically focused downstream service-delivery projects and pilots. Evidence-based policies/programmes and evidence-based planning, even with increased resources, will not lead to real changes to the most disadvantaged people if downstream implementation, management capacities and local health and governance systems remain weak. During interviews with district-level managers and planners, the problems of a weak financial management support system and management capacities among local managers to lead, manage, prioritize, efficiently allocate, and utilize resources that can be mobilized from the central as well as at the local level were constantly raised.

FEEDBACK FROM FIELD VISITS

The context:
District X is a hill district with a population of about 340,000. Although the district is close to Kathmandu valley, the topography stretches from the Indian border to the Plateau of Tibet and has a distinct eco-geographic, economic, cultural characteristics, with ranking of 41 of 75 districts, (lower/middle) in the Human Development Index (HDI). The district has 50 Village Development Committees (VDCs) with no municipalities; each VDC is divided into 9 wards. The infrastructure (road, water, and electricity) with most of its population engaged in agriculture. About 15.4% has no access to safe drinking water (national average 179%), adult literacy rate is 48.6%, just above the national average of 40.4%, though female literacy is substantially lower than for males, and over 35% of the population is the poor, marginalized ethnic population.

In terms of the health system structure, the district has one 15-bed hospital (District Hospital), 2 PHCCs, 33 HPs, 16 SHPs, 225 immunization satellite clinics, 191 Outreach Centers, and 48FCVHs. All Health Posts and SHPs were devolved and handed over to the HFMOCs established by the VDCs around 2005/2006. HFMOCs are responsible for mobilizing local health facilities, NGOs, community organisations, and people to plan and prioritize health activities. Health status in the district lags behind the national average: the infant mortality rate (IMR) is 59.8 per 1,000 live births (nearly double the national average of 46 deaths per 1,000 LB), under-five mortality rates is 101 per 1,000 (national average 54 per 1,000 LB) (http://www.shatinepal.org/wp-content/content_id_462).

In VDCs supported by the investment case approach, local level actors motivated by different reasons, collected evidence, compiled, analyzed data, and made decisions based on local-level analysis. Findings from both health facilities/VCDS found that these actors involved in the local planning process have different religious, social, cultural values and their motivations for the process are not the same, while some are driven by religious values, while others value social status and social responsibilities. Local level capacity building in planning and budgeting led to increased commitment to and prioritization in the health sector generally and the MNCH sector specifically, which created an enabling environment for community engagement and local level resource mobilization.

Some evidence, although not assessed scientifically although we could not obtain service statistics to validate the effectiveness of evidence-based local-level planning and budgeting leading to reduced morbidity and mortality among women and children, we observed positive changes in perceptions among local-level actors that maternal mortality and childhood morbidity and mortality in their villages were decreasing and institutional delivery increasing substantially. For example, in HP-B, the facility manager mentioned that institutional deliveries increased to 85-90% of pregnant women in some villages where there were no SBAs and no birthing centers. Similarly in HP-A, ANC 3 coverage had increased from below 40% to 60%.

Feedback from field visits.

“Beforehand, planning process have been one person decision making and decisions others just go there and listen and clap hands. But now, after the evidence-based planning, the process involves whole community. It is good that people are involved in the process, so that at least they can own the plan. (HFMOC member and FCHV, HP-B)”

It was perceived by some health providers and managers of the facilities that attitudes by local authorities and political groups towards health workers and health facility have improved, which has led to improved trust relationship among the actors involved in health planning and increased number of community-led initiatives became supported by the VDCs and local players such as business people.

“Since this had started, VDC became more positively supporting us. They support us now because whole district and the community had campaign through appreciative inquiry approach and they own the process. (Health Facility In Charge, HP-A)”
“Before this started, I did not know my role sincerely, but after taking part in meetings and trainings and orientations, I feel recognized and I now know my weaknesses and have been working hard for changing my weaknesses into strengths.” (FCHV, HP-B)

Despite the positive changes described above, there were key challenges that local level actors faced in terms of planning, budgeting and allocation of funds, with several potential factors explaining these realities identified by this assessment.

Bottom-up plans or top-down plans? Where do they (or do they never) meet and who influence the decisions at local level?

Nepal’s fiscal year runs from July 16 to the following July 15. At the central level, the Ministry of Health and Population (MoHP) is responsible for developing health policy, planning, financing, ensuring international cooperation, managing human resources, and monitoring health care delivery, while funds/revenues are pooled and allocated through the Ministry of Finance. The National Planning Commission (NPC), an advisory body to the government, controls ministerial budget ceilings, although interviews with various actors at the central level suggest NPC’s decision control power seems somewhat weakened in the past several years. The financial management staff members are part of the financial planning and control division of the MoF, although the health sector budget is compiled at DOHS and passed on to the MoHP for finalization, there is limited financial control and financial management capacity in accounts sections of both DoHs and MoHP.

At sub-national level, District Public Health Office (DPHO) compiles health components of the local level plans, derived from the bottom-up approach (14 steps planning process) starting consultative meetings at ward-level, Village Development Committee (VDC) level, and then at District Development Committee (DDC) level. Field visits confirmed central level findings that senior officials at district HQ perceive that district plans (all VDC plans are first compiled at DDC, then health components of the plan is disaggregated by DPHO) are neither reviewed nor given full consideration by the central level officials (especially divisions within DoHS) who do not spend time to see our diversity. “(Senior official in the District X)

Divisions within DoHS) who do not spend time to see our diversity. “(Senior official in the District X)

The local level planning process has been implemented the past 4-5 years in the districts of Nepal. There are guidelines “Local resource mobilization & management work procedure 2069 (2012)” to be followed with the whole planning process. These frameworks are introduced from Decemberto around December/January for the new fiscal year. For example, according to the guidelines, each VDC has to allocate 16% for women, 10% for children, and 15% for the elderly (lowest priority) whereas, the VDC’s at the district told us implementation of the guidelines and decision making for priority setting is influenced by political parties who do not understand the guidelines’ criteria or interpret the guidelines in a way they like.

Nonetheless, each planning step follows a deliberative process, although influenced by the political machinery. First, at each ward level, two to three consultative meetings are arranged in different places, for example, “health” and community stakeholders select priorities in that topic/agenda. After further deliberation and intensive dialogue, community will come up with one priority. Once priorities are made for different sectors, it goes to the next step, which is ward-level political party consultation, then to VDC-level. At VDC level, final decisions on VDC plan (including priority setting for health and other social sector programmes) are mainly made by a small group of people such as VDC secretaries, major political parties, health facility technical officers and manager. The problem at this level seems to be that, decision makers are more likely to have to compromise with and are unable to get action from the ward level, or the lower ward level, or the most disadvantaged and lowerperforming wards, as some influential political groups believe that resources should be allocated equally across the wards, and not based on evidence-based needs. In the context of post-conflict and unstable political coalition building stage, relationship with political parties and their coalitions influence decision making and priority-setting process.

Needs-based or evidence-based planning?

However, there is a grey area between what is evidence-based and what needs-based planning process is. As described earlier, the 14 steps bottom-up planning process is “needs-based” and follows a different sequence of steps identified through consultation and consensus building process. Although some interviewees mentioned that community “needs” are validated from technical point of views of health facility managers and health facility management committee members, in reality this validation exercise can be influenced by political groups and depends also on technical and leadership capability of HFMOC and the health facility manager. Furthermore, the 14 steps planning guidelines of the local level is not very strict and does not specify how local communities should bring about their needs and prioritize those using “data” or “evidence”; as a result, communities’ needs may not match with what the “data” or “evidence” tells us. For example, in H-PA, the facility staffs of HDHMOC, through the evidence-based planning process, made a decision to increase institutional delivery as the first priority of

The facility/VDC, however, it is still not community’s highest priority. Thus planning can be done, but actual implementation suffers due to lack of awareness among community members. In order to raise awareness and promote institutional delivery, this HFMOC decided to apply new rule to provide financial incentive to FCHVs (not for the official government rule) if they could convince and bring a pregnant woman to delivery at the birthing center or the facility. In one of the wards, mothers’ group decided to charge fine of 1000 NRS for pregnant women who did not deliver at facilities.

Although, in both facilities visited and interviewed, bottleneck analysis and investment case approach supported by UNICEF had helped communities to use more evidence-based data in 16 lowerperforming VDCs, however, the same approach had not been applied in other sectors and other VDC. Although it is beyond the limit of this assessment to question, robustness and technical validity of data collected and analysis conducted at local community level require more attention.

Disbursement and Allocation of Funds

What influences the decisions at sub-national level? How funds are allocated?

The allocation of funds within health sector from district to a particular facility or particular priority area is neither pre-determined nor evidence-based. The Director of the HDHMOC has financial autonomy to prioritize allocate funds, often based on previous year allocation, observation, meetings, and district-level priorities agreed in these meetings. In the district, the budgeting process can be participatory, involving focal point technical officers of DHO/DPHO office using the sub-district level plans submitted by the facilities.

At facility-level, HFMOCs that are active and under strong leadership seem to have stronger power and autonomy to make financial decisions, whereas in other facilities, health facility managers hold stronger power over the HFMOCs. Furthermore, expenditures by district and lower-level facilities are usually monitored by the DOHS Divisions. The expenditure report was compiled at the Ministry of Finance (Finance Comptroller Office, Financial Management Information System (FMIS)).

Delayed disbursement of funds from central level hampering implementation of policy and programmes Field- visits found delayed disbursement of funds from central level to district level hampered implementation of health programmes. About 80% of funding for public health facilities go through the finance section at the Department of Health Services (DoHS)-Management Division (MD) to the DPHO through the local financial Comptroller’s Office under MoF (after DoHS authorized the funds’ release and the DPHO submitted a request to the local finance office). Occasionally, small funds were disbursed early to allow DHO/DPHOs to have some funds at the beginning of the financial year, when the budget had not been finalized. These funds were often used as a basis of standards to the districts. Although some efforts are made by central level authorities, once MoF allocate resources to sector ministries, first disbursement of funds actually arrived in October (end of first trimester mid-July to mid-October), which is not uncommon practice in Nepal and elsewhere. Local-level strategies (use of personal money of the facility manager or staff, use of HFMOC funds) are often applied as coping strategies until funds are disbursed later.

Allocation of funds from central level is sufficient? Is local level funds reliable source of income?

Field-level interviews provided mixed views on sufficiency of funds allocation as against their plans. For example, at the DDC-level, the central grant (about 75% of total budget) has increased the past several years, while local revenue (15%) has plateaued. The past 3 years, the district have been receiving 10.26 % less of the fiscal year cash given by the central government at the time of planning, while it used to receive 100% of ceiling until 3-4 years ago. Due to this, the DDC faces the challenge of every sector complaining about reduction of their budgets, also.

In the study district, allocation to health sector was 10%, well below 20% Social Welfare, 19% for Water, 14% for Education (DDC data, 2014-2015 budget allocation).

District-level managers are coping with these challenges by mobilizing local resources, cutting down activities, and re-appropriation of heads within their limited authority and capacity. For example, the district managed to recruit an additional 60 skilled birth attendants (ANMs) with the help of VDCs (50% of their salaries are provided by the VDCs) since the beginning of investment case approach. Sixty (60) birthing centers were built in the district and equipment was provided from central, external donors, INGOs/local NGOs, and VDCs. However, since this year, due to the decision made by the Commission for the Investigation of Abuse of Authority (CIAA), an independent anti-corruption body established since 2007, VDCs are now prohibited to use its development budget (VDC budget) to pay salaries of locally recruited health providers, such as ANMs who are key technical position in delivering MNCH services. District officials struggle to find alternative resources to cover those additionally recruited/contracted ANMs (whose salaries are not allocated from central level) to address district’s top priority (to improve ANC coverage and planning institutions). For example, a focus group conducted on the basis of mobilized external donors (INGOs) to support some staff’s salaries, and even cut ANN’s salary.

Comparison of two VDCs/HPs also highlight challenges faced at local level in terms of mobilizing local resources to supplement gap between local plan and central allocation. It also highlights “implementation capability”.
problem within weak local level health systems capacity. For example in HP-A, the facility received 1,370,000 NRS income 2 years ago, while only 296,000 NRS (1/3 was from VDC and 2/3 was from DHO) was received last year. This substantial decrease was due to onetime installation of funds to strengthen infrastructure of the village through centrally-led “model village” project, but the facility also received only half of planned budget from VDC which led to decision on cutting some programme activities (orientation and awareness) to save funds to pay salaries of locally contracted staff (ANMs and helpers). In HP-B, on the other hand, interviews with HFMOCS and the facility in-charge clearly suggest they are satisfied with the budgets allocated. This HP has a relative strong and active HFMOC and a senior local facility manager and the HFMOC has a separate account form the facility and generate income from running ambulance services (4,100 NRS to Kathmandu, 1,600 to the District Hospital). Furthermore, the VDC of this facility mobilized local resources to recruit three ANMs (all receives different salary, one is VDC standard, the other is as per DPHO rules), to incentivize FCHVs and to build infrastructure such as water and birthing center. This comparison also suggest important role the HFMOC plays in supporting the health facility in raising additional source of funds and also acting as catalyst between VDCs and the health facilities.