NEPAL HEALTH SECTOR PROGRAM II (NHSP II)
The Second Joint Annual Review (JAR), January 16-18, 2012.
AIDE-MÉMOIRE

1. Background

The second Joint Annual Review (JAR) of the Nepal Health Sector Program II (NHSP II) took place from January 16-18, 2012, organized by the Ministry of Health and Population (MOHP) and with participation by various line agencies of the Government of Nepal GON) , External Development Partners (EDPs), civil society organizations and other state and non-state actors. The full list of participants is reflected in Annex 1. MOHP prepared a number of reports as outlined in the Joint Financing Arrangement and these reports formed the basis for the discussions during the JAR. The reports will soon be available on MOHP's website. This Aide-Mémoire summarizes the main issues discussed and agreed actions. The Aide Mémoire will be complemented by a number of reports documenting the progress made in several areas of NHSP II.

2. Progress

The JAR made a systematic assessment of the performance of NHSP II against its stated objective as elaborated in the results framework. This assessment was based on data from the Nepal Demographic and Health Survey (NDHS 2011), the Service Tracking Survey (STS 2011) and the Health Management Information System (HMIS). The results from the two surveys are preliminary and the full and final DHS report, which contains disaggregated results by income and social groups, will be made available next month. Two tables summarizing the achievements against the targets are presented in Annex 2. The assessment shows that the results are mixed: while good progress has been made in a broad range of indicators, there are areas where performance is lagging and require focused attention in the coming year.

Good progress has been made in a number of areas. The target for the Under-5 Mortality Rate was met (NDHS 2011) and the percentage of children receiving all basic vaccines has increased significantly from 83 in 2006 to 86.6 percent in 2011 and exceeded the target (HMIS, verified by NDHS 2011). The percentage of births attended by skilled birth attendant has increased significantly to 36.0 in 2011 from 18.7 percent in 2006 (HMIS, verified by NDHS 2011). Similarly the percentage of children under 5 with Acute Respiratory Infections who received antibiotics increased from 25.1 in 2006 to 41 percent in 2011 (HMIS) and exceeded the target. The percentage of health facilities with social audit reached 40 percent against the end of project target of 25 percent (STS 2011). The Total Fertility Rate (TFR) has declined from 3.0 to 2.6 between 2006 and 2011 (NDHS 2011). Tuberculosis case detection rate and cure (success) rates exceeded the targets at 76.3 and 90 percent respectively (HMIS). The Malaria Annual Parasite Incidence (API) was maintained at 0.15 during this year HMIS).

However progress is not uniform across all indicators. Child health targets including the Infant Mortality Rate (IMR) (NDHS 2011), Neonatal Mortality Rate (NMR) (NDHS 2011), and provision of zinc supplementation for children with diarrhea (HMIS) fell short of achieving the

stipulated targets. A total of 909 SBAs were trained against the target of 1134 (HMIS). At 21 percent, the percentage of primary health care centers (PHCCs) providing all Basic Emergency Obstetric Care (BEOC) signal functions also falls slightly short of the target of 23 percent (STS 2011). There is a slight decrease in the Contraceptive Prevalence Rate (CPR, modern methods) from 44.2 percent in 2006 to 43.2 percent to date, despite the fact that the TFR continues to decline as mentioned above. Of significant concern is the availability of health services: only 11 percent of health posts provide both 24/7 delivery services and short term contraception (hormonal and non-hormonal), implant and Intra-Uterine Contraceptive Device (IUCD) services, against the target of 45 percent (STS 2011). Similarly, only 61 percent of the sanctioned doctors and nurses positions in PHCCs and hospitals were filled while the target was 85 percent (STS 2011). In order to address this issue, however, MOHP has addressed this issue through the employment of 365 doctors who completed their medical education with the support of scholarships to work in health facilities (district hospitals and Primary Health Care Centers) outside Kathmandu valley.

3. Issues and agreed actions

The following focuses on key issues raised and an action agreed, and does not document the full account of detail of the discussions.

i) Strategic direction and expenditure priorities: The presentation and report on the strategic direction and expenditure priorities for the forthcoming fiscal Year (FY) were in line with NHSP II but more detail is required on the way future activities and expenditures will prioritize the areas in which the indicators are lagging.

> ***Action:*** It was agreed that the Ministry and EDPs will elaborate on the priorities and associated expenditures outlined in the first draft Annual Work Plan and Budget (AWPB) by March 2012 during the first Joint Consultative Meeting (JCM) so that adequate attention is given to improving the performance of lagging indicators.

ii) Monitoring and evaluation: Absence of a national M&E framework has resulted in a weak M&E system. Moreover, the further use of data for decision making will need continued priority. In addition, progress at the JAR was presented against the 2010 Results Framework (RF) although the RF was revised late 2011.

> ***Action:*** The Ministry will lead the work to finalize the M&E framework with the support of EDPs and produce a guideline and an implementation plan by the end of the current FY. Furthermore the M&E division will take the lead in producing the interim progress reports for each trimester on the performance of NHSP II. MOHP and EDPs will collaborate to finalize the revised RF for NHSP II by the end of February 2012.

iii) Technical assistance: There was an expressed concern by the Department of Health Services (DOHS) on the type and quality of technical assistance (TA) provided by EDPs and the extent to which it contributes to the results of NHSP II and capacity development. Given the

time elapsed between now and the design stage of NHSP II, there was a suggestion to review TA requirements.

> ***Action:*** It was agreed that such assessment will be done this year together with the mid-term review of NHSP II. Furthermore, in order to make sure that TA is provided based on the demand from MOHP and DOHS, it was agreed that the Ministry will present its need for TA during the AWPB consultations so that the total financial as well as TA requirements for the implementation of AWPB will be discussed in order to have a financial and TA support package agreed upon by the time the AWPB is finalized. This practice will begin starting from the current AWPB preparation and will be subject to the bilateral and multilateral agreements for Technical Assistance and Technical Cooperation between MOHP and the various development partners.

iv) Fiduciary: Financial management continues to be a challenge for MOHP and shows little improvement over previous years. Delays in submitting Financial Monitoring Reports (FMRs), unresolved audit issues, and the unsatisfactory status of financial management action plan of the Governance and Accountability Action Plan (GAAP) are examples of these weaknesses. In summary the issues are: a) the third trimester report of FY2010/11 was submitted with delays and the first trimmest report FY2011/12 is already overdue; b) the unaudited financial statements of FY2010/11 is also overdue; and c) the audit issue of FY2009/10 has yet not been resolved. No satisfactory response was received to the audit issues raised in last year's audit. Finally, despite previous commitment, procurement plans have never been produced in time to be incorporated in the AWPB document.

> ***Action:*** It was agreed that the Ministry will give high priority to completing the overdue trimester reports and submit by the end of January 2012. As per the letter of December 15, 2011, the pooled partners will consider the audit of FY 2009/10 complete with qualification. Furthermore, it was agreed that the procurement plan is included in the AWPB document of next FY. MOHP will establish an audit committee to prevent recurrence of audit observations, put in place measures to limit the number of future audit observations and address future audit observations in a timely manner. The EDPs will support the work of this committee through Technical Assistance and Technical Cooperation.

v) Drug stock-outs: A large proportions of health facilities are facing stock outs of essential drugs. According to the Department of Health Services, the Logistics Management Division and the Management Division, this is mainly due to lack of distribution from district stores to health facilities.

> ***Action:*** Alternative ways of distributing drugs and supplies from district stores to health facilities, including partnering with private agencies, will be explored by GON with support from EDPs. This action will be incorporated in the coming AWPB.

vi) Participation of NGOs and the private sector in national programs: The ministry has expressed its disappointment with some private and non-government health institutions' unwillingness to participate in national programs such as the Aama program. At the same time it appears that the institutions' reservation to participate in the program is partly to avoid the risk of reimbursement being denied for the services delivered. This situation can be managed if an explicit contractual agreement is entered between MOHP and the institutions concerned where payments are made based on verified performance.

> ***Action:*** It was agreed that the Ministry will start a performance based payment system with hospitals, including NGO and private sector facilities, during the next Fiscal year. Performance indicators and the modalities will be elaborated by end of April 2012.

vii) Physical asset management: The need to further consolidate the physical asset management initiatives was once again highlighted in the JAR based on an assessment of the functionality of physical assets across the health system. While an adequate level of funding needs to be assured for the completion of on-going infrastructure projects and related equipment, it is also crucial that adequate budgetary allocations are made for the maintenance of health facilities and medical equipment.

> ***Action:*** All stakeholders involved in the preparation of the AWPB for FY12/13 will collaborate to ensure an increased budget allocation for maintenance and the completion of the ongoing 527 infrastructure projects.

viii) Medical Waste Management: During the field trips it was observed that the practice of health waste management at the level of health facilities leaves much to be desired and that this poses a hazard to personal and environmental health.

> ***Action:*** The MOHP will print the Environmental Health Impact Assessment (EHIA)-plan and Environmental Management Framework-plan and organize a workshop in order to disseminate and and distribute them to the health facilities. The compliance of the health facilities with the plans will be presented in the next JAR. The MOHP will assess the situation of health care waste management at different health facilities including the functioning of placenta pits and come up with a strategy for medical waste management considering geographical locations and the volume of waste generated at different facilities by mid March, 2012.

ix) Urban Health: The responsibility for the financing and provision of health services in municipalities lies with the Ministry of Local Development (MOLD) and MOHP has the responsibility of providing technical assistance to MOLD. However, little interaction exists between the two ministries on the subject and urban health is allocated very little priority by MOLD as became obvious from observations during the field trip. This has led to a situation whereby the urban poor have limited access to priority programs unless they can afford to access them from private sector facilities or the few NGOs operating health facilities in municipalities.

Action: MOHP will approach the National Planning Commission in order to initiate a multi-sectoral approach to urban health under the coordination by the National Planning Commission by June 2012.

x) ***Gender Equality and Social Inclusion (GESI):*** NHSP II contains a clear GESI strategy and encouraging progress has been made with a number of programs initiated to address the issues of inequity and Gender-Based Violence. These programs will be scaled up during the next FY. However, it is clear that addressing inequity issues will require the attention and efforts of all programs and systems – i.e. GESI will need to be mainstreamed into everyday planning and implementation.

Action: All departments, divisions and centers will be encouraged to take into consideration the issue of reaching the under-served and include specific actions and budgets in their workplan and budget for the next Fiscal Year as a way of demonstrating commitment to GESI priorities.

xi) Harmonization and alignment: The JAR takes note of KfW, German Financial Cooperation joining the Joint Financing Arrangement as a pooling partner on January 27, 2012.

Action: All stakeholders look forward to an agreement with the GoN on finalizing the Joint Technical Assistance Arrangement (JTAA) within FY 2011/12.

4. Next steps

a) The JCM will be held in the fourth week of March 2012.

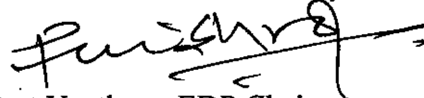
b) The National Planning Commission and the Ministry of Finance will be invited to JCMs.

c) The Mid Term Review (MTR) of NHSP II will take place during the 2013 based on an independent review of progress against NHSP II as set out in the JFA. MOHP and EDPs will prepare for and agree the format and timing of the MTR during the next JCM, including any additional analysis, activities or resources that may be required for the review.

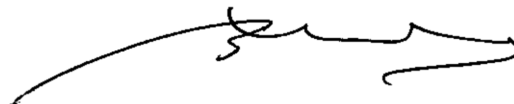
d) The partners and MOHP have agreed that this Aide Mémoire will be classified as a public document.

e) The dates for the JAR 2013 will be January 28, 29 and 30, 2013

Signed for the Ministry of Health and Population, Dr Praveen Mishra, Secretary



Singed for the External Development Partners, Dr. Bert Voetberg, EDP Chair



Date: February 16, 2012

Annex 1: Participating Organisations in Joint Annual Review , 16th -18th January 2012

	Name of Organisation (EDPs)	Name of Organisation (I/NGOs & Other Professional Organisations)	Name of Organisation (Government)	Name of Organisation (Hospitals/Councils/Associations/Academics)
1	DFID	CARE Nepal	Ministry of Health & Population	Nepal Eye Hospital
2	World Bank	Family Planning Association of Nepal	Department of Health Services	Patan Academy of Health Sciences
3	GAVI	Nepal Family Health Programme	Ministry of Finance	Nepal Nursing Association
4	WHO	Save The Children	National Tuberculosis Center	Nepal Public Health Association
6	UNFPA	IPAS	Department of Urban Development & Building Construction	Institute of Medicine
7	USAID	Rotary International	Nepal Health Research Council	Nepal Health Economics Association
8	AusAID	Health Research and Social Dev. Forum	Regional Health Directorate (RHD), Eastern Region	BP Koirala Institute of Health Sciences, Dharan
9	KfW	Nepal Netra Jyoti Sangh	RHD, Central Region	Kathmandu School of Medical Sciences
10	GIZ	International Vaccine Institute, South Korea	RHD, Far Western Region	Association of NGO Hospitals
11	UNICEF	Good Neighbours International	RHD, Mid Western Region	
13	UNAIDS	Population Services International	DPHO, Bhaktapur	
14	UNDP	New Era	DPHO, Kathmandu	
15	KOICA	UCSF-University of California San Fransisco	DPHO, Lalitpur	
16	SDC	RTI - Neglected Tropical Disease	Department of Ayurveda	
17	NHSSP	Netherlands Leprosy Relief	Department of Drug Administration	
19	UNODC	CHPRS	Kathmandu Metropolitan City	
20		Merlin	Sahid Gangalal National Heart Center	
21		The Kathmandu Post	TU, Teaching Hospital	
22		Himalayan Media	Teku Hospital	
23		Resource Center for Primary Health Care	Cancer Hospital, Chitwan	
24		Child Welfare Scheme	Nepal Army Hospital	
25		SAIPAL	Nepal Police Hospital	
26		SABIN Vac. Intl.	Ayurvedic Hospital	
27			Bir Hospital	
28			Maternity Hospital	
29			National Planning Commission	

Annex 2: Key indicator tables

Table 1: Indicators that have been achieved in 2011

Indicator	Target 2011	Achieved 2011
Total Fertility Rate	3.0	2.6
Under-five Mortality Rate	55	54
% of children under five years of age, who are underweight	34	28.8
Tuberculosis case detection rate (%)	75	76.3
Tuberculosis case success rates (%)	89	90
Malaria annual parasite incidence per 1,000	0.15	0.15
% of children that have received all basic vaccines by 12 months of age	85	86.6
% of births delivered in a health facility	27	28.1
% of women aged 15-49 with comprehensive knowledge about AIDS	24	71
% of children under the age of five who had symptoms of Acute Respiratory Infection (ARI) and who received antibiotics	30	41
% of clients satisfied with their health care at district facilities	68	96
% of health facilities subjected to social audits	0	40

Table 2: Indicators that have not been achieved in 2011

Indicator	Target 2011	Achieved 2011
Contraceptive Prevalence Rate (modern methods) for currently married women	48	43.2
Infant Mortality Rate	44	46
Neonatal Mortality Rate	30	33
% of children under-5 with diarrhoea that have been treated with zinc	7	6.2
% of community –based emergency funds granted	19	2.8
% of PHCCs that provide all BEOC signal functions	23	21
% of health posts that provide delivery services 24/7 and short term hormonal and non-hormonal and IUCD and implants	45	11
C-section rate	4.0	2.3
% of sanctioned doctors and nurses posts at PHCCs and hospitals that are filled	85	61
Number of HPs per 5,000 population	1	0.13
Number of PHCCs per 50,000 population	1	0.39
% of health facilities with no stock-outs of 'essential drugs' in last 1 year	70	15
Number of Skilled Birth Attendants trained	1,134	909