International Health Partnership National ‘Compact’

between

Ministry of Health and Population,
Federal Democratic Republic of Nepal

and

External Development Partners

February, 2009
Part I: Background to the Nepal Public Health Sector, Official Development Assistance, and the International Health Partnership

Brief Introduction: Progress in the Nepal Public Health Sector

At the beginning of this millennium we set as a goal to meet the health-related Millennium Development Goals (MDGs) in the context of Nepal’s country-specific challenges. In 2004, we committed ourselves to the Nepal Health Sector Program Implementation Plan (NHSP-IP, 2004-09) led by the Ministry of Health and Population (MoHP) and supported by eleven External Development Partners (EDPs). NHSP is the first sector wide programme in Nepal. NHSP-IP aimed at achieving health-sector MDGs with improved health outcomes for the poor and those living in remote areas and a consequent reduction in poverty in Nepal. It also aimed at achieving increased development assistance effectiveness through donor harmonization, alignment and coordination with Government of Nepal (GoN) health policies and plans.

Since the success of the pro-democracy movement of April 2006, important changes have taken place in the development of the health sector in Nepal. As part of the new government, MoHP has issued a 10 Point Policy Guideline (see Annex 2) emphasizing health as a fundamental human right of the Nepali people and setting out certain fundamental policy commitments. The Interim Constitution, 2063 (2007) is informed by a comprehensive vision of an inclusive society, where peoples of all ethnic groups, castes, religions, political persuasions, social and economic status, and genders live in peace and harmony, and, enjoy equal rights without discrimination. It has established two health-related fundamental rights of Nepali citizens as follows:

"16.2. Every citizen shall have the right to receive basic health care services free of charge from the state as provided for in law."

"20.2. Every woman shall have the right to reproductive health and reproduction related rights."

To ensure that the health sector actively and consistently contributes to realization of that vision is the guiding principle for the policies, plans and programmes of MoHP. To this end, a Three-year Interim Health Plan (2007/08 – 2010) was developed and is in effect (see Annex 3). Particularly significant from the point of view of meeting the MDGs, the GoN established universal free essential health services at the health post and sub-health post levels, and targeted free health care in Primary Health Centres and District Hospitals, and plans to expand these
programmes up to higher levels. Most recently, free maternity care has been instituted country-wide from mid-January, 2009.

With the participation of all the partners, MOHP conducts a Joint Annual Review (JAR) every six months (November and June). Historically, JAR has focused on planning in June and programme review in November, to provide an ongoing assessment of the performance of the health sector. EDPs and health sector officials analyse and assess difficulties encountered and progress made, and develop a mutually agreed upon Aide Memoire to guide coordinated work for the next six month period. An External Development Partner’s Forum has also been formed and meets regularly, which assists partners to prepare their organisational plans based on the government health sector plan.

The Mid-term review of the NHSP-IP found that satisfactory overall progress was being achieved, and that a number of the targets of NHSP-IP had already been met by 2006 (See Table 1). In the changed governmental context, a recent Joint Annual Review meeting and the mid-term review of NHSP-IP suggested alignment of NHSP targets and indicators with those of the Three-year Interim Plan. It was therefore agreed to extend the NHSP-IP timeframe from 2009 to 2010 to bring it into alignment with the Three-year Interim Plan. This alignment exercise produced a revised NHSP Log-frame (see Annex 4) which incorporated updated 2010 targets in areas where progress had exceeded earlier targets (see Table 1 and Annex 4). Preliminary studies indicate that new policies adopted by GON have increased people’s access to health services and are likely accelerating progress on the health-related MDGs.
Table 1.

Some Key MDG-related NHSP Targets and Achievements

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<tbody>
<tr>
<td>Maternal mortality rate (per 100,000 live births)</td>
<td>5</td>
<td>325</td>
<td>300</td>
<td>281</td>
<td>270</td>
</tr>
<tr>
<td>Skilled birth attendance</td>
<td>5</td>
<td>n/a</td>
<td>22%</td>
<td>19% (DHS)</td>
<td>28%</td>
</tr>
<tr>
<td>Health worker birth attendance</td>
<td>5</td>
<td>22%</td>
<td>35%</td>
<td>23.4% (HMIS)</td>
<td>25% (DHS)</td>
</tr>
<tr>
<td>Total fertility rate</td>
<td>5</td>
<td>3.8</td>
<td>3.5</td>
<td>3.1</td>
<td>3.0</td>
</tr>
<tr>
<td>Contraceptive prevalence rate</td>
<td>5</td>
<td>43%</td>
<td>47%</td>
<td>42%</td>
<td>48% modern method; (54% any method)</td>
</tr>
<tr>
<td>Under 5 mortality rate (per 1000 live births)</td>
<td>4</td>
<td>70</td>
<td>65</td>
<td>61</td>
<td>55</td>
</tr>
<tr>
<td>Infant mortality rate (per 1000 live births)</td>
<td>4</td>
<td>50</td>
<td>45</td>
<td>48</td>
<td>44</td>
</tr>
<tr>
<td>Child Immunization-DPT3</td>
<td>4</td>
<td>78%</td>
<td>90%</td>
<td>93% (HMIS)</td>
<td>90%</td>
</tr>
<tr>
<td>HIV knowledge</td>
<td>6</td>
<td>45% (F); 60% (M)</td>
<td>72% (F); 85% (M)</td>
<td>64.6% (F); 81.1% (M)</td>
<td>75% (F); 85% (M)</td>
</tr>
<tr>
<td>Underweight Children (under 5)</td>
<td>1</td>
<td></td>
<td>39% (DHS)</td>
<td></td>
<td>34%</td>
</tr>
</tbody>
</table>

NHSP-II (2010-2015) will be developed to ensure continuity as well as incorporating any necessary changes in order to accomplish meeting the MDG goals and Nepal’s other major health policy objectives. The signatories to this NHDP will strive to ensure that NHSP-II is a well-costed implementation plan for the national health policy (see Annex 5).

National Health Development Partnership
February 2009 / Magh 2065, p. 4
Brief Overview: Financing Modalities and Gaps

The Contribution of Official Development Assistance

Over the period of NHSP (2004-2009), official development assistance (ODA) has comprised forty to fifty percent of the health budget. Since not all modalities of development assistance are recorded in the Government budget, and since EDPs vary in their reporting practices for ODA commitment levels, the exact percentage is unknown. ODA is provided in a number of ways:

i) budget support (which currently accounts for fifty percent of known ODA)

ii) project aid (i.e. funds managed through the government systems with various donor management requirements).

iii) technical cooperation/assistance (with the resources managed through the EDPs systems or jointly managed by MoHP)

The GoN’s preferred official development assistance modality is budget support. This modality can reduce transaction costs and enables priorities to be set and reflected in the use of domestic revenue and ODA.

The National Health Budget and Financing Gaps

Since the 2006 People’s Movement, MoHP has strongly advocated for a greater percentage of the national budget to be dedicated to health. There has been marked success in this effort, with the health allocation exceeding 7% of the national budget for the first time in 2007/08. However, while the overall amount allocated to health increased modestly for the 2008/09 FY, the health budget as a percentage of the national budget did not increase, and remains well short of the MoHP target of 10%.

Several commitments in this Nepal Health Development Partnership will facilitate greater alignment of ODA with the GON planning and budgeting cycle, and provide fuller accounting of ODA to MoHP, thus facilitating MoHP’s overall sector planning and budget advocacy. These alignment and harmonization efforts can assist MoHP to advocate for increasing the percentage of the national budget allocated to health. At the same time, existing financing gaps (see Table 2), as well as still unfunded priorities, show that sustained and even increased ODA commitments will be needed for the near and medium term in order to meet the MDGs and strengthen Nepal’s health system for long-term sustainability and increasing self-reliance.
Table 2.

Assessment of MTEF and Budget Allocation, 2007/08 to 2009/10

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>USS in millions</th>
</tr>
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<tbody>
<tr>
<td>2007/08</td>
<td>161</td>
</tr>
<tr>
<td>2008/09</td>
<td>199</td>
</tr>
<tr>
<td>2009/10</td>
<td>247</td>
</tr>
</tbody>
</table>


A number of priorities set out in the Three Year Interim Plan also remain unfunded or under-funded. Besides the important areas of geriatric care and mental health, these also include a number of programme areas which directly impact the ability to meet the MDGs: adolescent health, nutrition programme, school health programme, urban health, and the upgrading of 1000 sub-health posts to health posts (500 approved). The incentive package for human resource retention and development in remote districts remains unfunded in the current fiscal year, and the funding gap precluded expansion of universal free care to the district hospital level in this fiscal year. More precise costing for the new free maternity care initiative will be possible as demand and usage are monitored and assessed, and can be incorporated into NHSP-II planning (see Annex 5). In sum, along with increased alignment and harmonization for most efficient use of resources, continuing commitments to address financing gaps will be critical to meeting the MDGs by 2015.

Brief Introduction: Nepal and the International Health Partnership

On 5 September, 2007, Nepal became one of the pioneer IHP countries. The IHP was signed by Nepal together with many of its key health-sector development partners. The overall goal and approach of the IHP is described within the international compact itself as follows:

National Health Development Partnership
February 2009 / Magh 2065, p. 6
“The goal of this partnership is to accelerate progress on the health-related MDGs. This will be achieved by increasing the numbers of people who have access to health services offering prevention, treatment and care to deal with their major health problems and promotion of healthy behaviour. The approach includes support to strong and comprehensive country and government-led national health plans in a well-coordinated way, through strengthening and using existing systems for coordination, coordinating support for implementation of sector plans and shared accountability for achieving results.”

The IHP Compact also expressed the following mutual commitment:

“As part of a Global Campaign for the Health MDGs, this compact reflects our global commitment. In the coming months, we will reflect these global commitments in strengthened country partnerships that reflect the unique situation in each country, channel support into country-owned health plans and secure fair and sustainable financing of national health systems.”

MOHP and EDPs have agreed to work together under a shared vision and on agreed-upon priorities. Nepal and its partners have been in the forefront of efforts to harmonize, coordinate and align ODA (see, for example, the 2004 Statement of Intent, Annex 1). Internationally, the Paris Aid Declaration, the 2007 International Health Partnership Compact, and the 2008 Accra Agenda for Action represent tangible commitments by EDPs to ODA harmonization, and to coordination and alignment with national priorities and policy.

This ‘National IHP Compact’, the Nepal Health Development Partnership, continues in the same spirit as these earlier agreements to ensure that EDP assistance to the health sector will be consistent with and supportive of the priorities of the new orientation in Nepal’s health policy, as reflected in the Interim Constitution, 10 Point Policy Guideline and Three-year Interim Health Plan. Similarly, EDPs will harmonize their support in annual planning, joint reviews and reporting and will share relevant information with all partners to facilitate their contributions to MoHP’s health sector development, and thus to strengthening of the health system.
Part II: Nepal Health Development Partnership (‘National Compact’)

In furtherance of the already agreed measurable targets for meeting the MDGs we, the signatories to this Nepal Health Development Partnership, have developed a set of additional commitments. These commitments are intended to bring our practices into greater alignment with the already agreed NHSP-IP/Three-year Interim Health Plan goals and targets as presented in the revised NHSP Log-frame (see Annex 4).

The agreed upon commitments to revise practices and conduct are designed to impact particularly on the following areas in which we believe that further strengthening will increase the likelihood of meeting the MDGs. These commitment areas address how ODA will become more effective and how the governance of NHSP will be improved.

Commitment Areas

1. Strengthen alignment and management of ODA in accord with national policy: Nepal’s strongly pro-poor health policy is the foundation for the noteworthy progress seen thus far in moving toward achieving the health-related MDGs. To maximize chances of success, all EDP and ODA-supported efforts to contribute to meeting the MDGs need to be aligned with and managed under the framework of the national health policy. Priority areas include fiscally sustainable upscaling of universal free health care to include Primary Health Centres and District Hospitals, provision of free maternity care from the local community to the central referral level, attraction and retention of health professionals in the government health services.

2. Advance citizens’ rights: Citizen participation, both as health system users, and as active monitors to ensure system strengthening, is crucial to meeting the MDGs. Citizens of Nepal have a constitutional right of access to free basic health care, and universal access to reproductive care as well. The Public Information Act gives citizens rights to information about the programs and policies implemented by their government. All health sector work, including programs and initiatives targeted at meeting the MDGs and at strengthening the health system should ensure and comply with these rights. Civil society and particularly community-based health organizations have an important role in the design and implementation and review of national plans. Therefore appropriate mechanisms to identify and ensure representation of civil society in these processes need to be established, and actions taken to generate and disseminate knowledge, guidance and tools in specific technical areas related to strengthening health systems and services.

National Health Development Partnership
February 2009 / Magh 2065, p. 8
3. **Improve financial planning and alignment:** A number of financial sector reforms have already been commenced, and some EDP commitments to greater alignment of ODA with national budgeting have been made. However, to properly cost the achievement of the MDGs, determine the funding sources to meet those costs, provide sustained and predictable funding to the public health sector, and effectively deliver and utilize that funding in order to achieve the MDGs with equity, further strengthening is required in this area.

4. **Increase access and service delivery effectiveness:** The best plans and policies will not achieve the MDGs if they are not effectively implemented to reach the populations in need. Strengthening of government procurement and disbursement mechanisms, scaling up of health worker skills, availability and capacity, infrastructure development (with reallocation of facilities if necessary), and strengthening of evidence-based, planning, monitoring and supervision capacity are key components of greater service delivery effectiveness.

5. **Advance equity and social inclusion:** Health indicators show that in order equitably to meet the MDGs, the most marginalised and disadvantaged populations will ultimately have to be reached. For MoHP, reaching the historically excluded and marginalized is also a fundamental responsibility under the Interim Constitution, 2063. Meeting the MDGs and Nepal’s national health policy goals with equity requires incorporation of socio-economic inclusion criteria in all planning and programme implementation design, including assessments of cost-effectiveness and financial sustainability.

6. **Strengthen SWAp:** The sector-wide approach (SWAp) has been considered key to many ongoing reforms in the health sector that directly contribute to meeting the MDGs. More effective implementation of SWAp will increase the likelihood of meeting the MDGs. Greater alignment, harmonization and coordination under the national health policy are important aspects of a successful well-integrated SWAp.

7. **Strengthen governance and accountability:** The strengthening of governance and accountability is necessary to ensure that resources in the health sector are utilized in an efficient and transparent manner.
The signatories of this IHP national 'compact' will meet each year to review progress against these commitments.

*We the signatories collectively commit:*

- To work together in more effective ways to improve health care and health outcomes under the leadership of the Government of the Federal Democratic Republic of Nepal, acting with the representatives of civil society and elected bodies. We will tackle the challenges in strengthening the national health system -- particularly the challenges of having enough trained health workers in the right place and with the motivation, incentive, skills, equipment, medicines and infrastructure to do their work.

- To build on and make efficient use of the existing system for planning, coordination, delivery and management of the health sector within NHSP and the overall national development framework, in order to achieve the MDGs.

- To engage in quarterly Health Sector Development Partners Forum meetings, and coordinated research.

- To develop and coordinate government/non-government partnerships in such a way as to strengthen the capacity of the public health sector for the long term. "Non-government" is understood to be all those entities participating in the health field that are not within the official governmental public sphere. These include, but are not limited to civil society organisations, professional organisations, registered NGOs, non-governmental cooperatives and community-based organisations, as well as private sector for-profit organisations, businesses and industries, subject to avoidance of any conflicts of interest.

- To involve the non-government sector in the NHSP review processes conducted through JAR so that the government may receive non-government partner feedback and partners can harmonize their own planning with NHSP in an informed manner.

- To plan jointly for the NHSP-II (2010-2015), making definite time commitments and providing technical cooperation and technical assistance as necessary. To participate in preparing NHSP-IP II (2010-2015), incorporating mutually accepted costing estimates for the agreed upon goals and targets. Epidemiological transition, disease burden, and equity and social justice considerations will be included among the bases for adjustment of cost estimates and programme priorities (cf. Annex 5).

National Health Development Partnership
February 2009 / Magh 2065, p. 10
• To full engagement in the JARs, and to completion of the Action Plans documented in the resulting Aide Memoires.

• To work towards agreement on how ODA is classified in the GON financial accounting system.

• To ensure that health workers and citizens of Nepal have access to agreed national public health documents through maintenance of an up-to-date MoHP website, and making them available in Nepali and in regional languages if necessary.

• To ensure that disease and population specific approaches and those to achieve broad health system strengthening are mutually reinforcing.
We the external development partners commit:

- To accept national health policies and plans as the basis for providing funding and technical cooperation and assistance, and avoid introducing new plans for projects that are inconsistent with national health plans and priorities.

- To use the shared process of the JARs to support national health plans and for managing and accounting for funds, reporting on progress, and reviewing implementation performance, country-led validation, and external evaluations.

- To reduce the number of EDP-specific monitoring and evaluation activities through:
  
  i) an increase in the proportion of joint EDP missions for analysis, monitoring and evaluation at the divisional/programme level as well as on broader health system issues
  
  ii) ensure all planned missions are factored into the relevant divisional plans to accommodate better co-ordination with the JAR process and MoHP monitoring and evaluation cycles.

- Improve the sustainability and predictability of funding for the National Health Plan. This includes:

  i) provide ODA on a rolling 3-year period basis aligned to the MTEF

  ii) provide estimated ODA figures by mid-March of each year. The ODA will be confirmed upon agreement on the next FY’s annual work plan and budget (AWPB). ODA could increase during the FY as determined by official monitoring findings or JAR evaluations, where mid-year flexible additions are indicated to meet a specific agreed-upon target or goal.

  iii) include all ODA in funding levels irrespective of how this will be executed (i.e. include ODA to government and non-government sectors).

  iv) ODA can be for various aspects of the National Health Plan, but where possible we will give flexible support to the plan.

  v) respond to agreed areas where there is a funding gap.

  vi) provide MoHP full and clear reporting of all the health-related ODA provided to the non-government sector, in support of MoHP’s sector-wide planning and coordination efforts.

- To provide timely statements of ODA expenditure by non-government implementers, whether directly or via government.
• To strive to increase annually the percentage of total EDP funding that goes into the pooled funding system, with progress in this area evaluated through the Joint Annual Review.

• To ensure all information is provided that is needed to reflect all ODA in the respective MOHP and DOHS divisional AWPBs. Ensure this is aligned with national health (and specific programme) planning and use MoHP review cycles, thus reducing agency specific reviews.

• To work to ensure that disease and population specific approaches and those to achieve broad health system strengthening are mutually reinforcing. We will test and evaluate ways to link our support to achieving results, primarily in strengthening of the public health system.

• To ensure that EDP-funded and other trainings are coordinated with MoHP and with each other in such a way as to avoid duplication, to align trainings with agreed policy and programme priorities, and particularly to minimize impact on service availability due to staff absences for trainings.

• To support MoHP in seeking adequate domestic and ODA resources for the higher costs of meetings the MDGs in the last 5 years, and to cover gaps as far as possible in order to implement NHSP-II and to meet the MDGs.

• To provide accurate (MoHP validated) Nepali language translations of any major health-sector documents we produce in English. “Major documents” will include agreed public health sector plan and policy-related reports/studies, programme guidelines, regulatory guidelines, evaluation reports, health sector-related studies, plus the proceedings of JAR (Aide-Memoire and presentations).
We the government commit:

- To use our national health plans, which are embedded in our overall development frameworks, to guide development of the health system and the use of resources in the health sector. Comprehensive health plans will incorporate priority programmes under the GON/MoHP framework.

- To utilize the JAR mechanism to work with national stakeholders and international agencies to develop a common vision for the health sector and to identify targets and develop budgets that reflect this vision when updating our health plans.

- To plan and evaluate ODA-funded technical cooperation and assistance, and programme implementation assistance for its contribution to public health sector capacity building.

- To implement national health plans effectively, through stronger health and financial management systems, striving for the most effective use of resources, and working with non-government partners as indicated. To this end, implement the agreed upon Financial Management Improvement Plan and the Governance and Accountability Plan, and take under consideration any EDP-proposed changes to those plans.

- To have publicly available a rolling MTEF.

- To work to ensure increased government revenue funding for health care and develop improved health financing mechanisms in order to increase access for the poor and most vulnerable and to protect people from excessive health expenditure, within our national budget strategy and macroeconomic constraints.

- To engage EDPs in the formulation of divisional AWPBs.

- To be responsive to our citizens and report on progress in reaching the targets and disbursing the amounts budgeted in annual plans. Reflect sources of funding and expenditure in the AWPB and take steps to ensure it is disseminated on a timely basis, maintaining transparency and access to public information.

- To ensure that health care staff, post-training, are retained in health facilities where this training can be utilized as far as possible.

- To take necessary steps to attract and retain skilled, motivated personnel in the public health sector.

National Health Development Partnership
February 2009 / Magh 2065, p. 14
* To advance, in a well planned manner, the policy to increase the coverage and quality of essential health care for needy and disadvantaged populations.
Monitoring of the National Health Development Partnership

* EDPs will present, based on a format agreed mutually with MoHP, their progress to the EDP Chair. The Chair will present to JAR the progress against each commitment on behalf of all EDP signatories (joint progress and individual progress).

* MoHP will continue to present Divisional reports of progress at the JARs, and will include progress against NHDP commitments as relevant in those reports.

* Fulfillment of the commitments made in this document will be measured against the indicators in Annex 6, at each JAR or annually at one JAR meeting as appropriate to the nature of the indicator.

Dispute Resolution, Amendment and Withdrawal Procedures; Legal Status

* All effort will be made to resolve differences of opinion regarding the implementation of this Nepal Health Development Partnership (NHDP) through discussion resulting in consensus.

However, the signatories to the NHDP will develop a dispute resolution procedure for resolving any intractable difference that may arise and which a signatory partner determines to require a formal resolution, and will endorse that procedure at the JAR following the signing of the NHDP itself.

* The NHDP is not time bound. It is, however, subject to amendment by mutual agreement of the signatory partners. Either signatory partner may request that an amendment be considered. Any such proposals will be tabled through the JAR process.

* The signatory partners will re-examine the provisions of this document for consistency with the NHSP-II targets and goals at the JAR following passage of NHSP-II.

* For purposes of dispute resolution and amendment, the “signatory partners” shall be understood to be the Ministry of Health and Population on the one hand, and the group of External Development Partners who have signed the NHDP on the other. Either MoHP or a two-thirds majority of the EDP signatories may table an amendment for consideration, or request that a disagreement be resolved by the agreed-upon formal dispute resolution mechanism.

* The NHDP shall not create legal relations. Any signatory may withdraw from the NHDP subject to three months’ prior written notice to the other signatories.
Signatories

These signatories represent the Ministry of Health and Population, Government of the Federal Democratic Republic of Nepal and external development partners and agencies committed to the principles outlined in this text.

Dr. Dipgh Singh Ban
Secretary, Ministry of Health and Population
Federal Democratic Republic of Nepal

Bronwyn Robbins
Counsellor, Development Cooperation for South Asia
Australian Agency for International Development (AusAID)

Ms. Bella Bird
Head, DFID Nepal
UK Government’s Department for International Development

Friediger Stierle
Sector Coordinator Health
German Development Corporation

Dr. Ms. Elena G. Filio-Barrandei
Country Coordinator
UNAIDS

Ian McFarlane
Representative
UNFPA

Gillian Mellsop
Representative
UNICEF

Ms. Susan G. Goldmark
Nepal Country Representative
World Bank

Dr. Alex Andjaparidze
Representative and Chief of Mission to Nepal
World Health Organisation

Signed this day
the first of February, two thousand and nine a.d. / the nineteenth of Magh, two thousand and sixty-five u.s.
at Kathmandu, Nepal

In support of the fundamental human right to health, the Nepali people’s constitutional right to free basic health care, and joint efforts to meet the health-related MDGs, this Nepal Health Development Partnership will remain open for signature to other EDPs and agencies who may in future decide to join in its commitments.

National Health Development Partnership
February 2009 / Magh 2065, p. 17
Annex 1


Context:

The Ministry of Health (MoH) with participation of the External Development Partners (EDPs) and other stakeholders and following extensive consultations during the last over two years, has developed the Nepal Health Sector Strategy: An Agenda for Reform. A sector program, Nepal Health Sector Program-Implementation Plan (NHSP-IP) has been developed based on the Health Sector Strategy. The Health Sector Strategy is to be used as a basis for joint planning and programming in the health sector. The key policy reforms outlined in the Health Sector Strategy include: decentralized delivery of Essential Health Care Services with increasing partnership of the private sector, strengthened Sector management, and Human Resource Development. Concomitantly HMGN has finalized the Tenth Five Year Development Plan (2002-2007), the Poverty Reduction Strategy Paper (PRSP). Primary focus of the health sector component of the Tenth Plan/PRSP is to ensure delivery of essential health care services nationwide in order to significantly reduce the burden of disease and target the underserved and poor to ensure their increased access to essential health services. The health objectives of the PRSP and the defined strategies are fully consistent with those underscored in the Nepal Health Sector Strategy - An Agenda for Reform.

Rationale for the joint agreement (HMG and EDPs in the Health Sector) on the Statement of Intent.

This Statement of Intent is designed as a foundation document in order to establish a formal working partnership between the MoH and the participating EDPs, and to develop a common framework for joint planning and programming to support Nepal’s development goals in the health sector, which in turn contribute to improved health of the people of Nepal. All parties recognize a need for coordinated partnership and acknowledge the importance of the “spirit of cooperation and collaboration” in Nepal. Therefore a formal commitment with the underlined operating principles and mechanisms is expected to improve the level of partnership between the MoH and the EDPs. The progress to date of the Second Long Term Health Plan, 1997; b) the continued collaboration and technical assistance in the development and design of Medium Term Strategic Plan, Health Sector Reform Strategy and the NHSP-IP; c) the consensus to work under a coherent strategic framework by developing the Health Sector Strategy; and d) a participatory exercise carried out during the NHSP-IP preparation process. This Statement of Intent also seeks to indicate a formal long-term partnership between Ministry of Health and the EDPs and to ensure the MoH of continued support from the EDPs, in order to implement the NHSP-IP, as an adequately funded and result driven quality work program implemented in an efficient and cost effective manner to achieve the stated goals of PRSP. Signing on the Statement of Intent will establish and ensure a formal partnership.
for a strong joint working relationship maintained in a transparent and accountable manner. This is consistent with the vision of HMG as presented in the Foreign Aid Policy that all external partners contribute to joint resourcing of the health sector (joint planning, programming and review). Joint plans and programs will continue to be developed within a flexible financing and implementation framework that allows individual EDPs to provide support to the MoH in line with their organization/agency's mandate, mechanisms and other requirements.

The MoH and the EDPs agree to the following Principles of Partnership:

a) The EDPs will ensure that all the assistance made by them in the sector will be fully consistent with the Health Sector Strategy - An Agenda for Reform

b) Harmonization of donor support in annual planning, review and reporting shall be encouraged. Financing of the sector shall be in accordance with each agency’s mandate, financing mechanisms and other requirements.

c) Develop and maintain a climate of transparency, openness and accountability and share relevant information with all partners to facilitate their contributions to health sector development.

d) Work together in partnership to build consensus between the MoH and the EDPs on actions needed to support MoH’s efforts to achieve the common vision.

e) Based on the health care needs on the one hand and based on the estimate of financial resources likely to be made available from HMG and EDPs on the other hand, the MoH and EDPs agree to develop a prioritized spending framework. This framework will guide the allocation of all resources available from HMG and the EDPs.

The MoH and the EDPs agree to the following Implementation Mechanisms of the Partnership:

a) Establish a formal Health Sector Development Partner Forum, which meets quarterly, and facilitates formal dialogue between the MoH and the EDPs. The meeting will be chaired by the Health Secretary/MoH.

b) Following the current practice, there will be a joint annual MoH/EDPs review of the Health Sector Program that will review the implementation progress and performance of the previous year and agree to adopt necessary reprogramming to achieve improvements in problem areas for the next year. Also annually the MoH and EDPs will identify priority actions and issues to be addressed in annual work programs and budget will be jointly

National Health Development Partnership
February 2009 / Maugh 2005, p. 19
developed and agreed upon.

c) In case of a conflict of views between the MoH and the EDPs, both sides will sit together and endeavor to resolve the issues through consensus building and compromise.

d) This Statement of Intent will be reviewed as required or when majority partners show evidence to do so and necessary amendment will be made.

**Statement of Intent (2004)**

The signatories of the is document reiterate their commitment to support HMGN to achieve its health development goal of establishing:

“A health system in which there is equitable access to coordinated quality health care services in rural and urban areas, characterized by: self-reliance, full community participation, decentralization, gender sensitivity, effective and efficient management, and private and NGO sector participation in the provision and financing of health services resulting in improved health status of the population” (Second Long Term Health Plan, 1997).

To support the achievement of the above development goal and Tenth Five-year Development Plan (2002-2007), the MoH and EDPs seek to:

a) Seek to Commit to the achievement of the common vision for health reform and development as above;

b) Set priorities to improve the allocation of resources to achieve the common vision;

c) Improve the efficiency and accountability of resource use with a focus on health outcomes;

d) Ensure that health sector activities are guided by current best practice;

e) Improve the coordination of external assistance to maximize its effectiveness to achieve the common vision.

**2004 Statement of Intent Signatories:**

1. His Majesty’s Government/Ministry of Health
2. External Development Partners (EDPs) Representatives
   2.1 Australian Agency for International Development (AusAID)
   2.2 Department for International Development (DFID)
   2.3 German Development Cooperation: Deutsche Gesellschaft für Technische

National Health Development Partnership
February 2009 / Magh 2005, p. 20
2.4 International Labor Organization (ILO)
2.5 Japanese International Cooperation Agency (JICA)
2.6 Swiss Agency for Development and Cooperation (SDC)
2.7 The World Bank
2.8 United Nations Children’s Fund (UNICEF)
2.9 United Nations Population Fund (UNFPA)
2.10 United States Agency for International Development (USAID)
2.11 World Health Organization (WHO)
Annex 2
Ten Point Policy Guideline, 2007
Ministry of Health and Population
Government of Nepal

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

1. Expressing our commitment to the universal principle that "health is a fundamental human right", while ensuring that health care is available to all Nepalis, we will continue to give special priority to those persons, genders, castes and ethnic groups, communities and regions that are socio-economically disadvantaged.

2. It is our firm principle that it shall be the main responsibility of the state to deliver all types of health services—preventive, rehabilitative and curative—to socio-economically disadvantaged people. These services will be organized in accord with the principles of the Alma Ata Declaration regarding primary health care. Ayurvedic and other alternative medical systems will be conserved and promoted.

3. The present health budget will be increased to deliver the necessary resources for health care. Steps will be taken to make available to the health sector, as to other social welfare sectors, funds which are cut from the budgets of the royal palace and the army. The budget set aside for the health sector will be utilized in an effective manner, and the international donors will also be encouraged to provide assistance in accord with the essence and spirit of this policy guideline. Administrative and financial corruption and irregularities will not be tolerated in the health sector. A reward and punishment policy will be responsibly implemented.

4. Special initiatives will be developed to create a proper working environment for doctors and health workers in rural and remote areas. Their financial advancement and opportunities for advanced study will be ensured. The two-way referral system will be activated.

5. In coordination with the Ministry of Education, universities, and other educational organizations, necessary steps will be taken to fulfill the responsibility of medical education to develop human resources in accord with Nepal's needs, and to involve educational centres in providing medical treatment to the people.

6. To ensure that the private sector is organized in a manner that is responsible toward the people, necessary assistance, policy directives and supervision will be provided. A Health Cooperatives policy that ensures people's participation and ownership will be put into practice.

7. Health work at the district level will be conducted in accord with the concepts of decentralization and an integrated approach. The people will be empowered through health related works by empowering the community health workers. Special steps will be taken to make effective use of the full inner potential of these health workers and volunteer health workers, who form the link between the people and the health facilities.

8. Realizing the integral relationship between health and development, continuous efforts will be made for effective inter-sectoral coordination.

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

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

National Health Development Partnership
February 2009 / Magh 2065, p. 22
Annex 3

Three-year Interim Health Plan (2007/08-2010) Objectives and Targets

I. Objectives of the Three Year Interim Health Plan

1. Provide equal opportunity for health development to all with special emphasis on equity for the socially disadvantaged, the poor, women, and disabled people as per the provision of ‘free basic health as a fundamental human right’ as set out in the Interim Constitution of Nepal, 2063 vs. (2006).

2. Strengthen ongoing high priority EHCS and achieve MDGs in accordance with the principles of primary health care, equity and social justice.

3. Redesign the health system to make it people-oriented, efficient and effective through reform in institutional management and health professional education.

4. Ensure availability of good quality essential drugs to all at affordable prices through well-regulated pharmacy services.

5. Strengthen Public-Private Partnership in a manner that strengthens the overall public health system.

6. Improve hospital services and referrals through integrated management of the district health system.

7. Initiate important services such as urban healthcare focused programs, and targeted healthcare for the elderly which are not currently included in EHCS.

8. Promote health research and health research systems.

9. Further develop Ayurvedic and other alternative systems of medicine.

10. Align population policies and programs with the goal of poverty eradication.

II. Targets of the Three Year Interim Health Plan

<table>
<thead>
<tr>
<th>S.N</th>
<th>Health Indicators</th>
<th>Status up to 2006</th>
<th>Target till 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Access to Essential Health Care Service (%)</td>
<td>78.83**</td>
<td>90</td>
</tr>
<tr>
<td>2</td>
<td>Availability of Essential drugs in Health Institutions (%)</td>
<td>93.3**</td>
<td>95</td>
</tr>
<tr>
<td>3</td>
<td>Women making 4 antenatal care visit (%)</td>
<td>29.4*</td>
<td>40</td>
</tr>
<tr>
<td>4</td>
<td>15-49 age group women receiving TT injection (%)</td>
<td>63*</td>
<td>75</td>
</tr>
<tr>
<td>5</td>
<td>Delivery by health worker (%)</td>
<td>19*</td>
<td>35</td>
</tr>
<tr>
<td>6</td>
<td>Current user of Contraceptive (%)</td>
<td>44.2*</td>
<td>53</td>
</tr>
<tr>
<td>7</td>
<td>Use of Condom (14-35 years) (%)</td>
<td>77*</td>
<td>85</td>
</tr>
<tr>
<td>8</td>
<td>Total Fertility Rate (15-49 year women) (%)</td>
<td>3.1*</td>
<td>3</td>
</tr>
<tr>
<td>9</td>
<td>Neonatal Mortality Rate (Per 1000 live births)</td>
<td>33**</td>
<td>31</td>
</tr>
<tr>
<td>10</td>
<td>Infant Mortality Rate (Per 1000 live births)</td>
<td>48*</td>
<td>44</td>
</tr>
<tr>
<td>11</td>
<td>Maternal Mortality Rate (Per 100000 live births)</td>
<td>281*</td>
<td>270</td>
</tr>
<tr>
<td>12</td>
<td>Child Mortality Rate (Under- five) (Per 1,000 live births)</td>
<td>61*</td>
<td>55</td>
</tr>
<tr>
<td>13</td>
<td>Knowledge of Women (15-49) on ways to avoid AIDS (%)</td>
<td>65*</td>
<td>75</td>
</tr>
</tbody>
</table>

**DHS/MoHP *NDHS, 2006

National Health Development Partnership
February 2009 / Magh 2065, p. 23
III. NHSP Targets & Indicators Aligned with Three-year Interim Health Plan (2007/8-2010)

The Nepal Health Sector Program is led by MoHP and supported by eleven EDPs who were signatories to the 2004 Statement of Intent to align development aid effectively with national health policy under the leadership of MoHP. The NHSP-IP, 2004-09 was prepared in accord with the Health Sector Reform Strategy: An Agenda for Change (2004), and facilitates implementation of the sector-wide approach (SWAp) that was initiated in 2004. The primary goal of the NHSP-IP is achievement of the health-sector MDGs in Nepal with improved health sector outcomes for the poor and those living in remote areas, with a consequent reduction in poverty. After thorough consultations between MoHP and EDPs, the NHSP targets and indicators were amended by the July 2008 Joint Annual Review to bring them into alignment with the Three-year Interim Health Plan (see Annex 4).
## Annex 4

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

Revised Log-frame Aligned to Three-year Interim Plan (2007/08-2010)

<table>
<thead>
<tr>
<th>Narrative Summary</th>
<th>Objectively Verifiable Indicators</th>
<th>Means of Verification</th>
<th>Assumptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal: Achievement of the health sector Millennium Development Goals in Nepal with improved health sector outcomes for the poor and those living in remote areas and a consequent reduction in poverty.</td>
<td>By the end of 2015:</td>
<td>Nepal Demographic Health Survey (NDHS)</td>
<td>Political Stability</td>
</tr>
<tr>
<td></td>
<td>• Proportion living on less than $1 a day halved (from 38% to 17%)</td>
<td>NDHS 2011 to measure 2010 targets</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Under-five mortality reduced by two thirds (from 161.6 per 1,000 in 1990 to 54 per 1,000)</td>
<td>Other poverty related surveys developed under GON</td>
<td></td>
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<tr>
<td></td>
<td>• Maternal mortality ratio reduced by three quarters to 134 per 100,000 live births</td>
<td>IBBS continued</td>
<td></td>
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<tr>
<td></td>
<td>• Achieve universal access to reproductive health</td>
<td>HIV prevalence: IBBS and sentinel surveillance</td>
<td></td>
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<tr>
<td></td>
<td>• Spread of HIV/AIDS halted and begun to reverse the trend</td>
<td></td>
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<tr>
<td></td>
<td>• Incidence of malaria and other major diseases, including TB, halted and trend reversed</td>
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<tr>
<td></td>
<td>By the end of July 2010:</td>
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<tr>
<td></td>
<td>• Total Fertility Rate reduced from 3.1 to 3.0</td>
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<tr>
<td></td>
<td>• Maternal mortality ratio reduced from 281 per 100,000 live births to 270</td>
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<tr>
<td></td>
<td>• CPR increased to 54 percent</td>
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<td></td>
<td>• Infant mortality reduced from 48 per 1,000 live births to 44</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>• Under-five mortality reduced from 61 per 1,000 live births to 55</td>
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<tr>
<td></td>
<td>• Neonatal mortality reduced from 34 per 1,000 live births to 30</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Prevalence of malaria reduced</td>
<td></td>
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<tr>
<td></td>
<td>• Estimated. Prevalence of all forms of TB reduced to 330 per 100,000</td>
<td></td>
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<tr>
<td></td>
<td>• HIV prevalence among IDU and migrants reduced (IDU from 34% (2008) to 20%; migrants from 1.9% (2006) to 0.75%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Proportion of government budget allocated to health sector increased to at least 10%</td>
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National Health Development Partnership

February 2009 / Magh 2065, p. 25
**Purpose:**
To improve the health status of the Nepalese population through increased utilisation of essential services delivered by a well managed health sector. "A health system in which there is equitable access to co-ordinated quality health care services in rural and urban areas, characterised by: self-reliance, full community participation, decentralisation, gender sensitivity, effective and efficient management, and private and NGO sector participation in the provision and financing of health services resulting in improved health status of the population."

<table>
<thead>
<tr>
<th>Objective</th>
<th>Programme</th>
<th>Indicators</th>
<th>Data Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>88% of children 12-23 months immunised against measles, 90% DPT3, and 80% DPT2 for lowest income quintile (note: 3-year interim plan recommends measles, mumps, rubella vaccination to be piloted)</td>
<td>NDHS</td>
<td>National Household Survey</td>
<td>National Livelihoods Survey</td>
</tr>
<tr>
<td>Births attended by a SBA, regardless of place, increased to 35%</td>
<td>Other poverty-related surveys developed by GON</td>
<td>PMAS</td>
<td>NASA</td>
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<tr>
<td>At least 48% Modern Contraceptive Prevalence and 35% for lowest quintile</td>
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<tr>
<td>Unmet need for family planning reduced to 21%</td>
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<tr>
<td>Utilisation of EHCS* at health and sub-health posts increases by 30% for 2 lowest wealth quintiles (*prevalence and treatment of fever for children under age five)</td>
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<tr>
<td>TB case detection rate increased to 80%</td>
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<tr>
<td>TB cases cured increased to 90%</td>
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<tr>
<td>Percentage of young people who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV (by age and sex group)</td>
<td></td>
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<tr>
<td>Young female (15-24 years) knowledge about HIV/AIDS increases from 27% to 50%</td>
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<tr>
<td>Young male (15-24 years) knowledge about HIV/AIDS increase from 44% to 70%</td>
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<tr>
<td>FSW, IDU and MSM knowledge about HIV/AIDS increases to 80%</td>
<td></td>
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<tr>
<td>Proportion of government funds to HIV and AIDS increased to 15% (from 8% in 2007)</td>
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<tr>
<td>Underweight children under five years of age reduced from 39% to 34%</td>
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<tr>
<td>At least 80% of the planned health sector budget will be spent in 2010</td>
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</table>

Strong political commitment
Health continues as a GON priority
Health budget will continue to increase
EDPs contributions continue to increase
Government committed and reduced reliance on external funding

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*National Health Development Partnership
February 2009 / Magh 2065, p. 26*
### Outputs:

1. Essential Health Care Services: EHCS costed, allocated the necessary resources and implemented. Clear system in place to ensure that the poor and vulnerable have priority for access. HIV/AIDS awareness increased and services extended to high-risk populations.

1.1. By the end of July 2010:
   - 40% of pregnant women receive at least 4 antenatal visits
   - 75% of pregnant women receive TT immunisation (at least 2)

1.2. Identified evidence-based interventions to address underweight children

1.3. Facility-based safe abortion services available in all 75 districts

1.4. 25% of deliveries are in facilities, 10% for lowest income quintile

1.5. 25% increase in total number of clients attending health and sub-health posts

1.6. 100% of poor and destitute clients attended by social service staff

1.7. 50% of health facilities providing quality STI services

1.8. 50% of NGO health facility providing quality STI services

1.9. Percentage and number of people with advanced HIV infection receiving antiretroviral combination therapy (by age and sex)

1.10. Facility-level quality improvement system in place in 50% of facilities by 2010

2. Decentralisation:

   Local responsible bodies are capable of managing health facilities in a participative, accountable and transparent way with effective support from the MOHP and its sector partners.

2.1. By the end of July 2010:

   MoHP provides formula-based block grants to District Health Offices with five-year plans to supplement grants to DDCs from MoLD to address local health needs

   - At least 30% of districts with five-year plans hire staff to fill vacant positions at facilities and offices
   - At least 50% of MoHP budget is allocated directly to District-level programs where Districts have five-year plans to address local health needs

HMIS/DHS
Monitoring survey report

Peace continues and programme can be implemented as planned

Strengthening of reproductive STI services prioritised by the government

Sustained funding to existing NGO services

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National Health Development Partnership
February 2009 / Magh 2065, p. 27
<table>
<thead>
<tr>
<th>3. Private/NGO sector development: The role of the private sector and NGOs in the delivery of health services is recognised and developed with participative representation at all levels which ensure consumers get access to cost-effective high quality services that offer value for money.</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1. Completion of Private Health Sector Assessments and legislative assessment by December 31, 2008</td>
</tr>
<tr>
<td>3.2. State—non-state policy and strategy prepared by July 15, 2009</td>
</tr>
<tr>
<td>3.3. At least 3 state—non-state models piloted and evaluated by 2009</td>
</tr>
<tr>
<td>3.4. Contracts signed with non-state hospitals/clinics in 5 districts to provide CEOC by 2010</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. Co-ordinated and consistent sector management (planning, programming, budgeting, financing, and performance management) in place within MOHP supported by the EDPs, to support service delivery with the involvement of NGOs and private sector</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1. Restructured MoHP as steward and to facilitate sector wide management by 2009/10</td>
</tr>
<tr>
<td>4.2. Ayurved and alternative medical section in MoHP and Ayurved units in 5 RHDs fully staffed by 2008/09</td>
</tr>
<tr>
<td>4.3. National Ayurveda Academy established by 2009</td>
</tr>
<tr>
<td>4.4. Ayurveda drug and medicinal plant policy formulated and programmes initiated for documentation, IPR protection, development and utilisation by 2010</td>
</tr>
<tr>
<td>4.5. AWBPB, inclusive of district, EDP, and civil society participation by 2009</td>
</tr>
<tr>
<td>4.6. Output-based AWBP initiated in 2008 and implemented by 2010 reflecting all known resources</td>
</tr>
<tr>
<td>4.7. End-year JAR combined with the MoHP regional and national review meetings by 2009</td>
</tr>
<tr>
<td>4.8. Nepal Health Sector Strategy II and NHP II prepared by a participatory process in 2009 for implementation</td>
</tr>
<tr>
<td>4.9. IHP accord finalised and signed by July 31, 2008</td>
</tr>
<tr>
<td>5. Health financing resource management: Sustainable development of health financing and resource allocation across the whole sector including alternative financing schemes in place</td>
</tr>
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</table>

| 6. Logistics management: Systems established and resources allocated within MOHP for the effective management of physical assets and procurement, distribution and rational use of drugs, supplies and equipment | 6.1. Stock-outs of 10 monitored drugs below 25% for all PHF (any stock-out in any quarter; baseline FY06/07: only 3 drugs below 25% stock-out) | MOHP Annual Report |  |
| | 6.2. National institutional pricing established for District-level procurement initiated 2008 and implemented by 2009 | HMIS/DHS |  |
| | 6.3. "Pull system" operating in 9 Districts in 2008 increased to 50 Districts and training completed by 2010 | DOHA Annual Report |  |
| | 6.4. Essential drugs procured annually or more frequently by 25 Districts by 2010 |  |  |
| | 6.5. Essential drugs available in 95% of designated health facilities by 2010 |  |  |
| | 6.6. 20% of total construction budget of FY 2008/09 and 2009/10 spent on building maintenance following the building maintenance plan |  |  |
| | 6.7. 1,000 sub-health posts upgraded to health posts by 2010 |  |  |
| | 6.8. Two regional Ayurveda hospitals, 90 Ayurveda dispensaries and 2 natural medicines centres established by 2010 |  |  |
| | 6.9. Plans for management of health waste developed and implemented in 2008 |  |  |
7. Human resource development: Clear and effective HRD policies, planning systems, and programs developed and functional.

7.1. Enhance staff skill-mix by 10% at sub-health posts, 15% at health posts, 20% at PHCCs, and 25% at District hospitals where BEOC and DOHS Annual Report CEOC are provided by 2010. Role shift accepted by all. MOHP Annual Report

7.2. At least 40% of health facilities (District and PHCC) fully staffed by SBAs (with skill mix, both number and types by 2010

7.3. Incentive package for doctors, nurses, paramedics, especially for remote areas designed in 2008 and implemented by 2009

7.4. Production of MDGP, DA, DGO, DCII and DCP for strengthening 30 district hospitals started from 2009


7.6. HR flexible fund established for short-term contracting of critical medical staff by 2009

7.7. e-HuDIS designed and implemented in 50% of health facilities by 2010
| 8. Integrated MIS: Comprehensive and integrated management information system for the whole health sector designed and functional at all levels as well as quality assurance mechanism in place for public and private sectors | 8.1. Completed system integration study to establish linkages by 2008  
HMIS/DHS | Appropriate skills mix of MOHP management |
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>8.2. Unified coding system for establishing linkages and standardising database by 2008</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.3. Simplified reporting formats to make more user-friendly by 2008</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.4. Strengthened information dissemination and increased access for general public by 2008</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.5. Integrated program-specific health data at DDC Information Centre to support decentralised health planning and management, and forwarded subset of data to central level by 2008</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.6. Captured and integrated NGO/ private sector data at DDC Information Centre for decentralised health planning and management and to promote PPP by 2009</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.7. Establish pro-poor monitoring system at sample of health facilities for quarterly or trimester data collection and analysis by 2008</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.8. Regulatory framework for NGO/ private sector health providers established by 2009 and implemented by 2010</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.9. Quality assurance program and monitoring established and implemented by 2008</td>
<td></td>
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</tr>
</tbody>
</table>
Annex 5
Roadmap for NHSP-II Planning and Preparation

I. First quarter 2009: Workshop to:
   i) design the NHSP-II preparation process
   ii) agree upon analytic work required*
   iii) agree upon division of labour and responsibilities
   iv) produce a detailed log-frame

II. Second half of 2009: Evaluation and Pre-appraisal to:
   i) conduct an NHSP-IP evaluation focused to identify both continuities and changes needed in NHSP-II
      ii) carry out a pre-appraisal of NHSP-II as it is developing, focused on assessing its adequacy as an implementation plan for the national health policy

III. First quarter of 2010: Appraisal to:
   i) evaluate the fully developed NHSP-II and identify further refinement or expansion as required
      ii) feed agreed upon aspects of NHSP-II into next FY planning process.

IV. Second half of 2010: Finalise NHSP-II in time to give continuity from NHSP-IP.

*N.B. NHSP-II preparation will include detailed costing work for 2010-2015 and will take into account equity issues as raised in such documents as the WHO Social Determinants of Health Report, and the Bamako Call for Action on Research for Health.

National Health Development Partnership
February 2009 / Magh 2065, p. 32
Annex 6

Indicators for Monitoring Implementation and/or Progress on Commitments

The Three-year Interim Plan targets (see Annex 3) and the NHSP-IP/Three-year Plan Aligned indicators (see Annex 4) provide the detailed measures of outcomes and results of public health sector work. This NHDP will contribute to alignment, harmonisation and coordination of signatory’s health sector work, and in that way is expected to have a positive impact on results. That impact is, however, not directly measurable. The additional indicators below (B, C, D) are intended to provide a relatively simple means to monitor implementation for some key NHDP commitment areas. These indicators can serve as the starting point for NHDP implementation review during the JAR process.

A. Results (Three-year Interim Plan and NHSP-IP)

Results of plan and policy implementation are monitored through the indicators listed under Targets of the Three-year Interim Health Plan (see Annex 3, Part II) and the NHSP-IP/Three-year Interim Health Plan Aligned Log-frame (see Annex 4)

B. Alignment and Harmonization

Percentage of:

- Actions documented in the action-plan of Aide-Memoire completed by next JAR
- International missions of EDPs participating in MoHP-scheduled joint strategic sector review missions with concomitant reduction in agency specific missions
- Joint MoHP-EDP programme-based monitoring missions/ joint reports with concomitant reduction in project or donor specific missions
- EDPs (and specific EDPs) providing figures for funding executed through non-government sector
C. Finance

Percentage of:

- EDPs reporting at JAR their contribution to the health sector (including expenditure) aligned to the agreed Annual Reporting format for EDPs (to be developed by MoHP)
- EDPs (and specific EDPs) providing ODA on rolling 3-year period basis
- Total ODA that is accounted for through rolling 3-year period basis reporting
- EDPs (and specific EDPs) providing estimated ODA by mid-March and confirming annual funding upon agreement of AWPB
- FMIP & GAP implemented on schedule
- Facilities receiving budgeted amount within one month of budget disbursement to MOHP, with clear-cut guidance for expenditure
- Distributions to districts of medicines and other budget for the free health care programmes that are reported to the public through newspapers or other appropriate media such as regional radio.