Government of Nepal
# Ministry of Health & Population

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Nepal

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Date: 31 August 2009

Julian Lob-Levyt
Executive Director
GAVI Alliance
C/O UNICEF, Palais des Nations
CH-1211-Geneva 10

**Subject: Submission of GVI HSS Proposal**

Dear Dr. Julian Lob-Levyt

It is my great pleasure to submit to you the Health System Strengthening (HSS) support proposal phase II. As for your kind information GAVI had already approved Nepal HSS support proposal for the period of two years (2008-2009).

The proposal was developed in a very participatory process with the involvement of high officials from government of Nepal, representatives from external development partners, civil societies, professional organizations and community health workers and volunteers. Several consultative meetings were organized to identify bottlenecks of existing health system and ways to resolve those constraints. Then the proposal was finalized, endorsed by the NHSCC members and approved by government of Nepal.

The original copy of the documents with supporting documents and CD will be send by WHO pouch.

Please let us know if there are any queries and concerns.

Thanking you,

Dr. Y.V. Pradhan
Chief
Policy Planning and International Cooperation Division
Ministry of Health and Population

# Application Form for:

# GAVI Alliance Health System Strengthening (HSS) Support 2009

## Ministry of Health and Population, Government of Nepal.

## September 2009

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## Abbreviations and Acronyms

| | |
|---|---|
| **ANM** | Auxiliary Nurse Midwife |
| **AHW** | Auxiliary Health Worker |
| **BEOC** | Basic Emergency Obstetric Care |
| **CB-IMCI** | Community Based Integrated Management of Childhood Illness |
| **CEOC** | Comprehensive Essential Obstetric Care |
| **CHD** | Child Health Division |
| **DFID** | Department for International Development |
| **DHO** | District Health Office |
| **DHS** | Demographic Health Survey |
| **DoHS** | Department of Health Services |
| **DTCO** | District Treasury Controller Office |
| **EDP** | External Development Partner |
| **EHCS** | Essential Health Care Services |
| **EPI** | Expanded Program for Immunization |
| **FCGO** | Financial Controller General Office |
| **FCHV** | Female Community Health Volunteer |
| **GAVI** | Global Alliance for Vaccines and Immunization |
| **GoN** | Government of Nepal |
| **GTZ** | Gesellschaft für Technische Zusammenarbeit (German Technical Agency) |
| **HFMC** | Health Facility Management Committee |
| **HMIS** | Health Management Information System |
| **HP** | Health Post |
| **HR** | Human Resource |
| **HSS** | Health System Strengthening |
| **ICC** | Interagency Co-ordination Committee |
| **JICA** | Japan International Co-operation Agency |
| **KFW** | Kreditanstalt für Wiederaufbau (German AID Agency) |
| **MCH** | Maternal & Child Health |
| **MDG** | Millennium Development Goal |
| **MoF** | Ministry of Finance |
| **MoHP** | Ministry of Health and Population |
| **MTEF** | Medium Term Expenditure Framework |
| **NDHS** | National Demographic Health Survey |
| **NGO** | Non-Governmental Organization |
| **NHSCC** | National Health Sector Coordination Committee |
| **NHSP-IP** | Nepal Health Sector Program - Implementation Plan (2004 – 2009) |
| **NHSS/HSRS** | Nepal Health Sector Strategy: an Agenda for Reform |
| **NHTC** | National Health Training Centre |
| **NSMNH-LTP** | National Safe Motherhood and Newborn Health Long Term Plan (2006 – 2017) |
| **PHC** | Primary Health Centre |
| **SBA** | Skilled Birth Attendant |
| **SSMP** | Support to Safer Motherhood Program |
| **SWAp** | Sector Wide Approach |
| **3YP** | Three Year Plan for Health Sector 2007 – 2009 (2064/65 -66/67) |
| **TWG** | Technical Working Group |
| **UNFPA** | United Nations Fund for Population Activity |
| **UNICEF** | United Nations Children's Fund |
| **USAID** | United States Agency for International Development |
| **VDC** | Village Development Committee |
| **VHW** | Village Health Worker |
| **WB** | World Bank |
| **WHO** | World Health Organization |

## Executive Summary

### Background to this proposal

The overall aim of the Ministry of Health and Population of Nepal is to provide an equitable, high quality health services for the Nepalese people. The overarching framework which is the Second Long Term Health Plan (SLTHP) 1997 – 2007 clearly reflects this aim. Setting a comprehensive strategic vision for Nepal, it stresses its focus on effective Child Survival, Safe Motherhood, and Essential Health Care Services (EHCS). With many interventions geared to achieve these objectives, the need to further strengthen the health system of Nepal has been clearly become obvious over the past decade. In 2007, the MoHP, Nepal had been successful to secure GAVI funds for Health Systems Strengthening, for a period of two years (2008-2009) in alignment with the National Health Sector Plan (NHSP). Realizing the increasing momentum in HSS activities being undertaken by the MoHP at central and district levels, the MoHP took a decision to make another submission seeking HSS funds for the period of 2010-2012.

The National Health Sector Coordination Committee (NHSCC), which was initially constituted in November 2006 under the Chairmanship of the Hon. Minister of Health and Population, to meet the need for a national forum to provide oversight to development and implementation of GAVI Health Systems Strengthening (HSS) steered the proposal development activities. Under the NHSCC a Technical Working Group (TWG) was established in May 2009 to lead and guide the preparation of this application. A national and two regional consultations were held with the participation of a wide range of health workers, development partners, NGOs and civil society representatives to identify critical system bottlenecks which need to be corrected through this proposal to ensure equitable access to essential health services.

The NHSCC coordinated and provided oversight to the HSS application development. The TWG under the Chairmanship of the Chief Specialist, Policy, Planning and International Co-operation (MoHP) led the drafting of the proposal, with technical assistance of WHO and UNICEF country offices. Many other stakeholders, development partners and focal points of WHO and UNICEF Regional Offices too provided inputs on the proposal. The NHSCC will continue to oversee HSS implementation and will coordinate the integration of future HSS efforts into the National Health Sector Reform Strategy.

### Health Sector vision

The MoHP formulated the 2004-2007 *Health Sector Strategy: An Agenda for Reform* (HSRS) in 2003, to guide a transformation of the health sector towards a sector-wide approach (SWAp) as well as to incorporate a more strategic approach to health planning. In addition, it emphasized on priority to interventions which will help achieve the MDGs.

To implement the reform agenda, the MoHP developed the *Nepal Health Sector Program Implementation Plan 2004 - 2009* (NHSP-IP) in 2004. It was accompanied by a pooled financing agreement signed by the GoN, DFID and the World Bank, with the government committing to increase budget support for the health sector in return for more predictable external financial aid flows. The NHSP-IP is an operation guideline that identified three key program outputs:

- Provision of essential health care services (EHCS);
- Decentralization of service delivery; and
- Implementation of Sector-Wide management and Public-Private Partnerships.

Further Nepal is a IHP country with its IHP + compact developed.

Objectives that will receive HSS support from GAVI were chosen after a multi-stage process, determined by evidence-based solutions that could deliver a significant and sustainable impact. The three objectives contained in the HSS proposal are in line with the three thematic groups, and will complement each other to achieve a sustainable improvement in MCH outcomes.

The MoHP is in the process of developing the NHSP-IP 2 for the period 2010-2015. This will ensure continuity with modifications if found to be necessary to accomplish meeting the MDGs and Nepal's other major health policy objectives. As part of the development process the MoHP has finalized the concept document which links NHSP IP 1 to the IHP + compact, three year national plan and would guide the development of the NHSP-IP 2.

**Goal**

The overall goal is to achieve and sustain maternal and child health related MDGs by 2015, by accelerating achievement of universal and equitable access and high utilization of maternal and child health services, including immunization.

**Objectives**

The proposed objectives are arranged under the three thematic areas that have been maintained throughout this proposal. They are:

1. To certify 1700 community-based health workers to manage delivery of MCH and immunization services to manage grass-root level health institutions by 2012.

2. To develop organization and management capacity for district health service delivery in 15 low performing districts and 25 municipalities by 2012

3. To ensure all 75 districts acquire essential logistics management facilities by 2012.

**Activities**

The activities have been carefully identified based on the outcomes of the regional and central consultations. The extensive consultative process with the regions, districts and sub-districts enabled the TWG to identify a list of priority interventions from the perspective of service delivery providers and users. These specific issues, grouped under three themes, were then compared to gaps in existing support required to deliver the strategic objectives and goals for the health sector, outlined in section 2.2.

**Expected Impact**

The proposal aims to expand and sustain high immunization coverage rates in all districts, and to improve health outcomes of women and children. It is aimed at addressing the critical gaps that prevent Nepal achieving high coverage of immunization and the equivalent level of provision of other Essential Health Care Servicers (EHCS). The strengthening of core system components and processes will ensure that the capacity to extend delivery of health services can be sustained over the long term.

**Management, Monitoring and Evaluation**

The GAVI Annual Progress Report (APR) for the HSS component will be prepared by the Policy, Planning and International Cooperation Division, MoHP, in collaboration with Family Health Division, Child Health Division, Management Division, Logistic Management Division and the National Health Training Centre (NHTC) , Department of Health Services (DoHS). The NHSCC will review, revise and endorse the APR prior to submission to GAVI.

The indicators selected for each activity are measurable and are based upon data that is already being regularly collected through the HMIS, DHS or as part of routine administrative data. In terms of the needs of M&E for the GAVI HSS activities there is no necessity for developing parallel systems in data collection and analysis for the indicators which have been identified in section six.

**Costs**

Based upon the birth cohort and Nepal being in the category that receives US$ 5/child, Nepal is eligible for US$ 14,540,690 of GAVI HSS support over the 3 year period covered by this application. The total cost for activities under the three objectives is US$ 14,540,852**.**

**Financial and Technical Sustainability**

The activities proposed through this proposal are part of a broader health sector development program (NHSP-IP) of Nepal that joins the Government with eleven External Development Partners[1] in a long-term financial commitment to support the health sector. This includes the commencement of a sizeable pooled funding mechanism, with all future contributions from the World Bank and DFID going into this pool, which is in turn used as part of the regular budget allocation for health. In addition, the other EDPs have pledged to reduce administrative overheads and support the priority strategies and policies of the government when drafting external aid packages.

A constitutional amendment has been made declaring health as a human right, which obligates the Government to pay for primary health care services for the entire population (3YP p. 3). On a programme level, as a matter of policy, the Ministry of Finance will only sign off on plans which it considers to be financially sustainable.

The Government has a track record for meeting financial sustainability targets as evidenced by its funding of the procurement of traditional vaccines and supplies. In addition, the health sector-wide approach to management as used in Nepal assures that pool funding will be used to cover high priority interventions, which includes safe motherhood and immunization.

Further provision of quality services will generate demand from the communities for health services, and contribute to getting community leaders more engaged in supporting local health services. Demand for new MCH services will be sustained through existing networks of FCHVs, community based organizations and NGOs at district and sub-district levels.

[1] The External Development Partners is an informal group, comprised of signatories of the NHSP-IP, who elect a rotating chair. They work to coordinate and harmonize support from all external sources, and liaise with the government to support the successful implementation of the NHSP-IP.

## Section 1: Application Development Process

### 1.1: The HSCC (or country equivalent)

**Name of HSCC (or equivalent):**

National Health Sector Coordination Committee (NHSCC).

**HSCC operational since:**

The NHSCC has been operational since November of 2006 and had been reorganized in July 2007 to include more senior level officials who are policy-makers from areas contributing to capacity development and health system strengthening (see section 1.3 for details)

**Organisational structure (e.g., sub-committee, stand-alone):**

The NHSCC is a stand-alone committee chaired by the Honourable Minister of Health and Population. Members include senior policy level officials of the Ministry of Health and Population (MoHP), representatives from the UN Specialized Agencies, The World Bank, the Chair of the National Health Research Council and the eleven External Development Partners (EDPs) who, along with the Government of Nepal (GoN) are signatories to the Nepal Health Sector Program - Implementation Plan 2011-2015 and almost all of them are signatories of the IHP + National Compact. In addition, nine of these EDPs currently sit on the ICC board (cMYP p. 37), and the Chairman of the EDP is member of the NHSCC (along with several other EDP members).

Under the NHSCC a Technical Working Group (TWG) was constituted on 6 May 2009 to support and develop the second GAVI HSS application for a further period of three years. The coordinator of the TWG is the Chief, Policy, Planning and International Cooperation Division, MoHP. The TWG is guided by the NHSCC.

**Frequency of meetings:**

The NHSCC has been meeting biannually. However, the NHSCC met three times in relation to development of the second HSS application for the period of 2010-2012.

However, following the decision of NHSCC to submit another application covering the period 2010 onwards, the TWG meet frequently to facilitate consultations, to collect and analyze technical information for the new proposal and top draft the proposal.

Regular meetings of the NHSCC will continue to harmonize government and all External Development Partner (EDP) assistance directed at HSS and to supervise HSS implementation and assess performance against the chosen indicators.

The Planning and International Cooperation Division of the MOHP, led by the Chief of Planning act as the secretariat for the NHSCC during such meetings assisting NHSCC to monitor and assess performance against pre-identified technical and financial indicators.

Regular meetings of the NHSCC will continue to supervise HSS implementation and assess performance against the chosen indicators.

**Overall role and function:**

The NHSCC was first constituted to meet the need for a national agency to provide oversight to development and implementation of GAVI HSS and to ensure that the efforts are consistent with and supportive of the national health sector development framework (SLTHP, NHSS, NHSP-IP; 3YP, IHP+ National Compact).

The NHSCC is supervising and reviewing the implementation of the ongoing GAVI HSS phase I activities which are planned for 2008-2009. It will also ensure that GAVI HSS supported efforts remain aligned with the new five year national sector development plan (NHSP-IP 2, 2010-2015), which will continue to work towards achievement of the MDGs, and the overarching Second Long-Term Health Plan 1997-2017.

Following the decision that Nepal is to apply for the second round of GAVI HSS assistance to scale up systems strengthening activities that have been already initiated, the NHSCC closely coordinated and provided oversight for the proposal development activities.

The main roles and functions of the NHSCC include:

- Advocating for political and financial commitments and mobilization of resources for health;
- Overseeing the development of the GAVI HSS application and exploring other opportunities for HSS;
- Ensuring the GAVI HSS and the National Health Sector Plan are in alignment;
- Endorsing the GAVI HSS application under the authority granted by the MoHP;
- Coordinating, supervising and monitoring the planning and implementation of the HSS activities, to ensure future HSS initiatives are integrative and complementary;
- Overseeing and reviewing the preparation of Annual Progress Reports to the GAVI Alliance on the outcomes of HSS support.

### 1.2: Overview of application development process

**Who led the drafting of the application? Was any technical assistance provided?**

The NHSCC, under the Chairmanship of the Honourable Minister for Health and Population, provided the oversight for the application development process. The NHSCC supervised activities of the TWG, and authorised consultative meetings to get information and feedback from central, regional and sub-district levels.

TWG under the chairmanship of Chief, Policy, Planning and International Cooperation Division, MoHP, led the drafting of the application. The TWG comprises of high level officials from MoHP, representatives from EDPs and civil society.

WHO & UNICEF provided technical assistance.

The final draft was reviewed and endorsed during the NHSCC meeting on the 21 August 2009.

**Give a brief time line of activities, meetings and reviews that led to the proposal submission.**

Government of Nepal had been successful in securing GAVI HSS funds for the period of 2008-2009 (two years) which was in alignment with the first National Health Sector Development Plan.

Realizing the need to maintain the momentum of Health Systems related activities already initiated especially in low performing districts, the government decided to submit a new proposal for the period 2010-2012. This section outlines the activities that have been carried out by the MoHP in relation to development of this proposal.

From May 2009 the TWG met regularly to develop the proposed GAVI HSS Proposal.

The first TWG meeting was organized to draw the road map for the proposal development process. During this meeting, the TOR for the TWG was finalized, and the road map with a time-specific action plan was developed.

During the second meeting, the TWG members reviewed the health systems bottlenecks identified in the previous GAVI HSS proposal (based on national health systems reviews) against the current evidence /knowledge. The draft of the GAVI HSS tracking study report too was reviewed In detail.

1. A national consultation meeting was organized by the MoHP on 14 July 2009 with the objective of providing an opportunity to a wider audience to air their perceptions on critical health system challenges that constrain the delivery of maternal and child health services. The Directors of the Department of Health Services (DoHS), senior officials of the MoHP, representatives of the technical agencies, Development Partners, representatives of community-based organizations, professional organizations and NGOs participated at the consultation. Many systems issues which are being faced at the national and sub-national levels were discussed in depth. The group work sessions further provided them an opportunity to highlight the root causes of some of these problems in detail, and allowed them to identify effective and efficient interventions which can be included in the GAVI HSS proposal.

2. Two regional level consultations were held on 20$^{th}$ July and 4$^{th}$ August to elicit information and opinions from field level stakeholders on the health system bottlenecks they face. District and sub-district staff was extensively consulted to assess the type of activities that had been successful in overcoming constraints to achieve a higher MCH service coverage. Participants included district health workers, civil society members, municipality health staff, community health workers and Female Community Health Volunteers, UNICEF, WHO, NGOs, Plan International, USAID, CARE, CORE, GTZ, Nepal Red Cross, Family Planning Association, and ADRA who are working at field level.

The above information-gathering sessions was a critical component of the evidence base used in redeveloping this new application for HSS support. In particular, it helped ensure that the views of district and sub-district level service providers and stakeholders continued to shape the development of the application for submission.

In a subsequent meeting the TWG discussed the activities that have been already identified in the 2008-2009 GAVI HSS proposal, and discussed the progress of their implementation paying more attention to the constrains the MoHP is facing in its implementation.

Two proposal development and writing workshops were organized subsequently.

Their compatibility with the current HS problems and challenges were critically analyzed.

**Who was involved in reviewing the application, and what was the process that was adopted?**

Members of the NHSCC and TWG comprised of high level officials from the MoHP and MoF, directors from the DoHS, and representatives from the National Planning Commission, the Nepal Health Research Council, the WHO, World Bank, USAID, UNFPA, UNICEF, and the chairperson of the External Development Partners have been involved in reviewing the application. The process included formal meetings (listed above) and consultations with several other stakeholders, such as AusAID, WHO SEARO, UNICEF-ROSA and JICA.

**Who approved and endorsed the application before submission to the GAVI Secretariat?**

The Chair of the NHSCC, along with senior officials from the Ministry of Health and Population and the Ministry of Finance and representatives of EDPs approved and endorsed the application on 21 August 2009.

**Was funding received from GAVI for HSS proposal development? If so, how much, when was it received, and what was it used for or what will it be used for?**

Some of the proposal development activities which were carried out through the proposal development grant received by MoHP to develop its first GAVI HSS proposal assisted the development of this proposal too.

However the MoHP Nepal did not receive funds from GAVI through the proposal development grant for development of this application.

### 1.3: Roles and responsibilities of key partners (HSCC members and others)

| Title / Post | Organisation | HSCC member yes/no | Please list the specific roles and responsibilities of this partner in the GAVI HSS application development |
|---|---|---|---|
| Minister | Ministry of Health and Population | Yes | Led the NHSCC in overseeing development of the application. Ensured the application was in line with the MoHP's 3YP and 2nd long-term Health Plan IHP+ National Compact; approved and endorsed application. |
| Secretary | Ministry of Health and Population | Yes | Provided overall guidance on application development, coordinated communication between the MoHP and MoF on the endorsement and approval of the application. |
| Chief, Policy Planning & International Cooperation Division | Ministry of Health and Population | Yes | As Chairperson of the TWG and member secretary of NHSCC, convened meetings of the TWG and NHSCC, provided technical input, coordinated communication between MoHP and other line ministries related to GAVI application, and provided input on technical policies and requirements of the MoHP. Ensured the application was in line with the MoHP's ongoing strategic plans. |
| Chief, Public Health Administrator, Monitoring & Evaluation Division | Ministry of Health and Population | Yes | Offered overall guidance on application development, provided feedback on monitoring and development of indicators. |
| Director General | Department of Health Services | Yes | Provided overall guidance on application development, provided input on identification of bottlenecks and activities to overcome those bottlenecks. |
| Joint Secretary | Ministry of Finance | Yes | Provided information on flow of funds and sustainable financing, and assisted in defining future funding gaps. |
| Joint Secretary | National Planning Commission | Yes | Gave guidance on proposal application and on linking planning of activities to national planning cycles. |
| Chief | Ministry of | Yes | Ensured linkage of proposed HSS activities to |

| Title / Post | Organisation | HSCC member yes/no | Please list the specific roles and responsibilities of this partner in the GAVI HSS application development |
|---|---|---|---|
| Coordinator Health Sector Reform Unit | Health and Population | | NHSP-IP |
| Chairman | Nepal Health Research Council | Yes | Provided overall guidance on application development, provided feedback on evidence-based used for priority-setting. |
| Representative | WHO | Yes | Offered overall technical input on assisting and identifying priority districts and constraints, and facilitated identification and hiring of an international consultant. |
| Representative | UNICEF | Yes | Provided technical input on development of application, and linkages to MCH, CB-IMCI and EHCS. |
| Representative | UNFPA | Yes | Presented technical input on health-related efforts in other sectors relevant to the development of an HSS strategy. |
| Health Section Chief | USAID | Yes | Gave feedback and technical input on development of application. |
| Health Section Chief | WB | Yes | Provided technical input on the area of sustainability financing for HSS. |
| Director, Child Health Division | Department of Health Services | No | Coordinated development of the application, and provided technical input on identification of service delivery bottlenecks and choosing the HSS interventions which would be supported by GAVI. |
| Director, Family Health Division | Department of Health Services | No | Provided technical input into the identification of MCH service delivery bottlenecks and selection of interventions. |
| Director, Logistic Management Division | Department of Health Services | No | Helped to identify logistic, transportation and supply management bottlenecks, and in assessing the system constraints causing them. |
| Director, National Health Education, Information and Communication Centre | Department of Health Services | No | Provided technical input on communication and demand-side health system weaknesses. |
| Member Secretary | Nepal Health Research Council | No | Provided technical input on local research relevant to developing strategies and activities to overcome systemic constraints to improved services. |
| Other representatives from WHO | WHO | No (TWG member) | Provided technical input on identification of bottlenecks of health system, HSS strategies, HSS financing, GAVI guidelines, and technical support to application development |

| Title / Post | Organisation | HSCC member yes/no | Please list the specific roles and responsibilities of this partner in the GAVI HSS application development |
|---|---|---|---|
| | | | and writing. |
| Other representatives from UNICEF | UNICEF | No (TWG member) | Provided technical input on integration of immunization, MCH and other services, linking HSS strategies to GAVI guidelines, and technical support to application development and writing. |
| EPI Manager | Department of Health Services | No | Shared experiences in overcoming system barriers to improved immunization services, and in managing development and implementation of GAVI supported strategies. |
| Program Officer | Department of Health Services | No | Provided information on communication, and on gaps in the health management information system (HMIS) |
| Various representatives of district health staffs, civil society, partners, NGOs | District and below level people | No | Assisted in identifying barriers and bottlenecks at the service delivery and facility levels. *Provided the sub-district viewpoint on priority interventions and lessons learnt to overcome those barriers.* (See Report of the Regional Consultative Meeting 2009, Doc. #7). |
| Medical Officer | Ministry of Health and Population | No | Provided information of human resource development and policy of MoHP on performance based incentives to health staff in rural and urban areas. |
| GAVI Focal Point | WHO | No | Assisted in organizing meetings of NHSCC and TWG, searching various documents related to the application process, and checking for compliance with GAVI HSS guidelines. |
| Various representatives of district health staffs, civil society, partners, NGOs | District and below level people | No | Assisted in identifying barriers and bottlenecks at the service delivery and facility levels. *Provided the sub-district viewpoint on priority interventions and lessons learnt to overcome those barriers.* (See Report of the Regional Consultative Meeting 2007, Doc. #7). |

### 1.4: Additional comments on the GAVI HSS application development process

In 2007, MoH Nepal was successful in securing GAVI HSS funding for a period of two years which was in line with the NHSP IP 2004-2009 and the Three-Year Government Health Plan. The development processes for the HSS proposal were interactive and inclusive under the full ownership of the MoHP.

The need to have access to health systems funds without an interruption prompted MoH to make another submission in September 2009 for a period of three years which will be in alignment with the proposed NHSP-IP 2 (2010 to 2015) which is being developed.

The development processes for the HSS proposal was comprehensive, interactive and inclusive under the full ownership of the MoHP. At the outset, the NHSCC with members representing senior officials from the MoHP, the MoF, and the National Planning Commission met to discuss implementation status, problems, constraints faced during the GAVI HSS first phase support. The NHSCC set out the guiding principles for the application development and formed a TWG to develop the actual application.

The guiding principles for the application development process were three fold: 1) ensure activities are in line with national health objectives contained in the concept paper developed to guide the development of the NHSP-IP 2 (2010-2015), the Three Year Government Health Plan for the Health Sector and IHP National Compact; 2.) ensure they are in alignment with the current GAVI HSS activities that are being implemented and 3) maintain an interactive consultation with all stakeholders involved in health care provision, financing and regulation. This included public health providers, private for-profit and private non-profit providers, local government representatives, line ministries, public and private organizations, and community and civil societies

The consultative workshops identified the health system strengths and weakness that had the greatest impact on service delivery especially at the sub-national level. These finding were synthesized at the central level and presented to the NHSSC. Based on the short listed system constraints and proposed activities the NHSCC prioritized the key system constraints, followed by identifying the activities required to overcome these systemic barriers that affect the MCH service provision. The NHSCC also reviewed the activities and implementation status from HSS phase I support and findings of the tracking study. The draft application prepared by the TWG was shared with the members of the NHSCC and with EDPs. After a series of discussions and revisions, the final draft was presented to the NHSCC for endorsement.

Lesson learned during the proposal development and first year of its implementation with the, problems faced is elaborated in the GAVI HSS Tracking study which emphasizes the benefits that have been brought by GAVI HSS funding.

## Section 2: Country Background Information

### 2.1: Current socio-demographic and economic country information[2]

| Information | Value | Information | Value |
|---|---|---|---|
| Population [2008][a] | 27,383,773 | GNI per capita [2008][b] | $US 290* |
| Annual Birth Cohort [2008][c] | 804,164 | Under five mortality rate [2006][d] | 61/1000 |
| Surviving Infants* [2008][a] | 751,261 | Infant mortality rate [2006][d] | 48/1000 |
| Percentage of GNI allocated to Health [2006][e] | 1.5 % | Percentage of Government expenditure on Health [2008][f] | 6.53 % |
| DPT3 coverage rate (by sex, where available) [2008][a] | 81.9 % | | |

[a] Health Management Information System, Management Division, DHS/MoHP, 2007.

[b] World Bank, World Development Indicators Database, July 2007. Data refers to 2006.

[c] cMYP, 2007-2011.

[d] Nepal Demographic and Health Survey 2006.

[e] UNDP Human Development Report 2006.

f[1] Government of Nepal Financial Comptroller General Office Consolidated Financial Statements FY 2005-2006.

### 2.2: Overview of the National Health Sector Strategic Plan (concept paper for the NHSP IP 2 being developed) (Document Number 4) and how it links to the cMYP (Document Number 5)

Nepal's Ministry of Health and Population's overall aim is to provide an equitable, high quality healthcare system for the Nepalese people. The overarching framework is the Second Long Term Health Plan (SLTHP) 1997–2017 (document 14). Setting a comprehensive strategic vision for Nepal, it stresses a focus on effective Child Survival, Safe Motherhood, and Essential Health Care Services (EHCS) emphasizing the need to achieve high immunization coverage. EHCS is a package of priority health services designed to reduce the leading causes of morbidity and mortality. The EHCS are implemented at the district and sub-district levels (p. 4-5 SLTHP).

Towards this aim, the GoN formulated the Health Sector Strategy: An Agenda for Reform (HSRS[3]) (Document1) in 2003 to guide a transformation of the health sector towards a sector-wide approach (SWAp) as well as to incorporate a more strategic approach to health planning. In addition, it gave "priority to interventions which will help achieve the MDGs." The set of EHCS (Child Health, control of communicable diseases such as Vaccine Preventable Diseases (VPDs), family planning, safe motherhood and improved out patient care) was placed centre-stage, to be delivered within a decentralised system that encouraged increased private sector and NGO participation (p. 10). In addition, the HSRS was consistent with the guidelines for the health sector contained in the 3YP.

Strategically, it detailed the strategies and polices required to strengthen equitable access to services, reduce financial barriers faced by the poor and marginalized, and called for decentralizing administrative and financial power to local authorities while simultaneously integrating separate disease-based programmes (p.8). Thus, it laid the framework for a sector-wide and integrated approach to Sector Management, including an integrated MIS and health sector financing

**[2] If the application identifies activities that are to be undertaken at a sub-national level, sub-national data will need to be provided where it is available. This will be in addition to the national data requested.**

[3] The NHSS is called for the Health Sector Reform Strategy (HSRS) in current GoN documents, including the 3YP.

approach. This is guiding the expansion of SWAp into a broader HSS strategy, which in turn defines the priorities used to select the activities to be included in this HSS proposal to GAVI.

To implement the NHSS reform agenda, the MoHP developed the Nepal Health Sector Program Implementation Plan 2004-2009 (NHSP-IP) in 2004 (Document 2). It was accompanied by a pooled financing agreement signed by the GoN, DFID and the World Bank, with the government committing to increase budget support for the health sector in return for more predictable external financial aid flows. The NHSP-IP was a series of operation guidelines that identified three key program outputs:

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

Consistent with the HSRS, outcome and impact indicators were linked to achievement of the MDGs (NHSP-IP pp. xv-xvii) and the pro-poor and equity objectives of the health components of the 3YP, consistent with the PRSP (MDG Progress Report 2005 p.39). Importantly, in Annex 1 of the NHSP-IP, the "Statement of Intent to Guide the Partnership of Health Sector Development in Nepal" sets a single framework ensuring that the MoHP and the 11 signatory External Development Partners[4] unified their objectives and activities for strengthening the health sector. In addition to an agreement on moving towards pooled funding, partners agreed to work within the operational guidelines of the NHSP-IP and the strategic vision for health of the HSRS.

***Nepal Health Sector Program Implementation Plan 2010 - 2015*** (NHSP-IP-2)

The MoHP is in the process of developing the NHSP-IP 2 for the period 2010-2015. NHSP IP 2 will ensure continuity while including any necessary changes in order to accomplish meeting the MDG goals and Nepal's other major health policy objectives. The need to pay more emphasis on maternal and child health services has been already highlighted. As part of the development process, the MoHP has finalized the concept document (document 4) which will guide the content of NHSP-IP 2. It aims to address the following key problems and challenges.

**Major Problems:**

- Human resources for health management, especially deployment and retention in remote and rural areas
- Human resources for safe delivery
- Logistic management, especially procurement of quality drugs and distribution throughout the country
- Infrastructure development, especially new construction at locations most likely to increase access iv poor, vulnerable and marginalised to meet their needs
- Low capacity of local bodies to govern and manage health facilities
- Poor supervision aid monitoring

[4] AusAID, DFID, GTZ, ILO, JICA, SDC, World Bank, UNICEF, UNFPA, USAID, WHO; p. 55 of NHSP-IP

**Challenges:**

- Strengthening the quality of health care services
- Increasing access to essential health care services
- Decreasing health disparities in utilisation of health services
- Decreasing the burden of non-communicable diseases, injury and violence
- Increasing prevention, care, support and treatment coverage for most at risk population affected by 14W infection
- Decreasing HIV seroprevalence in migrant health workers
- Making progress in improving nutritional status of children
- Regulating growth of private health sector and utilising private human resources for health training at educational institutions
- Ensuring the constitutional rights of citizens and ensuring "basic health as a fundamental right"

Nepal's interim Three Year Plan (15 July 2007-14 July 2010) is a strategic plan developed in the context of the current political scenario of Nepal (document 3). It aims to provide continuity and strength to the NHSP-IP, and to extend the HSRS through 2010 (the 2009-10 fiscal year ends 14 July 2010). This will allow time for the completion of the next strategic plan.

The Three Year Plan (3YP) lists the following 10 key objectives:

1. To provide equal opportunity for health development to all with special emphasis to socially disadvantaged, poor, women, and disable people as per the provision of "Basic Health as Human Rights" in the Interim Constitution of Nepal 2006.
2. To strengthen ongoing high priority Essential Health Care Services (EHCS) and achieve the Millennium Development Goals in accordance with the principles of Primary Health Care, equity and social justice.
3. To redesign the health system to make people oriented, efficient and effective through reform in institutional management and health professional education.
4. To ensure availability of good quality essential drugs to all at affordable prices through pharmacy services.
5. To strengthen Public Private Partnerships.
6. To improve hospital services and referrals through integrated management and the District Health System.
7. To initiate important services such as urban health and health of elderly, which are not currently included in EHCS.
8. To promote Health Research and Health Research Systems.
9. To develop Ayurvedic and other alternative systems of medicine.
10. To align population policies and progress with the goal of poverty eradication.

**International Health Partnership (IHP+) National Compact:**

On 2007 Nepal signed the IHP Compact together with many of its key health-sector development partners.

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 to implementation of sector plans and shared accountability for achieving results.

The '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 points 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.

In furtherance of the already agreed measurable targets for meeting the MDGs the signatories of Nepal Health Development Partnership, have developed a set of additional commitments. These are:

1. Strengthen alignment and management of ODA in accord with national policy

2. Advance citizens' rights

3. Improve financial planning and alignment

4. Increase access and service delivery effectiveness

5. Advance equity and social inclusion

6. Strengthen SWAp

The fulfilment of the commitments made in this document will be measured against the indicators at each Joint Annual Review (JAR) or annually at one JAR meeting as appropriate to the nature of the indicator

Consistent with the above vision for the health sector is the National Immunization Program's Multi-Year Plan of Action 2007 – 2011 (cMYP). The National Immunization Program is within the Child Health Division of the Department of Health Services. The cMYP is in line with the drive for integrated and sector-wide management of health programs, and a rationalization of operations to create synergies and economies of scale, as called for in the NHSP-IP (pp. 78-79 Outputs 4 and 8). Additionally, immunization indicators are part of the assessment of EHCS provision, and are collected through the HMIS. Relevant areas of the cMYP are discussed in Section 3.1-3.4.

## Section 3: Situation Analysis / Needs Assessment

3.1: Recent health system or immunization assessments

| Title of the assessment | Participating agencies | Main findings in terms of child mortality, immunisation coverage or health systems weaknesses | Dates |
|---|---|---|---|
| Consolidated Report of The central and two Regional Consultative Meeting for Planning GAVI HSS Support<br>(document 7) | MoHP, USAID, AusAid, private health institutions, CBOs, WB, NRCS, FPAN, NHRC, health workers from different levels, Female Community Health Volunteers, Plan International, CARE, UNICEF, WHO, civil societies, professional organizations, local bodies | • The activities being carried out through GAVI HSS (first phase) to address weaknesses identified in 2007 to be continued Inadequate Health workforce as per population lack of adequate skill and motivation for MCH services<br>• Weak organization and management of health services, poor accountability and governance, low utilization of available services more among the disadvantage group Inadequate Heath infrastructure, Inadequate transportation facilities, irregular power supply, | 2009 |
| National Immunization Program of Nepal, Multi-Year Plan (cMYP)<br>(document 5) | MoHP, DoHS, ICC, WHO, UNICEF | • pp.24-25:<br>• Inequitable implementation: municipal areas and urban poor<br>• Poor district capacity to manage decentralised services, which are becoming increasingly integrated (expansion of EHCS)<br>• HMIS data at district level manually entered and tabulated: data reporting slow, incomplete and prone to errors; little computer skills amongst staff<br>• FCHVs absent in municipalities, essential to extending immunization coverage at sub-district level<br>• Health HR skills outdated and low; training is motivational and could help reduce high staff turnover, which particularly hinder BEOC and CEOC provision<br>• 43 of 75 districts lack essential physical infrastructure: vehicles, communication systems, health posts (e.g. birthing centres, which help attract mothers and increase demand for other services like EPI)<br>• Low female literacy rates hinder effectiveness of demand generation strategies<br>• Geographic barriers limiting access, and lack telephones in HPs and SHPs prevent timely reporting, hinder outbreak response | 2007 |
| Three Year Plan | MoHP | • P.5-6 | |

| Title of the assessment | Participating agencies | Main findings in terms of child mortality, immunisation coverage or health systems weaknesses | Dates |
|---|---|---|---|
| (document 3) | | • Adds programmes missing from NHSP-IP: putting into practice "Free Basic Health Service to All", commencing with poor and socially marginalized in 22 low districts with low Health Data Indicators (**Annex 2** Performance Evaluation of Districts)<br>• Implementation via SWAp, yet capacity to manage decentralization is weak<br>• Need to involve Private Sector and NGOs, to increase service efficiency<br>• Response to epidemiological transition requires more preventative activities to reduce needs for tertiary care | |
| Nepal Demographic and Health Survey (document 9) | MoHP, New ERA, USAID, Macro International Inc. | • Neonatal, child under 5 years of age and maternal mortality has reduced but is not yet on line with MDG targets.<br>• Immunization coverage improving, as is bednet coverage and coverage by EHCS.<br>• Remote and urban poor continue to have limited access to EHCS. | 2006 |
| Annual Report 2007/2008 (document 10) | DoHS | • Differentials of services utilization by Residence, Socio- Economic and Ecological Reasons<br>• Fulfilment and Retention of Human Resources in the sanctioned posts especially in the Hill and Mountain districts<br>• Upgrading of the Local Health Management Committees<br>• Proper coordination on Planning at Local and Central levels<br>• Need for availability of twenty four hour maternity services by the S BAs<br>• Changing blanket policy of health institution establishment based on the population size and its density.<br>• Need for sustaining the current high coverage of Immunization and of some specific health services.<br>• Problem with urban and peri-urban immunization<br>• Vacant post of vaccinators<br>• Inappropriate distribution of staff at different level | 2007/08 |
| | | • Need for strengthening and empowering health management committees, | 2009 |

| Title of the assessment | Participating agencies | Main findings in terms of child mortality, immunisation coverage or health systems weaknesses | Dates |
|---|---|---|---|
| Nepal Health Sector Program Implementation Plan 2 (concept paper) (document 4) | MoHP, EDP, Civil Societies, NGOs, Private Sector | community ownership of program at local levels<br>• Limited human resources proportional to population density<br>• Neo-natal mortality remains a particular challenge.<br>• Access to health services is not equitable. About twenty-two percent of the population still doesn't have access to even the basic health care services.<br>• Nutritional status in under five years children has not improved over the years and remains constantly poor.<br>• Nepal also faces the emerging threat of human Immunodeficiency Virus (HIV) /Acquired Immunodeficiency Syndrome (AIDS) the prevalence of which is highest in the region.<br>• A significant level of inequity in health outcomes still exists<br>• Marked differences have been seen in the IMR when the data is disaggregated geographical region, by economic status, and by educational level | |
| Nepal Health Development Partnership, IHP National Compact<br>(document 14) | MoHP, AusAID, DFID, UNFPA, GTZ, UNAIDS, UNICEF, WB, WHO | • Strengthen alignment and management of ODA in accord with national policy:<br>• Advance citizens' rights<br>• Improve financial planning and alignment<br>• Increase access and service delivery effectiveness<br>• Advance equity and social inclusion<br>• Strengthen SWAp<br>• Strengthen governance and accountability | 2009 |
| Nepal Health Development Partner Joint Annual Review<br>(document 15) | MoHP and EDPs in Health | • 20% of staff is not available to deliver health services<br>• The capacity of local health management committees to be enhanced to fill vacant posts | 2008 |
| Health Systems Strengthening Tracking Study ( document 18) | CHPRD | • Pool of HWs not receiving basic IMCI training<br>• Scaling of urban MCH | 2009 |

| Title of the assessment | Participating agencies | Main findings in terms of child mortality, immunisation coverage or health systems weaknesses | Dates |
|---|---|---|---|
| | | • Inadequate demand side barriers during need assessment | |
| Equity analysis of health care utilization and outcomes ( document 19) | MoHP, RTI/HSRSP | • Decreased utilization and unequal access to services<br>• Inequity in attendance of delivery by SBAs | 2008 |
| Examining the Impact of Nepal's Free Health Care Policy" (document 20) | MoHP, RTI/HSRSP | • Impact on service delivery due to vacant post<br>• Need for reliable method of transportation to minimize stock out of essential drugs,<br>• Free care monitoring committees need to become functional<br>• Different level organizational levels need to provide regular supervision and support | 2009 |
| FCHV Strategy<br>(document 17) | MoHP and partners | • Formation of Mothers group in each ward (the lowest administrative unit in Nepal) | 2008 |

### 3.2: Major barriers to improving immunisation coverage identified in recent assessments

The barriers that have been identified in 3.1 reflect the weaknesses in the national strategic plan outlined in section 2.2 above, based on the priorities set out in the HSRS, NHSP-IP 2, 3YP and IHP-National Compact. These include meeting the health needs including immunization children and women, providing equitable access to services for marginalised, remote and poor population segments, and involving communities and women in local health planning. The recent regional consultations have identified shortage of health workers and logistics (to reach out) as critical health system bottlenecks.

Barriers were prioritized according to review of performance data on districts (Annex 2), annual report 2007/08 and regional reviews to determine which were the leading causes of low immunization coverage, low provision of EHCS, poor utilization of facilities (particularly for antenatal care, and delivery in facilities by a SBA) and areas with inequitable access to services. The principal barriers identified from this review are organized and categorized according to the three main themes from the GAVI guidelines. Details for how each activity addresses specific constraints are provided in sections 4.1 and 4.2 below.

**1. Health workforce mobilization, distribution, and motivation.**

- Shortage of grass-root level health workers to provide MCH related services in remote rural districts (Regional Consultative Meeting 2009, NSHP-IP 2, Annual Report, DoHS 2007/08)
- Inappropriate distribution of staff at different level (Regional Consultative Meeting 2009, Annual Report, DoHS 2007/08)
- Limited capacity in regional and national training centres to train health workers
- Lack of motivation and difficulty in retention of health workers especially in remote rural districts. (NHSP-IP 2 Concept note, Examining the Impact of Nepal's Free Health Care Policy")
- Inadequate provision for sustaining the motivation of Female Community Health Volunteers (FCHVs)
- The skill level of health workers at the sub-district level (sub health posts, health posts and PHC facilities) are inadequate to deliver MCH, newborn and IMCI services. High turnover of such workers create a pool of untrained personnel who needs training
- Absence of sanctioned posts of Auxiliary Nurse Midwife (ANM) and other level of health cadres in the health facilities in the districts. (Examining the Impact of Nepal's Free Health Care Policy")
- High turnover of doctors and qualified nurses which hampers service delivery, especially Basic Obstetric Emergency Care (BEOC) and Comprehensive Emergency Obstetric Care (CEOC)

**2. Organization and management of district based health services especially for mothers and children.**

- Decentralization of the management of health services is slow
- Absence of urban MCH services to address the health needs of the urban poor (Annual report, DoHS 2007/08, Regional consultative meeting 2009)
- Weak micro-planning capacity in districts

- Inadequate provision of maternal and newborn care services due to insufficient infrastructure. Lack of infrastructure even to carryout outreach immunization programmes in remote districts

- Lack of buildings and equipment to provide safe delivery and newborn care at sub-district level

- Supervision and monitoring at all level is weak due to lack of transport, communication and responsive action following supervision, supervision not integrated, lack of proper reporting and feedback, lack of appropriate system for compilation and use of supervision reports (Annual Report DoHS 2007/08)

- Although the HMIS system is developed, disaggregated data in terms of gender and ethnicity is not available

- Community-level capacity to administer decentralized health management functions is inadequate at sub-district level. Community ownership tends to be weak.

- Lack of coordination between the public and private sectors with regards to service provision, human resources, quality and accountability (WHO country cooperation strategy 2006-2011)

- Significant health inequities persist between upper and lower household income quintiles, for women, between urban and rural areas, and amongst different ethnic groups (3YP 2007/08-2009/10)

- Managerial weakness at district and sub-district level (*3YP 2007/08-2009/10*)

- The need for demand creation and awareness at the community level is much felt. One of the strategies proposed is 'vitalization/establishment of mother's group' in each ward of the country. This will not only act as a means of creating awareness but will also help in improving local governance at the health institute. The FCHV strategy 2008 has clearly discussed the need for such activity.

**3. Transportation, communication and infrastructure.**

- Insufficient means of transport for supervision and monitoring, timely delivery of logistics and vaccine supply, and response to emergencies and outbreaks (cMYP)

- Insufficient means of communication in the majority of district health offices and health facilities (Regional Consultative meetings 2009)

- Inadequate infrastructure and lack of proper maintenance at sub-district level hampers retention of health staff and provision of quality services (3YP 2007/08-2009/10)

- Lack of continuous power supply (Regional consultative meeting 2009)

### 3.3: Barriers that are being adequately addressed with existing resources

Over years, the successive Governments of Nepal have been investing to minimize the barriers at all level through policies and strategies, programme planning and implementation at various levels. Support is sought from GAVI and other sources of external support to address some of these remaining gaps. Proposed GAVI funding is not for solely new activities but would complements the activities that are aligned with the government policy and planning and supported by partners to further reduce the barriers.

**1. Health workforce mobilization, distribution, and motivation.**

- With a view to reduce the shortage of grass-root level health workers to provide MCH related services especially in remote rural districts the government has already developed a policy and started to hire ANMs on contract basis using pool funds.

- Rectification of inappropriate distribution of staff at different level was an identified need and the government is also upgrading heath facilities each year. Each year the government has plans to upgrade 500 SHP to HP to provide quality service as well as better staffing of the health institutes.

- The lack of motivation and difficulty in retention of health workers especially in remote rural districts has been seen as a problem. The government since last few years have started to hire medical officers on contract paying them much higher scale of salary than the regular staff based on the remoteness of the area where they work. The government has further plans to introduce a package of performance-based incentives for service delivery and will be addressed in the new NHSP-IP 2. Revitalization and or formation of new mother's group would help the FCHVs to perform better and reach to every family in the country.

- To sustain the motivation of Female Community Health Volunteers (FCHVs), the government has brought in place the FCVH fund to be solely used as a revolving fund by the FCHVs at each village level. The government has also announced incentive of NRs 3000 per FCHV every year in recognition of their voluntary service.

- The skill level of health workers at the sub-district level (sub health posts, health posts and PHC facilities) are inadequate to deliver MCH, newborn and IMCI services. To address this the government is conducting review monitoring meetings on CB-IMCI and other MCH activities in more than 51 districts of the country every year and needs support for remaining districts.

**2. Organization and management of district based health services especially for mothers and children.**

- There is lack of urban MCH services to address the health needs of the urban poor (Annual report, DoHS 2007/08, Regional consultative meeting 2009). The government is addressing this issue by Urban Health program and has already formulated policy for the same.

- To address inequity in health services, the government has announced free primary health care services as well as Aama Suraksha program to ensure that mothers and children can avail MCH care.

- The government has owned the concept of birthing centres and have started to build birthing centres all over the country to address the issue of lack of infrastructure for delivery and newborn services. The government is seeking additional support to expanding the birthing centres.

- Supervision and monitoring at all level is weak due to lack of transport, communication and responsive action following supervision, non-integrated supervision, lack of proper reporting and feedback, lack of appropriate system for compilation and use of supervision reports (Annual Report DoHS 2007/08). To address this issue the government is initiating PBMS as pilot program where the monitoring is judged based on the performance of the health system and appropriate incentives provided to the best performer. The government is planning to expand this to more districts.

- Although the HMIS system is well-developed, the data disaggregated by age, gender and ethnicity comes only from 10 districts and the government wants to expand this to more districts.

- In order to enhance the community-level capacity to administer decentralized health management the government has handed over health institutions to the communities and have oriented the HFMOC in many districts and now needs support to expand this to more districts.

**3. Transportation, communication and infrastructure.**

- With support of the Government of Japan, a significant increase in cold stores capacity was achieved, with all 75 districts now having cold chain capacity sufficient for current routine immunization needs. However, central and regional cold chain capacity is insufficient to handle the frequent surges in stocks associated with campaigns (JE, measles, Polio all occur annually or more often). In addition, Pentavalent introduction will require additional capacity at central and regional stores (cMYP p. 20). These are partly being addressed by existing GAVI support under the NVS and ISS windows, and will be the focus of new GAVI proposals for ISS and NVS support. In addition, JICA, UNICEF and WHO provide assistance in cold stores support and management.

- UNFPA, WHO and other partners do donate some vehicles, but these donation are insufficient to meet the needs of supervision and monitoring, timely delivery of logistics supply, and response to emergencies and outbreaks in remote and rural districts.

- HMIS has been supported by GoN, UNFPA, UNICEF and WHO. Central level data management has improved, and annual reports are now produced with much better data quality. However, use of data for planning remains poor. A contributing factor is incomplete and late reporting from districts, caused by a lack of supervisory visits, scarcity of communications infrastructure (telephones, computers) and shortage of human resources. Resource requirements to augment communications and supervisory capacity to needed levels significantly outstrip current commitments by donors.

- Support received from GAVI to date has led to solid gains in strengthening the capacity of the immunization systems. Lessons learnt from these experiences informed the development of this proposal.

- Support of Immunization Services Strengthening allowed for intensive micro planning in 9 low coverage districts, orientation of health workers on best practices for handling AEFI, supported provision of technical training and skills updating, and helped to launch the data Quality Self-Assessment Audit in 10 districts. It was also used to improve supervisory and management capacity, supporting quarterly review meetings at district levels, coverage data analysis followed by action plan development at district and levels below. The latter includes the use of improve micro-planning strategies originating from the RED approach. RED has been highly successful in improving the micro-planning at the sub-district level, and the same approach is proposed to be piloted for integrated services delivery.

- Under Injection Safety support, the Government of Nepal has been able to procure all auto-destruct syringes and safety boxes for routine immunization using the government pool fund (World Bank, DFID)

- With GAVI support of New Vaccine Introduction, Nepal was able to introduce HepB monovalent into routine immunization schedule in 17 districts in November 2002. By 2004 it was expanded to all 75 districts. By July 2005 monovalent was replaced by tetravalent vaccine in all 75 districts in sequential manner.

GoN plans to take advantage of other system strengthening activities, originally initiated to improve immunization services. One important example is the Polio Surveillance Network. This will become the basis for integrated disease surveillance and outbreak investigations (3YP p.16: 9.2.1.6).

### 3.4: Barriers not being adequately addressed (in order of highest priority)

The Government is making a serious attempt to address the system barriers that have been identified in the recent past through review meetings, consultations and evaluations. Despite its efforts and restricted by limited financial resources, some of the constraints have still not been addressed adequately. Some of the critical areas that are yet to be addressed are:

1. Although Government of Nepal has taken a policy decision to provide a financial incentive to those that deliver in a health the home delivery rates still remain high. The facility-based delivery services are provided only in selected districts while in several geographical areas the necessary infrastructure for institutional deliveries remains grossly inadequate. Taking into consideration the extremely difficult terrain in these areas, the need to construct birthing centres to enhance institutional deliveries is of primary importance. These centres also will provide ANC including advocacy to promote age appropriate immunization of children.

2. Upgrading the skills of the primary care level health workers (community-based health workers) especially VHWs is a priority in the context of the government is upgrading 500 grass-root level health institutions per year with limited financial resources to ensure basic services at the village level. There is a need to upgrade the AHWs and VHWs to fulfil the health workforce needs in the upgraded health institutions.

3. Maintenance of the CB-IMCI programme after its expansion to all 75 districts has not yet received priority in terms of funding, despite being a priority programme of Nepal to achieve the MGD 4. The need to train newly recruited health workers in CB IMCI remains a priority.

4. To keep pace with the increasing challenges of district health management, the Government of Nepal has not been able to adequately invest on developing the management skills of its district health managers through need based in-service programmes due to funding gaps.

5. The country has started to experience frequent irregular power interruptions and the condition is predicted to be the same for another 5-10 years. The Government has no immediate or contingency plans to address this problem.

6. The key for Nepal's health system is community-based programmes. The community-based programmes are being conducted through the outreach clinics but most outreach clinics do not have suitable venues for their conduction and are run on ad hoc basis. Further in several remote rural districts there is no infrastructure to stimulate the community groups involved in monitoring village level health services to gather on regular basis

7. Although there is a need to strengthen and empower communities to take health development initiatives and to maintain ownership in community health development activities, systematic organization of such community groups is yet to take place.

### 3.5: Describe specific barriers to civil society and the private sector in delivering immunization services and strengthening health systems or becoming part of the national process to increase immunization coverage

The Non-Government sector and the private sector too play an important role in providing immunization services and other selected Primary Health Care services in Nepal.

**Specific barriers:**

- Lack of interest and awareness among private sectors to deliver immunization services, because EPI is conventionally perceived as government program
- Strong presence of private sectors is limited geographical only to peri-urban areas
- Lack of clear government strategy on involvement of private sectors in immunization (monitoring and supervision mechanism, recording and reporting mechanism, capacity building of private sector etc.)
- Inadequate coordination and cooperation of district health office with private partners
- Inadequate infrastructure for cold chain system and trained manpower for cold chain management
- Government is keen on public private partnership, but it is yet to be fully operational.

## Section 4: Goals and Objectives of GAVI HSS Support

### 4.1: Goals of GAVI HSS support

The overall goal is to achieve and sustain maternal and child health related MDGs by 2015, by accelerating achievement of universal and equitable access and high utilization of maternal and child health services, including immunization.

GAVI HSS support contributes to the overall goal for the Health Sector in Nepal, set out in the GoN's "Three Year Plan" and "NHSP-IP 2 concept paper": To bring about improvement in the health status of all the Nepalese population with the provision of equal opportunity for quality health care services through an effective and equitable health system as per provision of " free basic health care" as the fundamental human right as set out in the interim constitution of Nepal and develop healthy and capable human power to support poverty alleviation and national development.

### 4.2: Objectives of GAVI HSS Support

The overarching objective is to address significant system barriers faced by the health system in ensuring adequate MCH services including immunization services. GAVI Support for HSS will contribute to a coherent and consistent effort to win long-term gains in the health status of women and children, meeting the responsibilities described in the "statement of Intent to Guide the Partnership of Health Sector Development in Nepal" (NHSP-IP Document 2).

The objectives are arranged under the three thematic areas that have been maintained throughout this proposal.

***The objectives are:***

***Objective 1: to certify 1700 community-based health workers to manage delivery of MCH and immunization services to manage grass-root level health institutions by 2012.***

To build a foundation for integrated delivery of maternal and child health services, especially in difficulty to reach districts, it is mandatory that sufficient numbers of competent health workers are deployed across all primary level health care facilities. VHWs, MCHWs and AHWs comprise the community based health-workforce which act as vaccinators. (Support for training of MCHWs is adequately being received through pool funds managed by DoHS).

***Objective 2: to develop organization and management capacity for district health service delivery in 15 low performing districts and 25 municipalities by 2012***

District level health management capacity is a critical factor which will ensure the success of service delivery. District micro-planning capacity, urban (Municipality) health planning capacity, training of HFMCs, developing social auditing mechanisms backed by a strong information system are vital elements proposed under this objective.

***Objective 3: to ensure all 75 districts acquire essential logistics management facilities by 2012.***

Nepal being a country with extremely difficult geographical terrain, the weak logistics in remote districts need to be heavily reinforced. Strengthening of transportation for distribution of supplies, outreach clinics, and supervision/ monitoring, and construction/refurbishment of birthing centres in strategic locations to enhance pregnant mothers to get admitted before they experience the labour pains and establishment of 'health huts' in remote areas around which people will gather to seek and obtain outreach MCH care are critical.

A detailed description on all activities, identified under each thematic area and objective, along with linkages to review documents, their rationale and expected outputs are given below.

**Theme I. Health workforce mobilization, distribution, and motivation:** In order to provide good quality MCH services including immunization services at the sub-district level it is essential to have motivated, competent health workforce.

***Objective 1: to certify 1700 community-based health workers to manage delivery of MCH and immunization services to manage grass-root level health institutions by 2012.***

To build a foundation for integrated delivery of maternal and child health services, human resources require sufficient skills and incentives to ensure all components of EHCS are effectively delivered. VHWs, MCHWs and AHWs[5] comprise the front-line vaccinators, and current vacancies threaten maintenance of immunization coverage gains (cMYP p.25). Support for training MCHWs is adequately covered by other sources.

The primary activities of this objective are:

*1.1 Skill upgrading training for 1400 VHWs from 25 districts, so they gain skills needed to deliver core EHCS components and to respond to a wider range of MCH needs at the sub-district (Village Development Committee) level.*

- Linkages: 3YP p. 8: Objective 2.1, p.13: 9.2 and p.14: 9.2.1.1; cMYP p.15; NHSP-IP 2 p.5;
- Rationale: This cadre of health worker is the backbone of sustainable health care, including EPI and EHCS, in the community, as VHWs come from the communities in which they work. VHWs have not received formal training since 1992, leaving them unaware of new initiatives and best practices to the provision of MCH and immunization services. Training to upgrade their skills will help provide some incentive to retain VHWs, especially in difficult areas. At the same time, by improving the quality of services to communities, this should contribute to the broader objective of increasing utilization of health facilities by mothers, increasing their demand for the full range of MCH services. Of note, EPI vaccinators are primarily VHWs, MCHWs and AHWs, and are assisted by female Community Health Volunteers. Demand for services shall be addressed in part through a Behaviour Change Communication module, which is included in the curriculum. The training will include training on BCC through a module so as to learn modalities of enhancing demand for services.

  With HSS I phase support skills of 2600 VHWs will be upgraded. Beside these 2600 VHWs there are still 1400 VHWs whose skills need to be upgraded from the remaining districts. Further, it complements the support started from HSS I phase.

- Expected output**:** By 2012, 1400 trained VHWs will be formally trained to provide high quality MCH services and manage effectively the MCH health needs of their areas.

*1.2 Six month training of 300 AHW as senior AHWs with essential competencies in MCH to provide higher level MCH and clinical services at the sub-district levels.*

- Linkages: 3YP p.8: Objective 2.1, p.13: 9.2 and p.14: 9.2.1.1;
- Rationale: The government Three Year Plan includes a strategy of gradually upgrading sub-health posts to health posts in order to provide quality services to all people. Health posts require Health Assistants or senior AHWs that have gone through this skill upgrading; however, the government does not have the funds to conduct these trainings. The curriculum is already established and is part of the government's training plan for EHCS. After 10 years of services AHWs who complete the 6-month training are eligible for

[5] VHWs: Village Health Workers; MCHW: Maternal Child Health Worker; AHW: Auxiliary Health Worker

promotion to senior AHW level, and can be posted at Health Posts undertaking greater responsibility. However, at present most of the new senior AHWs receive no additional training to effectively manage the decentralised health services they are responsible for providing. Government training occurs, but due to insufficient funding it only covers 60 AHWs per year. By funding training of all eligible AHWs, motivation and incentives are provided for them to remain in their posts, which, for new senior AHWs, are normally in remote places. Training will allow the AHWs to carry out their new duties, and thus enhance other efforts to provide incentives to retain staff at rural posts. Further, it will provide higher quality MCH and immunization services in remote districts prone to low services coverage.

With GAVI HSS I phase support skills of 400 AHWs will be upgraded. As continuation with first phase support 300 AHWs will be upgraded with HSS second phase support.

- Expected output: 300 AHWs will be able to provide higher level MCH and clinical services with high retention rate by the end of 2012 in health service posts.

*1.3, 1.4 and 1.7 Pre-service training to newly recruited 100 MOs deployed to districts; and Need-based in-service Management Training to 90 district/regional level health managers; Training of 100 district financing staff on financial management*

- Linkages: Annual Progress Report, DoHS 2007/08 p. 281, 3YP p 8: 3.2 GAVI proposal development Consultative Meeting 2009

- Rationale: There are several public health activities conducted in the districts which are not included in pre-service curriculum. The new program managers face difficulty in implementing various public health programs due to lack of program management skills. The district also needs to have good financial and administrative system in place. Proper management of technical, financial and administrative activities is critical for successful achievement of targets. The government provides management training to certain numbers of managers each year. But due to lack of sufficient funds, the government is unable to conduct management training for all district managers. Each year medical officers are recruited by the MoHP for posting at district health offices, hospitals or PHCs. With pre-service orientation, they will be well orientated to efficiently carry out their duty at the place of their assignment. To enhance proper financial resource management and timely reporting Government has developed a soft ware and is being introduced. The need to train district financial staff on using this programme is essential.

- Expected output**:**

1. Management skills of 90 district managers will be upgraded to manage public health interventions efficiently by 2012.

2. By 2012, 100 Medical Officers will receive pre-service orientation to efficiently carry out their duty at the place of their assignment.

3. 100 financing staff from districts will be trained on financial management by 2012

1.5 *Training on CB-IMCI to newly recruited health staff at the sub-district levels (1000)*.

- Linkages: 3YP p14: 9.2.1.4; Annual Progress Report 2007/08 p. 70 Regional consultative Meeting 2009

- Rationale: CB-IMCI has been expanded to all 75 districts in Nepal. The expansion of CB-IMCI in last 11 districts was supported by GAVI HSS I phase support. Every year new health staffs are recruited who have no knowledge on clinical skills as well as recording and reporting and calculation of drugs necessary as recommended by CB IMCI. Training will be

contracted out to private non-profit NGOs with past experience in CB IMCI training such as the NEPAS, INFOAIDS and NTAG[6].

- Expected output**:** a) 1000 newly recruited health staff will be trained in provision of CB-IMCI services by 2012

*1.6 Provision of supplies and equipment to five Regional Training Centres to scale up training*

- Rationale**:** Throughout country, the Government of Nepal attempts to meet the pre-service and in-service demands of its health workforce (especially community based health workforce) by providing pre service and in service training through the Regional and District Training Centres and the NHTC. However, their capacity (in terms of infrastructure, training faculty, audiovisual aids, level of financing etc.) in conducting quality training remains low in comparison to other similar intuitions of the region.

  The proposed activity will allow the training facilities to be reviewed in a systemic manner, and identify the gaps against the national vision, and will facilitate mobilizing resources for their development.

- Expected output**:** five Regional training centres will have adequate training capacity to undertake need based training in regions.

**Theme II. Organization and management of district based health services for mothers and children:** In order to ensure equitable delivery of high quality MCH services including immunization services, the health system organization and management at district level plays a critical role.

***Objective 2: to develop organization and management capacity for district health service delivery in 15 low performing districts and 25 municipalities by 2012***

2.1 *Integrated microplanning for effective delivery of MCH and newborn health (including immunization) expanded in 15 low performing districts* (see Annex 5 for the Performance Evaluation of Districts' table used to identify lowest performing districts).

- Linkages: NSMNH-LTP p. 9; cMYP p. 29; HSRS p.14: 9.2.1.1 Regional Consultative Meeting 2009

- Rationale: RED (Reach Every District) is a proven strategy, pioneered by EPI, to ensure service delivery at district and sub-district levels. Evidence on the success of this strategy in improving immunization coverage rates has led to the desire to expand RED to provision of other services. To address the inequitable distribution of health services among ethnic groups, geographic regions and gender, an integrated microplanning process was utilized to identify and target services to marginalized, remote and underserved populations, based upon this new RED strategic approach using HSS I phase support. Microplanning will be expanded to include a broader range of MCH services and initiatives.

  With HSS phase II support integrated microplanning will be conducted and implemented in 15 additional low performing districts.

- Expected output**:** 15 low performing districts develop comprehensive MCH microplans

*2.2 Developing and implementing an urban MCH health plan in 25 major municipalities (see Annex 5).*

- Linkages: 3YP p. 25: 9.7.1; NHSP-IP2 p. 5

[6] UMN: United Mission to Nepal is a Christian-based NGO; NTAG: Nepali Technical Assistance Group is a NGO conducting training for Village development Committees and municipalities; the InfoAIDS NGO trains in districts.

- Rationale: This is a crucial first step in delivering a key priority of the Three Year Plan, which is to add an Urban Health Program to the current NHSP-IP2. Currently, municipalities in Nepal receive few services from the national public health system, i.e. a total package of public health services (including immunization) is not consistently available in municipalities. There is high internal migration of population from rural to urban zones, linked to civil unrest. These migratory populations often are not provided any public health services. Because of the large numbers of unregistered migrants, actual immunization coverage is likely to be overestimated (DHS 2006). Further, while the middle and upper class urban dwellers can purchase some curative services, they have little access to public health promotive initiatives and preventative services designed to mitigate effects of the epidemiological transition in Nepal. The Government will continue to address the HSRS target of increasing private sector involvement in increasing access to the EHCS. It includes the development of a public and private partnership among the government, the Municipality Association of Nepal, and NGOs working within the municipalities. This shall strengthen and formalize the role of municipalities in addressing the health needs of their catchment populations, especially in the delivery of EHCS services including immunization.

  The activity used operations research to develop and pilot a strategic plan for public health services in 5 urban municipalities with HSS phase I support. The activity will be further expanded to 25 municipalities with HSS phase II support.

- Expected output**:** 25 municipalities develop and implement urban MCH plans

*2.3 Expand Community Based New Born Care Program (CB-NCP) into 6 districts.*

- Linkages: Annual Progress Report, DoHS p. 62;

- Rationale: Neonatal mortality is the largest proportion of Under 5 and infant mortality and a large number of preventable neonatal deaths occur every year. As an urgent step to reduce neonatal mortality, Ministry of Health and Population initiated a new program called Community Based New Born Care Program (CB-NCP) based on the National Neonatal Health Strategy 2004. The government with support from other partners (UNICEF, CARE, SAVE and PLAN) is in the process of implementing this activity in 10 districts in 2009. With GAVI HSS II phase support the programme will be expanded to an additional six districts by the year 2012.

- Expected output**:** Health workers in 6 districts will be trained to provide new born care as per CB-NCP by 2012

2.4, 2.6 and 2.7: *Training of Health Facility Management Committees (HFMCs), reactivation of mothers group especially in disadvantaged communities and social auditing on roles and responsibilities in order to improve the management of community run health facilities and create demand from the community for the services and thus create community ownership*

- Linkages: 3YP p.19-21: 9.3.2, p. 27 9.8.3; NHSP-IP2 p. 5 Regional Consultative Meeting 2009

- Rationale: To achieve the GoN's plan to decentralize health care to the districts, the turning over of "ownership" of health facilities began in 2002; 1400 health facilities from 28 districts have been handed over to local community control so far. This means that the Village Development Committees will now be fully responsible for overall management. This comprises supervision and monitoring of all activities including immunization services, local resource mobilization to conduct outreach services, and responsibility for some HR functions, such as setting work schedules and leaves. The central government will continue to provide salaries, hire and pay for staff training. However, development of local capacity

to manage operations and services delivery at these facilities has not kept pace with devolution. The planned support will increase ownership by VDCs and community members, and stimulate community demand for health services. With HSS I phase support 405 HFMOCs from 10 districts were trained. With II phase support the training will be expanded to an additional 821 HFMOCs from 15 districts. The government in its NHSP-IP 2 (Concept Paper) has explicitly stated the need for strengthening and empowering of community level health management committees, hospital development committees' interaction with health care providers, community ownership of and contributions to health policy and programs at local level. Funds from HSS II phase will be used to reactivate mothers group and carry out social auditing of public health programs. Each ward in the village has a mother's group created. Each mother's group is supposed to meet every month to discuss service delivery and other health related achievements such as immunization coverage. Their involvement and ownership will help create demand from the community as well as monitor the implementation of the activities.

The Government is in process in developing the policy and strategy for introducing social auditing with a view to enhance community responsibility and accountability of health staff. With GAVI support this could be expanded to all 75 districts.

- Expected outputs**:** Eight hundred and twenty one HFMOCs in the 15 districts will be trained and be able to manage financial resource, human resource, and operations (including microplanning for delivering health services) of local health facility through an already established national system

    1. 3600 members of 'mother's groups' from 60 districts (3600 members) will be reactivated to create service demand for MCH services by achieving 90% DPT3 coverage, and 50% of pregnant women will receive a 4$^{th}$ antenatal care visit by 2012.

    2. Social audits will be conducted in 75 districts creating accountability toward health system measured by > than 95% EPI outreach session conducted by 2012

2.5 *Provide integrated child health care package in 5 districts*

- Linkages: NHSP-IP2 p.6.

- Rationale**:** In terms of Infant mortality, Nepal is very much on track to achieve the MDG 4 on child mortality. However it has been noted that many health problems in terms of acute infections, nutritional problems etc. do persist among children. The rate of malnutrition is nearly 50% (stunting). Therefore it is necessary to have a cohesive effort to develop an integrated child hood development package reaching children especially those who are poor and marginalized and from remote rural areas. Through this intervention it is expected that children between 6 months to 23 months will be targeted, and the necessary interventions will be delivered depending on their age (1.5 Kg food per child aged 6-11 months per month; 2.5 Kg food per child aged 12-23 months per month). This opportunity will be exploited to provide immunization services.

- Expected outcome**:** I*ntegrated child health care package is implemented in 5 districts*

**Theme III: Transportation, communication and infrastructure:** Logistics support for supervision, monitoring and data management, supply and distribution of drugs and vaccines, response to disease outbreaks, and infrastructure for provision of MCH facilities are critical system constraints.

***Objective 3: to ensure all 75 districts acquire essential logistics management facilities by 2012.***

To develop transportation and logistics systems to effectively meet the needs of decentralised and integrated health services (HSRS p. 8; 3YP . 19), systemic gaps in infrastructure currently deterring delivery of services need to be eliminated (cMYP p. 25; Regional Consultation Report 2009). At present, internally displaced populations, urban poor, remote villages, as well as socially excluded groups, are often reliant upon mobile and outreach strategies for accessing EHCS and immunizations. It is these groups that are most likely to suffer from insufficient infrastructure and logistics capacity.

The government has been unable to raise funds to cover the urgent need for a significant capital investment in vehicles, construction of Health Posts and power backup systems, though recurrent and maintenance costs can and will be covered through the regular budget (FSP p.30-31).

The primary activities of this objective are:

*3.1, 3.2 and 3.3 Provide 40 'pick-up' vehicles for District Health Offices to enable logistics distribution, to facilitate field supervision, distribution of medicines, vaccines and other medical products, transportation to carryout outreach clinics and respond to emergencies and outbreaks. The operational cost for these vehicles such as fuel and maintenance too are included.*

- Linkages: 3YP p.19: 9.3.1; Annual Report DoHS 2007/08 p. 243: 1.1.15 capacity to carry out integrated supervision; cMYP p. 25; Regional Consultative Meeting 2009

- Rationale: Insufficient vehicles are available to enable health workers to conduct integrated outreach services and supervisory visits[7], carry out effective referrals, respond to outbreaks and other emergencies, provide ambulance services, and move equipment and supplies including vaccines. To reduce vaccine and health supply stock-outs, and take advantage of improved cold-chain capacity obtained with support by the Government of Japan (cMYP p. 20), supply side constraints to management of stocks require further investment in transportation capacity. While a revised supervisory checklist has been developed to promote improved services delivery and microplanning, remote areas lack a sufficient number of supervisory visits. Such barriers, largely due to a shortage of means of transport within districts, also impede expansion of services to underserved and internally displaced populations (cMYP p.25).

  With support from HSS I phase support, 37 pickups and 105 motorcycles are being procured. Forty additional pick-up trucks and 100 motorcycles will be purchased and distributed to district health offices by 2012.

- Expected output**:** 100% of districts conduct all 12 monthly supervisory visits using the integrated supervision checklist by 2012.

*3.4 Construction of HP with birthing centres (69) to establishing a new standard of maternal and neonatal care at the sub-district level.*

- Linkages: 3YP p.11: 9.1.2, p.14: 9.2.1.1; NSMNH-LTP pp.14-15; NHSP-IP2 p.5

- Background: This activity reinforces government funded efforts to increase demand for Skilled Birth Attendance (SBA). The MoHP has begun implementing a demand-side scheme using incentives for health care workers and pregnant women to promote facility-based deliveries. Under the national SBA policy, drafted in July 2005, *GoN provides cost-sharing incentives* to promote SBA through free nationwide transport for women to deliver in health

[7] The government is in the process of fully implementing integrated surveillance for all health interventions (3YP p.24)

facilities, free delivery services in all districts, and incentives to health workers for delivering in facilities as well as attending home births. In addition, upgrading of the skills of MCHWs and SBAs is ongoing. The national policy is to increase birth delivery in health institutions as well as to reduce the physical barrier for pregnant women to reach health facilities. The government has also introduced non targeted free delivery service at all health facilities to promote institutional deliveries. On the other hand, many communities have MCHWs trained as SBAs, yet lack health facilities in which to provide safe delivery services. Only 19% of mothers currently have deliveries at a health facility in the presence of a SBA and figures are even lower for women from the poorest households (DHS 2006). The World Bank estimates maternal deaths would be reduced by 74% with full SBA access[8]. Increasing the proportion of the births attended by SBAs is a key factor in reducing maternal and perinatal morbidity and mortality. This activity aims to increase access to quality maternal and neonatal health services, especially by the poor and marginalized, plus reinforce and extend gains in the percentage of women having institutional deliveries, as mandated under the national SBA strategy. With HSS II support the HPs with birthing centres will be constructed in 60 additional VDCs.

- Expected output: 69 health posts with birthing centres constructed and are available to provide safe delivery services at the sub-district level, to utilize available and already trained health workers (SBAs), by 2012.

*3.5 Establish solar backup system in 61 districts*

- Linkages: Regional Consultative Meeting 2009, p.

- Rationale: In past few years there has been dramatic shortage of electricity supply causing long hours of power cut in Nepal. The power cuts are expected to continue for few more years. Due to long hours of power cut several health services and reporting system have been hampered; diagnostic procedures, operational procedures, storage of vaccine and other lab reagents have been affected. With HSS II phase support the government wants to establish solar backups system in 60 districts to support emergency and urgent health related activities.

- Expected output: Solar backup system established in 61 districts by 2012 resulting in decrease vaccine wastage from irregular electrical supply.

*3.6 Establishing 1308 "Health Huts" in five selected districts*

- Linkages: NHSP-IP2 p.6. Regional Consultative Meeting 2009

- Background: Every year the government provides immunization and other maternal health services to population through outreach services. Each village has 3-5 EPI outreach services and 35 PHC/ORC centres. These outreach centre do not have a permanent structure and are usually located either in FCHV house or in open space. Several services are provided through these outreach centres and many times they face difficulties to examine the mothers, provide counselling or provide immunization due to rain or not having a secure place. The government has decided to expand and strengthen PHC/ORC and EPI Outreach outlet into permanent structures retaining its mobile services. The ownership of maintaining of these huts will be given to mother group of that area. These huts will be used to provide immunization, FP, education, counselling and other health related services. The local community will provide land and share 50% of total cost for the construction of huts.

- Expected output: 1308 Health Huts will be constructed to provide MCH services at the village level as measured by > 95% outreach sessions conducted by 2012

[8] Nepal safe Motherhood and Neonatal Long Term Health Plan (2006-2017), GoN, MoHP.

# Section 5: GAVI HSS Activities and Implementation Schedule

## 5.1: Sustainability of GAVI HSS support

### *5.1.1 Financial sustainability*

This proposed HSS activities is part of the broader health sector development program that seamlessly integrates the government's health programming with eleven External Development Partners[9] with a view of strengthening long-term financial commitment to financially support the health sector. This includes the commencement of a sizeable pooled funding mechanism, with all future financial contributions from the World Bank and DFID going into this pool, which in turn is used as part of the regular budget allocation for health. In addition, the other EDPs have pledged to reduce administrative overheads and support the priority strategies and policies of the government when drafting external aid packages. Government is committed to not to reduce the government health budget at any stage which is evident in the increasing health budget over the past several years.

The overall responsibility for identifying financing gaps and initiating the process of mobilizing additional resources rests with the NHSCC. The NHSCC also ensures that the activities planned to be financed with HSS support will not result in the creation of parallel posts or systems at any level of the health system. All strategies, activities implementation, monitoring and evaluation will follow and build upon the existing health care system of the country.

The constitution of Nepal has made a clear declaration accepting health as a human right, which obligates the government to provide primary health care services for the entire population (3YP p. 3).

On a programmatic level, as a matter of policy, the Ministry of Finance will only sign off on plans which it considers to be financially sustainable. This is in keeping with its obligations under the conditions for public financing set out in the PRSP, and embodied under the fifth Medium Term Expenditure Framework for the MoF. Under the 10th Plan/PRSP, and in the agreement with IMF on the PRGF, GoN must limit its fiscal deficit to under 5 percent of GDP and domestic borrowing to under 2 percent of its GDP by the end of the plan period (2006/2007). The ability of the government to assume greater debt loads to maintain health services will be bound by these two limitations (NHSP-IP p.44).

The Government has a track record for meeting financial sustainability targets as evidenced by its funding of the procurement of vaccines (Polio, BCG, TT and JE) and supplies (e.g. autodestruct syringes for EPI). In addition, the health SWAp which is active over the past several years has provided an opportunity to manage pooled funds to cover high priority interventions. Interventions related to child health, immunization and safe motherhood are interventions of topmost priority and budget lines associated with their provision enjoy a more protected status.

Example of purchase of traditional vaccines by the Government is a strong indication to show government has successfully implemented elements of FSP. Nepal is currently paying for the procurement costs of all polio, BCG, measles and TT vaccines, and is committed to meet the financing costs associated with pentavalent introduction.

In terms of capital expenditures, the MoHP standard operating procedures for maintenance of buildings and logistics will apply to all capital investments made under this application (including newly constructed birthing centres). All maintenance and overheads (e.g. phone line charges and electricity for computers) are to be covered from the regular budget.

[9] The External Development Partners is an informal group, comprised of signatories of the NHSP-IP, who elect a rotating chair. They work to coordinate and harmonize support from all external sources, and liaise with the government to support the successful implementation of the NHSP-IP.

In addition, more and more local governments collect taxes, allowing fiscally stronger districts to contribute to improving the quality of local services. In some geographical areas communities have come forward to bear the cost of fuel (kerosene) for cold chain maintenance. Municipality authorities have taken responsibility of sustaining activities supported by MoHP for MCH, including immunization. Under decentralization, they are gradually assuming the costs of human resources management, outreach services and many basic health services. Once GAVI support ends, the MoHP will continue to pay for training, data analysis, and overheads, while local communities will cover daily operating costs.

#### *5.1.2 Technical sustainability*

Capacity building through skills upgrading will help to maintain the impact of the initiatives being proposed, both in terms of sustained high immunization coverage rates and quality for expanding access to a full range of EHCS. Skill upgrading with accompanying promotion will improve retention of experienced health staff especially in rural remote areas and sustain quality health services at the sub-district level. As most of the activities will be implemented through the existing health care delivery system, enhancement of technical capacity will lead to long lasting effect.

Investment made on the training of HFMCs will lead to improved local resource mobilization and more effective budget allocation from the local development annual budget. This, in turn, will help reach and sustain an improved level of local health services.

Past experience shows that provision of quality services will generate demand from the communities for health services, and contribute to getting community leaders more engaged in supporting local health services. In addition to mobilising more funds for health, the presence of higher quality services increases the effectiveness of social mobilization and behaviour change strategies (NSMNH-LTP).

Demand for new MCH services will be sustained through existing networks of FCHVs, community based organizations and NGOs at district and sub-district levels. Upgrading the skills of the Village Health Workers (VHWs) will improve their retention, and will contribute to sustaining high immunization coverage rates, as they are the primary vaccinators in communities. Support for community-based interventions is extremely high among partners, and no lack of technical support is envisioned for supporting the strengthening of VHWs, MCHWs and AHWs. Only financial constraints have hindered a more rapid progression of upgrading the skills of these health workers.

Weakness in the current HMIS includes lack of timely reports from several districts due to inadequate data management and reporting infrastructure. Filling these critical gaps will put into place an essential component of the GoN's "Poverty Monitoring and Analysis System" at the district level. Technical assistance to monitor progress on objectives of the 10$^{th}$ Plan/PRSP has already been included in support provided by the World Bank and DFID. The infrastructure investments in filling in the gaps in the health communication network will be complemented by technical training and HMIS support from several partners, maximizing the value of this investment.

## 5.2: Major Activities and Implementation Schedule

| Major Activities | Year 1 (20…) | | | | Year 2 (20…) | | | | Year 3 (20…) | | | | Year 4 (20…) | | | | Year 5 (20…) | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 |
| ***Objective 1: to certify 1700 community-based health workers to manage delivery of MCH and immunization services to manage grass-root level health institutions by 2012.*** | | | | | | | | | | | | | | | | | | | | |
| A1.1 Skill upgrading training for 1400 VHWs from 25 districts | | | X | X | X | X | X | X | | | | | | | | | | | | |
| A1.2 Six month training of 300 AHW as senior AHWs with essential competencies in MCH | | | X | X | X | X | X | X | X | X | X | X | | | | | | | | |
| A1.3 Pre-service training to newly recruited 100 MOs deployed to districts | | | X | X | X | X | X | X | X | X | X | X | | | | | | | | |
| A1.4 Need-based in-service Management Training to 90 district/regional level health managers | | | X | X | X | X | X | X | X | X | X | X | | | | | | | | |
| A1.5 Training on CB-IMCI to newly 1000 newly deployed health staff (20/batch) | | | X | X | X | X | X | X | X | X | X | X | | | | | | | | |
| A1.6 Provision of supplies and equipment to five Regional Training Centres to scale up training | | | X | X | | | | | | | | | | | | | | | | |
| A1.7 Training of 100 district financial staff on financial management | | | X | X | X | X | X | X | X | X | X | X | | | | | | | | |
| ***Objective 2: to develop organization and management capacity for district health service delivery in 15 low performing districts and 25 municipalities by 2012*** | | | | | | | | | | | | | | | | | | | | |
| 2.1 Organize training programmes for health workers of 15 districts on micro-planning [a] | | | X | X | X | X | X | X | X | X | X | X | | | | | | | | |

| Major Activities | Year 1 (20…) | | | | Year 2 (20…) | | | | Year 3 (20…) | | | | Year 4 (20…) | | | | Year 5 (20…) | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 |
| 2.2 Train and support 25 municipalities to develop Urban Health plans [b] | | | X | X | X | X | X | X | X | X | X | X | | | | | | | | |
| 2.3 Expand CBNCP in six districts [c] | | | X | X | X | X | X | X | X | X | X | X | | | | | | | | |
| 2.4 Reactivate 3600 mother's groups especially in disadvantaged communities in 60 districts [d] | | | X | X | X | X | X | X | X | X | X | X | | | | | | | | |
| 2.5 Introduce Integrated child health and care package in five districts [e] | | | X | X | X | X | X | X | X | X | X | X | | | | | | | | |
| 2.6 Establish Social auditing mechanisms in 75 (all) districts | | | X | X | X | X | X | X | | | | | | | | | | | | |
| 2.7 Training of 821 Health Facility Management Committees (HFMC) in 15 districts [f] | | | X | X | X | X | X | X | X | X | X | X | | | | | | | | |
| ***Objective 3: to ensure all 75 districts acquire essential logistics management facilities by 2012.*** | | | | | | | | | | | | | | | | | | | | |
| 3.1 Purchase 40 'pick-up' vehicles for supervision and logistics distribution | | | X | X | X | X | X | X | | | | | | | | | | | | |
| 3.2 Operation cost for transportation | | | | | X | X | X | X | X | X | X | X | | | | | | | | |
| 3.3 Purchase 100 motorcycles for monitoring and out-reach clinics | | | X | X | | | | | | | | | | | | | | | | |
| 3.4 Construction of HP with birthing centres (69) | | | X | X | X | X | X | X | X | X | X | X | | | | | | | | |
| 3.5 Establish solar backup system 61 districts | | | X | X | X | X | X | X | | | | | | | | | | | | |
| 3.6 Construct 1308 "health hut" 5 districts | | | X | X | X | X | X | X | | | | | | | | | | | | |

The details of districts in relation to proposed activities are given in the table below

| | |
|---|---|
| a | Micro planning districts ( based on 3 lowest performing district from each region and which have not done any MP in the past): Udayapur, Taplejung, Ilam, Sindupalchowk, Ktm, Sindhuli, Kapilbastu, Nawalparasi, Palpa, Jumla, Salyan, Rolpa, Bajang, Baitadi, Darchula |
| b | Urban Health (5 municipalities/region priority given to those without any government health structure): EDR-Mechinagar (Jhapa), Raibiraj (Saptari), Dharan (Sunsari), Siraha (Siraha), Triyuga (Udayapur), CDR-Bharatpur (Chitwan), Kirtipur (Kathmandu), Hetauda (Makwanpur), Kalaiya (Bara), Bidur (Sinduli), WDR-Taulihawa (Kapilbastu), Sidharthanagar (Rupendehi), Ramgram (Nawalparasi), Tansen (Palpa), Byas (Tanahu), MWDR-Tribhuvan & Tulsipur (Dang), Birendranagar (Surkhet), Gularaia (Bardiya), Narayan (Dailekh), FWDR- Dhangadi, Tikapur (Kailali), Mahendranagar (Kanchanpur), Dipayal (Doti), Dasharathchnad (Baitadi) |
| c | CBNCP districts ( based on by region/by population/by high NNMR): EDR-Updayapur, CDR-Bara, WDR-Gulmi, MWDR-Surkhet, Salyan, FWDR-Kailali |
| d | Reactivation of mother group ( based on by region/exclude Himali/ low population): district not included are: Soulkhumbu, Mustang, Manang, Dolpa, Mugu, Humla, Jumla, sankhuwashava, Rasuwa, Bhaktapur, lalitpur, Bajura, Kalikot, Myagdi, Terhathum |
| e | Integrated child health care package ( based on one district per region): Bajgang, Jajarkot, Gulmi, Dolkha, Sankuwashava (1st year-Bajgang, Jajarkot, 2nd year-Gulmi, Dolkha, 3rd Year-Sankhuwashava) |
| f | HFMOC districts 1st year: Bara, Panchthar, Kapilbastu, Surkhet, Kanchanpur (289 VDCs); 2nd year: Sindupalchowk, Sunsari, Gulmi, Jajarkot, Baitadi (303 VDCs); 3rd year: Udayapur, Sindhuli, Syangja, Dang, Bajura (229 VDCS) |
| g | Health hut (based on 1district/region and in each district 4 huts/VDC): Ilam, Kavre, Gulmi, Dang and Doti |

### 5.3: Costed implementation plan for the first year of implementation

| Activity | Unit Cost US $ | Sub-activity | Inputs | Outputs | Responsibility | Time frame | Budget |
|---|---|---|---|---|---|---|---|
| 1.1 Training for 700 VHWs | 522 Per Trainee | | Training facilities, trainers, Training material | 700 VHWs trained | NHTC/RTCs | July-Dec | 365,249 |
| 1.2 Training of 100 AHW | 1,304 Per Trainee | | Training facilities, trainers, Training material | 100 AHWs trained | NHTC/RTCs | July-Dec | 130,446 |
| 1.3 Pre-service training to 40 MOs | 665 Per Trainee | | Training facilities, trainers, Training material | 40 MOs oriented in MCH services | NHTC/RTCs | October | 26,611 |
| 1.4 In-service Management Training to 30 health managers | 1,304 Per Trainee | | Training facilities, trainers, Training material | 30 health managers trained on Management Training | Management Development Unit of DHS | October | 39,134 |
| 1.5 Training on CB-IMCI to 400 newly deployed health staff | 6,522 per batch of 20 Trainees | | Training facilities, trainers, Training material | 400 newly deployed health staff trained on CB-IMCI | Child Health Division of DHS | Sep-Nov | 130,446 |
| 1.6 Provision of supplies and equipment to five Regional Training Centres to scale up training | 19,567 per training centre | Identify the shortage by centre. Purchase equipment. | Training equipment | Five Regional Training Centres equipped with training supplies and equipment | Logistics Division | Sep | 98,835 |
| 1.7 Training of 30 district focal points on finance management | 300 per participant | | Training facilities, trainers, Training material | 30 district focal points trained on finance management | Finance Division | Nov | 9,000 |

| Activity | Unit Cost US $ | Sub-activity | Inputs | Outputs | Responsibility | Time frame | Budget |
|---|---|---|---|---|---|---|---|
| 2.1 Training of health workers of 5 districts on micro-planning | 32,612 per district | | Training facilities, trainers, Training material | 5 districts develop MCH micro-plans | Management and Child Health Development Unit of DHS | July-Dec | 163,058 |
| 2.2 Train and support 8 municipalities to develop Urban Health plans | 26,089 per municipality | Training<br>Planning<br>Implementation | Training facilities, trainers, Training material<br>Inputs to implement microplans | 8 municipalities develop Urban Health plans | Management and Child Health Development Unit of DHS | July-Dec | 208,714 |
| 2.3 Expand CBNCP into two districts | 117,402 per district | Training<br>Planning<br>Implementation | Training facilities, trainers, Training material<br>Inputs to implement the programme | CBNCP expanded to two districts | Child Health Development Unit of DHS | July-Dec | 234,803 |
| 2.4 Reactivate mother's groups (12,000 members) in 20 districts | 235 per VDC | | Training facilities, trainers, Training material | Mother's groups establish/reactivated in 20 districts | District Health Officers | Sep-Dec | 281,764 |
| 2.5 Introduce Integrated child health and care package in two districts | 519,882 per district | Training<br>Planning<br>Implementation | Training<br>Equipment<br>Material | Integrated child health and care package introduced in two districts | Child Health Development Unit of DHS | Sep-Dec | 859,458 |
| 2.6 Establish Social auditing mechanisms in 37 districts (2000VDCs) | 13 per VDC | | Training facilities, trainers, Training material | Social auditing mechanisms established in 37 districts | District Health Officers | Sep-Dec | 26,089 |
| 2.7 Training of 289 HFMCs | 143 per HFMC | | Training facilities, trainers, Training material | Members of 289 HFMCs trained | District Health Officers | Sep-Dec | 41,469 |

| Activity | Unit Cost US $ | Sub-activity | Inputs | Outputs | Responsibility | Time frame | Budget |
|---|---|---|---|---|---|---|---|
| 3.1 Purchase 20 'pick-up' vehicles | 27,394 per vehicle | | | District monitoring/transportation improved in 20 | Logistics Division | Sep-Oct | 547,874 |
| 3.2 Operation cost for transportation | - | - | - | - | - | - | 0 |
| 3.3 Purchase 100 motorcycles | 1,304 per motorcycle | | | District monitoring/transportation improved in 20 | Logistics Division | Sep-Oct | 130,446 |
| 3.4 Construction of HP with birthing centres (25) | 65,223 per centre | | Skilled services | 25 HP constructed with birthing centres | Logistics Division | Sep-Dec | 1,630,577 |
| 3.5 Establish solar backup system 40 districts | 10,436 per district | Identify individual needs<br>Purchase equipment<br>Fix equipment | Equipment<br>Skilled services | Selected institutions of 40 districts backed by solar backup systems | Logistics Division | Sep-Dec | 417,428 |
| 3.6 Construct 728 health huts in 3 districts | 652 per health hut | | | 728 health huts constructed in 5 districts | Logistics Division | Sep-Dec | 474,824 |
| | | | | | | **Total** | **5,816,225** |

*Exchange rate 1 USD = NPR 76.66*

## Section 6: Monitoring, Evaluation and Operational Research

### 6.1: Impact and Outcome Indicators (data should be consistent with other GAVI applications and annual progress reports from the country)

| Indicator | Data Source | Baseline Value | Source | Date of Baseline | Target | Date for Target |
|---|---|---|---|---|---|---|
| 1. National DTP3 coverage (%) | HMIS | 82 % | WHO/UNICEF Joint Reporting Form for 2008 | 2008 | 90% | 2012 |
| 2. % of districts achieving =90% DTP3 coverage | HMIS | 16% | WHO/UNICEF Joint Reporting Form for 2008 | 2008 | 90% | 2012 |
| 3. Under five mortality rate (per 1000 Live births) | Survey | 61/1000 | NDHS 2006 | 2006 | 55/1000 | 2012 |
| 4. % of districts achieving 80% measles coverage | HMIS | 37.3% | WHO/UNICEF Joint Reporting Form for 2008 | 2008 | 90% | 2012 |
| 5. % births attended by SBA | HMIS | 18.7% | HMIS Annual Report 2008, DoHS | 2008 | 35% | 2012 |
| 6. % of pneumonia cases among new ARI cases (among under 5) | HMIS | 30.9% | HMIS Annual Report 2008, DoHS | 2008 | 20% | 2012 |

### 6.2: Output Indicators (one per objective)

| Indicator | Numerator | Denominator | Data Source | Baseline ValueError! Bookmark not defined. | Source | Date of Baseline | Target | Date for Target |
|---|---|---|---|---|---|---|---|---|
| 1. Number districts with 90% of HPs and SHPs filled with trained VHWs. | Number of districts with 90% HPs and SHPs filled with trained VHWs. | Total number of districts | Administrative data from Districts | 50 districts | MoHP | 2008 | 75 districts | 2012 |
| 2. % districts with integrated micro plans (health) according to new guidelines/criteria | Number of districts with integrated health plans | Total number of districts | Administrative data from Districts | 15% | MoHP | 2009 | 35% | 2012 |
| 3. % district with at least two health facilities backed up by Solar power | Number of district with at least two health facilities backed up by Solar power | Total number of districts | Administrative data from Districts | 0% | MoHP | 2008 | 80% | 2012 |

### 6.3: Process Indicators (one per objective)

| Indicator | Numerator | Denominator | Data Source | Baseline ValueError! Bookmark not defined. | Source | Date of Baseline | Target | Date for Target |
|---|---|---|---|---|---|---|---|---|
| 1. Number of VHWs trained. | Number of VHDs trained | Not Applicable | Regular reporting from training centres | 2600 (2008) | Regular reporting from training centres | 2008 | 4000 | 2012 |
| 4. Number of HFMCs trained | Number of HFMC members trained | Not Applicable | Reports of training centres | 405 | Reports of training centres | 2008 | 1226 | 2012 |
| 5. Number of Health Posts constructed with berthing centres | Number Health Posts constructed with berthing centres | Not Applicable | HMIS | 90 | HMIS | 2008 | 159 | 2012 |

### 6.4: Data collection, analysis and use

| Indicator | Data collection | Data analysis | Use of data |
|---|---|---|---|
| Impact and outcome: | | | |
| 1. National DPT3 coverage (%) | Through existing EPI routine data collection system (HMIS). Flow of data and compilation of reports from HF to district to central level. | Automated analysis conducted at central level and reported quarterly and annually. Data verification conducted at district, region and national level annually. As part of analysis, DPT3 coverage figures are also assessed by district. | ▪ Used to measure sustained high immunization coverage<br>▪ Progress assessed in relation to cMYP objectives.<br>▪ Data shared with stakeholders in annual review and planning workshops. |
| 2. % of districts achieving =80% DTP3 coverage | Through existing EPI routine data collection system (HMIS). Flow of data and compilation of reports from HF to district to central level. | Automated analysis conducted at central level and reported quarterly and annually. Data verification conducted at district, region and national level annually. | ▪ Used as a benchmark for districts to assess their own coverage level for planning and problem solving.<br>▪ Data used for district EPI microplanning.<br>▪ Feedback to districts for planning and problem solving.<br>▪ Progress assessed in relation to cMYP objectives.<br>▪ Data shared with stakeholders in annual review and planning workshops. |
| 3. Under five mortality rate (per 1000) | Collected nationally only through NDHS. The next NDHS will be in 2011. | Standard DHS cluster analysis. | ▪ Feedback to MoHP and the National Planning Commission for planning.<br>▪ Progress assessed in relation to Millennium Develop Goals.<br>▪ Data shared with stakeholders and across other health programs. |
| 4. % of districts achieving 80% measles coverage | Through existing EPI routine data collection system (HMIS). Flow of data and compilation of reports from HF to district to central level. | Automated analysis conducted at central level and reported quarterly and annually. Data verification conducted at district, region and national | ▪ Used as a benchmark for districts to assess their own coverage level for planning and problem solving.<br>▪ Data used for district EPI microplanning. |

| Indicator | Data collection | Data analysis | Use of data |
|---|---|---|---|
| | | level annually. | ▪ Feedback to districts for planning and problem solving.<br>▪ Progress assessed in relation to cMYP objectives.<br>▪ Data shared with stakeholders in annual review and planning workshops. |
| 5. % births attended by SBA | Through safe motherhood routine data collection system (HMIS). Flow of data and compilation of reports from HF to district to central level. | Automated analysis conducted at central level and reported quarterly and annually. Data verification conducted at district, region and national level annually. | ▪ To measure progress towards Objectives 1, 3 & 4 by NHSCC.<br>▪ Feedback to districts for planning and problem solving.<br>▪ To measure BCC strategy success.<br>▪ To monitor government's 3-Year Plan objectives. |
| 6. % severe pneumonia cases among new ARI cases | Through child health routine data collection system (HMIS). Flow of data and compilation of reports from HF to district to central level. | Automated analysis conducted at central level and reported quarterly and annually. Data verification conducted at district, region and national level annually. | ▪ To measure progress towards Objective 2 by NHSCC.<br>▪ Feedback to MoHP and districts for performance management. |
| Output | Data collection | Data analysis | Use of data |
| 1. Number districts with 90% of HPs and SHPs filled with trained VHWs. | Routine administrative data collected by Child Health Division and Regional and District Health Offices | Comparison of achievement with targets. | Used by NHTC to identify candidates for training and NHSCC to ensure quarterly targets met under GAVI HSS |
| 2. % districts with integrated MCH microplans according to new guidelines/criteria | Routine administrative data collection by Family Health Division | Comparison of achievement with targets. | Used by Child Health Division to ensure quarterly targets met under GAVI HSS support |
| 3. % district with at least two health facilities backed up by Solar power | Routine administrative data collection by Logistics Management Division | Comparison of achievement with targets. | Used by NHSCC to ensure annual targets met under GAVI HSS |

| Process | Data collection | Data analysis | Use of data |
|---|---|---|---|
| 1. Number of VHWs trained. | Data will be collected through reports from the training centres compiled by the NHTC | Data analysis will be done at the NHTC who will be responsible for monitoring the implementation. | Used by NHTC and Planning Unit to identify candidates for training and NHSCC to ensure quarterly targets met under GAVI HSS. |
| 2. Number of HFMC committees trained | Data will be collected through DHOs and training centres and will be compiled by the Child Health Division of DoH | Data analysis will be done at the Child Health Division of DoH who will be responsible for monitoring the implementation. | Used by Child Health Division of DoH to ensure proper candidates have been selected for training and NHSCC to ensure quarterly targets met under GAVI HSS. |
| 3. Number of Health Posts constructed with berthing centres | Data will be collected through HMIS reports, validated by the District Health Officers. | Data analysis will be done at the planning Unit who will be responsible for monitoring the implementation. | Used by Planning Unit to monitor the progress of GAVI HSS activities. |

**6.5: Strengthening M&E system**

The GAVI Annual Progress Report (APR) for the HSS component will be prepared by the Policy, Planning and International Cooperation Division, MoHP, in collaboration with Child Health Division, Family Health Division, Management Division, Logistic Management Division and the National Health Training Centre, DoHS. The NHSCC will review, revise and endorse the APR prior to submission to GAVI.

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

Currently communication is limited among the various levels of the health system, which hampers effective monitoring and supervision. The telephone lines that have been provided to the sub-district level (all PHCs) from the first proposal of GAVI HSS will open lines of communication. These will be used to support rapid outbreak reporting, as well as for the transmission of electronic reports of data collected on a range of heath indicators. These include immunization coverage and under five morbidity and mortality figures.

However, in the broader context of M&E, problems have been identified in M&E systems and activities have been included in this application to overcome these barriers:

**Activity 2.1**: Integrated micro-planning for effective delivery of MCH and newborn health (including immunization) will be introduced in the 15 low performing districts. This builds upon the success of the RED strategy, and helps to explore how a more sector-wide approach to managing integrated services will be tracked and monitored. In combination with introduction of the DQS, a base is being laid down for managing effective and efficient delivery of high quality health services within a decentralised environment.

**Activity 2.7**: Health Facility Management Committees will be trained to oversee the proper functioning of the health facilities. In addition to supervising staff and operations, they will help ensure the timeliness and completeness of monthly reports attains 100%.

**Activities3.1, 3.2 and 3.3**: These activities have been included with the objective of strengthening district monitoring and evaluation activities through providing the district health management with transportation facilities.

### 6.6: Operational Research

The MoHP Nepal recognizes that it needs to improve the evidence base for further developing and refining its own health system. At this stage, it is felt that the financial capacity to undertake operational research is not available amidst restricted health budget. Therefore, the MoHP has decided to proceed introduce two activities on pilot basis, which will be systematically monitored and evaluated for the outcome. The lead evaluation agencies will be the Child Health Division (activity 4.2) and Family Health Division of DoHS (activity 4.1).

A report of the findings will be issued by the corresponding lead technical agency for the evaluation of the pilot programme. Findings will be presented to the NHSCC for review, and to assess how the piloted strategies, modified as needed, will be expanded to other areas.

The protocol and the finer details of the evaluation will be developed, and the funds for the evaluation will be borne by the Government Budget.

## Section 7: Implementation Arrangements

### 7.1: Management of GAVI HSS support

| Management mechanism | Description |
|---|---|
| Give details on the management costs and mechanisms (especially if a partner will be managing parts of the GAVI HSS proposal) | The GAVI HSS support will be managed through existing structures. The Department of Health Services (DoHS) is the implementing department of the MoHP and is the coordinating body for many other divisions including the Child Health Division, The Director General is the head of the DoHS and is responsible for the implementation and M&E of the GAVI HSS.<br><br>The management cost of the GAVI HSS activities including other development activities that are being supported by other development partners is being borne through the regular government budget. |
| Name of lead individual / unit responsible for managing GAVI HSS implementation / M&E etc. | The relevant Directors of the Department of Health Services are responsible for the implementation of the programme. The Director General is the head of the DoHS and is responsible for the programme management and M&E of the GAVI HSS activities. |
| Role of HSCC (or equivalent) in implementation of GAVI HSS and M&E | Led by Minister of Health and Population and high-level officers of the Ministry of Finance, the National Planning Commission, and international development partners, the NHSCC has the role of:<br><br>• Providing high-level technical and financial oversight and guidance;<br><br>• Coordinating among stakeholders;<br><br>• Approving annual work plans;<br><br>• Conducting quarterly reviews of progress and process indicators. |
| Mechanism for coordinating GAVI HSS support with other health system strengthening activities and programs | The NHSCC is the coordinating body which coordinates all government initiatives and development assistance in relation to HSS. The secretarial assistance is being provided by the Planning Division. |

### 7.2: Roles and responsibilities of key partners (HSCC members and others)

| Title / Post | Organisation | HSCC member yes/no | Please list the specific roles and responsibilities of this partner in the GAVI HSS implementation |
|---|---|---|---|
| Minister | MoHP | Yes | As Chairman of the NHSCC, takes lead role in technical and financial oversight and guidance of the program. Monitor the progress of implementation. |
| Secretary | MoHP | Yes | As vice-Chairman of the NHSCC, represents the GAVI HSS program to all stakeholders and takes lead role in technical and financial oversight and guidance of the program. Monitor the progress of implementation. |

| Title / Post | Organisation | HSCC member yes/no | Please list the specific roles and responsibilities of this partner in the GAVI HSS implementation |
|---|---|---|---|
| Chief Specialist, Policy, Planning and International Coordination Division | MoHP | Yes | Oversight for implementation of activities in regards to compliance with the stated GAVI HSS activities. |
| Director General | DoHS | Yes | Responsible for implementation of activities and the coordination among DoHS divisions and other partners. |
| Joint Secretary | MoF | No | Oversight for financial aspects of GAVI HSS program, including monetary flow, and monitoring of budget activities. |
| Representative | WHO | Yes | Technical assistance and support. |
| Representative | UNICEF | Yes | Technical assistance and support. |
| Representative | UNFPA | Yes | Technical assistance and support. |
| Health Section Chief | USAID | Yes | Technical assistance and support. |
| Health Section Chief | WB | Yes | Technical assistance and support. |

### 7.3: Funding arrangements

| Mechanism / procedure | Status / Description |
|---|---|
| Has a GAVI FMA been conducted: yes / no | No |
| When was the last FMA conducted: mm/yyyy | Not Applicable (NA) |
| If yes: Has an Aide Memoire been signed: yes / no (Document Number.....) | NA |
| If yes: Will the present Aide Memoire govern the financial management of the GAVI HSS funds: yes / no | NA |
| If no: Reasons for not following all the agreements in the last Aide Memoire | NA |

| Mechanism / procedure | Status / Description |
|---|---|
| Next FMA scheduled for: mm/yyyy | Nepal is an IHP country. There is a mechanism for financial auditing agreed by all partners. Whenever requested by GAVI Nepal will conduct the FMA. |
| Has a joint financing mechanism been established for the health sector: yes / no | Yes. Nepal follows a SWAp mechanism with fund pooling since 2005 |
| If yes: Will this joint financing mechanism be used for managing GAVI HSS funds: yes/ no<br>(Document Number.....) | No |
| If no: Reasons for not using the joint financing mechanism | Nepal has been supported by GAVI through ISS support and HSS. There are established mechanisms approved by Government of Nepal to channel GAVI funding through the Finance Ministry of Nepal.<br><br>Keeping in line with previous experience, it is proposed that funding of this proposal too will be received through the same channels opened before. |
| Please provide a detailed description of the financing mechanism proposed for the management of GAVI HSS funds if all the agreements in the last Aide Memo is not followed or a FMA has yet to be conducted. | Channelling of GAVI HSS funds will utilize the same mechanism used for all programs of the MoHP. After receiving the approval of programs with budget from the MoF, the MoHP provides authority of expenditure to the Director General (DG), Department of Health Services. The DG then authorizes district health offices to make expenses as per approved annual plan. MoF then releases the budget to District Treasury Comptroller's Office (DTCO) as per approved plan.<br><br>After receiving the authority letter from the DG, which outlines the activities and budget, districts health offices receive from DTCO 1/3 of the approved annual budget or the total amount of funds required to carry out activities in the first quarter of the year, whichever is higher. |
| Title(s) of document(s) governing the annual budgeting process for the use GAVI HSS funds<br>(Document Number 18) | MoHP prepares an Annual Plan with budget of Government of Nepal (Document 18), which is then submitted to National Planning Commission for approval of the programs. After approval of the activities/programs, the plan is submitted to the MoF for budget allocation. After approval of the budget by the MoF, the annual health plan together with the national plan is submitted to parliament for approval. Once the plan is approved by parliament it is reflected as the annual consolidated plan in the "Red Book". The MoF sends the approved plan with budget to MoHP. MoHP gives authority to DoHS for implementation of plan. DoHS send authority to all districts health offices for expenditure of the fund as per approved activities in the annual plan. |

| Mechanism / procedure | Status / Description |
|---|---|
| Title(s) of document(s) governing the financial management (accounting, recording and reporting) of the GAVI HSS funds<br>Document - http://www.oagnep.gov.np/ | Financial rules and regulations of the Government of Nepal (The auditing will be carried out by the Auditor General's Office)<br><br>The link to guidelines for the audit of public sector enterprises is given in<br>http://www.oagnep.gov.np/ |
| Title(s) of document(s) governing the audit of the GAVI HSS funds<br>Document<br>http://www.oagnep.gov.np/ | The health sector budget including GAVI HSS budget will undergo internal as well as external audit as per established procedures of the government of Nepal. District health offices maintain district level accounts by budget heading and send monthly expenditure statements to the departments and respective DTCOs for internal audit. DTCOs carry out quarterly internal audits at district level. External audit is carried out by the Auditor General Office annually on the consolidated statement prepared by Ministry of Health and Ministry of Finance after internal audit. |
| Frequency of internal audits planned for GAVI HSS funds? | Annually |
| Frequency of external audit planned for GAVI HSS funds? | Annually |
| Title(s) of document(s) governing procurement procedures for GAVI HSS funds<br>(http://www.hsrsp.org/index.php?page=otherpage.php&id=35) | Procurement of goods and services by the MoHP are governed by the procurement law (procurement Act 2006 and Financial Rules and Regulation 1999). The fundamental principles on which procurement procedures were established are transparency, protection against corruption, and efficiency. Procurement of goods and services occurs at all levels as per allocated budget in the annual plan (Red Book).<br><br>Procurement of items that cost less than NRs 100,000 (US$ 1500) is done locally by designated person without bidding. A separate mechanism is used for procurement of items that cost greater than US$1500:<br><br>1. Local Competition Bidding (LCB)—up to US$ 15,500<br>2. National Competition Bidding (NCB)—US$ 15,000 to 500,000<br>3. International Competition Bidding (ICB)—greater than US$ 500,000 |

### 7.4: Reporting arrangements

Centres and districts will carry out activities reflected on annual plan "Red Book" as per rules and regulation of the government. There are 2 kinds of reporting:

1. Financial Reporting - Monthly expenditure statements are sent to District Treasury Comptroller's Offices (DTCOs) by 7th of every month for reimbursement based on monthly expenditure. DTCO send the report to FCGO which compiles reports from all over the country and submits to OAG for verification and audit. District Health Offices also send monthly expenditures to departments. Department compiles yearly statements sent from all districts and send the report to FCGO.

2. Activity Progress Reporting – Activity progress reports are sent from peripheral health facilities to districts. The districts compile all reports received from the periphery and send reports to HMIS and the Regional Health Directorate (RHD) every month. HMIS analyzes the information received from districts and feedback is given to all divisions and districts quarterly. HMIS also produces an annual report at the end of each year. GAVI-HSS support program will be monitored through existing HMIS using the indicators listed in the application.

The MoHP plans to carry out mid-term review of the HSS program with the involvement of main partners (WHO, UNICEF & WB). The findings from the review will be utilized for further strengthening of implementation.

The Annual Progress Report (APR) for ISS funds is prepared by the EPI Section, Child Health Division, DoHS. Progress report on GAVI HSS activities will be prepared by the Planning and International cooperation Division of MoHP. Regular monitoring of the progress against benchmarks and targets of the impact and outcome indicators as described in the application will be done by respective implementing Divisions and overall monitoring will be done by the Director General, DoHS.

### 7.5: Technical assistance requirements

| Activities requiring technical assistance | Anticipated duration | Anticipated timing (year, quarter) | Anticipated source (local, partner etc.) |
|---|---|---|---|
| The management training programme proposed for district health managers will need technical support in terms of training Needs Assessment, Programme development and programme evaluation. It is very much in line with the current WHO support and WHO has shown the commitment to continue its support. | Throughout period | Through resident WHO experts, continuous support will be sought. | WHO Country Office Nepal |

## Section 8: Budgeting and Funding for GAVI HSS supported activities

### 8.1: Budget for implementing GAVI HSS support

| Area for support | *Cost per year in US$ (,000)* | | | | | | |
|---|---|---|---|---|---|---|---|
| | Unit cost, if applicable | Year 1 of implementation | Year 2 of implementation | Year 3 of implementation | Year 4 of implementation | Year 5 of implementation | **TOTAL COSTS** |
| | US$ | 2010 | 2011 | 2012 | 20… | 20… | |
| **Activity costs** | | | | | | | |
| ***Objective 1*** | | | | | | | |
| Activity 1.1 | 522 PP | 365,249 | 365,249 | - | | | 730,498 |
| Activity 1.2 | 1,304 PP | 130,446 | 130,446 | 130,446 | | | 391,338 |
| Activity 1.3 | 665 PP | 26,611 | 19,958 | 19,958 | | | 66,527 |
| Activity 1.4 | 1,304 PP | 39,134 | 39,134 | 39,134 | | | 117,402 |
| Activity 1.5 | 6,522 per batch of 20 | 130,446 | 97,835 | 97,835 | | | 326,116 |
| Activity 1.6 | 19,567 per, training centre | 97835 | - | - | | | 97,835 |
| Activity 1.7 | 300 /pp | 9,000 | 9,000 | 12000 | | | 30,000 |
| ***Objective 2*** | | | | | | | |
| Activity 2.1 | 32,612 per district | 163,058 | 163,058 | 163,058 | | | 489,173 |
| Activity 2.2 | 26,089 per municipality | 208,714 | 208,714 | 234,803 | | | 652,231 |
| Activity 2.3 | 117,402 per district | 234,803 | 234,803 | 234,803 | | | 704,409 |
| Activity 2.4 | 235 per VDC | 281,764 | 281,764 | 281,764 | | | 845,292 |
| Activity 2.5 | 519,882 per district | 859,458 | 1,359,239 | 380,712 | | | 2,599,409 |
| Activity 2.6 | 13 per VDC | 26,089 | 26,089 | - | | | 52,178 |
| Activity 2.7 | 143 per VDC | 41,469 | 43,478 | 32,859 | | | 117,806 |
| ***Objective 3*** | | | | | | | |
| Activity 3.1 | 27,394 per vehicle | 547,874 | 547,874 | - | | | 1,095,748 |
| Activity 3.2 | 1,304 per vehicle | - | 52,178 | 52,178 | | | 104,356 |
| Activity 3.3 | 1,304 per motorcycle | 130,446 | - | - | | | 130,446 |
| Activity 3.4 | 65,223 per centre | 1,630,577 | 1,630,577 | 1,239,238 | | | 4,500,392 |
| Activity 3.5 | 10,436 per district | 417,428 | 219,149 | - | | | 636,577 |

| Area for support | *Cost per year in US$ (,000)* | | | | | | |
|---|---|---|---|---|---|---|---|
| | Unit cost, if applicable | Year 1 of implementation | Year 2 of implementation | Year 3 of implementation | Year 4 of implementation | Year 5 of implementation | **TOTAL COSTS** |
| | US$ | 2010 | 2011 | 2012 | 20… | 20… | |
| Activity 3.6 | 652 per health hut | 474,824 | 378,294 | - | | | 853,118 |
| **Support costs** | | | | | | | |
| Management costs | | | | | | | |
| M&E support costs | | | | | | | |
| Technical support | | | | | | | |
| | | | | | | **TOTAL COSTS** | 14,540,851 |

### 8.2: Calculation of GAVI HSS country allocation (this number should be consistent with data used in other GAVI applications and annual progress reports)

| GAVI HSS Allocation | **Allocation per year (US$)** | | | | | | |
|---|---|---|---|---|---|---|---|
| | Year of GAVI application | Year 1 of implementation | Year 2 of implementation | Year 3 of implementation | Year 4 of implementation | Year 5 of implementation | **TOTAL FUNDS** |
| | 2009 | 2010 | 2011 | 2012 | 20… | 20… | |
| Birth cohort (number)* | 887,520 | 931,389 | 977,522 | 999,227 | | | |
| Allocation per newborn ($) | | 5 | 5 | 5 | | | |
| **Annual allocation ($)** | | 4,656,945 | 4,887,610 | 4,996,135 | | | 14,540,690 |

*Source: cMYP, 2007-2011

### 8.3: Sources of all expected funding for health systems strengthening activities

| Funding Sources | **Allocation per year (US$)** | | | | | | |
|---|---|---|---|---|---|---|---|
| | Year of GAVI application | Year 1 of implementation | Year 2 of implementation | Year 3 of implementation | Year 4 of implementation | Year 5 of implementation | **TOTAL FUNDS** |
| | 2009 | 2010 | 2011 | 2012 | 20… | 20… | |
| **GAVI** | 2,769,829 | 4,953,740 | 5,214,085 | 5,355,257 | | | 18,292,911 |
| **Government** | 9,317,772 | 10,249,549 | 11,27,504 | 12,401,955 | | | 3,3096,780 |
| Specific indication on what contributions this source of funding provides for health systems strengthening | | | | | | | |
| **Donor 1. DFID** | 745,039 | 819,543 | 901,497 | 991,647 | | | 3,457,726 |
| Specific indication on what contributions this source of funding provides for health systems strengthening | | | | | | | |
| **Donor 2. Global Fund** | 493,878 | 543,266 | 597,592 | 657,352 | | | 2,292,088 |

| Funding Sources | Allocation per year (US$) | | | | | | |
|---|---|---|---|---|---|---|---|
| | Year of GAVI application | Year 1 of implement ation | Year 2 of implement ation | Year 3 of implement ation | Year 4 of implement ation | Year 5 of implement ation | **TOTAL FUNDS** |
| | 2009 | 2010 | 2011 | 2012 | 20… | 20… | |
| Specific indication on what contributions this source of funding provides for health systems strengthening | | | | | | | |
| **Pooled Fund** | 4,992,326 | 5,491,559 | 6,040,714 | 6,644,786 | | | 23,169,385 |
| **USAID** | 835,937 | 919,531 | 1,011,484 | 1,112,632 | | | 3,879,584 |
| **TOTAL FUNDING** | 19,154,781 | 22,977,188 | 13,765,372 | 27,163,629 | | | 65,903,605 |

### 8.4: Describe how GAVI HSS funding will complement other sources of HSS funding

In addition to its own resources, the MoHP receives substantial direct financial and technical assistance through bilateral aid, multilateral agencies, UN agencies and global partnerships such as the Global Fund for strengthening planning and implementation of priority health projects. The contribution of partners (mainly international organizations) has been remarkable – a significant portion of Ministry of Health's budget is being financed through external resources.

Through the National Health Sector Coordination Committee the MoHP makes an effort to effectively coordinate the volume of assistance minimizing duplication. The NHSCC is technical supported by the Planning Department of the MoH to play its role. Further Nepal having a SWAp mechanism with fund pooling, the 'Joint Annual Reviews' too provide a pedestal for the government to use external resources in a complementary manner.

## Section 9: Terms and Conditions of GAVI Support

### GAVI ALLIANCE

### TERMS AND CONDITIONS

**FUNDING USED SOLELY FOR APPROVED PROGRAMMES**

The applicant country ("Country") confirms that all funding provided by the GAVI Alliance for this application will be used and applied for the sole purpose of fulfilling the programme(s) described in this application . Any significant change from the approved programme(s) must be reviewed and approved in advance by the GAVI Alliance. All funding decisions for this application are made at the discretion of the GAVI Alliance Board and are subject to IRC processes and the availability of funds.

**AMENDMENT TO THIS PROPOSAL**

The Country will notify the GAVI Alliance in its Annual Progress Report if it wishes to propose any change to the programme(s) description in this application. The GAVI Alliance will document any change approved by the GAVI Alliance, and this application will be amended.

**RETURN OF FUNDS**

The Country agrees to reimburse to the GAVI Alliance, all funding amounts that are not used for the programme(s) described in this application. The country's reimbursement must be in US dollars and be provided, unless otherwise decided by the GAVI Alliance, within sixty (60) days after the Country receives the GAVI Alliance's request for a reimbursement and be paid to the account or accounts as directed by the GAVI Alliance.

**SUSPENSION/ TERMINATION**

The GAVI Alliance may suspend all or part of its funding to the Country if it has reason to suspect that funds have been used for purpose other than for the programmes described in this application, or any GAVI Alliance-approved amendment to this application. The GAVI Alliance retains the right to terminate its support to the Country for the programmes described in this application if a misuse of GAVI Alliance funds is confirmed.

**ANTICORRUPTION**

The Country confirms that funds provided by the GAVI Alliance shall not be offered by the Country to any third person, nor will the Country seek in connection with this application any gift, payment or benefit directly or indirectly that could be construed as an illegal or corrupt practice.

**AUDITS AND RECORDS**

The Country will conduct annual financial audits, and share these with the GAVI Alliance, as requested. The GAVI Alliance reserves the right, on its own or through an agent, to perform audits or other financial management assessment to ensure the accountability of funds disbursed to the Country.

The Country will maintain accurate accounting records documenting how GAVI Alliance funds are used. The Country will maintain its accounting records in accordance with its government-approved accounting standards for at least three years after the date of last disbursement of GAVI Alliance funds. If there is any claims of misuse of funds, Country will maintain such records until the audit findings are final. The Country agrees not to assert any documentary privilege against the GAVI Alliance in connection with any audit.

## CONFIRMATION OF LEGAL VALIDITY

The Country and the signatories for the government confirm that this proposal is accurate and correct and forms a legally binding obligation on the Country, under the Country's law, to perform the programmes described in this application.

## CONFIRMATION OF COMPLIANCE WITH THE GAVI ALLIANCE TRANSPARANCY AND ACCOUNTABILITY POLICY

The Country confirms that it is familiar with the GAVI Alliance Transparency and Accountability Policy (TAP) and will comply with its requirements.

## ARBITRATION

Any dispute between the Country and the GAVI Alliance arising out of or relating to this application that is not settled amicably within a reasonable period of time, will be submitted to arbitration at the request of either the GAVI Alliance or the Country. The arbitration will be conducted in accordance with the then-current UNCITRAL Arbitration Rules. The parties agree to be bound by the arbitration award, as the final adjudication of any such dispute. The place of arbitration will be Geneva, Switzerland. The language of the arbitration will be English.

For any dispute for which the amount at issue is US$ 100,000 or less, there will be one arbitrator appointed by the GAVI Alliance. For any dispute for which the amount at issue is greater than US $100,000 there will be three arbitrators appointed as follows: The GAVI Alliance and the Country will each appoint one arbitrator, and the two arbitrators so appointed will jointly appoint a third arbitrator who shall be the chairperson.

The GAVI Alliance will not be liable to the Country for any claim or loss relating to the programmes described in this application , including without limitation, any financial loss, reliance claims, any harm to property, or personal injury or death. Country is solely responsible for all aspects of managing and implementing the programmes described in this application.

## Section 10: Endorsement of the Application

### 10.1: Government endorsement

The Government of Nepal commits itself to providing immunisation and other child and maternal health services on a sustainable basis. Performance on strengthening health systems will be reviewed annually through a transparent monitoring system. The Government requests that the GAVI Alliance funding partners contribute financial assistance to support the strengthening of health systems as outlined in this application.

Please note that this application will not be reviewed or approved by the Independent Review Committee without the signatures of both the Minister of Health & Finance or their delegated authority.

***Minister of Health:***

Name: Mr Umakant Chaudhary

Signature: Umakant Chaudhary

Date: Aug 31st, 2009

Government of Nepal
Ministry of Health & Population

***Minister of Finance:***

Name: Mr Surendra Pande

Signature: Pande

Date: Aug. 31st 2009

Government of Nepal
Ministry of Finance

**10.2: Endorsement by Health Sector Coordination Committee (HSCC) or country equivalent**

Members of the Health Sector Coordination Committee or equivalent endorsed this application at a meeting on 21st August 2009. The signed minutes are attached as Annex 1.

***Chair of NHSCC (or equivalent):***
Name: Mr. Umakant Charudhary
Signature: Umakant Chaudhary - Date: Aug 31st 2009

Post / Organisation:
Minister of Health and Population

**10.3: Government official to contact in case of programmatic enquiries:**

Name: Dr. Y.V. Pradhan

Title: Chief Policy Planning and International Division; MoHP

Tel No: 977-1-4262865

Address: Ministry of Health and Population
Ramshah Path
Kathmandu, Nepal

Fax No: 977-1-4262468

Email: pradhan_yv@yahoo.com

**10.4: Government official who is the focal point for overseeing the financial management of GAVI HSS funds:**

Name: Mr. Yogendra Gauchan

Title: Financial Comptroller MoHP

Tel No: 977-1-4262706

Address: Ministry of Health and Population
Ramshah Path
Kathmandu, Nepal

Fax No. 977-1-4262468

Email: gahanyogendra@yahoo.com

## ANNEX 1 Documents Submitted in Support of the GAVI HSS Application and final checklist

| Document (with equivalent name used in-country) | Available (Yes/No) | Duration | Attachment Number |
|---|---|---|---|
| Health Sector Strategy: An Agenda for Reform | Yes | 2004-2007 | 1 |
| Nepal Health Sector Program Implementation Plan | Yes | 2004-2009 | 2 |
| Three Year Plan | Yes | 2007-2010 | 3 |
| Concept paper for the Nepal Health Sector Program Implementation Plan 2 | Yes | 2010-2015 | 4 |
| cMYP | Yes | 2007-2011 | 5 |
| MTEF | Yes | | 6 |
| Compilation of the Central and Regional Consultative Meetings 2009: Final recommendations of the consultative meetings. | Yes | 2009 | 7 |
| National Safe Motherhood and Newborn Health Long Term Plan | Yes | 2006 – 2017 | 8 |
| NDHS 2006 | Yes | 2006 | 9 |
| Annual Report, DoHS | Yes | 2007/2008 | 10 |
| NHSCC meeting minutes | Yes | | 11 |
| PRSP | Yes | | 12 |
| Second Long-Term Health Plan | Yes | 1997-2017 | 13 |
| IHP + National Compact | Yes | | 14 |
| National Health Development Partner Joint Annual Review | Yes | 2008 | 15 |
| Annual Work Plan and Budget of Government of Nepal | Yes | 2008-2009 | 16 |
| FCHV Strategy | Yes | 2008 | 17 |
| MOU between GoN and EDPs to align GAVI HSS proposal with NHSP 2 | Yes | 2009 | 18 |
| GAVI Tracking Study | Yes | 2009 | 19 |
| Equity Analysis of Health Care Outcomes | Yes | 2008 | 20 |
| Examine the impact of free health care outcomes | Yes | 2008 | 21 |

## ANNEX 2 Banking Form

| GLOBAL ALLIANCE FOR VACCINES AND IMMUNISATION | Banking Form |
|---|---|

***In accordance with the decision on financial support made by the Global Alliance for Vaccines and Immunisation dated . . . . . , the Government of Neapl hereby requests that a payment be made, via electronic bank transfer, as detailed below:***

| | | | |
|---|---|---|---|
| **Name of Institution:** ***(Account Holder)*** | Financial Comptroller General Office, Government of Nepal | | |
| | Financial Comptroller General Office | | |
| **Address:** | Anamnagar | | |
| **City – Country:** | Kathmandu; Nepal | | |
| **Telephone No.:** | 977-1-4414325 | **Fax No.:** 977-1-4414651 | |
| **Amount in USD:** | (To be filled in by GAVI Secretariat) | **Currency of the bank account:** | USD |
| **For credit to:** ***Bank account's title*** | *Foreign Aid Account* | | |
| **Bank account No.:** | KA-7-13 | | |
| **At:** ***Bank's name*** | Nepal Rastra Bank, Banking Office, Kathmandu | | |

Is the bank account exclusively to be used by this program? YES ( √ ) NO ( )

By whom is the account audited? **Auditor General Office**

Signature of Government's authorizing official:

| | | |
|---|---|---|
| Name: | **Ms Sudha Sharma** | **Seal:** |
| Title: | **Secretary, Ministry Health and Population** | |
| Signature: | | |
| **Date:** | Aug 31st, 2009 | |

| FINANCIAL INSTITUTION | | CORRESPONDENT BANK *(In the United States)* |
|---|---|---|
| Bank Name: | Nepal Rastra Bank | City Bank, New York, USA |
| Branch Name: | Banking Office | American Express Bank, New York, USA |
| Address: | Thapathali | |
| | | |
| City – Country: | Kathmandu Nepal | |
| Swift code: | NRBLNPKA | |
| Sort code: | Email: nrbkso@ntc.net.np | |
| ABA No.: | | |
| Telephone No.: | 977-1-4226822 | |
| Fax No.: | 977-1-4227378 | |

**I certify that the account No. KA -7-13, Is held by** Financial Comptroller General Office, Government of Nepal **at this banking institution.**

| | |
|---|---|
| **The account is to be signed jointly by at least two *(number of signatories)* of the following authorized signatories:** | **Name of bank's authorizing official:** Mr. Siddhi Krishna Joshi Executive Director |
| 1 Name: Mr. Phanendra Raj Regmi | Signature: |
| Title: Deputy Financial Comptroller | Date: 2009 - 08 - 31 |
| 2 Name: Mr. Kuber Prashad Suvedi | Seal: |
| Title: Account Officer | |
| 3 Name: | |
| Title: | |
| 4 Name: | |
| Title: | |

TO:
GAVI Alliance Secretariat,
Att. Dr Julian Lob-Levyt
Executive Secretary
Chemin de Mines 2.
CH 1202 Geneva,
Switzerland

***On the 03 September 2009., I received the original of the BANKING DETAILS form, which is attached.***

***I certify that the form does bear the signatures of the following officials:***

| | Name | Title |
|---|---|---|
| **Government's authorizing official** | ***Ms Sudha Sharma*** | ***Secretary, Health and Population*** |
| **Bank's authorizing official** | ***Mr. Siddhi Krishna Joshi*** | ***Executive Director*** |

**Signature of UNICEF Representative:**

**Name** ***Ms. Gillian Mellsop***

**Signature** Gillian mellsop

**Date** 3/9/09

UNITED NATIONS CHILDREN'S FUND
NEPAL

# ANNEX 3 MoHP Performance Ranking by District FY 2007/2008

| Rank | District | % | Grade |
|---|---|---|---|
| 1 | Rasuma | 83.16 | B |
| 2 | Morang | 82.22 | B |
| 3 | Lamjung | 81.98 | B |
| 4 | Banke | 81.77 | B |
| 5 | Jhapa | 81.45 | B |
| 6 | Rupandehi | 81.44 | B |
| 7 | Surkhet | 80.76 | B |
| 8 | Kaski | 80.73 | B |
| 9 | Kailali | 80.26 | B |
| 10 | Mygdi | 79.78 | B |
| 11 | Kanchanpur | 79.46 | B |
| 12 | Sunsari | 78.81 | B |
| 13 | Dhading | 78.73 | B |
| 14 | Syangya | 78.73 | B |
| 15 | Dang | 78.72 | B |
| 16 | Accham | 78.54 | B |
| 17 | dadeldhura | 78.53 | B |
| 18 | Dhanusha | 78.24 | B |
| 19 | Rauthat | 78.00 | B |
| 20 | Lalitpur | 77.94 | B |
| 21 | Gulmi | 77.90 | B |
| 22 | Pyuthan | 77.87 | B |
| 23 | Arghakhanchi | 77.85 | B |
| 24 | Baglung | 77.82 | B |
| 25 | Kavre | 77.75 | B |
| 26 | Dailekh | 77.63 | B |
| 27 | Dardia | 77.37 | B |
| 28 | Saptari | 77.02 | B |
| 29 | Parbat | 76.42 | B |
| 30 | Bara | 76.16 | B |
| 31 | Tanahau | 76.13 | B |
| 32 | Makawanp | 76.04 | B |
| 33 | Jajarkot | 75.93 | B |
| 34 | Palpa | 75.82 | B |
| 35 | Ramechap | 75.43 | B |
| 36 | Bhaktapur | 75.10 | B |
| 37 | Chitwan | 74.88 | C |
| 38 | Sarlahi | 74.86 | C |
| 39 | Nawalpara | 74.81 | C |
| 40 | Parsa | 74.74 | C |
| 41 | Mahottari | 74.71 | C |
| 42 | Pancthar | 73.97 | C |
| 43 | Nuwakot | 73.92 | C |
| 44 | Sindhuli | 73.62 | C |
| 45 | Doti | 73.51 | C |
| 46 | Gorkha | 73.46 | C |
| 47 | Rolpa | 73.46 | C |
| 48 | Bajura | 72.92 | C |
| 49 | Mugu | 72.80 | C |
| 50 | Siraha | 72.59 | C |
| 51 | Kapilvastu | 72.54 | C |
| 52 | Dolpa | 71.51 | C |
| 53 | Terathum | 71.44 | C |
| 54 | Darchula | 71.18 | C |
| 55 | Baitadi | 70.96 | C |
| 56 | Sankhuwas | 70.60 | C |
| 57 | Jumla | 70.58 | C |
| 58 | Bhojpur | 70.57 | C |
| 59 | Salyan | 70.47 | C |
| 60 | Kathmandu | 70.40 | C |
| 61 | Sindhupalc | 70.30 | C |
| 62 | Rukum | 69.76 | C |
| 63 | Dhankuta | 69.74 | C |
| 64 | Kalikot | 69.37 | C |
| 65 | Okhaldhun | 69.28 | C |
| 66 | Khotang | 69.13 | C |
| 67 | Ilam | 68.75 | C |
| 68 | Taplejung | 68.71 | C |
| 69 | Udayapur | 67.46 | C |
| 70 | Solukhumb | 67.26 | C |
| 71 | Dolakha | 67.20 | C |
| 72 | Bajhang | 66.77 | C |
| 73 | Manag | 60.87 | C |
| 74 | Mustang | 59.38 | C |
| 75 | Humla | 58.61 | C |

**List of Indicators used for performance ranking**

**1.EPI**

DPT3 Coverage,

DPT1 Vs DPT3 drop out rate

**2.Nutrition**

proportion of malnurished children

**3.CDD**

% of severe dehydration among new cases

**4.ARI**

% severe Pneumonia

**5.FP current users**

Target vs Achieved

**6.FP(Sterlization)**

Sterlization % achieved

**7.SM**

% of Four ANC Visit among 1st Visit

**8.SM**

Delivers conducted by trained persons

**9.PHC out reach clinic**

% of PHC out reach clinic conducted

**10.TB**

Case finding tgt vs achvt,

Treatment success rate

**11.Leprosy**

% of RFT performance-Average RX completion rate

**12.Malaria**

slide collection,Target vs achievemnt

Slide Examination Rate

**13.Reporting Status**

complete reporting ofHospitals,PHC, HP,SHP.

**14.Timely Reporting**

Reporting within specified date

**15.Attendence and Response**

Fully participation=3

good response=2

**16.Remoteness of Districts**

Ka'region=5

'ng' region=1

**17.Acheivement Uniformity**

Standard deviation of achievement in selected indicator

The more the deviation the less the marks

**18.District profile**

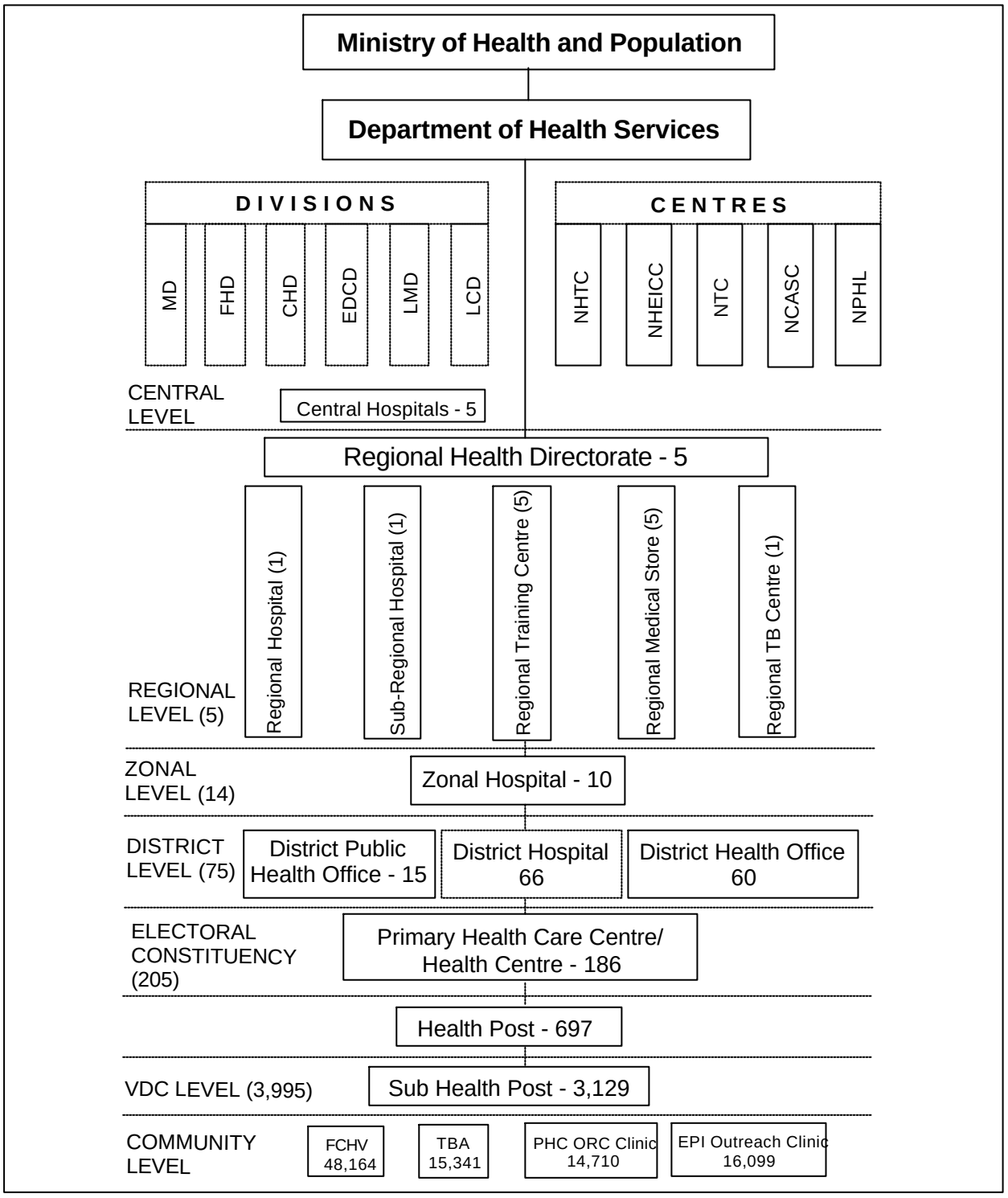
Regular updating of Monitoring sheet

**19.Financial mgmt**

1.Absorption capacity

2.financial discipline

## ANNEX 4 Organogram of the DoHS

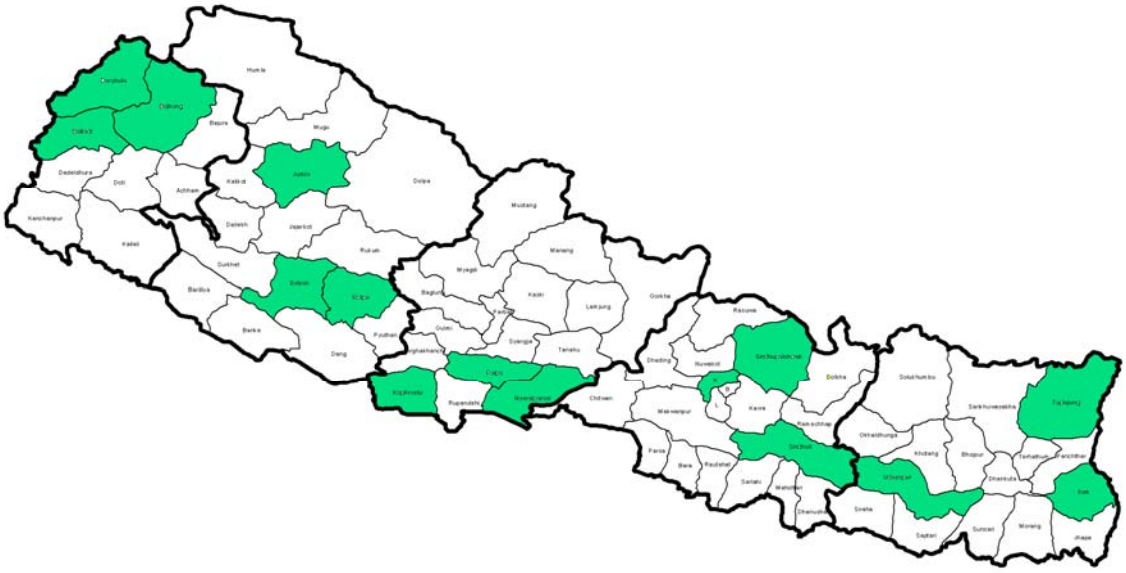



**Acronyms**

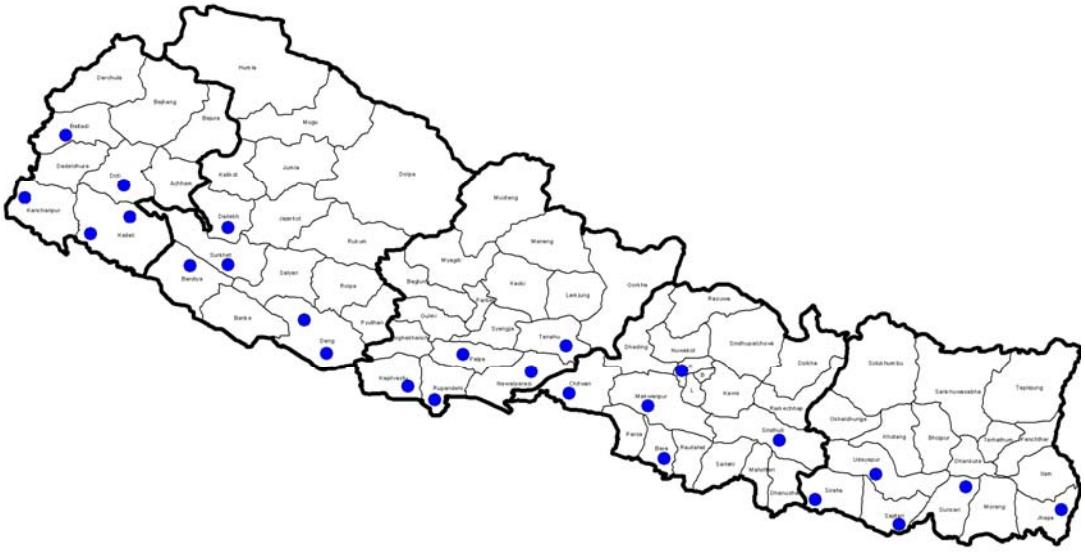
| | |
|---|---|
| *MD* | *Management Division* |
| *FHD* | *Family Health Division* |
| *CHD* | *Child Health Division* |
| *EDCD* | *Epidemiology and Disease Control Division* |
| *LMD* | *Logistics Management Division* |
| *LCD* | *Leprosy Control Division* |
| *NHTC* | *National Health Training Centre* |
| *NHEICC* | *National Health Education, Information and Communication Centre* |
| *NTC* | *National Tuberculosis Centre* |
| *NCASC* | *National Centre for AIDS and STD Control* |
| *NPHL* | *National Public Health Laboratory* |
| *FCHV* | *Female Community Health Volunteer* |
| *TBA* | *Traditional Birth Attendant* |
| *PHC/ORC* | *Primary Health Care Outreach Clinic* |
| *EPI* | *Expanded Programme on Immunisation* |

## ANNEX 5 Geographical Distribution of Proposed Activities.

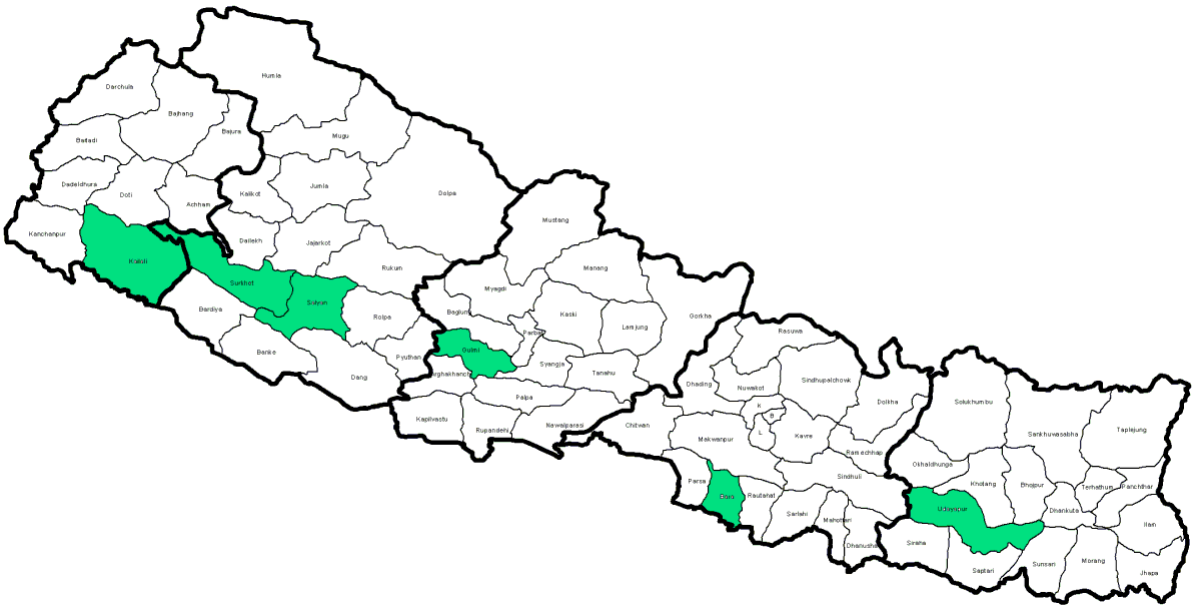
**Activity 2.1:** Integrated microplanning for effective delivery of MCH and newborn health (including immunization) expanded in 15 districts.



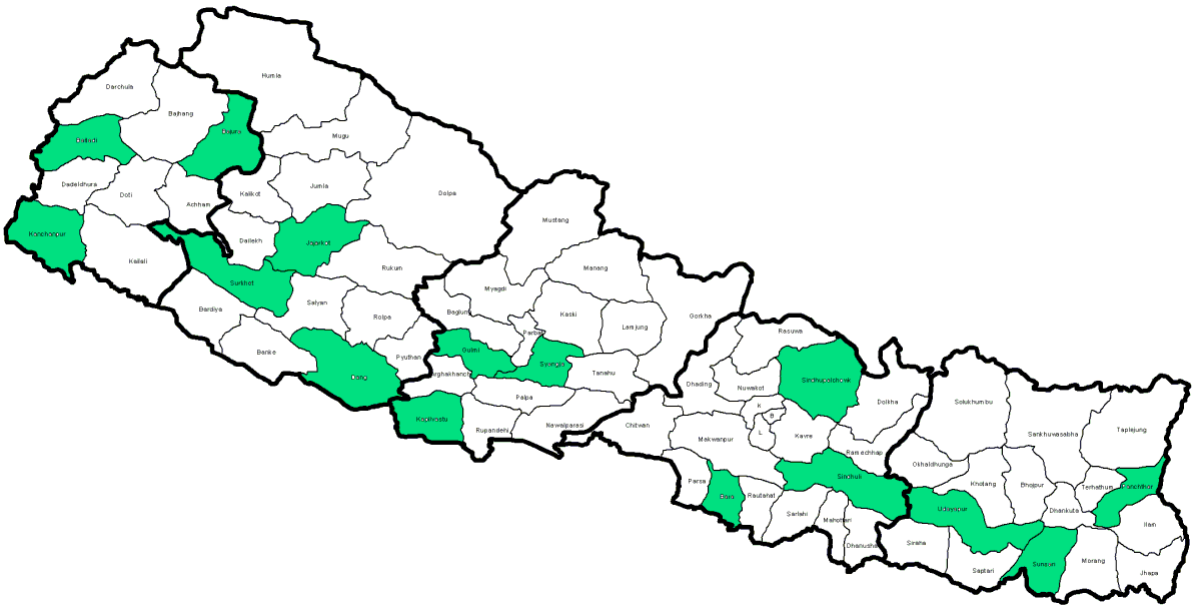
**Activity 2.2:** Developing and implementing and urban MCH health plan in 25 major municipalities.



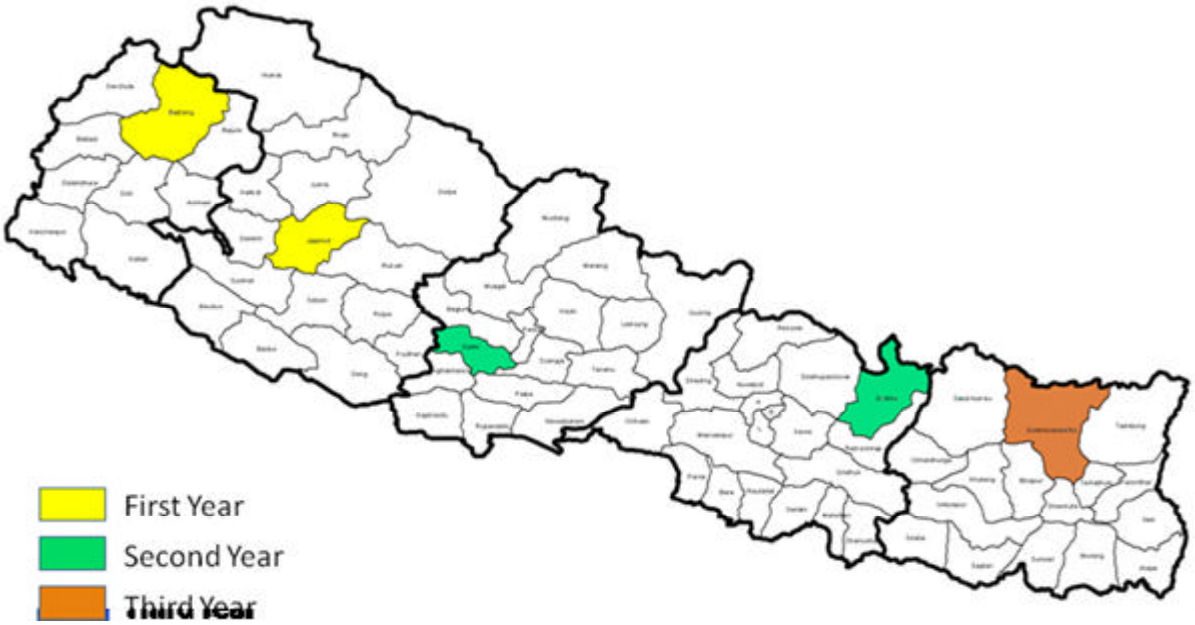
**Activity 2.3:** Expended community Based New Born Care Program (CB-NCP) plans.



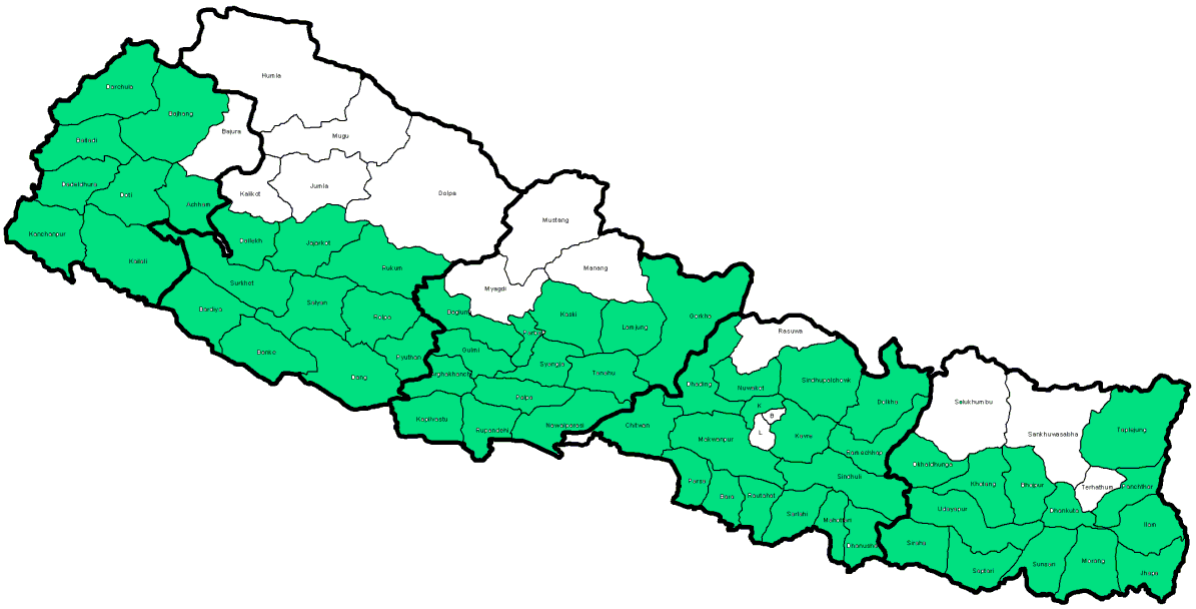
**Activity 2.4:** Training of Health Facility Management Committees (HFMCs)



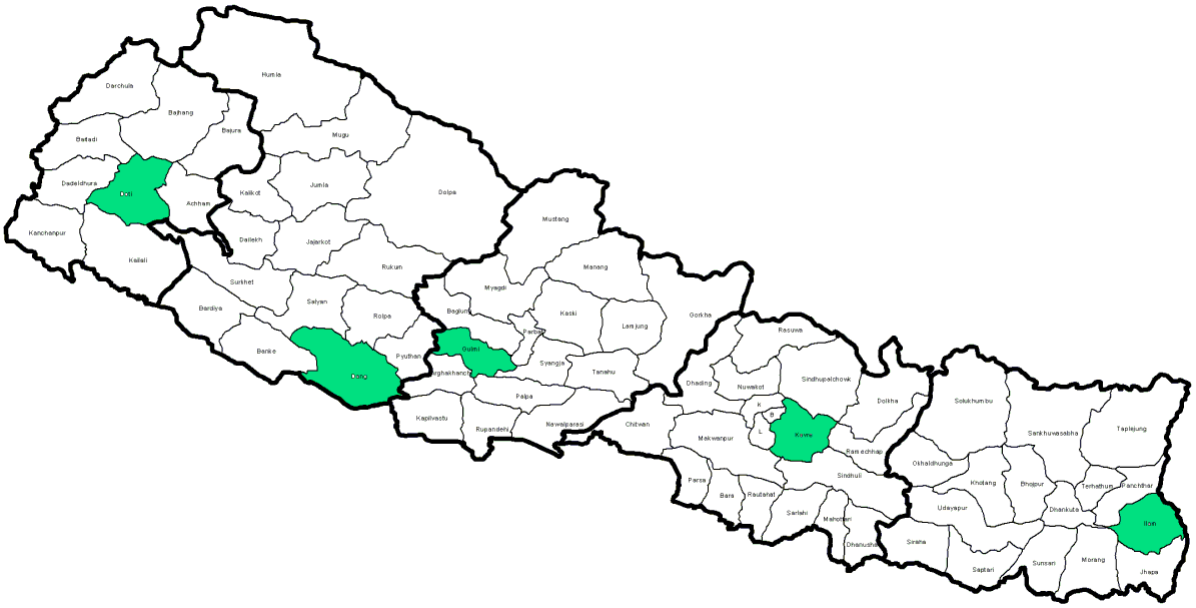
**Activity 2.5:** Provide integrated child health care package in 5 districts.




**Activity 2.6:** Reactivation of mothers group especially disadvantaged communities.



**Activity 3.6:** Establishing 1308 "Health Hut" in 5 selected districts.



***List of Names of National Health Sector Coordination Committee members***

| | |
|---|---|
| 1. Hon'ble Minister of Health and Population - | Chairperson Mr.Umakant Chaudhary |
| 2. Secretary, (MoH&P) – | Member Dr. Sudha Shrma |
| 3. Chief Specialist, Policy and planning division – | Member Secretary Dr. Y.V. Pradhan |
| 4. Chief Specialist, PHAME division – | Member Dr. Padam Bahadu Chand |
| 5. Director General, Department of Health Services – | Member Dr. Govind Pd Ojha |
| 6. Representative, MoF, Joint Secretary – | Member Kapil Dev Ghemire |
| 7. Representative, NPC- | Member G.K.Shrestha |
| 8. Chairman, Nepal Health Research Council – | Member Dr. Mahesh Maskey |
| 9. WHO Representative – | Member Dr. Alex Andjaparidze |
| 10. UNICEF Representative – | Member Ms Gillian Mellsop |
| 11. UNFPA Representative – | Member Ian McForlane |
| 12, Health Section Chief, USAID – | Member Ms Anne M Peniston |
| 13. Health Section Chief, WB – | Member Dr. Nastu Pd Shrma |
| 14. Chief CHSRUnit - | Member Surya Pd Acharya |