



**SSMP/NEPAL**  
Support to the Safe Motherhood Programme

# **Support to Safe Motherhood Programme, Nepal**

**A part of HMG/N Nepal National Safe Motherhood Programme (NNSMP)**

## **Financial & Contractual Arrangements and District Prioritisation Issues within the SSMP**

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## **ACRONYMS**

|           |   |
|-----------|---|
| ADB       | Asian Development Bank                                  |
| BEOC      | Basic Obstetric Care Services                           |
| CFAA      | Country Financial Accountability Assessment             |
| CEOC      | Comprehensive Emergency Obstetric Care Services         |
| DAC       | Development Assistance Committee (of OECD)              |
| DAP       | Development Action Plan (in CFAA)                       |
| DACAW     | Decentralized Action for Children and Women (of UNICEF) |
| DDC       | District Development Committees                         |
| DFID      | Department for International Development                |
| DHS       | Department of Health Services                           |
| EAA       | Equity and Access Agency                                |
| EHCS      | Essential Health Care Services                          |
| FA        | Financial Aid   |
| FHD       | Family Health Division                                  |
| INGO      | International Non Government Organisations              |
| ISI       | Integrated Supervisory Instrument                       |
| HMGN      | His Majesty's Government of Nepal                       |
| MDG       | Millennium Development Goals                            |
| MoHPP     | Ministry of Health and Population and Population        |
| NHSP – IP | National Health Sector Programme Implementation Plan    |
| NGO       | Non Government Organisations                            |
| OECD      | Organisation for Economic Cooperation and Development.  |
| PRSP      | Poverty Reduction Strategy Paper                        |
| SWC       | Social Welfare Council                                  |
| SSMP      | Support to Safe Motherhood Programme                    |
| TC        | Technical Cooperation                                   |
| UNDP      | United Nations Development Programme                    |
| UPHCP     | Urban Primary Health Care Programme                     |
| VFM       | Value for Money   |

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## EXECUTIVE SUMMARY & RECOMMENDATIONS

The Terms of Reference for this advisory work is contained in Annex A. It covers three tasks:

1. "Review the financial arrangements for the SSMP as set out in the Financing Agreement, particularly in relation to the modalities of transition from TC to FA, and specific queries raised in earlier consultancy work.
2. Advise as to what information might be collected by the newly appointed SSMP team members to prepare agreements with NGOs and other organisations that would allow for smooth transition to contracts with Government at a later stage, and taking into consideration the indicators and parameters set out in the Government/DFID SSMP Financing Agreement.
3. Review the strategy for targeting the 25 low HDI districts as proposed by Government, and consider its value as a part of an appropriate strategy for resource allocation in Nepal, taking into account questions of equity, effectiveness and efficiency".

Key findings and recommendations are provided in relation to each of the three tasks. Since each represented a mini-consultancy, they are reported separately.

### Financial Arrangements for SSMP

- i) The operating environment has changed since the programme was conceived, in particular due to the political changes in February 2005. This creates considerable uncertainty and makes the migration from technical cooperation (project) type modalities to financial aid modalities higher risk, especially in terms of governance;
- ii) It is understood that DFID would not be prepared to provide general budget support at this time. However the provision of sector budget support (including funding of SSMP) raises essentially the same issues and concerns, given the concept of fungibility;
- iii) (Possibly in response to these higher risks) development partners, notably UNICEF, have advised that they would be unable to accept direct funding from Government. It is anticipated that NGOs may reach similar conclusions. Relations between Government and NGOs are under some strain: one contributory factor may be recommendations from the 2005 Financial Accountability Assessment to tighten supervision of NGOs and to consider cancelling the registration of those unable or unwilling to accept such supervision. In such circumstances, the benefits of moving ahead with the migration to financial aid could be out-weighed by the dis-benefits;
- iv) The current annexes to the draft Financing Agreement include a reporting framework. It can be expanded to include the envisaged Cost Sharing Budget lines. However this reporting is only as good as the reporting back from Districts (see v below). In addition the characteristics of safe motherhood mean that effective earmarking of expenditures/budget lines to particular activities may not prove to be very conclusive as staff costs, consumable costs (such as fuel) etc may prove to be too generic to enable effective tracking;
- v) Despite recent analyses (the 2005 Financial Accountability Assessment and the Report on Decentralisation and Sector Devolution in Nepal), the understanding of financial flows and controls at a district level is limited. This is a high risk environment to be supporting new initiatives such as cost-sharing. SSMP will be appointing a specialist to assist with this, but much depends on system capabilities, which remain unproven for spending of this type;
- vi) In these circumstances, consideration should be given to preparing for a Financial Tracking Study, or its equivalent. The Financing Arrangement should include reference to this (including, possibly, a draft ToR). Prior agreement should be sought with the Financial Comptroller General. This recommendation is consistent with the World Bank design of the Health Sector Programme;

- vii) One challenge is managing the considerable uncertainties in terms of the contracting of UNICEF and NGOs. It is accepted that the programme should move forward quickly despite these uncertainties, but the contractual implications of having differing end-points is quite significant. These will impact on UNICEF (and NGO) staff contracts and other operational matters;
- viii) The report addresses issues concerning security, comparative advantage, sustainability and operational management.
- ix) DFID is in a position to pre-fund UNICEF and under the existing TC contractual arrangements Options, as the SSMP consultants, can contract NGOs. The Government may find it difficult to contract NGOs. This could mean that NGOs face cash flow constraints if they accept contracts from Government, potentially jeopardising execution of the programme. This issue should be explored further by the Procurement Adviser, once appointed;
- x) A linked issue is whether or not the Government will be able to commit to multi-year expenditure programmes (for example for hospital infrastructure). Recent IMF reports have been positive regarding the quality of economic management and Nepal has a functioning Medium Term Expenditure Framework, but political uncertainties will tend to increase fiscal constraints;
- xi) The Annexes to the Financing Agreement look satisfactory as templates, but need to be updated to include codes for Maternity Cost Sharing. Whilst the proposed templates are believed to be consistent with the Government's accounting structures, the issue of whether they provide an effective management and monitoring instrument can only be determined at District level;
- xii) Given the "high fiduciary risk" environment a regular and independent financial assessment is justified.

#### **NGO Arrangements**

- xiii) A key challenge is to improve the collection of information, if possible, before partners are contracted. This maximises the potential of ensuring that watertight agreements are prepared;
- xiv) Where possible level playing fields should be established, by ensuring that information is made available to all interested parties at the same time. Pre-selection of partners, solely based on past experience, is not generally adequate in terms of ensuring future performance;
- xv) Relevant models have been developed in other countries in order to monitor NGO performance. The Integrated Supervisory Instrument (ISI) prepared with ADB support as part of the Urban Primary Health Care Programme in Bangladesh is one example [and can be made available by the consultant];
- xvi) Monitoring of Safe Motherhood should be linked into the MoHP's planning and budget preparation cycle – this means that it should be focused on the period between four and six months into the financial year (when as much information from the previous year as possible is available), but in time to influence the following year's budget preparation process.

### Strategy for Focusing on Specific Districts

- xvii) A district-level needs analysis for maternal health services has been undertaken based on data from the Annual Report of the Department of Health Services (2003/04) and the UNDP Nepal Human Development Report, 2004. This indicates that there are considerable variations in unmet needs between districts.
- xviii) The Government wishes to focus resources on the 25 Districts with the lowest HDI rankings. Whilst these low-HDI Districts have substantial unmet needs they form only a low proportion of total unmet needs, in part because they typically have lower than average populations (as shown in Table 2 low HDI districts represent one third of all districts but have only 25.9% of the national population);
- xix) In terms of regions, mountainous districts perform worst in relative terms, with health workers (using MoHPP definitions) being present at only 9.2% of deliveries compared to 18.2% in hill districts and 19.9% of terai districts (see Table 3);
- xx) In absolute terms the situation is reversed (see –? of the estimated 752,290 births each year in Nepal which do not have a skilled health worker present, mountainous districts account for 69,834 or 9.3% of the total, with greatest unmet needs being in terai (356,051 or 47.3%) and hill districts (326,405 or 43.4%). This is also in Table 3;
- xxi) Unmet needs have been analysed for low HDI districts. Table 4 shows that unmet needs, in terms of births without a health worker being present, are highest in low-HDI terai districts (87,340 or 39.8% of the estimated total of 218,471); this is closely followed by low-HDI hill districts (86,092 or 39.4%); mountainous districts account for the remainder (45,039 or 20.6%);
- xxii) Table 5 shows average met and unmet needs. *Average unmet needs for low HDI districts are estimated to be 8,739 compared to average unmet needs for all districts of 10,031. This is a very significant finding. On this criterion, a strategy of targeting low HDI districts will achieve less in terms of satisfying total needs than a strategy which focuses on districts with higher populations, even if they are not low-HDI. Average unmet needs in terai districts, estimated at 17,803 per annum are more than double that of average unmet needs in low HDI districts of 8,739.*
- xxiii) Envisaged coverage of SSMP has been reviewed. Unmet needs in terms of deliveries without health workers in the 13 districts for which support is planned are estimated to be 169,436 per annum out of the 752,290 nationally, or 22.5%. This is a considerable achievement and these districts have greater than average unmet needs.
- xxiv) It is, however the case that only 3 of the 13 districts are low HDI, largely to the lack of appropriate development partners. The SSMP team has been seeking ways to identify how improvements could be introduced to additional low-HDI districts. Table 7 identifies an additional four low HDI districts which could be targeted (Dailekh, Humla, Jumla and Doti). These are thinly populated hill and mountain districts but have high unmet needs. In total these 17 districts would account for 25% of all deliveries and 26% of current unmet needs (as is shown in Table 8);
- xxv) The report explores the future potential direction of Safe Motherhood in terms of met and unmet needs. It identifies a further 5 low-HDI districts (Siraha, Rautahat, Sarlaha, Sindhupalchowk and Dhading) which have the highest remaining unmet needs of low-HDI districts. Covering these districts would enable total coverage of the programme to reach 35% of all deliveries, and 36% of unmet needs.
- xxvi) As noted above most of the low HDI districts have low populations. *It would be possible to raise the overall reach of the programme by selecting more highly populated districts with significant unmet needs. Taking this into account, it would be rational for the MoHP to review its policy of focusing on targeting low-HDI districts. There are clear tradeoffs to be made and more deliveries could be reached if the focus was on higher population districts.*
- xxvii) The trade-offs could be analysed in more depth taking account of value for money considerations, by estimating the costs of providing maternal health care services in

different locations, taking account of both capital investment (infrastructure etc) and operating costs (staff, non-wage recurrent costs such as drugs, utilities etc).

- xxviii) Other factors which may influence the selection of districts to prioritise for improved safe motherhood programme (SMP) services may include: average travel times and terrain; population density; rate of in-migration or out-migration; conflict intensity; proportion of Dalits / Janajatis in the population; accessibility, existence of roads and travel times; demand from other districts; perceived quality of care at facilities; staff turnover and retention rates. Consideration of these variables would justify consideration, although a comprehensive analysis lies beyond the scope or resources committed to this report.

Key overall recommendations are as follows:

- a) To consider undertaking a **financial tracking study**, to be undertaken in 2007, in order to establish how effectively funds are flowing into maternal health care services and to provide greater understanding of how district finances are functioning in the face of Maoist activities;
- b) To consider undertaking additional **district-level fieldwork** with potential development partners, NGOs etc, in order to i) create a *level playing field* and improve transparency of process, ii) to provide greater confidence about the *precise services needed* at district level and iii) to ensure that the contracting of development partners (including UNICEF) includes realistic *indicators of performance and milestones* against which progress can be assessed. Note that this recommendation should not hold up the EAA contracting and that overall it should save time during mobilisation and subsequent management of contracts;
- c) To **review the policy of focusing on low-HDI Districts** because it can only reach a low proportion of unmet needs for maternal health care services. Consideration should be given to a *balanced strategy* to include more of the districts with high populations, since this is where there is the *highest number of unmet needs*;
- d) To consider undertaking a more detailed **cost benefit analysis**, in order to provide disaggregated data on the relative benefits of supporting districts in the second phase. This analysis should not hold-up the roll-out of the first phase.

## **1. INTRODUCTION**

This consultancy study was undertaken as part of the Support to Safe Motherhood Programme (SSMP). This programme is funded by the Department for International Development (DFID) and aims to improve maternal and newborn healthcare in Nepal, with the objective of reducing the high rate of maternal and newborn deaths.

The programme supports the Division of Family Health in the Ministry of Health and Population. Support is already being provided centrally, but most maternal health services must be provided locally and this entails effective district level support. The programme will work partly through improving the demand for maternal health services through an Equity and Access Agency, and partly by supporting improvements to the delivery of maternal health services, facilitated in part by development partners and NGOs working at district level.

The vision of the Support to Safe Motherhood Programme (SSMP) is to migrate from technical assistance (TA) funding, which follows DFID procurement and accounting procedures, to Financial Aid (FA), which will follow the Government of Nepal's procedures. The Financing Arrangement is the contractual agreement between the UK and the Nepal Government providing the framework to facilitate this. This consultancy was commissioned to address outstanding issues in order to move forward with this process. It takes place at a time of transition: some changes had not been anticipated when the structure of SSMP was designed. This is contractually challenging, and the consultancy addresses three key issues:

- financial arrangements for the SSMP as set out in the Financing Agreement, particularly in relation to the modalities of transition from TC to FA;
- the preparation of agreements with NGOs and other organisations that would allow for smooth transition to contracts with Government at a later stage;
- the strategy of targeting the 25 low HDI districts as proposed by Government, taking into account questions of equity, effectiveness and efficiency.

Terms of Reference for the assignment are contained in Appendix A. Following the Executive Summary each of the three tasks is addressed separately in Sections 2, 3 and 4 of the report. References are provided as footnotes, and a list of people met is provided as Appendix B.

The fieldwork for this assignment was undertaken from 12<sup>th</sup> to 24<sup>th</sup> June.

## **2. TASK 1: “Review the financial arrangements for the SSMP as set out in the financing agreement, particularly in relation to the modalities of transition from TC and FA and specific queries raised in earlier consultancy work”**

### **2.1 Evolving Backdrop to the Programme**

It is realistic to identify six key “operating environment” factors that are relevant to the execution of the programme and impact on the content of the Financial Agreement. These are:

- The political changes of February 2005, and their implications for governance and fiduciary risk management;
- The joint Financial Accountability Review by HMGN/DFID and the World Bank undertaken in May 2005;
- The decentralisation process and its implications for management of financial and operational resources at district level;
- The changing attitude of Government towards the NGO sector, which is particularly crucial to SSMP as a means of executing and sustaining service (and demand-side) improvements;
- The likely response of the NGO/civil society partners to working with Government. UNICEF has advised that it is not in a position to accept funding directly from Government;
- The ongoing discussions regarding which districts should benefit from SSMP and in which sequence: key determinants include the desire of the Ministry of Health and Population (MoHP) to focus on low-HDI districts, the uneven availability of development partners/ NGOs and large unmet needs in all districts including better off, highly populated terai districts.

Each of these is assessed in turn, to establish their implications for the Financing Agreement.

#### **2.1.1 Political Changes**

The dismissal of the Cabinet by the King has profound implications for all donors. Whilst it lies beyond the scope of this report to make any assessment of the implications for the HMGN/ donor policy dialogue, DFID is understood to consider that it makes it inappropriate to consider general budget support<sup>1</sup> at this time. A usual prerequisite of general budget support is that budgets are approved by parliament and budget execution is subject to scrutiny by elected politicians, in order to minimise fiduciary risks<sup>2</sup>.

The provision of financial aid in support of SSMP is a form of sector budget support. It is envisaged that the agreement will mirror that for the broader health sector support. It will however be linked to particular budget lines in a manner not envisaged for the health Sector Wide Approach (SWAp) funding, which is being supported by the World Bank and DFID. However in accounting terms it is unlikely that common cost items (such as fuel and communications) can realistically be attributed to SSMP activities as against other health expenditures.

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<sup>1</sup> General budget support is the non-targeted release of funds to the Government, to be used in accordance with the approved budget.

<sup>2</sup> Fiduciary risk is defined as the risk that financial resources are “not used for the intended purpose; is not properly accounted for and does not achieve value for money”. See “Managing Fiduciary Risk when Providing Direct Budget Support” DFID, March 2002.

The principles of fungibility<sup>3</sup> mean that earmarking<sup>4</sup> to specific budget lines would probably not achieve very much, particularly in a context where significant control over relevant areas of expenditure is managed at a district level and not by the MoHP at central level. The accounting mechanisms envisaged may mean that it is difficult to establish significant additionality<sup>5</sup>, especially in the short term (ie over the first year or two). Investment in maternal health improvements entails a multi-year commitment, spread across a number of activities such as construction of infrastructure, training, expansion of skilled birth attendants etc. This makes it difficult to establish, from financial reports alone, what the trend is in terms of investment, operational activities and expenditure levels.

A related point to note is that the broader SWAp has only the most aggregate assessment of additionality. This programme is to monitor public expenditure in terms of total funding flows to the sector in terms of percentage of GDP by both the Government and other sources. Given the expected build-up of financial flows from the Global Fund for HIV/AIDS, TB and Malaria, this may not exert any significant pressure on the Government to increase public sector spending on health. It should, however, be acknowledged that compared to other countries in the region, the Government of Nepal has made reasonably substantial financial commitments to the sector (see the UNDP Human Development Report, 2004).

What can we conclude with respect to changing governance? At a period of such political uncertainty, it may be desirable to tighten the terms of the Financing Agreement rather than loosen it. This appears to be consistent with the recently published UK Government paper on "Partnerships for Poverty Reduction: Changing Aid Conditionality" published in March 2005. This states that the UK Government will continue to support "process" conditionality; it supports a transparent process and wants to achieve greater predictability; it also reserves the right to respond to changes in circumstances. A key question is whether or not the Financing Arrangement as it stands is sufficiently explicit and clear to be able to monitor the effectiveness of the programme.

### **2.1.2 Fiduciary Assessment:**

The key finding of the recent HMGN/DFID and World Bank Financial Accountability Review Mission, as reported in its aide memoire of 7<sup>th</sup> June 2005, is that: "*Nepal has one of the most advanced financial management systems in the developing world, requiring that both budget allocation and budget release be tied to successful implementation, but that this advanced system was not being implemented as intended. The consequence was that fiduciary risk was considered high despite the existing advanced system*"

Overall the report is positive about the trends, noting that progress has been made in a difficult environment to implement the Development Action Plan (DAP) included in the 2002 Country Financial Accountability Assessment. It notes "*serious reform efforts are underway in improving public financial accountability.....and that improvement in financial management and fiscal discipline remains a high priority of the Government*".

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<sup>3</sup> Fungibility concerns the displacement of financial resources: if a donor provides earmarked funding for budget lines which would, in any event, be financed by Government, then it is in effect financing other parts of the budget over which it has no particular insight or scrutiny.

<sup>4</sup> Earmarking of financial support may be through pre-funding or reimbursement of agreed budget lines.

<sup>5</sup> Additionality refers to the net incremental spending which results from an increase in funding from an external source/donor. It is challenging to measure because: i) it relies on assumptions on what would have taken place in the event that the support was not forthcoming (the "counter-factual"); ii) can only be estimated with good time-series information (for example covering several years of expenditure) and iii) because in many cases it takes a year or more to incur expenditure once the decision is made to go ahead (for example for infrastructure investment or when more staff have to be trained). Investment in maternal health improvements is generally multi-year making it difficult to establish, from financial reports alone, trends in terms of investment and operational expenditures.

It flags two areas where there has been only limited progress. These concern efforts to bring:

- i) all donor funds within the HMGN budgetary framework;
- ii) the activities and finances of NGOs into clearer public accountability and government focus. The CFAA in 2002 recommended that NGOs should file audited financial statements annually with the Social Welfare Council (SWC).

The 2005 Financial Accountability Assessment also states that: *“In order to bring more transparency in the funds flowing through NGOs, it is critically important for HMGN to engage in a serious and transparent process with the SWC, NGOs and INGOs with a view to explaining why HMGN has a legitimate interest in non-Government Activities. HMGN may also want to ask donors funding NGOs and INGOs to insist on high standards of transparency in the NGOs/INGOs they fund as well as ensure that the outcomes of their activities are aligned to PRSP outcomes. Failing this HMGN may wish to take action such as cancellation of registration. HMGN should also agree with the NGOs/INGOs on fair rules and guidelines designed to protect the public interest and ensure NGOs/INGOs transparency without unduly burdening them or hampering their legitimate interests”.*

This element of the assessment seems surprisingly centralist and controlling in its aspirations at a time when the legitimacy of Government has been challenged by recent events. It could have significant implications in terms of the engagement and relationship between NGOs and the government and needs to be kept under close review by SSMP. It is understood that the Government is already taking action against some NGOs that are considered to be transgressing particular boundaries and such action could be justified by the findings of the Financial Accountability Review mission. It is to be hoped that its recommendations do not result in unintended and unforeseen consequences (see section on Government/NGO relations below).

As noted by the Financial Accountability Review new procurement legislation has been prepared and is in the final stages of discussions. This legislation, modelled on best international practice, will be complemented by the training of a specialist cadre of procurement staff. Given the importance of the procurement element of SSMP, close engagement will help to ensure that the contracting of NGOs is undertaken in a manner consistent with HMGN procedures. It should be noted that service contracts are typically more challenging to manage than works contracts and this may make it particularly important to ensure that the contract design and management is as watertight as possible. The DFID-funded SSMP programme will be supporting procurement with full-time international and national technical assistance.

The financial assessment is sketchy with respect to what is happening at district level. It contains statements such as: *“Life in many villages has been so disrupted by insurgency that financial accountability of their villages might have been negatively affected”*. It also states that *“Those municipalities, districts and villages not affected by violence continue to function and implement the financial procedures with no more than the usual difficulties”* (see page 11 of the Financial Assessment report). This doesn't appear to be a ringing endorsement of confidence.

Some additional insights into district finances are contained in a recently commissioned report on Decentralisation and Sector Devolution<sup>6</sup>, which are summarised below.

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<sup>6</sup> See “Report on Decentralisation and Sector Devolution in Nepal, Draft Report, June 2005” by Jagadish Pokharel et al, the Development Resource Mobilisation Network commissioned by DFID Nepal.

### 2.1.3 Implications of the Decentralisation Process

The draft report on Decentralisation and Sector Devolution identifies considerable variations in management and performance in different parts of the country. In part this depends on whether districts are fully under the control of the Government, fully under the control of Maoists or in a state of flux. It also depends on the district level leadership structures both across and within sectors. This report focuses more on governance issues – highlighting the weaknesses in public accountability resulting from the absence of elected representatives, rather than financial tracking, the extent to which funds can be vired from one budget head to another and other key issues of relevance to specific programmes such as maternal health.

With respect to SSMP, issues of critical importance include:

- ensuring that the overall level of resources is adequate to provide good maternal health care services;
- this, in turn, requires realistic budgeting and effective expenditure management within both annual budget cycles and over the medium term;
- the operational flexibility to adjust the application of resources (human and financial) to reflect district level needs;
- the control mechanisms needed to ensure that “cost sharing” – the payment of grants towards travel costs to encourage women to seek out professional maternal health care services – is undertaken in an accountable manner that minimises the potential diversion of funds.

A key difficulty is that it is difficult to be confident about the financial management environment at district level. Neither the Financial Accountability review mission nor the Report on decentralisation shed much light on this. The fiduciary risks at district level need to be acknowledged in the Financing Agreement.

This poses a real challenge with respect to programme management of SSMP and impacts upon the contracting of both umbrella and individual NGOs. Many of the characteristics of the programme entail “process” elements which cannot be precisely specified at the beginning. Key factors that will determine the success of individual district level interventions lie outside the control of SSMP management and its development partners.

**Recommendation:** Given the lack of certainty about district level finances, it is recommended that consideration should be given to commissioning a Financial Tracking Study, which would analyse the flow of finances for safe motherhood activities through both the Government and the NGO/INGO routes. It should be noted that this recommendation is consistent with the World Bank’s Project Appraisal Document (Report No 29651-NP) on a Proposed Grant and Proposed Credit to the Kingdom of Nepal for a Health Sector Programme dated 4<sup>th</sup> August 2004. This states (see page 13) *“To strengthen internal controls, MoHP may recruit independent reviewers, preferably professionally qualified accounting and auditing firms, to visit districts and evaluate the work of District Health Office (DHO)/District Public Health Office (DPHO) and of the outreach health facilities and communities”*.

Consideration needs to be given to whether this should be contracted for SSMP separately or as part of the broader SWAp fiduciary management process. There are advantages and disadvantages in each. The concept of fungibility means that a joined-up approach is appropriate. However there are specific issues related to SSMP, such as the cost-sharing initiative, which mean that particular attention should be paid to safe motherhood, and this could be diluted if such financial assessments are only a sub-set of the overall SWAp process.

Taking account of the needs of SSMP, it is recommended that the financial tracking/financial review process should be commissioned with TOR targeting a small number of districts, to be selected at the time. It would be appropriate that it should take place 18 months to two years into the new programme (say, in early 2007), when sufficient progress has been made to provide an adequate basis for the assessment. Prior agreement should be sought from the Financial Comptroller General, and it is suggested that this should be requested now in order that reference to it can be included in the Financing Arrangement. Draft ToR could be developed for inclusion, as an annex to the Financing Agreement, in order that there should be no misunderstanding about the purpose or scope of work.

#### **2.1.4 Dynamics of the Government/NGO Relations**

It is evident that there are complex dynamics in the relationship between Government and civil society, including both for-profit and not-for-profit service providers. On the one hand it is policy to acknowledge that the public sector should not seek to be a complete service provider, and the important role of NGOs etc is recognised in policy documents including those covering the health sector. On the other hand there is a strong centralising, command type dynamic linked to the political situation and ongoing Maoist rebellion.

As noted above the Social Welfare Council has a key role to play in monitoring NGO and INGO performance. It is reported in the Financial Accountability Assessment that between 2002 and 2005 affiliation to the Council has increased substantially from 13,000 to 18,000 NGOs and from 106 to 123 INGOs. Given the large numbers of NGOs operating in Nepal, effective monitoring of their performance, including sanctions against those failing to maintain adequate fiduciary standards, is likely to be constrained.

Conversely attempts to increase regulation of the NGO sector may mean that NGOs become more wary of Government interference and as a result become less willing to accept contracts directly from Government. This could lead to a risk premium being required or lengthy delays and contractual negotiations concerning key sticking points. Experience from other countries suggests that crucial issues will relate to:

- the unit costs of services provided (for example reimbursement of staff rates);
- vehicle procurement and reimbursement of purchase and operating costs;
- the potential cost of security measures;
- payment of taxes and levies, and
- pre-funding of activities, cash flow management and the provision of performance and financial guarantees.

A key question is whether these matters need to be resolved in the Financing Agreement or whether national standards and norms are adequate. The preferred situation, consistent with OECD DAC best practice/guidelines<sup>7</sup>, is to avoid complex and potential contradictory project/programme agreements and to harmonise around common procedures.

With respect to UN agencies it is now known that UNICEF is unwilling to accept direct contracts by Government in Nepal. This has significant implications for SSMP programme execution with respect to:

- content and scope of the Financing Arrangement;
- programme sustainability.

It is possible to identify three strategic choices resulting from this constraint:

- i) The role to be undertaken by UNICEF would need to be phased out over time, perhaps by migrating it to other civil society partners who are able to accept contracts

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<sup>7</sup> See OECD DAC guidelines: "Harmonising Donor Practices for Effective Aid Delivery Vol 2: Budget Support, Sector Wide Approaches and Capacity Development in Public Finance Management" February 2005

from Government or by building sufficient capacity in the public sector that it is able to provide maternal health services of sufficient quality that external support is no longer needed.

- ii) The move to financial aid for this element of the SSMP programme would need to be deferred indefinitely, or
- iii) Alternative funding sources, perhaps one of the Global or Trust Funds, could be persuaded to take over the funding role for UNICEF.

These different end-points require differing approaches with respect to the programme execution (and as a consequence to the UNICEF and NGO partnership agreements). For example UNICEF (and the NGOs linked to the programme) will recruit staff on the basis of secure funding over an agreed number of years. Similarly when the performance of the programme is monitored, it needs to be monitored against time-bound targets. There is a particular design risk that whereas UNICEF (and other NGOs) should be seeking a sustainable solution, this means that staff may be working to put themselves out of a job, thereby creating perverse performance incentives. These are serious concerns, although they have been faced in other environments where migration from project to on-budget programme modalities has been faced.<sup>8</sup>

### **2.1.5 Confirming the Roll-Out of Support to Districts**

Appropriate and well-planned packaging of contracts will help to ensure that the implementation of programme is outcome-focused and cost-effective. It will be recognised that individual districts have differing needs, and that the start-up and operating costs vary from location to location. Key issues concern:

- Security and its implications for effective service delivery;
- Comparative advantage and sustainability; and
- Operational management.

Security is a key and multi-faceted consideration with important contractual implications. Aspects to be considered include:

- i) Whether it is appropriate that some development partners should be awarded agreements covering both Government controlled and Maoist controlled districts or is it desirable that these should be separated out? Which of these options will minimise risks to the executing parties? Which will limit the potential for complicity with rent-seeking behaviour etc?
- ii) How can contracts be structured in order to ensure that they may be adjusted to reflect changes in the security situation (impacting on both the Government /district level officials service providers and on the NGO partner)?
- iii) Where does liability sit in the event that staff are kidnapped, injured or killed? What obligations are there on the donor, on the programme and on the Government to ensure a secure and safe environment?
- iv) How does the security situation impact on insurance cover?

It is, of course, sensible that the programme should seek to appoint partners which will be able to contribute as effectively as possible to the objectives of SSMP. This requires realistic assessment of the comparative advantages and experience of each potential partner. This depends in part on local perceptions of the partner's work, which may be most effectively gained by pre-contract, on the ground, assessment. Whilst in some cases this may not be possible for security, timing or operational reasons, it should be considered where practical. Similarly, as experience is built up, particular partners will gain in comparative advantage. Whilst it is desirable to protect and make use of this experience, it counteracts the tendering process by giving some partners an "unfair" advantage. This needs to be kept in mind with

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<sup>8</sup> For example the MASSAJ programme in Malawi, a DFID funded programme to support the police and justice system.

respect to contract duration and may impact on the Financing Agreement. The benefit of taking explicit account of these issues from the outset is that it minimises the risk of subsequent misunderstandings and disagreements.

Operational management issues concern programme execution. Is it an advantage to “cluster” districts in order that linkages between services can be maximised? This would mean that natural synergies could be developed to the maximum extent possible, for example in terms of shared use of referral hospitals, or in terms of sharing common overheads, such as having a rotating financial adviser or controller able to work in several districts. Transport and communication linkages will also be significant: it may not make sense to travel through an un-served district in order to reach a remote served district.

It may also be logical to link NGOs in order to maximise their potential. Some may have comparative advantages and be able to offer mentoring skills to others. If this is envisaged, care should be taken to formalise this in their terms of reference and contracts, and thus provide a platform for monitoring their performance in this regard. Equally this should be built into their contracts in order to ensure that they are remunerated for these value added activities.

#### **2.1.6 Other Financial Agreement Issues**

Two other points need to be flagged in terms of financial commitments under TC and then Financial Aid arrangements:

- i) Will pre-funding of activities be permitted by the Government once the migration to financial aid has taken place?
- ii) What is the ability of the NGO to incur commitments?

Will the NGO be pre-funded for services to be provided under the programme? This is permitted under the reimbursable grant process<sup>9</sup>, but may not be consistent with the Government of Nepal’s procurement processes. This has governance and risk management dimensions (for example it is often difficult for NGOs to raise bank guarantees as they lack the collateral, and often public institutions are unwilling to pre-fund unless a valid bank guarantee is in place). This needs further examination, and partly depends on the Government of Nepal’s procurement regulations.

The issue about commitments is difficult. Normally Governments constrain their operating departments from making multi-year commitments ahead of having an approved budget for that activity. This particularly applies to non-wage and development expenditure (indeed traditionally a high share of development expenditure has been funded by donors in an environment such as Nepal). Wage expenditure in the public sector is controlled by having a limit on the number of establishment posts. In this context the key issue is whether NGOs can undertake multi-year planning (for example the recruitment of staff with permanent contracts) when it is not clear whether the Government will be able to fund the programme in future years from its own resources. The Medium Term Expenditure Framework (MTEF) is in place, and the last IMF review<sup>10</sup> was relatively positive, although of course the situation is changing. This needs to be investigated in greater detail, which will probably involve further discussions at both central and district level.

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<sup>9</sup> For further details on reimbursable grants, it is probably best to speak directly to Mr Phanindra Adhikary, Deputy Programme Manager, DFID. Such grants are generally paid in advance, with subsequent releases only made once the previous but trimester is properly accounted for.

<sup>10</sup> See “Memorandum of Economic and Financial Policies Under the PRGF”, 2003-04 to 2004-05, October 4<sup>th</sup> 2004, [www.IMF.org](http://www.IMF.org)

## **2.2 Implications for the Current Draft Financing Arrangement**

When the draft Financing Agreement is reviewed taking account of the factors noted above, it can be seen that although it provides a framework, it does not provide specificity or detail to describe operational modalities. This may not be too much of a problem providing there is a consensus on these detailed modalities. The key question is does such a consensus exist? If there are areas which lack clarity at present, what process should be engaged upon to ensure that uncertainties are identified and analysed and risks managed?

Work on the preparation of the Financing Arrangement for SSMP has been undertaken on the basis that the content should be broadly similar to that for the health SWAp, which is supported by the World Bank and DFID. This is certainly logical, although SSMP functions in support of specific functions within the MoHP of the MoHP and its progress must be appraised against more disaggregated indicators. This level of detail is contained in the Annexes to the agreement which are reviewed below.

### **2.2.1 Financial reporting**

The draft agreement, as it now stands, includes an Annex covering financial reporting.

A key issue with respect to financial reporting is that the focus of monitoring is based on the FHD budget. However key areas of expenditure such as training, is likely to flow through the budget of the Training Division, whilst infrastructure investment will also be overseen by external parties – the Ministry of Works or Ministry of Local Government. A further meeting with the MoHP Director of Finance and Administration may be required to confirm the precise modalities of the financial flows for these areas of expenditure.

Annex 3 covers an outline statement of expenditure, using item-based coding. It is understood from discussions with the MoHP<sup>11</sup> that this can be expanded to include item 3.2 Maternity Cost Sharing (if through local Government) and item 3.3 if through MoHP's own systems.

Annex 4 contains an output based progress report showing the annual budget shared between the HMGN and DFID and divided into five sub-heads. This looks satisfactory as far as it goes but is clearly dependant on timely and accurate reporting back from the districts concerning budget releases and expenditure. This is also true of Annex 5 covering the programme Based Annual Work Plan and Budget. The difficulty with maternal health care (as compared to, for example, immunisation) is that there tends to be a high proportion of common overheads. In smaller facilities the same staff may be attending to other patients as well as maternal cases. This poses the question of how realistic the disaggregation of costs really is, and whether it is applied on a consistent basis both i) from year to year in order to provide time series information; and ii) between facilities and/or districts, in order to identify the degree of equity and efficiency in the allocation of resources.

Overall the proposed templates are understood to be consistent with the Government's accounting structures, but the issue of whether they provide an effective management and monitoring instrument remains to be clarified. This can only really be established at a district level – and might need a relatively large sample of districts benefiting from the programme given the consensus that the situation differs from district to district. Although it is appreciated that the cost sharing arrangement will apply country-wide whilst the SSMP has a narrower geographic focus (especially in the early years) there are benefits in linking the financial monitoring processes in order that a more holistic picture of financial flows and accountability for all SSMP can be provided.

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<sup>11</sup> The reader may refer to Mr Tanka Mani Sharma, Head of Finance and Administration, MoHP for more information about the cost coding used by the MoHP. The annexes to the Financing Agreement should be amended to include these codes [NB Mark Watson has these annexes in paper form only].

Whilst it is important not to hold the agreement up, in an environment which is described as “high fiduciary risk” in the recent Financial Assessment, and a proper risk containment system, with regular assessment of progress is needed. This is consistent with meeting both UK Government (DFID and National Audit Office) and HMGN (Financial Comptroller General) requirements.

**3. TASK 2: “Advise as to what information might be collected by the newly appointed SSMP team members to prepare agreements with NGOs and other organisations that would allow for smooth transition to contracts with Governments at a later stage, and taking into consideration the indicators and parameters set out in the Govt/DFID SSMP Financing Agreement”.**

**3.1 Introduction**

SSMP will work through partners to support:

- Equity and access issues related to demand for maternal health services;
- Capacity building to improve the availability and quality of the supply of maternal health services.

A key challenge when appointing NGOs and other organisations to undertake capacity building is to be extremely specific regarding the scope of work and services to be provided. It is important to record in writing, as part of a contract, precisely what is expected from each partner and time-bound milestones should be agreed against which progress can be measured.

This is a similar requirement whether the contracting authority is the SSMP programme, using TC funds, or the Government of Nepal. Good procurement practice – and in essence this is a procurement process – is one which minimises the potential for disagreement regarding the scope of work, method of execution or outcomes expected. Furthermore, regardless of the contracting authority, the focus of performance monitoring has moved from being largely concentrating on monitoring the inputs (numbers of people, expenditures incurred) to monitoring of outputs and outcomes (the results of the intervention).

[There are, however, issues concerning cash balances and the ability to pre-fund expenditure which are specific to the transfer of the programme from to financial aid modalities. These were explored as part of Task 1].

There are three fundamental factors which may hinder achievement of sound operational agreements with non-Government partners including the contractor for the Equity and Access Agency (EAA), UNICEF, UMN and NGOs:

- i) Scarcity of accurate information about existing services, infrastructure, demand, human resources and operational matters at the design stage;
- ii) Poor accountability and/or inadequate monitoring of performance;
- iii) Changes in circumstances (for example in relation to security or Government funding) in the course of execution of the programme.

It is appreciated that these partners face differing potential roles and circumstances. However experience of service contracts in many environments indicates that in most cases difficulties were avoidable and risks can be managed with sound planning and common understanding of the expectations of each party.

Care needs to be taken to mitigate these factors to the extent possible. Each is addressed in turn below:

**3.2 Collecting Key Information Regarding Prevailing Conditions**

The challenge is to ensure that information is gathered in a comprehensive and consistent manner, and made available to all stakeholders. This should include the MoHP at central and district level, as well as District Development Committees (DDCs) and other local

stakeholders. It may be desirable to bring in potential development partners at an early stage. However the risk is that this may undermine a bidding process and may create unfair advantages. The alternative is therefore to undertake the preliminary information gathering and make it available in a printed summary form to interested parties.

In the case of the EAA fieldwork may not be practical, although once an organisation is selected an early and joint inception visit should be organised. This may also be the case with UNICEF and UMN although joint visits would help to identify and crystallise contractual issues and expectations, as well as facilitating early engagement by the MoHP, especially at District level.

In the case of participation of district level NGOs, an early field visit could be organised which would culminate in a question and answer meeting, with all stakeholders present. It would be sensible to record all the key points made, again to reduce the risk of subsequent disagreements or misunderstandings. Where commitments are made about particular inputs, for example the availability of government staff, it is important to check that these commitments lie within the authority of those making them.

It is also important that the principle that this is the Government's programme is built into the analysis from the beginning: SSMP should therefore be seeking to empower and guide the MoHP and the DDCs rather than controlling or directly executing activities. This is an evolution of process compared to that used under most project modalities, and it is also a very different way of working to that of many NGO partners (although UN bodies such as UNICEF should be familiar with it).

One key area of control and linkage is over budgets. It should be remembered that the budget preparation and execution process is a political one, and concerns choice over the allocation of scarce resources. In the Nepal context this clearly poses issues given the political changes at a central level. However one key intention of moving towards financial aid, working through Government budgets, rather than project modalities, is to increase transparency of process and to support public accountability.

It should be noted that DDCs must be empowered alongside the MoHP, so that local NGOs at the later stage can in time be managed directly by DDC directly in agreement with the relevant part of central Government (in this case the FHD of the MoHP). As noted by SSMP's Contracts Adviser, current legislation permits DDCs to be directly funded by the MoHP or by external donors (although presumably these must be fully recorded in the Red Book of the budget). Working more directly with the DDCs should help improve accountability at the local level.

Plans should be consistent with the Ministry or District Government's development plans, and linked into spending plans including the medium term expenditure framework and the annual budget. A key requirement is *affordability*, and this necessitates linking *planning activities at a maternal health level with overall financial and budget preparation process*. In terms of the migration from TC funds to financial aid, the *predictability of expenditure releases* is important. Therefore it is appropriate, when visiting districts, to establish whether funds have been released in accordance with the budget and at the appropriate time.

One particularly sensitive area is the provision of allowances to Government employees by the programme, for performing their normal duties and/or attending workshops, training etc.... It is understood that this is not permitted by the Government. It may be appropriate to make this clear in agreements with NGOs. Equally travel allowances etc may need to be

standardised to avoid this potential area of dispute.<sup>12</sup> As is often the case, there is a trade-off between programmatic performance objectives and overall public service affordability, and wage ceilings as a percentage of total public expenditure and/or GDP. Clearly SSMP must be consistent with national parameters in this regard.

### 3.3 Improving Accountability and Monitoring Performance

The overall objective of the accounting and monitoring system is to gain an accurate reflection of performance on a comprehensive and consistent basis. However this needs to be achieved in a manner which is affordable and manageable. There is no point in spending so many resources on information gathering that it overwhelms the capacity for proactive management. Information must be available in a time-bound manner, and linked into SSMP's reporting framework.

The Urban Primary Health Care Programme in Bangladesh works through NGO partners<sup>13</sup> which have been contracted following competitive tender. This programme has a large maternal healthcare element and has many common features with SSMP<sup>14</sup>. In order to monitor performance on a consistent basis an **Integrated Supervisory Instrument (ISI)** has been developed<sup>15</sup>. There are some features of this system which are relevant and justify consideration for the SSMP in Nepal.

The ISI is divided into several components, each of which is designed to monitor the performance of different elements of the programme. Each element is attributed a score. The scoring system seeks to be as specific as possible in order to ensure that performance is monitored over time.

Key elements are summarised below:

- **Scope of Partnership** area (this is for mapping catchment of the service provision area);
- The **Quality and Execution of the Workplan**. This identifies a series of service components (such as TT immunisation, anti-natal care, PNC and different aspects of emergency obstetric care) against pre-agreed criteria for assessment covering resources, intervention type, time and the target for provision;
- **Personnel** are ranked by staff category against the total number sanctioned and number currently working. Performance is scored against the percentage of those working against agreed posts';
- **Training and orientation** of programme staff is assessed against the provision of orientation, technical and refresher training;
- **Accounting systems** are assessed against the cash book; ledger book; availability of supporting vouchers; whether there is an up to date fixed asset register; and whether procurement has followed correct procedures;
- In Bangladesh, where user charges are imposed, **revenues** are also assessed.

In Bangladesh performance monitoring has been contracted out to a third party (under URPHC I to Mitra and Associates). There are advantages and disadvantages to contracting this performance monitoring out, and it is not self-evident that this is the most appropriate way forward in Nepal. However it is clearly desirable to set common service standards and

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<sup>12</sup> Mr Sunil Khadka, Contracts Adviser to SSMP, notes that good existing practice models of contracting and developing partnerships with NGOs include the tripartite agreements between the Swiss Development Committee and the local users' Committee of NGOs..

<sup>13</sup> It is worth noting that one of the partners in Bangladesh is the Marie Stopes Society.

<sup>14</sup> In Bangladesh the two key facility types are the Primary Health Care Centre (PHCC) and the Comprehensive Reproductive Health Care Centre (CRHCC)

<sup>15</sup> Mark Watson has a hard copy of all sections of the Integrated Supervisory Instrument but does not have an electronic copy.

to monitor districts on a consistent basis. It may therefore justify developing, in conjunction with colleagues in the MoHP, an equivalent instrument.

It should be made available and discussed with the authorities at a district level and with potential NGO partners in order that they are clear about the criteria to be applied to assessing their performance.

### **3.4 Monitoring Changes in Performance**

The final key challenge is to identify how to act when performance shortcomings are identified. There is an important dimension related to timing.

Monitoring needs to take place for two purposes:

- i) to ensure that NGOs and other development partners (including the Government operated facilities at district level) perform as well as possible and are held to account for their performance against pre-agreed work-plans;
- ii) to feed into the overall planning and resource management process

The first of these is self-evident: the objective is to ensure that service delivery is improved and NGOs contribute effectively. The latter reflects the need for monitoring to be linked as closely as possible to the Government's financial year and budget preparation process.

Some kinds of information become available much more quickly than others. It is important to recognise this as part of the planning process, and to anticipate in a realistic manner when information can and should be made available. For example comprehensive comparisons between districts are only possible once data from all districts has been assembled: if some districts have a record of being slow in submitting returns, it is sensible to establish why this should be the case, and to see whether improvements in performance can be achieved.

Timely collection and analysis of performance at a district level (and subsequently nationally) will contribute to effective programme management by the MoHP. It will also feed into the budget submissions by the Ministry of Health and Population to the Ministry of Finance, thereby helping to ensure that maternal health services are properly funded. Monitoring should be focused on the period between four and six months into the financial year (when as much information from the previous year as possible is available), whilst being sufficiently early to influence the following year's budget preparation process.

#### 4. TASK C: “Review the strategy for targeting the 25 low HDI districts as proposed by government, and consider its value as part of an appropriate strategy for resource allocation in Nepal, taking into account questions of equity, effectiveness and efficiency”.

##### 4.1 Introduction

Reduction of maternal mortality in Nepal from the very high estimated rate of 539 per 100,000 live births is a key challenge. Expansion of safe motherhood service delivery has been identified as a key component of the Essential Health Care Services (EHCS) package in the National Health Sector Programme Implementation Plan (NHSP – IP). The approach is elaborated in the planning matrix included in the Safe Motherhood Plan, 2002-2017 (SMP).

The SMP identifies three main outputs of the strategy:

- i) *Increased access to all relevant maternal health information and services ensured.* This principally concerns the **demand** aspects of safe motherhood.
- ii) *Increased equity and availability of quality maternal health services ensured.* These **supply**-related outputs set targets for the roll-out of functioning Comprehensive Emergency Obstetric Care facilities (CEOC) sites to 63 Districts by 2017, and envisages 33 Districts being covered by 2006; and 48 districts by 2011. It also envisages functioning Basic Emergency Obstetric Care (BEOC) facilities in all 137 PHCs, although it doesn't specify when this will be met.
- iii) *The legal and social status of women increased.* This is being addressed through a number of legal initiatives (such as the legalisation of abortion, which has occurred), improved educational enrolment etc.

A key reason for the low take-up of maternal health services is their high cost to the user. The cost of delivery in a hospital facility has been estimated to be Rs 6,348 for a normal delivery and Rs 11,961 for a caesarean section. Transport costs represent a high proportion of total costs, comprising almost 60% of the total cost of a normal delivery in hospital and just over 30% the cost of a caesarean section. Transport costs are particularly high for those living in hilly and mountainous areas due to poor accessibility<sup>16</sup>.

The Government has responded to concerns about the costs of accessing maternal health care with an initiative which will:

- provide exemption from charges for all women requiring maternity services in 25 Districts with the lowest Human Development Index (HDI)<sup>17</sup>;
- provide a transport “cost-sharing” grant to all women requiring maternity services set at Rs 500 per case for those in terai districts; Rs 1,000 for those in hill districts and Rs 1,500 for those in mountainous districts.

It is anticipated that these measures will increase the demand for services. Supply of, and demand for, services will be further increased by work being undertaken by the Department of Health Services/Family Health Division of the MoHP assisted by support provided under the SSMP. This support has a technical cooperation (TC) component and in addition a financial aid (FA) component which will channel funds through government financial systems.

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<sup>16</sup> “Coping with the Burden of the Costs of Maternal Health” by Jo Borghi, Tim Ensor, Basu Dev Neupane and Suresh Tiwari, Options/Nepal Safer Motherhood Project, April 2004

<sup>17</sup> The HDI index is a composite measure of development prepared by the UNDP, reflecting life expectancy; adult literacy rates; mean years of schooling and GDP per capita (PPP in US\$). See [www.undp.org](http://www.undp.org) which contains this index and other indicators for Nepal.

Support under the Nepal Safer Motherhood Programme was focused on an initial three districts and subsequently expanded to an additional six districts. Development partners such as UNICEF have been supporting other Districts under the Decentralised Action for Children and Women (DACAW) programme.

Prior to the decision by the Government to provide free maternal health care services in 25 low-HDI Districts it had been assumed that the expansion of the programme would focus on expansion to 13 districts. However of these only three are also low HDI districts.

The challenge for delivery of the SSMP is to match up resources and capacity effectively in order to ensure that service provision and demand for services are met to the maximum possible extent in an **efficient** and **equitable** manner. It is therefore appropriate to review the strategy for targeting the 25 low HDI districts as proposed by Government, considering its value as part of an appropriate strategy for resource allocation in Nepal, taking into account questions of equity, effectiveness and efficiency.

#### **4.2 What is meant by Equity, Effectiveness and Efficiency?**

The concept of efficiency is based on the cost effective provision of maternal health services (comprising pregnancy, delivery and post-partum elements) to as many women as possible. This is determined by our capacity to expand the **coverage** of existing services whilst improving the **quality** of service delivery.

Overall population, and the changing demographics of women of child-rearing age, can be directly linked to national and district coverage using data from the Department of Health Services Annual Report (see Annex 1, page 419 of the 2060/61 (2003/04) report). This is extrapolated from a combination of the 2001 census and service usage records. It allows for potential uptake and therefore provides a key input to identification of the cost of provision per service provided at a district level. This is crucial for the assessment of value for money (VFM) of the investment in maternal healthcare provision<sup>18</sup>.

The concept of **equity** embraces several dimensions. The overall objective is to be fair in terms of providing access to services, but there is no single definition of how to achieve this. Key aspects/variables may be summarised as follows:

**Equity among districts:** With respect to needs some districts are more disadvantaged than others. In order to address this, the Government of Nepal is placing particular emphasis on improving services to the 25 lowest HDI districts. As a composite index it provides a partial presentation of overall national needs for maternal health services: for example many of the lowest HDI districts have relatively low populations with a correspondingly lower number of expected pregnancies. Some districts with higher HDIs also contain a large number of very poor households. In addition, the HDI ranking does not take account of other groups who may be marginalised, including dalits and other socially excluded groups. Their relative deprivation differs between regions: for example the 2004 UNDP Human Development report indicates that 44% of dalits in the terai are landless compared to only 15% of hill dalits.

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<sup>18</sup> DFID define Value for Money as follows: "Value for Money can be broadly defined as incorporating the concepts of economy, efficiency and effectiveness in the use of resources. Within Government systems key issues in ensuring VFM are:

- The design of government policies and programmes;
- The effectiveness and transparency of public procurement;
- Effective management of personnel and payroll;
- The capacity of the system to absorb additional resources & convert them into the delivery of services;
- The extent of transparency & risks of corruption, especially in the procurement of goods and services".

Source: "Managing Fiduciary Risk when Providing Direct Budget Support", DFID March 2002.

**Equity within districts** also varies. Some parts of districts are particularly isolated or deprived. Some districts have greater income disparities than others, as measured by the gini co-efficient<sup>19</sup>. It may be appropriate to provide additional support to Districts with high levels of income inequality, in order to improve the “reach” of service provision to the poorest within those districts. Average figures, for example concerning accessibility, can be deceptive and this is why it is sensible not to rely too much on them. It is worth noting that one of the weaknesses of the Millennium Development Goals (MDGs) is that they do not disaggregate between different categories of the population. Therefore it would be possible to achieve particular MDG targets whilst totally failing to reach particular marginal or socially excluded groups. DFID and several other donors have acknowledged this and are also now requesting disaggregated data. In the context of Nepal, special focus should be paid to the Janajati and other minority people to offset this concern.

#### 4.3 Provision of Maternal Health Services

In addition to demand issues, the provision of maternal health services is uneven across districts of Nepal. It is not realistic to introduce full maternal health facilities simultaneously in all remaining districts because of human resource, financial and operational constraints. Taking these in turn:

- A Skilled Birth Attendant (SBA) policy has recently been agreed defining skilled birth attendants and this highlights the need to scale up the number and distribution of skilled birth attendants/ nurse-midwives. It is estimated that provision will need to increase from around 2,000 at present by more than 50% (to some 3,038) in order to reach some 60% of total needs and this is planned for 2005;
- In operational terms the public sector requires support to enhance provision of maternal health services. Operational capacity is partly determined by existing public sector facilities and resources and partly by the presence of potential civil society and international NGO partners, such as UNICEF<sup>20</sup>;
- Financial considerations, which include the budget ceilings available to the sector; financial sustainability and the degree of earmarking of expenditures. For example a public sector wage freeze, which may be necessary to reduce the degree of “crowding out”<sup>21</sup> of other expenditure, could impact upon the ability of the MoHP to recruit and retain skilled birth attendants.

Taking account of both demand and supply considerations, the challenge is therefore to expand provision in a managed way with realistic timeframes for each task and milestones of progress that can be quantified and monitored. It is highly desirable that the analysis of options should take account of both demand and supply issues. By analysing the various factors affecting effective roll-out it should be possible to mitigate risks and ensure that the programme is deliverable.

In terms of this analysis we lack complete information and this is a constraint. Generally the demand data, which is largely based on the 2001 census, is reasonably complete, although some issues – such as travel time to facilities - may require further consideration at a disaggregated, local level. On the supply side further work is required to identify infrastructure needs as well as implementation capacity at a district and sub-district level.

It is important to cost options in order to ensure that they are affordable, and within the budget and priorities of the NHSP-IP. Given the programmatic approach, all costs (whether

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<sup>19</sup> See UNDP, Nepal Human Development Report, 2004

<sup>20</sup> UNICEF has an agreed strategy with Government of Nepal focusing on 19 districts. It is not able to re-programme its resources to cover additional or alternative districts in the short term.

<sup>21</sup> The IMF frequently seeks a cap on the public sector wage bill because of concerns that it may not be sustainable or it may “crowd out”, and damage the effectiveness of other parts of the economy.

borne by the Government or by development partners) should be included. It is particularly important that improvements in service provision should be sustainable, and this means taking full account of their operational costs (such as staff, maintenance, provision of drugs etc) as well as their capital (start-up) costs.

The roll-out of the programme should take account of the existing provision of services, as well as ease of expansion. However this should not be the sole determinant of service provision, as considerations of equity may justify additional investment in order to improve provision to disadvantaged districts or communities.

#### 4.4 Needs Assessment

Using the UNDP data low HDI districts and their relative rankings are summarised in Table 1:

**Table 1: Low HDI Districts in Nepal by Terrain and National Ranking**

| Flat/Tarai     | Hill          | Mountain            |
|----------------|---------------|---------------------|
| Siraha (51)    | Dhading (55)  | Rasuwa (62)         |
| Mahottari (59) | Dailekh (66)  | Sindhupalchowk (54) |
| Rautahat (56)  | Jajarkot (71) | Dolpa (67)          |
| Sarlahi (58)   | Pyuthan (53)  | Humla (68)          |
| Dang (57)      | Rolpa (65)    | Jumla (70)          |
|                | Rukum (64)    | Kalikot (73)        |
|                | Salyan (61)   | Mugu (75)           |
|                | Achham (69)   | Bajhang (72)        |
|                | Baitadi (63)  | Bajura (74)         |
|                | Doti (60)     | Darchula (52)       |

The population of these low HDI districts, as measured in the 2001 census was 6.8 million, compared to the total population of Nepal of 25.1million, as can be seen from Table 2 below. Although the 25 low HDI districts represent one third of all 75 Districts in Nepal, it represents only one quarter of the total population. Therefore a strategy which solely prioritised the low HDI districts would neglect three quarters of the population of Nepal.

**Table 2: Population Distribution, 2001**

| Terrain      | Low HDI Districts | All districts     | Low HDI Districts as % of Total by Terrain |
|--------------|-------------------|-------------------|--|
| Terai        | 2,999,596         | 12,220,112        | 24.5%                                      |
| Hill         | 2,352,514         | 11,057,588        | 21.3%                                      |
| Mountain     | 1,132,757         | 1,806,288         | 62.7%                                      |
| <b>Total</b> | <b>6,484,867</b>  | <b>25,083,988</b> | <b>25.9%</b>                               |

As population at a district level varies considerably, this impacts upon the demand for and unit cost of supplying maternal health services. Using data derived from the Annual Report of the Department of Health Services 2060/61 (2003/2004) maternal health service needs are identified in Table 3, presented by terrain. Using the figures in columns 2 and 3 below, it can be seen that total deliveries are highest in the terai, with some 444,672 births out of a national total of 920,648. Thus the terai represents almost half (48.3%) of total annual deliveries. Despite the fact that the coverage by health workers<sup>22</sup> is slightly higher than for hill areas, the terai also represents the greatest unmet need in terms of deliveries without the

<sup>22</sup> The term "health worker" has been used because this is the term used in the source information contained in the Annual Report of the Department of Health Services (2003/2004) see page 435. SSMP will need to establish whether this may be equated to the "Skilled Health Worker" as defined in the policy developed/agreed in June 2005. However it does not include Traditional Birth Attendants which are reported separately.

presence of health workers with some 356,051 out of 752,290 or 47.3% of the national total deliveries with no health worker present. It is closely followed by the hill districts where a further 326,405 births do not have health workers present.

According to the MOHP Department of Health Services [and using its terminology/definition in terms of who constitutes a health worker] health workers are present at only 9.2% of deliveries in mountainous districts. As can be seen from the right hand column of Table 3 this is only half the percentage achieved in hill districts (18.2%) and in the terai (19.9%). In absolute terms the situation is reversed – of the estimated 752,290 births each year in Nepal which do not have a skilled health worker present, mountainous districts account for 69,834 or 9.3% of the total, with greatest unmet needs being in terai (356,051 or 47.3%) and hill districts (326,405 or 43.4%) So it would be difficult to argue for a strategy which is primarily geared to improving the proportion of births attended by health workers in mountainous districts whilst neglecting other hill and terai districts.

**Table 3: Estimated Coverage of Deliveries by Health Workers for all Districts (Annual)**

| Terrain             | Estimated Total Deliveries Conducted by Health Workers | Estimated Total Deliveries without Health Workers | Estimated Total Deliveries | % Coverage with Health Workers |
|---------------------|--|---|----------------------------|--------------------------------|
| Terai <sup>23</sup> | 88,621   | 356,051   | 444,672                    | 19.9%                          |
| Hill                | 72,688   | 326,405   | 399,093                    | 18.2%                          |
| Mountain            | 7,049  | 69,834  | 76,883                     | 9.2%                           |
| <b>Total</b>        | <b>168,358</b>   | <b>752,290</b>                                    | <b>920,648</b>             | <b>18.3%</b>                   |

Whilst the table above provides national estimates, the Government is particularly concerned with the 25 low-HDI districts. It is therefore appropriate to undertake a comparison of these, and this is provided in Table 4 below. Low-HDI terai districts represent some 87,340 deliveries without health workers being present out of the total for all low-HDI districts of 218,471. This represents 39.8% of the total. Low-HDI hill districts represent a further 39.4% (86,092 of the total of 218,471). The mountainous districts account for 45,039 which is 20.6% the total for all low-HDI districts.

As noted in Table 2, the population of districts varies greatly and this impacts on the number of deliveries in each district. Table 5 focuses on average district needs. The average number of deliveries without health workers present in all terai districts, at 17,803 is almost four times as great as average number of deliveries without health workers in mountainous districts of 4,365. As might be anticipated, hill districts on average fall between the two with an average of 8,369 deliveries without health workers. Low HDI districts (many of which are, of course, mountainous districts) also have low service coverage averaging 13.6% compared to an average for all districts of 18.3%, thus on average their performance is over one-third less good than the average for all districts. Whilst this is an apparent endorsement of the MoHP's strategy of wanting to focus service improvements on low-HDI districts, it does not take account of absolute numbers needing services.

**Table 4: Estimated Coverage of Deliveries by Health Workers for low-HDI Districts (Annual)**

| Terrain | Estimated Total Deliveries Conducted by Health Workers | Estimated Total Deliveries without Health Workers | Estimated Total Deliveries | % Coverage with Health Workers |
|---------|--|---|----------------------------|--------------------------------|
|         |  |   |                            |                                |

<sup>23</sup> Note that the UNDP Nepal Human Development Report uses the term Flat rather than Terai in all its statistical annexes.

|                                |        |         |         |       |
|--------------------------------|--------|---------|---------|-------|
| <b>Terai</b>                   | 20,039 | 87,340  | 107,379 | 18.7% |
| <b>Hill</b>                    | 10,625 | 86,092  | 96,717  | 11.0% |
| <b>Mountain</b>                | 3,730  | 45,039  | 48,769  | 7.6%  |
| <b>Low HDI Districts (all)</b> | 34,394 | 218,471 | 252,865 | 13.6% |

Average unmet needs for low-HDI districts are estimated to be 8,739 compared to average unmet needs for all districts of 10,031. This is a very significant finding. What it means is that on this criteria, a strategy of targeting low-HDI districts will achieve less in terms of satisfying total needs than a strategy which focuses on districts with higher populations, even if they are not low-HDI. Average unmet needs in terai districts, estimated at 17,803 per annum are more than double that of average unmet needs in low HDI districts of 8,739.

**Table 5: Average Met/Unmet Needs Maternal Health Services by District**

| <b>Terrain</b>                                  | <b>Estimated Total Deliveries Conducted by Health Workers</b> | <b>Estimated Total Deliveries without Health Workers</b> | <b>Estimated Total Deliveries</b> | <b>% Coverage with Health Workers</b> |
|---|---|--|-----------------------------------|---------------------------------------|
| <b>Average needs for Low HDI districts</b>      | 1,376   | 8,739  | 10,115                            | 13.6%                                 |
| <b>Average needs for all terai districts</b>    | 4,431   | 17,803   | 22,234                            | 19.9%                                 |
| <b>Average needs for all hill districts</b>     | 1,864   | 8,369  | 10,233                            | 18.2%                                 |
| <b>Average needs for all mountain districts</b> | 441   | 4,365  | 4,805                             | 9.2%                                  |
| <b>Average needs for all districts</b>          | 2,244   | 10,031   | 12,275                            | 18.3%                                 |

#### **4.5 Envisaged Improvements to Service Provision**

The SSMP programme, working in conjunction with other parts of the MoHP and non-Government development partners, has identified a number of districts for potential upgrading and support in terms of maternal health services. It is envisaged that the introduction of improved maternal health facilities to low-HDI districts (the Government's recently stated priority) will be phased in a manner which is compatible with supply related issues, including the availability of partner organisations and existing availability of government services (especially in terms of skilled personnel).

An assessment has been undertaken of these needs in the context of expected pregnancies divided into met and unmet services. These figures are presented in Table 6. As above, this has been measured in terms of estimated total deliveries with and without health workers (using, as above, MoHP Department of Health Services data and definitions). These have been further separated into those districts expected to receive full CEOC and (BEOC) facilities.

**Table 6: Districts Proposed for CEOC and BEOC Services for 2005 - 6**

| <i>Districts Proposed for CEOC services</i> |                |                   |   |  |                                   |                                       |
|---|----------------|-------------------|---|--|-----------------------------------|---------------------------------------|
| <b>District</b>                             | <b>Terrain</b> | <b>HDI status</b> | <b>Estimated Total Deliveries Conducted by Health</b> | <b>Estimated Total Deliveries without Health</b> | <b>Estimated Total Deliveries</b> | <b>% Coverage with Health Workers</b> |

|  |          |         | Workers       | Workers        |                |              |
|--|----------|---------|---------------|----------------|----------------|--------------|
| <b>Udyapaur</b>                                    | Hill     | No      | 1,249         | 9,658          | 10,907         | 11.5%        |
| <b>Acham</b>                                       | Hill     | Low HDI | 1,724         | 9,136          | 10,860         | 15.9%        |
| <b>Solukhumbu</b>                                  | Mountain | No      | 577           | 4,278          | 4,855          | 11.9%        |
| <b>Banke</b>                                       | Flat     | No      | 2,823         | 12,473         | 15,296         | 18.5%        |
| <b>Morang</b>                                      | Flat     | No      | 7,769         | 27,237         | 35,006         | 22.2%        |
| <b><i>Districts Proposed for BEOC services</i></b> |          |         |               |                |                |              |
| <b>Tanahu</b>                                      | Hill     | No      | 1,139         | 11,473         | 12,612         | 9.0%         |
| <b>Saptari</b>                                     | Flat     | No      | 5,225         | 17,672         | 22,897         | 22.8%        |
| <b>Dang</b>  | Flat     | Low HDI | 3,385         | 14,908         | 18,293         | 18.5%        |
| <b>Panchthar</b>                                   | Hill     | No      | 1,130         | 6,506          | 7,636          | 14.8%        |
| <b>Mugu</b>  | Mountain | Low HDI | 88            | 1,968          | 2,056          | 4.3%         |
| <b>Nawalparasi</b>                                 | Flat     | No      | 3,013         | 19,338         | 22,351         | 13.5%        |
| <b>Rupandehi</b>                                   | Flat     | No      | 6,047         | 21,892         | 27,939         | 21.6%        |
| <b>Kavre</b>                                       | Hill     | No      | 1,728         | 12,896         | 14,624         | 11.8%        |
| <b>Proposed Combined CEOC and/or BEOC services</b> |          |         | <b>35,897</b> | <b>169,436</b> | <b>205,332</b> | <b>17.5%</b> |

An analysis of this type has its limitations: estimates relate to district totals. Within districts accessibility and other factors such as cultural attitudes will determine the numbers of expectant mothers who will in reality benefit from these services. Thus this analysis is principally useful for inter-district comparison rather than at a more disaggregated level. It can be seen that the potential improvements to coverage by supporting these districts provides potential support.

Unmet needs in terms of deliveries without health workers in the 13 districts are estimated to be 169,436 per annum out of the 752,290<sup>24</sup> nationally, or 22.5%. Given that one objective of SSMP is to improve the quality of care, it is also worth noting total births, including those currently attended by a health worker: these total some 205,332 expected births annually out of the national total births estimated at some 920,648 which is 22.3% of the national total. Given the immense task in scaling-up capacity and addressing quality issues, this is a considerable leap in coverage. It also targets districts with below-average existing coverage, with an average of 17.5% of births attended by health workers against a national average of 18.3%, as was shown in Table 5 above.

It should however be acknowledged that this envisaged roll-out is not tightly targeted on low-HDI districts during this initial phase as only 3 of the 13 districts are amongst the government's target list of 25 low HDI districts. This is largely because of the lack of development partners, particularly UNICEF, working in the low-HDI districts, which makes it difficult to improve services in many of these districts in the short term. However the SSMP

<sup>24</sup> As is shown in Table 3.

team has been working to identify ways in which improvements could take place in additional low-HDI districts. These additional districts are presented in Table 7.

**Table 7: Potential Additional Support to Low HDI Districts for 2005 - 6**

| District     | Terrain  | HDI Status | Estimated Total Deliveries Conducted by Health Workers | Estimated Total Deliveries without Health Workers | Estimated Total Deliveries | % Coverage with Health Workers |
|--------------|----------|------------|--|---|----------------------------|--------------------------------|
| Dailekh      | Hill     | Low HDI    | 1,110  | 8,869   | 9,979                      | 11.1%                          |
| Humla        | Mountain | Low HDI    | 102  | 1,781   | 1,883                      | 5.4%                           |
| Jumla        | Mountain | Low HDI    | 428  | 3,848   | 4,276                      | 10.0%                          |
| Doti         | Hill     | Low HDI    | 973  | 8,406   | 9,379                      | 10.4%                          |
| <b>Total</b> |          |            | 2,613  | 22,904  | 25,517                     | 10.2%                          |

The effect of working with additional partners to extend the extent of the programme in the first phase is shown in Table 8. This shows an increase in the number of low HDI districts being covered in the first phase to 7, as well as raising potential coverage to 25% of all births (205,332 plus 25,517 = 230,849 out of a national total of 920,648). It also has the impact of improving targeting towards districts which have a higher level of unmet need, in the form of the percentage of births which are not attended by skilled staff. Under the programme as originally envisaged 17.5% of needs were met (and conversely 82.5% were not met). With these additional low-HDI districts 16.7% of births are attended by health workers (and therefore 83.3% were not met). So at a district level, targeting is improved in terms of this parameter. However the counter-argument is that higher absolute numbers of births could be reached by targeting districts with high populations even if they are not low-HDI.

*There is an equity argument that suggests that the highest overall objective should be to ensure that as many pregnancies as possible are safe with (skilled) health workers present. This would justify moving away from the low-HDI focus to districts with the greatest unmet need in absolute terms.*

**Table 8: Potential Coverage of Phase I**

|   | Estimated Total Deliveries Conducted by Health Workers | Estimated Total Deliveries without Health Workers | Estimated Total Deliveries | % Coverage with Health Workers |
|---|--|---|----------------------------|--------------------------------|
| <b>Potential support in 2005 - 6</b>                                      |  |   |                            |                                |
| Coverage CEOC/BEOC and additional support                                 | 38,509   | 192,340   | 230,849                    | 16.7%                          |
| As % of expected demand for all districts                                 | 23%  | 26%   | 25%                        |                                |
| Totals for all low-HDI Districts to be covered by this expanded programme | 7,809  | 48,917  | 56,726                     | 13.8%                          |
| As % of expected demand for all low-HDI districts                         | 23%  | 22%   | 22%                        |                                |

This is clearly a substantial step forward, but still means that only 7 out of 25 low HDI Districts will be covered even in the expanded plan. If MoHP objectives are to be reached of targeting low-HDI districts, it would be necessary to put in place a strategy which seeks to identify ways to expand coverage to more low-HDI districts in the second Phase, which may be planned in accordance with the build-up of skilled maternal health staff and available funding.

Table 9 provides details of those low HDI districts which have the highest unmet demand in absolute terms for low-HDI (not all) districts. Between them these districts will increase coverage to reach 35% of total demand. Of particular significance in terms of satisfying equity objectives, they will expand coverage to meet almost 60% of all low-HDI demand. [NB This is not to argue that it makes the best use of efficient resources to focus on low-HDI districts, merely that on the basis of needs, if that strategy is adopted, and other factors being equal, then it is worth considering the districts identified in Table 9].

Since partners are not believed to be available at the moment in these districts, a strategy would need to be adopted to either encourage existing partners to move into these districts or to help in the development of new local partners. Clearly this will be a time consuming and resource intensive process.

**Table 9: Potential Phase II Priority Districts based on Low HDI and High Unmet Needs**

| District   | Terrain  | HDI     | Met    | Unmet   | Total   | %Met/Total |
|--|----------|---------|--------|---------|---------|------------|
| Siraha   | Flat     | Low HDI | 4,050  | 18,452  | 22,502  | 18.0%      |
| Rautahat   | Flat     | Low HDI | 3,352  | 17,606  | 20,959  | 16.0%      |
| Sarlahi  | Flat     | Low HDI | 2,427  | 21,875  | 24,302  | 10.0%      |
| Sindhupalchowk                                   | Mountain | Low HDI | 1,110  | 12,401  | 13,511  | 8.2%       |
| Dhading  | Hill     | Low HDI | 1,499  | 11,358  | 12,857  | 11.7%      |
| Total potential coverage for Phase II            |          |         | 12,439 | 81,692  | 94,131  | 13.2%      |
| Total potential coverage for Phase I and II      |          |         | 50,948 | 274,033 | 324,980 | 15.7%      |
| Coverage as a % of projected national deliveries |          |         | 30%    | 36%     | 35%     |            |
| Combined low HDI coverage Phase I & II           |          |         | 20,247 | 130,610 | 150,857 | 13.4%      |
| Percentage of all low HDI needs                  |          |         | 58.9%  | 59.8%   | 59.7%   |            |

It may be noted that expanding the programme to these additional 5 districts will increase overall reach of the programme from 25% to 35% of all anticipated deliveries. As noted above, most of the low HDI districts have low populations. It would be possible to raise the overall reach of the programme by selecting more highly populated districts with significant unmet needs, but this would not be consistent with satisfying MoHP objectives in terms of targeting low-HDI districts.

There are, therefore, clear tradeoffs to be made. These could be analysed in more depth taking account of value for money considerations, by estimating the costs of providing maternal health care services in different locations, taking account of both capital investment (infrastructure etc) and operating costs (staff, non-wage recurrent costs such as drugs, utilities etc. Given lack of data, this could be done in terms of cost banding to simplify the analysis. Such a cost-benefit analysis would need to be adequately resourced in order to ensure that reliable data is obtained and realistic estimates prepared.

#### **4.6 Consideration of Additional Factors Determining the Degree of Take-up of Maternal Health Services**

Other factors which may influence the selection of districts to prioritise for improved safe motherhood programme (SMP) services may include:

- average travel times and terrain;
- population density;
- rate of in-migration or out-migration;
- Conflict intensity;
- Proportion of Dalits / Janajatis in the population;
- Accessibility, existence of roads and travel times;
- Demand from other districts;
- Perceived quality of care at facilities;
- Staff turnover and retention rates.

Consideration of these variables would justify consideration, although a comprehensive analysis lies beyond the scope or resources committed to this report. Brief mention is made of the following:

**Average travel times:** these impact upon the take-up of maternity services, and have costs identified on a sample basis. Whilst travel times are largely determined by factors outside the control of SSP, some demand side support measures are possible (linked to cost sharing or user charges) and supply side measures may include the siting or re-siting of maternal care facilities.

**Population migration:** A high rate of net in-migration at a district level (most migration is between districts) may be used to argue for a high investment in service provision on the basis of increasing unmet needs; but the opposite logic could also be applied: resources should be rebalanced in order to reduce the pace of migration. Migration (both internal and external) has accelerated as a result of the conflict. Non-conflict determinants of migration include rural livelihoods, access to land and alternative employment opportunities, infrastructure and other services provision and environmental sustainability.

**Conflict intensity:** The conflict and security-situation may have implications for the realism of providing services and the uptake of those services although it is understood that past reports have downplayed the impact of the conflict – see, for example, Beun and Neupane 2004. Despite this some districts are known to be more insecure than others and which is likely to impact on the willingness of health service workers to visit or be based in them, even though it is understood that the providers of health care services have not been deliberately targeted. The conflict may also deter NGO partners from providing services and could carry fiduciary risks in terms of the diversion of financial and other resources. The Government may wish to rebalance service provision to offset the economic and social dislocation caused by the conflict.

**Migration between districts:** Migration patterns within Nepal are significant and this is highlighted as was highlighted in the results of the 2001 census and the UNDP Nepal Human Development Report, 2004. In terms of maternal care requirements it may be anticipated, and in some circumstances desirable, for women to travel from districts with no or poor facilities to neighbouring districts. The SSMP team anticipate that Nepalgunj hospital, for example, will be receiving many such patients especially once the cost-sharing scheme has been implemented.

**Proportion of Dalits / Janajatis in the population:** The targeting of populations of particular beneficiary groups on grounds of ethnicity or caste is always sensitive and can cause resentment precipitate other unforeseen reactions. However prioritisation of districts inevitably impacts upon particular groups, whether or not this is an explicit criteria for selection.

**Accessibility, existence of roads and travel times:** Physical infrastructure is clearly very important in Nepal and in the past two years the World Bank has been leading efforts to include road density as a key development indicator<sup>25</sup>, as a proxy measure of accessibility.

#### **4.7 Overall Conclusions and Recommendations**

A phased roll-out of maternal health services should recognise the need for balance between targeting low HDI districts and targeting districts with greatest absolute numbers of expectant mothers who are receiving inadequate, or indeed any, maternal health care services.

As noted above although the 25 low HDI districts represent one third of all 75 Districts in Nepal, it represents only one quarter of the total population. Therefore a strategy which solely prioritised the low HDI districts would neglect three quarters of the population of Nepal.

Average maternal health service needs in flat (terai) districts is almost four times as great as average demand for maternal health services in mountain districts. Hill districts on average fall between the two.

The proposed strategy envisages a series of quick wins in those districts which have both substantial needs and service partners which can work with the MoHP in the delivery of high quality maternal health services. It also identifies a number of additional low HDI districts where it is believed that some service provision enhancements can be achieved in the short term.

Five other highly populated low-HDI districts have been identified which justify consideration at an envisaged later stage. There may be good reasons not to proceed in some of these districts for security reasons or because of the lack of partners, but it is recommended that further attention is paid to seeing if it is possible to support these in the longer term in support of the government's overall policy.

Total coverage could be improved by focusing on more of the higher population districts, and since this would involve a change in the stated strategy of focusing on low HDI districts this should be considered.

It will be important to avoid over-stretching professional and management capacity given shortages of skilled staff, particularly skilled birth attendants. The expansion of the programme is already ambitious and it is crucial that a critical mass of support (human resource, financial and management) is mobilised at district level in order that sustainable improvements can be achieved. The pace of roll-out should be consistent with this objective.

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<sup>25</sup> At a conference in Addis Ababa in September 2004, African transport ministers support the inclusion of road density as equal to a Millennium Development indicator.

Overall it should be acknowledged that the Government finds it difficult to provide staff to the most remote districts: if this it to be addressed financial (and other) incentive structures will need to be improved.

## APPENDIX A



# Support to the Safe Motherhood Programme, Nepal (SSMP)

## Terms of Reference: Short-term Consultancy

### Advisory work on financial and contractual arrangements Within the SSMP

**Mark Watson, May 2005**

#### 1. General Background

The National Safe Motherhood Programme (SMP) is a priority within His Majesty's Government Nepal's (HMGN) Nepal Health Sector Strategy which works towards meeting the Tenth 5-year Plan/PRSP and the health sector targets set out in the Millennium Development Goals (MDG). The goal for maternal health is to reduce the maternal mortality ratio (MMR) by three quarters between 1990 and 2015. The framework for implementation of the SMP is the National Safe Motherhood Plan 2002-2017, the goal of which is, "maternal and neonatal health improved" and the purpose, "sustained increase in utilisation of quality maternal health services".

In July 2004, DFID committed £20 million for the next 5 years in support of the National Safe Motherhood Programme (SMP). DFID support to safe motherhood in Nepal will be termed "Support to the Safe Motherhood Programme" (SSMP). Inputs will be designed with MOHP/DOHS, other government departments and non-governmental partners to the national programme. SSMP recognises the need for support to health systems strengthening in order to enhance the quality and quantity of services.

## **2. Specific Background**

The financial arrangements for the SSMP are complex for several reasons:

- (a) There are two distinct main funding flows, one being technical cooperation (TC) that flows through the Programme, and the other being financial aid (FA) that flows directly to Government, via Crown Agents into the Nepal Treasury.
- (b) The FA mechanism will gradually displace the TC mechanism over time, so a smooth transition must be planned.
- (c) While the Programme and the consortium running it are not responsible for the management of FA, clearly the SSMP will be best placed to advise on the setting of priorities in relation to use of FA. They will also be the source of advice and support to the Ministry of Health and Population (MoHP) and Department of Health (DoH) in relation to the timing of disbursement, earmarking (if that is done) and monitoring of such funds.
- (d) It is envisaged that funding will flow from TC funds at the start of the programme to several NGOs or other non-profit organisations, on the basis of a Memorandum of Understanding in each case, to support Safe Motherhood work in districts. Over time, the responsibility for managing such work will be handed over to government and will be financed from FA. There will be a need to ensure that such a transition involves the minimum number of changes in management including financial management systems.
- (e) The disbursement of funds through either mechanism, needs to be carried out on the basis of clear policy guidelines for example – and most urgently – in relation to questions of equity. There is an urgent need for criteria for resource allocation between districts, and for a clear strategy regarding questions of targeting selected districts. A proposal has been tabled within the DoH for targeting extra resources towards 25 districts with the lowest Human Development Indicators in Nepal (low HDI districts). This proposal needs careful analysis and consideration.

Consultancy work undertaken in March has identified several areas of the draft Financing Agreement concerning which clarification may be needed. There is a need to look at these, and related questions, sooner rather than later.

## **3. Purpose**

To study and advise on key financial and contracting arrangements within the SSMP, and undertake preliminary work on a strategy for Govt/SSMP resource allocation within the Nepal health sector for Safe Motherhood – related work.

## **4 Tasks**

1. At the start of the work hold a briefing meeting with the Senior Adviser of the SSMP to review the Terms of Reference and agree an approach to the work.
2. Review the financial arrangements for the SSMP as set out in the Financing Agreement, particularly in relation to the modalities of transition from TC to FA, and specific queries raised in earlier consultancy work.
3. Advise as to what information might be collected by the newly appointed SSMP team members to prepare agreements with NGOs and other organisations that would allow for smooth transition to contracts with Government at a later stage, and talking into consideration the indicators and parameters set out in the Govt/DFID SSMP Financing Agreement.

4. Review the strategy for targeting the 25 low HDI districts as proposed by Government, and consider its value as a part of an appropriate strategy for resource allocation in Nepal, taking into account questions of equity, effectiveness and efficiency.
5. Before departure, hold a debriefing meeting with the Senior Adviser and other persons as appropriate.

## **5 Outputs**

1. A report containing reviews of the above-mentioned topics and recommendations concerning each item.
2. Proposals for any specific modifications to the Financing Agreement that the consultant considers advisable.
3. Proposals for early work in relation to the requirement for agreements with NGOs and other organisations.
4. Comment on HMGN's plan to roll out free maternity care to the 25 low HDI districts' strategy, and propose how to take this issue forward in order to achieve a workable approach to equity issues in Nepal that takes into account social justice and fairness but is also practical and cost efficient.

## **6 Timeframe**

**Three weeks in-country work beginning in May 2005.**

## **7 Reporting**

A brief report, in which most of the above outputs can be presented as annexes, should be made available within a ten day period following the consultancy to the Senior Adviser, formatted according to the standard format rules for SSMP.

## **APPENDIX B: PEOPLE MET**

|                         |  |
|-------------------------|--|
| Mr Lavkumar Debkota     | Secretary, Ministry of Health and Population                                       |
| Dr Bishnu Prasad Pandit | Director General, Department of Health Services, Ministry of Health and Population |
| Dr Rajendra Peeyoosch   | Director of Family Health Services, Ministry of Health and Population              |
| Mr Tankamani Sharma     | Under Secretary (Finance Unit), Ministry of Health and Population                  |
| Mr Ajit Pradhan         | Chief, Demography Section, Family Health Division MoHP                             |
| Mr Mark Mallalieu       | Head, Department for International Development, Nepal                              |
| Ms Susan Clapham        | Senior Health Adviser, Nepal   |
| Mr Andrew Hall          | Senior Economic Adviser, DFID Nepal  |
| Mr Phanindra Adhikary   | Deputy Programme Manager, DFID Nepal   |
| Dr Carol Barker         | Senior Adviser, Support to Safe Motherhood Programme                               |
| Dr Indira Ganga         | Senior Maternal Health Adviser, SSMP   |
| Ms Deepa Pokharel       | Equity and Access Adviser, SSMP  |
| Dr Jagadish Pokharel    | Chairman, Development Resource Mobilisation Network                                |
| Ms Melissa Cole         | Programme Manager, Options Consultancy Services                                    |
| Mr Greg Whiteside       | Institutional Advisor, SSMP  |