

## PROJECT INFORMATION DOCUMENT (PID) APPRAISAL STAGE

Report No.: PIDA62125

<b>Project Name</b>	Nepal Health Sector Management Project (P150801)
<b>Region</b>	SOUTH ASIA
<b>Country</b>	Nepal
<b>Sector(s)</b>	Health (50%), Non-compulsory health finance (10%), Compulsory health finance (10%), Public administration- Health (30%)
<b>Theme(s)</b>	Health system performance (50%), Public expenditure, financial management and procurement (25%), Managing for development results (2 5%)
<b>Lending Instrument</b>	Investment Project Financing
<b>Project ID</b>	P150801
<b>Borrower(s)</b>	Ministry of Finance
<b>Implementing Agency</b>	Ministry of Health and Population
<b>Environmental Category</b>	B-Partial Assessment
<b>Date PID Prepared/Updated</b>	06-Apr-2016
<b>Date PID Approved/Disclosed</b>	07-Apr-2016
<b>Estimated Date of Appraisal Completion</b>	12-Apr-2016
<b>Estimated Date of Board Approval</b>	16-Jun-2016
<b>Appraisal Review Decision (from Decision Note)</b>	The Decision Meeting held on March 28, 2016 authorized the team to appraise the Project.

### I. Project Context

#### Country Context

1. Nepal has made exemplary progress in poverty reduction and human development. Despite a decade-long insurgency that ended in 2006, Nepal halved extreme poverty in seven years from 53 percent in 2003/2004 to 25 percent in 2010/2011, and thus attained the first Millennium Development Goal (MDG) ahead of time. Life expectancy has been steadily increasing to almost 68 years in 2013, up from about 38 years in 1960. In addition, Nepal has achieved gender parity in education and sharp reductions in infant and maternal mortality. However, poverty continues to be high in rural areas (27 percent) compared to urban areas (15 percent), and is particularly severe in mountainous areas (42 percent). The twin impacts of the earthquake series since April 2015 and the economic slowdown resulting from the disruption in trade between September 2015 and February 2016 are also projected to erode recent progress in poverty reduction.

2. Nepal continues to pass through a complex and challenging political transition. A new constitution was promulgated in September 2015 amid often violent protests. Notwithstanding the

constitutional amendments in January 2016, implementation remains impeded by a lack of clarity and consensus over contentious issues such as provincial demarcation and the specifics of federalism. This has resulted in renewed political uncertainty and social tension which come with the risk of policy paralysis, institutional erosion and poor service delivery and outreach. In addition, the current political environment could lead to delays in the implementation of government programs. Federalism, whatever form it takes, will also change the way services are delivered.

3. Despite political uncertainty, macroeconomic policy and economic priorities remained sound and supportive of stable growth until 2014-15. Between 2006 and 2014 economic growth averaged 4.4 percent, and the budget moved from a position of modest deficits to surpluses from FY13 onwards, reaching 2.2 percent of GDP in FY14. However, the recent political and economic crises are likely to set back the situation. Nepal ranks 130 of 168 on Transparency International's Corruption Perception Index for 2015 which represents a 4 point drop over the 2014 figures. Poor transparency and accountability in the public sector remains a major concern and impacts the efficiency of expenditure and growth. Also, Nepal still ranks low on the UN's Human Development Index, at 145 out of 187 countries in 2014, and much remains to be done to bring human development indicators to middle income country levels.

4. On April 25, 2015, a major earthquake occurred in central Nepal causing widespread destruction. According to a Post Disaster Needs Assessment (PDNA) the total needs in the health sector amounted to US\$147 million accounting for 2.2 percent of total reconstruction costs. Over 1000 health facilities were partially damaged or completely destroyed. While significant funds have been pledged for reconstruction, the challenge is to "build back better" so as to strengthen institutional resilience. Building institutional capacity for better public management would enable more timely and effective responses to situations of public health crises including natural disasters.

### **Sectoral and institutional Context**

5. Over the past two decades Nepal has successfully reduced infant and maternal deaths, and achieved the MDGs related to maternal and child mortality. Between 1996 and 2006, the maternal mortality ratio (MMR) decreased from 790 per 100,000 live births to 281; and further reduced to an estimated 190 by 2013; while under five child mortality decreased from 141 deaths per 1,000 live births in 1990 to 36 in 2014. Further, Nepal has met the MDG target for measles immunization coverage with 92.6 percent of children vaccinated by their first birthday.

6. Despite these significant achievements at the national level, not all segments of society have benefited equally from the improvements recorded. For instance, under-five mortality rate is 75 per 1,000 live births for the poorest quintile and 36 per 1,000 live births for the richest quintile. There is evidence of systemic exclusion of several population groups to access health services due to a variety of circumstances, including household income and education levels, location of residence, gender, social, ethnic and religious identity, and linguistic background. Women living in urban areas are almost twice more likely to get skilled birth attendance as compared to women living in rural areas; women with secondary education are almost two times more likely to access that service as compared to women with no education, and women in the Tarai are twice more likely to benefit than women in the mountain regions. In terms of socioeconomic groups, the percentage of deliveries assisted by skilled birth attendants is 10.7 percent for the poorest and 81.5 percent for the richest quintile. Further, while utilization of pre-natal care is not significantly different between urban (95.1 percent) and rural (85.3 percent) areas, only 27.9 percent of births

amongst the bottom 20 percent of the population took place at a health facility compared to 90.7 percent in the richest quintile. This is further compounded by low quality of care at health facilities. Only 60 percent of Basic Emergency Obstetric and Neonatal Care facilities provided round-the-clock functions expected of them.

7. Public spending on health in Nepal is higher than the South Asian average. Nepal spends about 2.6 percent of GDP of public funds on health compared to the South Asian average of 1.3 percent of GDP. In terms of the share of government spending of total health spending, Nepal performs better than the low income countries average (43.3 percent vs. 41.5 percent) and South Asian average share (43.3 percent vs. 33 percent). Nepal also performs better in terms of prioritizing health as defined by the share of health spending out of total government spending: 11.9 percent compared to approximately 4.5 percent for South Asia.

8. While national policy commits Nepal to provide free basic health services for all, financial protection is poor and high out of pocket payments for such services persist. Structural and institutional inefficiencies in planning, management and delivery of the program result in the lack of timely availability of these free services and drugs, particularly to poor and difficult to reach population groups. The National Health Accounts estimates indicate that the out-of-pocket expenditure (OOP) share of total health expenditure was 55 percent in 2009, and noted that the majority of this expenditure was on drugs provided for out-patient care. As a result of the high OOP, an estimated 6.7 percent of households fall into poverty in a given year as a consequence of payments to health care. OOP among the poor are twice as large as that of the richest (60.5 percent vs 30.3 percent).

9. Weaknesses in health systems and public sector management inefficiencies contribute to low quality of care and inequities in health outcomes:

(a) There is a deficit of qualified health workers in various health facilities, primarily due to inefficient cadre management and the political economy of human resource management which leads to inability to fill posts in remote areas. The percentage of sanctioned posts filled by doctors and nurses at various levels of health facilities range from 23 to 55 percent. Strategies to enhance an appropriate skill-mix and equitable distribution of professional and support staff especially in remote areas, and their retention, will be crucial for Nepal to realize its agenda of Universal Health Care (UHC).

(b) Drug stock-outs and expiry resulting from a poor distribution system is a major source of inefficiency in the delivery of health services. Drugs and medical supplies constitute about 20 percent of health sector expenditures. A recent report by the Office of the Auditor General (OAG) identified drug stock-outs and drug expiry as major performance issues. While drug stock out is a critical problem that occurs at all levels of health facilities, the duration of stock outs is higher among the lower level and more distant health facilities. There are at least two reasons for this - the drug distribution system below the district level is performing poorly; and the remaining shelf-life of procured drugs is short.

(c) Weaknesses in public financial management are a major cause of sector inefficiency and the health system's ability to achieve desired outcomes. Poor resource allocation to sector priorities undermines the achievement of equity and access to essential services. Sector budget formulation processes remain ad hoc, and largely uninformed by inputs from decentralized units and facilities where service delivery occurs. At the same time, weak expenditure management and unreliable financial reporting has resulted in poor expenditure tracking, and weak accountability. Poor accounting systems have led to delays in the preparation of financial reports which in turn delays

the release of funds for program implementation, and ultimately results in low execution rate of the annual budgets.

(d) Fiduciary integrity remains a challenge. The last five years have seen persisting audit irregularities and ineffective follow up of audit findings. The system of internal controls needs to be substantially strengthened to reduce the risk of resources not being used for their intended purpose, misappropriation of assets, and poor value for money in the procurement of essential commodities and equipment.

(e) Public procurement capacity is low and the Logistics Management Division (LMD), in the Ministry of Health (MoH), responsible for health sector procurement has typically been staffed with doctors and administrative personnel with no specific knowledge or training in procurement and limited tenures. These weaknesses are further compounded by systemic weaknesses in supply chain management.

(f) Accountability for results is low at all levels. This is evidenced by weak planning and monitoring for evidence based decision making. Current patterns of public spending do not particularly benefit the poorest and most marginalized populations/districts.

(g) A citizen engagement mechanism for holding policy makers and providers accountable for service provision is not in place so far. MoH's Gender Equity and Social Inclusion (GESI) strategy, which was developed and implemented during the Nepal Health Sector Program 2 (NHSP 2), enables strengthened citizen engagement, however is yet to be implemented in full.

10. Nepal's Health Sector Strategy (NHSS) 2015-2020 recognizes these challenges and outlines the government's roadmap towards achieving its goal of UHC. The NHSS incorporates institutional and systemic reforms alongside a renewed focus on delivering more effectively and efficiently so that the poorest and most marginalized populations access services. The Strategy builds upon detailed consultations with Development Partners (DP), academia and civil society, and has incorporated lessons learned from the implementation of the previous five-year programs. The strategy is based on the principles of universal health coverage, quality, access and equity and has nine goals. Six of the nine goals of NHSS relate to improved public sector governance, health system financing, procurement and supply chain management, decentralized planning, evidence based decision making and equitable utilization of services. There is a strong focus on improving institutional arrangements that impact service delivery – including human resources, procurement, contract management systems, budget planning, execution and reporting, as well as expanding citizen engagement to create better transparency and accountability. In parallel, it focuses on ensuring that services and financial protection mechanisms are targeted to populations in greatest need. Together, this theory of change should create more resilient and sustainable institutions, and better targeting of services to the most disadvantaged populations.

11. Extensive discussions with the government and partners during the last two years have identified a number of binding constraints. Diagnostic consultations with all stakeholders resulted in the development of a Procurement Reform Action Plan and a Financial Management Improvement Plan which has been endorsed by MoH. MoH has also carried out a detailed Organization and Management Review which provides a framework for organizational reforms for procurement. This understanding of critical constraints has informed the design of this project.

12. This IDA-financed project is embedded within the Government's NHSS. The NHSS has been prepared in collaboration with DPs. Based on the analysis and consultation, the Bank will focus its support on strengthening specific areas of public management and governance in the health sector (procurement, financial management, citizen engagement). Other DPs will support linked areas of public management (e.g., human resources, equipment management and quality assurance, decentralized planning), thereby, supporting the NHSS.

## II. Proposed Development Objectives

The objective of the project is to improve efficiency in public resource management systems of the health sector in Nepal.

## III. Project Description

### Component Name

I. Improve Public Financial Management and Procurement in the Health Sector

### Comments (optional)

Component 1 will improve resource management through supply-side interventions such as improved procurement, contract management systems, supply chain systems; and budget planning, execution and reporting. The success of these interventions and the release of IDA funds will be linked to the achievement of disbursement linked indicators (DLIs) in the following areas: (A i) Enhanced systems and institutional capacity at MoH for managing procurement; (A ii) Effective operational logistics and supply chain management system; (B i) Enhanced systems for annual planning and budgeting; (B ii) Enhanced systems for expenditure reporting; and (B iii) Timely response to audit reports.

### Component Name

II. Improve Reporting and Information Sharing for Enhanced Accountability and Transparency

### Comments (optional)

Component 2 will support NHSS to design and strengthen systems for regular data capture and monitoring of disaggregated data. Mechanisms for public access to information in keeping with the GESI Strategy and Nepal's Right to Information Act will also be developed. The success of these interventions and the release of IDA funds will be linked to the achievement of disbursement linked indicators (DLIs) in the following areas: (C i) Improved monitoring mechanisms for service delivery; and (C ii) Enhanced citizen engagement.

## IV. Financing (in USD Million)

Total Project Cost:	150.00	Total Bank Financing:	150.00
Financing Gap:	0.00		
<b>For Loans/Credits/Others</b>			<b>Amount</b>
BORROWER/RECIPIENT			0.00
International Development Association (IDA)			150.00
Total			150.00

## V. Implementation

13. The MoH will be responsible for implementing the activities of the project through its various organizational structures including its departments, divisions and centers. The Ministry of Finance (MoF), Financial Comptroller General Office (FCGO), Office of the Auditor General (OAG), and Public Procurement Monitoring Office (PPMO) will provide policy support and guidelines to facilitate the process.

14. A Management cell at MoH chaired by the chief of the Policy, Planning and International Cooperation Division (PPICD) will implement the project. It will consist of Director Generals of all departments, head of the Human Resource and Financial Management Division, accounts officer and the accountant. There will be a Project Steering Committee, which meets quarterly, chaired by

the Secretary, MoH, with representatives from MoF, FCGO and OAG to provide overall guidance, resolve project specific issues and ensure inter-ministerial and sectoral coordination.

## VI. Safeguard Policies (including public consultation)

<b>Safeguard Policies Triggered by the Project</b>	<b>Yes</b>	<b>No</b>
Environmental Assessment OP/BP 4.01	<b>x</b>	
Natural Habitats OP/BP 4.04		<b>x</b>
Forests OP/BP 4.36		<b>x</b>
Pest Management OP 4.09		<b>x</b>
Physical Cultural Resources OP/BP 4.11		<b>x</b>
Indigenous Peoples OP/BP 4.10	<b>x</b>	
Involuntary Resettlement OP/BP 4.12		<b>x</b>
Safety of Dams OP/BP 4.37		<b>x</b>
Projects on International Waterways OP/BP 7.50		<b>x</b>
Projects in Disputed Areas OP/BP 7.60		<b>x</b>

**Comments (optional)**

## VII. Contact point

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