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Report No. PAD 110303

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROGRAM APPRAISAL DOCUMENT

ON A

PROPOSED CREDIT

IN THE AMOUNT OF SDR 107.6 MILLION

(US$150 MILLION EQUIVALENT)

TO

NEPAL

FOR A

HEALTH SECTOR MANAGEMENT REFORM PROGRAM-FOR-RESULTS

December 20, 2016

Health, Nutrition and Population Global Practice
South Asia Region

CURRENCY EQUIVALENTS

(Exchange Rate Effective as of August 31, 2016)
Currency Unit = Nepalese Rupee (NPR)
NPR 107.15 = US$1
US$1.39 = SDR 1

FISCAL YEAR
July 16 – July 15

ABBREVIATIONS AND ACRONYMS

AWPB	Annual Work Plan and Budget
CAPP	Consolidated Annual Procurement Plan
CIAA	Commission for the Investigation of Abuse of Authority
CPS	Country Partnership Strategy
DFID	Department for International Development (United Kingdom)
DHIS	District Health Information System
DHO/DPHO	District Health Office/District Public Health Office
DLI	Disbursement-linked Indicator
DoHS	Department of Health Services
DP	Development Partner
DTCO	District Treasury Controller Office
eAWPB	Electronic Annual Work Plan and Budget
ESSA	Environmental and Social Systems Assessment
EVM	Effective Vaccine Management
FCGO	Financial Comptroller General Office
FM	Financial Management
FMIP	Financial Management Improvement Plan
FMIS	Financial Management Information System
FSA	Fiduciary Systems Assessment
FY	Financial Year
GAVI	Gavi, the Vaccine Alliance
GDC/KfW	German Development Cooperation/*Kreditanstalt für Wiederaufbau*
GDP	Gross Domestic Product
GESI	Gender Equality and Social Inclusion
GIZ	German Agency for International Cooperation (*Deutsche Gesellschaft für Internationale Zusammenarbeit*)
GoN	Government of Nepal
GRM	Grievance Redress Mechanism
GRS	Grievance Redress Service (of the World Bank)
HMIS	Health Management Information System
HNP	Health, Nutrition and Population
ICB	International Competitive Bidding
ICR	Implementation Completion and Results Report
IDA	International Development Association
IEG	Independent Evaluation Group
IECCD	International Economic Cooperation Coordination Division
IO	Intermediate Indicator
IVA	Independent Verification Agency

JAR	Joint Annual Review
JFA	Joint Financing Arrangement
LMD	Logistics Management Division
LMIS	Logistics Management Information System
M&E	Monitoring and Evaluation
MICS	Multiple Indicator Cluster Survey
MoF	Ministry of Finance
MoH	Ministry of Health
MoPE	Ministry of Population and Environment
NCB	National Competitive Bidding
NGO	Nongovernmental Organization
NHRC	Nepal Health Research Council
NHSP	Nepal Health Sector Program
NHSS	Nepal Health Sector Strategy
NPC	National Planning Commission
NPV	Net Present Value
OAG	Office of the Auditor General
OOP	Out-of-pocket
PAP	Program Action Plan
PDO	Program Development Objective
PEFA	Public Expenditure and Financial Accountability
PFM	Public Financial Management
PforR	Program for Results
PPICD	Policy, Planning, and International Cooperation Division
PPMO	Public Procurement Monitoring Office
PSM	Public Sector Management
SWAp	Sector Wide Approach
TA	Technical Assistance
TABUCS	Transaction Accounting and Budget Control System
TSA	Treasury Single Account
UHC	Universal Health Coverage
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
WHO	World Health Organization

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HEALTH SECTOR MANAGEMENT REFORM PROGRAM-FOR-RESULTS

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PAD DATA SHEET

Nepal

Health Sector Management Reform Program-for-Results (P160207)

PROGRAM APPRAISAL DOCUMENT

South Asia
Health, Nutrition and Population
GHN19

Report No.: PAD 110303

Basic Information			
Date:	December 20, 2016	Sectors:	Health (50%); Noncompulsory health finance (10%); Compulsory health finance (10%); Public Administration-Health (30%)
Country Director:	Qimiao Fan	Themes:	Health System Performance (50%); Public Expenditure, financial management, and procurement (25%); Managing for development results (25%)
Practice Manager:	E. Gail Richardson / Alexandre Arrobbio		
Global Practice Vice President:	Keith Hansen / Jan Walliser		
Program ID:	P160207		
Team Leader(s):	Preeti Kudesia and Vikram Menon		
Program Implementation Period:	Start Date: March 15, 2017	End Date: July 15, 2021	
Expected Financing Effectiveness Date: March 15, 2017 Expected Financing Closing Date: July 15, 2021			

Program Financing Data (in US$, millions)		
[ ] Loan [X] Credit	[] Grant	[ ] Other

For Loans/Credits/Others (US$, millions):

Total Program Cost:	340.00	Total Bank Financing:	150.00
Total Cofinancing:	0.00	Financing Gap:	0.00

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Financing Sources	Amount
BORROWER/RECIPIENT	190.00
IBRD/IDA	150.00
Total	340.00

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Borrower: Ministry of Finance

Responsible Agency: Ministry of Health

Contact:	Dr. Senendra Raj Upreti	Title:	Secretary
Telephone No.:	+977-1-4262542 ext. 227	Email:	secretaryhp@mohp.gov.np

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Expected Disbursements (in US$, millions)

Fiscal Year	2017	2018	2019	2020	2021	2022			
Annual	22	27	29	35	30	7			
Cumulative	22	49	78	113	143	150			

Program Development Objective(s)

The Program Development Objective is to improve efficiency in public resource management systems of the health sector in Nepal.

Compliance

Policy

Does the program depart from the CAS in content or in other significant respects?	Yes [ ] No [X]
Does the program require any waivers of Bank policies applicable to PforR operations?	Yes [ ] No [X]
Have these been approved by Bank management?	Yes [ ] No [X]
Is approval for any policy waiver sought from the Board?	Yes [ ] No [X]

Overall Risk Rating: High

Legal Covenants

Name	Recurrent	Due Date	Frequency
Maintenance of the Program Steering Committee	X		Continuous

Description of Covenant

The Recipient shall maintain, throughout the period of implementation of the Program, the Program Steering Committee, with membership, powers, functions and competencies acceptable to the Association.

Name	Recurrent	Due Date	Frequency
Maintenance of the Independent Verification Agency	X		Continuous

Description of Covenant

The Recipient shall maintain, throughout the period of implementation of the Program, the Independent Verification Agency, with the qualifications acceptable to the Association.

Name	Recurrent	Due Date	Frequency
Maintenance of the DLI Management and Coordination Unit	X		Continuous

Description of Covenant

The Recipient shall maintain throughout the period of implementation of the Program, the DLI Management and Coordination Unit, housed within MoH, under terms of reference satisfactory to the Association: (i) headed by a Program Coordinator; (ii) assisted by competent staff, all with experience and qualification; and (iii) provided with such powers financial resources, functions and competencies, appropriate to fulfill their respective functions under the Program.

Name	Recurrent	Due Date	Frequency
Implementation of the Program Action Plan	X		Continuous

Description of Covenant

The Recipient shall carry out the Program Action Plan in accordance with the schedule set out in the said Program Action Plan in a manner satisfactory to the Association.

Name	Recurrent	Due Date	Frequency
Program Financial Audits	X	9 months after the end of the fiscal year	Annually

Description of Covenant

The Recipient shall have the Financial Statements audited in accordance with the schedule set out in the provisions of Section 4.09 (b) of the General Conditions. Each audit shall cover the period of one fiscal year, and shall be furnished to the Association not later than nine (9) months after the end of such period.

Name	Recurrent	Due Date	Frequency
Program Reports	X	45 days after the end of report period.	Annually

Description of Covenant

The Recipient shall monitor and evaluate the progress of the Program and prepare Program Reports in accordance with the provisions of Section 4.08 of the General Conditions. Each Program Report shall cover the period of one fiscal year, and shall be furnished to the Association not later than 45 days after the end of the period covered by such report.

Team Composition			
Bank Staff			
Name	**Title**	**Specialization**	**Unit**
Preeti Kudesia	Senior Health Specialist	Public Health	GHN06
Vikram Menon	Senior Public Sector Specialist	Governance	GGO18
Atin Kumar Rastogi	Procurement Specialist	Procurement	GGO06
Franck Bessette	Program Manager	Financial Management	GG024
Anna Pinto Hebert	Senior Operations Officer	Integrity	INTSC
Annu Rajbhandari	Environmental Specialist	Environment	GEN06
Bandita Sijapati	Consultant	Social	GSURR
Junko Funahashi	Lead Counsel	Legal	LEGES
Jaya Karki	Program Assistant	Program Assistant	SACNP
Manav Bhattarai	Health Specialist	Health	GHN19
Maria Gracheva	Senior Operations Officer	Operations	GHNGE
Martha Vargas	Program Assistant	Program Assistant	GHN06
Phoebe Folger	Operations Officer	Operations	GHN19
Ruma Tavorath	Environmental Specialist	Environment	GEN07
Tekabe Ayalew Belay	Senior Economist	Economics	GHN02
Yogesh Bom Malla	Financial Management Specialist	Financial Management	GGO24
Kari Hurt	Senior Operations Officer	Operations	GHN19
Hannah Kim	Young Professional	Economics	GGOOS

I. STRATEGIC CONTEXT

A. Country Context

1. **Nepal has made significant progress in poverty reduction and human development, but these are now at risk.** With an annual per capita income of US$730 (2014), about 25 percent of Nepal's population of 27.5 million lives on less than US$1.25 per day and 82 percent lives in rural areas. The proportion of the population living on less than US$1.25 per day has been halved from 53 percent in 2003/04. Life expectancy is 70 years (2014), up from 62 in 2000. Nepal has also achieved gender parity in education and sharp reductions in child and maternal mortality. Also, between 2006 and 2014, economic growth averaged 4.4 percent per year, and the budget has moved from a position of modest deficits to surpluses from FY2013 onward. Despite these positive trends, significant disparities persist, and the recent shocks, including the series of earthquakes since April 2015 and the disruption in trade between September 2015 and February 2016, have affected progress in poverty reduction. During FY 2015/16, growth plunged to a 14-year low of 0.77 percent, owing to the twin shocks of the earthquakes and prolonged disruption in supplies on account of the border crisis. Nepal ranks 130 of 168 on Transparency International's Corruption Perception Index for 2015, and poor transparency and accountability in the public sector remain a major concern.

2. **Nepal continues to pass through a complex and challenging political transition.** A new constitution was promulgated in September 2015. However, segments of the population have expressed dissatisfaction with some provisions of the constitution in its current form. A new government formed in August 2016 has promised to introduce constitutional amendments to address grievances.

B. Sectoral (or Multisectoral) and Institutional Context

3. **Nepal has achieved significant improvements in health indicators but challenges remain.** Between 1996 and 2013, the maternal mortality ratio decreased from 790 to 190 per 100,000 live births,[1] while under-five child mortality decreased from 141 per 1,000 in 1990 to 36 per 1,000 in 2014.[2] At the same time, although there have been improvements; the proportion of under-five children who are stunted due to chronic malnutrition remains high at 37.5 percent. Similarly, health service utilization indicators have improved but gaps remain. While 85 percent of children ages 12–23 months have been vaccinated against measles, only 67 percent have received all recommended immunizations. Only 55.2 percent of births are in a health facility, and this proportion is only 27.9 percent among the poorest quintile.[3]

4. **Although out-of-pocket health spending is significant, government services are important providers of health care to the population.** Total spending on health in Nepal is US$40 per capita, of which 40 percent is public spending (2014), higher than the South Asian average of 30 percent. Public spending on health in Nepal is 11.3 percent of total government spending and represents 2.3 percent of gross domestic product (GDP), compared to the average in South Asia of 1.4 percent. Government health services are provided through a network of about 4,100 health facilities and 31,500 staff across the country. Health posts and primary health care centers offer basic services free of charge to the entire population, while higher-level facilities offer services free of charge to the poor. The population often relies on

[1] WHO (World Health Organization) *et al*. 2014. *Trends in Maternal Mortality: 1990 to 2013*. Geneva.
[2] UNICEF (United Nations Children's Fund) *et al*. 2015. *Levels and Trends in Child Mortality: Report 2015*. New York.
[3] Multiple Indicator Cluster Survey (MICS) 2014.

government services for primary health care; for example, 8 out of 10 births in health facilities take place in government facilities.[4]

5. **Weaknesses in management of the government health system undermine access and quality of services.**

(a) **Health services suffer from stock-outs and expiry of medicines resulting from an inefficient supply chain management and distribution system.** Drugs and medical supplies constitute about 20 percent of government health expenditures. The Office of the Auditor General (OAG) identified drug stock-outs and drug expiry as major performance issues. A 2012/13 OAG survey found that 72 percent of primary health centers, 69 percent of health posts, 87 percent of sub-health posts, and 50 percent of hospitals surveyed had experienced stock-outs of one or more essential drugs. The duration of stock-outs ranged from eight to nine weeks in health posts and sub-health posts, to four weeks in primary health centers and one week in hospitals.[5] Drug supply problems are greatest among lower-level and more remote health facilities.

(b) **Low public procurement capacity contributes to drug supply problems.** 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 limited tenures and no specific background or training in procurement. Inappropriate delegation for decision-making and contractor payment authorization also leads to significant delays and complaints. These problems are further compounded by systemic weaknesses in supply chain management.

(c) **Weaknesses in financial management (FM) undermine effective resource allocation.** Poor resource allocation to sector priorities undermines equity and access to essential services. Sector budget formulation processes remain ad hoc, largely uninformed by information from decentralized units where service delivery occurs. At the same time, weak expenditure management, weak internal controls and unreliable financial reporting have resulted in poor expenditure tracking and weak accountability. Poor financial management systems have led to delays in the preparation of financial reports, which in turn delays the release of funds for program implementation and results in poor execution of annual budgets.

(d) **Fiduciary integrity remains a major challenge.** Over the last five years, there has been an increasing trend in the number of audit irregularities as well as ineffective follow-up of audit findings.[6] The system of internal controls needs to be substantially strengthened to reduce the risk of resources not being used for their intended purposes, misappropriation of assets, and poor value for money in the procurement of essential commodities and equipment. Over the past year, the MoH has made serious efforts to settle OAG's reported irregularities.

(e) **There is a deficit of qualified health workers, particularly in remote areas, because of difficult living and working conditions and inefficiencies in human resource management.** The proportions of sanctioned posts that are filled by

[4] MICS 2014.
[5] 2012 Service Tracking Survey; 2013 Service Tracking Survey.
[6] The OAG's annual reports of the health sector (2010–14).

doctors and nurses at various levels of health facilities range from 23 percent to 55 percent.[7] Effective strategies are needed to encourage an appropriate skill-mix and equitable distribution and retention of professional and support staff, especially in remote areas. Support on these issues is being provided by development partners (DPs) such as the WHO and the U.K. Department for International Development (DFID).

(f) **Monitoring and evaluation (M&E) systems remain weak.** Evidence-based decision-making is undermined by poor monitoring systems and the inability to measure results. This affects planning and resource allocation, leads to the persistence of inequalities, and reduces the accountability of policy makers.

(g) **There is poor accountability for results at all levels.** Citizen engagement mechanisms need to be implemented to contribute to improved accountability of policy makers and service providers. The MoH's Gender Equality and Social Inclusion (GESI) strategy includes measures to strengthen citizen engagement. The strategy aims to provide citizens with the information they need to access services, as well as mechanisms for receiving their feedback. However, implementation of the strategy has been limited.

C. Relationship to the CAS/CPF and Rationale for Use of Instrument

6. **The Program for Results (PforR) is well aligned with the World Bank Group's Nepal Country Partnership Strategy (CPS) 2014–2018.**[8] The CPS's objective is to support Nepal's aspirations for increasing economic growth and competitiveness (Pillar 1), while providing support to make growth more inclusive and help equalize opportunities across groups and communities (Pillar 2). A cross-cutting theme of the CPS is the need to address systemic constraints to public sector governance and improve the efficiency, effectiveness, and accountability of public expenditure. This PforR will contribute to that theme as well as the second pillar of the strategy, which includes a focus on improved health and nutrition services.

7. **The PforR contributes to the Health, Nutrition and Population (HNP) Global Practice strategy.** Specifically, the Program reflects one of the four result areas of the HNP strategy, namely, to improve governance, accountability, and transparency in the sector. Ultimately, the Program will contribute to the objective of universal health coverage (UHC), including the HNP Global Practice's goals of ensuring access to health services and financial protection for everyone by 2030. The Program will also contribute to the Governance Global Practice's goal of supporting sustainable public resource management, effective service delivery, policy implementation, and open and accountable government.

8. **Over the past decade, coordinated international support has focused on expansion of health service coverage in Nepal.** Indeed, during the last five years, about 30 percent of public health spending in Nepal was from international sources. Over the past decade, the World Bank joined other DPs in a Sector Wide Approach (SWAp) to support development of the health sector. The outcomes of the IDA support to the first SWAp—Nepal Health Sector Program (NHSP) 1, which closed in July 2010—was rated Satisfactory by the Independent Evaluation Group (IEG) of the World Bank; the outcome rating for IDA support to NHSP 2,

[7] Service Tracking Survey 2013.
[8] Report #88866, discussed by the Executive Directors on May 29, 2014.

which closed in January 2016, is pending the completion of the Implementation Completion and Results Report (ICR) and Independent Evaluation Group (IEG) validation.

9. **It is widely acknowledged that joint domestic and DP support to a common policy and financing platform has significantly improved policy dialogue and coordination.** Domestic and international resources have been jointly applied to achieve common objectives for improved public health service delivery. The World Bank also provided fiduciary oversight and due diligence as part of its and other DP's support to the SWAp, which has also served as a capacity-building mechanism to improve government systems.

10. **Nonetheless, weaknesses in public sector management (PSM) persist and require more focused attention.** While capacity and systems development as well as reforms in policies and practices have been attempted, technical assistance (TA) in these areas has often tended to substitute for government capacity. To be sustainable, it is critical that institutional and organizational reform be driven and owned by the Government.

11. **The PforR instrument was selected to focus government attention on critical policy, institutional, and management reforms outlined in the current 2015–2021 Nepal Health Sector Strategy (NHSS).** The instrument was selected because it explicitly aims to improve efficiency and effectiveness of expenditures by disbursing based on the achievement of results. Disbursement-linked Indicators (DLIs) will focus on actions and results to address key public sector management constraints that have persisted over the past decade of the SWAp. The achievement of the DLIs will contribute to improving the government program's effectiveness, efficiency, accountability, and sustainability.

II. PROGRAM DESCRIPTION

A. Government Program

12. **The Government's health sector program is defined in the NHSS (2015–21), which was approved by the Cabinet in October 2015 and also includes an implementation plan for 2016–21.** The NHSS outlines the Government's program toward achieving its goal of universal health coverage. The NHSS is the third in a series of government sectoral health programs and was preceded by the two Nepal Health Sector Programs (NHSP 1 and NHSP 2) supported by DPs through a SWAp arrangement, as discussed. The current program builds upon detailed consultations with DPs, academia, and civil society and has incorporated lessons learned from the implementation of the previous two five-year programs.

13. **The objectives and expected outcomes of the NHSS are based on four strategic directions.** These are (a) equitable access to health services; (b) quality health services; (c) health systems reform; and (d) multisectoral approach. These are further defined by the following nine program outcomes:

(i) Rebuilt and strengthened health systems: infrastructure, human resources, procurement, and supply chain management

(ii) Improved quality of care at point of delivery

(iii) Equitable utilization of health care services

(iv) Strengthened decentralized planning and budgeting

(v) Improved sector management and governance

(vi) Improved sustainability of health sector financing

(vii) Improved healthy lifestyles and environment

(viii) Strengthened management of public health emergencies

(ix) Improved availability and use of evidence in decision-making processes

14. **The estimated government budget to implement the NHSS is US$2,662 million described in Table 1:**

Table 1. NHSS Budget, 2016–2021 (US$, million)

	Outcome Statement	2016/17	2017/18	2018/19	2019/20	2020/21	Total
1	Rebuilt and strengthened health systems: infrastructure, human resources for health, procurement and supply chain management	223.7	261.4	292.9	302.8	312.6	1,393.4
2	Improved quality of care at point of delivery	38.1	39.8	42.9	45.3	47.6	213.7
3	Equitable utilization of health care services	65.8	82.5	103.0	120.5	130.0	501.8
4	Strengthened decentralized planning and budgeting	20.5	19.9	20.6	21.3	22.0	104.3
5	Improved sector management and governance	25.3	35.0	42.4	41.2	39.7	183.6
6	Improved sustainability of health sector financing	21.5	28.7	34.1	40.0	46.5	170.8
7	Improved healthy lifestyles and environment	1.8	2.2	2.3	2.3	2.5	11.1
8	Strengthened management of public health emergencies	5.3	5.9	7.0	7.8	8.3	34.3
9	Improved availability and use of evidence in decision-making processes	5.4	9.9	11.5	11.1	11.1	49.0
	Total	**407.4**	**485.3**	**556.7**	**592.3**	**620.3**	**2,662.0**

*Note: The table above refers to the NHSS implementation plan with funding covering the period of 2016-2021; while 2015-2016 is considered as the preparatory period for the NHSS due to the 2015 earthquake and subsequent crises.

Donor Support to NHSS

15. **Donor engagement in the health sector continues to be important. However, unlike in the past, there will no co-financing of the IDA supported operation.** DPs will contribute to the government budget for the NHSS using a variety of funding modalities including budget support, results-based financing, parallel financing, and TA for an estimated US$450 million. These include DFID, the Vaccine Alliance (GAVI), the German Agency for International Cooperation (*Deutsche Gesellschaft für Internationale Zusammenarbeit*, GIZ), *Kreditanstalt für Wiederaufbau* (KfW), the U.S. Agency for International Development (USAID). WHO, UNICEF, United Nations Population Fund (UNFPA), and the Global Fund to Fight AIDS, Tuberculosis, and Malaria.

16. **The NHSS recognizes that improved public sector governance is critical to achieving further improved health outcomes.** The focus of NHSP 1 and NHSP 2 was primarily on improving coverage and access. The NHSS expands this focus to include equity and quality of care as well as financial protection. This expansion of focus emerges out of lessons learned from 10 years of SWAp engagement, which highlighted that further movement toward UHC could be slowed by the persisting institutional weaknesses and the resulting inefficiencies in the use of public resources. The NHSS, therefore, has a strong focus on improving institutional arrangements that affect service delivery-including procurement, contract management systems, budget planning, execution, and reporting, as well as expanding citizen engagement to enhance better transparency and accountability. In parallel, it also focuses on ensuring that services and financial protection mechanisms are targeted to populations in greatest need.

B. Program Development Objective/s (PDO) and Key Results

17. **The Program Development Objective is to improve efficiency in public resource management systems of the health sector in Nepal.**

18. **Progress toward meeting the PDO will be assessed using the following indicators:**

(a) Percentage reduction of stock-outs of tracer drugs;

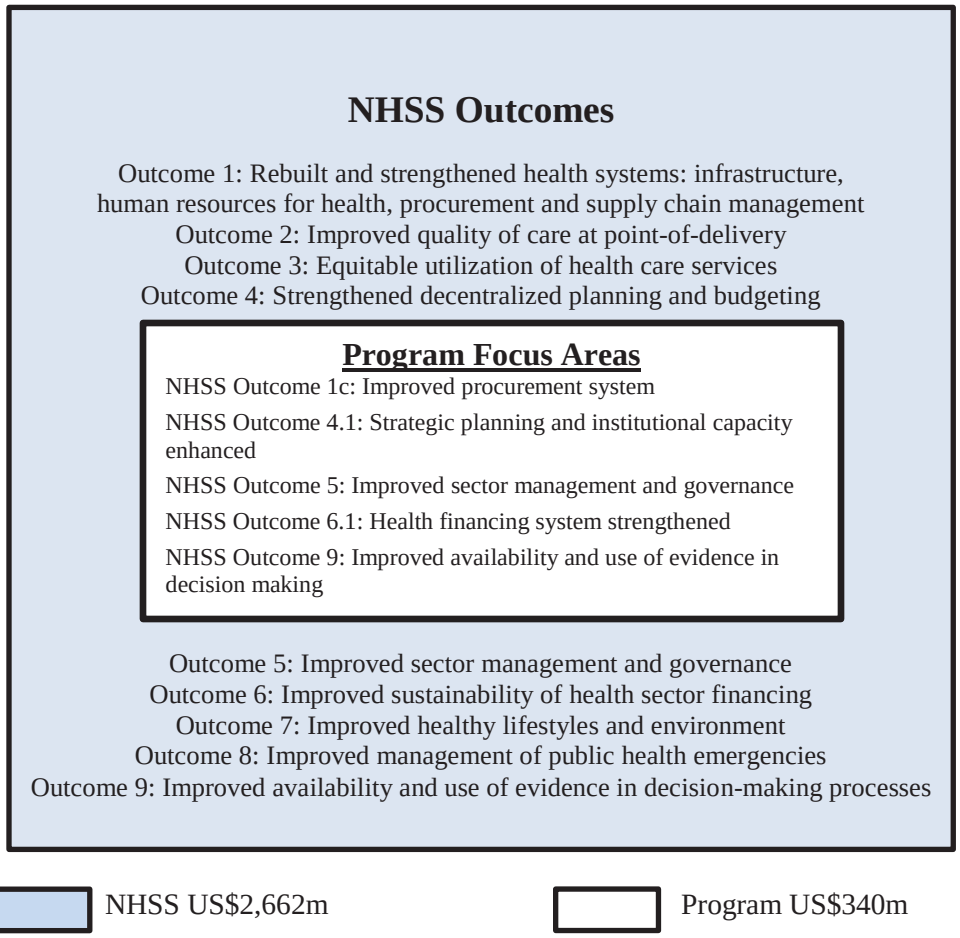
(b) Percentage of the MoH's annual spending captured by the Transaction Accounting and Budget Control System (TABUCS); and

(c) Percentage of districts which have all facilities reporting annual disaggregated data using the District Health Information System 2 (DHIS 2).

C. PforR Program Scope

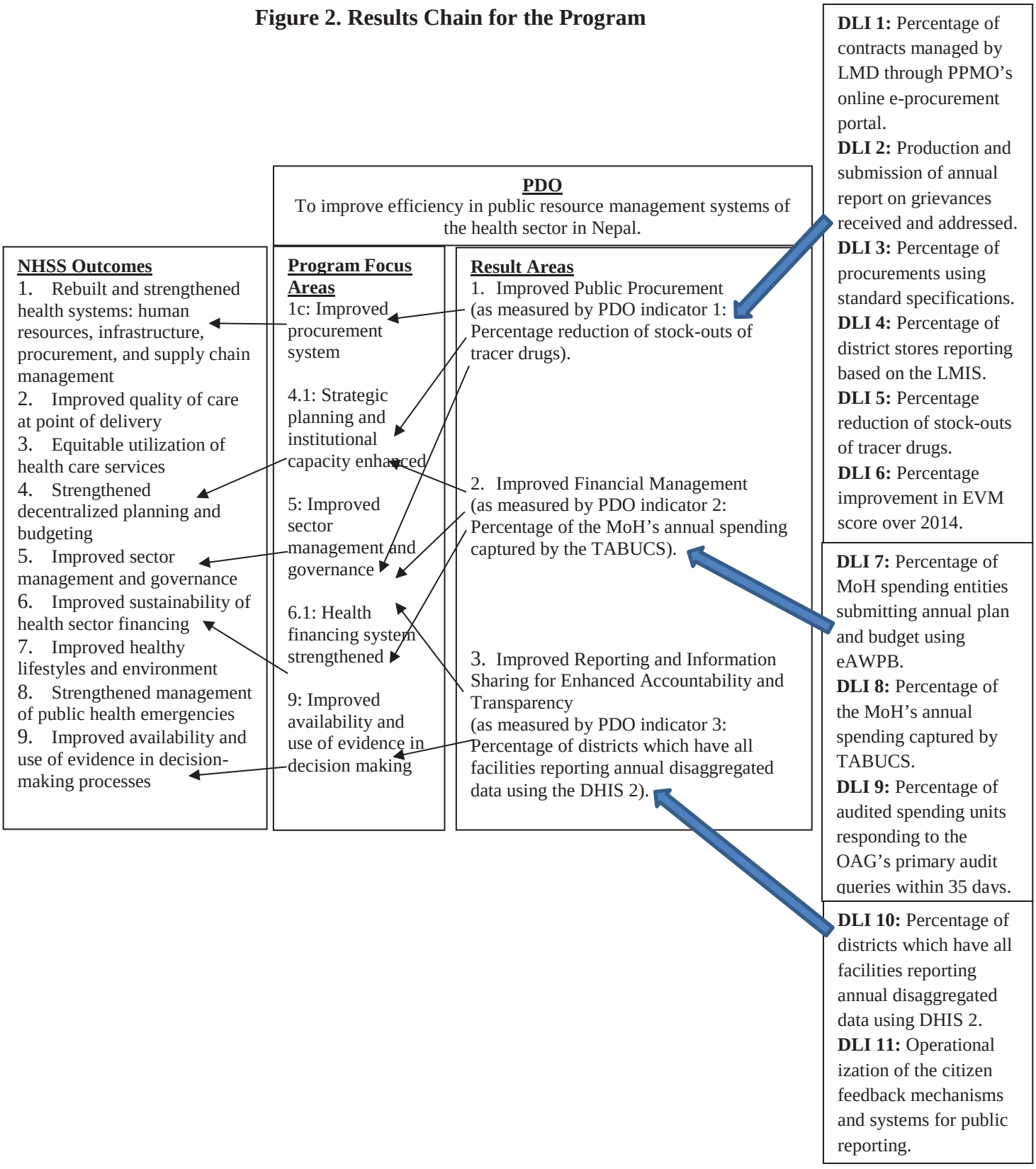
19. **The Program to be supported by the PforR financing is a subset of the larger NHSS program of the Government of Nepal (GoN) and focuses on specific NHSS outcomes in critical areas of public management reforms.** The Government's reform program recognizes that improved health outcomes hinge on the ability of the MoH to direct public resources to areas of need and to react to and make evidence-based decisions. While it is important to continue to invest in expanding service delivery and improving equity, better-developed government systems for financial management, procurement, and evidence-based decision-making will enhance the sustainability of these investments. Therefore, the PforR will support five of the nine outcomes of the NHSS, focusing on three themes: public procurement, financial management, and evidence-based decision-making for greater accountability and transparency (see Figure 1).

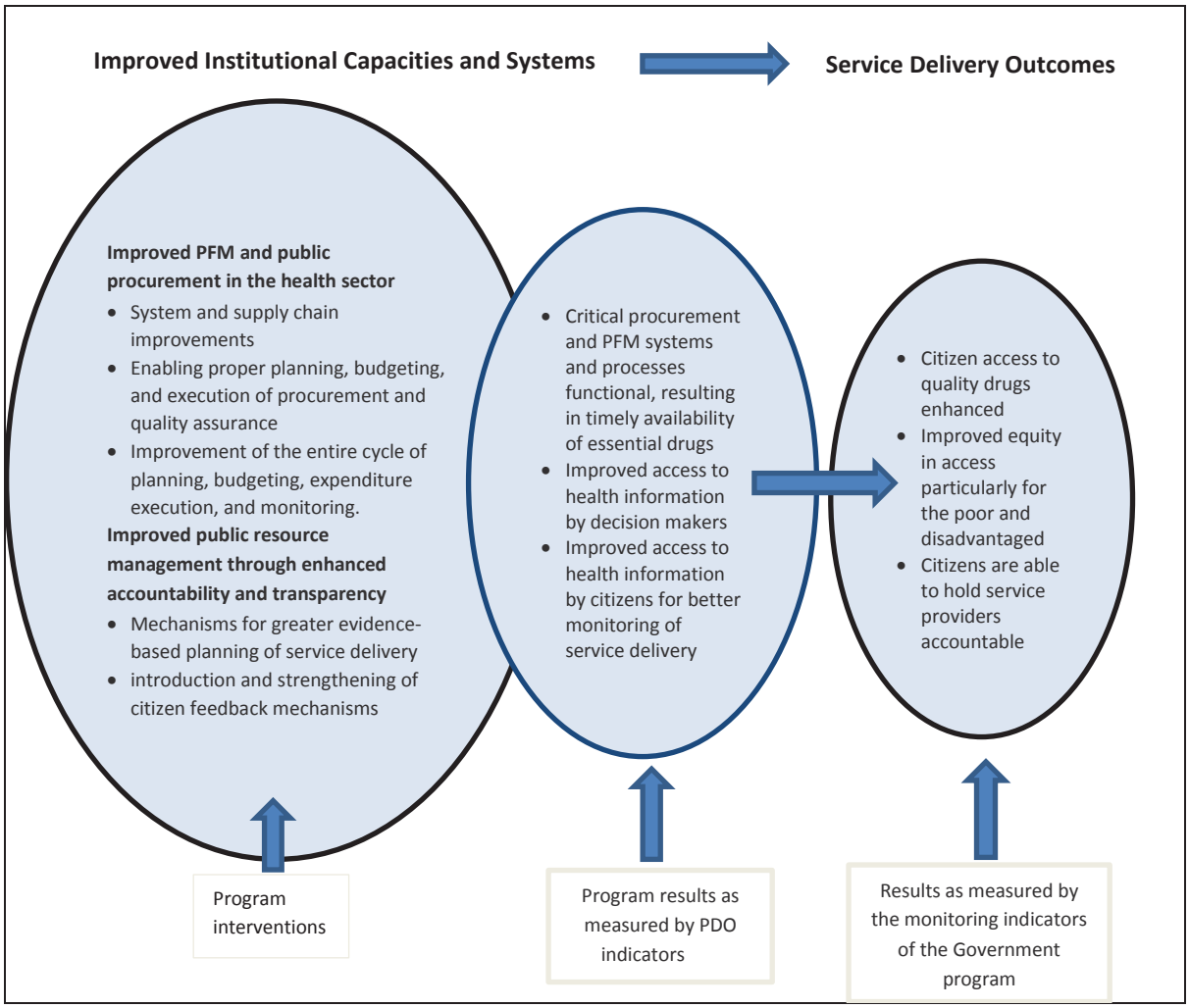
Figure 1. NHSS and Result Areas of the Program



20. **The Program boundaries will include those outcomes / sub-outcomes of the NHSS that focus on strengthening supply- and demand-side constraints of institutional performance.** Specifically, the Program interventions aim to improve the timeliness of drug availability and quality. This includes improving the capacity of the MoH to manage public procurement through strengthening the capacity of the LMD and establishing mechanisms for logistics management and quality assurance. Financial management will be strengthened by linking every spending unit in the health sector with an online expenditure tracking and management system and strengthening the overall audit function. At the same time, the Program will also support better planning and targeting through strengthening data availability and analysis. Demand-side accountability mechanisms to integrate citizen engagement into the process of public governance will also be supported. Together, these activities will support more efficient use of resources for targeted and better service delivery over time. Establishing rigorous institutional systems and sound accountability mechanisms requires long-term changes in process and institutional culture. Program financing will move away from transaction-intensive investments on goods and services toward an incentive-based, results-oriented approach that fits better with the outcomes it seeks to achieve, yielding a more effective use of public resources. Improved institutional capacities will strengthen governance and accountability and enable the public health system in Nepal to be more efficient and allow for more equitable service delivery. This theory of change is illustrated through the results chain in Figure 2.

Figure 2. Results Chain for the Program





21. **These improvements in public resource management of the health sector will enhance efficiency and support sustained equitable and affordable health services.** Although public spending on health in Nepal is above the average of its South Asian neighbors, health system inefficiencies diminish the quality of spending. The Program will address key areas of public management in the health sector and engage citizens to strengthen accountability. These improvements will address micro-level inefficiencies that include procurement of drugs and its supply chain, stock-outs, improved financial management processes and outcomes, evidence-based decision-making by policy makers, and citizen engagement.

Program Beneficiaries

22. **Program interventions will directly benefit the MoH team at the central level and health managers and personnel at the decentralized levels by building the capacity of staff responsible for planning, implementation, and oversight of health programs.** The ultimate beneficiaries will be the users of health facilities including vulnerable and disadvantaged groups who will benefit from the predictable availability of drugs and from better targeting of public resources.

23. **The Program will support gender inclusiveness.** This support will take forward the Government's Gender Equality and Social Inclusion strategy. This strategy focuses on sensitizing both providers and users of services. It will support providers to be gender-sensitive in planning and delivering services including making health facilities more gender-friendly and

providing information, education, and communication to improve health-seeking behavior. The Program will support the GESI strategy by ensuring that data disaggregated by gender, geography, and ethnicity is made available and appropriately analyzed by the MoH to enable evidence-based targeting and resource allocation. Specifically, three DLIs will also have the potential to monitor and influence gender related discussions. DLI 11, which focuses on piloting citizen engagement, will ensure voice and participation of women. DLI 10, which supports operationalization of DHIS 2, will enable disaggregated data by several key parameters including gender to be available for monitoring and policy decisions. DLI 2 will incentivize establishment of a complaint redressal mechanism, which, once established, will also have the potential to monitor gender-disaggregated data.

24. **The Program will support the MoH to develop a framework for citizen engagement.** This will include mechanisms for consultation with disadvantaged populations including vulnerable communities. This is critical, as the MoH has hitherto not had a strategy or institutionalized mechanism to ensure that citizen voice feeds into decision-making and also is used as a tool for holding providers accountable for service delivery. DLIs 2, 10 and 11 reflect this focus. DLI 11 will specifically focus on establishment of the framework and its implementation by piloting six interventions, which will be monitored, and also incentivized through the DLI targets. The Ministry of Health will work with a range of partners including community-based organizations to develop appropriate methodologies and pilot and monitor these interventions in selected districts.

Program Financing

25. The total cost of the NHSS is estimated at US$2,662 million of which the Program supported by the PforR is estimated to cost US$340 million. The World Bank will finance US$150 million of the total Program cost through the PforR.

Table 2. Program Financing (US$, million)

Source	Amount	% of Total
Government	190	55.9
IDA Credit (PforR)	150	44.1
Total Program Financing	**340**	**100.0**

26. **The PforR will disburse against achievement of the agreed DLIs over the program period of five years (2016–2021).** Program expenditures will finance consumption, operational and service, and production expenses as articulated in the annual budget.

27. **The budget lines included in the Program Expenditure Framework will finance critical inputs required for Program implementation and thereby, DLI achievement**. Consumption expenses include various establishment and human resource costs including allowances and salaries, while service and production expenses cover training, learning materials, and skills development costs. Operational and service expenses relate to the costs associated with communication and overhead costs for running official establishments related to the health sector (see Annex 4, Table 4.3). These costs are directly related to the roll out of different activities that would need to be implemented for the achievement of the DLIs. Improving the institutional functionality and capacity of human resources across the health sector is critical to improving the efficiency of public sector management. The PforR directly focuses on facilitating these capacity improvements. A provision has been included in the Financing Agreement to allow for withdrawals up to an aggregate amount not to exceed

SDR14.34 million (US$20 million equivalent) for disbursement linked results achieved prior to the date of the Financing Agreement but on or after July 16, 2016.

28. **The expenditures allocated to the Program are assessed to be appropriate. The government pre-finances the health sector by providing MoH an annual budget which includes government's revenues and donors'contribution.** While the total budget is adequate, the annual absorption rate of the sector budget is relatively low, at 70-85 percent which negatively affects the implementation of planned activities. Recognizing this, the PforR focuses on improving institutional capacity for planning and budgeting and financial management to allow for better budget execution and improved service delivery. The Program finances those expenditures in the MoH budget which for the last five years have not had any significant audit observations.

D. Disbursement-linked Indicators and Verification Protocols

29. **The PforR operation will support the Program through a series of DLIs, which form the basis for disbursement.** The DLIs are expected to signal to key stakeholders the importance of focusing on critical results. These DLIs correspond to key priority areas of the Government's NHSS program and focus on the major bottlenecks along the results chain. They provide incentives for addressing these bottlenecks to improve public resource management in the health sector. Linking payments to results promotes transparency and accountability in the system thereby reducing leakages. It is therefore likely to incentivize the MoH to take a more proactive stand in addressing stewardship functions in public sector management, which, over time, will facilitate improved equitable and affordable service delivery, leading to the path to UHC.

30. **The DLIs reflect key results of the Program.** The design of the DLIs was based on a number of criteria: (a) DLIs need to be achievable and challenging at the same time so that the financial risk attached to each DLI will have the appropriate impact; (b) DLIs should allow for a regular disbursement flow; and (c) DLIs must be strongly aligned with government priorities, which should guarantee a multiplier effect and ensure sustainability.

31. **There are 11 DLIs that focus on critical aspects of health sector management including priority areas in procurement and financial management and reporting and information management for better evidence-based planning.** The achievements of these DLIs will support the NHSS to fully or partially meet its Outcomes 1, 4, 5, 6, and 9 and establish a robust institutional framework for public management, accountability, and transparency in the health sector.

32. **The design of the DLIs reflects a variety of result areas each of which requires a different approach to when and how each DLI would be considered achieved (see Annex 3), as follows:**

(a) Some DLIs can be financed as and when they are achieved.

(b) Some DLI targets are scalable whereby the disbursement will be proportional to the progress toward achieving the DLI subject to the achievement of a minimum threshold. These thresholds are detailed in Annex 3 under "disbursement rules" for each target and in the Disbursement Table in the same Annex.

Result Area 1: Improved Public Procurement

33. **DLIs 1 to 6 will support the Government's institutional reform plan for procurement and supply chain management.**

- **DLI 1 (US$15 million):** Percentage of contracts managed by the LMD through the PPMO's online e-procurement portal. This DLI will focus on enhancing the capacity of the LMD to better manage procurement by incentivizing e-procurement.

- **DLI 2 (US$11 million):** Production and submission of Annual Report on grievances received and addressed through a web based Grievance Redressal Mechanism. This DLI will focus on enhancing the capacity of the LMD to better manage procurement through the use of a grievance redressal mechanism. This mechanism, when established, will also have the ability to provide gender disaggregated data.

- **DLI 3 (US$14 million):** Percentage of procurements done by the LMD using standard specifications. This DLI will focus on creating greater transparency in the procurement of the basic package of drugs and equipment by establishing the use of standard specifications.

- **DLI 4 (US$16 million):** Percentage of district stores[9] reporting based on the LMIS. This DLI will focus on supporting the revision of a Logistics Management Information System (LMIS) and training personnel on its use to produce real-time web-based information for managing and reporting inventory of drugs.

- **DLI 5 (US$10 million):** Percentage reduction of stock-outs of tracer drugs in district stores. This DLI will reflect improvements in how the MoH uses the information available through the revised LMIS to better analyze stock-outs and create systems to manage stock inventory, thereby contributing to the timely availability of drugs to the population.

- **DLI 6 (US$4 million):** Percentage improvement in Effective Vaccine Management (EVM)[10] score over 2014 baseline. This DLI focuses on improvements in the quality of preshipment, cold chain and warehouse management, stock management, and information systems for vaccines, serving as a marker for management of the entire cold chain.

34. **Theory of change.** Enabling proper planning, budgeting, and execution of procurement and quality assurance will lead to reductions in drug stock-outs and enable the timely availability of the basic package of drugs at all health facilities and to all populations.

[9] These stores refer to drug storehouses at what, in current administrative practice, is known as the district. During the life of Program implementation, in response to administrative changes this nomenclature may change and the new nomenclature in place will be appropriately documented.

[10] EVM is a standard score consisting of nine parameters to determine the management and quality of vaccine management in a country at the central, regional, and service delivery levels. It is measured every two years by a joint team involving the Government, WHO, and UNICEF, using a standardized methodology by WHO and UNICEF.

Result Area 2: Improved Financial Management

35. **DLIs 7 to 9 will support the Government's reform plan to improve the health sector public financial management (PFM) cycle of planning, budgeting, expenditure execution, and monitoring**.

- **DLI 7 (US$15 million):** Percentage of MoH spending entities submitting annual plan and budget using Electronic Annual Work Plan and Budget (eAWPB). This DLI focuses on reforms that support better convergence and coordination in plan and budget preparation through an online planning and budgeting system. This will result in less duplication and ultimately enable better prioritization and monitoring of the sector program.

- **DLI 8 (US$20 million):** Percentage of the MoH's annual spending captured by TABUCS. This DLI focuses on reforms to improve internal budgetary control systems by incentivizing the use of an online expenditure reporting system by every MoH spending unit. This will result in better reporting, tracking, and monitoring of the use of public resources in the health sector and allow for evidence-based financial management.

- **DLI 9 (US$15 million):** Percentage of audited spending units responding to the OAG's primary audit queries within 35 days. This DLI focuses on enhancing accountability through improving the internal control framework for financial management in the MoH. This will result in establishing institutional mechanisms for tracking and responding to audit queries on time by audited spending units.

36. **Theory of change.** Improved PFM in the health sector will reduce existing inefficiencies in public expenditure planning and spending and thereby facilitate better redistribution of resources through more evidence-based resource allocation to ensure that affordable and appropriate health services are available to the Nepalese population, particularly the disadvantaged.

Result Area 3: Improved Reporting and Information Sharing for Enhanced Accountability and Transparency

37. **DLIs 10 and 11 will support strengthening MoH's system for capturing and making use of health service data to improve decision-making and accountability.** This will be done through support to (a) the design and strengthening of systems for data capture and monitoring of disaggregated data and the development of mechanisms for public access to information and (b) the development and piloting of citizen engagement mechanisms to gather feedback, including on availability of drugs and services provided by health facilities.

- **DLI 10 (US$20 million):** Percentage of districts which have all facilities reporting annual disaggregated data using DHIS 2. This DLI focuses on improvements in planning and monitoring for evidence-based decision-making through the establishment and use of DHIS 2 to access data disaggregated by geography, gender, and ethnicity. This will contribute to better targeting to improve access and equity.

- **DLI 11 (US$10 million):** Operationalization of the citizen feedback mechanisms and systems for public reporting. This DLI focuses on developing and piloting citizen engagement mechanisms in different geographical contexts to gain

feedback on availability of drugs and facility-level services to institutionalize demand-side monitoring for better accountability. The availability of gender-disaggregated data from the pilots will provide information to monitor whether women are being excluded from access to services and drugs, and enable equal voice and participation in the monitoring process.

38. **Theory of change.** Improved systems will allow for regular data capture and monitoring of disaggregated data. The MoH will use consolidated reports for planning and decision-making. Strengthened citizen engagement by improving their access to information and capturing their voice and feedback will improve state responsiveness in addressing constraints to access. Improved accountability will help encourage service providers to 'supply' the services for which they are responsible.

39. **Verification of DLIs.** The achievement of DLIs will be verified by an independent institution based on a detailed DLI verification protocol jointly endorsed by the MoH and IDA. The Nepal Health Research Council (NHRC) has been selected by the MoH to be the Independent Verification Agency (IVA) based on established selection criteria. The NHRC is a statutory and autonomous institution as promulgated by the Nepal Health Research Council Act No. 129 of 1991. A Memorandum of Understanding (MOU) outlining the specific responsibilities of the NHRC with respect to the verification of Program implementation was signed between the NHRC and the MoH on September 25, 2016.

E. Capacity Building and Institutional Strengthening

40. **Capacity constraints are recognized and well reflected in the NHSS.** There are challenges identified in the areas of procurement and supply chain management of drugs and equipment. Financial management, internal controls, human resource management, and various information systems for management are also recognized as areas that need to be strengthened.

41. **The NHSS defines a Health Sector Partnership Forum, designed as a common platform for joint planning, programming, and review by the MoH, the DPs, non-governmental organizations (NGOs), and the private sector.** This is expected to be functional by January 2017. This forum will also discuss and monitor the TA provided and required to build the capacity of the sector to deliver the outcomes of the NHSS. Donors and the Government have identified TA needs, and this is documented in a TA plan, which will be a part of the Joint Financing Arrangement (JFA). The JFA is a framework for donor coordination and describes ways of working and systems for joint monitoring with the MoH. The JFA has been signed by DFID, USAID, WHO and UNFPA, and IDA will be a signatory to it.

42. **A number of donors are supporting the NHSS through TA.** USAID has committed to support the establishment of a supply chain management system including a Logistics Management Information System (LMIS). Technical assistance for procurement systems reforms is being provided by DFID. UNICEF and GAVI are committed to help the sector in effective vaccine supply chain management. Human resource challenges will be addressed through support from various donors. DFID and WHO will provide TA for the implementation of DHIS 2 as well as M&E which will help generate information for better planning and resource allocation.

43. Development Partners will provide TA to the larger NHSS through support to the sector budget. This modality of financing by the donors is outside the PforR Expenditure

Framework. Therefore, these donors' contributions are considered as parallel financing to IDA's financing and will reinforce GoN's commitment to these critical reforms. Table 3 describes the likely areas of TA support by different DPs to the NHSS, including the areas supported by the PforR.

Table 3. NHSS Technical Assistance Plan (5 Program focus areas)

NHSS Outcomes	Capacity Building	Institutional Reform	Demand Creation	Commodities and Supplies	Building Evidence, Reviews, and Assessments
Outcome 1: Strengthened function of health systems: infrastructure, human resources for health, procurement, supply chain management	UNICEF, WHO, USAID, KOICA, UNFPA, GIZ, GDC/KfW	WHO, DFID, UNAIDS, USAID, UNFPA, GDC/KfW	USAID	UNFPA, UNICEF, WHO, USAID, KOICA	UNICEF, USAID, DFID, UNFPA, WHO
Outcome 4: Strengthened decentralized planning and budgeting	UNICEF, UNAIDS, USAID, DFID, WHO, GIZ, UNFPA	USAID, WHO, GIZ, DFID	USAID	USAID	GIZ, WHO, DFID, UNFPA
Outcome 5: Improved sector management and governance	DFID, UNICEF, USAID, WHO, GIZ	USAID, GIZ, DFID	USAID		WHO, DFID, USAID
Outcome 6: Improved sustainability of health sector financing	DFID, GIZ, WHO	WHO, GIZ	KOICA	KOICA	WHO
Outcome 9: Improved availability and use of evidence in decision-making processes at all levels	UNICEF, WHO, USAID, DFID, GIZ, UNFPA	WHO, DFID, GIZ	USAID	GIZ, WHO	USAID, UNAIDS, DFID, UNFPA, WHO, GIZ

Note: KOICA = Korea International Cooperation Agency; UNAIDS = The Joint United Nations Programme on HIV/AIDS.

44. The DPs have agreed on a joint TA plan with clear implementation timeframes. The coordination risks are therefore substantially mitigated.

III. PROGRAM IMPLEMENTATION

A. Institutional and Implementation Arrangements

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

46. **A DLI Management and Coordination Unit at the MoH, headed by a Program Coordinator and supported by competent staff with experience and qualification will support implementation of the Program.** This Unit will include directors of all MoH departments, the director of the LMD, the head of the Human Resource and Financial Management Division, and the accounts officer of the MoH. Day-to-day implementation and monitoring of results in the four key areas will be the responsibility of the LMD director for procurement related DLIs; the head of the Human Resources and Financial Management Division for PFM related DLIs; the director, Management Division, Department of Health Services (DoHS) for DLIs related to M&E and DHIS 2; and the director, Primary Health Care and Revitalization Division, for DLIs related to citizen engagement.

47. **A Program Steering Committee, which was formed in April 2016,** will meet quarterly, chaired by the Secretary of the MoH, and include the Director General of DoHS; Chair, PPICD; the head of the Human Resource and Financial Management Division; and representatives from the MoF. Representation from the FCGO and the OAG will be invited as needed. This Committee will provide overall guidance, resolve Program-specific issues, and ensure inter-ministerial and sectoral coordination.

48. **There is considerable donor commitment to the Program and to the overall Nepal Health Strategy.** A coordinated approach amongst donors for providing both targeted technical assistance and for monitoring and supervision will be critical for implementation. The JFA provides a clear framework for joint review and monitoring. A collaborative approach has also been taken to identify technical assistance needs as described in paragraphs 41-44 above.

B. Results Monitoring and Evaluation

49. **Outcome indicators, intermediate outcome indicators, and specific targets for DLIs have been agreed with the MoH and have also been discussed and agreed with the DPs.** The design of the Program encourages reinforcement of systems for better M&E of results, and hence Program indicators focus on process and system improvements for the most part. At the same time, some key indicators focus explicitly on achieving sustainable outcomes and impacts on the population, such as expected, for example, under PDO indicator #1 which will measure the percentage reduction of stock-outs of tracer drugs. The achievement of the target under this PDO indicator will have profound positive consequences on increasing access to critical drugs for all population groups, including the disadvantaged, and hence influencing improved health outcomes. The Program supports the institutionalization of robust monitoring and reporting systems by strengthening mechanisms for both data collection and analysis, as well as through supporting systems for citizen engagement and feedback. Pilots will be

supported under the Program to obtain citizen feedback on, among others, drug and doctor availability at the facility level. Data will also be available from various national surveys done at different times. For example, Nepal Demographic Health Survey; Nepal Multiple Indicator Cluster Survey (MICS); Service Tracking Surveys 2011, 2012, and 2013; Nepal Health Facility Survey 2015; and Facility-based Assessment for Reproductive Health Commodities and Services. These different data sources will also be used for discussions and monitoring, including any additional need-based surveys that may be done, subject to the availability of resources.

C. Disbursement Arrangements

50. **Disbursements will be made against achievement of DLI targets.** The disbursement will be contingent upon the Borrower furnishing evidence satisfactory to IDA that it has achieved the respective DLI targets. Applications for withdrawal from the World Bank's financing account of amounts allocated to individual DLIs will be sent to IDA any time after the World Bank has notified the GoN in writing that it has accepted evidence of achievement of the DLIs. The withdrawal amount against the DLIs achieved will not exceed the amount of the financing confirmed by IDA for the specific DLIs. All withdrawals from the Credit Account will be made into an account maintained at the Nepal Rastra Bank.

51. In the case of scalable DLI targets, disbursement of financing proceeds will be proportional to the progress toward achieving the DLI, subject to the achievement of a minimum threshold, as outlined in the Disbursement Table in Annex 3.

IV. ASSESSMENT SUMMARY

A. Technical

Program's Strategic Relevance and Technical Soundness of the Approach

52. **Weaknesses in management of the government health system undermine coverage and quality of services.** The Government's current five-year program, the NHSS, includes institutional and management reforms necessary to improve coverage, equity, and quality of health service delivery. There is consensus that systemic and institutional weaknesses constitute the binding constraints to Nepal achieving the goal of UHC. Five of the nine goals of the NHSS relate to improved public sector governance and include the areas of procurement and supply chain management, PFM, decentralized planning, and evidence-based decision-making.

53. **The Program is designed to support the Government to address these weaknesses in PSM and thereby facilitate the NHSS to achieve its stated outcomes.** The Program's focus on institutional strengthening by addressing specific PSM weaknesses in the health sector in Nepal is appropriate and timely. The design is based on detailed technical analysis and consultations with stakeholders. The technical analysis preceding design has defined the scope of the Program supported by the PforR, which is limited to the NHSS outcomes focusing on systems strengthening in areas of public procurement, PFM, and monitoring and reporting.

54. **Expenditures of the Program are related to those expenditures in the annual budget that finance consumption, operational and service, and production expenses as articulated in the MoH's annual budget.** The Program supports institutional reform, and therefore, does not include the procurement of goods, works or services under high value contracts (above the OPRC threshold levels). Any person or entity debarred or suspended by

the Bank will not be awarded a contract under or otherwise allowed to participate in the Program during the period of such debarment or suspension, per the Bank's Guidelines on Preventing and Combating Fraud and Corruption in PforR Financing (dated February 1, 2012 and revised July 10, 2015).

55. **The PforR will disburse against the achievement of 11 agreed DLIs.** Time-bound, actionable, and measurable targets have been set for the DLIs. The achievement of the DLIs will be monitored and reported against the targets outlined in the Program. These achievements of targets will be verified by the IVA.

56. **Adequate institutional arrangements are in place to implement the Program.** The MoH will be responsible for the implementation and the achievement of agreed results. A DLI Management and Coordination Unit at the MoH chaired by the chief of the PPICD will support the day-to-day implementation of the Program and monitoring of results. There will also be a Program Steering Committee, which meets quarterly, chaired by the secretary of the MoH. The Program Steering Committee will provide overall guidance, resolve Program-specific issues, and ensure interministerial and sectoral coordination. Both the DLI Management and Coordination Unit and the Program Steering Committee have been established.

57. **The economic analysis confirms that the scope and rationale of the Program are valid and will generate positive returns.** The expected net impact realized through improving the public resource management systems of the health sector in Nepal is estimated at US$74 million, which is the sum of estimated net benefits arising from Program implementation. The analysis assumes an exchange rate of NPR 107 per U.S. dollar, a 12 percent discount rate, and a short time horizon of five years from 2017 to 2021 (details provided in Annex 4). At the same time, many of the gains expected from the program such as those coming from better reporting, tracking and monitoring of the use of public resources and of health outcomes are not easily measurable in monetary terms, but will result in positive economic benefits and greater value for money.

B. Fiduciary

58. **The Fiduciary Systems Assessment (FSA) conducted as per the Bank's PforR Financing policy/directive (issued July 10, 2015) concludes that the Program's fiduciary systems provide reasonable assurance that the financing proceeds will be used for intended purposes, provided an agreed fiduciary mitigation program is implemented.**

59. **The Program's fiduciary risks are rated as High.** This is in view of specific country and sector risks associated with financial management, procurement, and fraud and corruption. However, institutional frameworks for mitigation are in place in most of these areas but need substantial scaling up and strengthening.

60. **A detailed procurement assessment was conducted as part of the FSA**. It noted the need to establish a procurement monitoring system, develop standard specifications for drugs and other health commodities, ensure adequate quality assurance and address weaknesses in supply chain management.

61. **The Program's Expenditure Framework will be entirely funded through the GoN's national budget.** It will be implemented through the use of the GoN's systems for budget preparation and execution, cash management, accounting, financial reporting, internal controls, and external audits. Based on the assessment of country systems, the following

significant fiduciary (financial management and procurement) risks have been identified for the Program:

(a) There are weak linkages between policy intent and budgeting of resources. There could be a potential concern about how IDA resources for the Program would be utilized and reported on.
(b) Capacity at the MoH to assess the performance of the Program and manage results indicators is weak.
(c) Weakness in the internal control framework within MoH poses a risk that Bank proceeds might be used in contradiction to the legal and regulatory framework or not used for the intended purpose and therefore be subjected to external audit queries.
(d) The complexity of the MoH expenditure framework, with more than 300 - 400[11] cost centers, including autonomous agencies, local level spending entities and the lack of sufficient accountability mechanisms at this level (local and autonomous levels), is a risk.
(e) Parliamentary oversight and the capacity of the Public Accounts Committee remains fragile.
(f) Weak capacity for managing and monitoring procurement of health sector commodities within the MoH (LMD), which can lead to lapses in accountability.
(g) Lack of standard specifications for drugs and equipment and limited organizational capacity for quality assurance.
(h) Delayed procurement decisions at every level in MoH, including a lack of a procurement monitoring system to see whether timely decisions are taken or not.

Fiduciary systems also present elements of strengths that constitute a solid basis for the Program.

(a) A sound government budget process in terms of timeliness, classification and execution control by Treasury.
(b) Transparency of the budget process with daily budget execution reports published on the FCGO's website and timely production and publication of budget documents and annual financial statements.
(c) A systematic external audit of government expenditures, including in the health sector, by an independent OAG and an increasing capacity of the OAG to conduct performance audit, including in the health sector.
(d) Institutional mechanisms for regulating procurement processes and providing oversight over departmental procurement in the form of a Public Procurement Monitoring Office.

62. **The above strengths form a good basis for an efficient fiduciary system, if complemented by a program of fiduciary system strengthening.** The Program fiduciary systems are generally in line with international standards with regard to budget process and transparency. Besides, the Expenditure Framework has been designed in view of minimizing the Program's exposure to country systems' risks. Nevertheless, a number of mitigation measures would need to be in place to get reasonable assurance that the financing under the Program will be used for the intended purposes. Existing deficiencies and weaknesses have the potential to affect the ability of the Program to achieve its intended results. Therefore, based on the findings and conclusions of the Fiduciary Risk Assessment, key measures have been integrated into a Program Action Plan (PAP). This will largely mitigate the fiduciary risks and

[11] The number of cost centers which are spending entities of MoH is determined every year during budget preparation. The Program will use the number provided by MoH by October 31st each year.

weaknesses identified. These recommendations are in line with the GoN's priorities as reflected in the current Financial Management and Procurement Health Action Plan and in the National PFM Strategy endorsed by the Public Expenditure and Financial Accountability (PEFA) Steering Committee in March 2016. In addition, a key mitigation measure related to fraud and corruption will be the compliance by government with the provisions of the Bank's Guidelines on Preventing and Combatting Fraud and Corruption in Program-for-Results Financing. Specifically, the Government of Nepal will provide periodic reports to the Bank on allegations of fraud and corruption related to the Program that: (a) have been received by the Governance Unit in the Department of Human Resources and Financial Management of the MoH from the CIAA; and (b) have been received by the Governance Unit and referred to the CIAA for further investigation. This report will be provided on an annual basis, no later than by September 1 every year, and contain the following information: (i) basic information and description of the allegation; (ii) date of allegation; and (iii) status of allegation handling.

C. Environmental and Social Effects

63. **An Environmental and Social Systems Assessment (ESSA) was undertaken by the World Bank team.** Its objectives were to (a) identify risks and impacts associated with the Program; (b) assess the strengths and weaknesses of the legal, institutional, and implementation frameworks; and (c) recommend measures to strengthen national systems and capacity to deliver the PforR in a sustainable manner.

64. **The ESSA concludes that the environmental and social impacts of the Program are Low.** While the Program boundaries and financing do not cover interventions at health care facilities, the Government's program has the following environmental and social risks associated with it: (a) risk of spread of infection through badly managed infectious waste and poor occupational health and safety practices and (b) contamination of land, water, and air through haphazard disposal and incineration of infectious and chemical solid and liquid waste. In addition, risks common to both the larger NHSS and the PforR are associated with (a) continued equity gap reflected by wide variations across different population groups with regard to health status and access to and utilization of health services and (b) poor levels of awareness, as well as inadequate consultations and citizen engagement, including with vulnerable groups.

65. **The ESSA found that an inadequate regulatory framework and lack of clarity on the roles and responsibilities of stakeholders have resulted in poor implementation and enforcement of environmental and social safeguard measures.** However, there is a willingness and interest expressed by the GoN, DPs, and NGOs for the NHSS to contribute toward reduced pollution and a better quality of life, as well as strengthened institutions. There are also many successful pilots being implemented in Nepal that can be scaled up and replicated. The PforR, therefore, provides an opportunity to strengthen systems to ensure improved equity outcomes and easy and safe accessibility to health services for all, particularly the disadvantaged and vulnerable groups, and better citizen engagement.

66. **These system improvements will be achieved through (a) strengthening the regulatory framework; (b) establishing institutional mechanisms and arrangements for implementation, coordination, and monitoring; and (c) enhancing institutional capacity through training, better guidelines, and development of standards.** Some of the key measures in the ESSA PAP include the following:

- The MoH and the Ministry of Population and Environment (MoPE) to develop a costed integrated infection control and health care waste management strategy by Year 1 and collaborate on revision of the draft health care waste management regulations for submission for consideration by the Cabinet by Year 2 of the Program.

- The MoH to revise and expand the GESI strategy and improve its mainstreaming for more equitable and coordinated provision of services including through one-stop crisis centers. This will include piloting of citizen feedback mechanisms and systems for public reporting.

67. **The findings of the ESSA and the recommended measures and actions were discussed with a wide range of stakeholders.** The DLI Management and Coordination Unit at the MoH will be responsible for the implementation of the PAP including key actions recommended in the ESSA in Year 1. This will be done in collaboration with the Management Division of the DoHS and Curative Division of the MoH. As part of the strategy development, the MoH will need to design an institutional arrangement that will be responsible for the coordination and implementation of the action plan and liaison with MoPE and other stakeholders on the regulations and other technical issues. Monitoring and supervision of due diligence measures related to environmental and social issues will be a part of World Bank implementation support.

68. **Communities and individuals who believe that they are adversely affected as a result of a Bank supported PforR operation, as defined by the applicable policy and procedures, may submit complaints to the existing Program grievance redress mechanism or the World Bank's Grievance Redress Service (GRS).** The GRS ensures that complaints received are promptly reviewed in order to address pertinent concerns. Affected communities and individuals may submit their complaint to the WB's independent Inspection Panel which determines whether harm occurred, or could occur, as a result of WB non-compliance with its policies and procedures. Complaints may be submitted at any time after concerns have been brought directly to the World Bank's attention, and Bank Management has been given an opportunity to respond. For information on how to submit complaints to the World Bank's corporate Grievance Redress Service (GRS), please visit http://www.worldbank.org/GRS. For information on how to submit complaints to the World Bank Inspection Panel, please visit www.inspectionpanel.org

69. The PforR was screened for climate and disaster risk on August 23, 2016. The results provide a characterization of risks caused by climate and geophysical hazard on program sub-sector and components. The potential impact due to exposure from hazards is low to moderate with the exception of earthquake and landslide where the risk is high. Likewise, the overall risk to the intended program outcome is low to moderate.

D. Risk Assessment

70. **The overall integrated risk of the Program is rated as High.** Although the technical design of the Government program is sound and is built on wide consultations, sector management and institutional capacities in the MoH are weak.

71. The High risk on 'Political and Governance' is largely due to the unstable political context where policy decisions may be undermined in an uncertain political environment. The shape and impact of federalism, as promulgated in the constitution, is so far uncertain, and this could have an impact on the existing institutional structures being utilized to deliver health

services and the Program. Fiduciary management in the health sector remains a concern with weak controls and reporting systems.

72. The risk rating for 'Institutional Capacity for Implementation and Sustainability' is High. As with most ministries in Nepal, the implementing agency faces major institutional capacity issues. Specifically, in the MoH, the majority of professionals are medical doctors with limited management skills and training. As a result, critical areas of sector management such as PFM and procurement remain inappropriately staffed.

73. The High risk on 'Fiduciary' is primarily due to an environment of poor transparency and accountability where public resources are often not used appropriately. The last five years have seen persisting audit irregularities (an increasing trend) and ineffective follow-up of audit findings. In addition, the procurement of equipment and medical supplies are highly risk-prone areas. Procurement reform is critical to the success of the Program and requires key institutional reforms within the LMD, which in turn demands political and administrative will.

74. The PforR recognizes the above mentioned risks and supports, both through DLIs and through the PAP, the development of sustainable mitigation mechanisms through policy and institutional reforms to facilitate more systemic transparency in procurement and in the use of public resources. It also supports a series of reforms that will support better reporting and monitoring of public finances and better internal controls within the MoH. Accountability will be improved through grievance redressal and citizen engagement mechanisms.

E. Program Action Plan

75. The Program Action Plan was developed based on recommendations of the technical assessment, the FSA and ESSA and Risk Assessment. Since the design of the PforR is such that the DLIs address a large number of recommendations of the assessments carried out by the Bank, the PAP includes additional critical actions agreed with the Government to further improve public sector management and access in Nepal. The implementation of this plan will be monitored and reviewed annually during the Joint Annual Review with MoH and the DPs. See Annex 8 for details.

Annex 1: Detailed Program Description

A. Overview and Government's Program

1. The NHSS 2015–21 outlines the Government's program toward achieving its goal of universal health coverage. It operationalizes the Nepal Health Policy 2014, which aims at developing people-centered and efficient management through the optimal utilization of available means and resources to provide promotive, preventive, curative, and rehabilitative health services. Its thematic areas and resultant outcomes include service delivery and equity; strengthened health systems including financial management and procurement; strengthened quality of care; monitoring and evidence-based decision-making; decentralized planning; and sound response to emerging diseases and emergencies. The strategy is built on the recognition that increased accountability and transparency in the use of public procurement and financial management systems is the critical foundation for further improvement in access and quality of service delivery. Improving the use of public resources through better management and targeting is key to Nepal achieving its goals of UHC.

2. The estimated Government budget to implement the NHSS is US$2,662 million, as detailed in Table 1 in the main text.

B. Program Development Objective

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

C. Program Scope and Typology of Activities

4. The Program will support a subset of the larger NHSS program of the GoN, focusing on specific NHSS outcomes in critical areas of public management reforms: public procurement, PFM, evidence-based decision-making based on improved monitoring and reporting, and citizen engagement. The Government's reform program recognizes that improved health outcomes hinge on the ability of the MoH to direct public resources to areas of need and to react to and make evidence-based decisions. While it is important to continue to focus on investing to expand service delivery and equity outcomes, in the absence of robust institutional mechanisms for PFM, procurement of drugs, and evidence-based decision-making, these investments and initiatives are not sustainable.

5. The Program boundaries of the PforR operation will include those outcomes / sub-outcomes of the NHSS that focus on strengthening supply and demand-side constraints of institutional performance. Specifically, the Program interventions aim to improve the timeliness of drug availability and quality. This includes improving the capacity of the MoH to manage public procurement through strengthening the capacity of the LMD and establishing mechanisms for logistics management and quality assurance. PFM will be strengthened by linking every spending unit in the health sector with an online expenditure tracking and management system and strengthening the overall audit function. At the same time, the Program also supports better planning and targeting through strengthening data availability and analysis. Demand-side accountability mechanisms to integrate citizen engagement into the process of public governance will also be supported. Together, these inputs will support more efficient use of resources for targeted and better service delivery over time. Establishing rigorous institutional systems and sound accountability mechanisms requires long-term changes in the process and institutional culture. Program financing moves away from transaction intensive investments on goods and services toward an incentive-based, results-

oriented approach that fits better with the outcomes it seeks to achieve—that is, the more effective use of public resources. Improved institutional capacities will strengthen governance and accountability and enable the public health system in Nepal to be more efficient and allow for more equitable service delivery.

6. The NHSS scope covers the entire health sector and the financing plan includes Government financing and on-budget, off-budget, and TA support from donors. Annual budgets would be allocated by the MoF based on the Annual Work Plan and Budget (AWPB) prepared by the MoH and would include all the budgets of its departments, divisions, and programs. The estimated projected costs for the NHSS of US$2,662 million is adequate for meeting the projected outcomes and emerges from detailed analysis done by the Government, supported by WHO.

7. Expenditures of the Program are related to those expenditures in the annual budget that finance consumption, operational and service, and production expenses as articulated in the budget. The Program supports institutional reform and therefore, the Program does not include the procurement of good, works or services under high value contracts (above OPRC threshold levels). Any person or entity debarred or suspended by the Bank will not be awarded a contract under or otherwise allowed to participate in the Program during the period of such debarment or suspension, per the Bank's Guidelines on Preventing and Combating Fraud and Corruption in PforR Financing (dated February 1, 2012 and revised July 10, 2015). Table 4.3 in Annex 4 (Technical Assessment) describes the main components of the expenditure program supported by the PforR.

8. The PforR operation supports the Program through a series of DLIs, which form the basis for disbursement. These DLIs correspond to the key priority areas of the Government's NHSS program and particularly, on the major bottlenecks along the results chain and provide incentives for removing these to improve public resource management in the health sector. There are 11 DLIs that focus on critical aspects of health sector management, including priority areas in procurement and PFM in the health sector, and reporting and information management for better evidence-based planning. The achievements of these DLIs will support the NHSS to achieve its Outcomes 1, 4, 5, 6, and 9 and establish a robust institutional framework for public management, accountability, and transparency in the health sector. Table 1.1 summarizes the DLIs by result areas.

Table 1.1. DLIs by Result Areas

Result Areas	DLI
1. Improved Public Procurement	**DLI 1:** Percentage of contracts managed by the LMD through the PPMO's online e-procurement portal. **DLI 2:** Production and submission of Annual Report on grievances received and addressed through a web based Grievance Redressal Mechanism. **DLI 3:** Percentage of procurements done by the LMD using standard specifications. **DLI 4:** Percentage of district stores reporting based on the LMIS. **DLI 5:** Percentage reduction of stock-outs of tracer drugs in district stores.

	DLI 6: Percentage improvement in EVM score over 2014 baseline.
2. Improved Financial Management	**DLI 7:** Percentage of all MoH spending entities submitting annual plan and budget using eAWPB. **DLI 8:** Percentage of the MoH's annual spending captured by TABUCS. **DLI 9:** Percentage of audited spending units responding to the OAG's primary audit queries within 35 days.
3. Improved Reporting and Information Sharing for Enhanced Accountability and Transparency	**DLI 10:** Percentage of districts which have all facilities reporting annual disaggregated data using DHIS 2. **DLI 11:** Operationalization of the citizen feedback mechanisms and systems for public reporting.

Result Area 1: Improved Public Procurement

9. DLIs 1 to 6 support the Government's institutional reform plan for procurement and supply chain management.

(a) Enhanced institutional capacity in the MoH for managing procurement. Health sector procurement is highly technical and complex. This requires a team with specialized skills and adequate tenure. The LMD has neither the systems nor human resources in place to manage and monitor procurement. The Program will support reforms aimed at enhancing management capacity and accountability. The following results would be incentivized through DLIs 1, 2 and 3 to achieve this objective: (i) increasing use of an online e-procurement portal (developed by the PPMO) for procurement of drugs and equipment; and standard bidding documents for drugs and equipment developed for use through e-procurement; (ii) web-based grievance redressal mechanism established for all procurements done at the LMD, including actions taken on the grievances received; and (iii) the use of standard specifications for procurement of the basic package of drugs and essential equipment.

(b) Effective operational logistics and supply chain management system. The MoH does not have a robust logistics and supply chain management system (LMIS) which makes it difficult to assess the availability of drugs at the regional and district level. The following results would be incentivized through DLIs 4-6 to achieve this objective: (i) the LMIS software revised to produce real-time web-based information available for use up to district level for managing and reporting inventory of drugs; (ii) central warehouse and district store personnel trained on revised LMIS; (iii) integrated LMIS report received at the central database; (iv) reduction in stock-outs of tracer drugs in district stores; and (v) the EVM score improved.

Result Area 2: Improved Financial Management

10. DLIs 7 to 9 support the Government's institutional reform plan for improving the entire planning, budgeting, expenditure, and monitoring cycle.

(a) Adherence by all spending units to mandated budget planning and preparation and submission guidelines. While guidelines exist for planning for health expenditure and timely budget submissions, these are rarely followed because of system and capacity constraints and lack of monitoring. To move from an ad hoc system to a more systematic and accountable system of planning and budgeting, the following results would be incentivized through DLI 7: (i) the MoH endorses implementation plan for capacity building for budget planning and preparation; (ii) the MoH endorses training manuals for planning and budget preparation; and (iii) spending units within the MoH comply with the budget preparation calendar.

(b) Comprehensive and timely reporting of sector expenditure through an online system - TABUCS. Manual reporting of expenditure leads to poor monitoring and a lack of accountability in budget execution. An online reporting system—TABUCS—was introduced under NHSP 2. Assessments indicate that changes are required in reporting and monitoring templates and incentives need to be created for rolling this out across the country. The following results would be incentivized through DLI 8: (i) TABUCS' expenditure reporting and monitoring templates revised; (ii) revised TABUCS rollout plan prepared; and (iii) spending of the AWPB captured by TABUCS.

(c) Timely and satisfactory responses to audit reports in the health sector**.** Compliance with internal controls remains weak and a lack of response to audit observations leads to a perception that accountability is weak and that resources may not be used for intended purposes in an efficient and economical manner. The Program will support incentives to improve responses to audit queries through the establishment of a credible audit clearance arrangement and support the clearance of outstanding observations. The following results would be incentivized through DLI 9: (i) the MoH prepares an action plan for ensuring that the spending units respond to audit query recommendations on time; and (ii) the MoH responds to audit queries within 35 days of the OAG's Primary Report.

Result Area 3: Improved Reporting and Information Sharing for Enhanced Accountability and Transparency

11. DLIs 10 and 11 strengthen the MoH's system for reporting and sharing information through improved systems for data capture and monitoring of disaggregated data and the development of mechanisms for public access to information and piloting of citizen engagement mechanisms.

(a) Improved monitoring mechanisms for service delivery. The following result would be incentivized through DLI 10: phased rollout of the DHIS 2 to 75 percent of all districts in Nepal.

(b) Enhanced citizen engagement. The following results would be incentivized through DLI 11: (i) supporting the development of a strategy and implementation mechanisms for obtaining citizen feedback in specific areas including availability of drugs and health care providers; and (ii) supporting through regular public dissemination of citizen feedback reports through appropriate channels.

D. Institutional Arrangements for the Program

12. The institutional arrangements for the Program will support the various reform areas envisioned under this PforR. The MoH will be responsible for implementing the activities of the Program through its various organizational structures including its departments, divisions, and centers. The MoH will make arrangements for financing procurement, human resources, and technical expertise to achieve agreed DLIs. The MoH will inform IDA upon the achievement of DLI targets. The MoH report regarding the DLI achievement will include a detailed report prepared by the IVA according to the verification protocols agreed between the MoH and IDA.

13. A DLI Management and Coordination Unit at the MoH chaired by the chief of the PPICD will support implementation of the Program. It will include director generals of all departments, director of the LMD, head of the Human Resource and Financial Management Division, and the accounts officer of the MoH. There will be a Program Steering Committee, which meets quarterly, chaired by the secretary of the MoH, and includes the director general, DoHS; the chair, PPICD; the head of the Human Resource and Financial Management Division, and a representative from the MoF. Representation from the FCGO and the OAG will be invited as needed. The Steering Committee will provide overall guidance, resolve specific issues, and ensure inter-ministerial and sectoral coordination. Day-to-day implementation and monitoring of results in the four key areas will be the responsibility of the LMD director for procurement-related DLIs; the head of the Human Resources and Financial Management Division for PFM-related DLIs; the director, Management Division, DoHS for M&E and DHIS 2; and the director, Primary Healthcare and Revitalization Division for citizen engagement.

14. The team formed at the MoH will take the responsibility of overseeing all the Program activities elaborated in the document. While the obligation of oversight rests on the MoH, the success of achieving the results lies on the efforts of various units within the MoH, toward working on the DLIs. The MoH will, therefore, work with its relevant departments, divisions, and centers, and motivate, incentivize, and regularly monitor their activities. There are three departments: (a) the DoHS; (b) the Department of Drug Administration; and (c) the Department of Ayurveda. Under the DoHS, there are various divisions including Child Health, Family Health, Epidemiology and Disease Control, Leprosy Control, and the Management Division, and the LMD. Under the MoH, there are other divisions including Population Division, Primary Health Care Revitalization Division, Curative Division, Human Resource and Financial Management Division, PPICD, and various centers such as the National Center for AIDS and STD Control, National Tuberculosis Center, and National Information, Education and Communication Center. The LMD is the primary procurement agency of the MoH.

Annex 2: Results Framework Matrix

Results Framework

PDO: The Program Development Objective is to improve efficiency in public resource management systems of the health sect								
PDO Indicator	**DLI #**	**Measure**	**Baseline**	**Results**				
				Year 1	**Year 2**	**Year 3**	**Year 4**	**Y**
PDO Indicator 1: Percentage reduction of stock-outs of tracer drugs	DLI 5	Percentage	Percentage as evidenced by LMIS data in year 3	—	—	—	15% reduction in stock-outs of tracer drugs in at least two regions over the baseline established in year 3 through the LMIS	25% red stock-ou tracer dr least tw over the establish 3 throug LMIS
PDO Indicator 2: Percentage of the MoH's annual spending captured by TABUCS	DLI 8	Percentage	70%	—	80% of MoH's annual spending captured by TABUCS	85% of MoH's annual spending captured by TABUCS	90% of MoH's annual spending captured by TABUCS	95% of annual s capture
PDO Indicator 3: Percentage of districts which have all facilities reporting annual disaggregated data using DHIS 2	DLI 10	Percentage	0%	—	Reports based on DHIS 2 available from all District Health Offices (DHOs)	Disaggregated DHIS 2 reports available for all facilities in 25% of districts	Disaggregated DHIS 2 reports available for all facilities in 50% of districts	Disaggr DHIS 2 availabl facilitie districts

Intermediate Indicator	DLI #	Measure	Baseline	Results				
				Year 1	Year 2	Year 3	Year 4	
Result Area 1: Improved Public Procurement								
(a) Percentage of contracts managed by LMD through PPMO's online e-procurement portal and production and submission of annual report on grievances received and addressed through a web-based Grievance Redressal Mechanism	DLI 1	Percentage	No contract is through online e-procurement developed by PPMO	(i) Training on the use of PPMO's online e-procurement completed for at least 20 MoH staff; (ii) standard bidding documents for drugs and equipment developed for online e-procurement	60% of value of total contracts managed by LMD done through online e-procurement	70% of value of total contracts managed by LMD done through online e-procurement	80% of value of total contracts managed by LMD done through online e-procurement	9 o c m L th o p
	DLI 2	Text	Web-based Grievance Redressal Mechanism for procurement is not established	Guidelines for Grievance Redressal Mechanism endorsed by MoH	(i) Web-based Grievance Redressal Mechanism established and functioning; (ii) training completed for all levels of staff responsible for grievance handling	Annual report on grievances received and addressed	Annual report on grievances received and addressed	A o re ac

Intermediate Indicator	DLI #	Measure	Baseline	Results				
				Year 1	Year 2	Year 3	Year 4	
(b) Percentage of procurements done by the LMD using standard specifications	DLI 3	Percentage	Not based on standard specifications	Standard specifications for basic package of drugs to be procured by LMD endorsed by MoH	70% of procurement of basic package of drugs based on the use of standard specifications Standard specifications for essential equipment to be procured by LMD and endorsed by MoH	80% of procurement of basic package of drugs and essential equipment based on the use of standard specifications	90% of procurement of basic package of drugs and essential equipment based on the use of standard specifications	9 p o p d e e b u s s
(c) Percentage of district stores reporting based on the LMIS	DLI 4	Percentage	0	—	—	—	LMIS reports received from all central warehouses, and all district stores of at least two regions	LM rec all wa and sto lea reg
(d) Installation of the LMIS to produce real-time web-based information	IO	Milestone	Real-time web-based LMIS not in place	—	Installation of LMIS to produce real-time web-based information in all central warehouses	—	—	—

Intermediate Indicator	DLI #	Measure	Baseline	Results				
				Year 1	Year 2	Year 3	Year 4	
(e) Training on LMIS completed in central warehouses and district stores	IO	Milestone	—	—	—	Training on operation of LMIS and installation completed for all central warehouses and district stores and baseline data generated for stock-outs of tracer drugs	—	—
(f) Percentage improvement in EVM score over 2014 baseline	DLI 6	Percentage	Average EVM score of 64%, with two attributes achieving 80%	—	Average EVM score of 70% (based on 2016 Survey), with at least three attributes achieving 80%	—	Average EVM score of 80% (based on 2018 Survey) with any six attributes achieving 80%	—
Result Area 2: Improved Financial Management								
(g) Percentage of all MoH spending entities submitting annual plan and budget using eAWPB	DLI 7	Percentage	Not all spending units submitting annual plan and budget using eAWPB	Access to operate eAWPB provided to MoH, all its departments, divisions, and centers.	eAWPB used for plan and budget submission by MoH and all departments, divisions, and centers	eAWPB used for plan and budget submission by MoH, all departments, divisions, and centers and 25% of the spending units	eAWPB used for plan and budget submission by MoH, all departments, divisions, centers, and 50% of the spending units	e fo bu su M de di ce 1 de sp u

Intermediate Indicator	DLI #	Measure	Baseline	Results				
				Year 1	Year 2	Year 3	Year 4	
(h) Percentage of audited spending units responding to the OAG's primary audit queries within 35 days	DLI 9	Percentage	Percentage as derived from MoH inventory of responses in the first year	All reports containing primary audit queries received by audited spending units available at the MoH and inventory of responses by date provided by individual audited spending units available at the MoH.	10 percentage points increase in the number of audited institutions responding to primary audit queries within 35 days over percentage derived from the MoH inventory of responses of the previous year	20 percentage points increase in the number of audited institutions responding to primary audit queries within 35 days over percentage derived from the MoH inventory of responses of the previous year	20 percentage points increase in the number of audited institutions responding to primary audit queries within 35 days over percentage derived from the MoH inventory of responses of the previous year	1 p i n a i r p q 3 p d t i r t y
Result Area 3: Improved Reporting and Information sharing for Enhanced accountability and Transparency								
(i) DHIS 2 implementation roadmap finalized	IO	Milestone	No DHIS 2	Plan for roll out of DHIS 2 finalized	—	—	—	—

Intermediate Indicator	DLI #	Measure	Baseline	Results				
				Year 1	Year 2	Year 3	Year 4	
(j) Operationalization of the citizen feedback mechanisms and systems for public reporting	DLI 11	Milestone	No citizen feedback mechanism in place	Citizen engagement mechanism options and public reporting systems developed by MoH for feedback on availability of drugs and facility- level services and disaggregated by gender	Selected different citizen engagement mechanisms piloted by MoH in six districts in different geographical regions	Citizen feedback reports, based on data from six pilots in targeted geographical areas, on availability of drugs and facility- level services and disaggregated by gender available in public domain including on MoH website	Citizen feedback reports, based on data from six pilots in targeted geographical areas, on availability of drugs and facility- level services and disaggregated by gender available in public domain including on MoH website	C fe re o si ta g a a d fa se d b a p i M

Note: IO = Intermediate Outcomes.

Annex 3: Disbursement-linked Indicators, Disbursement Arrangements, and Verification Proto

Disbursement-Linked Indicators	Baseline	Indicative Timeline for DLI achievement				
		Year 1 (July 16, 2016 – July 15, 2017)	**Year 2 (July 16, 2017 – July 15, 2018)**	**Year 3 (July 16, 2018 – July 15, 2019)**	**Year 4 (July 16, 2019 – July 15, 2020)**	
DLI 1: Percentage of contracts managed by the LMD through the PPMO's online e-procurement portal	No contract is through online e-procurement developed by the PPMO	**DLI Target 1.1** Training on the use of the PPMO's online e-procurement completed for at least 20 MoH staff (US$1,000,000) **DLI Target 1.2** Standard Bidding documents for drugs and equipment developed for online e-procurement (US$1,000,000)	**DLI Target 1.3** At least 60% of value of total contracts managed by LMD done through online e-procurement of Year 2	**DLI Target 1.4** 70% of value of total contracts managed by LMD done through online e-procurement of Year 3 (***Disbursement rule***: US$3,000,000 for 60% of total contracts managed by the LMD done through e-procurement and US$100,000 for every percentage point over 60% up to a maximum of 70% in Year 3)	**DLI Target 1.5** 80% of value of total contracts managed by LMD done through online e-procurement of Year 4 (***Disbursement rule***: US$2,000,000 for 70% of total contracts managed by the LMD done through e-procurement and US$100,000 for every percentage point over 70% up to a maximum of 80% in Year 4)	
DLI Value		**US$2,000,000**	**US$3,000,000**	**US$4,000,000**	**US$3,000,000**	
DLI 1 Total Allocation		**US$15,000,000**				
DLI 2: Production and submission of Annual Report on grievances received and addressed through a web-based Grievance Redressal Mechanism.	Web-based Grievance Redressal Mechanism not established	**DLI Target 2.1** Guidelines for Grievance Redressal Mechanism endorsed by MoH	**DLI Target 2.2** Web-based Grievance Redressal Mechanism established and functioning; and training completed for various levels of staff responsible for grievance handling.	**DLI Target 2.3** Annual Report on grievances received and addressed	**DLI Target 2.4** Annual Report on grievances received and addressed	

Disbursement-Linked Indicators	Baseline	Indicative Timeline for DLI achievement				
		Year 1 (July 16, 2016 – July 15, 2017)	**Year 2 (July 16, 2017 – July 15, 2018)**	**Year 3 (July 16, 2018 – July 15, 2019)**	**Year 4 (July 16, 2019 – July 15, 2020)**	
			(***Disbursement rule:*** US$1,500,000 for the establishment of the GRM and US$1,500,000 for completion of training)			
DLI Value		**US$2,000,000**	**US$3,000,000**	**US$2,000,000**	**US$2,000,000**	**U**
DLI 2 Total Allocation		**US$11,000,000**				
DLI 3: Percentage of procurements done by the LMD using standard specifications.	Procurement not based on standard specifications	**DLI Target 3.1** MoH endorses standard specifications for basic package of free drugs to be procured by LMD (US$4,000,000)	**DLI Target 3.2** For Year 2 procurement, 70% of procurement of basic package of free drugs based on the use of standard specifications[12] (US$2,000,000) **DLI Target 3.3** MoH endorses standard specifications for essential equipment to be procured by LMD[13] (US$1,000,000)	**DLI Target 3.4** For Year 3 procurement, 80% procurement of basic package of free drugs and essential equipment based on the use of standard specifications. (***Disbursement rule***: US$1,500,000 for the achievement of a target of 80% for the procurement of a package of free drugs; US$1,500,000 for the achievement of a target of 80% for the procurement of essential equipment)	**DLI Target 3.5** For Year 4 procurement, 90% procurement of basic package of free drugs and essential equipment based on the use of standard specifications. (***Disbursement rule***: US$1,000,000 for the achievement of a target of 90% for the procurement of a package of free drugs; US$1,000,000 for the achievement of a target of 90% for the procurement of essential equipment)	**D** F 9 b d e u s (U a c p p U a c p e
DLI Value		**US$4,000,000**	**US$3,000,000**	**US$3,000,000**	**US$2,000,000**	**U**

[12] In the event standard specifications are not being used for specific drugs, the Recipient will furnish to the Association an explanation of the deviation in a manner satis revised technical specification will have to be disclosed publicly prior to issuing the tender notice.

[13] Essential equipment list will be provided to the Bank by the MoH

Disbursement-Linked Indicators	Baseline	Indicative Timeline for DLI achievement				
		Year 1 (July 16, 2016 – July 15, 2017)	**Year 2 (July 16, 2017 – July 15, 2018)**	**Year 3 (July 16, 2018 – July 15, 2019)**	**Year 4 (July 16, 2019 – July 15, 2020)**	
DLI 3 Total Allocation		**US$14,000,000**				
DLI 4: Percentage of district stores reporting based on the LMIS.	LMIS not in place		**DLI Target 4.1** LMIS installed in all warehouses of the center and district stores of two regions[14]	**DLI Target 4.2** Training on, and installation and operation of, LMIS completed for all central warehouses and district stores of at least two regions; and baseline data generated for stock-outs of tracer drugs.	**DLI Target 4.3** LMIS reports for program Year 4 received from central and all district stores of two regions. (***Disbursement rule***: US$2,500,000 for LMIS reports received from central warehouses and all district stores of at least two regions, and additional US$500,000 provided for each additional region).	
DLI Value			**US$3,000,000**	**US$3,000,000**	**US$4,000,000**	
DLI 4 Total Allocation		***US$16,000,000***				
DLI 5: Percentage reduction of stock-outs of tracer drugs in district stores.	Percentage as evidenced by LMIS data in year 3 for at least two regions				**DLI Target 5.1.** 15% reduction in stock-outs of tracer drugs over the baseline established in Year 3 in district stores through the LMIS for at least two regions.	

[14] Regions refer to the five administrative development regions in Nepal. This organizational set up is likely to change with the establishment of the new Federal structu Constitution.

Disbursement-Linked Indicators	Baseline	Indicative Timeline for DLI achievement				
		Year 1 (July 16, 2016 – July 15, 2017)	**Year 2 (July 16, 2017 – July 15, 2018)**	**Year 3 (July 16, 2018 – July 15, 2019)**	**Year 4 (July 16, 2019 – July 15, 2020)**	
DLI Value					**US$4,000,000**	
DLI 5 Total Allocation		**US$10,000,000**				
DLI 6: Percentage improvement in EVM score over 2014 baseline.	Average EVM score of 64%, with two attributes achieving 80%		**DLI Target 6.1** Average EVM score of 70% (based on 2016 survey), with any 3 attributes in EVM score achieving 80% (***Disbursement rule:*** US$1,000,000 for achievement of EVM score of 70% and US$1,000,000 for achieving 80% in any 3 attributes)		**DLI Target 6.2** Average EVM score of 80% (based on 2018 survey) with any 6 attributes in EVM score achieving 80% (***Disbursement rule:*** US$1,000,000 for achievement of EVM score of 80% and US$1,000,000 for achieving 80% in any 6 attributes)	
DLI Value			**US$2,000,000**		**US$2,000,000**	
DLI 6 Total Allocation		**US$4,000,000**				
DLI 7: Percentage of the MoH spending entities submitting annual plan and budget using eAWPB.	Not all spending units submit their annual plan and budget using eAWPB	**DLI Target 7.1** MoH and all its departments, divisions, and centers are given access to operate on eAWPB	**DLI Target 7.2** eAWPB used for planning and budget submission by MoH and all departments, divisions, and centers	**DLI Target 7.3** eAWPB used in Year 3 for planning and budget submission by MoH and all departments, divisions, centers, and 25% of	**DLI Target 7.4** eAWPB used in Year 4 for plan and budget submission by MoH, all departments, divisions, centers, and 50% of	

Disbursement-Linked Indicators	Baseline	Indicative Timeline for DLI achievement				
		Year 1 (July 16, 2016 – July 15, 2017)	**Year 2 (July 16, 2017 – July 15, 2018)**	**Year 3 (July 16, 2018 – July 15, 2019)**	**Year 4 (July 16, 2019 – July 15, 2020)**	
				decentralized spending units	decentralized spending units	
DLI Value		**US$2,000,000**	**US$1,000,000**	**US$4,000,000**	**US$4,000,000**	**U**
DLI 7 Total Allocation		**US$15,000,000**				
DLI 8: Percentage of the MoH's annual spending captured by the TABUCS.	70%	**DLI Target 8.1** MoH has issued a circular mandating expenditure reporting through TABUCS by all spending units	**DLI Target 8.2** 80% of MoH's spending in Year 2 captured by TABUCS	**DLI Target 8.3** 85% of MoH's spending in Year 3 captured by TABUCS	**DLI Target 8.4** 90% of MoH's spending in Year 4 captured by TABUCS	**D** 9 i T
DLI Value		**US$4,000,000**	**US$4,000,000**	**US$4,000,000**	**US$4,000,000**	**U**
DLI 8 Total Allocation		**US$20,000,000**				
DLI 9: Percentage of audited spending units responding to the OAG's primary audit queries within 35 days.	Percentage as derived from MoH inventory of responses in Year 1	**DLI Target 9.1** All reports containing primary audit queries received by audited spending units are available at MoH; and inventory of responses by date provided by individual audited spending units are available at MoH (***Disbursement rule:*** US$2,000,000 for reports being available at MOH; and US$1,000,000 for inventory of	**DLI Target 9.2** 10 percentage points increase in audited institutions responding to primary audit queries within mandated 35 days over percentage derived from the MoH inventory of responses of Year 1	**DLI Target 9.3** 20 percentage points increase in audited institutions responding to primary audit queries within mandated 35 days over percentage derived from the MoH inventory of responses of Year 2	**DLI Target 9.4** 20 percentage points increase in audited institutions responding to primary audit queries within mandated 35 days over percentage derived from the MoH inventory of responses of Year 3	**D** 1 i i p w o f o

Disbursement-Linked Indicators	Baseline	Indicative Timeline for DLI achievement				
		Year 1 (July 16, 2016 – July 15, 2017)	**Year 2 (July 16, 2017 – July 15, 2018)**	**Year 3 (July 16, 2018 – July 15, 2019)**	**Year 4 (July 16, 2019 – July 15, 2020)**	
		responses available at MOH)				
DLI Value		**US$3,000,000**	**US$3,000,000**	**US$3,000,000**	**US$3,000,000**	**U**
DLI 9 Total Allocation		**US$15,000,000**				
DLI 10: Percentage of districts which have all facilities reporting annual disaggregated data using District Health Information System (DHIS 2).	0%	**DLI Target 10.1** Plan for roll out of DHIS 2 finalized and DHIS 2 rolled out up to DHO level (***Disbursement rule:*** US$1,000,000 for plan finalized and US$2,000,000 for the roll out of DHIS2)	**DLI Target 10.2** Reports based on DHIS 2 available from all DHOs	**DLI Target 10.3** Disaggregated DHIS 2 reports available for all facilities in 25% of districts	**DLI Target 10.4** Disaggregated DHIS 2 reports available for all facilities in 50% of districts	**D** D r f d
DLI Value		**US$3,000,000**	**US$3,000,000**	**US$4,000,000**	**US$5,000,000**	**U**
DLI 10 Total Allocation		**US$20,000,000**				
DLI 11: Operationalization of the citizen feedback mechanisms and systems for public reporting.	No institutionalized citizen feedback mechanisms in place	**DLI Target 11.1** Citizen engagement mechanism options and public reporting systems developed by MoH for citizens' feedback, including on availability of drugs and facility level services and disaggregated by gender	**DLI Target 11.2** Pilot of citizen engagement mechanisms completed in 6 targeted districts	**DLI Target 11.3** Citizen feedback reports produced at the end of each pilot, made available on the MoH's website for the 6 targeted pilots. (***Disbursement rule***: US$1,100,000 for citizen feedback reports produced at the end of each pilot, made available on the MoH's website for the 3 targeted pilots; and	**DLI Target 11.4** Citizen feedback reports produced at the end of each pilot, made available on the MoH's website for the 6 targeted pilots. (***Disbursement rule***: US$1,100,000 for citizen feedback reports produced at the end of each pilot, made available on the MoH's website for the 3 targeted pilots; and	**D** C p e a w p

Disbursement-Linked Indicators	Baseline	Indicative Timeline for DLI achievement				
		Year 1 (July 16, 2016 – July 15, 2017)	**Year 2 (July 16, 2017 – July 15, 2018)**	**Year 3 (July 16, 2018 – July 15, 2019)**	**Year 4 (July 16, 2019 – July 15, 2020)**	
				$300,000 for reports from every additional targeted pilot up to a maximum of 3 additional targeted pilots)	$300,000 for reports from every additional targeted pilot up to a maximum of 3 additional targeted pilots)	
DLI Value		**US$2,000,000**	**US$2,000,000**	**US$2,000,000**	**US$2,000,000**	**U**
DLI 11 Total Allocation		**US$10,000,000**				
Total DLI Allocation		**US$150,000,000**				

DLI Verification Protocol Table
Independent Verification Agency: NHRC

	DLIs	Definitions/Description of Achievement	Protocol to Verify Achievement	
			Data Source	Based on Submitted Doc its Own Independent F NHRC
1	Percentage of contracts managed by the LMD through the PPMO's online e-procurement portal	Contracts managed by the LMD done through online e-procurement portal developed by the PPMO.	MoH, LMD, and PPMO records	Year 1 - Verify that at leas have completed training or procurement portal develo Year 1 - Verify that standa for drugs and equipment h endorsed by the PPMO for procurement portal. Years 2, 3, 4, and 5 - Verif 80%, and 90% of the value awarded by the LMD have procurement by cross chec plan and documenting the s Also, provide a report on th value of total contracts awa through e-procurement of Y
2	Production and submission of Annual Report on grievances received and addressed through a web based Grievance Redressal Mechanism.	Grievance redressal mechanism established.	LMD and MoH records	Year 1 - Verify from the M guidelines for a web-based mechanism have been end Year 2 - Verify that a softw grievance redressal mecha use. Year 2 - Verify that staff a responsible for handling gr the use of the software. Years 3, 4, and 5 - Verify t submitted by the MoH on responded correspond to th website on grievance redre
3	Percentage of procurements done by the LMD using standard specifications.	Standard specifications for basic package of free drugs and essential equipment, to be procured by the LMD,	LMD's data source, LMIS, records, MoH records	Year 1 - Verify that the M a public notification, stand basic package of free drug

	DLIs	Definitions/Description of Achievement	Protocol to Verify Achievement	
			Data Source	Based on Submitted Doc its Own Independent E NHRC
		developed, endorsed, and used by the MoH.		Year 2 - Verify through exa documents, that 70% of the package of free drugs is do endorsed standard specifica
				Year 2 - Verify that the Mo notification, has endorsed for essential equipment pro
		Procurement of basic package of drugs and essential equipment based on the specified and agreed standards.		Year 3 - Verify, through ex documents, that 80% of th package of free drugs and done by the LMD using or endorsed standard specific
				Year 4 - Verify, through ex documents, that 90% of th package of free drugs and done by the LMD using or endorsed standard specific
				Year 5 - Verify, through ex documents, that 90% of th package of free drugs and done using or continuing t standard specifications.
4	Percentage of district stores reporting based on the LMIS.	Central web-based information on inventory of drugs available at the district stores and central warehouses.	LMIS	Year 2 - Verify through site warehouses that web-based installed.
		Central warehouses and district stores personnel trained on the LMIS.		Year 3 - Verify through the training has been conducte personnel at the central wa stores of at least two regio stock-outs of tracer drugs is

	DLIs	Definitions/Description of Achievement	Protocol to Verify Achievement	
			Data Source	Based on Submitted Doc its Own Independent E NHRC
		The LMIS report received from central warehouses and district stores.		Year 4 - Verify through an reports from all central war stores in minimum of two r the MoH. Also report on st received from all district st regions. Year 5 - Verify through an LMIS reports from the all c all district stores in minimu accessible or continue to be Also report on status of the from all district stores of re
5	Percentage reduction of stock-outs of tracer drugs in district stores.[1]	Reduction in stock-outs of tracer drugs at district stores in two regions. These regions will be identified and notified to IDA by Year 3 when the baseline will also be made available.	LMIS	Year 4 - Verify through an tracer drugs from district st overall reduction in stock-o the Year 3 LMIS baseline. Year 5 - Verify through an tracer drugs from district st overall reduction in stock-o the Year 3 LMIS baseline.
6	Percentage improvement in EVM score over 2014 baseline.	EVM based on nine attributes[2] measured every two years in the country by a joint team of the MoH, WHO, and UNICEF.	Joint MoH, WHO, and UNICEF survey reports of 2016 and 2018	Year 2 - Verify from the jo UNICEF assessment, that t improved from 64% (basel to 70% (2016 survey report Year 2 - Verify from the jo UNICEF assessment, that a attributes achieved 80% (20 any 2 attributes achieving 8 Year 4 - Verify from the jo UNICEF assessment that th improved to 80% (based on Year 4 - Verify from the jo UNICEF assessment that a attributes achieved 80% (ba

	DLIs	Definitions/Description of Achievement	Protocol to Verify Achievement	
			Data Source	Based on Submitted Doc its Own Independent F NHRC
7	Percentage of all MoH spending entities[3] submitting annual plan and budget using eAWPB.	AWPB submitted by all MoH spending entities using eAWPB.	MoH reports/records eAWPB software of MoH	Year 1 - Verify that the Mo departments, divisions, and operate on the eAWPB by out from the eAWPB at eve above. Year 2 - Verify through an eAWPB has been used by departments, divisions, and their AWPB. Year 3 - Verify through an eAWPB has been used by departments, divisions, and decentralized spending uni AWPB. Year 4 - Verify through an eAWPB has been used by departments, divisions, cer decentralized spending uni AWPB. Year 5 - Verify through an eAWPB has been used by departments, divisions, cer decentralized spending uni AWPB.
8	Percentage of the MoH's annual spending captured by TABUCS.	Annual spend of the MoH captured by TABUCS - an online expenditure tracking system.	MoH record and report from TABUCS and treasury single account (TSA) (FCGO/MoF)	Year 1 - Verify the issuanc circular mandating expend TABUCS by all spending Year 2 - Verify through an MoH that expenditure repo comprises at least 80% of 2, and provide report of ac Year 3 - Verify through an MoH that expenditure repo comprises at least 85% of Year 3 and provide report

	DLIs	Definitions/Description of Achievement	Protocol to Verify Achievement	
			Data Source	Based on Submitted Doc its Own Independent F NHRC
				Year 4 - Verify through an MoH that expenditure repo comprises at least 90% of Year 4 and provide report
				Year 5 - Verify through an MoH that expenditure repo comprises at least 95% of Year 5 and provide report
9	Percentage of audited spending units responding to the OAG's primary audit queries within 35 days.	Audited spending units to respond to the OAG's primary audit queries within 35 days of receiving the report.	MoH records and the OAG's primary and final reports	Year 1 - Verify at the MoH reports containing primary by audited spending units and match this with the nu audited by the OAG.
				Year 1 – Verify at the MoH inventory of the responses spending units by date. Ve provide a report containing between receipt of primary response to it by the spend baseline indicating the per institutions that responded
				Years 2, 3, 4, and 5 - Verif MoH inventory data the pe in number of audited instit primary audit queries with audit report, over the achie year.
10	Percentage of districts which have all facilities reporting annual disaggregated data using DHIS 2.	Data disaggregated by geography, gender, and ethnicity reported by facilities using DHIS 2.	MoH records and website	Year 1 - Verify at the MoH implementation of the DH
				Year 1 - Verify through a r 20% of the districts that D checking that the software
				Year 2 - Verify through on that reports based on DHIS districts are accessible.

	DLIs	Definitions/Description of Achievement	Protocol to Verify Achievement	
			Data Source	Based on Submitted Doc its Own Independent F NHRC
				Year 3 - Verify through on that disaggregated DHIS 2 in 25% of the districts are
				Year 4 - Verify through on that reports based on disag from all facilities in 50% o accessible.
				Year 5 - Verify through on that reports based on disag from all facilities in 75% o accessible.
11	Operationalization of the citizen feedback mechanisms and systems for public reporting.	Institutionalized citizen feedback mechanisms and public reporting system in place.	MoH reports and MoH website	Year 1 - Verify at the MoH document describing optio mechanisms and public rep feedback on availability of services and disaggregated
				Year 2 - Verify through ra pilot sites that citizen enga six targeted districts in diff (mountains, hills, and terai
				Years 3, 4, and 5 -Verify e checks that citizen feedbac from ongoing six pilots, in drugs and facility-level ser MoH website.

Note:

1. While the list of tracer drugs remains to be officially endorsed by the MoH, these currently include: Albendazole, Amoxicillin Tab/Cap, Ben ointment, Chloramphenicol Caps/Application, Ciprofloxacin infusion/ear/eye-drop, Cotrimoxazole suspension or dispersible pediatric dozed ta combination tablet, Gentamycin Injection, Metronidazole tab/syrup, ORS, Oxytocin (orther uterotonic), Paracetamol tablet/injection, Povidone Salbutamol tab/inhaler, Zinc Sulphate tab, Isoniazid+Rifampicin +Pyrazinamide (RHZ), Ringers Lactate, and Vitamin A.
2. Pre-shipment and arrival procedures apply to primary store level only; storage within recommended temperature ranges; cold storage, dry st capacity. Including NUVI capacity; buildings, cold chain equipment and transport systems; maintenance; stock management; distribution; app management policies; information systems and supportive management functions.
3. Spending entities within the MoH – its three departments, 7 divisions, 5 centers, and 240 decentralized spending units at regional and distric of these spending units could change during the Program period. This change will be notified to IDA and recorded.

Bank Disbursement Table

#	DLI	Bank Financing Allocated to the DLI	Deadline for DLI Achievement	Minimum DLI Value to be Achieved to Trigger Disbursements of Bank Financing	Maximum DLI value(s) Expected to be Achieved for Bank Disbursement Purposes	Determinati Amount to against Achie DLI
1	Percentage of contracts managed by the LMD through the PPMO's online e-procurement portal.	SDR equivalent of US$15,000,000	DLI 1.1–1.6 (July 15, 2021)	DLI 1.4 (60%)	DLI 1.4 (70%)	DLI 1.1 [SDR US$1,000,000 the use of the procurement c least 20 MoH DLI 1.2 [SDR US$1,000,000 bidding docun and equipmen online e-procu DLI 1.3 [SDR US$3,000,000 of value of tot managed by th through online year 2. DLI 1.4 Maxi US$4,000,000 following rule of US$3,000,0 total contracts LMD done thr procurement a equivalent of every percenta 60% up to a m in year 3.

#	DLI	Bank Financing Allocated to the DLI	Deadline for DLI Achievement	Minimum DLI Value to be Achieved to Trigger Disbursements of Bank Financing	Maximum DLI value(s) Expected to be Achieved for Bank Disbursement Purposes	Determinati Amount to against Achie DLI
				DLI 1.5 (70%)	DLI 1.5 (80%)	DLI 1.5 Maxi US$3,000,000 following rule of US$2,000,0 total contracts LMD done thr procurement a equivalent of every percenta 70% up to a m in year 4].
				DLI 1.6 (80%)	DLI 1.6 (90%)	DLI 1.6 Maxi US$3,000,000 following rule of US$2,000,0 total contracts LMD done thr procurement a equivalent of every percenta 80% up to a m in year 5].
2	Production and submission of the Annual Report on grievances received and addressed through a web-based Grievance	SDR equivalent of US$11,000,000	DLI 2.1 – 2.5 (July 15, 2021)			DLI 2.1 [SDR US$2,000,000 for Grievance Mechanism en MoH. DLI 2.2 [SDR US$1,500,000 Grievance Rec

#	DLI	Bank Financing Allocated to the DLI	Deadline for DLI Achievement	Minimum DLI Value to be Achieved to Trigger Disbursements of Bank Financing	Maximum DLI value(s) Expected to be Achieved for Bank Disbursement Purposes	Determinati Amount to against Achie DLI
	Redressal Mechanism					Mechanism es functioning; a equivalent of for Training c various levels responsible fo handling. DLI 2.3 [SDR US$2,000,000 Report on grie and addressed DLI 2.4 [SDR US$2,000,000 Report on grie and addressed DLI 2.5 [SDR US$2,000,000 Report on grie and addressed
3	Percentage of procurements done by the LMD using standard specifications.	SDR-equivalent of US$14,000,000	DLI 3.1-3.6 (July 15, 2021)			DLI 3.1 [SDR US$4,000,000 endorsement o specifications of free drugs t the LMD. DLI 3.2 For y [SDR-equival US$2,000,000

#	DLI	Bank Financing Allocated to the DLI	Deadline for DLI Achievement	Minimum DLI Value to be Achieved to Trigger Disbursements of Bank Financing	Maximum DLI value(s) Expected to be Achieved for Bank Disbursement Purposes	Determinati Amount to against Achie DLI
						procurement c of free drugs b of standard sp DLI 3.3 [SDR US$1,000,000 endorsement c specifications equipment to LMD. DLI 3.4 For y - [SDR-equiva US$1,500,000 procurement c of free drugs b of standard sp [SDR-equival US$1,500,000 procurement c equipment bas standard speci DLI 3.5 For y - [SDR-equiva US$1,000,000 procurement c of free drugs b of standard sp [SDR-equival US$1,000,000 procurement c

#	DLI	Bank Financing Allocated to the DLI	Deadline for DLI Achievement	Minimum DLI Value to be Achieved to Trigger Disbursements of Bank Financing	Maximum DLI value(s) Expected to be Achieved for Bank Disbursement Purposes	Determinati Amount to against Achie DLI
						equipment bas standard speci DLI 3.6 For y -[SDR-equiva US$1,000,000 procurement c of free drugs b of standard sp [SDR-equival US$1,000,000 procurement c equipment bas standard speci
4	Percentage of district stores reporting based on the LMIS.	SDR-equivalent of US$16,000,000	DLI 4.1 - 4.4 (July 15, 2021)	DLI 4.3 and DLI 4.4 (reports from central and district	DLI 4.3 and DLI 4.4 (reports from central	DLI 4.1 [SDR US$3,000,000 installed in all warehouses ar of two regions DLI 4.2 [SDR US$3,000,000 and installatio of, the LMIS c central wareho stores of at lea and baseline d stock-outs of t DLI 4.3 Maxi [SDR-equival US$2,500,000

#	DLI	Bank Financing Allocated to the DLI	Deadline for DLI Achievement	Minimum DLI Value to be Achieved to Trigger Disbursements of Bank Financing	Maximum DLI value(s) Expected to be Achieved for Bank Disbursement Purposes	Determinati Amount to against Achie DLI
				stores of at least two regions)	and district stores in maximum five regions)	reports for pro received from warehouses ar stores of two r additional [SD US$500,000] additional regi DLI 4.4 Maxi [SDR-equival US$4,500,000 reports for pro received from warehouses ar stores of two r additional [SD US$500,000] additional regi
5	Percentage reduction of stock-outs of tracer drugs in district stores.	SDR-equivalent of US$10,000,000	DLI 5.1-5.2 (July 15, 2021)	DLI 5.2 (15%)	DLI 5.2 (25%)	DLI 5.1 [SDR US$4,000,000 reduction in st drugs over the established in the LMIS for a regions. DLI 5.2 Maxi US$6,000,000 of US$6,000,0 reduction in st drugs over the established in

#	DLI	Bank Financing Allocated to the DLI	Deadline for DLI Achievement	Minimum DLI Value to be Achieved to Trigger Disbursements of Bank Financing	Maximum DLI value(s) Expected to be Achieved for Bank Disbursement Purposes	Determinati Amount to against Achie DLI
						the LMIS for a regions. [SDR US$4,800,000 reduction in st equivalent of U for at least 15% stock-outs.
6	Percentage improvement in the EVM score over 2014 baseline.	SDR-equivalent of US$4,000,000	DLI 6.1 - 6.2 (July 15, 2021)			DLI 6.1 [SDR US$1,000,000 EVM score of [SDR-equivale US$1,000,000 attributes in E achieving 80% DLI 6.2 [SDR US$1,000,000 EVM score of equivalent of U for any 6 attrib score achievin
7	Percentage of the MoH spending entities submitting annual plan and budget using eAWPB.	SDR-equivalent of US$15,000,000	DLI 7.1 – 7.5 (July 15, 2021)			DLI 7.1 [SDR US$2,000,000 and all its dep divisions, and given access t eAWPB. DLI 7.2 [SDR US$1,000,000 used for plann

#	DLI	Bank Financing Allocated to the DLI	Deadline for DLI Achievement	Minimum DLI Value to be Achieved to Trigger Disbursements of Bank Financing	Maximum DLI value(s) Expected to be Achieved for Bank Disbursement Purposes	Determinati Amount to against Achie DLI
						submission by departments, c centers. DLI 7.3 [SDR US$4,000,000 used in year 3 budget submis and all departı centers, and 2 decentralized DLI 7.4 [SDR US$4,000,000 used in year 4 budget submis all department centers, and 5 decentralized DLI 7.5 [SDR US$4,000,000 used in year 5 budget submis and all departı centers, and al spending units
8	Percentage of the MoH's annual spending captured by the TABUCS	SDR-equivalent of US$20,000,000	DLI 8.1 – 8.5 (July 15, 2021)			DLI 8.1 [SDR US$4,000,000 issuing a circu expenditure re TABUCS by a

#	DLI	Bank Financing Allocated to the DLI	Deadline for DLI Achievement	Minimum DLI Value to be Achieved to Trigger Disbursements of Bank Financing	Maximum DLI value(s) Expected to be Achieved for Bank Disbursement Purposes	Determinati Amount to against Achie DLI
						DLI 8.2 [SDR US$4,000,000 MoH's spendi captured by T DLI 8.3 [SDR US$4,000,000 MoH's spendi captured by T DLI 8.4 [SDR US$4,000,000 MoH's spendi captured by T DLI 8.5 [SDR US$4,000,000 MoH's spendi captured by T
9	Percentage of audited spending units responding to the OAG's primary audit queries within 35 days	SDR-equivalent of US$15,000,000	DLI 9.1 – 9.5 (July 15, 2021)			DLI 9.1 [SDR US$2,000,000 containing pri queries receiv spending units the MoH; and of US$1,000,0 of responses b by individual units available DLI 9.2 [SDR US$3,000,000

#	DLI	Bank Financing Allocated to the DLI	Deadline for DLI Achievement	Minimum DLI Value to be Achieved to Trigger Disbursements of Bank Financing	Maximum DLI value(s) Expected to be Achieved for Bank Disbursement Purposes	Determinati Amount to against Achie DLI
						percentage po audited institu to primary auc mandated 35 c percentage der MoH inventor Year 1. DLI 9.3 [SDR US$3,000,000 percentage po audited institu to primary auc mandated 35 c percentage der MoH inventor Year 2. DLI 9.4 [SDR US$3,000,000 percentage po audited institu to primary auc mandated 35 c percentage der MoH inventor Year 3 DLI 9.5 [SDR US$3,000,000 percentage po audited institu

#	DLI	Bank Financing Allocated to the DLI	Deadline for DLI Achievement	Minimum DLI Value to be Achieved to Trigger Disbursements of Bank Financing	Maximum DLI value(s) Expected to be Achieved for Bank Disbursement Purposes	Determinati Amount to against Achie DLI
						to primary auc mandated 35 c percentage der MoH inventor Year 4.
10	Percentage of districts which have all facilities reporting annual disaggregated data using DHIS 2	SDR-equivalent of US$20,000,000	DLI 10.1 – 10.5 (July 15, 2021)			DLI 10.1 [SDI US$1,000,000 rollout of DHI [SDR-equivale US$2,000,000 rolled out up t DLI 10.2 [SDI US$3,000,000 based on DHIS all DHOs. DLI 10.3 [SDI US$4,000,000 disaggregated available for a 25% of distric DLI 10.4 [SDI US$5,000,000 disaggregated available for a 50% of distric DLI 10.5 [SDI US$5,000,000 disaggregated

#	DLI	Bank Financing Allocated to the DLI	Deadline for DLI Achievement	Minimum DLI Value to be Achieved to Trigger Disbursements of Bank Financing	Maximum DLI value(s) Expected to be Achieved for Bank Disbursement Purposes	Determinati Amount to against Achie DLI
						available for a 75% of distric
11	Operationalizatio n of the citizen feedback mechanisms and systems for public reporting.	SDR-equivalent of US$10,000,000	DLI 11.1–11.5 (July 15, 2021)	DLI 11.3–DLI 11.4 (minimum 3 districts)	DLI 11.3–DLI 11.4 (maximum 6 districts)	DLI 11.1 [SD US$2,000,000 engagement m and public rep developed by citizens' feedb availability of facility-level s disaggregated DLI 11.2 [SD US$2,000,000 engagement m piloted in six t DLI 11.3 [SD US$1,100,000 feedback repo the end of eac available on th for 3 targeted equivalent of reports from e targeted pilot of 3 additiona DLI 11.4 [SD US$1,100,000 feedback repo the end of eac

#	DLI	Bank Financing Allocated to the DLI	Deadline for DLI Achievement	Minimum DLI Value to be Achieved to Trigger Disbursements of Bank Financing	Maximum DLI value(s) Expected to be Achieved for Bank Disbursement Purposes	Determinati Amount to against Achie DLI
						available on th for 3 targeted equivalent of reports from e targeted pilot of 3 additiona DLI 11.5 [SD US$2,000,000 feedback repo the end of eac available on th for the 6 targe

Annex 4: Technical Assessment

A. Strategic Relevance and Technical Soundness of the Program

A.1 Strategic Relevance

1. Nepal has achieved significant improvements in health indicators but challenges remain. Between 1996 and 2013, the maternal mortality ratio decreased from 790 to 190 per 100,000 live births,[15] while under-five child mortality decreased from 141 per 1,000 in 1990 to 36 per 1,000 in 2014.[16] At the same time, although there have been improvements; the proportion of under-five children who are stunted due to chronic malnutrition remains high at 37.5 percent. Similarly, health service utilization indicators have improved but gaps remain. While 85 percent of children of ages 12–23 months have been vaccinated against measles, only 67 percent have received all recommended immunizations. Only 55.2 percent of births are in a health facility, and this proportion is only 27.9 percent among the poorest quintile.[17]

2. Although out-of-pocket health spending is significant, government services are important providers of health care to the population. Total spending on health in Nepal is US$40 per capita, of which 40 percent is public spending (2014), higher than the South Asian average of 30 percent. Public spending on health in Nepal is 11.3 percent of total government spending and represents 2.3 percent of GDP, compared to the average in South Asia of 1.4 percent. Government health services are provided through a network of about 4,100 health facilities and 31,500 staff across the country. Health posts and primary health care centers offer basic services free of charge to the entire population, while higher-level facilities offer services free of charge to the poor. The population often relies on government services for primary health care; for example, 8 out of 10 births in health facilities take place in government facilities.[18]

3. However, weaknesses in management of the government health system undermine coverage and quality of services, including the following:

(a) Health services suffer from stock-outs and expiry of medicines resulting from an inefficient supply chain management and distribution system. Drugs and medical supplies constitute about 20 percent of government health expenditures. The OAG identified drug stock-outs and drug expiry as major performance issues. A 2012/13 OAG survey found that 72 percent of primary health centers, 69 percent of health posts, 87 percent of sub-health posts, and 50 percent of hospitals surveyed had experienced stock-outs of one or more essential drugs. The duration of stock-outs ranged from eight to nine weeks in health posts and sub-health posts, to four weeks in primary health centers and one week in hospitals.[19] Drug supply problems are greatest among lower level and more remote health facilities.

[15] WHO *et al*. 2014. *Trends in Maternal Mortality: 1990 to 2013.* Geneva.
[16] UNICEF *et al*. 2015. *Levels and Trends in Child Mortality: Report 2015*. New York.
[17] MICS 2014.
[18] MICS 2014.
[19] 2012–13 Service Tracking Survey.

(b) Low public procurement capacity contributes to drug supply problems. The LMD in the 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. Inappropriate delegation for decision-making and contractor payment authorization also leads to significant delays and complaints. These problems are further compounded by systemic weaknesses in supply chain management.

(c) Weaknesses in PFM undermine effective resource allocation. Poor resource allocation to sector priorities undermines equity and access to essential services. Sector budget formulation processes remain ad hoc, largely uninformed by information from decentralized units where service delivery occurs. At the same time, weak expenditure management and unreliable financial reporting have 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 results in poor execution of annual budgets.

(d) Fiduciary integrity remains a major challenge. Over the last five years, there has been an increasing trend in the number of audit irregularities as well as ineffective follow-up of audit findings.[20] The system of internal controls needs to be substantially strengthened to reduce the risk of resources not being used for their intended purposes, misappropriation of assets, and poor value for money in the procurement of essential commodities and equipment.

(e) There is a deficit of qualified health workers, particularly in remote areas, because of difficult living and working conditions and inefficiencies in human resource management. The proportions of sanctioned posts that are filled by doctors and nurses at various levels of health facilities range from 23 to 55 percent.[21] Effective strategies are needed to encourage an appropriate skill-mix and equitable distribution and retention of professional and support staff, especially in remote areas. Support on these issues is being provided by DPs such as the WHO and DFID.

(f) Monitoring and evaluation systems remain weak. Evidence-based decision-making is undermined by poor monitoring systems and the inability to measure results. This affects planning and resource allocation, leads to the persistence of inequalities and reduces the accountability of policy makers.

(g) There is poor accountability for results at all levels. Citizen engagement mechanisms need to be implemented in order to contribute to improved accountability of policy makers and service providers. The MoH's Gender Equality and Social Inclusion strategy includes measures to strengthen citizen engagement. The strategy aims to provide citizens with the information they need to access services, as well as mechanisms for receiving their feedback. However, implementation of the strategy has been limited.

[20] The OAG's annual reports of the health sector. (2010-14)
[21] Service Tracking Survey 2013.

4. The Government's current five-year program, the NHSS (2015–2021) includes institutional and management reforms necessary to improve coverage, equity, and quality of health service delivery. The program builds upon detailed consultations with DPs, academia, and civil society and has incorporated lessons learned from the implementation of the previous two five-year programs. The NHSS aims to achieve progress toward UHC. There is consensus that the systemic and institutional weaknesses alluded to constitute the binding constraints to Nepal achieving the goals of universal coverage without impoverishment. Five of the nine goals of the NHSS relate to improved public sector governance, including in the areas of procurement and supply chain management, health system financing, decentralized planning, and evidence-based decision-making.

5. The Program is designed to support the Government to address these weaknesses in PSM, thereby facilitating the NHSS to achieve its stated outcomes.

A.2 Technical Soundness

6. The Program's focus on institutional strengthening by addressing specific PSM weaknesses in Nepal's health sector is appropriate based on the detailed technical analysis and discussions with all stakeholders. The NHSS was designed through a structured and organized process involving the DPs, civil society, academia, and the Government. A number of thematic groups were formed and a series of consultations were held between January 2014 and June 2015. The NHSS Program Development Team worked on the outputs of various thematic areas and produced a five-year sector strategic document with nine outcomes. The document was endorsed by the GoN on October 6, 2015.

7. Consultations during the design of the NHSS noted the necessity of management reforms for improving the efficiency of the public sector for delivery of health services. Weaknesses in procurement and financial management of the health sector were seen as major constraints. The need for institutionalizing processes for evidence-based decision-making was recognized as a key foundational activity for better resource allocation and targeting of health services. Ten years of experience of funding the health sector has resulted in a recognition that expanding the envelope of inputs without changing the organizational and incentive regime for management is unlikely to result in further gains.

Addressing Weak Public Procurement and Supply Chain Management Systems

8. The technical assessment of the Program identifies key procurement challenges in the health sector, as follows:

(a) Health sector procurement is highly technical, complex, and diverse involving a large volume of procurement. This requires a sustainable team of procurement managers, procurement experts, pharmacologists, biomedical engineers, supply chain management experts, and so on, to effectively manage the procurement. However, the staff working in the LMD/DoHS are primarily from the bureaucracy under the Health Service Act, and some under the Civil Service Act, and are general doctors, health technicians, and administrative persons who generally have no specific knowledge

and experience in procurement. There is currently no mechanism to ensure that a specialized team of experts will be available on a continuous basis.

(b) Weak procurement capacity of the LMD/DoHS because 'nontechnical' staff are responsible for procurement. According to the current Health Service Act, any staff under the ministry, including the LMD staff, can be transferred after two years. There is no provision to retain trained staff in an effort to continue to build institutional capacity.

(c) Weak/nonexistent supply chain management system. Currently, there is no provision to employ professionals with expertise in this area. In addition, testing facilities, pre-/post shipment inspection, quality stores, and the information management system are all inadequate.

(d) Delays in making procurement decisions have been one of the key concerns in the LMD. The delays are mainly because of a lack of decision-making authority in the LMD. This has adversely affected the credibility of the procurement system within the DoHS/LMD resulting in low or no participation in bidding, high bid prices, rebidding, no interest from potential bidders, and so on.

(e) Availability of budget for making timely payment. There have been several recent cases wherein the LMD has been unable to make advance payments and interim/final payments because of unavailability of budget (which is managed by individual departments within the MoH where planning is often weak), thereby adversely affecting its credibility.

Addressing Financial Management in the Health Sector

9. The structural and institutional arrangements for managing health sector procurement are weak, which affects the quality and timely availability of drugs. The Program's design to support the Government's reform plan for system and supply chain improvements to improve efficiency and transparency will enable proper planning, budgeting, and execution of procurement and quality assurance leading to reductions in drug stock-outs and enable the timely availability of the basic package of drugs at all health facilities and to all populations.

10. While some progress has been made in improving PFM systems in the health sector during the last five years of health sector engagement by DPs, significant weaknesses persist. Continued attention is needed in improving the entire planning, budgeting, expenditure, and monitoring cycle.

11. The technical assessment of the program identifies key PFM challenges in the health sector, as follows:

(a) Delays in expenditure reporting. This has been a crucial challenge over the last several years. Contributing factors include not having the right staffing mix and not getting access or connectivity to the central Financial Management Information System (FMIS) of the FCGO. These delays contribute to disbursement delays. Manual reporting of expenditure leads to poor monitoring and a lack of accountability in budget execution. An online reporting system—TABUCS—was introduced under

NHSP 2. Assessments indicate that changes are required in reporting and monitoring templates and incentives need to be created for rolling these out across the country to ensure comprehensive and timely reporting of sector expenditure.

(b) Weak capacity and internal control system. Compliance with internal controls remains weak and a lack of response to audit observations leads to a perception that accountability is weak and that resources may not be used for intended purposes in an efficient and economical manner. Concerns raised by the auditors and various independent fiduciary reviews relate to noncompliance with set rules/policies, lack of budgetary controls, inadequate reporting of transactions, weak control over advances, occurrence of similar audit irregularities year after year, and no audit follow-up action plan to monitor resolution of audit irregularities. Guidelines exist for planning of health expenditure and timely budget submission, but these are rarely followed because of system and capacity constraints and a lack of monitoring.

(c) The Program's focus on supporting improved PFM in the health sector will reduce existing inefficiencies in public expenditure planning and spending. This will in turn facilitate better redistribution of resources through more evidence-based resource allocation to ensure that affordable and appropriate health services are available to the Nepalese population, particularly the disadvantaged.

Improved Reporting and Information Sharing for Enhanced Accountability and Transparency

12. While the MoH has a system for reporting on overall health outcomes, the Government recognizes that availability of data and reporting on access and health outcomes for different population groups needs to be strengthened and used for decision-making. This is critical, as there remain significant inequalities in access and quality of care. Public resources are not necessarily targeted to populations and geographic areas with the poorest health outcomes. Robust disaggregated data (based on income, ethnicity, gender, and geographical location) are not available on a regular basis and are definitely not presented to, or used by, policy makers for decision-making. At the same time, there is no system/mechanism in place to provide reliable and timely information to citizens that will enable them to hold the health system accountable for accessibility, affordability, and quality of service delivery. The Program’s support to the MoH to strengthen systems for regular data capture and monitoring of disaggregated data and develop mechanisms for public access to information in keeping with Nepal’s Right to Information Act will enhance the accountability of policy makers and services providers. This will include citizen feedback mechanisms for key areas such as availability of drugs and health care providers as well as appropriate citizen grievance redress processes.

13. Strengthened citizen engagement can improve access by providing citizens with the information and capabilities they need to access a given service and capturing information from citizens, through voice and feedback, to improve state responsiveness in addressing access constraints. Improved accountability can help ensure that service providers ‘supply’ the service as agreed, thus ensuring that affordable access is provided and maintained. At present, there is no formal mechanism in the health sector in Nepal that enables this process. International experience shows that to establish such processes, particularly in fragile and unstable countries, this endeavor

is unlikely to be institutionalized during the short life of a Program; however, this should not hinder initiating the establishment of such systems.

B. Expenditure Framework

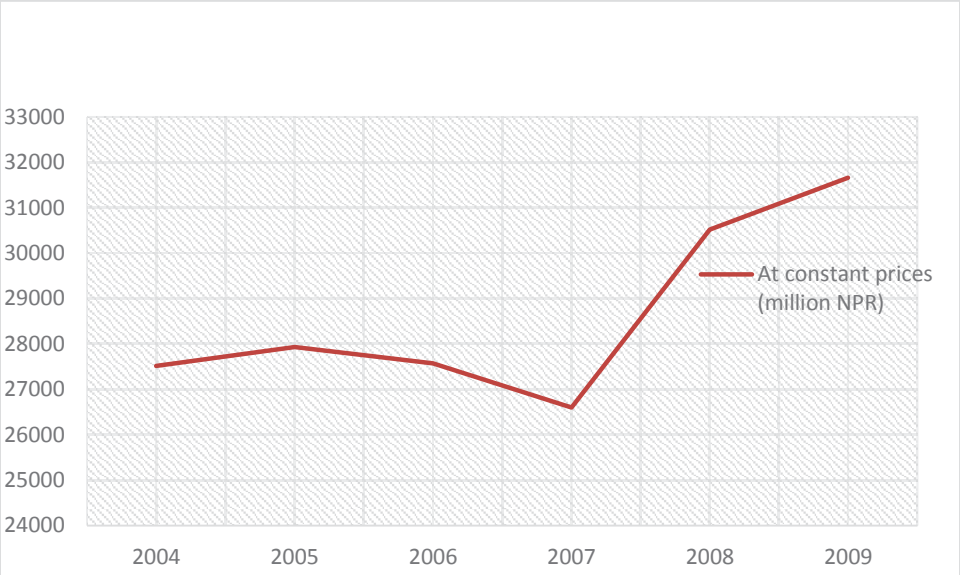
Public Expenditure on Health

14. Public spending on health in Nepal is higher than the South Asian average. Nepal spends about 2.3 percent of GDP for public funds on health compared to the South Asian average of 1.3 percent of GDP. With regard to the share of government spending of the total health spending, Nepal performs better than the low-income countries average (43.3 percent versus 41.5 percent) and South Asian average share (43.3 percent versus 33 percent).[22] Nepal also performs better in 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.

15. While national policy commits Nepal to provide free basic health services for all, financial protection is poor and high out-of-pocket (OOP) 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 OOP expenditure share of the total health expenditure was 55 percent in 2009,[23] and noted that the majority of this expenditure was on drugs provided for outpatient care. As a result of the high OOP, and as a consequence of payments to health care, an estimated 6.7 percent of households fall into poverty in a given year.[24] The OOP expenditures among the poor are twice as large as that of the richest (60.5 percent versus 30.3 percent, respectively).

[22] Health Nutrition and Population Statistics database. 2013.
[23] The Ministry of Health and Population. 2012; National Health Accounts 2006/07–2008/09.
[24] The figure is computed using a poverty line of US$1.25 per capita per day. See World Bank 2012 Health Equity and Financial Protection Datasheet – Nepal. Washington, DC.

Figure 4.1. Trend in Total Health Expenditure



Source: MoHP, 2012. Nepal National Health Accounts, 2006/07–2008/09.

Estimated Costs for Five-Year NHSS

16. The NHSS scope covers the entire health sector and the financing plan includes government financing and on-budget, off-budget and TA support from donors. Annual budgets will be allocated by the MoF based on the Annual Work Plan and Budget prepared by the MoH and will include all the budgets of its departments, divisions, and programs. The estimated projected cost for the NHSS of US$2,662 million is adequate for meeting the projected outcomes and emerges from the detailed analysis done by the Government supported by WHO.

Table 4.1. NHSS Estimated Cost by Outcomes and Outputs (Nepalese Rupees, million)

Code	Outcome/Output Statement	2016/17	2017/18	2018/19	2019/20	2020/21	Total
OC1	Rebuilt and strengthened health systems: Infrastructure, human resources for health, and PSM	22,372	26,143	29,286	30,280	31,260	139,341
OP1a.1,2	Health infrastructure developed as per plan and standards	4,815	6,675	8,080	7,840	7,560	34,970
OP1a.3	Improved management of health infrastructure	1,693	2,399	2,909	2,821	2,719	12,541
OP1b.1	Improved staff availability at all levels	13,229	14,168	15,160	16,220	17,356	76,133
OP1b.2	Improved human resource education and competencies	2,546	2,819	3,049	3,303	3,521	15,238
OP1c.1	**Improved procurement system**	**89**	**82**	**88**	**96**	**104**	**459**
OC2	Improved quality of care at point of delivery	3,806	3,983	4,293	4,527	4,756	21,365
OP2.1	Health services delivered as per standards and protocols	1,836	1,815	1,905	1,995	2,091	9,643
OP2.2	Quality assurance system strengthened	1,951	2,140	2,347	2,489	2,618	11,545

Code	Outcome/Output Statement	2016/17	2017/18	2018/19	2019/20	2020/21	Total
OP2.3	Improved infection prevention and health care waste management	19	28	41	43	47	177
OC3	Equitable utilization of health care services	6,581	8,248	10,305	12,046	13,004	50,184
OP3.1	Improved access to health services, especially for unreached population	6,490	8,040	9,971	11,588	12,417	48,506
OP3.2	Health service networks including referral system strengthened	91	208	334	458	587	1,678
OC4	**Strengthened decentralized planning and budgeting**	**2,052**	**1,986**	**2,056**	**2,128**	**2,202**	**10,424**
OP4.1	**Strategic planning and institutional capacity enhanced**	**2,052**	**1,986**	**2,056**	**2,128**	**2,202**	**10,424**
OC5	**Improved sector management and governance**	**2,529**	**3,505**	**4,242**	**4,117**	**3,969**	**18,362**
OC5.1	MoH structure is responsive to needs	469	650	787	764	736	3,406
OP5.2, OP5.3, and OP5.4	Improved governance and coordination	2,051	2,843	3,441	3,339	3,220	14,894
OP5.5	Improved PFM within the MoH	9	12	14	14	13	62
OC6	**Improved sustainability of health sector financing**	**2,154**	**2,866**	**3,410**	**4,003**	**4,652**	**17,085**
OP6.1	**Health financing system strengthened**	**3**	**3**	**4**	**4**	**4**	**18**
OP6.2	Social health protection mechanisms strengthened	2,151	2,863	3,406	3,999	4,648	17,067
OC7	Improved healthy lifestyles and environment	178	219	229	237	246	1,109
OP7.1	Health behaviors and practices promoted	178	219	229	237	246	1,109
OC8	Strengthened management of public health emergencies	530	591	699	782	828	3,430
OP8.1	Improved preparedness for public health emergencies	499	557	659	742	788	3,245
OP8.2	Strengthened response to public health emergencies	31	34	40	40	40	185
OC9	**Improved availability and use of evidence in decision-making**	**543**	**990**	**1,151**	**1,107**	**1,109**	**4,900**
OP9.1	**Integrated information management approach practiced**	**137**	**447**	**469**	**486**	**504**	**2,043**
OP9.2	**Survey, research, and studies conducted**	**105**	**258**	**381**	**302**	**268**	**1,314**
OP9.3	**Improved health sector reviews with functional linkage to planning process**	**301**	**285**	**301**	**319**	**337**	**1,543**
	Total	**40,745**	**48,531**	**55,671**	**59,227**	**62,026**	**266,200**

PforR Program Expenditure

17. The scope of the Program supported by the PforR is limited to the NHSS outcomes focusing on systems strengthening in areas of public procurement, PFM, and monitoring and reporting.

18. Table 4.2 below shows the NHSS results areas financed by the Program.

Table 4.2. NHSS 2015–2021 Outcome Codes

	WHO estimates (US$341.6 m) for these results	DLIs
OP1c	**Procurement and supply chain management**	
OP1c.1	*Improved procurement system*	1-6
OP4	**Strengthened decentralized planning and budgeting**	
OP4.1	*Strategic planning and institutional capacity enhanced*	4, 7, 8 and 9
OP5	***Improved sector management and governance***	5, 7, 8 and 9
OP6	**Improved Sustainability of health sector financing**	
OP6.1	*Health financing system strengthened*	7, 8 and 9
OP9	***Improved availability and use of evidence in decision-making***	10 and 11
OP9.1	*Integrated information management approach practiced*	
OP9.2	*Surveys, research, and studies conducted*	
OP9.3	*Improved health sector reviews with functional linkage to planning process*	

19. Expenditures of the Program are related to those expenditures in the annual budget that finance consumption, operational and service, and production expenses as articulated in the budget. Table 4.3 describes the main components of the expenditure program supported by the PforR.

Table 4.3. PforR Expenditure Framework

MoH Budget Line Items	Total	%
Consumption expenses	194,512,427	57
Office operation and service expenses	40,300,573	12
Service and production expenses	106,798,308	31
Total	341,611,309	100

Note: The relevant PforR Expenditure Framework budget codes include: (i) consumption expenses (21111-21114, 21119, 21121, 21122); (ii) Office Operations and Service Expenses (22111, 22112, 22121, 22122, 22211-22213, 22311, 22312, 22314, 22411, 22412, 22711); (iii) Service and Production Expenses (22313, 22511, 22512, 22522, 22529, 22611, 22612).

20. The budget lines included in the Program Expenditure Framework will finance critical inputs required for program implementation and thereby, DLI achievement. Consumption expenses include various establishment and human resource costs including allowances and salaries, while service and production expenses cover training, learning materials, and skills development costs. Operational and service expenses relate to the costs associated with communication and overhead costs for running official establishments related to the health sector. These costs are directly related to the roll out of different activities that would need to be implemented the achievement of the DLIs. Improving the institutional functionality and capacity

of human resources across the health sector is critical to improving the efficiency of public sector management. The PforR directly focuses on facilitating these capacity improvements.

21. The expenditures allocated to the Program are assessed to be appropriate. The government pre-finances the health sector by giving MoH an annual budget which includes government's own source of revenue and donors contribution. While the total budget is adequate, the annual absorption rate of the sector budget is low, at 70-85 percent which affects the implementation of planned activities. Recognizing this, the PforR focuses on improving institutional capacity for planning and budgeting and financial management to allow for better budget execution and improved service delivery. The Program finances those expenditures in the MoH budget, which for the last five years have not had any significant audit observations.

C. Results Chain/Program's Results Framework and Monitoring

22. Realistic, specific, time-bound, actionable, and measurable targets have been set for the key performance indicators, DLIs and intermediate outcome indicators in discussion with stakeholders in Nepal including the MoH and DPs. Actionable DLIs have been set, and their progress will be monitored and reported against the targets laid down in the Program. The achievement of DLIs will be verified by an independent agency.

23. The responsibility of monitoring the progress toward results of the sector program lies with the MoH through its various structures. Information on the progress of the sector program is generated through different resources, including management information systems, disease surveillance, vital registration, census, sentinel reporting, surveys, rapid assessments, and research. The Health Management Information System (HMIS) is the most consistent and reliable of all the management information systems, the information from which has been used for future planning and implementation. The HMIS is analyzed by the Management Division of the DoHS, and the data are published in a yearly report of the DoHS. The data can be disaggregated by districts, which means that the data from the peripheral health centers including health posts, outreach clinics, and Female Community Health Volunteers are aggregated respectively in the higher chain and at the District Health Office/District Public Health Office (DHO/DPHOs). Currently, the HMIS has been revised to be able to disaggregate some selected indicators by caste/ethnicity, enable facility-level data reporting, and ensure data are collected from all health facilities across the country including police and army hospitals, mission hospitals, teaching hospitals, and all nonpublic facilities.

24. Other information systems are available: the LMIS, FMIS, Health Infrastructure Information System, Planning and Management of Assets in Health Care System, Human Resource Information System, and Training Information Management System. While the information generated by many of them has not been optimally used for evidence-based planning, for some like the LMIS, a complete change has been recommended for required information generation.

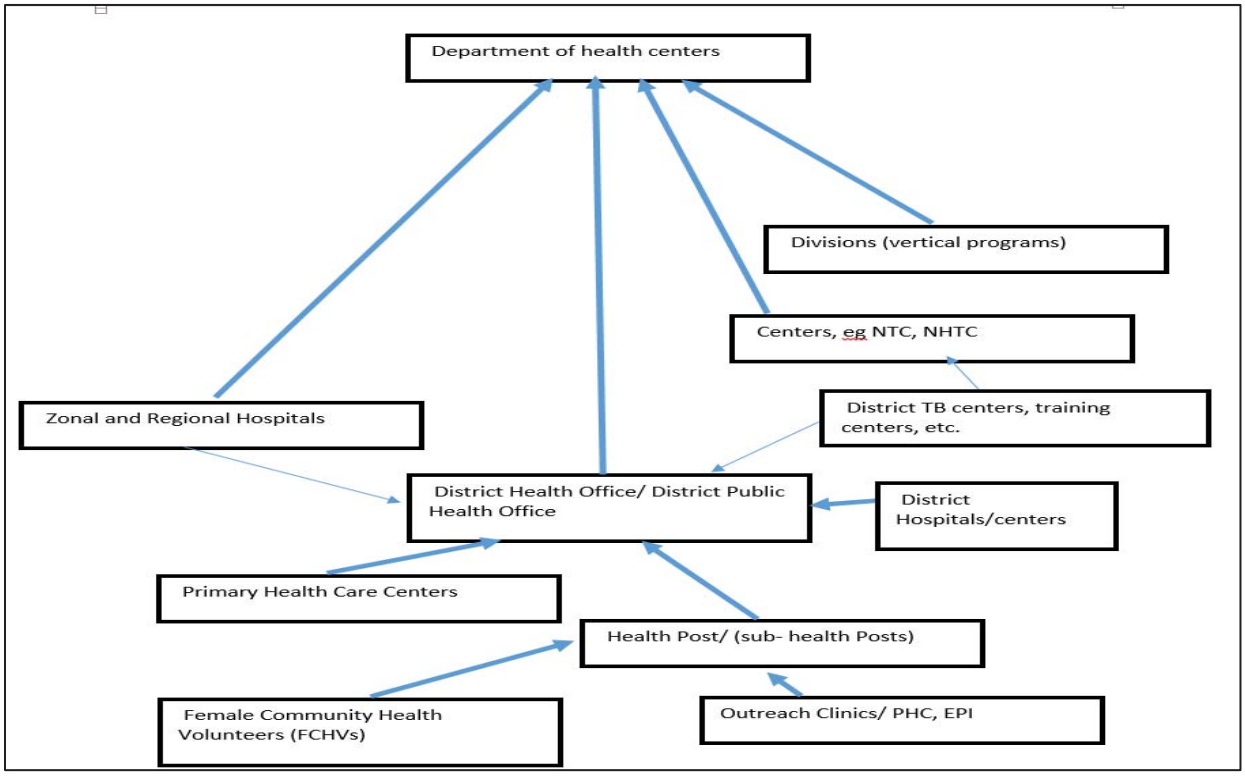
25. Yearly progress of the sector program is monitored during various regional annual reviews and a national annual review usually takes place between September and November every year. Joint annual field visits with the donors are organized, followed by the Joint Annual Review (JAR) in the presence of other stakeholders including civil society.

26. Household surveys including Demographic and Health Surveys, Nepal Living Standards Survey, and MICSs conducted at specified intervals provide information that seems to correlate well with the information generated from the regular HMIS. The timing of such surveys and the addition of relevant modules commensurate with the Results Framework of the NHSS will be discussed with the donor partners and other government agencies supporting the surveys. WHO and UNICEF also support the survey for determining the EVM score for vaccine management once every two years.

27. JARs (by March 31 of every year) and a midterm review (September 2018) will support M&E and allow for midcourse correction. A Midterm Review will be conducted by the World Bank in collaboration with the GoN and DPs and will include recommendations for restructuring, if required.

28. The M&E cell in the MoH is adequately placed to monitor the results of the Program. Any additional TA needs will be jointly identified and provided by the MoH and the partners, including areas that would lend for longer-term capacity within the Government.

Figure 4.2. Flow of Data at the MoH



D. Governance Structure and Institutional Arrangements

29. Adequate institutional arrangements are in place to implement the Program. The MoH will be responsible for the implementation and the achievement of agreed results through its various organizational structures including its departments, divisions, and centers. The MoH will make arrangements for financing procurement, human resource, and technical expertise to achieve the agreed DLIs.

30. A DLI Management and Coordination Unit at the MoH chaired by the chief of the PPICD will support implementation of the Program. It will include director generals of all departments, director of the LMD, head of the Human Resource and Financial Management Division, and the accounts officer of the MoH. There will be a Program Steering Committee, which meets quarterly, chaired by the secretary of the MoH, and includes the director general, DoHS; the chair, PPICD; the head of the Human Resource and Financial Management Division and a representative from the MoF. Representation from the FCGO and the OAG will be invited as needed. The Steering Committee will provide overall guidance, resolve specific issues and ensure inter-ministerial and sectoral coordination. Day-to-day implementation and monitoring of results in the four key areas will be the responsibility of the LMD director for procurement-related DLIs; the head of the Human Resources and Financial Management Division for PFM-related DLIs; the director, Management Division, DoHS for M&E and DHIS 2; and the director, Primary Health Care and Revitalization Division for citizen engagement. Both the DLI Management and Coordination Unit and the Program Steering Committee have been established.

31. While the obligation of implementation of the Program rests on the MoH, the success of achieving the results lies on the efforts of various units within the MoH towards working on the DLIs. The MoH will, therefore, work with its relevant departments, divisions, and centers and motivate, incentivize, and regularly monitor their activities. Currently, there are three departments which includes the DoHS, the Department of Drug Administration and the Department of Ayurveda. Under the DoHS, there are various divisions including Child Health, Family Health, Epidemiology and Disease Control, Leprosy Control, Management Division and Logistic Management Division. Under the MoH, there are other divisions including Population Division, Primary Health Care Revitalization Division, Curative Division, Human Resource and Financial Management Division, PPICD, and various centers such as the National Center for AIDS and STD Control, National Tuberculosis Center and National Information, Education and Communication Center. The LMD is the primary procurement agency of the MoH.

32. The capacity constraints identified during PforR preparation will be addressed through the TA plan agreed with DPs and the MoH.

33. *Role of Partners.* The DPs will also agree to a JFA with the MoH and the MoF. Individual DPs will have their own reporting requirements, including financing mechanisms. These will all be spelt out in the JFA. Progress and results as described in the NHSS Results Framework will be evaluated and discussed at the JARs.

E. Economic and Financial Analysis of the Program

34. The Program supports efficiency improvements in public resource management systems of the health sector in Nepal**.** Nepal's Health Sector Strategy 2015–2021 outlines the government's roadmap toward achieving the goal of UHC. The key UHC challenges for Nepal are primarily inequity and high OOP spending on health. At the same time, the changing burden of disease in Nepal and therefore the need to expand the package of free services is placing pressure on public health expenditures. Hence, for Nepal the path toward UHC involves careful balancing of the trade-off between expanding the package of free services and the need to increase access to existing services for those who have no/limited access. The Program aims to contribute to this

effort by improving the procurement and financial management systems in the sector as well as institute accountability and transparency in public spending in the sector.

35. Although public spending on health in Nepal, at 2.3 percent of GDP, is above the average of its South Asian neighbors[25], health system inefficiencies diminish the quality of spending. The health system suffers from a range of inefficiencies including drug stock outs, health worker absenteeism, weak public finance management and weak procurement leading to wastages and leakage, and lack of transparency and accountability of service providers. Such inefficiencies impact negatively on access and the quality of care. The Program will address key areas of public management in the health sector, and engage citizens to strengthen accountability. These improvements will address micro-level inefficiencies that affect the sector. Efficiency gains are key in creating the fiscal space necessary for achieving Nepal's vision of UHC.

36. Rationale for public sector intervention. Government intervention in the health sector in Nepal is strongly justified on the grounds of further improving equity. The poor are highly dependent on the public sector for services especially in rural areas where choices are limited. However, inefficiencies in public management results in lower quality of care and outreach. Given this, the Program focus on institutional reforms in the health sector is apt and will support and enhance the way the public sector intervenes in the health sector. The reforms that the Program will support in the health sector including reforms in PFM, public procurement and transparency and accountability are critical to improving the impact of public intervention in the sector.

Summary of benefits and costs

37. Improving public management in the health sector will result in positive economic and financial benefits. More efficient procurement of drugs and equipment, reduced drug stock outs, better planning, monitoring and reporting and citizen oversight will result in greater value for money. The expected net impact realized through improving the public resource management systems of the health sector in Nepal is valued at US$74 million. This represents the sum of estimated net benefits arising from Program implementation as a whole across the three results areas. The lower than expected NPV estimate for the program as a whole is the result of the negative cash flow for Results Area 3. In addition, adding in inflation, contingency and a high discount rate of 12 percent leads to a lower NPV estimate. The summary of the cost and benefits are presented in the table below, while the corresponding subsections contain details on the methodology applied to generate these estimates in each of the Program's three results areas. The analysis assumes an exchange rate of 107 NPR per USD and a 12 percent discount rate. It also adjusts for a 10 percent contingency for unexpected delays and 8 percent inflation using a time horizon of five years, from 2017-2021, consistent with the Program's time frame.[26]

[25] The Ministry of Health and Population 2012. The average for South Asian countries was 1.3 percent
[26] This is consistent with the IMF 2015 Article IV consultation.

Table 4.4: Summary of Economic and Financial Analysis (USD)

		2017	2018	2019	2020	2021	Total
Result area 1: Improved Public Procurement	costs	123,635,514	123,635,514	123,635,514	123,635,514	123,635,514	618,177,570
	benefits	31,905,000	63,810,000	210,898,808	242,369,783	273,840,758	822,824,350
Result area 2: Improved Financial Management	costs	84,112	112,150	130,841	130,841	121,495	579,439
	benefits	3,146,714	6,293,428	9,440,142	12,586,856	12,586,856	44,053,997
Result area 3: Improved Reporting and Information Sharing for Enhanced Accountability and Transparency	costs	10,149,533	18,495,327	21,523,364	20,682,243	20,719,626	91,570,093
	benefits	3,153,090	6,306,179	9,459,269	12,612,359	15,765,448	47,296,345
Costs Subtotal		133,869,159	142,242,991	145,289,720	144,448,598	144,476,636	710,327,103
Benefits Subtotal		38,204,804	76,409,608	229,798,220	267,568,998	302,193,063	914,174,692
Contingency (10%)		-9,566,436	-6,583,338	8,450,850	12,312,040	15,771,643	20,384,759
Inflation (8%)		-7,653,148	-5,266,671	6,760,680	9,849,632	12,617,314	16,307,807
NET BENEFITS		**-78,444,771**	**-53,983,374**	**69,296,970**	**100,958,728**	**129,327,471**	**167,155,023**
Net Present Value (NPV) at 12%							**73,794,002**

Results Area 1: Improved Public Procurement

38. The net present value under this results area is estimated to be US$76 million as a result of a reduction of stock outs of tracer drugs as well as time savings for procurement staff. There is evidence that drugs expire at district medical stores while a number of health facilities in the district run out of drugs. The Program will support training to enable proper planning, budgeting and execution of procurement in order to reduce drug stock outs and enable the timely availability of a basic package of drugs at all health facilities and to all populations. The net costs under this results area are estimated at US$618 million. These include staff time, taken from the line item on salary and benefits under Outcome 1 of the WHO costing exercise conducted in February 2016. The opportunity cost of staff time spent under the implementation of these reforms was not counted separately because Program financing may partially cover salaries of staff who will be working on these reforms full-time. As such, the analysis assumes that staff are not making a trade-off between their regular tasks and these reforms. The benefits under this results area are estimated to be US$823 million. This is estimated through savings on reduced drug stock outs as a result of improving public procurement and procurement staff time savings.

Table 4.5: Economic and Financial Analysis Results Area 1 (US$)

Costs	**2017**	**2018**	**2019**	**2020**	**2021**	**Total**
Health sector staff time	123,635,514	123,635,514	123,635,514	123,635,514	123,635,514	618,177,570
Costs Subtotal	123,635,514	123,635,514	123,635,514	123,635,514	123,635,514	618,177,570
Benefits	**2016**	**2017**	**2018**	**2019**	**2020**	**Total**
Cost savings from reduced drug stock-outs						
Volume of drug stock-outs as a % of total public health spending			8,246,475	7,812,450	7,378,425	23,437,350
OOP spending on drugs per capita			47,260,000	47,260,000	47,260,000	141,780,000
Opportunity cost of time spent from beneficiaries on finding needed drugs			59,677,333	59,677,333	59,677,333	179,032,000
Increased efficiency in the procurement of drugs						
Difference between budgeted and contracted amount for drugs	638,100,000	638,100,000	638,100,000	638,100,000	638,100,000	3,190,500,000
Improvement by year	5%	10%	15%	20%	25%	
Value of procurement savings	31,905,000	63,810,000	95,715,000	127,620,000	159,525,000	478,575,000
Benefits Subtotal	**31,905,000**	**63,810,000**	**210,898,808**	**242,369,783**	**273,840,758**	**822,824,350**
Net Benefits	-91,730,514	-59,825,514	87,263,294	118,734,269	150,205,244	204,646,780
Contingency (10%)	-9,173,051	-5,982,551	8,726,329	11,873,427	15,020,524	20,464,678
Inflation (8%)	-7,338,441	-4,786,041	6,981,064	9,498,742	12,016,420	16,371,742
Net Benefits	**-75,219,021**	**-49,056,921**	**71,555,901**	**97,362,101**	**123,168,300**	**167,810,360**
Net Present Value (NPV) at 12%						**76,428,736**

39. To estimate the savings as a result of reduced drug stock outs, analysis examined the percentage of total public health spending that is earmarked for drugs and multiplied this by the amount of time drug stock outs last. Primary health facilities run out of drugs for about two months of the year and while they know which drugs they run out of, they do not know the quantity that is needed given the demand. The analysis also calculates expected savings from reduced OOP spending on drugs per capita as part of the benefits. When drug stock outs happen in health facilities, most of the OOP spending goes to drugs. The analysis calculates the average OOP

spending on drugs per capita and multiplies this by a quarter of the population, assuming that at least this proportion of the population is affected by drug stock outs. It is assumed that these benefits start to accrue in 2018. Another way to undertake this analysis could have been to look at the difference between drugs in stock and out of stock, but this data at the country level is currently not available. In addition, the analysis estimates the opportunity cost of time spent by beneficiaries on finding needed drugs as foregone wages. The assessment is based on the assumption that on average, beneficiaries would spend one week per year to find drugs that they need when health facilities run out of them, and use the minimum monthly salaries of enterprises for an estimate of wages, starting in 2018. Finally, an estimation of the value of procurement savings calculated as small improvements of 5 percent in the gap between the amounts budgeted and contracted in any given year has also been undertaken. The numbers used for the amounts budgeted and contracted are preliminary estimates from procurement staff at the time of project preparation and these numbers could change during the course of project implementation. Under the Program, we assume that the efficiency in the procurement of drugs can be measured by the decrease in the gap between the amount budgeted and contracted for drugs.

Results Area 2: Improved Financial Management

40. The net present value under this results area is estimated to be US$24 million as a result of reducing existing inefficiencies in public expenditure planning and spending. The net costs under this results area are estimated at US$579,439. This includes staff time spent on training and capacity building, taken from the line item on improved PFM under Outcome 5 of the WHO costing exercise conducted in February 2016. The opportunity cost of staff time spent under the implementation of these reforms was not counted separately because the Program financing may partially cover salaries of staff who will be working on these reforms full-time. As such, the assumption is that staff are not making a trade-off between their regular tasks and these reforms. The net benefits under this result area are estimated to be US$44 million. This includes savings from higher operational efficiency.

Table 4.6: Economic and Financial Analysis Results Area 2 (US$)

Costs	**2017**	**2018**	**2019**	**2020**	**2021**	**Total**
Staff time spent on training and capacity building	84,112	112,150	130,841	130,841	121,495	579,439
Costs Subtotal	84,112	112,150	130,841	130,841	121,495	579,439
Benefits	**2016**	**2017**	**2018**	**2019**	**2020**	**Total**
Productivity gains in regional and district offices						
Total wages of health staff	62,934,282	62,934,282	62,934,282	62,934,282	62,934,282	
Total hours saved by staff for transactions, reconciliation and reporting	5%	10%	15%	20%	25%	
Value of staff time savings	3,146,714	6,293,428	9,440,142	12,586,856	12,586,856	44,053,997

Benefits Subtotal	**3,146,714**	**6,293,428**	**9,440,142**	**12,586,856**	**12,586,856**	**44,053,997**
Net Benefits	3,062,602	6,181,279	9,309,301	12,456,015	12,465,361	43,474,558
Contingency (10%)	306,260	618,128	930,930	1,245,602	1,246,536	1,855,318
Inflation (8%)	245,008	494,502	744.744	996,481	997,229	3,477,965
Net Benefits	**2,511,334**	**5,068,649**	**7,633,627**	**10,213,933**	**10,221,596**	**38,141,275**
Net Present Value (NPV) at 12%						**24,007,569**

41. As more of the MoH's annual spending is captured by an online expenditure reporting system at the level of every spending unit, financial department staff are expected to spend less time liaising and coordinating with those not using an online expenditure reporting system. Most of the gains under this result area – such as those coming from better reporting, tracking and monitoring of the use of public resources in the health sector – are not measurable in monetary terms. Therefore, the analysis quantifies the benefits from increased use of this online monitoring system as a proxy.

42. To estimate the magnitude of potential efficiency gains from using better expenditure reporting systems, the value of staff time savings not spent on reconciling manual entries, consolidating expenditures from different sources, and on responding to audit queries is estimated. The analysis uses the percentage of the total wages of health staff and assumes a saving of about 5 percent each year. A better estimate would have a specific number of staff working in financial departments and multiply that by their average annual gross salary. The assumed total reduction in working hours spent by financial department staff results in annual savings of approximately US$44 million.

Results Area 3: Improved Reporting and Information Sharing for Enhanced Accountability and Transparency

43. The net present value under this results area is estimated to be a loss of US$26 million. The net costs under this results area are estimated at US$92 million which exceeds the benefits which are valued at US$47 million. This includes staff time spent on training and capacity building taken from the line item on salary and benefits under Outcome 9 of the WHO costing exercise conducted in February 2016. The opportunity cost of staff time spent under the implementation of these reforms was not counted separately because the Program financing may partially cover salaries of staff who will be working on these reforms full-time. As such, it is assumed that staff are not making a trade-off between their regular tasks and these reforms. The net loss under this result area is estimated to be US$37 million. While the NPV under this results area is negative, when accounting for the net benefits for the other results areas, the Program as a whole results in a positive NPV.

44. Similar to the benefits from results area 2, most of the gains under results area 3 – such as those coming from improved systems for reporting and sharing information will allow for regular data capture and monitoring of disaggregated data – are not easily measurable in monetary terms.

Therefore, the analysis quantifies the benefits from increased use of this online monitoring system as a proxy.

45. To estimate the magnitude of potential efficiency gains from using better annual disaggregated data, the value of staff time savings not spent on collecting data is estimated. The analysis uses the percentage of the total wages of health staff and assumes savings of 5 percent each year. The assumed total reduction in working hours spent by health department employee's results in total savings of approximately US$47 million. The analysis also estimates savings from reduced travel allowances as more health facilities continue to report on availability of drugs and services on a real time basis. The assumption used is that travel allowances will decrease by 5 percent each year, resulting in total savings of approximately US$95,633. However, the cost of staff time spent on training and capacity building exceeds the benefits from the project activities. This is mainly because the benefits from enhanced monitoring and evaluation systems will have a more tangible impact years after the Program ends.

Table 4.7: Economic and Financial Analysis Results Area 3 (US$)

Costs	**2017**	**2018**	**2019**	**2020**	**2021**	**Total**
Staff time spent on training and capacity building	10,149,533	18,495,327	21,523,364	20,682,243	20,719,626	91,570,093
Costs Subtotal	10,149,533	18,495,327	21,523,364	20,682,243	20,719,626	91,570,093
Benefits	**2016**	**2017**	**2018**	**2019**	**2020**	**Total**
Productivity gains in regional and district offices						
Total wages of health staff	62,934,282	62,934,282	62,934,282	62,934,282	62,934,282	
Total hours saved by staff for transactions, reconciliation and reporting	5%	10%	15%	20%	25%	
Value of staff time savings	3,146,714	6,293,428	9,440,142	12,586,856	15,733,571	47,200,712
Travel allowances	127,511	127,511	127,511	127,511	127,511	
Reductions in travel allowances	5%	10%	15%	20%	25%	
Value of travel allowance savings	6,376	12,751	19,127	25,502	31,878	95,633
Benefits Subtotal	**3,153,090**	**6,306,179**	**9,459,269**	**12,612,359**	**15,765,448**	**47,296,345**
Net Benefits	-6,996,443	-12,189,148	-12,064,096	-8,069,884	-4,954,178	-44,273,749
Contingency (10%)	-699,644	-1,218,915	-1,206,410	-806,988	-495,418	-3,124,969
Inflation (8%)	-559,715	-975,132	-965,128	-645,591	-396,334	-3,541,900

Net Benefits	**-5,737,083**	**-9,995,101**	**-9,892,558**	**-6,617,305**	**-4,062,426**	**-37,606,880**
Net Present Value (NPV) at 12%						**-26,642,304**

Key Technical Risks and Mitigation Strategies

46. The overall integrated risk for the Program is rated as "High". Although the technical design of the government's program is sound and is built on wide consultations, sector management and institutional capacities in MoH are weak. The political context is unstable and policy decisions may be undermined in an uncertain political environment. The shape and impact of federalism, as promulgated in the constitution, is so far unknown and this could affect the existing institutional structures being utilized to deliver health services and the Program. Globally the procurement of equipment and medical supplies are highly risk prone areas, and this risk remains high in the context of Nepal. Further, public resources are often not used appropriately given an environment of poor transparency and accountability. The Program recognizes these risks and supports the development of sustainable mitigation mechanisms through supporting policy and institutional reforms to facilitate more systemic transparency in procurement and in the use of public resources. It also supports accountability through building grievance redressal and citizen engagement mechanisms.

47. As with most ministries in Nepal, the implementing agency faces major institutional capacity issues. Specifically, in the MoH, the majority of professionals are trained doctors with limited management skills and training. As a result, critical areas of sector management such as PFM and procurement remain inappropriately staffed. Procurement reform is critical to the success of the Program. This requires key institutional reforms within the LMD, which in turn demands political and administrative will. This is a high implementation risk and will be closely monitored and assessed by the development partners.

Annex 5: Summary Fiduciary Systems Assessment

I. Introduction

1. This document is the Fiduciary Systems Assessment (FSA) of the IDA-financed Nepal Health Program-for-Results ("the Program"). The Bank fiduciary team conducted it at the identification and assessment phases as per the requirements of Bank policy on 'Program-for-Results Financing', in close collaboration with the Bank technical team, through analysis of available documents and working sessions with the main stakeholders.

2. The FSA considers whether the Program's fiduciary systems provide reasonable assurance that the financing proceeds will be used for intended purposes, with due attention to the principles of economy, efficiency, effectiveness, transparency, and accountability. It covers the Program's institutional arrangements, financial management and procurement systems, and governance systems.

3. The FSA was conducted based on current knowledge of Nepal's public procurement and financial management systems, previous diagnostics and reports. The Bank fiduciary team was involved from the preparation stage and met with the country's control bodies including the OAG, as well as the FCGO and the Directorate of Budget, the PPMO, the CIAA, the National Vigilance Commission and the MoH including the LMD, the Directorate of Budget and the DoHS.

4. This FSA concludes that the Program's fiduciary systems provide reasonable assurance that the financing proceeds will be used for intended purposes, provided an agreed fiduciary mitigation program is implemented during implementation.

II. Program Description, Institutional arrangements and Expenditure Framework

(a) Program Description

5. The US$150 million IDA financing will support, in addition to Government financing, a subset of the Government's NHSS 2015–21, which has been jointly prepared by the government and DPs. Specifically, the Program will support two components to improve efficiency of resource management of the government's Program through (a) supply-side interventions such as improved procurement, contract management systems, supply chain systems and budget planning, execution and reporting; and (b) demand-side interventions focused on effective citizen engagement for enhanced accountability.

6. The GoN has implemented an ambitious program of PFM reform leading to improved alignment of Nepal's public procurement and financial management systems with international practices. These positive developments over the past decade have been documented and evidenced in the 2015 PEFA assessment. Budget execution is generally predictable and does not deviate substantially from planned and voted budget. A second phase of the national PFM reform was endorsed in March 2016 by the PEFA steering committee and aims to consolidate and further improve Nepal's PFM and procurement systems.

(b) Institutional Arrangements

7. The MoH will be responsible for implementing Program activities through its various organizational structures including its departments, divisions, and centers. The MoF, FCGO, and PPMO will provide policy support and guidelines to facilitate the process.

8. A DLI Management and Coordination Unit at the MoH, chaired by the chief of the PPICD, will support implementation of the Program. It will include director generals of all departments, the director of the LMD, the head of the Human Resource and Financial Management Division, and the accounts officer of the MoH. There will be a Program Steering Committee, which meets quarterly, chaired by the secretary of the MoH, and include the director general, DoHS; chair, PPICD; the head of Human Resource and Financial Management Division; and representatives from the MoF. Representation from the FCGO and the OAG will be invited as needed. The Program Steering Committee, which was formed in April 2016, will provide overall guidance, resolve specific issues, and ensure inter-ministerial and sectoral coordination. Day-to-day implementation and monitoring of results in the four key areas will be the responsibility of the LMD director, for procurement related DLIs; the head of the Human Resources and Financial Management Division, for PFM related DLIs; the director, Management Division, DoHS for M&E and DHIS 2; and the director, Primary Health Care and Revitalization Division, for citizen engagement.

Role of various stakeholders

9. **The Ministry of Health's** various Departments and Divisions will be stakeholders in implementing the fiduciary aspects of the Program. **The Health Management Division** supports health programs and the District Offices of Health (DoH) in their service delivery functions by: (i) facilitating preparation of annual plans, programs and necessary arrangements to obtain approval from the National Planning Commission (NPC) and the MoF; (ii) support preparation and compilation of the annual budget and programs of the Regional Health Directorates and District Public Health Offices; (iii) monitor program implementation and carry out periodic performance reviews and support quality improvements in the health sector and; (iv) manage the HMIS. **The PPICD** will manage the Program. Its mandate includes preparing annual programs and budgets, preparing short and long-term strategies for central and local level, formulating policies and other strategies for effective utilization of foreign grants and other sources. **The Human Resource and Financial Management Division** manages MoH's human resources and financial management. The Human Resource Section is responsible for preparing annual, short term and long-term strategies, policies and programs relating to employees in the health sector. The Financial Administration Section manages financial plans and programs, implementation of budgets and financial policies, settlement of irregularities reported in audit reports, preparation of financial statements of Ministry. The Division also contains a Governance Unit which is responsible for maintaining a database of complaints and grievances received from different sources (for example from the Prime Minister's Office, the CIAA and directly from contractors, bidders and users of health services).

10. The MoH comprises a complex network of centers, departments, councils, and hospitals with varying levels of autonomy. **The LMD**, an agency for procurement of health sector goods, was established as a unit under the DoHS in 1993. The LMD is responsible for procurement of

health sector goods, contract management, storage in warehouses and onward distribution of health goods to more than 4,000 health facilities in Nepal.

11. **National Planning Commission**. The Prime Minister chairs the NPC and a Vice Chairperson appointed by the government is responsible for its day-to-day functioning. The NPC formulates development policies and prepares periodic development plans within the framework of a long-term development perspective, and has other related functions in terms of planning and investment management. The role of the NPC will be fairly limited in the Program.

12. **Office of the Auditor General.** Pursuant to Article 241 of Nepal's Constitution, the OAG is mandated to conduct the audit of all levels of government offices and other organizations as specified by law following established standards and procedures considering regularity, economy, efficiency, effectiveness and propriety. The Auditor General submits an annual report to the President which is tabled in the parliament and discussed in the Public Accounts Committee. Major functions include: (a) certification and providing opinion on the Consolidated Financial Statement of the GoN and Financial Statements of State Owned Enterprises (SoEs) and DP assisted projects/programs; (b) prescribing formats for the accounting of financial transactions; and (c) following up on previous audit observations and recommendations of audit reports.

13. **The Commission for the Investigation of Abuse of Authority.** The CIAA is a constitutional body created by the Constitution of Nepal 2007, Part 21, Article 238. It is one of two main anti-corruption agencies, with the CIAA having the legal authority to take action against corruption. The CIAA can present cases it has investigated to a special court, and outcomes can address corrupt acts of the types described in various anti-corruption laws and other legislation, including the CIAA Act 1991, the Prevention of Corruption Act 2002, the CIAA rules 2002, and the Anti-Corruption Committee Action Plan, 2008. The CIAA is required to work in accordance with the legislation mentioned, apart from the Code of Conduct for CIAA Commissioners and Staff, 2008. As mandated by the law, the CIAA presents an annual report to the President, who then presents the report to the legislature.

14. **Public Accounts Committee.** The Public Accounts Committee is a parliamentary committee of the House of Representatives. It is headed by a member of the main opposition party and comprises of members representing all parties in the Parliament. The main functions of the PAC are to: (a) examine GoN accounts and (b) discuss the OAG's report.

15. **Financial Comptroller General Office**. The major responsibility of the FCGO is treasury management. The FCGO oversees all government expenditures against the budget, centrally records revenue collection and other receipts, and prepares consolidated financial statements. Its functions cover conducting internal audit of revenue and expenditures. Responsibilities include ensuring timely repayment of internal and external debts, investing in loans and equity of public enterprises, and maintaining records of these financial transactions. It also manages pension distribution to retired government employees. The FCGO has 4 divisions and 14 sections. Its field offices are spread across all 75 districts of the country. Each district has a District Treasury Controller Office (DTCO) that is involved in making payments based on request of the spending units within the approved budgets of government offices, budgetary controls, and reporting. One office under FCGO manages pensions of retired civil servants. The Government Dues Recovery Office is responsible for recoveries. The FCGO is a key stakeholder of the Program.

16. **Public Procurement Monitoring Office**. The main function of the PPMO is to prepare a public procurement policy and recommend implementation measures to the Government. The office also coordinates procurement, including debarment proceedings, and supports capacity building through professional development plans and training for public officials and bidders. It also plans and coordinates TA on public procurement and functions as the secretariat of the Procurement Review Committee. The PPMO reports to the Government annually. It also monitors public procurement through site visits. It is a key stakeholder of the Program.

17. **Ministry of Finance**. In addition to the FCGO, the MoF will be involved mainly through the International Economic Cooperation Coordination Division (IECCD), which is responsible for mobilization and optimal use of resources through foreign aid for accomplishing the development goals of reducing poverty and realizing sustainable, high-economic growth. The Budget and Program Division helps in implementing government fiscal policies by preparing public expenditure plans needed for attaining sustainable and pro-poor growth facilitated by a stable, prudent, and sustainable macroeconomic environment. The PEFA secretariat was established in 2009 to coordinate PFM reform activities. The Finance Secretary is the chair of the Steering Committee, which provides overall policy and reform guidance. A Working Committee with representatives from all PFM-related institutions executes the reforms. The role of the PEFA secretariat in the Program is important as a number of fiduciary improvement actions will require coordination between the MoH and the MoF. The PFM and procurement reform agendas of the MoH need to be coherent with the reforms led by the MoF.

(c) Expenditure Framework

18. The Program's Expenditure Framework[27] will be entirely funded through the GoN's National Budget, and will be implemented through the use of GoN's systems in terms of budget preparation and execution, cash management, accounting, financial reporting, internal controls and external audits. The GoN's budget is a credible predictor of actual expenditures since the difference between actual and original budgeted expenditure is generally below 5 percent. While the overall NHSS program has been costed, it is not possible to directly correlate budget line items with the NHSS outcomes covered by the Program since the GoN budget does not present a program-based classification that could link inputs to outcomes. Nevertheless, the budget execution reporting mechanisms (cash management, financial reporting, and external audit) allow for a sufficient monitoring of budget proceeds as indicated in this assessment.

19. Bank proceeds will be transferred to the GoN's consolidated fund (the General Fund) at the Nepal Rastra Bank in Nepali Rupees and fund the execution of the GoN's budget. The IMF safeguards assessment mission of September 2015, while making important recommendations to improve the internal control framework of the Nepal Rastra Bank has not indicated that specific safeguards measures would be required.

20. The Program's Expenditure Framework has been designed to minimize its exposure to fiduciary risks, and in particular, the risks related to procurement. The Program's Expenditure Framework does not include procurement of pharmaceuticals, medical equipment and civil works.

[27] A complete description of the Expenditure Framework is found in Annex 4 "technical assessment", section B and will not be repeated here.

III. Program's Fiduciary Performance and Significant Fiduciary Risks

(a) Financial Management Systems

21. The Program's FM implementation arrangements have been assessed to evaluate the capacity of the implementing agency to record, control, and manage all Program resources and produce timely, understandable, relevant, and reliable financial information for stakeholders.

Program Planning, Budgeting and Transparency

22. Nepal's health budget is based on an item-based administrative classification complemented with an economic classification. The functional classification is too aggregated to be useful at sector level. There have been attempts to introduce a performance or output-based budget in relation to the attempt to introduce performance-based grant agreements between MoH and health institutions. However, these attempts have remained tentative and limited.

23. Nepal's annual non-salary health budget is spread amongst 300-400 spending units which is a challenge during the planning and budget preparation phase. The progressive introduction of eAWPB at the spending unit level started in 2011/12, and supported by the Program, has the potential to halve the budget preparation time and reduce the scope for error, abuse and loss of spending control. Overall, the budget preparation process is characterized by limited coherence between the planning phase and the budget preparation phase. The medium-term perspective in budget preparation is limited and the Medium Term Expenditure Framework developed at the MoF level has not been used so far by the MoH in the annual budget preparation phase.

24. Off-budget expenditures are likely to be substantial at the health facility level since there is currently no national mechanism to capture the local income and expenditure of health facilities. This may contribute to increasing fiduciary risk at health facility level. Planned activities and budget data are recorded in the Line Ministry Budget Information System, whereas expenditure is recorded using TABUCS computer software by offices. The TABUCS enables MoH to capture local revenues, which addresses in part the issue of risk in facilities where it is deployed. The Program incentivizes more robust and complete reporting through rolling out TABUCS to all cost centers.

Program Accounting and Financial Reporting

25. The FSA identifies substantial weaknesses in terms of recording and reporting of expenditures because of the difficulty in collecting financial reports from cost centers in a timely fashion. The MoH has access to the Treasury Single Account (TSA) data, but these do not provide activity-based information. There are issues of reconciliation between FCGO accounts and the accounts produced by the MoH which may be partly due to delays from the MoF to produce information on virements.

26. Accounting and financial reporting is the function of the FCGO which manages the consolidated fund of the government at the Nepal Rastra Bank (central bank) through a network of DTCOs. Accounting is done at the DTCO level and centralized at the FCGO which produces annual financial statements. These annual financial statements are published on the FCGO website. An IT TSA has been developed and is used in all 75 districts to support this expenditure

management and reporting process. A parallel system, that is, TABUCS has been developed in the MoH to cater to the following needs at cost center level:

- To have a system that would record revenue and expenditures of individual cost centers at activity level. The TSA system managed by the FCGO does not allow capture of expenditures at activity level and does not record off-budget revenue collected directly at the health center level.
- To have a unique computerized system in DHOs.
- To prepare consolidated financial reports to FCGO for reconciliation with TSA data, the OAG and to external donor partners.

27. TABUCS is yet to be rolled out to all cost centers. At present TABUCS is not connected to the TSA or other MoH FMIS sub-systems like the eAWPB and the LMIS. The Program incentivizes the regular use of TABUCS across all cost centers and linkages with the eAWPB. At the same time, the potential of TABUCS to be a comprehensive tool for budget planning, monitoring and reporting and function as an internal control mechanism is weakened by the lack of connection to the MoF budget preparation and management system. Establishing these connections has been assessed to be technically feasible but ownership for this is required by MoH.

Treasury Management and Funds Flow

28. Line ministries are provided reliable information on commitment ceilings in advance. Rule 32 of the Financial Procedures Regulations, 2007 states that after the enactment of the Appropriation Act, the Finance Secretary will send the budget statements and an authorization letter to the secretaries of ministries, and the secretaries of ministries will send to departments and offices similar authorization letters, approved programs, sources of expenditure, and detailed line items within 15 days of the receipt of the MoF authorization. Priority one projects (80 plus of total budget) are assured one-third of funds from the approved budget on the first day of the fiscal year and expenditure funds are replenished on the day statement of expenditure is submitted to the DTCOs. Likewise, priority two and three budget lines are assured one-sixth or an amount equal to two months of the approved budget value.

29. Upon enactment of the Appropriation Act by Parliament, a statement of programs and projects with the ceiling of the budgeted amounts (the Red Book) is issued simultaneously. The Red Book provides ministries with reliable indication of actual resources available for commitment more than one and half months in advance.

30. There are transparent legal provisions for adjustment and virement from one budget heading to another and one source of financing to another. Nevertheless, the amount and number of in-year budget transfers is significant, as evidenced by the 2015 PEFA assessment.

31. Substantial progress has been achieved in the last few years in terms of treasury management and funds flow in Nepal with the implementation of the TSA system. This system has reduced the number of bank accounts controlled by the government (from 14,000 accounts for 4,500 cost centers to around 400, controlled by DTCOs) and integrated them into a TSA. This allows for real-time monitoring of budget expenditures and the daily publication of budget execution reports (BER) on www.fcgo.gov.np/publications. All budgeted public expenditures are

captured across all 75 districts. The TSA comprises a revenue collection module (RMIS) now covering more than 80 percent of government budgeted revenues and a commitment recording system is being implemented, starting in 2016. This system is IT based and has strengthened ex-ante budget controls, the credibility of budget execution data and the knowledge of Treasury cash position and forecast.

32. Assessment of the system has identified several weak points. For budget execution, the flow of funds is entirely under the control of FCGO. Line ministries send payment orders to the DTCO which processes payments through its network. In the case of MoH, it transfers about 50 percent of its budget to the decentralized spending levels. There is an accountability gap below the district level and the TSA does not cover expenditures incurred at village development committee (VDC) or municipality level. These local entities receive grants that are spent outside the system and reported ex-post at the DTCO level. This ad-hoc reporting mechanism is not automated and is not always complied with, or is prone to omissions and errors. TABUCS was designed to cover these risks once it is rolled out to all spending units. Secondly, all expenditures and revenues incurred at decentralized levels are not always captured by the system. For example, revenues collected and expenditures incurred at the level of health facilities are not fully captured at MoH. Similarly, there is a lack of complete reporting of donor-funded expenditures that are off-Treasury and for autonomous government agencies. The autonomous government agencies in the health sector are complex with a large number of health facilities, centers and other entities with varying legal status and varying degrees of integration in the government budget system. At the country level, the OAG estimates the number of autonomous government agencies to be around 1460 units, representing 25 percent of public sector expenditures.

Program's internal controls, including internal audit

33. There is no national framework for internal controls in the public sector in Nepal. There are internal control guidelines published in the MoH but implementation and ownership remain weak. In practice, expenditure management does not provide for sufficient ex-ante controls to prevent expenses from being incurred in contradiction with the legal and regulatory framework, in the absence or insufficiency of credits, or in contradiction with the intended purposes of these credits. Consequently, particularly in the health ministry, an increasing amount of expenditures are questioned or declared ineligible by the OAG in its annual audit reports. As per the audit report of the OAG for the year ended July 15, 2015, questionable irregularities amount for MoH was Rs. 2,236.4 million including outstanding advance of Rs.529.2 million. The OAG is also limited in the scope of its audit because books of accounts of MoH's expenditures of Rs. 107.80 million consisting Rs. 49.3 million of National Tuberculosis Center, Rs. 54.8 million of National Tuberculosis Center and Rs. 13.7 million of DHOs were not presented to audit and Rs.17,024.9 million was not included in the accounts of the ministry. There are various possible reasons for this, one being that several MoH entities are subject every year to an investigation by the CIAA and therefore cannot submit their accounts before this investigation is settled. During NHSP 2 a Financial Management Improvement Plan (FMIP) was prepared and is jointly being monitored by the DPs and government. Since then, several of these audit irregularities have been resolved by MoH resulting in a final ineligible amount of Rs. 241.65 million. The ineligible expenditure due to IDA was refunded on December 15, 2016.

34. The OAG is the final authority to report on weaknesses in the internal control system. It identifies irregularities, errors and omissions in the expenditure cycle. There is an extensive backlog of unsettled audit queries that the MoH is having difficulties in reducing. While audit clearance guidelines have been issued by the MoH to this effect they are not systematically implemented. An efficient internal control framework is critical to avoid this situation.

Program audit

35. Each year, the OAG conducts a compulsory final audit of all MoH cost centers. It also conducts random performance audits, which were carried out in around five health institutions in the last two years. These performance audits are made available to the Bank and also reported in OAG's annual report. MoH gives a high priority to responding to audit queries. However, there remains a sizeable volume of unaudited expenditure. For this, MoH, has prepared a detailed record of the audit queries related to all its cost centers. This report has been published and distributed to all responsible authorities under MoH as evidence of the extent of the problem. The report has been also uploaded on to MoH's TABUCS website http://pfmis.mohp.gov.np for access by MoH officials and TABUCS users.

36. The program expenditures that can be financed under the PforR financing need to be expenditures with budget codes in the PforR Expenditure Program Framework (see Table 4.3 above). Towards Program closure, a reconciliation of expenditures that can be financed under the Program and disbursements made by the Bank would be made. In order to facilitate this reconciliation, the expenditures with budget codes that can be financed under the Program must be distinctly presented in the audited statements. The aggregate disbursements under the Program should not exceed the total program expenditures by the Government, taking into account other sources of financing, if any. If, by Program completion, Bank financing exceeds the total amount of Program expenditures, the Borrower is required to refund the difference to the Bank.

37. MoH formed an Audit Committee in April 2012 formed with high-level MoH officers. The secretary of MoH chairs the committee. The committee's role according to its terms of reference includes strengthening the internal control system, ensuring financial discipline, organizing regular meetings and responding to audit queries. This committee has taken the lead in preparing and finalizing MoH's audit clearance guidelines and internal control guidelines. The committee recently instructed all concerned cost centers to clear their audit backlogs and also committed to build the capacity of finance officers on clearing audit backlogs.

38. There is evidence, confirmed by conversations with the OAG's leadership, that the OAG will be able to prepare audit reports on MoH's expenditures as well as performance. The OAG usually produces its reports on MoH quite late which has complex reasons related to audit programming, dispersion of cost centers, late submission of accounts and supporting documents by MoH. The Bank is reinforcing its dialogue with the OAG to find adequate solutions to improve the situation. A joint Bank-OAG workshop took place June 27, 2016 around this topic and elements of an action plan have been discussed.

(b) Procurement Systems

Arrangements for procurement under the Program

The legal framework*:*

39. The LMD within MoH is responsible for procurement and supply chain management of about 70 percent of health sector commodities for the entire country.

40. The LMD's procurement is governed by Nepal's Public Procurement Act (2007) and Public Procurement Regulations (2007). Under these provisions, a PPMO was established and functions directly under the Prime Minister. It has powers to evolve policies concerning procurement and has also authority of oversight over all procurement agencies including the LMD. It entertains complaints from all stakeholders, calls for reports from the procurement agencies and takes suitable actions. Under the present legal framework, open tender is mandatory for procurement above NPR one million, whereas sealed quotations are required for procurement between NPR 0.15 and 1 million. The LMD has to follow these regulations as well as any other directions of the PPMO. Under these overall guidelines, the LMD follows International Competitive Bidding (ICB) for bids above US$500,000 and National Competitive Bidding (NCB) for amounts below this.

Procurement Planning

41. Under the Procurement Regulations, the LMD has to prepare a Master Procurement Plan (MPP) and a Consolidated Annual Procurement Plan (CAPP) and submit it to the PPMO. While the MPP is for long term, the CAPP is prepared annually, which guides the procurement operations of the LMD. For the preparation of the CAPP, the divisions of the DoHS provide the inputs on what they need during the year, with the LMD playing a coordinating role. The division heads assess the requirement for their programs, approve their requirement for the year and identify the funds in consultation with the finance units. The LMD holds a series of meetings with the divisions before consolidating the requirements of pharmaceuticals, medical equipment and health commodities along with funds. Once the annual budget is finalized by the government, necessary changes are made in the CAPP to bring the requirements in line with the available funds. The final CAPP is then sent to the PPMO which publishes it on its website. The LMD also publishes it on its website, although there is no legal requirement to do so.

Supply Chain Management

42. The LMD is running two central warehouses and five regional warehouses. The procured goods are delivered at these warehouses from which they are transported to the district warehouses by transport contractors. These warehouses are managed by the employees of the LMD. LMD has a LMIS to collect inventory data from these as well as the district warehouses. In addition, inventory data from health facilities is collected to monitor stock outs. However, it is not an online system. Paper-based reports are generated every quarter, though not from all the facilities. As of July 2016, the paper-based report is available only for April 2016 with only 74 percent reporting. Thus, the reports are neither complete nor up-to-date, and hence cannot be used in a meaningful way for effective supply chain management.

Major Issues Faced by the LMD

43. Many studies on the working of the LMD have been undertaken over the years identifying constraints which are briefly discussed in the following paragraphs.

Structural Weakness

44. LMD is led by a Director who is a medical professional. The procurement wing within LMD is managed by an Under Secretary who has little exposure to procurement. Since the tenure is normally two years, he moves on by the time he gains some knowledge. Similar is the problem with the logistics wing, which is now under a Section Officer, who has no exposure to supply chain management or LMIS. Absence of a trained quality assurance manager has affected quality assurance. This major organizational weakness has been addressed by employing embedded TA, but it has not always been successful.

Delays in Procurement Decisions

45. Finalization of the CAPP itself takes considerable time. Similarly, procurement decisions at every level are delayed for various reasons. There is no procurement monitoring system to see whether timely decisions are taken or not. It is reported that procurement is bunched in the last quarter of the year.

Standardization

46. Specifications for drugs and other health goods have not been standardized and are often left to the discretion of the program divisions. Since the country does not have its own pharmacopeia, the tender document permits the bidders to adopt any of the major pharmacopeia. This is certainly not a good system; it is better that LMD finalizes its own specifications and adopts it in its tenders to simplify its procurement process avoiding delays and disputes on interpretations.

Poor Quality Assurance System

47. There is no organizational capacity for pre-shipment or post-shipment quality assurance – in fact, post-shipment quality assurance is not even attempted.

Weakness in Supply Chain

48. The LMIS is not online and the LMD does not have access to real time data. No useful management information statements are generated to help the management take decisions. The capacity of warehouses could be a constraint in addition to the capacity of the people managing the warehouses. As a result, there are reports of frequent stock outs as well as excess stock leading to wastage. For example, Chloroquine had a stock for 224 months as of December 2015, while Primaquine for 199 months. Even when the stocks of these goods were in excess, orders for further quantities had been placed[28]. The concept of buffer stock, maximum stock, orders based on the stock position to maintain the desired stock level is not followed. It is estimated that Amoxycillin expiring in December 2015 was worth more than US$500,000; at the same time a rapid assessment showed that almost 60 percent of the centers surveyed were out of stock of Amoxycillin[29]. In short, procurement and supply chain management have not been integrated and managed well to maintain the optimum inventory levels at the district warehouses.

[28] NHSSP data.
[29] Pharmaceutical Supply Chain in Nepal

49. Based on the data collected from the LMD for April, 2016, an analysis of inventory of top 17 goods whose consumption was the highest was made. The analysis showed that stocks of many goods were just for a few months, although the LMD has stipulated that the minimum stock should be for 12 months and the maximum 24 months. The stocks of a few goods far exceeded the prescribed levels. Further, in the list of 215 goods for which stock position was given, stock outs were reported for 11 goods, 37 had a stock of less than 1,000 units and 68 had less than 10,000 units. If this was the overall position, much worse would be distributed position. This highlights the need for an online system coupled with good supply chain management capabilities.

Performance of the LMD

Value of Procurement

50. While the Program will not finance procurement of vaccines, medical equipment and drugs, the value of procurement by the LMD during the year 2015-16, as indicated below, will inform the overall estimations of such procurement for several DLIs:

NPR in millions

S.No	Commodities	Allocated	Contracted	Percentage
1	Vaccines	320	273.5	85.47
2	Equipment	290	48.8	16.83
3	Drug	1000	408.4	40.84

(Source: LMD)

Contracts Settled

51. Similarly, the details of the number of contracts planned and the number finalized for the year 2015-16 are furnished in the table below:

S. No	Procurement Method	Number of contracts	Number started bidding processes	Contract finished
1	ICB (Goods)	161	148	54
2	ICB (Works)			
3	Direct Contract(DC)			
4	LIB			
5	NCB (Goods)	33	11	11
6	NCB (Works)	1	1	1

7	NCB (Non Consulting Service)	6	6	6
8	QCBS (Consulting service)	3	1	0

(Source: NHSSP)

52. From the above, it may be seen that the procurement performance of the LMD is below par leading to stock outs and excesses. Poor supply chain management further aggravates the stock outs.

Independent Procurement Review

53. The Independent Procurement Review done as part of this assessment highlights the need for standardization of specifications, preparation of sector specific standard bidding documents, and a compendium of instructions or a manual for procurement. It also highlights the need for staff adequately trained on procurement and contract management, to be available on a sustained basis within LMD. The report points out the absence of a systematic mechanism to receive and deal with complaints from bidders / suppliers / consultants. It has rated bidder participation, bid evaluation time, and the time taken for payment from invoice as satisfactory.

Procurement Reform Action Plan

54. A World Bank study done at the request of the GoN in 2014, suggested a number of models for improving procurement and supply chain management in the MoF. After in-depth internal discussions and consultations with the DPs and experts, a Procurement Reform Action plan was prepared by the LMD, which was approved by the MoH in April 2015. This plan is expected to address all the above mentioned deficiencies faced by the LMD within a timeframe so that quality health goods are available for the people of Nepal without any shortage or excess. This Procurement Reform Action Plan may need to be revised if institutional and structural changes occur following decisions about a new federal structure.

(c) Fraud, Corruption and Debarment of contractors

55. The main objective of the integrity review, as part of the FSA, was to confirm whether the legal framework and institutional mechanisms in place would enable MoH to abide by the Bank's Guidelines on Preventing and Combating Fraud and Corruption in Program-for-Results Financing.

56. While there are weaknesses in accountability, the review of the status of integrity systems in the sector found that there is increasing recognition within the GoN of challenges posed by fraud and corruption to development outcomes. This is seen in particular in the fact that the budget for the financial year 2016-2017, presented by the Finance Minister in late May 2016, had several paragraphs devoted to anti-corruption[30]). This notes that "…*intensive monitoring will be made to end the improper and corrupted activities between beneficiaries and service providers….Middlemen will be under surveillance….Social awareness against corruption, recognition of zero tolerance against corruption and integrity will be promoted." Moreover,*

[30] The GoN, Finance Minister Budget Speech, 2016, pp 54-55, para 363-366

resources will be assigned to this work, i.e., "…The capacity of constitutional bodies related to investigation and prosecution will be developed. Necessary law, resource and manpower will be arranged." This may indicate a renewed focus on these issues and suggests that resources may be assigned to this area, and to efforts to redress the - weaknesses as described below.

57. The integrity review corroborated the national view and identified fraud and corruption risks in the sector as High. This was also observed in a recently completed in-depth audit conducted by the WB's Integrity Vice-Presidency (INT) that highlighted fraud and corruption risks associated with procurement of medical and pharmaceutical supplies. Of note, in this area is the high level of investigative or related activities in the sector of the country's anti-corruption authority. The CIAA reported it noted about 1422 complaints concerning the Department of Health (DoH) over the course of the past financial year, and, although many of these had been looked into by the time of the review, the CIAA still had 122 cases open.

58. The review found that MoH had weak integrity /ethics systems, policies and procedures covering complaints-handling of integrity or fraud and corruption issues, and systems to monitor redress of misconduct as defined by the Bank's Guidelines on Preventing and Combating Fraud and Corruption for PforR Financing. However, the Program's expenditure framework of US$340 million which includes expenditures in the annual budget that finance consumption expenses, operational and service and production expenses, is likely to ring-fence these funds from the types of procurement-related fraud and corruption risks that have been reported and highlighted by the investigations mentioned above. Reportedly, audits performed by the OAG and the Bank's health sector team's experience over the past ten years, indicate that fraud and corruption issues have not been reported in salary-related expenditures.

59. **Local authorities.** The CIAA is a constitutional body created by the Constitution of Nepal 2007, Part 21, Article 238. Complaints are reported in a variety of ways, including, but not limited to: in-person at the CIAA main office or district offices, by mail, by phone, by email, or through the web link attached to the CIAA website (http://ciaa.gov.np).

60. **The National Vigilance Center** is another agency that may look into fraud and corruption issues that are reported to or observed by the center in the course of conducting special reviews or audits. For example, the center carries out a periodic Technical Audit of bridges and other infrastructure that has been financed under the World Bank-supported Bridges Improvement and Maintenance PforR, which is the only other PforR currently in the WB portfolio. The CIAA is present, or is at least invited, whenever the National Vigilance Center presents findings of its Technical Audit, as agreed under arrangements for this PforR.

61. The review also found that MoH does not have specific preventive mechanisms in place to identify and prevent the types of misconduct defined in the Guidelines on Preventing and Combating Fraud and Corruption in PforR Financing. Improvements in this area are envisioned throughout implementation of the PforR, given its emphasis on improving internal and fiduciary systems. The review also noted that MoH does not have systems that are able to address a potential issue that a complaint raises in a systematic manner, in order that the relevant internal control mechanism may prevent recurrence of such issues. Internal control mechanisms, especially with respect to procurement, are weak, and thus are not able to prevent recurrence of identified fraud and corruption issues. However, the thrust of the overall PforR is aimed at strengthening a variety

of internal management areas, including those related to integrity and fiduciary matters, thus the intention of the Program is to support reforms to improve the current situation.

62. **Ethics and Code of Conduct.** The review did not find a system that continuously supports and monitors a code of conduct in MoH. Monitoring of complaints however, is done by a Governance Unit placed within the Human Resources and Financial Management Division in an agreed format. Complaints and grievances received relating to fraud and corruption and other administrative matters from across the GoN are updated periodically in the MoH and action taken reports provided to senior management. The Program will support further strengthening of this function.

63. **Whistleblower.** There are no organized avenues for civil servants to report fraud and corruption complaints anonymously; although they can use the various channels the public uses to report complaints to the CIAA.

64. In conclusion, given the weaknesses or lack of systems in this area, and the high level of fraud and corruption risks at the sector level, under the PforR, the Government and the Bank have agreed on a modality to share with the Bank complaints received under the Program regarding fraud and corruption. This is part of the PAP.

(d) Summary of significant fiduciary risks

65. Based on the assessment of fiduciary systems conducted in the above section, the following significant fiduciary risks have been identified for the Program:

i). There is a weak link between policy intent and the budgeting of resources. This leads to the question of how IDA proceeds that would be used to achieve the objectives of the Program will be reflected in the Budget, and used towards achieving the objectives of the Program.
ii). The capacity at the MoH to assess the performance of the Program and manage results indicators is weak.
iii). Weakness in the internal control framework within MoH poses a risk that Bank proceeds might be expensed in contradiction with the legal and regulatory framework and therefore be subjected to external audit queries.
iv). Low capacity of the unit in charge of MoH procurement.
v). In particular, the complexity of the MoH expenditure framework, with more than 400 cost centers, including autonomous agencies, local level spending entities and the lack of sufficient accountability mechanisms at this level (local and autonomous levels), is a risk. Parliamentary oversight and the capacity of the Public Accounts Committee remains fragile.

66. Fiduciary systems also present elements of strengths that will constitute a sound basis for the Program if complemented by measures to strengthen the fiduciary system:

i). A sound government budget process in terms of timeliness, classification and execution control by Treasury.

ii). Transparency of the budget process with daily budget execution reports published on the FCGO's website and timely production and publication of Budget documents and annual financial statements

iii). A systematic external audit of government expenditures, including in the Health sector, by an independent OAG and an increasing capacity of the OAG to conduct performance audit, including in the Health sector.

iv). A Program that has been designed to avoid the major identified risks in procurement and fraud and corruption.

IV. Mitigation Measures and Monitoring of Fiduciary Performance

67. The Program fiduciary systems are generally in line with international standards in terms of budget process and transparency. Besides, the Program Expenditure Framework has been designed in view of minimizing the Program's exposure to country systems' risks. At least eight of the eleven DLIs under the program directly address fiduciary risks described above and serve as robust mitigation measures that institutionalize new ways of working. This provides reasonable assurance that the financing under the Program will be used for the intended purposes. Existing deficiencies and weaknesses have the potential to affect the ability of the Program to achieve its intended results. Therefore, key measures have been integrated into a Program Action Plan based on the findings and conclusions of the Fiduciary Risk Assessment. This will largely mitigate the fiduciary risks and weaknesses identified. The recommendations in the Fiduciary Action Plan are in line with the GoN's priorities as reflected in the current FM and Procurement Health Action Plan and in the National PFM Strategy endorsed by the PEFA Steering Committee in March 2016. In addition, a key mitigation measure related to fraud and corruption will be the compliance by government with the provisions of the Bank's Guidelines on Preventing and Combatting Fraud and Corruption in Program-for-Results Financing.

68. Nevertheless, considering the existing weaknesses in Program fiduciary systems and the time and effort required to implement the Program Action Plan and the capacity building initiatives, the residual fiduciary risk rating for the Program is rated as ***High***.

Mitigation Principles

69. The assessment suggests the following mitigation principles that could form the basis of a fiduciary action plan for improving the general performance of fiduciary systems supporting Program implementation. Critical actions that the Program will directly support are included in the Program Action Plan (see Annex 8).

i). In compliance with the Guidelines on Preventing and Combating Fraud and Corruption in PforR Financing, the Government of Nepal will provide periodic reports to the Bank on allegations of fraud and corruption related to the Program that: (a) have been received by the Governance Unit in the Department of Human Resources and Financial Management of the MoH from the Commission for the Investigation of Abuse of Authority; and (b) have been received by the Governance Unit and referred to the CIAA for further investigation. This report will be provided on an annual basis, no later than by September 1 every year, and contain the following information: (a) basic information and description of the allegation; (b) date of allegation; and (c) status of allegation handling.

ii). The establishment of a Program Fiduciary Committee jointly chaired by the MoF and the MoH. It would include key stakeholders of the MoH as well as the FCGO and IECCD in the MoF and representatives from the OAG. The PEFA secretariat will have a key role in insuring coherence between the fiduciary strengthening program of the MoH and PFM reforms lead by the MoF. This committee will meet once in 4 months in a year, in alignment with the production of key Program monitoring documents and be responsible for financial management and procurement aspects of the program. It will follow the implementation of the fiduciary dimension of the Program Action Plan (PAP) and adopt rectification measures if needed. (MoH, MoF, OAG)

iii). Develop the capacity of human resources working in financial management (MoH/Departments DoHS and spending units) through an integrated phased training program. The objective will be to support the capacity of the staff to establish financial statement and produce financial information as well as conducting results-based monitoring. (MoH, MoF, World Bank)

iv). MoH will need to provide quarterly Interim Unaudited Financial Reports for the NHSS. Annual audited Reports will be provided by the OAG. These will be provided no later than 45 days and 9 months respectively after the end of the period covered and the same will be used by the Program for fiduciary due diligence. (MoH)

v). The OAG, in addition to the Program's financial audit could conduct annually a performance audit of the Program, focused on its entirety or specific aspects of it. (OAG, MoH)

vi). Strengthen payroll controls through reconciling staff lists and payroll and implementing the internal control manual in its payroll aspects. (MoH, MoF)

vii). Strengthening the internal audit function of MoH.

viii). Building a PFM performance M&E system and regularly monitoring progress in this area. This periodic evaluation will feed into the fine-tuning of the FMIP. The methodology used will be based on a small number of key PEFA indicators (e.g. internal control, asset management, public investment management) (MoH, MoF).

Annex 6: Summary Environmental and Social Systems Assessment

1. In accordance with the World Bank's Policy/Directive on "Program-for-Results Financing", the World Bank has conducted an ESSA of Nepal's existing environmental and social management systems for the health sector. The ESSA was undertaken to (a) identify risks and impacts associated with the Program; (b) assess the strengths and weaknesses of the legal, institutional, and implementation frameworks; and (c) recommend measures to strengthen national systems and capacity to deliver the PforR in a sustainable manner.

2. The ESSA concludes that the environmental and social impacts of the Program are low. While the Program boundaries and financing do not cover interventions at health care facilities, the Government's program has the following environmental and social risks associated with it: (a) risk of spread of infection through badly managed infectious waste and poor occupational health and safety practices and (b) contamination of land, water, and air through haphazard disposal and incineration of infectious and chemical solid and liquid waste. In addition, risks common to both the larger NHSS and the PforR are (a) continued equity gap and wide variations across different population groups with regard to health status and access to health services and utilization and (b) lack of awareness, inadequate consultations, and citizen engagement, including with vulnerable groups.

3. The ESSA was undertaken as per the requirements of Bank policy on PforR Financing to effectively manage Program risks and promote sustainable development. The analysis was conducted using the Strengths-Weaknesses-Opportunities-and-Threats approach. The 'weaknesses' or gaps, are considered on two levels: (a) the system as written in laws, regulations, procedures and applied in practice and (b) the capacity of Program institutions to effectively implement the system as demonstrated by performance thus far. The analysis focused on the strengths and gaps associated with the systems in place in the health sector to address the potential environmental and social impacts commensurate with the nature, scale, and scope of operations.

4. The main Government institutions with responsibilities for environmental and social management in the health sector include the following:

- **The MoH** has overarching responsibility for infection control within its premises and management of infectious waste as the generator. However, there is no separate unit/cell within the ministry nor at the departmental or hospital level with the responsibility for overseeing the overall environmental issues relating to the health sector. The management division within the DoHS has the mandate to monitor program implementation status and carry out periodic performance reviews which includes health care waste management. Capacity building and training are the responsibility of the management division. An M&E Department in the MoH is responsible for monitoring all the activities related to health services including health care waste, but does not have adequate support and human resource to undertake this activity.
- The **GESI Steering Committee** at the ministry level is responsible for mainstreaming GESI in the health sector, and taking the lead role in institutionalizing GESI. There are Technical Working Groups at various levels, which are responsible for

implementing GESI-related activities and mainstreaming GESI in divisional programs.

- The **NHRC** drafted the first health care waste management guidelines, in collaboration with WHO, with the aim to help health care institutions implement a sound health care waste management system. The guidelines were successful in sensitizing the Government, health care institutions, policy makers, planners, and the civil society of Nepal.
- **MoPE** is the legally mandated agency for approving and giving clearances to Environment Impact Assessments and is currently in the process of drafting the health care waste management regulations.
- **Solid Waste Management Technical Support Centre** under the Ministry of Federal Affairs and Local Government is responsible for formulating policies pertaining to solid waste management and for providing technical support to municipalities for management of solid waste but does not directly undertake solid waste management operations.
- The **Ministry of Urban Development** has the mandate to develop and manage basic urban infrastructure services such as housing and solid waste management.
- The **Ministry of Water Supply and Sanitation** formulates policies related to water supply and sanitation, formulates plans and programs, implements, monitors, and evaluates works related to water supply and sanitation.

5. The Environment Protection Act (1997), Solid Waste Management Act (2011), Gender Equality Act, 2006, National Foundation for Upliftment of Adivasi/Janjati Act, 2002, and Domestic Violence (Crime and Punishment) Act, 2009 and so on, are the primary legislations that support environmental and social management in the health sector in Nepal.

6. The ESSA found that current practices at most health care facilities are deficient and inadequate, with poor infection control and occupational health and safety practices, unsatisfactory infectious waste management, including treatment and disposal of infectious wastes posing a high risk of spread of infections and other infectious diseases. Pilot programs on good infection control practices, zero-waste initiatives, and use of nonburn technologies have been successfully initiated and implemented, although not systematically replicated. Health care waste management guidelines prepared by the MoH are being implemented, but in a piecemeal manner. There has been no systematic implementation because of (a) lack of a regulatory framework for infectious waste management; (b) absence of a national coordinating institutional mechanism and strategy; (c) narrow view of health care waste management rather than a cradle-to-grave view of infection control and waste management; (d) insufficient and dedicated budget; and (e) lack of clarity of roles and responsibilities of various agencies involved in waste management. The draft health care waste management regulations and the existing health care waste management guidelines need revisiting and enhancement to include clarity on processes and responsibilities of different ministries and agencies.

7. The major social risks associated with the Program are primarily related to:(a) continued equity gap in health care services and wide variations across different population groups with regard to access to and availability of health services due to a number of barriers namely, financial, sociocultural, geographical, and institutional and (b) inadequate consultations and citizen

engagement, including with vulnerable groups and lack of awareness. The Program will support better outcomes with regard to equity outcomes and citizen engagement with all population groups. Improved PFM in the health sector linked with DLIs 7-9 will reduce the existing inefficiencies in public expenditure planning and spending and also facilitate better redistribution of resources through more evidence-based resource allocation and better targeting linked to DLI 10. This will contribute toward ensuring that affordable and appropriate health services are available to all, particularly the disadvantaged and vulnerable groups. DLI 2 and 11 on the Grievance Redressal and Citizen Feedback mechanisms and systems for public reporting is particularly relevant from a social development perspective.

8. The ESSA concludes that the environmental and social impacts of the Program are low. The analysis indicated that three of the six Core Principles were applicable to this Program. They are the following:

(a) **Core Principle 1: General Principle of Environmental and Social Management.** The analysis found that this principle is relevant for the Program with regard to improving infection control and waste management practices that have a direct impact on the objective of providing clean and safe health services.

(b) **Core Principle 3: Public and Worker Safety.** Issues related to infection control and good operating practices by health care workers dealing with chemicals and facing risks from infectious diseases. The provisions in Core Principle 3 are considered under Core Principle 1.

(c) **Core Principle 5: Indigenous Peoples and Vulnerable Groups.** The analysis found that it was relevant in ensuring that vulnerable and marginalized groups, including indigenous people, are included in the planning process (especially needs prioritization), implementation, and monitoring of Program activities; that vulnerable groups have access to Program benefits; and that the needs of vulnerable groups are considered with respect to the Programs impacts. Vulnerable groups include groups who have been systematically excluded over a long time because of economic, caste/ethnic, disability, and geographic reasons (for example, women, Dalits, indigenous people, Madhesis, Muslims, people with disabilities, senior citizens, sexual and gender minorities, and people living in remote regions), poor, unreached groups and those in underserved areas (geographical areas where health services are not adequately available due to various reasons including lack of staff, unavailability of drugs, geographic location, financial and management limitations).

9. The Program provides an opportunity to strengthen systems to ensure improved equity outcomes and easy and safe accessibility to health services for all, particularly the disadvantaged and vulnerable groups; better citizen engagement; and provision of safe, clean, and hygienic health services with reduced risk of infections. These systemic outcomes will be achieved through (a) strengthening the regulatory framework; (b) establishing institutional mechanisms and arrangements for implementation, coordination, and monitoring; and (c) enhancing institutional capacity through training, better guidelines, and development of standards. Monitoring and supervision of due diligence measures related to environmental and social issues will be a part of World Bank implementation support. Discussions and consultations carried out as part of the

ESSA analysis indicate a commitment, agreement, and willingness by the GoN, donor partners, and NGOs to address issues that are compromising the efficiency of health services and posing a threat to the environment. The findings of the ESSA and the recommended measures and action plans were discussed with a wide range of stakeholders. The recommended measures are shown in Table 6.1.

Table 6.1. Measures to Strengthen System Performance for Environmental and Social Management

Objective	Measures
Systems for environmental management	• The MoH to develop an Integrated Infection Control and health care waste management strategy by Year 1 (including implementation plan and institutional responsibilities for coordination, implementation, monitoring, and reporting) • Based on the strategy, the MoH to liaise with MoPE for the review and revision of the existing health care waste management regulations which will (a) mandate institutional, implementation and enforcement responsibilities related to infection control and waste treatment and disposal and (b) annual budgetary allocations. This will be done in consultation with all key stakeholders in government, private and NGO sector and donor agencies; • MoH will facilitate MoPE and ensure that the regulations are submitted for consideration by cabinet by Year 1.5 of the Program. • The GoN to approve revised health care waste management regulations by Year 3 of the program
Systems for mainstreaming GESI	• The MoH to expand the scope of GESI and improve the operational guidelines to include issues of disability, mental disabilities geriatrics, and rehabilitation of gender-based violence victims; and ensure interministerial collaboration and coordination with civil societies and strengthen one-stop crisis centers
Budgetary and institutional mechanism	• DLI Management and Coordination Unit at the MoH will be responsible for implementation of the ESSA action plan. (This could be done in collaboration with the management division of DoHS and the curative division of the MoH • The MoH to discuss with the MoF the requirement of a dedicated budget line with annual allocations within the MoH annual budget by Year 3. A flexible funding mechanism for DHOs/DPHOs to respond to local health needs and disparities and formalize criteria and implementation guidance to ensure that the needs and priorities of women and poor and excluded people, identified through the DHIS and citizen engagement, are addressed.
Technical guidance and implementation capacity	• The MoH to revise health care waste management guidelines to standardize procedures, processes, and implementation arrangements for infection control and waste treatment and disposal; demarcate roles and responsibilities of primary agencies including enforcement, multiagency coordination and budgetary requirements (in parallel with revision of the regulations) by Year 2. The guidelines should also include recommendations on waste treatment and disposal technologies, infrastructure and practices; use of personal protective equipment and occupational health and safety practices and supervision and reporting mechanisms. • The MoH to develop and/or update existing guidelines and training modules and methodologies in line with the revised regulations; rolling out of training at central, regional, district and primary health center levels by Year 3. • The MoH to develop a strategy for strengthening capacity of institutions and health facilities for mainstreaming GESI in planning, budgeting, implementation, and monitoring. This will include improving coordination and collaboration between different levels with other government sectors, external DPs, and civil society.

	• The MoH to provide support to gathering and analysis of evidence required for effective GESI planning, especially by utilizing information from the DHIS and citizen engagement procedures. • Continue consultations (with health staff and local community-based organizations, and NGOs working in the health sector, at the divisional, central, district, and regional levels) during the preparation of annual work plans and budgets to mainstream GESI activities. • Continue trainings to strengthen the skills of staff and focal points for mainstreaming GESI in planning, budgeting, implementation, and monitoring (especially with regard to identification of barriers faced by vulnerable groups in accessing health services, disaggregation of data, and delivering services in a GESI-sensitive manner).
Systems for information disclosure and stakeholder consultation	• DLI 2, which focuses on establishing a grievance redressal mechanism, will enable the provision of information on grievances received and addressed and thereby provide full disclosure and transparency. • DLI 11 will focus on developing and piloting citizen engagement mechanisms to gain feedback on the availability of drugs and facility-level services. In accordance with this DLI, the MoH will develop and operationalize pilot citizen feedback mechanisms and systems for public reporting for different geographical contexts and will adapt accordingly. • The MoH will monitor and evaluate citizen engagement plans and improve district- and central-level responses. This will include a functional mechanism to ensure that findings from these citizen engagement mechanisms are used to improve the accountability of service providers responsible for 'supplying' services.

Annex 7: Systematic Operations Risk Rating (SORT)

Table 7.1 Systematic Operations Risk Rating (SORT)

Systematic Operations Risk Rating Tool (SORT)	
Risk Category	**Rating**
1. Political and governance	High
2. Macroeconomic	Moderate
3. Sector strategies and policies	Moderate
4. Technical design of Program	Moderate
5. Institutional capacity for implementation and sustainability	High
6. Fiduciary	High
7. Environment and social	Low
8. Stakeholders	Moderate
9. Other (DLIs)	Moderate
Overall	High

1. The overall integrated risk for the program is rated as High. Although the technical design of the Government's program is sound and is built on wide consultations, sector management and institutional capacities in the MoH are weak. The political context is unstable and policy decisions may be undermined in an uncertain political environment. The shape and impact of federalism, as promulgated in the constitution, is so far unknown and this could affect the existing institutional structures that are being utilized to deliver health services and the Program. Globally the procurement of equipment and medical supplies are highly risk-prone areas, and this risk remains high in the context of Nepal. Further, given an environment of poor transparency and accountability, public resources are often not used appropriately. The Program recognizes these risks and supports the development of sustainable mitigation mechanisms through supporting policy and institutional reforms to facilitate more systemic transparency in procurement and in the use of public resources. It also supports accountability through building grievance redressal and citizen engagement mechanisms.

2. As with most ministries in Nepal, the implementing agency faces major institutional capacity issues. Specifically, in the MoH, the majority of professionals are trained doctors with limited management skills and training. As a result, critical areas of sector management such as PFM and procurement remain inappropriately staffed. Procurement reform is critical to the success of the Program. This requires key institutional reforms within the LMD, which in turn demands political and administrative will. This is a high implementation risk and will be closely monitored and assessed by the DPs.

3. The overall fiduciary risk remains high. The last five years have seen persisting audit irregularities (an increasing trend) and ineffective follow-up of audit findings. To address the fiduciary concerns, the Program is supporting, both through DLIs, and through the Program Action Plan, a series of reforms that will support better reporting and monitoring of public finances and support better internal controls within the MoH.

4. The overall environment and social risk is assessed as low. The Program's boundaries and financing do not cover interventions at health care facilities and therefore do not face risks associated with infection control at health care facilities and those associated with hospital construction. On the other hand, the Program's scope includes addressing equity and gender issues and therefore the Program interventions aim to ensure improved social inclusion and gender equality, and have been designed to mitigate risks. At the same time, the Program will also try and leverage policy dialogue and systems strengthening to mitigate some of the risks associated with the Government's larger program.

Annex 8: Program Action Plan

Table 8.1 Program Action Plan

Action Description	DLI	Covenant	Due Date	Responsible Party	Completion Measurement
1. Technical					
Establish and maintain a Health Sector Partnership Forum (HSPF) at the MoH	—	—	HSPF established by January 2017 and regular consultations held every year.	MoH	HSPF established and annual consultations held every year.
2. Environmental and Social Systems					
2.1 Revise regulations for infection control and health care waste management and submit for cabinet approval. 2.2 Expand GESI strategy (to include issues of disability, geriatrics, and rehabilitation of gender-based violence victims.	—	—	Within two years of implementation	MoH, MoPE	2.1 (a) Integrated infection control and health care waste management strategy developed to define roles and responsibilities of different actors and roadmap for implementation; (b) Revised regulations submitted to the cabinet by Year 2; (c) Status report on implementation of recommendations of strategy provided in years 3, 4, and 5 to the World Bank 2.2. The MoH to revise by end of year 2 GESI strategy to include expanded scope (including issues of disability, geriatrics, and rehabilitation of gender-based violence victims) and mainstreaming GESI in planning, budgeting, implementation, and monitoring.
3. Fiduciary Systems					
3.1 Strengthen the LMD capacity for planning and budgeting, procurement, supply chain, monitoring, and quality assurance. 3.2 Finalize CAPP by August 3.3 Establish a post shipment quality assurance system	—	—	3.1. Within one-and–a-half years of implementation 3.2 Each year by August 3.3 Continuous process	MoH (LMD)	3.1. Dedicated personnel in place to handle various functions separately. 3.2 CAPP prepared every year by August 3.3 (a) Terms of reference for post shipment quality assurance system approved

Action Description	DLI	Covenant	Due Date	Responsible Party	Completion Measurement
					and selection process initiated by end of Year 1 (b) Post shipment quality assurance system established and operational by end of Year 2
3.4 Improve accountability and reporting mechanisms of grants provided by the MoH to different entities	—	—	3.4 Continuous process	MoH	3.4 Grants provided to autonomous bodies are captured by TABUCS.
3.5 Undertake a Public Expenditure Tracking Survey in the health sector			3.5 By July 15, 2017		3.5 Public Expenditure Tracking Survey in health sector done
3.6 Strengthen the internal control environment of the MoH: (a) Analyze compliance gaps between actual practice and the MoH internal control framework (b) Identify key measures to strengthen internal controls within the MoH particularly for budget execution control and financial reporting			3.6 Continuous process		3.6 (a) Analysis done and (b) key measures identified and presented at the relevant PFM committee
3.7 The MoH reports on allegations regarding fraud and corruption related to the Program to the World Bank that: (a) have been received by the Governance Unit in the Department of Human Resources and Financial Management of the MoH from the Commission for the Investigation of Abuse of Authority; and (b) have been received by the Governance Unit and referred to the CIAA for further investigation. This report will contain the following information: (i) basic information and description of the allegation; (ii) date of allegation; and (iii) status of allegation handling.	—	—	3.7 Annually by September 1	MoH	3.7 Report on allegations regarding fraud and corruption related to the Program submitted to the World Bank annually.

Annex 9: Implementation Support Plan

1. The proposed implementation plan is consistent with the Program-for-Results operational guidelines and is based on lessons learned from the implementation of past and ongoing projects in Nepal, as well as the Program's specific challenges and risks. Program implementation rests under the responsibility of the MoH, with targeted and continuous implementation support and technical advice from the World Bank and DPs. The Bank's implementation support will broadly consist of:

- Capacity building activities to strengthen the ability to implement the program, covering the technical, fiduciary, and social and environmental dimensions.
- Provision of technical advice and implementation support geared to the attainment of the PDOs.
- On-going monitoring of implementation progress, including regularly reviewing key outcome and intermediate indicators, and identification of bottlenecks.
- Review and verification of DLI protocols.
- Monitoring risks and identification of corresponding mitigation measures.
- Close coordination with other donors and DPs to leverage resources, ensure coordination of efforts, and avoid duplication.

2. The Bank's implementation support team will be composed of a Health, Nutrition, and Population Global Practice co-task team leader, a Governance Global Practice co-task team leader (to ensure continued cross-practice collaboration), country based and HQ staff in the areas of health, financial management, procurement, safeguards, health financing and operations. The team members will be responsible for supporting the implementation of Program specific elements in their areas of expertise.

3. During implementation, fiduciary specialists will work with the borrower to identify underperforming areas (if any) and adjust the PAP and the TA requirements to better address the constraints. Fiduciary support includes (a) review of financial and progress reports prepared by the borrower and audit reports prepared by internal and external auditors; (b) reviewing implementation progress and achievement of Program results and DLIs that are of a fiduciary nature or relevance; (c) providing support for implementation issues and institutional capacity building; (d) monitoring the continuing adequacy of systems through Program monitoring and audit reports, and the implementation of the PAP; and (e) monitoring changes in fiduciary risks and, as relevant, compliance with the fiduciary provisions of legal covenants.

4. In particular, the Bank will monitor the adequacy and implementation of the FMIP and the procurement reform plan.

5. Further, implementation support will include the provision of capacity strengthening in procurement, financial management and governance and anti-corruption. Donors and government have identified TA needs and this is documented in a TA plan**.** A number of DPs are supporting the GoN through TA. USAID has committed to support the establishment of a supply chain management system including a LMIS. TA for procurement systems reforms is being provided by the DFID. UNICEF and GAVI are committed to help the sector in effective vaccine supply chain management. Human resource challenges will be addressed through support from various donors.

The DFID and WHO will provide TA for the implementation of DHIS 2 as well as M&E which will help generate information for better planning and resource allocation. The TA plan will be reviewed annually jointly by the DPs and MoH.

Table 9.1 Main focus of Implementation Support

Time	***Focus***	***Skills Needed***	***Resource Estimate***	***Partner Role***
First twelve months	Institutional capacity enhancement to strengthen country systems. Technical advice to support Program implementation.	Technical, fiduciary, environment, and social	2 implementation support visits by technical specialists focused on capacity building, technical assistance and monitoring. 2 implementation support visits by fiduciary specialists focused on capacity building 1 implementation support visit by environment and social specialists focused on capacity building and reviewing/strengthening effectiveness of redress mechanism	
12-24 months	Continued institutional capacity enhancement to strengthen implementation capacity Implementation monitoring Technical advice to support program implementation	Technical, fiduciary, environment, and social	2 implementation support visits by technical and fiduciary specialists focused fiduciary support and implementation support 1 implementation support visit by social and environmental specialists focused on strengthening local capacity and implementation support	

Implementation Mid-term	Implementation progress review and identification of necessary midcourse adjustments	Technical, fiduciary, environment, social, and operational	1 implementation support visit including technical, fiduciary, social, environment, M&E and operational specialists	
24-48 months	Implementation monitoring and evaluation Technical advice to support program implementation	Technical and fiduciary		

Figure 9.1 Task Team Skills Mix Requirements for Implementation Support

Skills Needed	***Number of Staff Weeks per FY***
Program Management (TTL x 2)	24
Health Specialist	3
FM Specialist	5
Procurement Specialist	5
Operations Officer	12
Client Engagement and Feedback Specialist	4
Social Specialist	2
Environmental Specialist	2
Administrative Support	6