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Report No: PAD4522

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROGRAM PAPER

ON A

PROPOSED ADDITIONAL CREDIT

IN THE AMOUNT OF SDR 34.9 MILLION
(US$50 MILLION EQUIVALENT)

AND A RESTRUCTURING

TO

NEPAL

FOR THE

# NEPAL HEALTH SECTOR MANAGEMENT REFORM PROGRAM-FOR-RESULTS

May 25, 2021

Health, Nutrition & Population Global Practice
South Asia Region

CURRENCY EQUIVALENTS

(Exchange Rate Effective April 30, 2021)

| | | |
|---|---|---|
| Currency Unit | = | NPR |
| NPR 118.51 | = | US$1 |
| US$ 1.44 | = | SDR 1 |

FISCAL YEAR
July 16 - July 15

| | |
|---|---|
| Regional Vice President: | Hartwig Schafer |
| Country Director: | Faris H. Hadad-Zervos |
| Regional Director: | Lynne D. Sherburne-Benz |
| Practice Manager: | E. Gail Richardson |
| Task Team Leader(s): | Sangeeta Carol Pinto, Manav Bhattarai |

## ABBREVIATIONS AND ACRONYMS

| | |
|---|---|
| ADM | Accountability and Decision Making |
| AF | Additional Financing |
| AWPB | Annual Work Plan and Budget |
| CCB | Climate Co-Benefit |
| CE | Citizen Engagement |
| CGAS | Computerized Government Accounting System |
| CIAA | Commission for the Investigation of Abuse of Authority |
| COVAX | COVID-19 Vaccines Global Access |
| CPF | Country Partnership Framework |
| DHIS 2 | District Health Information System 2 |
| DLI | Disbursement Linked Indicator |
| DLR | Disbursement Linked Results |
| DOHS | Department of Health Services |
| DPs | Development Partners |
| DTCO | District Treasury Controller Office |
| E&S | Environment and Social |
| e-LMIS | e-Logistics Management Information System |
| ESSA | Environment and Social Systems Assessment |
| EVM | Effective Vaccine Management |
| FCGO | Financial Comptroller General Office |
| FM | Financial Management |
| FSA | Fiduciary System Assessment |
| GAVI | Global Vaccine Alliance |
| GBV | Gender Based Violence |
| GESI | Gender Equality and Social Inclusion |
| GFATM | Global Fund to Fight AIDS, Tuberculosis and Malaria |
| GIZ | German Agency for International Cooperation |
| GON | Government of Nepal |
| HCWM | Health Care Waste Management |
| IBRD | International Bank of Reconstruction and Development |
| IDA | International Development Association |
| IFC | International Financial Corporation |
| IP | Implementation Progress |
| ISRR | Implementation Status and Results Report |
| IUFR | Interim Unaudited Financial Report |
| IVA | Independent Verification Agency |
| KfW | Kreditanstalt für Wiederaufbau |
| LGOA | Local Government Operations Act |

| | |
|---|---|
| LiST | Lives Saved Tool |
| LMBIS | Line Ministry Budgetary Information System |
| MD | Management Division |
| MOF | Ministry of Finance |
| MOHP | Ministry of Health and Population |
| MOU | Memorandum of Understanding |
| NHRC | National Health Research Council |
| NHSMRP4R | Nepal Health Sector Management Reform Program-for-Results |
| NHSP | Nepal Health Sector Program |
| NHSS | Nepal Health Sector Strategy |
| NPV | Net Present Value |
| OAG | Office of the Auditor General |
| OPRC | Operations Procurement Review Committee |
| P4R | Program-for-Results |
| PAD | Project Appraisal Document |
| PAP | Program Action Plan |
| PBA | Performance Based Accounting |
| PDO | Project Development Objective |
| PEFA | Public Expenditure and Financial Accountability |
| PFM | Public Financial Management |
| PPICD | Policy, Planning, and International Cooperation Division |
| PPMO | Public Procurement Monitoring Office |
| PSM | Public Sector Management |
| SA | Social Accountability |
| SNG | Sub-National Government |
| SuTRA | Sub-National Treasury Regulation Application |
| TA | Technical Assistance |
| TABUCS | Transaction Accounting and Budget Control System |
| TSA | Treasury Single Account |
| UHC | Universal Health Coverage |
| UNICEF | United Nations Children's Education Fund |
| WBG | World Bank Group |
| WHO | World Health Organization |
| UNAIDS | United Nations Program on HIV/AIDS |
| UNFPA | United Nations Fund for Population Activities |
| USAID | United States Agency for International Development |
| WB | World Bank |
| WASH | Water, Sanitation and Hygiene |

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## BASIC INFORMATION – PARENT (Nepal Health Sector Management Reform Program - P160207)

| Country | Product Line | Team Leader(s) | |
|---|---|---|---|
| Nepal | IBRD/IDA | Manav Bhattarai | |
| Project ID | Financing Instrument | Does this operation have an IPF component? | Practice Area (Lead) |
| P160207 | Program-for-Results Financing | No | Health, Nutrition & Population |

Implementing Agency: Ministry of Health and Population

| Is this a regionally tagged project? | Bank/IFC Collaboration | |
|---|---|---|
| No | No | |
| Original Approval Date | Effectiveness Date | Closing Date |
| 13-Jan-2017 | 13-Apr-2017 | 15-Jul-2021 |

### Program Development Objective(s)

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

### Ratings (from Parent ISR)

| | Implementation | Latest ISR |
|---|---|---|

| | 08-May-2018 | 07-Nov-2018 | 02-May-2019 | 26-Nov-2019 | 19-Jun-2020 | 19-Jan-2021 |
|---|---|---|---|---|---|---|
| Progress towards achievement of PDO | S | S | S | S | S | S |
| Overall Implementation Progress (IP) | MS | MS | MS | S | S | S |
| Overall Risk | H | H | H | H | S | S |
| Technical | MS | MS | MS | S | S | S |
| Fiduciary Systems | S | MS | MS | S | MS | S |
| E&S Systems | MS | MS | MS | MS | MS | S |
| Disbursement Linked Indicators (DLI) | S | S | S | S | S | S |
| Monitoring and Evaluation | MS | MS | MS | S | S | S |

**BASIC INFORMATION – ADDITIONAL FINANCING (Additional Financing for Nepal Health Sector Management Reform Program for Results - P176694)**

| Project ID | Project Name | Additional Financing Type | |
|---|---|---|---|
| P176694 | Additional Financing for Nepal Health Sector Management Reform Program for Results | Restructuring, Scale Up | |
| Financing instrument | Product line | Approval Date | Will there be additional financing for the IPF component? |
| Program-for-Results Financing | IBRD/IDA | 08-Jul-2021 | No |
| Projected Date of Full Disbursement | Bank/IFC Collaboration | | |
| 29-Jul-2022 | No | | |

Is this a regionally tagged project?

No

### Disbursement Summary (from Parent ISR)

| Source of Funds | Net Commitments | Total Disbursed | Remaining Balance | Disbursed |
|---|---|---|---|---|
| IBRD | | | | % |
| IDA | 150.00 | 133.95 | 18.13 | 88 % |
| Grants | | | | % |

## PROGRAM FINANCING DATA – ADDITIONAL FINANCING (Additional Financing for Nepal Health Sector Management Reform Program for Results - P176694)

### FINANCING DATA (US$, Millions)

### SUMMARY (Total Financing)

| | Current Financing | Proposed Additional Financing | Total Proposed Financing |
|---|---|---|---|
| **Government program Cost** | 2662.00 | 682.40 | 3344.40 |
| **Total Operation Cost** | 219.82 | 78.66 | 298.48 |
| Total Program Cost | 219.82 | 78.66 | 298.48 |
| **Total Financing** | 219.82 | 78.66 | 298.48 |
| **Financing Gap** | 0 | 0 | 0 |

### DETAILS – Additional Financing

| | |
|---|---|
| **Counterpart Funding** | **28.66** |
| Borrower/Recipient | 28.66 |
| **International Development Association (IDA)** | **50.00** |
| IDA Credit | 50.00 |

### IDA Resources (in US$, Millions)

| | Credit Amount | Grant Amount | Total Amount |
|---|---|---|---|
| **Nepal** | 50.00 | 0.00 | 50.00 |
| National PBA | 50.00 | 0.00 | 50.00 |
| **Total** | **50.00** | **0.00** | **50.00** |

## COMPLIANCE

### Policy

Has the parent Program been under implementation for at least 12 months?

Yes

Have the DO and IP ratings for the parent Program been rated moderately satisfactory or better for at least the last 12 months?

Yes

Does the program depart from the CPF in content or in other significant respects?

No

Does the Program require any waivers from Bank policies?

No

## INSTITUTIONAL DATA

### Practice Area (Lead)

Health, Nutrition & Population

### Contributing Practice Areas

Governance

### Climate Change and Disaster Screening

This operation has been screened for short and long-term climate change and disaster risks

## TASK TEAM

### Bank Staff

| Name | Role | Specialization | Unit |
|---|---|---|---|
| Sangeeta Carol Pinto | Team Leader (ADM Responsible) | Sr. Operations Officer | HSAHP |
| Manav Bhattarai | Team Leader | Sr. Health Specialist | HSAHP |
| Heenaben Yatin Doshi | Procurement Specialist (ADM Responsible) | Public Procurement and Contract Management | ESARU |
| Shambhu Prasad Uprety | Procurement Specialist | Procurement | ESARU |
| Bishwa Raj Basaula | Financial Management Specialist (ADM Responsible) | FM | ESAG2 |
| Annu Rajbhandari | Environmental Specialist (ADM Responsible) | Environment | SSAEN |
| Jaya Sharma | Social Specialist (ADM Responsible) | Social Safeguards | SSAS1 |
| Hanna Jang | Counsel | Legal | LEGAS |
| Mamata Ghimire | Team Member | Extended Term Consultant | HSAHP |
| Neil Pravin Ashar | Counsel | Legal | LEGAS |
| Sunita Gurung | Team Member | Program Assistant Kathmandu | SACNP |

### Extended Team

| Name | Title | Organization | Location |
|---|---|---|---|

**Nepal**

**Additional Financing for Nepal Health Sector Management Reform Program-for-Results**

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## I. BACKGROUND AND RATIONALE FOR ADDITIONAL FINANCING

**1. Nepal has delivered significant achievements on its ambitious agenda for human development in the last two decades.** Concomitant improvements in health and education indicators resulted in improvement of the Human Capital Index (measure of future productivity of a Nepalese child born today), from 0.49 in 2017 to 0.505 in 2020[1]. Impressive gains have been made on child survival and maternal health—Under 5 mortality reduced by 62 percent[2] and maternal mortality by 66 percent in the last two decades [3]. Leprosy is eliminated and Nepal has achieved polio free status and measles mortality reduction goal. The country is on track to eliminate trachoma, kala azar, lymphatic filariasis and become malaria free by 2025. Treatment rates for tuberculosis have remained above 90 percent since 2010, while HIV prevalence in populations 15-49 years has been maintained at 0.1 percent since 2016.

**2. The global COVID-19 pandemic has severely tested the efficiency and effectiveness of Nepal's health system and seriously threatens to reverse Nepal's hard-won human development achievements.** Nepal responded expeditiously to the unprecedented challenges posed by the pandemic, when the first case was detected in January 2020. Public health and social measures, including a nation-wide lockdown and targeted prohibitory orders in hot-spots were put in place to minimize the spread of COVID-19. The government strategized four-monthly costed, rapid action plans, approved by the Cabinet, to adapt and respond to the crisis. The World Bank, as a reliable partner, approved US$29 million in April 2020 to support the launch of a robust public health response in Nepal with testing, tracing and treatment through a strengthened health system; risk communications and community engagement; and implementation management and monitoring and evaluation. With the availability of new therapies to prevent the infection, the World Bank has also approved an additional financing in the amount of US$75 million, to purchase, supply and distribute safe and effective COVID-19 vaccines and to augment the ongoing health response in the country. With a second wave of COVID-19 sweeping Nepal, as of April 30, 2021, the Ministry of Health and Population has reported 323,187 confirmed COVID-19 cases, of which 86.9 percent have recovered and 3,273 have died. Men are disproportionately affected (65 percent) as also those aged 55 years and above. Nepal has supplemented its public health response to the pandemic with expedited implementation of its National Deployment and Vaccination Plan. With timely procurement of vaccines using domestic resources and grant vaccines available from COVAX, as well as from several vaccines producing countries, over 2.09 million citizens have received their first dose of vaccines and 366,661 citizens have received a second dose, towards Nepal's ambitious goal of vaccinating 72 percent of its citizens to achieve population level immunity.

**3. In addition to the devastating impact of the pandemic, challenges abound for Nepal with burgeoning non-communicable diseases, equitable coverage of health services, quality of care and financing for health, especially in the newly federalized context.** Modeling estimates using the Lives Saved Tool (LiST) model show that COVID-19-related disruptions could leave many women and children without access to essential services and result in increased maternal and child morbidity and mortality, thereby compromising Nepal's progress towards achievement of universal health coverage.

**4. Nepal Health Sector Strategy (NHSS, 2015-2021) defines the roadmap for achievement of Universal Health Coverage (UHC)** through (a) equitable access to health services; (b) quality health services; (c) health systems

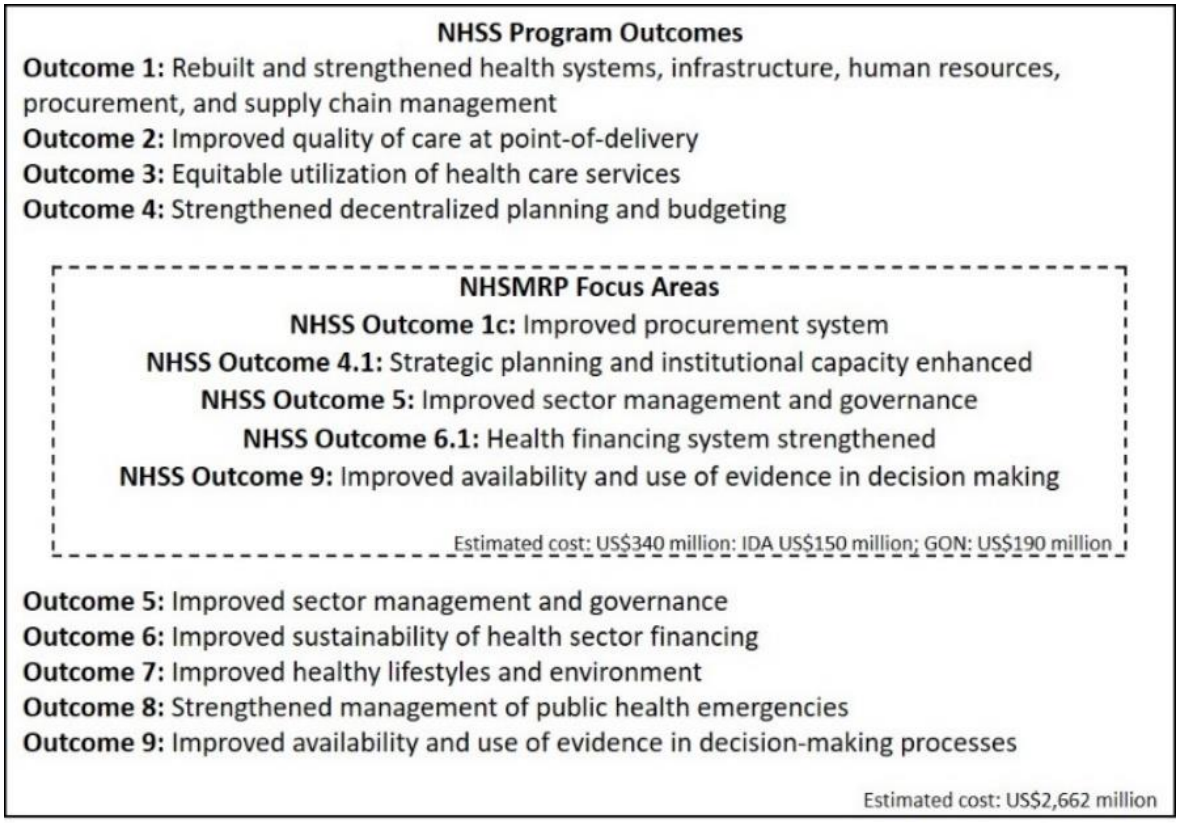
[1] *https://data.worldbank.org/indicator/HD.HCI.OVRL?end=2020&locations=NP&start=2017&view=chart*

[2] UN Inter-agency Group for Child Mortality Estimation (UNICEF, WHO, World Bank, UN DESA Population Division)

[3] WHO, UNICEF, UNFPA, World Bank Group, and the United Nations Population Division; Trends in Maternal Mortality: 2000 to 2017

reform; and (d) a multi-sectoral approach. An estimated budget of US$ 2,662 million was earmarked to implement the NHSS and deliver nine specified program outcomes (see Figure 1). The Nepal Health Sector Management Reform Program-for-Results ("NHSMRP4R" or "Program") is a 5-year operation with International Development Association (IDA) financing US$150 million and contributing to the five program outcomes of the NHSS, for improved public sector governance in the areas of procurement and supply chain management, Public Financial Management (PFM), decentralized planning, and evidence-based decision-making.

**Figure 1: NHSS Program Outcomes and NHSMRP Focus Areas**




**5. Several development partners (DPs) support the implementation of NHSS through financing support, results-based and parallel financing and technical assistance (TA).** UK Aid (erstwhile DFID) supports parallel financing and TA for reform of procurement systems and jointly with the World Health Organization (WHO), data for improved programming as well as the District Health Information System 2 (DHIS 2) platform. The Gavi, the Vaccine Alliance and United Nations Children's Fund (UNICEF) support effective vaccine supply chain management. The US Agency for International Development (USAID) supports the supply chain management system including the logistics management information system. These partners, together with the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), German Agency for International Cooperation (GIZ), KfW, United Nations Population Fund (UNFPA), Korea International Cooperation Agency and the Joint United Nations Program on HIV/AIDS (UNAIDS) have agreed on a coordinated TA plan for NHSS with clear implementation timelines for effective implementation.

**6. The World Bank on March 23, 2021, received a request for an Additional Financing (AF) in the amount of US$50 million to the NHSMRP4R to support the implementation of the NHSS over a one-year extension period of FY 2021/22.** To align with the NHSS one-year extension, the extension of the Program Closing Date has also been requested.

**7. The proposed AF is an essential and critically important support in the implementation of the NHSS, particularly as Nepal's health sector addresses the protracted challenges posed by the COVID-19 pandemic.** The implementation period of NHSS (estimated US$3,344.4 million for six years), though approved by the Cabinet for 2016-2021, is extended by the Ministry of Health and Population (MOHP) by a year until July 15, 2022. The COVID-19 pandemic has stretched the MOHP, first in deploying a nationwide emergency health response and thereafter in late 2020 in developing and deploying Nepal's National Deployment and Vaccination Plan. Lockdowns, mobility restrictions and requirements of social distancing have constrained MOHP to consultatively develop the next NHSS, justifying deferment of its development, approval and implementation to 2022. The sluggish growth (down from 7 percent in 2019 to 0.2 percent in 2020) and significantly decreased government revenues (0.2 percent in 2020, lowest in two decades) in the pandemic year have constrained fiscal space and sectoral allocations for the transitional year. Although the Government has also requested support from other Development Partners to meet the enhanced NHSS cost, a financing gap persists. IDA being one of the major co-financiers of the NHSS 2016-2021, the request for IDA to continue co-financing the five program outcomes supported through the NHSMRP4R in the extension phase is logical, particularly to strengthen an efficient and accountable public health management system that is critical to a sustained and effective health response to ongoing COVID-19 pandemic. The AF provides an opportunity to further entrench the public management reforms initiated by the NHSMRP4R and achieve more ambitious results in the extension year, thereby (a) providing timely and adequate liquidity to the Government of Nepal (GON) to robustly address the pandemic, its harsher subsequent waves as well as deploy other health sector programs in a constrained fiscal environment, (b) priming the public health system to rise to the challenges of a new COVID-sensitive NHSS (2022-2027), and (c) enhancing budgetary allocations for a strong deployment of the new COVID-sensitive NHSS (2022-2027). A new World Bank Program could not be operationalized as there is no new NHSS on which the new Program could be developed. The GON has also requested the World Bank for support to the next NHSS (2022-2027) through a follow-on P4R, which is currently scheduled for delivery in FY 2023.

**8. The proposed AF is fully aligned with the World Bank Group's (WBG) reconfigured[4] and active Country Partnership Framework (CPF)[5] for Nepal articulated in its WBGs Approach Paper "Saving Lives, Scaling Up Impact and Getting Back on Track", and which has been adjusted to respond to the pandemic (refer to Annex 1).** Specifically, it is well aligned with Pillar 1: Support to health for saving lives threatened by the virus, and Pillar 4: Support for strengthening policies, institutions, and investments for resilient and sustainable recovery of the reconfigured CPF. The AF by continuing to strengthen systems and institutions at federal and sub-national levels to deliver accessible and robust health sector programs with equity, quality, transparency, and accountability, will safeguard the health and productivity of Nepali citizens and their economy.

**9. In the fifth year of implementation, progress towards achievement of development objectives as well as implementation progress for the NHSMRP4R is assessed to be Satisfactory as documented in the ISR of January 2021.** Rating for technical and fiduciary performance, compliance with environment and social safeguards, DLI performance and Monitoring and Evaluation too is rated Satisfactory. The Program has disbursed 88 percent of the IDA credit (US$133.95 million). Of the eleven DLI results due for Year 4 (FY 2019/20), nine were assessed to be fully

[4] Details provided in Annex 1: Nepal: COVID-19 Response Program – Shifts in WBG Country Partnership Framework
[5] Country Partnership Framework FY19-23 (Report No. 83148-NP), July 10, 2018 discussed at the Board on August 7, 2018

achieved. The National Health Research Council (NHRC) is designated as the independent verification agency (IVA) for the DLRs. The performance of NHRC is commendable thus far, smoothly transitioning from field-based verification of achievement of DLRs to virtual assessments and cross-validation of information through complementing data sources during the pandemic. Of the nine actions articulated in the Program Action Plan (PAP), six are recurrent in nature and progressing as per plan. Of the remaining three timed actions items, two have been completed, while progress towards a third action (evaluation of implication and options for establishing a post shipment quality assurance system) is ongoing. Detailed performance of the DLIs and PAP are provided in Annexes 8 and 9 respectively.

**10. The COVID-19 pandemic has impacted physical progress of and financial expenditures under NHSMRP4R.** Achievement of two DLRs by July 2020 was compromised by the pandemic. DLR 11.4 was partially achieved (social audit guidelines were not disseminated to sub-national levels due to suspended meetings/trainings/workshops on account of COVID-19) and DLR 6.2 (Effective Vaccine Management Survey was not conducted due to COVID-19 restrictions on mobility and physical interactions) was not achieved as anticipated. The MOHP is confident that the pending DLI results from Year 4 as well as the impending DLI results for Year 5 (except DLR 11.5) will be fully achieved by July 15, 2021 as per schedule. MOHP also anticipates all actions (recurrent and timed) in the PAP will be fully completed by the current program closing date of July 15, 2021. An analysis of the audited expenditures for the FY 2016/17 to FY 2018/19, unaudited expenditures for FY 2019/20 and interim unaudited financial reports up till Quarter 2 of FY 2020/21 for the budget codes comprising the NHSMRP4R expenditure framework indicates expenditures of US$210 million and an estimated additional US$10 million in the final quadrimester of the five-year program period. The budgets for travel, workshops and other operational expenses under the Program could not be executed as envisaged because of restricted mobility brought by COVID-19 impact and hence, resulted in a budget execution of 59 percent in FY 2019/20 and 39 percent in FY 2020/21 (unaudited figures for two quadrimesters only).

**11. The COVID-19 pandemic has been appropriately managed leveraging the health sector management reforms, especially procurement systems, supported by the NHSMRP4R.** The procurement reforms instituted by the NHSMRP4R allowed for transparent and expedited procurements of equipment, diagnostics, drugs, consumables, and personal protective equipment (PPE) using the e-procurement systems. Equipment and commodities necessary to launch a strong health response to the pandemic were procured using standard specifications. The e-LMIS was fully leveraged to ensure timely and rationalized supply of equipment, drugs, and commodities to manage the pandemic from the central to the provincial and sub-provincial stores. Data from the e-LMIS was managed to address stock situation, which even in an environment of globally challenged supply chains, had a slightly increased status of understock of essential drugs at 47 percent for a six month period as compared to previous annual understock rate of 41 percent. The national distribution of COVID-19 vaccines and supporting ancillary consumables was also actualized through the e-LMIS. The absence of such transparent, functioning procurement systems with complete, quality data, would have significantly stalled Nepal's effective response to COVID-19. While available data points to a well-functioning fiduciary system that was effectively leveraged to support Nepal's response to the pandemic, the true measure of the functionality of these systems will be assessed by the independent verification agency post July 15, 2021.

## II. INTRODUCTION

**12. This Program Paper seeks the approval of the Executive Directors to provide an additional credit in an amount of US$ 50 million to NHSMRP4R (P160207).** The Program was approved with the support of an original

IDA credit in the amount of US$150 million on January 13, 2017 for a five-year implementation period till July 15, 2021. Since its effectiveness on April 13, 2017, NHSMRP4R has consistently demonstrated strong implementation progress with a disbursement curve ahead of projections, to indicate an IDA credit disbursement of US$133.95 million (88 percent) as of May 15, 2021. In addition to the AF, the GON has also requested the World Bank for support to the NHSS (2022-2027) through a follow-on P4R, which is tentatively scheduled for delivery in FY 2023. The proposed additional credit would help finance the expenditures associated with scale-up of five program outcomes of the NHSS over the extension year (2021-2022) to further entrench the public management reforms initiated by the NHSMRP4R and address the fiscal gap in the health sector for the extended year of the Government's program.

## III. PROPOSED CHANGES

**13. The following changes will be made to the Program:** (a) revision of the Program Expenditure Framework to accommodate the US$50 million; (b) addition of Year 6 targets for DLIs; (c) revision of allocation for the Year 5 DLI results; (d) addition of enhanced Year 6 targets for existing PDO and intermediate indicators of the results framework; and (e) extension of the closing date of the Program till July 16, 2022. The enhanced Year 6 targets for DLIs, which will be reflected in the results framework, will further entrench the fiduciary, transparency and accountability measures incentivized by the Program in the health sector. This continued raising of bar on performance of these systems during the exceptionally stressed period of COVID-19 is critical to not losing the gains accrued by the established systems thus far as well as for creating a bedrock to deploy stronger reforms agenda through the proposed follow-on engagement.

**14. The changes proposed to NHSMRP4R through this AF are consequent to the enhanced cost and timeline of implementation of the Government's program.** The estimated six-year cost of outcomes and outputs of the NHSS (2015-2021) is increased by US$682.4 million to US$3,344.4 million (fifth year cost adjusted for 6.5 percent inflation, 10 percent contingency and 10 percent Nepal Rupee depreciation for the sixth year estimated cost). Based on actual Program expenditures to date and informed projections, the estimated Program cost for the original five-year implementation period is rationalized to US$219.82 million instead of the original estimate of US$340 million. An assessment of the nature of Program expenditures on the budget codes comprising the Program expenditure framework indicates, the budget for travel, workshops and other operational expenses under the Program could not be executed as envisaged because of restricted mobility brought by the COVID-19 pandemic. In having achieved most of Program results, as indicated by preliminary data from the MOHP on Year 5 DLRs, it is evident that the NHSMRP4R was able to quickly adapt to the COVID-19 environment and identified virtual platforms to undertaken M&E and capacity building interventions, thereby accruing efficiencies in Program implementation.

**Table 1: Program Boundary (US$ million)**

| Government program | | | NHSMRP4R Program Costs | | | |
|---|---|---|---|---|---|---|
| | Five-year | Six-year | Current Five-Year Estimate | | Current Six-Year Estimate | |
| **Outcome 1:** Rebuilt and strengthened health systems, infrastructure, human resources, procurement, and supply chain mgmt. | $1,393.4 | $1,737.3 | **1c.1:** Improved procurement system | $3.3 | **1c.1:** Improved procurement system | $4.4 |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Outcome 2:** Improved quality of care at point-of-delivery | $213.7 | $266.0 | - | | - | - |
| **Outcome 3:** Equitable utilization of health care services | $501.8 | $644.9 | - | | - | - |
| **Outcome 4:** Strengthened decentralized planning and budgeting | $104.3 | $128.5 | **4.1:** Strategic planning and institutional capacity enhanced | $76.7 | **4.1:** Strategic planning and institutional capacity enhanced | $100.25 |
| **Outcome 5:** Improved sector management and governance | $183.6 | $227.3 | **5:** Improved sector mgmt. and governance | $111.96 | **5:** Improved sector mgmt. and governance | $154.4 |
| **Outcome 6:** Improved sustainability of health sector financing | $170.8 | $222.0 | **6.1:** Health financing system strengthened | $0.12 | **6.1:** Health financing system strengthened | $0.16 |
| **Outcome 7:** Improved healthy lifestyles and environment | $11.1 | $13.8 | - | | - | - |
| **Outcome 8:** Strengthened mgmt. of public health emergencies | $34.3 | $43.4 | - | | - | - |
| **Outcome 9:** Improved availability and use of evidence in decision-making processes | $49.0 | $61.2 | **9:** Improved availability and use of evidence in decision-making processes | $27.742 | **9:** Improved availability and use of evidence in decision-making processes | $39.27 |
| **Total** | **$2,662.0** | **$3,344.4** | | **$219.82** | | **$298.48** |

**15. The Program expenditure framework will be revised to accommodate the US$50 million AF.** Adjusting the Year five cost estimate of US$74 million for 6.5 percent inflation in 2020, contingency of 10 percent and Nepali Rupee depreciation of 10 percent, the Year 6 cost estimated for the ongoing Program is estimated to be US$78.66 million. Consequently, the total cost of the Program for six years, taking into account the actual expenditures and projected cost for the remaining duration, is now estimated at US$298.48 million. The additional IDA credit would finance US$50 million (or 63 percent) of Year-6 cost estimate and counterpart funding of US$28.66 million from GON would finance the remaining balance. If approved, the total IDA financing share in the Six-Year Program would increase to 67 percent (US$200 million of US$298.48 million Program cost). IDA contribution would increase on account of (i) higher costs for achievements of results (6.5 percent inflation and NPR depreciation) and (ii) fiscal-space constraints in the COVID context.

**Table 2: Program Financing**

| Financing Source | Current Year 1-5 | Year 6 Proposed | Total Financing for Six-Year Program |
|---|---|---|---|
| GOVERNMENT OF NEPAL | $69.82 | $28.66 | $98.48 |
| IDA | $150.00 | $50.00 | $200.00 |
| **TOTAL** | **$219.82** | **$78.66** | **$298.48** |

**16. DLI allocations for some Year 5 results have been revised as described below and results for Year 6 DLIs are introduced for the one-year extended implementation period of the health sector strategy.** Targets set for the scaled-up Year 6 DLRs are based on verified Year 4 performance (performance of Year 5 targets will be verified in

July 2021). Enhanced targets for Year 6 are proposed for seven DLI results (DLR 1.7, DLR 3.7, DLR 5.3, DLR 7.6, DLR 9.6, DLR 10.6 and DLR 11.6), while 100% achievement is prescribed for two DLRs 2.6 and DLR 4.5 and Year 5 targets are maintained through Year 6 for DLR 8.6. DLR 6.2 scheduled to be achieved in Year 4 and delayed on account of COVID-19 is shifted for achievement in Year 5. The disbursement rules for Year 5 targets (and consequently Year 6 targets) of DLIs 3, 4, 8 and 9 are changed to enhance the per percentage point/unit incentivization, thereby increasing availability of financing to the health sector to offset the fiscal pressure introduced by COVID-19 (Annex 4 provides details of the rationale for the changes to Year 4, 5 and 6 DLRs and associated disbursement rules). This increased incentivization is expected the enhance the focus of the implementing agencies on achievement of results and maintain the public management reform gains accrued by the health sector thus far through the Program. The results framework, which mirrors the DLI results will be revised to include enhanced Year 6 targets for existing PDO and intermediate indicators.

**17. The closing date of the Program will need to be extended by one year till July 16, 2022 to allow for the implementation of the AF.** This Program level 2 restructuring is concurrently processed with this AF Program Paper.

**18. The proposed AF does not entail any changes to the original PDO, program scope, or results areas[6] .** The AF will continue to support the achievement of five of the nine NHSS outcomes, i.e. outcomes 1, 4, 5, 6 and 9 over the extension year through the eleven DLIs as was done through the initial IDA Program financing. The leadership role and core functions of the MOHP that the NHSMRP4R aims to strengthen—(a) procurement, logistics and supply chain management; (b) budgetary planning, execution and reporting; (c) monitoring and supervision of performance; and (d) engagement with key stakeholders for an efficient and effective health system, continue to remain relevant, both in a federated context and particularly as COVID-19 challenges the health system. Consequently, the assumptions for and the theory of change followed for the NHSMRP4R continue to be maintained for the AF and in the one-year extension period.

**19. No changes are proposed to the institutional arrangements, fiduciary and environment and social arrangements, disbursement arrangements, and DLI verification protocols for the Additional Financing.** The MOHP will continue to lead implementation of the NHSMRP4R with the support of its Department of Health Services (DOHS) and other relevant Divisions, including the Management Division, Curative Services Division and Nursing Service Division. Procurement and Financial Management arrangements will be maintained in the extension phase. Detailed assessments indicate adequate Program Expenditures in the six-year implementation period to cover the AF, therefore no changes are proposed in the budget codes contributing to the Program Expenditure Framework. The findings of the Environment and Social Safeguards Assessment (ESSA) and disclosure arrangements of NHSMRP4R are assessed to suffice for the AF, and consequently the environment and social (E&S) arrangements of the Program remain unchanged. The disbursement will continue to be made to the Government Treasury in NPR and reimbursement will be made against verified achievement of DLI results. The verification protocol for DLI results will be extended to the Year 6 results. The NHRC will continue to function as the IVA for assessing achievement of the DLI results.

**20. Program's focus on efficiency gains in public resource management remains unchanged.** The AF will continue to improve and sustain the efficiency achievements accrued in public resource management of the health sector in Nepal through NHSMRP4R. By consistently improving the procurement and financial management systems in the sector as well as instituting accountability and transparency in public spending it is supporting evidence-based

[6] The Program has three Result Areas: (i) Improved Public Procurement; (ii) Improved Financial Management; and (iii) Improved Reporting and Information Sharing for Enhanced Accountability and Transparency

policy decisions, improved drug stocks and reduced wastage. The enhanced accountability of financial management systems has maximized the impact of public sector resources and value for money. The poor are highly dependent on the public sector for services especially in rural areas where choices are limited. This system strengthening has reduced inefficiencies in public management resulting in improved quality of care and outreach for the poorest and most vulnerable.

## IV. APPRAISAL SUMMARY

### A. Technical

**21. Weaknesses in management of the government health system undermine coverage and quality of services.** The Government's current five-year strategy, 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 binding constraints for Nepal to achieve 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, Public Financial Management (PFM), decentralized planning, and evidence-based decision-making.

**22. The Program is designed to support the Government to address these weaknesses in public sector management (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 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, which is limited to the NHSS outcomes focusing on systems strengthening in areas of public procurement, PFM, and monitoring and reporting.

**23. 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 MoHP'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 P4R Financing (dated February 1, 2012 and revised July 10, 2015).

**24. The P4R credit including the proposed additional credit 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.

**25. Adequate institutional arrangements are in place to implement the Program.** The MoHP is responsible for the implementation and the achievement of agreed results. A DLI Management and Coordination Unit at the MoHP chaired by the Chief of the Policy, Planning, and International Cooperation Division (PPICD) is supporting the day-to-day implementation of the Program and monitoring of results. There is a Program Steering Committee, which meets quarterly, chaired by the MOHP Secretary. The Program Steering Committee provides overall guidance, resolve Program-specific issues, and ensure inter-ministerial and sectoral coordination. Both the DLI Management and Coordination Unit and the Program Steering Committee have been established.

**26. The health sector outcomes of the Government's program have been moderately affected by COVID-19.** Preliminary analysis of health care services of last fiscal year (FY 2020/21), which includes the first six months of COVID period, shows that there has been some decline in service delivery (Table 3). The delivery of nutrition commodities seems to have been significantly affected than others.

**Table 3: Key service delivery indicators**

| Fiscal Year | Percentage of children aged 12-23 months immunized with measles/rubella 2 | Percentage of children under one year immunized with BCG | Percentage of births attended by a Skilled Birth Attendant (SBA) | Percentage of women who had four ANC check-ups as per protocol (4th, 6th, 8th and 9th months) and delivered in a health facility) | Percentage of children under five years with diarrhea treated with zinc and ORS[7] | % of children aged 6-23 months who received at least one cycle (60 Sachets) Micronutrient powder (MNP) |
|---|---|---|---|---|---|---|
| FY 2018/19 | 72.8 | 90.9 | 59.8 | 55.9 | 95.5 | 50.82 |
| FY 2019/20 | 70.6 | 86 | 62.4 | 52.6 | 94.7 | 33.42 |

Source: DHIS2

**27. Despite the impact of COVID-19 on availability of donor financing and priorities for investment, the focus of key DPs on sustained technical and financial support to public management reforms in health sector is maintained in the implementation phase of the AF.** UK Aid is providing technical assistance through their Nepal Health Sector Support Program to the MOHP/DOHS particularly in public financial management and procurement reforms, with emphasis on the three provinces of Lumbini, Sudurpaschim and Province 2. Support to strengthening (a) the governance, leadership and stewardship role of all three tiers of the government, (b) data for decision making, and (c) standard-setting for improved quality of care, with emphasis on the afore-mentioned three provinces, will be intensified. Additionally, it is supporting strengthening social accountability for service delivery and health outcomes and integration of GESI strategy in health sector, particularly in the prioritized provinces. USAID is providing technical and financial support towards strengthening e-LMIS roll out in more than 900 sites, including its management and optimal utilization for heath sector programming and service delivery decisions in the implementation phase of the AF. Gavi, WHO and UNICEF are providing technical and financial assistance to effective vaccine supply chain management, with WHO and UNICEF also supporting data for improved programming as well as the District Health Information System 2 (DHIS 2) platform.

**28. 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 for the additional one year is estimated at US$115 million, which is the sum of estimated net benefits arising from the results areas supported by the Program. The analysis assumes an exchange rate of NPR 113.9 per U.S. dollar and a 12 percent discount rate (details provided in attached Technical Addendum). 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.

[7] This is a proportion of the children with diarrhea who visited a health facility for care

## B. Fiduciary

**29. MOHP will continue to strengthen financial management (FM), procurement, and governance for the AF program.** MOHP shall coordinate with all the sub-national governments including the health institutions and units for fiduciary control. Ensuring adequate FM arrangement including for FM staffing, planning and budgeting, fund flow, procurement, accounting and reporting, internal control and internal audit, assurance for accomplishing final audit and adequate follow up on the audit issues are the responsibility of the MOHP. MOHP shall provide assurance about the adherence of the Bank's anti-corruption policy and shall make corruption-related reports to the Bank as agreed during the Updated Fiduciary Systems Assessment (FSA). Until now, as reported by the MOHP, there has been no cases of fraud and corruption related to the Program Expenditure.

**30. MOHP shall coordinate with all the program implementing units for planning and budgeting, entering the Annual Work Plan and Budget (AWPB) in the Line Ministry Budgetary Information System (LMBIS).** The fund flow arrangement shall follow similar process as the Program's original credit i.e. the funds shall be channeled through the District Treasury Controller Offices (DTCOs). Procurement capacity gaps identified during the FSA shall be overcome through adequate manpower and required capacity development programs like training and monitoring and supervision. The increased risk, due to the federalization and low capacity of subnational governments shall be mitigated through orientation and training of FM staff, regular review and monitoring supports, feedback on the financial reports etc. Enhanced use of Computerized Government Accounting System (CGAS), Sub-national Treasury Regulatory Application (SuTRA), and Transaction Accounting and Budget Control System (TABUCS), inter alia, their interface and consolidation in coordination with the Financial Comptroller General Office (FCGO) shall be emphasized. Internal audit gaps shall be minimized with the adequate internal audit arrangement, regularity of internal audit, quality enhancing of internal audit report and follow up on the issues.

**31. There are no overdue audit reports of the Program.** The three annual audit reports received so far do not have significant audit issues related to the Program Expenditure. The FY 2019/20 audit report submission timeline is extended up to July 15, 2021 due to COVID-19 pandemic situation and is expected to be received by that time. If there are audit issues related to Program Expenditure in future, these will be discussed with the MOHP to maintain a record and resolve them with adequate action plan. The AF's audit reports submission timeline follows Program auditing timelines, i.e. nine months from the close of the fiscal year. MOHP has complied with the audit covenants subject to submitting the audit report for FY 2018/19 delayed by about two months in the COVID-19 situation.

### Disbursement

**32. Disbursement will be DLI-based with the provision of government pre-financing.** The disbursement shall be followed upon DLI verification as agreed. The disbursement against the DLIs/ DLRs will be contingent upon the Government furnishing IVA Report about the achievement satisfactory to IDA as per the DLIs/DLRs verification protocol. The MOHP will submit the DLI verification report of IVA along with the achievement report and a letter for reimbursement to the Bank as part of the supporting documentation. The World Bank may further review the evidence of the DLRs achievement. Program expenditure will be reconciled at the end of the Operation. Budget codes as provided in paragraph 5 of the Technical Assessment – Addendum would be used for the reconciliation. The program expenditure framework of this AF shall be reconciled only with the expenditure codes as mentioned and included as per Schedule 1 of the Fiduciary Systems Assessment - Addendum for the AF period. Contribution of other DPs if any and large value contract expenditure as included in the FA will be excluded from the program expenditures in the reconciliation.

**33. Allocations to Year 5 DLRs have been revised for all except DLIs 1, 2, 5 and 10 resulting in change in disbursement categories.** Annex 4 provides details of the rationale for the changes to Year 4, 5 and 6 DLRs and associated disbursement rules.

## C. Environment and Social

**34. Implementation of the ESSA has been satisfactory.** Despite initial delays, appreciable progress has been achieved on the action plan for environment. The recently enacted Public Health Act 2018 and associated public health regulations address majority of the health care waste management concerns, infection control and occupational health and safety, and unsatisfactory infectious waste management which poses a risk of spread of infectious diseases. The recently enforced National HCWM Standards and Operating Procedures 2020 address health care waste management risks.

**35. An ESSA Addendum is not necessary for the operation**. The Additional Financing supports activities that are within the scope of the Parent Program. Hence the original ESSA of Nepal Health Sector Management Reform Program (P160207) will suffice.

**36. The AF will provide an opportunity to further strengthen the implementation, monitoring and the roll out of Public Health Service Regulations and National HCWM work plan towards a functional and sustainable system for waste management.** Towards strengthening the capacity of the three tiers of Government for effective implementation of National HCWM standards and operating procedures, MOHP has organized various capacity building programs. These include trainings for representatives of Provincial Ministry of Social Development, Provincial Health Directorate and other divisions, provincial health laboratories as well as deep dive trainings for provincial hospitals and on-site trainings to demonstrate safe HCWM at central and provincial hospitals. Towards roll out of Public Health Service Regulations 2020, Standards of HCWM and Water, Sanitation and Hygiene (WASH) have been prepared and are is in process of securing approval. Three-year work plan has been prepared and dedicated budget lines for HCWM have been created for smooth implementation. Learning resource package for Environmental Health, Health care waste management and WASH modules have been prepared with plans to deploy the Training of Trainers in coming months of calendar year 2021.

**37. The MOHP has revised the GESI operational guideline and is currently awaiting approval from the Cabinet for mainstreaming GESI.** Several other guidelines that are part of the GESI strategy have been consultatively developed, approved and deployed.[8] However, GESI mainstreaming within the MOHP and its institutions is yet to be programmed and made functional due to the challenges of COVID-19, resource constraints for capacity building and lack of technical assistance. The AF provides an opportunity to approve, operationalize and capacitate the federal, provincial, and local structure under the MOHP on the provisions of the GESI strategy.

**38. A Grievance Redressal Mechanism is established and functional and supports Information disclosure and stakeholder consultation.** Towards operationalizing a pilot citizen feedback mechanism, the Social Accountability (SA) guidelines for health sector in Nepal are approved at the Ministerial level. The orientation to the SA guidelines at the provincial level are ongoing.[9] Similarly, a three year action plan has been proposed for extending the SA

[8] Disability Inclusive National Service Guidelines for health care providers, Mental Health Strategy and Action Plan, Crisis management center guidelines for GBV for one stop crisis management centers (OCMC)

[9] Orientations for Provinces 3, 4, 5, 6 and 7 are successfully completed and the orientation for Provinces 1 and 2 are being proposed to complete this FY.

mechanisms at sub-national level, which includes the development of a manual for social audit, TOTs followed by training at provincial and local government for administering SA at health facilities. These actions are yet to be initiated and may not be achieved by July 15, 2021. The AF will provide MOHP the opportunity to extend the SA at the sub-national government level in a phased manner, with the extension allowing the results to be sustained.

## D. Waivers of Bank policies

**39.** No waivers of Bank policies are proposed for this AF.

## E. Corporate requirements

**40. COVID-19 response:** The NHSMRP4R's continued support to reforms in public management systems for health are buttressing a strong COVID-19 health response. The MOHP leads the Nepal's COVID-19 health response with the support of its various departments, divisions and agencies. In strengthening the procurement related function of the MOHP through its Management Division, to undertake transparent and expedited e-procurement for medical equipment, test kits, reagents, drugs and consumables, the MOHP was able to launch a strong health response with the support of all three tiers of the federated state. The e-LMIS established in all warehouses and sub-national stores has supported timely and rationalized delivery of supplies to manage the pandemic despite the mobility restrictions. Stock-outs have been appreciably managed despite challenges of stalled global supply chains. The COVID-19 vaccine supply too was managed through the e-LMIS platform. While the low rates of budget execution of the Program in FY 2020/21 do not point to systemic issues, rather the constraints imposed by the pandemic, it is expected the financial management systems have served the objective of transparent planning, reporting and oversight/controls of health sector expenditures even during the pandemic.

**41. Gender:** The gender tag accorded to NHSMRP4R remains unchanged. DLI for strengthening DHIS2 platform tracks service uptake by females and informs gender sensitive demand and supply-side programmatic decisions. DLI 11 incentivizes women's voice and participation in social accountability platforms for health. Additionally, the discrete action in PAP supports finalization, approval and implementation of the Government's GESI Strategy. The achievement of Year 1-4 results associated with DLIs 10 and 11 (partial achievement) as well as completion of the action associated with the GESI strategy provides assurance for maintenance of the gender tag until the extended Program Closing Date.

**42. Citizen Engagement:** The NHSMRP4R has a strong component of citizen engagement (CE) reflected in DLIs 2, 10 and 11 and the PAP. Progress towards the associated DLRs has been appreciable, except for Year 5 DLR piloting of social accountability mechanisms in three local governments each of two provinces, on account of COVID-19 mobility and meeting restrictions. The Additional Financing in supporting enhanced results in Year 6 towards DLIs 2, 10 and 11 will further strengthen citizen voice, participation and empower them to hold to account public health management through various social accountability platforms in the community. The achievement of Year 1-4 results associated with DLIs 2, 10 and 11 (partial achievement) provides assurance that citizen engagement will only be additionally strengthened, specifically through social audits in at least four provinces of Nepal, thereby also meeting corporate requirements for the same.

**43. Climate Change: The Additional Financing to the Nepal Health Sector Management Reform Program-for-Results (NHSMRP4R) is screened for climate and disaster risks.** The NHSMRP4R aims to address supply- and demand-side constraints in the efficient institutional performance in the health sector. The components of the P4R

strongly support health care system strengthening which is imperative while also responding to climate change impacts and achieving the aim of the National Climate Change Policy (NCCP) in relation to health, drinking water and sanitation sector. The strategies put forward by the NCCP are linked with strengthening institutions through improved sector management and governance, strategic planning and institutional capacity, and improved financing management i.e., the development of a mechanism to prepare, forecast and prevent and avoid the epidemic of vector-borne and communicable diseases induced by climate change, proper management of harmful and hazardous water and the use of biodegradable waste for energy production, and increase access to and easy availability of drinking water through water harvesting and storage along with water source protection. The DLIs of the P4R support targets set out in Nepal's Nationally Determined Contributions (NDCs)[10].Therefore, the P4R contributes to reducing vulnerability of the populations and health sector to climate change, while contributing to reducing GHG emissions through improved healthcare waste management. Details of how the Program accrues adaptation and mitigation co-benefits is articulated in Annex 8.

**44. Maximizing Finance for Development:** The NHSMRP4R complemented the technical assistance and financing of UK Aid (erstwhile DFID), Global Vaccine Alliance (GAVI), USAID, WHO and UNICEF in strengthening the public management function of the health sector at all three tiers of the government. USAID supports the MOHP at federal level and sub-national governments (SNG) with technical and financial resources for establishment of a supply chain management system for health, including a Logistics Management Information System (e-LMIS). TA for procurement systems reforms is being provided by the UK Aid and USAID. UNICEF, GAVI and WHO support effective vaccine supply chain management with technical assistance as well as stronger use of DHIS 2 as a reporting platform for health programs. From German Cooperation, GIZ has been providing technical assistance in DHIS 2 Systems and Health Care Waste Management while KFW has been providing budgetary support to NHSS. The AF presents an opportunity to rally support from the afore-mentioned partnerships for continued TA to health sector reforms in the extension phase of the NHSS 2015-2021, and where gaps exist to initiate dialogue with the External Development Partners network to bridge the gaps appropriately.

## V. KEY RISKS

**45. The overall risk to achieving the PDO with AF supporting the NHSS 2015-2021 over the extension year is maintained at Substantial.**

**46. Political and Governance residual risks are High.** The political situation in Nepal is currently evolving as a result of the recent breakup of the incumbent ruling coalition. Through exercising the provisions of the 2015 Constitution, new alliances are in the offing as Nepal is likely to be headed for a coalition government or new elections. To mitigate this risk, the World Bank has been meeting with key members of all political parties to build continuous relationships and has confirmed that health sector reforms are a priority across the political spectrum. In addition, all recent political changes remain within the parameters of the 2015 Constitution, highlighting that the country remains on a trajectory of post-2015 institutional development. Federalism and COVID-19 also pose significant challenges for Nepal's development landscape, as weak intergovernmental coordination and low subnational capacity can undermine the implementation of reforms. Mitigation measures include the World Bank's

[10] NDC target related to health sector: (1) By 2025, climate-sensitive diseases surveillance systems will be strengthened through the integration of climate and weather information into existing surveillance systems; (2) By 2030, the population with access to the basic water supply will increase from 88 percent to 99 percent; and population with improved water supply will increase from 20 percent to 40 percent; (3) By 2025, climate risk assessment mechanisms will be integrated into WASH program planning and implementation cycle.

sustained dialogue at all levels of government and the continued support to strengthen the federal institutions through the proposed Additional Financing and the Federalism Platform.

**47. Residual macroeconomic risks are maintained at Substantial on account of the significant supply and demand shock to Nepal's economy on account of the COVID-19 pandemic, compounded by halted growth and decreased revenues.** Delayed vaccination deployment and a further escalation of the COVID-19 outbreak domestically and globally would dampen the nascent momentum for economic recovery, especially in tourism. The recent political uncertainty, if prolonged, could further undermine investment sentiments. On the upside, effective vaccination campaigns in Nepal and abroad could facilitate the resumption of tourism and hospitality services. Donor commitments for the health sector in Nepal may be constrained given the global fiscal crisis, as well as channelized to a COVID-19 health response rather than strengthening/sustaining public management reforms. The AF will continue dialogue with partnering agencies to ensure sustained TA and financial support to the health sector reform agenda.

**48. Residual fiduciary risks are rated Moderate based upon the robust performance of the program on relevant DLRs and risk mitigation actions within the program action plan.** The Program has performed well with respect to financial and procurement management capacities, internal controls, transparency, and accountability. The DLRs associated with procurement and financial management in the NHSMRP4R and its AF, as well as the PAP, aim at further strengthening the fiduciary systems, compliance, transparency and accountabilities with close supervision and incentives.

**49. Others: Impact of COVID-19 on health sector management and reform agenda and financing:** The residual risk associated with impact of an ongoing and intensifying COVID-19 pandemic on health sector reform agenda is substantial. The scale and impact of COVID-19 on the health sector has been substantive, pulling away resources financial and personnel from existing programs to prioritize planning, prevention, and management of a COVID-19. Despite the incentives of a results-based operation, the COVID-19 fatigue in the health sector can spill over to the program delaying results as an emergency response takes precedence. At the request of Nepal, Development Partners may have to recalibrate their technical assistance and financing mapped to public management reform in the health sector towards emergency COVID-response and economic recovery efforts. It is anticipated the structured response of MOHP in concert with Development Partners to the pandemic, leveraging systems strengthened by the P4R, will prevent the increase of this risk from existing threshold.

## VI. WORLD BANK GRIEVANCE REDRESS

**50.** Communities and individuals who believe that they are adversely affected by a World Bank (WB) supported project may submit complaints to existing project-level grievance redress mechanisms or the WB's Grievance Redress Service (GRS). The GRS ensures that complaints received are promptly reviewed in order to address project-related concerns. Project 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/en/projects-operations/products-and-services/grievance-redress-service*. For information on how to submit complaints to the World Bank Inspection Panel, please visit *www.inspectionpanel.org*

## VII. SUMMARY TABLE OF CHANGES

| | Changed | Not Changed |
|---|---|---|
| Change in Results Framework | ✓ | |
| Change in Loan Closing Date(s) | ✓ | |
| Reallocation between Disbursement Categories | ✓ | |
| Change in Program Action Plan | ✓ | |
| Change in Implementing Agency | | ✓ |
| Change in Project's Development Objectives | | ✓ |
| Change in Program Scope | | ✓ |
| Cancellations Proposed | | ✓ |
| Change in Disbursements Arrangements | | ✓ |
| Change in Safeguard Policies Triggered | | ✓ |
| Change in Legal Covenants | | ✓ |
| Change in Institutional Arrangements | | ✓ |
| Change in Technical Method | | ✓ |
| Change in Fiduciary | | ✓ |
| Change in Environmental and Social Aspects | | ✓ |
| Other Change(s) | | ✓ |

## VIII. DETAILED CHANGE(S)

### LOAN CLOSING DATE(S)

| Ln/Cr/Tf | Status | Original Closing | Current Closing(s) | Proposed Closing | Proposed Deadline for Withdrawal Applications |
|---|---|---|---|---|---|
| IDA-59130 | Effective | 15-Jul-2021 | 15-Jul-2021 | 15-Jul-2022 | 15-Jan-2023 |

## IX. RESULTS FRAMEWORK AND MONITORING

**Results Framework**
**COUNTRY: Nepal**
**Additional Financing for Nepal Health Sector Management Reform Program for Results**

### Program Development Objective(s)

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

### Project Development Objective Indicators by Objectives/ Outcomes

| Indicator Name | DLI | Baseline | Intermediate Targets | | | | | End Target |
|---|---|---|---|---|---|---|---|---|
| | | | 1 | 2 | 3 | 4 | 5 | |
| **The PDO is to improve efficiency in public resource management systems of the health sector in Nepal** | | | | | | | | |
| Percentage reduction of less than minimum stocks (understock) of tracer health commodities in sub-provincial medical stores (DLI 5) (Text) | | Baseline to be established in Year 3 | | | | DLR 5.1 15% reduction in the understock of tracer health commodities in Year 4 over the baseline established for the sub-provincial (district) medical stores through the eLMIS for two Provinces | DLR 5.2 25% reduction in understock of tracer health commodities in Year 5 over the baseline established for the sub-provincial (district) stores through the eLMIS for two Provinces | DLR 5.3: 35% reduction in understock of tracer health commodities in Year 6 over the baseline established for the sub-provincial (district) stores through the eLMIS for two Provinces. |

| Indicator Name | DLI | Baseline | Intermediate Targets | | | | | End Target |
|---|---|---|---|---|---|---|---|---|
| | | | 1 | 2 | 3 | 4 | 5 | |
| ***Action: This indicator has been Revised*** | ***Rationale:*** ***Target for Year 6 included*** | | | | | | | |
| Percentage of the MoHP's annual spending captured by the TABUCS/CGAS. (DLI 8) (Text) | | 0.70 | DLR 8.1 MoHP has issued a circular mandating expenditure reporting through TABUCS by all spending units | DLR 8.2 80% of MoHP's spending in Year 2 captured by TABUCS | DLR 8.3 85% of MoHP spending in Year 3 captured by TABUCS | DLR 8.4 90% of MoHP spending in Year 4 captured by TABUCS | DLR 8.5 95% of MoHP spending in Year 5 captured by TABUCS | DLR 8.6: 95% of MoHP spending in Year 6 captured by TABUCS/CGAS |
| ***Action: This indicator has been Revised*** | ***Rationale:*** ***The definition of indicator revised to include Computerized Government Accounting Software (CGAS) added to align with the Government's new mandatory accounting system; Year 6 target included*** | | | | | | | |
| Health facilities reporting annual disaggregated data using District Health Information System (DHIS 2) in a timely manner. (DLI 10) (Text) | | 0.00 | DLR 10.1 Plan for roll out of DHIS 2 finalized and DHIS 2 rolled out up to DHO level | DLR 10.2 Reports based on DHIS 2 available from all DHOs | DLR 10.3a HMIS/DHIS 2 training provided to all Provinces DLR 10.3b HMIS/DHIS 2 dashboard includes indicator measuring timely reporting from health facilities | DLR 10.4 HMIS/DHIS 2 shows timely reporting from at least 40% of public health facilities in Year 4 | DLR 10.5 HMIS/DHIS 2 shows timely reporting from at least 50% of public health facilities in Year 5 | DLR 10.6 HMIS/DHIS 2 shows timely reporting from at least 70% of public health facilities in Year 6 |
| ***Action: This indicator has been Revised*** | ***Rationale:*** ***Year 6 targets included*** | | | | | | | |

## Intermediate Results Indicators by Results Areas

| Indicator Name | DLI | Baseline | Intermediate Targets | | | | | End Target |
|---|---|---|---|---|---|---|---|---|
| | | | 1 | 2 | 3 | 4 | 5 | |
| **1. Improved Public Procurement** | | | | | | | | |
| Percentage of contracts managed by the MD through the PPMO's online procurement portal (DLI 1) (Text) | | No contract is through online e-procurement developed by the Public Procurement Management Office (PPMO) | DLR 1.1 Training on the use of the PPMO's online e-procurement completed for at least 20 MoHP staff | DLR 1.3 At least 60% of value of total contracts managed by MD done through online e-procurement of Year 2 | DDLR 1.2 Training on procurement/e-procurement and standard bidding documents to all Provinces completedDLR 1.4 70% of value of total contracts managed by MD done through online e-procurement of Year 3 | DLR 1.5 80% of value of total contracts managed by MD done through online e-procurement of Year 4 | DLR 1.6 90% of value of total contracts managed by MD done through online e-procurement of Year 5 | DLR 1.7: 95% of value of total contracts managed by MD done through online e-procurement of Year 6 |
| ***Action: This indicator has been Revised*** | ***Rationale:***<br>***Year 6 targets included*** | | | | | | | |
| Establishment and functioning of web-based grievance redressal mechanism (DLI 2) (Text) | | Web-based Grievance Redressal Mechanism not established | DLR 2.1 Guidelines for Grievance Redressal Mechanism endorsed by MoHP | DLR 2.2 Web-based Grievance Redressal Mechanism established and functioning; and training completed for various levels of staff responsible for | DLR 2.3 MoHP has made available on its website an annual report on the status of grievances received in Year 3 | DLR 2.4 MoHP has made available on its website an annual report on the status of grievances received in Year 4 | DLR 2.5 MoHP has made available on its website an annual report on the status of grievances received in Year 5 | DLR 2.6: MoHP has made available on its website an annual report on the status of grievances received in Year 6 |

| Indicator Name | DLI | Baseline | Intermediate Targets | | | | | End Target |
|---|---|---|---|---|---|---|---|---|
| | | | 1 | 2 | 3 | 4 | 5 | |
| | | | | grievance handling. | | | | |
| ***Action: This indicator has been Revised*** | ***Rationale:*** ***Year 6 targets included*** | | | | | | | |
| Percentage of procurements done by Management Division (MD) using standard specifications (DLI 3) (Text) | | Procurement not based on standard specifications | DLR 3.1 MoHP endorses standard specifications for basic package of free drugs to be procured by MD | DLR 3.2 For Year 2 procurement, 70% of procurement of basic package of free drugs based on the use of standard specifications | DLR 3.3 MoHP endorses standard specifications for essential equipment to be procured by MD DLR 3.4 For Year 3 procurement, 80% procurement of health commodities, as specified in the list of health commodities with standard specifications and procured by MD, is based on the use of standard specifications | DLR 3.5a For Year 4 procurement, 90% of health commodities procured by MD, is based on the use of standard specifications DLR 3.5b For Year 4 procurement, 70% of equipment procured by MD is based on the use of standard specifications | DLR 3.6a For Year 5 procurement, 90% of health commodities procured by MD, is based on the use of standard specificationsDLR 3.6b For Year 5 procurement, 70% of equipment procured by MD is based on the use of standard specifications | DLR 3.7a For Year 6 procurement, 95% of health commodities procured by MD, is based on the use of standard specifications DLR 3.7b For Year 6 procurement, 80% of equipment procured by MD is based on the use of standard specifications |
| ***Action: This indicator has been Revised*** | ***Rationale:*** ***Year 6 targets included*** | | | | | | | |
| Central medical stores and medical stores of Provinces report through eLMIS (DLI 4) (Text) | | eLMIS not in place | | DLR 4.1 eLMIS installed in all warehouses of the | DLR 4.2a Training on, and installation and operation of eLMIS | DLR 4.3 eLMIS information for program Year 4 is | DLR 4.4 eLMIS information for program Year 5 is | DLR 4.5: eLMIS information for program Year 6 is |

| Indicator Name | DLI | Baseline | Intermediate Targets | | | | | End Target |
|---|---|---|---|---|---|---|---|---|
| | | | 1 | 2 | 3 | 4 | 5 | |
| | | | | center and district stores of two regions | completed for all central and provincial (including sub-provincial) medical stores of at least two Provinces DLR 4.2b Baseline data generated for minimum stocks of tracer health commodities in two Provinces | available from central and provincial (including sub-provincial) stores of Provinces. | available from central and provincial (including sub-provincial) stores of Provinces. | available from central and provincial (including sub-provincial) stores of Provinces. |
| ***Action: This indicator has been Revised*** | ***Rationale:*** ***Year 6 targets included*** | | | | | | | |
| Percentage improvement in EVM score over 2014 baseline. (DLI 6) (Text) | | Average EVM Score of 64%, with two attributes achieving 80% | | DLR 6.1 Average EVM Score of 70% (based on 2016 survey), with any 3 attributes in EVM Score achieving 80% | | | | DLR 6.2a Average EVM Score of 70% (based on a survey conducted in 2019 or later) DLR 6.2b Any four (4) attributes in EVM Score achieving at least 80% |
| ***Action: This indicator has been Revised*** | ***Rationale:*** ***Year 5 targets included*** | | | | | | | |
| **2. Improved Financial Management** | | | | | | | | |

| Indicator Name | DLI | Baseline | Intermediate Targets | | | | | End Target |
|---|---|---|---|---|---|---|---|---|
| | | | 1 | 2 | 3 | 4 | 5 | |
| Percentage of the MoHP spending entities submitting annual plan and budget using eAWPB. (DLI 7) (Text) | | Not all spending units submit their annual plan and budget using eAWPB | DLR 7.1 MoHP and all its departments, divisions, and centers are given access to operate on eAWPB | DLR 7.2 eAWPB used for planning and budget submission by MoHP and all departments, divisions, and centers | DLR 7.3a eAWPB used in Year 3 for planning and budget submission by MoHP and all its departments, divisions and centers DLR 7.3b eAWPB used in Year 3 for 25% of remaining spending units (excluding units included under DLR 7.3a) under the MoHP | DLR 7.4a eAWPB used in Year 4 for planning and budget submission by MoHP and all its departments, divisions and center, DLR 7.4b eAWPB used in Year 4 for 50% of remaining spending units (excluding units included under DLR 7.4a) under MoHP | DLR 7.5a eAWPB used in Year 5 for planning and budget submission by MoHP and all its departments, divisions and centers DLR 7.5b eAWPB used in Year 5 for and 75% of remaining spending units (excluding units included under DLR 7.5a) under MoHP | DLR 7.6a eAWPB used in Year 6 for planning and budget submission by MoHP and all its departments, divisions and centers DLR 7.6b eAWPB used in Year 6 for and 95% of remaining spending units (excluding units included under DLR 7.6a) under MoHP |
| ***Action: This indicator has been Revised*** | ***Rationale:*** ***Year 6 targets included*** | | | | | | | |
| Percentage of audited spending units responding to the OAG's primary audit queries within 35 days. (DLI 9) (Text) | | Percentage as derived from MoHP inventory of responses in Year 1 | DLR 9.1 All reports containing primary audit queries received by audited spending units are available at MoHP; and inventory of responses by date provided by individual audited | DLR 9.2 10 percentage points increase in audited institutions responding to primary audit queries within mandated 35 days over percentage derived from the | DLR 9.3 60% of spending units reporting to the MoHP respond to primary audit queries within mandated 35 days | DLR 9.4 65% of spending units reporting to the MoHP respond to primary audit queries within mandated 35 days | DLR 9.5 70% of spending units reporting to the MoHP respond to primary audit queries within mandated 35 days | DLR 9.6 80% of spending units reporting to the MoHP respond to primary audit queries within mandated 35 days |

| Indicator Name | DLI | Baseline | Intermediate Targets | | | | | End Target |
|---|---|---|---|---|---|---|---|---|
| | | | 1 | 2 | 3 | 4 | 5 | |
| | | | spending units are available at MoHP | MoHP inventory of responses of Year 1 | | | | |
| ***Action: This indicator has been Revised*** | ***Rationale:***<br>***Year 6 targets included*** | | | | | | | |
| **3. Improved Reporting and Information Sharing for Enhanced Accountability and Transparency** | | | | | | | | |
| MoHP to provide guidance and support to the subnational governments on citizen engagement mechanism (DLI 11) (Text) | | No formal guidelines for citizen feedback mechanisms in place for Provinces and/or Local Governments | DLR 11.1 Citizen engagement mechanism options and public reporting systems developed by MoHP for citizens' feedback, including on availability of drugs and facility level services and disaggregated by gender | | DLR 11.3: MoHP provided orientation training to all Provinces on social audit mechanism | DLR 11.4: MoHP updated social audit guidelines to guide the Provinces and/or Local Governments. | DLR 11.5: MOHP provided orientation to all Provinces and/or Local Governments on the new Social Accountability Framework | DLR 11.6: MoHP provided on-site support to at least three (3) Local Governments each in at least four Provinces in conducting social audits |
| ***Action: This indicator has been Revised*** | ***Rationale:***<br>***Year 4 and 5 targets revised and Year 6 target included*** | | | | | | | |

| Monitoring & Evaluation Plan: PDO Indicators | | | | | |
|---|---|---|---|---|---|
| **Indicator Name** | **Definition/Description** | **Frequency** | **Datasource** | **Methodology for Data Collection** | **Responsibility for Data Collection** |
| Percentage reduction of less than minimum stocks (understock) of tracer health commodities in sub-provincial medical stores (DLI 5) | The list of "tracer health commodities" procured by the MD will be jointly agreed by the government and partners. The required minimum stock of tracer health commodities will be agreed and defined in the baseline for Year 3. Any stock below the minimum required level will be labelled as "understock". | Year 4, 5 and 6 of the Program | MoHP and MD records and eLMIS | by visiting eLMIS software and its indicators at dashboard | MD/MoHP |
| Percentage of the MoHP's annual spending captured by the TABUCS/CGAS. (DLI 8) | Audited spending units to respond to the OAG's primary audit queries within 35 days of receiving the report. | Every year starting from Year 2 | MoHP record and report from TABUCS and treasury single account (TSA) (FCGO/MoF) | Year 1 - Verify the issuance by the MoHP of a circular mandating expenditure reporting through TABUCS by all spending units.<br>Year 2 - Verify through an online check at the MoHP that expenditure reported through TABUCS comprises at least 80% of MoHP's spending in Year 2, and provide report of actual | MoHP spending units input expenditure through TABUCS/CGAS and Nepal Health Research Council verifies |

| | | | | | |
|---|---|---|---|---|---|
| | | | | spending.<br>Year 3 - Verify through an online check at the MoHP that expenditure reported through TABUCS comprises up to 85% of the MoHP's spending in Year 3 and provide report of actual spending.<br>Year 4 - Verify through an online check at the MoHP that expenditure reported through TABUCS comprises up to 90% of the MoHP's spending in Year 4 and provide report of the actual spending.<br>Year 5 - Verify through an online check at the MoHP that expenditure reported through TABUCS comprises up to 95% of the MoHP's spending in Year 5 and provide report of the actual spending.<br>Year 6 - Verify through an online check at the | |

| | | | | | |
|---|---|---|---|---|---|
| | | | | MoHP that expenditure reported through TABUCS/CGAS comprises up to 95% of the MoHP's spending in Year 6 and provide report of the actual spending. | |
| Health facilities reporting annual disaggregated data using District Health Information System (DHIS 2) in a timely manner. (DLI 10) | Data disaggregated by geography, gender, and ethnicity reported by facilities using DHIS 2 | Every year starting from Year 3 | MoHP records and website | Year 1 - Verify at the MoHP that plan for implementation of the DHIS 2 is available<br>Year 1 - Verify through a random check in at least 20% of the districts that DHIS 2 is rolled out by checking that the software is installed in all DHOs.<br>Year 2 - Verify through online check at the MoHP that reports based on DHIS 2 from all DHO's districts are accessible.<br>DLRs 10.3 Verify through MD/MOHP/Provincial records that training on DHIS 2 is completed and visit DHIS2 dashboard to | MoHP |

| | | | | | |
|---|---|---|---|---|---|
| | | | | see that "timely reporting" can be tracked.<br>DLRs 10.4, 10.5 and 10.6 - Verify through HMIS records/DHIS 2 software that the said % of public health facilities have timely reported through DHIS 2. This will be verified through DHIS2, one month after the end of the fiscal year, by calculating the preceding 12 months median. | |

| Monitoring & Evaluation Plan: Intermediate Results Indicators | | | | | |
|---|---|---|---|---|---|
| **Indicator Name** | **Definition/Description** | **Frequency** | **Datasource** | **Methodology for Data Collection** | **Responsibility for Data Collection** |
| Percentage of contracts managed by the MD through the PPMO's online procurement portal (DLI 1) | | | LMD and MoHP records | | |
| Establishment and functioning of web-based grievance redressal mechanism (DLI 2) | Grievance Redressal Mechanism will track complaints and responses | Every year. | LMD & MoHP records | | MoHP/MD |

| | | | | | |
|---|---|---|---|---|---|
| | related to procurement and supply chain management. | | | | |
| Percentage of procurements done by Management Division (MD) using standard specifications (DLI 3) | All procurements done by Management Division will be tracked. Standard specifications are as defined by MoHP and publicly disclosed | Every year. | MD's data source, MoHP records. | By accessing Consolidated Annual Procurement Plan and tender notices through MD website and records. | MoHP |
| Central medical stores and medical stores of Provinces report through eLMIS (DLI 4) | Medical stores are the public warehouses for storing drugs. eLMIS is the real time online logistic management information system which provides information on stocks of drugs and has various functionalities as defined in the verification protocol matrix. | Every year. | eLMIS/MD records | By visiting the eLMIS system, | Mangement Division/ MoHP |
| Percentage improvement in EVM score over 2014 baseline. (DLI 6) | 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 | Every two years. | Joint MoHP, WHO, and UNICEF survey reports of 2016 and 2018. | Survey | MoHP |
| Percentage of the MoHP spending entities submitting annual plan and budget using | eAWPB is a software at MoHP used for annual | Every year. | MoHP reports/recor | By visit the eAWPB software of the MoHP | MoHP |

| | | | | | |
|---|---|---|---|---|---|
| eAWPB. (DLI 7) | workplan and budgeting. | | ds; eAWPB software of MoHP. | and verifying the yearly targets. | |
| Percentage of audited spending units responding to the OAG's primary audit queries within 35 days. (DLI 9) | OAG sends primary audit queries to the respective audited spending units and gives them 35 days to respond. | Every Year. | MoHP records and the OAG's primary and final reports. | Access records of OAG's primary audit queries to audited institutions and their responses and compute the indicator. | MoHP |
| MoHP to provide guidance and support to the subnational governments on citizen engagement mechanism (DLI 11) | Social audit is the most frequently used citizen engagement mechanism in the health sector. | Every year | MoHP reports | MoHP submits a back to office reports to be verified by the verification agency. | MoHP |

**Disbursement Linked Indicators Matrix**

| **DLI 1** | Percentage of contracts managed by the MD through the PPMO's online procurement portal (DLI 1) | | | |
|---|---|---|---|---|
| **Type of DLI** | **Scalability** | **Unit of Measure** | **Total Allocated Amount (USD)** | **As % of Total Financing Amount** |
| Intermediate Outcome | Yes | Text | 16,000,000.00 | 0.20 |
| **Period** | **Value** | | **Allocated Amount (USD)** | **Formula** |
| Baseline | No contract is through online e-procurement developed by the Public Procurement Management Office (PPMO) | | | |

| | | | |
|---|---|---|---|
| July 16, 2016 - July 15, 2017 | DLR 1.1 Training on the use of the PPMO's online e-procurement completed for at least 20 MoHP staff | 1,000,000.00 | See Matrix. |
| July 16, 2017 - July 15, 2018 | DLR 1.3 At least 60% of value of total contracts managed by MD done through online e-procurement of Year 2 | 3,000,000.00 | See Matrix. |
| July 16, 2018 - July 15, 2019 | DLR 1.2 Training on procurement/e-procurement and standard bidding documents to all Provinces completed DLR 1.4 70% of value of total contracts managed by MD done through online e-procurement of Year 3 | 6,000,000.00 | See Matrix. |
| July 15, 2019 - July 15, 2020 | DLR 1.5 80% of value of total contracts managed by MD done through online e-procurement of Year 4 | 3,000,000.00 | See Matrix. |
| July 16, 2020 - July 15, 2021 | DLR 1.6 90% of value of total contracts managed by MD done through online e-procurement of Year 5 | 3,000,000.00 | See Matrix. |
| July 16, 2021 - July 16, 2022 | | 0.00 | |

***Action: This DLI has been Revised. See below.***

| ***DLI 1*** | *Percentage of contracts managed by the MD through the PPMO's online procurement portal (DLI 1)* | | | |
|---|---|---|---|---|
| ***Type of DLI*** | ***Scalability*** | ***Unit of Measure*** | ***Total Allocated Amount (USD)*** | ***As % of Total Financing Amount*** |
| *Intermediate Outcome* | *Yes* | *Text* | *19,597,452.00* | *0.25* |
| ***Period*** | ***Value*** | | ***Allocated Amount (USD)*** | ***Formula*** |

| | | | |
|---|---|---|---|
| *Baseline* | *No contract is through online e-procurement developed by the Public Procurement Management Office (PPMO)* | | |
| *July 16, 2016 - July 15, 2017* | *DLR 1.1 Training on the use of the PPMO's online e-procurement completed for at least 20 MoHP staff* | *1,000,000.00* | *See Matrix.* |
| *July 16, 2017 - July 15, 2018* | *DLR 1.3 At least 60% of value of total contracts managed by MD done through online e-procurement of Year 2* | *3,000,000.00* | *See Matrix.* |
| *July 16, 2018 - July 15, 2019* | *DLR 1.2 Training on procurement/e-procurement and standard bidding documents to all Provinces completedDLR 1.4 70% of value of total contracts managed by MD done through online e-procurement of Year 3* | *6,000,000.00* | *See Matrix.* |
| *July 15, 2019 - July 15, 2020* | *DLR 1.5 80% of value of total contracts managed by MD done through online e-procurement of Year 4* | *3,000,000.00* | *See Matrix.* |
| *July 16, 2020 - July 15, 2021* | *DLR 1.6 90% of value of total contracts managed by MD done through online e-procurement of Year 5* | *3,097,452.00* | *See Matrix.* |
| *July 16, 2021 - July 16, 2022* | *DLR 1.7: 95% of value of total contracts managed by MD done through online e-procurement of Year 6* | *3,500,000.00* | *See Matrix* |
| ***Rationale:***<br>***Year 6 targets included*** | | | |

| DLI 2 | Establishment and functioning of web-based grievance redressal mechanism (DLI 2) | | | |
|---|---|---|---|---|
| **Type of DLI** | **Scalability** | **Unit of Measure** | **Total Allocated Amount (USD)** | **As % of Total Financing Amount** |
| Intermediate Outcome | No | Text | 11,000,000.00 | 0.14 |
| **Period** | **Value** | | **Allocated Amount (USD)** | **Formula** |
| Baseline | Web-based Grievance Redressal Mechanism not established | | | |
| July 16, 2016 - July 15, 2017 | DLR 2.1 Guidelines for Grievance Redressal Mechanism endorsed by MoHP | | 2,000,000.00 | See Matrix. |
| July 16, 2017 - July 15, 2018 | DLR 2.2 Web-based Grievance Redressal Mechanism established and functioning; and training completed for various levels of staff responsible for grievance handling. | | 3,000,000.00 | See Matrix. |
| July 16, 2018 - July 15, 2019 | DLR 2.3 MoHP has made available on its website an annual report on the status of grievances received in Year 3 | | 2,000,000.00 | See Matrix. |
| July 15, 2019 - July 15, 2020 | DLR 2.4 MoHP has made available on its website an annual report on the status of grievances received in Year 4 | | 2,000,000.00 | See Matrix. |
| July 16, 2020 - July 15, 2021 | DLR 2.5 MoHP has made available on its website an annual report on the status of grievances received in Year 5 | | 2,000,000.00 | See Matrix. |
| July 16, 2021 - July 16, 2022 | | | 0.00 | |
| ***Action: This DLI has been Revised. See below.*** | | | | |

| *DLI 2* | *Establishment and functioning of web-based grievance redressal mechanism (DLI 2)* | | | |
|---|---|---|---|---|
| ***Type of DLI*** | ***Scalability*** | ***Unit of Measure*** | ***Total Allocated Amount (USD)*** | ***As % of Total Financing Amount*** |
| *Intermediate Outcome* | *No* | *Text* | *13,064,968.00* | *0.17* |
| ***Period*** | ***Value*** | | ***Allocated Amount (USD)*** | ***Formula*** |
| *Baseline* | *Web-based Grievance Redressal Mechanism not established* | | | |
| *July 16, 2016 - July 15, 2017* | *DLR 2.1 Guidelines for Grievance Redressal Mechanism endorsed by MoHP* | | *2,000,000.00* | *See Matrix.* |
| *July 16, 2017 - July 15, 2018* | *DLR 2.2 Web-based Grievance Redressal Mechanism established and functioning; and training completed for various levels of staff responsible for grievance handling.* | | *3,000,000.00* | *See Matrix.* |
| *July 16, 2018 - July 15, 2019* | *DLR 2.3 MoHP has made available on its website an annual report on the status of grievances received in Year 3* | | *2,000,000.00* | *See Matrix.* |
| *July 15, 2019 - July 15, 2020* | *DLR 2.4 MoHP has made available on its website an annual report on the status of grievances received in Year 4* | | *2,000,000.00* | *See Matrix.* |
| *July 16, 2020 - July 15, 2021* | *DLR 2.5 MoHP has made available on its website an annual report on the status of grievances received in Year 5* | | *2,064,968.00* | *See Matrix.* |
| *July 16, 2021 - July 16, 2022* | *DLR 2.6: MoHP has made available on its website an annual report on the status of grievances received in Year 6* | | *2,000,000.00* | *See Matrix* |

***Rationale:***
***Year 6 targets included***

| **DLI 3** | Percentage of procurements done by Management Division (MD) using standard specifications (DLI 3) | | | |
|---|---|---|---|---|
| **Type of DLI** | **Scalability** | **Unit of Measure** | **Total Allocated Amount (USD)** | **As % of Total Financing Amount** |
| Intermediate Outcome | Yes | Text | 12,500,000.00 | 0.16 |
| **Period** | **Value** | | **Allocated Amount (USD)** | **Formula** |
| Baseline | Procurement not based on standard specifications | | | |
| July 16, 2016 - July 15, 2017 | DLR 3.1 MoHP endorses standard specifications for basic package of free drugs to be procured by MD | | 4,000,000.00 | See Matrix. |
| July 16, 2017 - July 15, 2018 | DLR 3.2 For Year 2 procurement, 70% of procurement of basic package of free drugs based on the use of standard specifications | | 2,000,000.00 | See Matrix. |
| July 16, 2018 - July 15, 2019 | DLR 3.3 MoHP endorses standard specifications for essential equipment to be procured by MD DLR 3.4 For Year 3 procurement, 80% procurement of health commodities, as specified in the list of health commodities with standard specifications and procured by MD, is based on the use of standard specifications | | 2,500,000.00 | See Matrix. |
| July 15, 2019 - July 15, 2020 | DLR 3.5a For Year 4 procurement, 90% of health commodities procured by MD, is based on the use of standard specifications DLR 3.5b For Year | | 2,000,000.00 | See Matrix. |

| | | | |
|---|---|---|---|
| | 4 procurement, 70% of equipment procured by MD is based on the use of standard specifications | | |
| July 16, 2020 - July 15, 2021 | DLR 3.6a For Year 5 procurement, 90% of health commodities procured by MD, is based on the use of standard specifications DLR 3.6b For Year 5 procurement, 70% of equipment procured by MD is based on the use of standard specifications | 2,000,000.00 | See Matrix. |
| July 16, 2021 - July 16, 2022 | | 0.00 | |
| ***Action: This DLI has been Revised. See below.*** | | | |

| ***DLI 3*** | *Percentage of procurements done by Management Division (MD) using standard specifications (DLI 3)* | | | |
|---|---|---|---|---|
| ***Type of DLI*** | ***Scalability*** | ***Unit of Measure*** | ***Total Allocated Amount (USD)*** | ***As % of Total Financing Amount*** |
| *Intermediate Outcome* | *Yes* | *Text* | *16,500,022.00* | *0.21* |
| ***Period*** | ***Value*** | | ***Allocated Amount (USD)*** | ***Formula*** |
| *Baseline* | *Procurement not based on standard specifications* | | | |
| *July 16, 2016 - July 15, 2017* | *DLR 3.1 MoHP endorses standard specifications for basic package of free drugs to be procured by MD* | | *4,000,000.00* | *See Matrix.* |
| *July 16, 2017 - July 15, 2018* | *DLR 3.2 For Year 2 procurement, 70% of procurement of basic package of free drugs based on the use of standard specifications* | | *2,000,000.00* | *See Matrix.* |

| | | | |
|---|---|---|---|
| *July 16, 2018 - July 15, 2019* | *DLR 3.3 MoHP endorses standard specifications for essential equipment to be procured by MD DLR 3.4 For Year 3 procurement, 80% procurement of health commodities, as specified in the list of health commodities with standard specifications and procured by MD, is based on the use of standard specifications* | *2,500,000.00* | *See Matrix.* |
| *July 15, 2019 - July 15, 2020* | *DLR 3.5a For Year 4 procurement, 90% of health commodities procured by MD, is based on the use of standard specificationsDLR 3.5b For Year 4 procurement, 70% of equipment procured by MD is based on the use of standard specifications* | *2,000,000.00* | *See Matrix.* |
| *July 16, 2020 - July 15, 2021* | *DLR 3.6a For Year 5 procurement, 90% of health commodities procured by MD, is based on the use of standard specificationsDLR 3.6b For Year 5 procurement, 70% of equipment procured by MD is based on the use of standard specifications* | *3,000,022.00* | *See Matrix.* |
| *July 16, 2021 - July 16, 2022* | *DLR 3.7 a: For Year 6 procurement, 95% of health commodities procured by MD, is based on the use of standard specificationsDLR 3.7 b: For Year 6 procurement, 80% of equipment procured by MD is based on the use of standard specifications* | *3,000,000.00* | *See Matrix* |
| ***Rationale:***<br>***Year 6 targets included and value of DLR for Year 5 revised to US$3,000,000*** | | | |

| DLI 4 | Central medical stores and medical stores of Provinces report through eLMIS (DLI 4) | | | |
|---|---|---|---|---|
| **Type of DLI** | **Scalability** | **Unit of Measure** | **Total Allocated Amount (USD)** | **As % of Total Financing Amount** |
| Intermediate Outcome | Yes | Text | 19,000,000.00 | 0.24 |
| **Period** | **Value** | | **Allocated Amount (USD)** | **Formula** |
| Baseline | eLMIS not in place | | | |
| July 16, 2016 - July 15, 2017 | | | 0.00 | |
| July 16, 2017 - July 15, 2018 | DLR 4.1 eLMIS installed in all warehouses of the center and district stores of two regions | | 3,000,000.00 | See Matrix. |
| July 16, 2018 - July 15, 2019 | DLR 4.2a Training on, and installation and operation of eLMIS completed for all central and provincial (including sub-provincial) medical stores of at least two Provinces DLR 4.2b Baseline data generated for minimum stocks of tracer health commodities in two Provinces | | 3,000,000.00 | See Matrix. |
| July 15, 2019 - July 15, 2020 | DLR 4.3 eLMIS information for program Year 4 is available from central and provincial (including sub-provincial) stores of Provinces. | | 5,500,000.00 | See Matrix. |
| July 16, 2020 - July 15, 2021 | DLR 4.4 eLMIS information for program Year 5 is available from central and provincial (including sub-provincial) stores of Provinces. | | 7,500,000.00 | See Matrix. |
| July 16, 2021 - July 16, 2022 | | | 0.00 | |
| ***Action: This DLI has been Revised. See below.*** | | | | |

| *DLI 4* | *Central medical stores and medical stores of Provinces report through eLMIS (DLI 4)* | | | |
|---|---|---|---|---|
| ***Type of DLI*** | ***Scalability*** | ***Unit of Measure*** | ***Total Allocated Amount (USD)*** | ***As % of Total Financing Amount*** |
| *Intermediate Outcome* | *Yes* | *Text* | *28,500,057.00* | *0.36* |
| ***Period*** | ***Value*** | | ***Allocated Amount (USD)*** | ***Formula*** |
| *Baseline* | *eLMIS not in place* | | | |
| *July 16, 2016 - July 15, 2017* | | | *0.00* | |
| *July 16, 2017 - July 15, 2018* | *DLR 4.1 eLMIS installed in all warehouses of the center and district stores of two regions* | | *3,000,000.00* | *See Matrix.* |
| *July 16, 2018 - July 15, 2019* | *DLR 4.2a Training on, and installation and operation of eLMIS completed for all central and provincial (including sub-provincial) medical stores of at least two Provinces DLR 4.2b Baseline data generated for minimum stocks of tracer health commodities in two Provinces* | | *3,000,000.00* | *See Matrix.* |
| *July 15, 2019 - July 15, 2020* | *DLR 4.3 eLMIS information for program Year 4 is available from central and provincial (including sub-provincial) stores of Provinces.* | | *5,500,000.00* | *See Matrix.* |
| *July 16, 2020 - July 15, 2021* | *DLR 4.4 eLMIS information for program Year 5 is available from central and provincial (including sub-provincial) stores of Provinces.* | | *8,500,057.00* | *See Matrix.* |
| *July 16, 2021 - July 16, 2022* | *DLR 4.5: eLMIS information for program Year 6 is available from central and provincial (including sub-provincial) stores of Provinces.* | | *8,500,000.00* | *See Matrix* |

***Rationale:***
***Year 6 targets included and DLR value for Year 5 revised to US$8,500,000***

| **DLI 5** | Percentage reduction of less than minimum stocks (understock) of tracer health commodities in sub-provincial medical stores (DLI 5) | | | |
|---|---|---|---|---|
| **Type of DLI** | **Scalability** | **Unit of Measure** | **Total Allocated Amount (USD)** | **As % of Total Financing Amount** |
| Outcome | Yes | Text | 10,050,000.00 | 0.13 |
| **Period** | **Value** | | **Allocated Amount (USD)** | **Formula** |
| Baseline | Baseline to be established in Year 3 | | | |
| July 16, 2016 - July 15, 2017 | | | 0.00 | |
| July 16, 2017 - July 15, 2018 | | | 0.00 | |
| July 16, 2018 - July 15, 2019 | | | 0.00 | |
| July 15, 2019 - July 15, 2020 | DLR 5.1 15% reduction in the understock of tracer health commodities in Year 4 over the baseline established for the sub-provincial (district) medical stores through the eLMIS for two Provinces | | 4,050,000.00 | See Matrix. |
| July 16, 2020 - July 15, 2021 | DLR 5.2 25% reduction in understock of tracer health commodities in Year 5 over the baseline established for the sub-provincial (district) stores through the eLMIS for two Provinces | | 6,000,000.00 | See Matrix. |

| | | | | |
|---|---|---|---|---|
| July 16, 2021 - July 16, 2022 | | | 0.00 | |
| ***Action: This DLI has been Revised. See below.*** | | | | |
| ***DLI 5*** | *Percentage reduction of less than minimum stocks (understock) of tracer health commodities in sub-provincial medical stores (DLI 5)* | | | |
| ***Type of DLI*** | ***Scalability*** | ***Unit of Measure*** | ***Total Allocated Amount (USD)*** | ***As % of Total Financing Amount*** |
| *Outcome* | *Yes* | *Text* | *18,644,042.00* | *0.24* |
| ***Period*** | ***Value*** | | ***Allocated Amount (USD)*** | ***Formula*** |
| *Baseline* | *Baseline to be established in Year 3* | | | |
| *July 16, 2016 - July 15, 2017* | | | *0.00* | |
| *July 16, 2017 - July 15, 2018* | | | *0.00* | |
| *July 16, 2018 - July 15, 2019* | | | *0.00* | |
| *July 15, 2019 - July 15, 2020* | *DLR 5.1 15% reduction in the understock of tracer health commodities in Year 4 over the baseline established for the sub-provincial (district) medical stores through the eLMIS for two Provinces* | | *4,050,000.00* | *See Matrix.* |
| *July 16, 2020 - July 15, 2021* | *DLR 5.2 25% reduction in understock of tracer health commodities in Year 5 over the baseline established for the sub-provincial (district) stores through the eLMIS for two Provinces* | | *6,194,042.00* | *See Matrix.* |

| | | | |
|---|---|---|---|
| *July 16, 2021 - July 16, 2022* | *DLR 5.3: 35% reduction in understock of tracer health commodities in Year 6 over the baseline established for the sub-provincial (district) stores through the eLMIS for two Provinces.* | *8,400,000.00* | *See Matrix* |
| ***Rationale:***<br>***Year 6 targets included*** | | | |

| **DLI 6** | Percentage improvement in EVM score over 2014 baseline. (DLI 6) | | | |
|---|---|---|---|---|
| **Type of DLI** | **Scalability** | **Unit of Measure** | **Total Allocated Amount (USD)** | **As % of Total Financing Amount** |
| Intermediate Outcome | Yes | Text | 5,000,000.00 | 0.06 |
| **Period** | **Value** | | **Allocated Amount (USD)** | **Formula** |
| Baseline | Average EVM Score of 64%, with two attributes achieving 80% | | | |
| July 16, 2016 - July 15, 2017 | | | 0.00 | |
| July 16, 2017 - July 15, 2018 | DLR 6.1 Average EVM Score of 70% (based on 2016 survey), with any 3 attributes in EVM Score achieving 80% | | 2,000,000.00 | See Matrix. |
| July 16, 2018 - July 15, 2019 | | | 0.00 | |
| July 15, 2019 - July 15, 2020 | DLR 6.2a Average EVM Score of 70% (based on a survey conducted in 2019 or later) DLR 6.2b Any four (4) attributes in EVM Score achieving at least 80% | | 3,000,000.00 | See Matrix |
| July 16, 2020 - July 15, 2021 | None | | 0.00 | |

| | | | | |
|---|---|---|---|---|
| July 16, 2021 - July 16, 2022 | | | 0.00 | |
| ***Action: This DLI has been Revised. See below.*** | | | | |

| | | | | |
|---|---|---|---|---|
| ***DLI 6*** | *Percentage improvement in EVM score over 2014 baseline. (DLI 6)* | | | |
| ***Type of DLI*** | ***Scalability*** | ***Unit of Measure*** | ***Total Allocated Amount (USD)*** | ***As % of Total Financing Amount*** |
| *Intermediate Outcome* | *Yes* | *Text* | *3,413,620.00* | *0.04* |
| ***Period*** | ***Value*** | | ***Allocated Amount (USD)*** | ***Formula*** |
| *Baseline* | *Average EVM Score of 64%, with two attributes achieving 80%* | | | |
| *July 16, 2016 - July 15, 2017* | | | *0.00* | |
| *July 16, 2017 - July 15, 2018* | *DLR 6.1 Average EVM Score of 70% (based on 2016 survey), with any 3 attributes in EVM Score achieving 80%* | | *2,000,000.00* | *See Matrix.* |
| *July 16, 2018 - July 15, 2019* | | | *0.00* | |
| *July 15, 2019 - July 15, 2020* | | | *0.00* | |
| *July 16, 2020 - July 15, 2021* | *DLR 6.2a Average EVM Score of 70% (based on a survey conducted in 2019 or later) DLR 6.2b Any four (4) attributes in EVM Score achieving at least 80%* | | *1,413,620.00* | *See Matrix* |
| *July 16, 2021 - July 16, 2022* | | | *0.00* | |
| ***Rationale:***<br>***Timeline for achievement of DLR 6.2 has been revised to Year 5 and value of DLR 6.2 revised.*** | | | | |

| DLI 7 | Percentage of the MoHP spending entities submitting annual plan and budget using eAWPB. (DLI 7) | | | |
|---|---|---|---|---|
| **Type of DLI** | **Scalability** | **Unit of Measure** | **Total Allocated Amount (USD)** | **As % of Total Financing Amount** |
| Intermediate Outcome | Yes | Text | 15,124,218.00 | 0.19 |
| **Period** | **Value** | | **Allocated Amount (USD)** | **Formula** |
| Baseline | Not all spending units submit their annual plan and budget using eAWPB | | | |
| July 16, 2016 - July 15, 2017 | DLR 7.1 MoHP and all its departments, divisions, and centers are given access to operate on eAWPB | | 2,000,000.00 | See Matrix. |
| July 16, 2017 - July 15, 2018 | DLR 7.2 eAWPB used for planning and budget submission by MoHP and all departments, divisions, and centers | | 1,000,000.00 | See Matrix. |
| July 16, 2018 - July 15, 2019 | DLR 7.3a eAWPB used in Year 3 for planning and budget submission by MoHP and all its departments, divisions and centers DLR 7.3b eAWPB used in Year 3 for 25% of remaining spending units (excluding units included under DLR 7.3a) under the MoHP | | 4,000,000.00 | See Matrix. |
| July 15, 2019 - July 15, 2020 | DLR 7.4a eAWPB used in Year 4 for planning and budget submission by MoHP and all its departments, divisions and center, DLR 7.4b eAWPB used in Year 4 for 50% of remaining spending units (excluding units included under DLR 7.4a) under MoHP | | 4,000,000.00 | See Matrix. |

| | | | |
|---|---|---|---|
| July 16, 2020 - July 15, 2021 | DLR 7.5a eAWPB used in Year 5 for planning and budget submission by MoHP and all its departments, divisions and centers DLR 7.5b eAWPB used in Year 5 for and 75% of remaining spending units (excluding units included under DLR 7.5a) under MoHP | 4,124,218.00 | See Matrix. |
| July 16, 2021 - July 16, 2022 | | 0.00 | |
| ***Action: This DLI has been Revised. See below.*** | | | |

| ***DLI 7*** | *Percentage of the MoHP spending entities submitting annual plan and budget using eAWPB. (DLI 7)* | | | |
|---|---|---|---|---|
| ***Type of DLI*** | ***Scalability*** | ***Unit of Measure*** | ***Total Allocated Amount (USD)*** | ***As % of Total Financing Amount*** |
| *Intermediate Outcome* | *Yes* | *Text* | *20,049,026.00* | *0.25* |
| ***Period*** | ***Value*** | | ***Allocated Amount (USD)*** | ***Formula*** |
| *Baseline* | *Not all spending units submit their annual plan and budget using eAWPB* | | | |
| *July 16, 2016 - July 15, 2017* | *DLR 7.1 MoHP and all its departments, divisions, and centers are given access to operate on eAWPB* | | *2,000,000.00* | *See Matrix.* |
| *July 16, 2017 - July 15, 2018* | *DLR 7.2 eAWPB used for planning and budget submission by MoHP and all departments, divisions, and centers* | | *1,000,000.00* | *See Matrix.* |
| *July 16, 2018 - July 15, 2019* | *DLR 7.3a eAWPB used in Year 3 for planning and budget submission by MoHP and all its departments, divisions and centers DLR 7.3b eAWPB used in Year 3 for 25% of remaining* | | *4,000,000.00* | *See Matrix.* |

| | | | |
|---|---|---|---|
| | *spending units (excluding units included under DLR 7.3a) under the MoHP* | | |
| *July 15, 2019 - July 15, 2020* | *DLR 7.4a eAWPB used in Year 4 for planning and budget submission by MoHP and all its departments, divisions and center, DLR 7.4b eAWPB used in Year 4 for 50% of remaining spending units (excluding units included under DLR 7.4a) under MoHP* | *4,000,000.00* | *See Matrix.* |
| *July 16, 2020 - July 15, 2021* | *DLR 7.5a eAWPB used in Year 5 for planning and budget submission by MoHP and all its departments, divisions and centers DLR 7.5b eAWPB used in Year 5 for and 75% of remaining spending units (excluding units included under DLR 7.5a) under MoHP* | *4,175,026.00* | *See Matrix.* |
| *July 16, 2021 - July 16, 2022* | *DLR 7.6a: eAWPB used in Year 6 for planning and budget submission by MoHP and all its departments, divisions and centers DLR 7.6b: eAWPB used in Year 6 for and 95% of remaining spending units (excluding units included under DLR 7.6a) under MoHP* | *4,874,000.00* | *See Matrix* |
| ***Rationale:***<br>***Year 6 targets included and value of DLR 7.5 revised to US$4,175,000*** | | | |

| **DLI 8** | Percentage of the MoHP's annual spending captured by the TABUCS. (DLI 8) | | | |
|---|---|---|---|---|
| **Type of DLI** | **Scalability** | **Unit of Measure** | **Total Allocated Amount (USD)** | **As % of Total Financing Amount** |
| Outcome | Yes | Text | 20,332,750.00 | 0.26 |
| **Period** | **Value** | | **Allocated Amount (USD)** | **Formula** |
| Baseline | 70% | | | |
| July 16, 2016 - July 15, 2017 | DLR 8.1 MoHP has issued a circular mandating expenditure reporting through TABUCS by all spending units | | 4,000,000.00 | See Matrix. |
| July 16, 2017 - July 15, 2018 | DLR 8.2 80% of MoHP's spending in Year 2 captured by TABUCS | | 4,000,000.00 | See Matrix. |
| July 16, 2018 - July 15, 2019 | DLR 8.3 85% of MoHP spending in Year 3 captured by TABUCS | | 4,007,750.00 | See Matrix. |
| July 15, 2019 - July 15, 2020 | DLR 8.4 90% of MoHP spending in Year 4 captured by TABUCS | | 4,050,000.00 | See Matrix. |
| July 16, 2020 - July 15, 2021 | DLR 8.5 95% of MoHP spending in Year 5 captured by TABUCS | | 4,275,000.00 | See Matrix. |
| July 16, 2021 - July 16, 2022 | | | 0.00 | |
| ***Action: This DLI has been Revised. See below.*** | | | | |

| ***DLI 8*** | *Percentage of the MoHP's annual spending captured by the TABUCS/CGAS. (DLI 8)* | | | |
|---|---|---|---|---|
| ***Type of DLI*** | ***Scalability*** | ***Unit of Measure*** | ***Total Allocated Amount (USD)*** | ***As % of Total Financing Amount*** |
| *Outcome* | *Yes* | *Text* | *25,957,785.00* | *0.33* |
| ***Period*** | ***Value*** | | ***Allocated Amount (USD)*** | ***Formula*** |
| *Baseline* | *70%* | | | |
| *July 16, 2016 - July 15, 2017* | *DLR 8.1 MoHP has issued a circular mandating expenditure reporting through TABUCS by all spending units* | | *4,000,000.00* | *See Matrix.* |
| *July 16, 2017 - July 15, 2018* | *DLR 8.2 80% of MoHP's spending in Year 2 captured by TABUCS* | | *4,000,000.00* | *See Matrix.* |
| *July 16, 2018 - July 15, 2019* | *DLR 8.3 85% of MoHP spending in Year 3 captured by TABUCS* | | *4,007,750.00* | *See Matrix.* |
| *July 15, 2019 - July 15, 2020* | *DLR 8.4 90% of MoHP spending in Year 4 captured by TABUCS* | | *4,050,000.00* | *See Matrix.* |
| *July 16, 2020 - July 15, 2021* | *DLR 8.5 95% of MoHP spending in Year 5 captured by TABUCS* | | *4,950,035.00* | *See Matrix.* |
| *July 16, 2021 - July 16, 2022* | *DLR 8.6: 95% of MoHP spending in Year 6 captured by TABUCS/CGAS* | | *4,950,000.00* | *See Matrix* |
| ***Rationale:***<br>***Year 6 targets included and value of Year 5 DLR revised*** | | | | |

| DLI 9 | Percentage of audited spending units responding to the OAG's primary audit queries within 35 days. (DLI 9) | | | |
|---|---|---|---|---|
| **Type of DLI** | **Scalability** | **Unit of Measure** | **Total Allocated Amount (USD)** | **As % of Total Financing Amount** |
| Intermediate Outcome | Yes | Text | 15,750,000.00 | 0.20 |
| **Period** | **Value** | | **Allocated Amount (USD)** | **Formula** |
| Baseline | Percentage as derived from MoHP inventory of responses in Year 1 | | | |
| July 16, 2016 - July 15, 2017 | DLR 9.1 All reports containing primary audit queries received by audited spending units are available at MoHP; and inventory of responses by date provided by individual audited spending units are available at MoHP | | 3,000,000.00 | See Matrix. |
| July 16, 2017 - July 15, 2018 | DLR 9.2 10 percentage points increase in audited institutions responding to primary audit queries within mandated 35 days over percentage derived from the MoHP inventory of responses of Year 1 | | 3,000,000.00 | See Matrix. |
| July 16, 2018 - July 15, 2019 | DLR 9.3 60% of spending units reporting to the MoHP respond to primary audit queries within mandated 35 days | | 3,000,000.00 | See Matrix. |
| July 15, 2019 - July 15, 2020 | DLR 9.4 65% of spending units reporting to the MoHP respond to primary audit queries within mandated 35 days | | 3,250,000.00 | See Matrix. |
| July 16, 2020 - July 15, 2021 | DLR 9.5 70% of spending units reporting to the MoHP respond to primary audit queries within mandated 35 days | | 3,500,000.00 | See Matrix. |

| | | | | |
|---|---|---|---|---|
| July 16, 2021 - July 16, 2022 | | | 0.00 | |
| ***Action: This DLI has been Revised. See below.*** | | | | |

| ***DLI 9*** | *Percentage of audited spending units responding to the OAG's primary audit queries within 35 days. (DLI 9)* | | | |
|---|---|---|---|---|
| ***Type of DLI*** | ***Scalability*** | ***Unit of Measure*** | ***Total Allocated Amount (USD)*** | ***As % of Total Financing Amount*** |
| *Intermediate Outcome* | *Yes* | *Text* | *21,250,027.00* | *0.27* |
| ***Period*** | ***Value*** | | ***Allocated Amount (USD)*** | ***Formula*** |
| *Baseline* | *Percentage as derived from MoHP inventory of responses in Year 1* | | | |
| *July 16, 2016 - July 15, 2017* | *DLR 9.1 All reports containing primary audit queries received by audited spending units are available at MoHP; and inventory of responses by date provided by individual audited spending units are available at MoHP* | | *3,000,000.00* | *See Matrix.* |
| *July 16, 2017 - July 15, 2018* | *DLR 9.2 10 percentage points increase in audited institutions responding to primary audit queries within mandated 35 days over percentage derived from the MoHP inventory of responses of Year 1* | | *3,000,000.00* | *See Matrix.* |
| *July 16, 2018 - July 15, 2019* | *DLR 9.3 60% of spending units reporting to the MoHP respond to primary audit queries within mandated 35 days* | | *3,000,000.00* | *See Matrix.* |
| *July 15, 2019 - July 15, 2020* | *DLR 9.4 65% of spending units reporting to the MoHP respond to primary audit queries within mandated 35 days* | | *3,250,000.00* | *See Matrix.* |

| | | | |
|---|---|---|---|
| *July 16, 2020 - July 15, 2021* | *DLR 9.5 70% of spending units reporting to the MoHP respond to primary audit queries within mandated 35 days* | *4,200,027.00* | *See Matrix.* |
| *July 16, 2021 - July 16, 2022* | *DLR 9.6: 80% of spending units reporting to the MoHP respond to primary audit queries within mandated 35 days* | *4,800,000.00* | *See Matrix* |

***Rationale:***
***Year 6 targets included and DLR value for Year 5 revised to US$4,200,000***

| **DLI 10** | Health facilities reporting annual disaggregated data using District Health Information System (DHIS 2) in a timely manner. (DLI 10) | | | |
|---|---|---|---|---|
| **Type of DLI** | **Scalability** | **Unit of Measure** | **Total Allocated Amount (USD)** | **As % of Total Financing Amount** |
| Outcome | Yes | Text | 20,000,000.00 | 0.25 |
| **Period** | **Value** | | **Allocated Amount (USD)** | **Formula** |
| Baseline | 0% | | | |
| July 16, 2016 - July 15, 2017 | DLR 10.1 Plan for roll out of DHIS 2 finalized and DHIS 2 rolled out up to DHO level | | 3,000,000.00 | See Matrix. |
| July 16, 2017 - July 15, 2018 | DLR 10.2 Reports based on DHIS 2 available from all DHOs | | 3,000,000.00 | See Matrix. |
| July 16, 2018 - July 15, 2019 | DLR 10.3a HMIS/DHIS 2 training provided to all Provinces DLR 10.3b HMIS/DHIS 2 dashboard includes indicator measuring timely reporting from health facilities | | 4,000,000.00 | See Matrix. |

| | | | |
|---|---|---|---|
| July 15, 2019 - July 15, 2020 | DLR 10.4 HMIS/DHIS 2 shows timely reporting from at least 40% of public health facilities in Year 4 | 5,000,000.00 | See Matrix. |
| July 16, 2020 - July 15, 2021 | DLR 10.5 HMIS/DHIS 2 shows timely reporting from at least 50% of public health facilities in Year 5 | 5,000,000.00 | See Matrix. |
| July 16, 2021 - July 16, 2022 | | 0.00 | |
| ***Action: This DLI has been Revised. See below.*** | | | |

| ***DLI 10*** | *Health facilities reporting annual disaggregated data using District Health Information System (DHIS 2) in a timely manner. (DLI 10)* | | | |
|---|---|---|---|---|
| ***Type of DLI*** | ***Scalability*** | ***Unit of Measure*** | ***Total Allocated Amount (USD)*** | ***As % of Total Financing Amount*** |
| *Outcome* | *Yes* | *Text* | *27,161,702.00* | *0.35* |
| ***Period*** | ***Value*** | | ***Allocated Amount (USD)*** | ***Formula*** |
| *Baseline* | *0%* | | | |
| *July 16, 2016 - July 15, 2017* | *DLR 10.1 Plan for roll out of DHIS 2 finalized and DHIS 2 rolled out up to DHO level* | | *3,000,000.00* | *See Matrix.* |
| *July 16, 2017 - July 15, 2018* | *DLR 10.2 Reports based on DHIS 2 available from all DHOs* | | *3,000,000.00* | *See Matrix.* |
| *July 16, 2018 - July 15, 2019* | *DLR 10.3a HMIS/DHIS 2 training provided to all Provinces DLR 10.3b HMIS/DHIS 2 dashboard includes indicator measuring timely reporting from health facilities* | | *4,000,000.00* | *See Matrix.* |

| | | | |
|---|---|---|---|
| *July 15, 2019 - July 15, 2020* | *DLR 10.4 HMIS/DHIS 2 shows timely reporting from at least 40% of public health facilities in Year 4* | *5,000,000.00* | *See Matrix.* |
| *July 16, 2020 - July 15, 2021* | *DLR 10.5 HMIS/DHIS 2 shows timely reporting from at least 50% of public health facilities in Year 5* | *5,161,702.00* | *See Matrix.* |
| *July 16, 2021 - July 16, 2022* | *DLR 10.6: HMIS/DHIS 2 shows timely reporting from at least 70% of public health facilities in Year 6* | *7,000,000.00* | *See Matrix* |
| ***Rationale:***<br>***Year 6 targets included*** | | | |

| **DLI 11** | MoHP to provide guidance and support to the subnational governments on citizen engagement mechanism (DLI 11) | | | |
|---|---|---|---|---|
| **Type of DLI** | **Scalability** | **Unit of Measure** | **Total Allocated Amount (USD)** | **As % of Total Financing Amount** |
| Intermediate Outcome | Yes | Text | 5,000,000.00 | 0.06 |
| **Period** | **Value** | | **Allocated Amount (USD)** | **Formula** |
| Baseline | No formal guidelines for citizen feedback mechanisms in place for Provinces and/or Local Governments | | | |
| July 16, 2016 - July 15, 2017 | DLR 11.1 Citizen engagement mechanism options and public reporting systems developed by MoHP for citizens' feedback, including on availability of drugs and facility level services and disaggregated by gender | | 2,000,000.00 | See Matrix. |

| | | | |
|---|---|---|---|
| July 16, 2017 - July 15, 2018 | | 0.00 | |
| July 16, 2018 - July 15, 2019 | DLR 11.3: MoHP provided orientation training to all Provinces on social audit mechanism | 1,000,000.00 | See Matrix. |
| July 15, 2019 - July 15, 2020 | DLR 11.4: MoHP updated social audit guidelines to guide the Provinces and/or Local Governments and disseminated to the Provinces and/or Local Governments | 1,000,000.00 | See Matrix. |
| July 16, 2020 - July 15, 2021 | DLR 11.5: MoHP provided on-site support to at least three (3) Local Governments each in at least two Provinces in conducting social audits | 1,000,000.00 | See Matrix. |
| July 16, 2021 - July 16, 2022 | | 0.00 | |
| ***Action: This DLI has been Revised. See below.*** | | | |

| ***DLI 11*** | *MoHP to provide guidance and support to the subnational governments on citizen engagement mechanism (DLI 11)* | | | |
|---|---|---|---|---|
| ***Type of DLI*** | ***Scalability*** | ***Unit of Measure*** | ***Total Allocated Amount (USD)*** | ***As % of Total Financing Amount*** |
| *Intermediate Outcome* | *Yes* | *Text* | *6,976,000.00* | *0.09* |
| ***Period*** | ***Value*** | | ***Allocated Amount (USD)*** | ***Formula*** |
| *Baseline* | *No formal guidelines for citizen feedback mechanisms in place for Provinces and/or Local Governments* | | | |
| *July 16, 2016 - July 15, 2017* | *DLR 11.1 Citizen engagement mechanism options and public reporting systems developed by MoHP for citizens' feedback, including on availability of drugs and facility level services and* | | *2,000,000.00* | *See Matrix.* |

| | | | |
|---|---|---|---|
| | *disaggregated by gender* | | |
| *July 16, 2017 - July 15, 2018* | | *0.00* | |
| *July 16, 2018 - July 15, 2019* | *DLR 11.3: MoHP provided orientation training to all Provinces on social audit mechanism* | *1,000,000.00* | *See Matrix.* |
| *July 15, 2019 - July 15, 2020* | *DLR 11.4: MoHP updated social audit guidelines to guide the Provinces and/or Local Governments* | *500,000.00* | *See Matrix.* |
| *July 16, 2020 - July 15, 2021* | *DLR 11.5: MOHP provided orientation to all Provinces and/or Local Governments on the new Social Accountability Framework* | *500,000.00* | *See Matrix.* |
| *July 16, 2021 - July 16, 2022* | *DLR 11.6: MoHP provided on-site support to at least three (3) Local Governments each in at least four Provinces in conducting social audits* | *2,976,000.00* | *See Matrix* |

***Rationale:***
***Metric for DLR achievement for Year 4 revised to "MoHP updated social audit guidelines to guide the Provinces and/or Local Governments" and allocation revised to US$500,000***
***Metric for DLR achievement for Year 5 revised to "MOHP provided orientation to all Provinces and/or Local Governments on the new Social Accountability Framework" and allocation revised to US$500,000; and***
***Year 6 target included***

| **Verification Protocol Table: Disbursement Linked Indicators** | |
|---|---|
| **DLI 1** | Percentage of contracts managed by the MD through the PPMO's online procurement portal (DLI 1) |
| **Description** | |

| | |
|---|---|
| **Data source/ Agency** | MOHP's records. |
| **Verification Entity** | Nepal Health Research Council |
| **Procedure** | DLR 1.1 - Verify that at least 20 staff of the MoH have completed training on the use of online e-procurement portal developed by the PPMO.<br>DLR 1.2 - Verify from the MoHP/MD's record of memorandum, training dates and sites, training minutes, and lists of participants that procurement training that includes the use of the standard bidding documents for health sector commodities is completed with relevant officials from all seven of the provinces.<br>DLRs 1.3, 1.4, 1.5, and 1.6 - Verify that at least 60% of the value of total contracts awarded by the MD have been through e-procurement by cross checking the procurement plan and documenting the status of each contract. Also, provide a report on the actual percentage of value of total contracts awarded by the MD through e-procurement of Years 2,3, 4, and 5. |
| **DLI 1** | Percentage of contracts managed by the MD through the PPMO's online procurement portal (DLI 1) |
| **Description** | e-procurement is the government procurement system established by the PPMO. For verification of DLI results, the program will track contracts up to the point of e-bidding in alignment with the existing eGP system |
| **Data source/ Agency** | MOHP's records. |
| **Verification Entity** | Nepal Health Research Council |
| **Procedure** | DLR 1.1 - Verify that at least 20 staff of the MoHP have completed training on the use of online e-procurement portal developed by the PPMO.<br>DLR 1.2 - Verify from the MoHP/MD's record of memorandum, training dates and sites, training minutes, and lists of participants that procurement training that includes the use of the standard bidding documents for health sector commodities is completed with relevant officials from all seven of the provinces.<br>DLRs 1.3, 1.4, 1.5, 1.6, and 1.7 - Verify that at least 60% of the value of total contracts awarded by the MD have been through e-procurement by cross checking the procurement plan and documenting the status of each contract. Also, provide a report on the actual percentage of value of total contracts awarded by the MD through e-procurement of Years 2, 3, 4, 5 |

| | |
|---|---|
| | and 6. |
| **DLI 2** | Establishment and functioning of web-based grievance redressal mechanism (DLI 2) |
| **Description** | Grievance Redressal Mechanism will track complaints and responses related to procurement and supply chain management. |
| **Data source/ Agency** | MOHP's/MD Records |
| **Verification Entity** | Nepal Health Research Council |
| **Procedure** | Year 1 - Verify from the MoH records that guidelines for a web-based grievance handling mechanism have been endorsed by the MoH.<br>Year 2 - Verify that a software for a web-based grievance redressal mechanism is established for use.<br>Year 2 - Verify that staff at various levels responsible for handling grievances are trained on the use of the software.<br>Year 3, 4 and 5- verify that annual reports are produced. |
| **DLI 2** | Establishment and functioning of web-based grievance redressal mechanism (DLI 2) |
| **Description** | Grievance Redressal Mechanism will track complaints and responses related to procurement and supply chain management. |
| **Data source/ Agency** | MOHP's/MD Records |
| **Verification Entity** | Nepal Health Research Council |
| **Procedure** | Year 1 - Verify from the MoHP records that guidelines for a web-based grievance handling mechanism have been endorsed by the MoHP.<br>Year 2 - Verify that a software for a web-based grievance redressal mechanism is established for use.<br>Year 2 - Verify that staff at various levels responsible for handling grievances are trained on the use of the software.<br>Year 3, 4, 5 and 6 - verify that annual reports are produced. |

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| **DLI 3** | Percentage of procurements done by Management Division (MD) using standard specifications (DLI 3) |
| **Description** | All procurements done by Management Division will be tracked. Standard specifications are as defined by MoHP and publicly disclosed |
| **Data source/ Agency** | MoHP/MD's Records |
| **Verification Entity** | Nepal Health Research Council |
| **Procedure** | Year 1 - Verify that the MoH has endorsed, through a public notification, standard specifications for basic package of free drugs procured by the LMD.<br>Year 2 - Verify through examination of bid documents, that 70% of the procurement of basic package of free drugs is done by the LMD using the endorsed standard specifications.<br>DLRs 3.4, 3.5 and 3.6- Verify, through examination of bid documents, procurements of health commodities (vaccines/Reproductive health commodities)/equipment as stated, done by the MD, contain the standard specifications. |

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| **DLI 3** | Percentage of procurements done by Management Division (MD) using standard specifications (DLI 3) |
| **Description** | All procurements done by Management Division will be tracked. Standard specifications are as defined by MoHP and publicly disclosed |
| **Data source/ Agency** | MoHP/MD's Records |
| **Verification Entity** | Nepal Health Research Council |
| **Procedure** | Year 1 - Verify that the MoHP has endorsed, through a public notification, standard specifications for basic package of free drugs procured by the LMD.<br>Year 2 - Verify through examination of bid documents, that 70% of the procurement of basic package of free drugs is done by the LMD using the endorsed standard specifications.<br>DLRs 3.4, 3.5, 3.6 and 3.7 - Verify, through examination of bid documents, procurements of health commodities |

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| | (vaccines/Reproductive health commodities)/equipment as stated, done by the MD, contain the standard specifications. |

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| **DLI 4** | Central medical stores and medical stores of Provinces report through eLMIS (DLI 4) |
| **Description** | Medical stores are the public warehouses for storing drugs. eLMIS is the real time online logistic management information system which provides information on stocks of drugs and has various functionalities as defined in the verification protocol matrix. |
| **Data source/ Agency** | MoHP/MD's Records |
| **Verification Entity** | Nepal Health Research Council or any other independent agency jointly agreed between the Bank and the government. |
| **Procedure** | DLR 4.2- Verify through MOHP/MD records that training for e-LMIS completed for all central medical stores, and at least two provincial medical stores and their sub-provincial/district stores. Verify that baseline data for understock of tracer health commodities is generated.<br>DLRs 4.3 and 4.4- Verify that eLMIS information are available for the central, provincial and sub-provincial medical stores as defined. |

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| **DLI 4** | Central medical stores and medical stores of Provinces report through eLMIS (DLI 4) |
| **Description** | Medical stores are the public warehouses for storing drugs. eLMIS is the real time online logistic management information system which provides information on stocks of drugs and has various functionalities as defined in the verification protocol matrix. |
| **Data source/ Agency** | MoHP/MD's Records |
| **Verification Entity** | Nepal Health Research Council or any other independent agency jointly agreed between the Bank and the government. |

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| **Procedure** | DLR 4.2- Verify through MOHP/MD records that training for e-LMIS completed for all central medical stores, and at least two provincial medical stores and their sub-provincial/district stores. Verify that baseline data for understock of tracer health commodities is generated.<br>DLRs 4.3, 4.4 and 4.5 - Verify that eLMIS information are available for the central, provincial and sub-provincial medical stores as defined. |
| **DLI 5** | Percentage reduction of less than minimum stocks (understock) of tracer health commodities in sub-provincial medical stores (DLI 5) |
| **Description** | The list of “tracer health commodities” procured by the MD will be jointly agreed by the government and partners. The required minimum stock of tracer health commodities will be agreed and defined in the baseline for Year 3. Any stock below the minimum required level will be labelled as "understock". |
| **Data source/ Agency** | eLMIS/MD records |
| **Verification Entity** | Nepal Health Research Council or any other independent agency jointly agreed between the World Bank and the government. |
| **Procedure** | By accessing eLMIS Dashboard |
| **DLI 5** | Percentage reduction of less than minimum stocks (understock) of tracer health commodities in sub-provincial medical stores (DLI 5) |
| **Description** | The list of “tracer health commodities” procured by the MD will be jointly agreed by the government and partners. The required minimum stock of tracer health commodities will be agreed and defined in the baseline for Year 3. Any stock below the minimum required level will be labelled as "understock". |
| **Data source/ Agency** | eLMIS/MD records |
| **Verification Entity** | Nepal Health Research Council or any other independent agency jointly agreed between the World Bank and the |

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| | government. |
| **Procedure** | By accessing eLMIS Dashboard |
| **DLI 6** | Percentage improvement in EVM score over 2014 baseline. (DLI 6) |
| **Description** | 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 |
| **Data source/ Agency** | Survey Report |
| **Verification Entity** | Nepal Health Research Council |
| **Procedure** | Year 2 - Verify from the joint MoH, WHO, and UNICEF assessment, that the average EVM score improved from 64% (baseline: 2014 survey report) to 70% (2016 survey report).<br>Year 2 - Verify from the joint MoH, WHO, and UNICEF assessment, that at least any 3 EVM attributes achieved 80% (2016 survey) compared to any 2 attributes achieving 80% in 2014.<br>DLR 6.2- Verify through survey report done in 2019 or later if the stated target has been achieved. |
| **DLI 6** | Percentage improvement in EVM score over 2014 baseline. (DLI 6) |
| **Description** | 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 |
| **Data source/ Agency** | Survey Report |
| **Verification Entity** | Nepal Health Research Council |
| **Procedure** | Year 2 - Verify from the joint MoHP, WHO, and UNICEF assessment, that the average EVM score improved from 64% (baseline: 2014 survey report) to 70% (2016 survey report).<br>Year 2 - Verify from the joint MoHP, WHO, and UNICEF assessment, that at least any 3 EVM attributes achieved 80% (2016 |

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| | survey) compared to any 2 attributes achieving 80% in 2014.<br>DLR 6.2- Verify through survey report done in 2019 or later if the stated target has been achieved. |

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| **DLI 7** | Percentage of the MoHP spending entities submitting annual plan and budget using eAWPB. (DLI 7) |
| **Description** | eAWPB is a software at MoHP used for annual workplan and budgeting. |
| **Data source/ Agency** | MoHP eAWPB web portal |
| **Verification Entity** | Nepal Health Research Council and any other independent agency jointly agreed between the Bank and the government. |
| **Procedure** | Year 1 - Verify that the MoH and all its departments, divisions, and centers have access to operate on the eAWPB by observing log-in and log-out from the eAWPB at every unit mentioned above.<br>Year 2 - Verify through an online check, that the eAWPB has been used by the MoHP and all departments, divisions, and centers for submitting their AWPB.<br>DLRs 7.3, 7.4 and 7.5- Verify through the online check that eAWPB has been used by the said % of spending units of the MoHP |

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| **DLI 7** | Percentage of the MoHP spending entities submitting annual plan and budget using eAWPB. (DLI 7) |
| **Description** | eAWPB, which is activity based programming software at MoHP or the Govt's LMBIS used for annual workplan and budgeting. |
| **Data source/ Agency** | MoHP eAWPB/LMBIS web portal |
| **Verification Entity** | Nepal Health Research Council and any other independent agency jointly agreed between the Bank and the government. |

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| **Procedure** | Year 1 - Verify that the MoHP and all its departments, divisions, and centers have access to operate on the eAWPB by observing log-in and log-out from the eAWPB at every unit mentioned above.<br>Year 2 - Verify through an online check, that the eAWPB has been used by the MoHP and all departments, divisions, and centers for submitting their AWPB.<br>DLRs 7.3 and 7.4 - Verify through the online check that eAWPB has been used by the said % of spending units of the MoHP<br>DLR 7.5 and 7.6 - Verify through the online check that eAWPB/LMBIS has been used by the said % of spending units of the MoHP |
| **DLI 8** | Percentage of the MoHP's annual spending captured by the TABUCS. (DLI 8) |
| **Description** | Audited spending units to respond to the OAG's primary audit queries within 35 days of receiving the report. |
| **Data source/ Agency** | MoHP record and report from TABUCS and treasury single account (TSA) (FCGO/MoF) |
| **Verification Entity** | Nepal Health Research Council or any other independent agency jointly agreed. |
| **Procedure** | Year 1 - Verify the issuance by the MoH of a circular mandating expenditure reporting through TABUCS by all spending units.<br>Year 2 - Verify through an online check at the MoH that expenditure reported through TABUCS comprises at least 80% of MoH's spending in Year 2, and provide report of actual spending.<br>Year 3, 4 and 5- Verify through an online check at the MoH that expenditure reported through TABUCS comprises up to the target % of MoHP's spending, and provide report of actual spending |
| **DLI 8** | Percentage of the MoHP's annual spending captured by the TABUCS/CGAS. (DLI 8) |
| **Description** | |

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| **Data source/ Agency** | MoHP record and report from TABUCS/CGAS and treasury single account (TSA) (FCGO/MoF) |
| **Verification Entity** | Nepal Health Research Council or any other independent agency jointly agreed. |
| **Procedure** | Year 1 - Verify the issuance by the MoHP of a circular mandating expenditure reporting through TABUCS by all spending units.<br>Year 2 - Verify through an online check at the MoHP that expenditure reported through TABUCS comprises at least 80% of MoHP's spending in Year 2, and provide report of actual spending.<br>Year 3, 4, 5- Verify through an online check at the MoHP that expenditure reported through TABUCS comprises up to the target % of MoHP's spending, and provide report of actual spending<br>Year 6 - Verify through an online check at the MoHP that expenditure reported through TABUCS/CGAS comprises up to the target % of MoHP's spending, and provide report of actual spending |

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| **DLI 9** | Percentage of audited spending units responding to the OAG's primary audit queries within 35 days. (DLI 9) |
| **Description** | OAG sends primary audit queries to the audited institutions which have to respond within 35 days. |
| **Data source/ Agency** | MoHP records and the OAG's primary and final reports |
| **Verification Entity** | Nepal Health Research Council and any other Independent Agency jointly agreed between the Bank and the government. |
| **Procedure** | Year 1 - Verify at the MoH that copies of the reports containing primary audit queries received by audited spending units are available at the MoH and match this with the number of spending units audited by the OAG.<br>Year 1 – Verify at the MoH the availability of an inventory of the responses sent by the audited spending units by date. Verification agency to provide a report containing analysis of time taken between receipt of primary audit report and the response to it by the spending unit to provide baseline indicating the percentage of audited institutions that responded within 35 days.<br>Years 2, 3, 4, and 5 - Verify, each year, from the MoHP inventory data the percentage points up to the targets specified, in |

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| | number of audited institutions responding to primary audit queries within 35 days of receipt of audit report.. |
| **DLI 9** | Percentage of audited spending units responding to the OAG's primary audit queries within 35 days. (DLI 9) |
| **Description** | OAG sends primary audit queries to the audited institutions which have to respond within 35 days. |
| **Data source/ Agency** | MoHP records and the OAG's primary and final reports |
| **Verification Entity** | Nepal Health Research Council and any other Independent Agency jointly agreed between the Bank and the government. |
| **Procedure** | Year 1 - Verify at the MoHP that copies of the reports containing primary audit queries received by audited spending units are available at the MoHP and match this with the number of spending units audited by the OAG.<br>Year 1 – Verify at the MoHP the availability of an inventory of the responses sent by the audited spending units by date. Verification agency to provide a report containing analysis of time taken between receipt of primary audit report and the response to it by the spending unit to provide baseline indicating the percentage of audited institutions that responded within 35 days.<br>Years 2, 3, 4, 5 and 6 - Verify, each year, from the MoHP inventory data the percentage points up to the targets specified, in number of audited institutions responding to primary audit queries within 35 days of receipt of audit report.. |
| **DLI 10** | Health facilities reporting annual disaggregated data using District Health Information System (DHIS 2) in a timely manner. (DLI 10) |
| **Description** | Data disaggregated by geography, gender, and ethnicity reported by facilities using DHIS 2 |
| **Data source/ Agency** | MoHP records and HMIS dashboard/ website |
| **Verification Entity** | Nepal Health Research Council |
| **Procedure** | Year 1 - Verify at the MoH that plan for implementation of the DHIS 2 is available.<br>Year 1 - Verify through a random check in at least 20% of the districts that DHIS 2 is rolled out by checking that the software is installed in all DHOs. |

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| | Year 2 - Verify through online check at the MoH that reports based on DHIS 2 from all DHO's districts are accessible.<br>DLRs 10.3 Verify through MD/MOHP/Provincial records that training on DHIS 2 is completed and visit DHIS2 dashboard to see that "timely reporting" can be tracked.<br>DLRs 10.4 and 10.5- Verify through HMIS records/DHIS 2 software that the said % of public health facilities have timely reported through DHIS 2. This will be verified through DHIS2, one month after the end of the fiscal year, by calculating the preceding 12 months average. |
| **DLI 10** | Health facilities reporting annual disaggregated data using District Health Information System (DHIS 2) in a timely manner. (DLI 10) |
| **Description** | Data disaggregated by geography, gender, and ethnicity reported by facilities using DHIS 2 |
| **Data source/ Agency** | MoHP records and HMIS dashboard/ website |
| **Verification Entity** | Nepal Health Research Council |
| **Procedure** | Year 1 - Verify at the MoHP that plan for implementation of the DHIS 2 is available.<br>Year 1 - Verify through a random check in at least 20% of the districts that DHIS 2 is rolled out by checking that the software is installed in all DHOs.<br>Year 2 - Verify through online check at the MoHP that reports based on DHIS 2 from all DHO's districts are accessible.<br>DLRs 10.3 Verify through MD/MOHP/Provincial records that training on DHIS 2 is completed and visit DHIS2 dashboard to see that "timely reporting" can be tracked.<br>DLRs 10.4, 10.5 and 10.6- Verify through HMIS records/DHIS 2 software that the said % of public health facilities have timely reported through DHIS 2. This will be verified through DHIS2, one month after the end of the fiscal year, by calculating the preceding 12 months median. |
| **DLI 11** | MoHP to provide guidance and support to the subnational governments on citizen engagement mechanism (DLI 11) |
| **Description** | Social audit is the most frequently used citizen engagement mechanism in the health sector. |

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| **Data source/ Agency** | MoHP reports |
| **Verification Entity** | Nepal Health Research Council and any other independent agency jointly agreed between the Bank and the government. |
| **Procedure** | Year 1 - Verify at the MoH, the availability of the document describing options for citizen engagement mechanisms and public reporting systems, for feedback on availability of drugs and facility-level services and disaggregated by gender.<br>DLR 11.3- Verify through MOHP/CSD records of participants list, and workshop agenda and dates/venue.<br>DLI 11.4- Verify that the Social Audit Guidelines are updated and adopted. Verify that that the Guidelines are circulated to subnational governments with a MOHP memorandum.<br>DLI11.5- Verify through MoHP records/municipal records that the said support was provided. |
| **DLI 11** | MoHP to provide guidance and support to the subnational governments on citizen engagement mechanism (DLI 11) |
| **Description** | Social audit is the most frequently used citizen engagement mechanism in the health sector. |
| **Data source/ Agency** | MoHP reports |
| **Verification Entity** | Nepal Health Research Council and any other independent agency jointly agreed between the Bank and the government. |
| **Procedure** | Year 1 - Verify at the MoHP, the availability of the document describing options for citizen engagement mechanisms and public reporting systems, for feedback on availability of drugs and facility-level services and disaggregated by gender.<br>DLR 11.3- Verify through MOHP/CSD records of participants list, and workshop agenda and dates/venue.<br>DLR 11.4- Verify that the Social Audit Guidelines are updated.<br>DLR 11.5 and 11.6- Verify through MoHP records/municipal records the Social Audit Guidelines were adopted. Verify that that the Guidelines are circulated to subnational governments with a MOHP memorandum and that the orientation and said support was provided. |

## ANNEX 1: NEPAL: COVID-19 RESPONSE PROGRAM - SHIFTS IN WBG COUNTRY PARTNERSHIPFRAMEWORK

**Nepal is facing a major public health and economic crisis as a result of COVID-19.** Nepal has recently been hit by a devastating second wave of COVID-19, with an exponential rise in positive cases, with May 2, 2021, registering a high of 7,388 new cases. Thirty-two districts have more than 200 active cases and seventeen districts more than 500 active cases. While the national cumulative positivity rate has slowly increased to 13.6 percent from 8 percent on January 7, 2021, with the ongoing second wave, the positivity rate as of May 3, 2021 has breached 40 percent in five of the seven provinces. Over 80 percent of the infected are in the 25-59 age group, with 63.8 percent of the affected being males. Case fatality ratios are highest in the age group 80-85+. COVID-19 ICU beds and ventilators are rapidly being occupied. In addition to the imminent shortage of ICU beds and ventilators, the nation is facing acute shortage of oxygen supplies—a critical therapy for patients with compromised lungs. The escalation in cases has prompted a series of localized lockdowns since April 19, 2021. The protracted pandemic has had significant consequences in terms of lost income; learning losses due to protracted closure of schools; increased morbidity and mortality from both COVID and non-COVID related illnesses as the population struggled to access timely and quality health care services. The psychological burden of the these impacts along with distanced social engagement has exacerbated stress levels universally.

**The recent COVID-19 pandemic is expected to derail the strong growth trajectory established over the past three years**. GDP growth averaged 7.8 percent between FY2017 and FY2019. It is estimated to have contracted by 1.9 percent in FY2020, the first economic contraction in 40 years, as prolonged nationwide mobility restrictions from March to July 2020 – imposed to curtail the spread of the virus – significantly impacted all sectors of the economy. The service sector took a hard hit, contracting by 3.6 percent due to national and localized lockdowns. Tourism activities ground to a halt and lockdowns hit transport and wholesale and retail trade hard. Estimates from the World Bank COVID-19 monitoring survey show that more than two in every five economically active workers reported a job loss or a prolonged work absence in 2020 due to the pandemic. On the fiscal side, tax revenue decreased by 5 percent in FY2020 due to widespread trade restrictions, supply chain disruptions and weaker demand. In response, the Government of Nepal contained discretionary spending to keep the fiscal deficit in check. The fiscal adjustment, together with difficulties in executing budgets due to the lockdown measures, led to lower budget execution: only 71.4 percent of the overall and 47 percent of the capital budget were spent in FY2020. Consequently, the fiscal deficit increased moderately from 5 percent of GDP in FY2019 to 5.2 percent of GDP in FY2020. Total public debt is estimated to have increased to 36 percent of GDP in FY2020, from 27.2 percent of GDP in FY2019.[11]

**The Government of Nepal has responded to the crisis through fiscal and monetary measures.** Fiscal measures fall into three broad categories. *First*, there are immediate health measures aimed at increasing access to testing for COVID-19 infections, establishment of quarantine facilities, and availability of medical items such as masks, sanitizer, and surgical gloves. *Second,* to reduce the crisis' impact on livelihoods, the government has ensured continued delivery of its core safety net programs, implemented food distribution programs, extended eligibility for the Prime Minister's Employment Program, and provided discounts on utility bills. *Third,* to provide economic support to firms, the government has deferred the payment of taxes and provided concessional loan facilities to severely affected sectors. The cumulative

[11] The large difference between debt and the deficit arises because the federal government devolves 30 percent of VAT revenue to sub-nationals which increases borrowing requirements.

cost of these programs is estimated at 5 percent of GDP. Measures taken by the Nepal Rastra Bank – the central bank – included a relaxation of regulatory requirements for banks and financial institutions and a reduction of targeted interest rates as part of the country's interest rate corridor and were aimed at providing liquidity support to banks and facilitating the provision of credit to the private sector.

**The economic framework to chart Nepal's emergence from the crisis is structured by the Government in three stages**: **relief, restructuring, and a resilient recovery.** During the ***relief stage***, the priority is on addressing the immediate health impacts of the pandemic and providing support to livelihoods and firms to reduce vulnerability. During the ***restructuring stage***, the focus is on strengthening health systems and adjusting to a new normal that prioritizes domestic employment generation in a greener and more digital economy. The ***resilient recovery stage*** focuses on new opportunities to invest and reforms to promote more sustainable, inclusive, and resilient growth in a post-COVID world. There is also understanding that economic recovery for a small, landlocked country like Nepal also requires cooperative engagement with the immediate neighborhood, recognizing the importance of connectivity and trade for growth and development.

**The WBG Country Partnership Framework (CPF)**[12] **continues to be relevant, albeit with some shifts** aiming at striking a balance between pivoting to address the short and medium-term needs from the COVID19 crisis and the focus on the long-term economic development path. World Bank, IFC and MIGA will continue to collaborate closely in implementing these shifts which also align with the four thematic pillars of the World Bank Group Approach Paper[13]. The World Bank Group will continue to work closely with the Government to ensure that the allocation of IDA 19 resources is in conformity with the COVID-19 related priorities and the four pillars of the World Bank Group Approach Paper, as detailed below.

***Pillar 1: Support to health for saving lives threatened by the virus.*** The Bank responded immediately to the crisis caused by COVID-19, via **US$29 million** IDA credit for the Nepal COVID-19 Emergency Response and Health System Preparedness Project approved in April 2020, to strengthen national systems for public health preparedness in the country. In addition, the US$75 million Additional Financing for the Nepal COVID-19 Emergency Response and Health System Preparedness Project which was approved in March 2021 will support the procurement of COVID-19 vaccines and related activities. The medium-term response will be framed through the envisaged continued support in the sector-wide program in the health sector.

***Pillar 2: S*ocial response for protecting poor and vulnerable people from the impact of the economic and social crisis triggered by the pandemic.** As a measure for immediate response to the COVID-19 crisis, **US$10.85 million** Global Partnership for Education (GPE) COVID 19 Accelerated Funds to respond to COVID-19 impact on the school sector, was approved in August 2020. Further, in FY21, with a view toward supporting the response to the COVID-19 pandemic, the following World Bank-financed projects have been approved: Rural Economic Development Project (US$80 million) and Urban Governance and

[12] Report No. 83148-NP; July 10, 2018 discussed at the Board on August 7, 2018

[13] The thematic pillars of the World Bank Group Approach Paper are: (i) support to health for saving lives threatened by the virus, (ii) social response for protecting poor and vulnerable people from the impact of the economic and social crisis triggered by the pandemic, (iii) economic response for saving livelihoods, preserving jobs, and ensuring more sustainable business growth and job creation by helping firms and financial institutions survive the initial crisis shock, restructure and recapitalize to build resilience in recovery (rebuilding better), and (iv) support for strengthening policies, institutions and investments for resilient and sustainable recovery.

Development Project (US$150 million). In FY22, Provincial and Local Roads Project, Finance for Growth Development Policy Financing 2, and Water Sector Governance and Infrastructure Support Project are potential areas of support. Additional Financing for School Sector Development Program and Nepal Health Sector Program of US$50 million each are also being provided to bridge the financing gap for FY2021/22 budget. The proposed Sustainable Tourism Project will be redefined to focus on reinvigorating the sector (the most impacted sector in Nepal) with a focus on grant and job-creation schemes. Across existing investments, including Youth Employment Transformation Initiative (YETI), Emergency Housing Reconstruction Project (EHRP), Strategic Road Connectivity and Trade Improvement Project (SRCTIP), and the recently approved Nepal Urban Governance and Development Project (NUGIP), World Bank investments are expected to create over 19 million person days of employment. This includes COVID responses to increase creation of temporary employment opportunities for the most vulnerable, including those COVID affected particularly under YETI and NUGIP. YETI supports the government's key employment program. The proposed US$80 million Unlocking Human Capital for a Prosperous Nepal aims to promote greater access to a set of inter-related and mutually complementary human capital services, particularly for over 100,000 poor and vulnerable households in selected disadvantaged areas, and the Nurturing Excellence in Higher Education Project (US$60 million) aims to modernize higher education sector through digitization, a key aspect of the response to the issues caused by the COVID-19 pandemic. The medium-term response will be framed through the envisaged continued support in the sector-wide program in the education sector.

***Pillar 3: E*conomic response for saving livelihoods, preserving jobs, and ensuring more sustainable business growth and job creation by helping firms and financial institutions survive the initial crisis shock, restructure, and recapitalize to build resilience in recovery (rebuilding better).** As a measure for immediate response, the Bank also initiated ***repurposing and restructuring of the ongoing World Bank portfolio*** through reallocations, cancellations, and creating CERC in six projects, and thereby making about US$300 million available for COVID-19 relief and recovery efforts. Initiatives were also undertaken to expedite release of about US$140 million in advances or accelerating achievement of results across the Program-for-Results (PforRs) operations. These represent approximately 18 percent of total committed amounts. The Government of Nepal and Development Partners14 have recently started a joint green recovery initiative to help Nepal get back on track to achieve Middle Income Status and the Sustainable Development Goals by 2030. The initiative follows the shared principles for green recovery support that will: (i) support the Government's plans and sector strategies, (ii) ensure the green recovery is inclusive, promotes stakeholder engagement and the active role of women and civil society in Nepal's development, and (iii) support the constitutional mandates of Nepal's local, provincial and federal governments.
IFC has been providing various types of support (advisory and investment) and will continue to explore more ways to help leverage the private sector's contribution to the COVID-19 pandemic recovery. IFC has notably been focusing on helping struggling firms to access critically needed capital to weather the impact of the pandemic.

In June 2020, IFC committed $25 million loan to NMB Bank to boost Small and Medium Enterprise (SME) and green financing. In May 2021, IFC committed $10 million to Dolma Impact Fund II (DIF II) to further deepen the private equity (PE) market in Nepal. IFC's equity in DIF II also includes $5 million from the IDA's Private Sector Window (IDA PSW). IFC's participation in this PE fund will send a strong signal to the

[14] Development partners associating themselves with this statement Include: ADB, EU, Finland, France, Germany, INGOs, JICA, KOICA, Norway SDC, UK, UN, USAID, and the World Bank.

market, especially given the ongoing new wave of COVID-19 cases in Nepal. DIF II will provide financing to SMEs in health care, renewable energy, technology, and other sectors in Nepal. First close of $40 million is supported by IFC, CDC, FMO and Swedfund. IFC is presently working toward a possible a possible $40 million loan this fiscal year to Global IME Bank to also support SMEs. On the advisory side, key engagements notably included knowledge sessions for banks have focused on crisis management and stress testing. IFC also assisted Nepal Rastra Bank in developing and approving the Quick Response (QR) Code Specifications and Standardization and Interoperability Framework, an important milestone for the promotion of digital banking. In Tourism, IFC has been helping to re-establish trust in the market by introducing appropriate enterprise standards and protocols that meet international expectations. More recently IFC helped the Nepal Tourism Board develop Standard Operating Procedures (SoP) for health/hygiene standards for mountain tourism enterprises; and co-organized an investment forum focused on Tourism Recovery and Sustained Growth with the aim of capitalizing on Nepal's competitive advantages in the post-COVID Era.

***Pillar 4: S*upport for strengthening policies, institutions, and investments for resilient and sustainable recovery.** The FY21 program includes a Finance for Growth DPC (US$200 million) series which responds to the challenges brought about by the COVID-19 pandemic through addressing financial stability, disaster risk finance, capital and insurance market reforms, and constraints to SME financing. This DPC reiterates WBG's focus on private sector-focused market solutions and similar approach would be expected in the upcoming operations including the Programmatic Fiscal Policy for Growth Recovery and Resilience DPC Series. The new Programmatic Fiscal Policy for Growth Recovery and Resilience DPC Series (US$100 million) will build on the previous series, with a focus on aspects of the COVID-19 response related to fiscal resilience and economic recovery aimed at sustainable and inclusive growth, as well as social protection to support the poor and vulnerable. These DPC initiatives draw on IFC advice as to key enabling environment reforms that can foster the increased private sector initiatives and investments required for a resilient recovery. Policy reform actions would be centered around the Government's 3R (Recovery, Restructuring, and Resilience) Plan. The FY22 pipeline may include the next series of Finance for Growth DPC and/or Fiscal Policy for Growth, Recovery, and Resilience DPC.

**The financing gap is expected to be bridged through the Crisis Response Window (CRW) and Scale Up Window (SUW).** Estimated resources available under IDA-19 concessional financing include US$956 million[15]. Total demand for FY21 is about US$845 million. To meet the financing gap, Nepal recently received additional allocation of US$210 million. For the proposed FY22 delivery, additional IDA resources including CRW and SUW will be explored.

[15] US$ amount may change due to exchange rate fluctuation against SDR. IDA 19 allocation is SDR 661.8 million.

## ANNEX 2: INTEGRATED RISK ASSESSMENT

### SYSTEMATIC OPERATIONS RISK-RATING TOOL (SORT)

| Risk Category | Latest ISR Rating | Current Rating |
|---|---|---|
| Political and Governance | High | High |
| Macroeconomic | Substantial | Substantial |
| Sector Strategies and Policies | Low | Moderate |
| Technical Design of Project or Program | Low | Moderate |
| Institutional Capacity for Implementation and Sustainability | Moderate | Moderate |
| Fiduciary | Moderate | Moderate |
| Environment and Social | Low | Low |
| Stakeholders | Moderate | Moderate |
| Other | Moderate | Moderate |
| Overall | Substantial | Substantial |

## ANNEX 3a: DLI MATRIX FOR AMENDMENT TO ORIGINAL FINANCING AGREEMENT

| DLIs | Baseline | Year 1 (July 16, 2016 to July 15, 2017) | Year 2 (July 16, 2017 to July 15, 2018) | Year 3 (July 16, 2018 to July 15, 2019) | Year 4 (July 16, 2019 to July 15, 2020) | Year 5 (July 16, 2020 to July 15, 2021) |
|---|---|---|---|---|---|---|
| **DLI 1:** Percentage of contracts managed by the MD through the PPMO's online procurement portal | No contract is through online e-procurement developed by the PPMO | **DLR 1.1**<br>Training on the use of the PPMO's online e-procurement completed for at least 20 MoHP staff | **DLR 1.3**<br>At least 60% of value of total contracts managed by MD done through online e-procurement of Year 2 | **DLR 1.2**<br>Training on procurement/e-procurement and standard bidding documents to all Provinces **(SDR 1,438,000)**<br><br>**DLR 1.4**<br>70% of value of total contracts managed by MD done through online e-procurement of Year 3 **(SDR 2,876,000)**<br><br>(***Disbursement rule for DLR 1.4***: **SDR 2,157,000** for minimum of 60% of total contracts managed by the MD done through e-procurement; **SDR 71,900** for every percentage point over 60% up | **DLR 1.5**<br>80% of value of total contracts managed by MD done through online e-procurement of Year 4<br><br>(***Disbursement rule***: **SDR 1,438,000** for minimum of 70% of total contracts managed by the MD done through e-procurement; **SDR 71,900** for every percentage point over 70% up to a maximum of 80% in Year 4) | **DLR 1.6**<br>90% of value of total contracts managed by MD done through online e-procurement of Year 5<br><br>(***Disbursement rule***: **SDR 1,438,000** for minimum of 80% of total contracts managed by the MD done through e-procurement; **SDR 71,900** for every percentage point over 80% up to a maximum of 90% in Year 5) |

| DLIs | Baseline | Year 1 (July 16, 2016 to July 15, 2017) | Year 2 (July 16, 2017 to July 15, 2018) | Year 3 (July 16, 2018 to July 15, 2019) | Year 4 (July 16, 2019 to July 15, 2020) | Year 5 (July 16, 2020 to July 15, 2021) |
|---|---|---|---|---|---|---|
| | | | | to a maximum of 70% in Year 3) | | |
| **DLI value** | | **SDR 717,333** | **SDR 2,152,000** | **SDR 4,314,000** | **SDR 2,157,000** | **SDR 2,157,000** |
| **DLI 2:** Establishment and functioning of web-based grievance redressal mechanism. | Web-based Grievance Redressal Mechanism not established | **DLR 2.1** Guidelines for Grievance Redressal Mechanism endorsed by MoHP | **DLR 2.2** Web-based Grievance Redressal Mechanism established and functioning; and training completed for various levels of staff responsible for grievance handling.<br><br>(***Disbursement rule:*** **SDR 1,076,000** for the establishment of the GRM; **SDR 1,076,000** for completion of training) | **DLR 2.3** MoHP has made available on its website an annual report on the status of grievances received in Year 3 | **DLR 2.4** MoHP has made available on its website an annual report on the status of grievances received in Year 4 | **DLR 2.5** MoHP has made available on its website an annual report on the status of grievances received in Year 5 |
| **DLI Value** | | **SDR 1,434,667** | **SDR 2,152,000** | **SDR 1,438,000** | **SDR 1,438,000** | **SDR 1,438,000** |
| **DLI 3:** Percentage of procurements done by Management Division (MD) using standard specifications. | Procurement not based on standard specifications | **DLR 3.1** MoHP endorses standard specifications for basic package of free drugs to be procured by MD | **DLR 3.2** For Year 2 procurement, 70% of procurement of basic package of free drugs based on the use of standard | **DLR 3.3** MoHP endorses standard specifications for essential equipment to be procured by MD[17] **(SDR 719,287)** | **DLR 3.5a** For Year 4 procurement, 90% of health commodities procured by MD, is based on the use of standard | **DLR 3.6a** For Year 5 procurement, 90% of health commodities procured by MD, is based on the use of standard specifications **(SDR 1,044,576)**<br><br>(***Disbursement rule DLR 3.6a***: **SDR** |

[17] Essential equipment list will be provided to the Bank by the MoHP

| DLIs | Baseline | Year 1 (July 16, 2016 to July 15, 2017) | Year 2 (July 16, 2017 to July 15, 2018) | Year 3 (July 16, 2018 to July 15, 2019) | Year 4 (July 16, 2019 to July 15, 2020) | Year 5 (July 16, 2020 to July 15, 2021) |
|---|---|---|---|---|---|---|
| | | | specifications[16] | **DLR 3.4**<br>For Year 3 procurement, 80% procurement of health commodities, as specified in the list of health commodities with standard specifications and procured by MD, is based on the use of standard specifications **(SDR 1,078,930)**<br><br>(***Disbursement rule for DLR 3.4***: **SDR 107,893** for every percentage point increase over 70% for achievement of up to the target of 80% for the procurement of health commodities in Year 3) | specifications<br><br>**(*Disbursement rule DLR3.5a:* SDR 35,950** for every percentage point increase over 70% for achievement of the target of 90% for the procurement of health commodities in Year 4) **(SDR 719,000)**<br><br>**DLIR 3.5b**<br>For Year 4 procurement, 70% of equipment procured by MD is based on the use of standard specifications **(SDR 719,000)**<br><br>(***Disbursement rule DLR 3.5b***: **SDR 35,950** for every percentage point increase over 50% | **52,228.80** for every percentage point increase over 70% for achievement of up to the target of 90% for the procurement of health commodities in Year 5)<br><br>**DLR 3.6b**<br>For Year 5 procurement, 70% of equipment procured by MD is based on the use of standard specifications **(SDR 1,044,846)**<br><br>***(Disbursement rule DLR 3.6b:* SDR 52,242.30** for every percentage point increase over 50% for achievement of up to the target of 70% for the procurement of equipment in Year 5) |

[16] 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 satisfactory to the Association. The revised technical specification will have to be disclosed publicly prior to issuing the tender notice.

| DLIs | Baseline | Year 1 (July 16, 2016 to July 15, 2017) | Year 2 (July 16, 2017 to July 15, 2018) | Year 3 (July 16, 2018 to July 15, 2019) | Year 4 (July 16, 2019 to July 15, 2020) | Year 5 (July 16, 2020 to July 15, 2021) |
|---|---|---|---|---|---|---|
| | | | | | for achievement of up to the target of 70% for the procurement of equipment in Year 4) | |
| **DLI value** | | **SDR 2,869,333** | **SDR 1,434,667** | **SDR 1,798,217** | **SDR 1,438,000** | **SDR 2,089,422** |
| **DLI 4:** Central medical stores and medical stores of Provinces report through eLMIS. | eLMIS not in place | | **DLR 4.1** eLMIS installed in all warehouses of the center and district stores of two regions | **DLR 4.2 a** Training on, and installation and operation of eLMIS completed for all central and provincial (including sub-provincial) medical stores of at least two Provinces **(SDR 1,438,000)**<br><br>**DLR 4.2b** Baseline data generated for minimum stocks of tracer health commodities in two Provinces **(SDR 719,000)** | **DLR 4.3** eLMIS information for program Year 4 is available from central and provincial (including sub-provincial) stores of Provinces.<br><br>***(Disbursement rule***: **SDR 1,797,250** for eLMIS available from central and sub-provincial stores of at least two Provinces; **SDR 431,340** provided for each additional Province) | **DLR 4.4** eLMIS information for program Year 5 is available from central and provincial (including sub-provincial) stores of Provinces.<br><br>(***Disbursement rule***: **SDR 3,133,730** for eLMIS available from central and sub-provincial stores of at least two Provinces; **SDR 557,106** provided for each additional Province). |
| **DLI value** | | | **SDR 2,152,000** | **SDR 2,157,000** | **SDR 3,953,950** | **SDR 5,919,260** |
| **DLI 5:** Percentage reduction of less than minimum | Baseline to be established in Year 3 | | | | **DLR 5.1** 15% reduction in the understock of tracer health | **DLR 5.2** 25% reduction in understock of tracer health commodities in Year 5 over the baseline established for |

| DLIs | Baseline | Year 1 (July 16, 2016 to July 15, 2017) | Year 2 (July 16, 2017 to July 15, 2018) | Year 3 (July 16, 2018 to July 15, 2019) | Year 4 (July 16, 2019 to July 15, 2020) | Year 5 (July 16, 2020 to July 15, 2021) |
|---|---|---|---|---|---|---|
| stocks (understock) of tracer health commodities in sub-provincial medical stores | | | | | commodities in Year 4 over the baseline established for the sub-provincial (district) medical stores through the eLMIS for two Provinces<br><br>***(Disbursement rule:*** **SDR 194,103** per percentage reduction over baseline up to a maximum of 15% reduction) | the sub-provincial (district) stores through the eLMIS for two Provinces.<br><br>***(Disbursement rule:*** **SDR 172,536** per percentage reduction over baseline up to a maximum of **SDR 4,313,400** for maximum of 25% reduction) |
| **DLI value** | | | | | **SDR 2,911,545** | **SDR 4,313,400** |
| **DLI 6:** Percentage improvement in EVM Score over 2014 baseline. | Average EVM Score of 64%, with two attributes achieving 80% | | **DLR 6.1**<br>Average EVM Score of 70% (based on 2016 survey), with any 3 attributes in EVM score achieving 80%<br><br>***(Disbursement rule:*** **SDR 717,333** for achievement of EVM Score of 70%; **SDR 717,333** for achieving 80% in any 3 attributes) | | | **DLR 6.2 a**<br>Average EVM Score of 70% (based on a survey conducted in 2019 or later)<br><br>***Disbursement rule DLR 6.2a***: **SDR 335,391** for a minimum average EVM score of 64%, **SDR 84,958** for every percentage point increase of average EVM Score over 64% for achievement up to a maximum of 70%)<br><br>**DLR 6.2b**<br>Any four (4) attributes in EVM |

| DLIs | Baseline | Year 1 (July 16, 2016 to July 15, 2017) | Year 2 (July 16, 2017 to July 15, 2018) | Year 3 (July 16, 2018 to July 15, 2019) | Year 4 (July 16, 2019 to July 15, 2020) | Year 5 (July 16, 2020 to July 15, 2021) |
|---|---|---|---|---|---|---|
| | | | | | | Score achieving 80%.<br><br>***(Disbursement rule DLR 6.2b*: SDR 34,819** per attribute achieving at least 80% up to four (4) attributes) |
| **DLI value** | | | **SDR 1,434,666** | | | **SDR 984,415** |
| **DLI 7:** Percentage of the MoHP spending entities submitting annual plan and budget using eAWPB. | Not all spending units submit their annual plan and budget using eAWPB | **DLR 7.1**<br>MoHP and all its departments, divisions, and centers are given access to operate on eAWPB | **DLR 7.2**<br>eAWPB used for planning and budget submission by MoHP and all departments, divisions, and centers | **DLR 7.3 a**<br>eAWPB used in Year 3 for planning and budget submission by MoHP and all its departments, divisions and centers **(SDR 1,078,350)**<br><br>**DLR 7.3b**<br>eAWPB used in Year 3 for 25% of remaining spending units (excluding units included under DLR 7.3a) under the MoHP<br><br>***(Disbursement rule 7.3b:* SDR 71,890** for use by each additional percentage of | **DLR 7.4a**<br>eAWPB used in Year 4 for planning and budget submission by MoHP and all its departments, divisions and center **(SDR 1,078,350)**<br><br>**DLR 7.4b**<br>eAWPB used in Year 4 for 50% of remaining spending units (excluding units included under DLR 7.4a) under MoHP<br><br>***(Disbursement rule DLR 7.4b:* SDR 35,945** for use by each additional percentage of remaining spending | **DLR 7.5a**<br>eAWPB[18] used in Year 5 for planning and budget submission by MoHP and all its departments, divisions and centers **(SDR 1,079,425)**<br><br>**DLR 7.5b**<br>eAWPB used in Year 5 for and 75% of remaining spending units (excluding units included under DLR 7.5a) under MoHP<br><br>***(Disbursement rule DLR 7.5b:* SDR 24,373** for use by each additional percentage of remaining spending units under MoHP up to a maximum of 75%) |

[18] eAWPB, which is activity-based programming software at MoHP or the Govt's LMBIS used for annual workplan and budgeting.

| DLIs | Baseline | Year 1 (July 16, 2016 to July 15, 2017) | Year 2 (July 16, 2017 to July 15, 2018) | Year 3 (July 16, 2018 to July 15, 2019) | Year 4 (July 16, 2019 to July 15, 2020) | Year 5 (July 16, 2020 to July 15, 2021) |
|---|---|---|---|---|---|---|
| | | | | remaining spending units under MoHP up to a maximum of 25%) | units under MoHP up to a maximum of 50%) | |
| **DLI value** | | **SDR 1,434,667** | **SDR 717,334** | **SDR 2,875,600** | **SDR 2,875,600** | **SDR 2,907,400** |
| **DLI 8:** Percentage of the MoHP's annual spending captured by the TABUCS. | **70%** | **DLR 8.1**<br>MoHP has issued a circular mandating expenditure reporting through TABUCS by all spending units | **DLR 8.2**<br>80% of MoHP's spending in Year 2 captured by TABUCS | **DLR 8.3**<br>85% of MoHP spending in Year 3 captured by TABUCS<br><br>***(Disbursement rule:*** **SDR 2,131,171** for 70% of MoHP spending in Year 3 captured by TABUCS, **SDR 50,000** for every percentage point increase of MoHP spending captured by TABUCs over 70% for achievement up to a maximum of 85%) | **DLR 8.4**<br>90% of MoHP spending in Year 4 captured by TABUCS<br><br>***(Disbursement rule:*** **SDR 1,911,545** for 70% of MoHP spending in Year 4 captured by TABUCS, **SDR 50,000** for every percentage point increase of MoHP spending captured by TABUCs over 70% for achievement up to a maximum of 90%) | **DLR 8.5**<br>95% of MoHP spending in Year 5 captured by TABUCS<br><br>**(*Disbursement rule:* SDR 1,880,250** for 70% of MoHP spending in Year 5 captured by TABUCS<br>**SDR 62,674** for every percentage point increase of the MoHP spending captured by TABUCS over 70% for achievement up to a maximum of 95%) |
| **DLI value** | | **SDR 2,869,333** | **SDR 2,869,333** | **SDR 2,881,171** | **SDR 2,911,545** | **SDR 3,447,100** |
| **DLI 9:** Percentage of audited spending units responding to the OAG's primary audit queries | Percentage as derived from MoHP inventory of responses in Year 1 | **DLR 9.1**<br>All reports containing primary audit queries received by audited spending units are | **DLR 9.2**<br>10 percentage points increase in audited institutions responding to primary audit | **DLR 9.3**<br>60% of spending units reporting to the MoHP respond to primary audit queries within | **DLR 9.4**<br>65% of spending units reporting to the MoHP respond to primary audit queries within | **DLR 9.5**<br>70% of spending units reporting to the MoHP respond to primary audit queries within mandated 35 days |

| DLIs | Baseline | Year 1 (July 16, 2016 to July 15, 2017) | Year 2 (July 16, 2017 to July 15, 2018) | Year 3 (July 16, 2018 to July 15, 2019) | Year 4 (July 16, 2019 to July 15, 2020) | Year 5 (July 16, 2020 to July 15, 2021) |
|---|---|---|---|---|---|---|
| within 35 days. | | available at MoHP; and inventory of responses by date provided by individual audited spending units are available at MoHP<br><br>Maximum (**SDR 2,152,000**) based on the following rule: (**SDR 1,434,667**) for all reports containing primary audit queries received by audited spending units are available at the MoHP; and (**SDR 717,333**) for inventory of responses by date provided by individual audited spending units available at the MoHP | queries within mandated 35 days over percentage derived from the MoHP inventory of responses of Year 1 | mandated 35 days<br><br>***(Disbursement rule:*** **SDR 35,950** per percentage point of MoHP audited spending units responding to primary audit queries within mandated 35 days up to a maximum of 60%) | mandated 35 days<br><br>***(Disbursement rule:*** **SDR 35,945** per percentage point of MoHP audited spending units responding to primary audit queries within mandated 35 days up to a maximum of 65%) | (***Disbursement rule:*** **SDR 41,783** per percentage point of MoHP audited spending units responding to primary audit queries within mandated 35 days up to a maximum of 70%) |
| **DLI value** | | **SDR 2,152,000** | **SDR 2,152,000** | **SDR 2,157,000** | **SDR 2,336,425** | **SDR 2,924,810** |
| **DLI 10:** Health facilities reporting annual disaggregated data using District | | **DLR 10.1**<br>Plan for roll out of DHIS 2 finalized and DHIS 2 rolled out up to DHO level | **DLR 10.2**<br>Reports based on DHIS 2 available from all DHOs | **DLR 10.3a**<br>HMIS/DHIS 2 training provided to all Provinces. **(SDR 1,437,800)** | **DLR 10.4**<br>HMIS/DHIS 2 shows timely reporting from at least 40% of public health | **DLR 10.5**<br>HMIS/DHIS 2 shows timely reporting from at least 50% of public health facilities in Year 5 |

| DLIs | Baseline | Year 1 (July 16, 2016 to July 15, 2017) | Year 2 (July 16, 2017 to July 15, 2018) | Year 3 (July 16, 2018 to July 15, 2019) | Year 4 (July 16, 2019 to July 15, 2020) | Year 5 (July 16, 2020 to July 15, 2021) |
|---|---|---|---|---|---|---|
| Health Information System (DHIS 2) in a timely manner. | | ***(Disbursement rule:*** Maximum (**SDR 2,152,000**) based on the following rule: (**SDR 717,333** for plan for rollout of DHIS 2 finalized; and **SDR 1,434,667** for DHIS 2 rolled out up to the DHO level) | | **DLR 10.3b** HMIS/DHIS 2 dashboard includes indicator measuring timely reporting from health facilities **(SDR 1,437,800)** | facilities in Year 4 (***Disbursement rule:*** **SDR 89,862.50** for each percentage point of public health facilities reporting timely to the HMIS/DHIS 2 up to a maximum of 40%) | (***Disbursement rule:*** **SDR 71,890** for each percentage point of public health facilities reporting timely to the HMIS/DHIS 2 up to a maximum of 50%) |
| **DLI value** | | **SDR 2,152,000** | **SDR 2,157,000** | **SDR 2,875,600** | **SDR 3,594,500** | **SDR 3,594,500** |
| **DLI 11:** MoHP to provide guidance and support to the subnational governments on citizen engagement mechanism | No formal guidelines for citizen feedback mechanisms in place for subnational governments | **DLR 11.1** Citizen engagement mechanism options and public reporting systems developed by MoHP for citizens' feedback, including on availability of drugs and facility level services and disaggregated by gender | | **DLR 11.3:** MoHP provided orientation training to all Provinces on social audit mechanism | **DLR 11.4:** MoHP updated social audit guidelines to guide the Provinces and/or Local Governments. (***Disbursement rule*:** **SDR 359,450** for updated social audit guidelines) | **DLR 11.5:** MOHP provided orientation to all Provinces and/or Local Governments on the new Social Accountability Framework **(SDR 348,190)** (***Disbursement rule:*** **SDR 49,741.43** for providing orientation per Province) |
| **DLI value** | | **SDR 1,434,667** | | **SDR 718,900** | **SDR 359,450** | **SDR 348,190** |

## ANNEX 3b: DLI MATRIX FOR FINANCING AGREEMENT FOR THE ADDITIONAL FINANCING

| DLIs | Year 6 (July 2021 until closing) |
|---|---|
| **DLI 1:** Percentage of contracts managed by the MD through the PPMO's online procurement portal | **DLR 1.7**<br>95% of value of total contracts managed by MD done through online e-procurement[19] of Year 6<br><br>(***Disbursement rule***: **SDR 1,404,500** for minimum of 80% of total contracts managed by the MD done through e-procurement; **SDR 69,700** for every percentage point over 80% up to a maximum of 95% in Year 6) |
| **DLI value** | **SDR 2,450,000** |
| **DLI 2:** Establishment and functioning of web-based grievance redressal mechanism. | **DLR 2.6**<br>MoHP has made available on its website an annual report on the status of grievances received in Year 6 |
| **DLI Value** | **SDR 1,400,000** |
| **DLI 3:** Percentage of procurements done by Management Division (MD) using standard specifications. | **DLR 3.7a**<br>For Year 6 procurement, 95% of health commodities procured by MD, is based on the use of standard specifications<br>**(SDR 1,050,000)**<br><br>(***Disbursement rule DLR 3.7a***: **SDR 52,500** for every percentage point increase over 75% for achievement of up to the target of 95% for the procurement of health commodities in Year 6)<br><br>**DLR 3.7b**<br>For Year 6 procurement, 80% of equipment procured by MD is based on the use of standard specifications<br>**(SDR 1,050,000)**<br><br>(***Disbursement rule DLR 3.7b****:* **SDR 52,500** for every percentage point increase over 60% for achievement of up to the target of 80% for the procurement of equipment in Year 6) |
| **DLI value** | **SDR 2,100,000** |
| **DLI 4:** Central medical stores and medical stores of Provinces report through eLMIS. | **DLR 4.5**<br>eLMIS information for program Year 6 is available from central and provincial (including sub-provincial) stores of Provinces. |

[19] e-procurement is the government procurement system established by the PPMO. For verification of DLI results, the program will track contracts up to the point of e-bidding in alignment with the existing eGP system

| DLIs | Year 6 (July 2021 until closing) |
|---|---|
| | (***Disbursement rule***: **SDR 3,140,000** for eLMIS available from central and sub-provincial stores of at least two Provinces; **SDR 552,000** provided for each additional Province). |
| **DLI value** | **SDR 5,900,000** |
| **DLI 5:** Percentage reduction of less than minimum stocks (understock) of tracer health commodities in sub-provincial medical stores | **DLR 5.3**<br>35% reduction in understock of tracer health commodities in Year 6 over the baseline established for the sub-provincial (district) stores through the eLMIS for two Provinces.<br><br>(***Disbursement rule:*** **SDR 167,142.86** per percentage reduction over baseline up to a maximum of **SDR 5,850,000** for maximum of 35% reduction) |
| **DLI value** | **SDR 5,850,000** |
| **DLI 6:** Percentage improvement in EVM Score over 2014 baseline. | |
| **DLI value** | |
| **DLI 7:** Percentage of the MoHP spending entities submitting annual plan and budget using eAWPB. | **DLR 7.6a**<br>eAWPB[20] used in Year 6 for planning and budget submission by MoHP and all its departments, divisions and centers **(SDR 1,079,910)**<br><br>**DLR 7.6b**<br>eAWPB used in Year 6 for and 95% of remaining spending units (excluding units included under DLR 7.6a) under MoHP<br><br>***(Disbursement rule DLR 7.6b:*** **SDR 24,422** for use by each additional percentage of remaining spending units under MoHP up to a maximum of 95%) |
| **DLI value** | **SDR 3,400,000** |
| **DLI 8:** Percentage of the MoHP's annual spending captured by the TABUCS. | **DLR 8.6**<br>95% of MoHP spending in Year 6 captured by TABUCS/CGAS<br><br>**(*Disbursement rule:*** **SDR 1,880,000** for 70% of MoHP spending in Year 6 captured by TABUCS/CGAS<br>**SDR 62,800** for every percentage point increase of the MoHP spending captured by TABUCS/CGAS over 70% for achievement up to a maximum of 95%) |
| **DLI value** | **SDR 3,450,000** |
| **DLI 9:** Percentage of audited spending units responding | **DLR 9.6**<br>80% of spending units reporting to the MoHP respond to primary audit queries within mandated 35 days |

[20] eAWPB, which is activity-based programming software at MoHP or the Govt's LMBIS used for annual workplan and budgeting.

| DLIs | Year 6 (July 2021 until closing) |
|---|---|
| to the OAG's primary audit queries within 35 days. | (***Disbursement rule:*** **SDR 41,875** per percentage point of MoHP audited spending units responding to primary audit queries within mandated 35 days up to a maximum of 80%) |
| **DLI value** | **SDR 3,350,000** |
| **DLI 10:** Health facilities reporting annual disaggregated data using District Health Information System (DHIS 2) in a timely manner. | **DLR 10.6**<br>HMIS/DHIS 2 shows timely reporting from at least 70% of public health facilities in Year 6<br><br>**(*Disbursement rule:*** **SDR 70,000** for each percentage point of public health facilities reporting timely to the HMIS/DHIS 2 up to a maximum of 70%) |
| **DLI value** | **SDR 4,900,000** |
| **DLI 11:** MoHP to provide guidance and support to the subnational governments on citizen engagement mechanism | **DLR 11.6:**<br>MoHP provided on-site support to at least three (3) Local Governments each in at least four Provinces in conducting social audits<br><br>(***Disbursement rule:*** **SDR 525,700** for providing on-site support to at least three (3) Local Governments of one Province up to maximum four province |
| **DLI value** | **SDR 2,100,000** |
| **TOTAL** | **SDR 34,900,000** |

## ANNEX 4: CHANGES IN YEAR 4-5 DLRs AND INTRODUCED DLRs FOR YEAR 6

| DLI Results | Changes/Additions | | Remarks |
|---|---|---|---|
| DLI 1 | Year 5: DLR 1.6: 90% of value of total contracts managed by MD done through online e-procurement of Year 5 | Year 5 Target: No Change<br>Disbursement rule: No change | No change |
| | Year 6: DLR 1.7: 95% of value of total contracts managed by MD done through online e-procurement of Year 6 | | Incremental target<br>Disbursement rule is same as previous year |
| DLI 2 | Year 5: DLR 2.5 MoHP has made available on its website an annual report on the status of grievances received in Year 5 | Year 5 Target: No Change<br>Disbursement rule: No Change | No Change |
| | Year 6: DLR 2.6: MoHP has made available on its website an annual report on the status of grievances received in Year 6 | | Disbursement rule same as previous year |
| DLI 3 | Year 5: DLR 3.6a: For Year 5 procurement, 90% of health commodities procured by MD, is based on the use of standard specifications<br><br>DLR 3.6b: For Year 5 procurement, 70% of equipment procured by MD is based on the use of standard specifications | Year 5 Target: No Change<br>Disbursement rule: Changed for **DLR 3.6a** and **DLR 3.6b** from SDR 35,950 per unit to SDR 52,228.80 per unit | Year 5: Disbursement rule changed to incentivize more and offset the fiscal pressure on health sector due to COVID-19 |
| | Year 6: DLR 3.7a: For Year 6 procurement, 95% of health commodities procured by MD, is based on the use of standard specifications DLR 3.7 b: For Year 6 procurement, 80% of equipment procured by MD is based on the use of standard specifications | | Year 6: incremental target<br>Disbursement rule same as previous year |
| DLI 4 | Year 5: DLR 4.4: eLMIS information for program Year 5 is available from central and provincial (including sub-provincial) stores of Provinces. | Year 5 Target: No Change<br>Disbursement rule: Changed for **DLR 4.4** from SDR 431,432 to SDR 557,106 per unit | Year 5: Disbursement rule changed to incentivize more and offset the fiscal pressure on health sector due to COVID-19 |
| | Year 6: DLR 4.5: eLMIS information for program Year 6 is available from central and provincial (including sub-provincial) stores of Provinces. | | Year 6: sustain achievement of Year 5 |
| DLI 5 | Year 5: DLR 5.2: 25% reduction in the understock of tracer health commodities in Year 4 over the baseline established for | Year 5 Target: No Change<br><br>Disbursement rule: No Change | No change |

| | | | |
|---|---|---|---|
| | the sub-provincial (district) medical stores through the eLMIS for two Provinces | | |
| | Year 6: DLR 5.3: 35% reduction in understock of tracer health commodities in Year 6 over the baseline established for the sub-provincial (district) stores through the eLMIS for two Provinces | | Year 6: Incremental target |
| DLI 6 | Year 4: DLR 6.2a: Average EVM Score of 70% (based on a survey conducted in 2019 or later)<br><br>DLR 6.2b: Any four (4) attributes in EVM Score achieving at least 80% | Year 4: DLRs moved to Year 5<br><br>Disbursement rule: Changed for **DLR 6.2a** from SDR 215,716.67 per unit to SDR 84,958 per unit.<br><br>Changed for **DLR 6.2b** from SDR 35,950 per unit to SDR 34,819 per unit. | EVM survey is on hold due to COVID-19 and MOHP expects it to be completed by early January 2022<br><br>The disbursement rule adjusted to account for the remaining funds available in Year 5 |
| | Year 5: DLR 6.2a Average EVM Score of 70% (based on a survey conducted in 2019 or later) DLR 6.2b Any four (4) attributes in EVM Score achieving at least 80% | | |
| DLI 7 | Year 5: DLR 7.5a: eAWPB used in Year 5 for planning and budget submission by MoHP and all its departments, divisions and centers<br><br>DLR 7.5b: eAWPB used in Year 5 for and 75% of remaining spending units (excluding units included under DLR 7.5a) under MoHP | Year 5 Target: No Change<br>Changed for **DLR 7.5b** from SDR 25,161.51 per unit to SDR 24,373 per unit. | The disbursement rule adjusted to account for the remaining funds available in Year 5 |
| | Year 6: DLR 7.6a: eAWPB used in Year 6 for planning and budget submission by MoHP and all its departments, divisions and centers<br><br>DLR 7.6b: eAWPB used in Year 6 for and 95% of remaining spending units (excluding units included under DLR 7.6a) under MoHP | | Year 6: incremental target |
| DLI 8 | Year 5: DLR 8.5: 95% of MoHP spending in Year 5 captured by TABUCS | Year 5 Target: No Change<br>Disbursement rule: Changed for **DLR 8.5** | Year 5: Disbursement rule changed to incentivize more and offset the fiscal pressure |

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| | | from SDR 50,000 to SDR 62,674 per unit | on health sector due to COVID-19 |
| | Year 6: DLR 8.6: 95% of MoHP spending in Year 6 captured by TABUCS/CGAS | | Year 6: target maintained as in previous year, CGAS added to align with the Government's new mandatory accounting system |
| DLI 9 | Year 5: DLR 9.5: 70% of spending units reporting to the MoHP respond to primary audit queries within mandated 35 days | Year 5 Target: No Change Disbursement rule Changed for **DLR 9.5** from SDR 35,945 to SDR 41,783 per unit | Year 5: Disbursement rule changed to incentivize more and offset the fiscal pressure on health sector due to COVID-19 |
| | Year 6: DLR 9.6: 80% of spending units reporting to the MoHP respond to primary audit queries within mandated 35 days | | Year 6: Incremental target |
| DLI 10 | Year 5- DLR 10.5 HMIS/DHIS 2 shows timely reporting from at least 50% of public health facilities in Year 5 | Year 5 Target: No Change Disbursement rule: No change | No Change |
| | Year 6: DLR 10.6: HMIS/DHIS 2 shows timely reporting from at least 70% of public health facilities in Year 6 | | Year 6: Incremental target |
| DLI 11 | Year 4: DLR 11.4: MoHP updated social audit guidelines to guide the Provinces and/or Local Governments and disseminated to the Local Governments. | Year 4 target for **DLR 11.4** revised to MOHP to update social audit guidelines to guide the provinces and/or local governments | COVID- 19 had impacted the achievement of original results due to shifting of priorities.<br><br>Before providing on-site support (original target), it was essential to orient all the provinces on new framework (new target), so the revised results for Year 5 reflects this. |
| | Year 5: DLR 11.5: MoHP provided on-site support to at least three (3) Local Governments each in at least two Provinces in conducting social audits | Year 5 target: revised **DLR 11.5**: MOHP provided orientation to all Provinces and/or Local Governments on the new Social Accountability Framework | |
| | Year 6: DLR 11.6: MoHP provided on-site support to at least three (3) Local Governments each in at least four Provinces in conducting social audits | | Year 6: Incremental target |

## ANNEX 5: MODIFIED PROGRAM ACTION PLAN

| Action Description | Source | DLI# | Responsibility | Timing | | Completion Measurement | Action |
|---|---|---|---|---|---|---|---|
| Establish (by January 2017) and maintain a Health Sector Partner Forum at the MoHP (with annual consultations). | Technical | | Client | Recurrent | Yearly | This Action is recurrent and will measured through the period of the Program. | No Change |
| Public Health Service Regulation addresses the health care waste management and infection prevention. | Environmental and Social Systems | | Client | Due Date | 15-Jul-2020 | (a) Regulations of the Public Health Service Act approved by Parliament incorporates health care waste management and infection control; and (b) Healthcare Waste management Guidelines Updated. | No Change |
| Expand GESI strategy (to include issues of disability, geriatrics and rehabilitation of gender-based violence victims). | Environmental and Social Systems | | Client | Other | July 15, 2019 to submit to Cabinet | Revised GESI strategy to include expanded scope approved; and (b) GESI mainstreamed in the planning, budgeting implementation and monitoring. | No Change |
| Procurement planning and budgeting capacity of the MoHP increased | Fiduciary Systems | | Client | Recurrent | Semi-Annually | Electronic Logistics Management and Information System data used for improved Consolidated Annual Procurement Plan. | No Change |
| Finalize CAPP by August every year. | Fiduciary Systems | | Client | Recurrent | Yearly | CAPP approval date each year and until the last year of the Program. | No Change |
| MoHP evaluates the implications | Fiduciary Systems | | Client | Due Date | 31-Dec-2020 | Position paper on post-shipment | No Change |

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| and the options for establishing a post-shipment quality assurance system | | | | | | quality assurance system developed and discussed, with agreement on next steps. | |
| Improve accountability and reporting mechanisms of grants provided by the MoHP to different entities (e.g. grants provided to autonomous bodies captured by TABUCS). | Fiduciary Systems | | Client | Recurrent | Continuous | The inclusion of autonomous bodies (academic and hospitals) reporting to the Federal Ministry of Health and Population will be measured as part of DLI 8. | No Change |
| Strengthen MoHP internal control environment: (a) analyze compliance gaps between actual practice & MoH internal control framework; (b) identify key measures to strengthen internal control within MoH for budget execution control & financial reporting | Fiduciary Systems | | Client | Recurrent | Continuous | (a) Analysis Completed; (b) Recommendations Identified, Presented to the relevant PFM committee; and (c) Inform the Financial Management Strengthening Plan. | No Change |
| The MoHP reports credible and material complaints regarding fraud and corruption related to the Program to the World Bank (annually by September 1) | Fiduciary Systems | | Client | Recurrent | Yearly | This Action is recurrent and will be measured for each year of the Program. | No Change |
| Learning resource package for environmental health care waste management and WASH modules | Environmental and Social Systems | | Client | Recurrent | Yearly | TOTs completed in all seven provinces with support of Provincial Training Center | New |

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| deployed nationally and sub-nationally through Training of Trainers approach | | | | | | | |
| TOT completed in all provinces on Social Accountability guidelines with support of Provincial Training Centers for conduct of timely and quality Social Audits | Environmental and Social Systems | DLI 11 | MOHP | Recurrent | Yearly | TOTs completed for all seven provinces for Provincial Training Centers in SA guidelines | New |
| Consultations with key stakeholders for development of Nepal Health Sector Strategy 2022-2027 | Technical | | MOHP | Recurrent | Yearly | Consultations with (i) all 7 provinces; (ii) at least one local government per province; (iii) External Development Partners towards development of NHSS (2022-2027) | New |

## ANNEX 6: PERFORMANCE OF DISBURSEMENT LINKED INDICATORS

| Year 1 DLI results | Value of DLR in US$ | Status of DLR as of end of Year 1 |
|---|---|---|
| **DLR 1.1:** Training on the use of the PPMO's online e-procurement completed for at least 20 MoHP staff | 1,000,000 | Achieved. Training on the use of PPMO's online e-procurement completed for at least 20 MoHP staff. |
| **DLR 2.1:** Guidelines for Grievance Redressal Mechanism endorsed by MoHP | 2,000,000 | Achieved. Guidelines for Grievance Redressal mechanism endorsed by MOHP. |
| **DLR 3.1:** MoHP endorses standard specifications for basic package of free drugs to be procured by MD | 4,000,000 | Achieved. MOHP endorses standard specifications for basic package of drugs to be procured by MD. |
| **DLR 7.1:** MoHP and all its departments, divisions, and centers are given access to operate on eAWPB | 2,000,000 | Achieved. MoHP and all its departments, divisions, and centers given access to operate on eAWPB |
| **DLR 8.1:** MoHP has issued a circular mandating expenditure reporting through TABUCS by all spending units | 4,000,000 | Achieved. |
| **DLR 9.1:** All reports containing primary audit queries received by audited spending units are available at MoHP; and inventory of responses by date provided by individual audited spending units are available at MoHP | 3,000,000 | Achieved. |
| **DLR 10.1:** Plan for roll out of DHIS 2 finalized and DHIS 2 rolled out up to DHO level | 3,000,000 | Achieved. DHIS 2 rolled out up to DHO level. |
| **DLR 11.1:** Citizen engagement mechanism options and public reporting systems developed by MoHP for citizens' feedback, including on availability of drugs and facility level services and disaggregated by gender | 2,000,000 | Achieved. |
| **Year 2 DLI results** | **Value of DLR in US$** | **Status of DLR as of end of Year 2** |
| **DLR 1.2:** Training on procurement/e-procurement and standard bidding documents to all Provinces | 2,000,000 | Achieved. |
| **DLR 2.2:** Web-based Grievance Redressal Mechanism established and functioning; and training completed for various levels of staff responsible for grievance handling. | 3,000,000 | Achieved. Web-based Grievance Redressal Mechanism established and functioning; and trainingcompleted for various levels of staff responsible for grievance handling. |

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| **DLR 3.2:** For Year 2 procurement, 70% of procurement of basic package of free drugs based on the use of standard specifications | 2,000,000 | Achieved. For Year 2 procurement, 100% of procurement of basic package of free drugs based on the use of standard specifications. |
| **DLR 4.1:** eLMIS installed in all warehouses of the center and district stores of two regions | 3,000,000 | Achieved. LMIS installation process in two provinces completed. |
| **DLR 6.1:** Average EVM Score of 70% (based on 2016 survey), with any 3 attributes in EVM score achieving 80% | 2,000,000 | Achieved. Average EVM score of 82% with 4 attributes in EVM score achieving 80%. |
| **DLR 7.2:** eAWPB used for planning and budget submission by MoHP and all departments, divisions, and centers | 1,000,000 | Achieved. 100% of MoHP and all departments, divisions, and centers used eAWPB used for planning and budget submission. |
| **DLR 8.2:** 80% of MoHP's spending in Year 2 captured by TABUCS | 4,000,000 | Achieved. 84% of MoHP's spending in Year 2 captured by TABUCS |
| **DLR 9.2:** 10 percentage points increase in audited institutions responding to primary audit queries within mandated 35 days over percentage derived from the MoHP inventory of responses of Year 1 | 3,000,000 | Achieved. 86.7% institutions responding to primary audit queries within mandated 35 days. |
| **DLR 10.2:** Reports based on DHIS 2 available from all DHOs | 3,000,000 | Achieved. |
| **Year 3 DLI results** | **Value of DLR in US$** | **Status of DLR as of end of Year 3** |
| **DLR 1.3:** At least 60% of value of total contracts managed by MD done through online e-procurement of Year 2 | 3,000,000 | Achieved. 81.55% of value of total contracts managed by MD done through online e- procurement of Year 2 |
| **DLR 1.4:** 70% of value of total contracts managed by MD done through online e-procurement of Year 3 | 4,000,000 | 97.8% of value of total contracts managed by MD done through online e-procurement of Year 4 |
| **DLR 2.3:** MoHP has made available on its website an annual report on the status of grievances received in Year 3 | 2,000,000 | Achieved. |
| **DLR 3.3:** MoHP endorses standard specifications for essential equipment to be procured by MD | 1,000,000 | Achieved. |
| **DLR 3.4:** For Year 3 procurement, 80% procurement of health commodities, as specified in the list of health commodities with standard specifications and procured by MD, is based on the use of standard specifications | 1,500,000 | Achieved. 100% procurement of health commodities, as specified in the list of health commodities with standard specifications and procured by MD, is based on the use of standard specifications. |

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| **DLR 4.2a:** Training on, and installation and operation of eLMIS completed for all central and provincial (including sub-provincial) medical stores of at least two Provinces | 2,000,000 | Achieved. |
| **DLR 4.2b:** Baseline data generated for minimum stocks of tracer health commodities in two Provinces | 1,000,000 | Achieved. |
| **DLR 7.3a:** eAWPB used in Year 3 for planning and budget submission by MoHP and all its departments, divisions and centers | 1,500,000 | Achieved. |
| **DLR 7.3b:** eAWPB used in Year 3 for 25% of remaining spending units (excluding units included under DLR 7.3a) under the MoHP | 2,500,000 | Achieved. 100% of remaining spending units (excluding units included under DLR 7.3a) under the MoHP. |
| **DLR 8.3:** 85% of MoHP spending in Year 3 captured by TABUCS | 4,007,750 | Achieved. 90.7% of MoHP spending in Year 3 captured by TABUCS. |
| **DLR 9.3:** 60% of spending units reporting to the MoHP respond to primary audit queries within mandated 35 days | 3,000,000 | Achieved. 60.99% of spending units reporting to the MoHP respond to primary audit queries within mandated 35 days. |
| **DLR 10.3a:** HMIS/DHIS 2 training provided to all Provinces. | 2,000,000 | Achieved. |
| **DLR 10.3b:** HMIS/DHIS 2 dashboard includes indicator measuring timely reporting from health facilities | 2,000,000 | Achieved. |
| **DLR 11.3:** MoHP provided orientation training to all Provinces on social audit mechanism | 1,000,000 | Achieved. |
| **Year 4 DLI results** | **Value of DLR in US$** | **Status as DLR as of end of Year 4** |
| **DLR 1.5:** 80% of value of total contracts managed by MD done through online e-procurement of Year 4 | 3,000,000 | 99.48% of value of total contracts managed by MD done through online e-procurement of Year 4 |
| **DLR 2.4:** MoHP has made available on its website an annual report on the status of grievances received in Year 4 | 2,000,000 | Achieved. |
| **DLR 3.5a:** For Year 4 procurement, 90% of health commodities procured by MD, is based on the use of standard specifications | 1,000,000 | Achieved. 100% of health commodities procured by MD, is based on the use of standard specifications. |
| **DLIR 3.5b:** For Year 4 procurement, 70% of equipment procured by MD is based on the use of standard specifications | 1,000,000 | Achieved. 100% of equipment procured by MD, is based on the use of standard specifications. |

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| **DLR 4.3:** eLMIS information for program Year 4 is available from central and provincial (including sub-provincial) stores of Provinces. | 5,500,000 | Achieved. |
| **DLR 5.1:** 15% reduction in the understock of tracer health commodities in Year 4 over the baseline established for the sub-provincial (district) medical stores through the eLMIS for two Provinces | 4,050,000 | Achieved. 43.67% and 41.65% reduction in the understock of the tracer health commodities from the baseline to Year 4 in the Provinces 5 and Karnali Province respectively |
| **DLR 7.4a:** eAWPB used in Year 4 for planning and budget submission by MoHP and all its departments, divisions and center | 1,500,000 | Achieved. |
| **DLR 7.4b:** eAWPB used in Year 4 for 50% of remaining spending units (excluding units included under DLR 7.4a) under MoHP | 2,500,000 | Achieved. |
| **DLR 8.4:** 90% of MoHP spending in Year 4 captured by TABUCS | 4,050,000 | Achieved. 91.2% of MoHP spending in Year 4 captured by TABUCS |
| **DLR 9.4:** 65% of spending units reporting to the MoHP respond to primary audit queries within mandated 35 days | 3,250,000 | Achieved.97.4% of spending units reporting to the MoHP respond to primary audit queries within mandated 35 days |
| **DLR 10.4:** HMIS/DHIS 2 shows timely reporting from at least 40% of public health facilities in Year 4 | 5,000,000 | Achieved. HMIS/DHIS 2 shows timely reporting from at least 66.03% of public health facilities in Year 4 |
| **DLR 11.4:** MoHP updated social audit guidelines to guide the Provinces and/or Local Governments and disseminated to the Local Governments | 1,000,000 | Achieved, however dissemination/orientation ongoing |

## ANNEX 7: PERFORMANCE OF PROGRAM ACTION PLAN

| S. No. | Action | Timing | Status |
|---|---|---|---|
| 1. | Establish (by January 2017) and maintain a Health Sector Partner Forum at the MoHP (with annual consultations). | Recurrent | In progress.<br><br>HSPF established in January 2017 and regular consultations are held each year. Last year due to competing priorities brought by federalism, the consultation forum could not be held. MoHP will hold the meeting by December 31, 2019. |
| 2. | Public Health Service Regulation addresses the health care waste management and infection prevention. | July 15, 2020 | Completed<br><br>(a) Regulations of the Public Health Service Act approved by Parliament incorporates health care waste management and infection control; and (b) Healthcare Waste management Guidelines Updated.<br><br>Health care waste management issues are now mentioned in the draft Regulations of the Public Health Service Act (PHSA) 2018. The Regulations were approved on September 21, 2020. |
| 3. | Expand GESI strategy (to include issues of disability, geriatrics and rehabilitation of gender-based violence victims). | July 15, 2019 | Completed<br><br>Revised GESI strategy to include expanded scope approved; and (b) GESI mainstreamed in the planning, budgeting implementation and monitoring.<br><br>The GESI Strategy has been finalized and the Nepali version is awaiting endorsement by the cabinet. |
| 4. | Procurement planning and budgeting capacity of the MoHP increased | Recurrent | In Progress |
| 5. | Finalize CAPP by August every year. | Recurrent | In Progress |
| 6. | MoHP evaluates the implications and the options for establishing a post-shipment quality assurance system | Dec 31, 2020 | In Progress<br><br>The specific consequences of a post-shipment quality assurance system need to be addressed, including the capacity, regulatory, procurement, financial and other parameters. |
| 7. | Improve accountability and reporting mechanisms of | Recurrent | In Progress |

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| | grants provided by the MoHP to different entities (e.g. grants provided to autonomous bodies captured by TABUCS). | | |
| 8. | Strengthen MoHP internal control environment: (a) analyze compliance gaps between actual practice & MoHP internal control framework; (b) identify key measures to strengthen internal control within MoHP for budget execution control & financial reporting | Recurrent | In Progress |
| 9. | The MoHP reports credible and material complaints regarding fraud and corruption related to the Program to the World Bank (annually by September 1) | Recurrent | In Progress with TA support from UK Aid |

## ANNEX 8: RATIONALE IN SUPPORT CLIMATE CO-BENEFIT ACCRUAL

**1. Climate Change: Nepal is ranked as one of the highly vulnerable country to climate change impacts due to a combination of political, geographic, and social factors. The country is ranked 128th out of 181 countries in the 2019 ND-GAIN Index[21].** According to Global Climate Risk Index (CRI), Nepal ranks 12 on 2019 and 10th on the long-term CRI; meaning it is the 10th most affected country with exceptionally devastating climate-change induced events during the past two decades: 191 events between 2000 and 2019. With the gradual increase in temperature[22] and occurrence of erratic rainfall pattern and increase in precipitation extremes[23], the country is experiencing several weather and climate extreme events. Mountains are warming faster than the Plains[24] triggering melting of ice and permafrost and increase in the risk of glacier lake outburst floods and landslides in the country. Changing climate has exacerbated more frequent and intense disaster events (drought, floods, landslides, disease outbreaks, heatwaves) leading to a cascading effect on the overall economic growth and development of the country. Recent studies suggest Nepal faces losing 2.2 percent of annual GDP due to climate change by 2050[25]. There is evidence that drought frequency in Nepal has increased between 1981-2012. As of 2010, the population annually affected by river flooding in Nepal is estimated at 157,000 people. Increased frequency of droughts and floods, severely constraint agricultural productivity and outputs. Food insecurity and consumption of poor quality of food results in undernutrition that is a leading cause of morbidity/mortality in the most vulnerable populations, resulting in poor human capital accumulation.

**2. Future climate is expected to be warmer and wetter in Nepal[26] which is predicted to affect the health and well-being of the people**. Temperature is projected to increase by 0.92-1.07 $^0$C in the medium-term (2016-2045 AD) and 1.3-1.8 $^0$C in the long-term period (2036-2065 AD). Similarly, annual precipitation is likely to increase by 2-6 percent in the medium-term period and by 8-12 percent in the long-term period. Extreme indices related to temperature and precipitation suggests that more extreme events are likely to occur in the future. Intense precipitation events are predicted to increase in frequency, with extremely wet days expected to increase at a higher rate which could induce more water-related hazards in the future. Consecutive Dry Days (CDD) are likely to increase thus inducing drought phenomenon in the country. The projected increase in the temperature indicates a higher risk of outbreak of vector-borne diseases (such as Malaria, Kalaazar and Japanese encephalitis and Dengue), water-borne diseases (such as diarrhea and hepatitis), and other health risks in Nepal. Water scarcity during dry and hot summers may lead to poor hygienic practices and an increase in the risk of disease prevalence. Water-borne diseases could also increase in the future due to a lack of access to clean sources of water during disasters such as floods or droughts. A projected increase in hot extremes, hot days, and warm spells in the already hot tropical lowlands could cause heat stress (waves) and forests fire leading to an increase in morbidity and mortality.

[21] The ND-GAIN Index ranks 181 countries using a score which calculates a country's vulnerability to climate change and other global challenges as well as their readiness to improve resilience. The more vulnerable a country is the lower their score, while the more ready a country is to improve its resilience the higher it will be

[22] Annually mean maximum temperature has been increasing by 0.056°C. Observed Climate Trend Analysis in the Districts and Physiographic Zones of Nepal (1971-2014). Government of Nepal, MoPE, DoHM, June 2017

[23] Rising Precipitation Extremes across Nepal. Retrieved from *http://www.dhm.gov.np/uploads/climatic/52837744climate-05-00004.pdf*

[24] Nepal's National Adaptation Plan (NAP) Process: Reflecting on lessons learned and the way forward. Ministry of Forests and Environment (MoFE) of the Government of Nepal, the NAL Global Network, Action on Climate Today (ACT) and Practical Action Nepal.

[25] URL: https://www.adb.org/sites/default/files/publication/42811/assessing-costs-climate-change-and-adaptation-southasia.pdf

[26] Climate Change Scenarios for Nepal for National Adaptation Plan (NAP), Ministry of Forests and Environment, Kathmandu

Additionally, the climate change will increase the risk of under nutrition resulting from diminished food production and impact on the health and well-being of the people as well as of the health workers.

**3. Nepal's already poor health care infrastructure makes the country more vulnerable to current and future climate change requiring appropriate interventions that foster institutional strengthening of the health care system.** Weakness in effective response mechanisms and strategies for dealing with healthcare needs related to natural hazards has historically exacerbated this vulnerability. Limited capacity within the health care system and institution on climate change coupled with data gap for assessment of climate vulnerability and risks in the sector due to lack of systematic data generation and repository mechanism has increased the vulnerability of the sector. Additionally, weaknesses in water quality monitoring system, limited coordination among stakeholders linked to limitation in the existing health financing system, strategic planning and institutional capacity and evidence-based decision making along with the procurement system has the overall reduced health care system and institutions response to climate change and its impacts in the sector. Recognizing the vulnerability of the health sector to climate change, the National Climate Change Policy (2019) identifies health, drinking water, and sanitation as one of the priority sectors requiring integrated approach for climate change adaptation.[27] To reduce the health sector's contribution to GHG emissions, Nepal's second NDC also sets the target that by 2030 the burning of healthcare waste in 1,400 healthcare facilities will be prohibited by proper management of healthcare waste through the application of non-burn technologies.[28]

**4. The Additional Financing for the Nepal Health Sector Management Reform Program-for-Results (NHSMRP4R) is screened for climate and disaster risks.** The NHSMRP4R aims to address supply- and demand-side constraints in the efficient institutional performance through a strengthened fiduciary system (both public procurement and financial management) and evidence-based decision making for greater accountability and transparency. The components of the P4R strongly support in enhancing institutional strength of the health care system which is imperative while also responding to climate change impacts in the sector and achieving the aim of the National Climate Change Policy (NCCP) in relation to health, drinking water and sanitation sector. The strategies put forward by the NCCP are linked with strengthening institution through improved sector management and governance, strategic planning and institutional capacity, and improved financing management i.e., the development of a mechanism to prepare, forecast and prevent and avoid the epidemic of vector-borne and communicable diseases induced by climate change, proper management of harmful and hazardous water and the use of biodegradable waste for energy production, and increase access to and easy availability of drinking water through water harvesting and storage along with water source protection. Along with this, DLI's of the P4R supports in achieving the target sets out in the country's Nationally Determined Contributions (NDCs)[29].Therefore, efficiency of the public resource management function and system buttressed by the P4R, contributes to reducing

[27] Government of Nepal (2020). Second Nationally Determined Contribution.
[28] Ibid.
[29] NDC target related to health sector: (1) By 2025, climate-sensitive diseases surveillance systems will be strengthened through the integration of climate and weather information into existing surveillance systems; (2) By 2030, the population with access to the basic water supply will increase from 88 percent to 99 percent; and population with improved water supply will increase from 20 percent to 40 percent; (3) By 2025, climate risk assessment mechanisms will be integrated into WASH program planning and implementation cycle.

vulnerability of the populations and health sector to climate change, while contributing to reducing GHG emissions through improved healthcare waste management.

**5. Towards adaptation co-benefits, the NHSMRP4R incentivizes efficiencies in the public sector management systems for health care in the realm of**

i. **Procurement (DLIs 1, 2, 3, 4, 5 and 6) to decrease vulnerability and improve resilience of Nepal to the health impacts of climate change with increased capacity of the health system to provide opportunities and choices for care thereby increasing**

- Share of value of total contracts to be managed via online procurement by the management division (DLI1). Use the e-procurement system enhances the speed and efficiency in the procurement of drugs and consumables, including those in needed during natural disaster related emergencies such as earthquakes, floods, heatwaves, disease outbreaks such as malaria, dengue, avian influenza, swine flu and even the COVID-19 pandemic, thus enhancing the quality service delivery at health facilities during climate-related disaster and contributes to enhancing climate resilience of health services that benefit climate-vulnerable populations.
- Use of standardized specifications of drugs, health commodities and equipment that not only accrue value for money but corroborate with good manufacturing practices (DLI3),
- Use of e-Logistics Management Information System to ensure rationalized supply of drugs, health commodities and equipment to where they are needed most, cutting out waste and enhancing the capacity of the health system to respond to needs, including those related to climate disasters and climate-sensitive diseases. (DLI4),
- Supporting strong inventory management to eliminate stock out of health commodities to ensure timely, quality and full provision of health care supplies, including supplies for climate change induced diseases and emic preparedness and management (DLI5),
- Functional and effective vaccine management system (EVM) (DLI6). The EVM system monitors sufficiency and quality of vaccines in the country, including in disaster-prone areas; the system enhances the continuity and predictability in the delivery of vaccines in these disaster-prone areas, and contributes in minimizing wastage of vaccine for preventable diseases, including climate-sensitive diseases such as pneumonia, severe diarrhea, influenza, rotavirus, Japanese Encephalitis, Typhoid, Hepatitis and such.
- Improved supply of essential health inputs (drugs, health commodities and equipment), including drugs and supplies for climate-sensitive diseases resulting in better quality of care at public health facilities and enhancing health facilities capacities to respond to short and long term emergencies induced from climate change (DLI5).
- Improved supply of inputs (drugs, health commodities and equipment) resulting in better quality of care at public health facilities improved the health and well-being of Nepali citizens and makes them less climate vulnerable (DLIs 1 to 6)
- Improved and predictable supply of inputs (drugs, health commodities and equipment) in public health facilities reduces fuel consumption in repeated trips to health facilities to secure commodities and appropriate care (DLI 4 and 5)

ii. **Financial management (DLIs 7, 8 and 9) to build institutional and strategic planning capacity for budget preparation, allocation and disbursement considering the multidimensional facets of climate change impacts in the health sector by way of**
   - Efficient and transparent work planning and budgeting for all spending entities, including centers and departments dedicated to managing climate-induced public health emergencies, of the Ministry of Health and Population (DLI7),
   - Transparent reporting, which informs subsequent budgetary releases, and oversight to ensure compliance with financial management principles of efficiency and use of funds for purposes intended, including managing climate-induced public health emergencies (DLI8).

iii. **Health data generation and repository creation is instrumental in assessing the climate vulnerability and risks assessment[30] and implement disease surveillance, risk monitoring and early warning, including pandemic preparedness and management to improve health outcomes by way of**
   - District Health Information System (DHIS). The DHIS is a software designed for collecting, managing, and visualizing health related information, including information related to temperature and precipitation induced diseases, on a regular basis. DLI 10 requires that health facilities report their annual disaggregated health information via DHIS ver.2 software on a timely basis. This will greatly enhance health authorities' capacity to monitor incidence of vector-borne/climate sensitive diseases, including early detection vector borne disease outbreaks and plan evidence-based interventions.

iv. **Adopting climate-smart technology, including digital record keeping/information management system, by health facilities (DLIs 1, 3, 4, 5, 6, 7, 8, 9, 10) enhances climate resilience of the service administration by:**
   - Improving worker productivity and efficiencies,
   - Reducing reliance on paper-based systems that rely on trees for raw material,
   - Reducing air and heat-pollution on account of reduced tree cover and its negative effects on health of population,
   - Eliminating need for storage requirements that interfere with land, water and soil use

v. **Strengthening and sustaining community approaches and voice (DLI 11) with access to timely knowledge of services, entitlements and risks and to hold the public management system accountable for health action by way of**
   - Promoting gender equity and social inclusion (GESI) through GESI sensitive health programs and their deployment,
   - Building capacity of climate-vulnerable community members through awareness raising events and allowing citizens to provide more timely and direct feedback to health workers in times of public health emergencies induced by natural disaster,

[30] It is mandated to have climate change vulnerability and risk assessment every five year as per the Environmental Protection Regulation, 2020.

- Establishing, capacitating and operationalizing social accountability platforms and measures at local government levels to hold the public health sector accountable to its people.

**6. Towards mitigation co-benefits, the reform supporting**

i. Energy efficient and low carbon footprint, electronic information systems for planning and implementing public health programs, and monitoring potential health impacts of climate change (disease surveillance, risk monitoring and early warning, including pandemic preparedness and management) and recording and reporting on service delivery outputs to improve health outcomes (DLIs 1 to 10) by way of

- e-procurement systems
- e-Logistics and Management System
- Effective Vaccine Management Systems
- e-Work Planning and Budgeting
- e-accounting on TABUCS

ii. reduced wastage with robust inventory management by virtue of new action introduced on program action plan related to deployment and training of health care personnel at provincial and local government levels in appropriate health care waste management and WASH practices

- minimizes the adverse impact of additional health care waste by virtue of appropriate collection, disinfection, transportation and disposal or recycling of waste generated in the delivery of health programs through the public health system.