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ACRONYMS

ANC	Antenatal Care
CPD	Continuing Professional Development
CMNN	Communicable, Maternal, Neonatal and Nutritional
DFID	UK Department for International Development
DoHS	Department of Health Services
EDPs	External Development Partners
FAQ	Frequently Asked Questions
FCHVs	Female Community Health Volunteers
GAP	Global Action Plan
GESI	Gender Equality and Social Inclusion
GoN	Government of Nepal
HA	Health Assistant
HCD	Health Coordination Division
HMIS	Health Management Information System
HP	Health Partnership
HS	Health System
HSS	Health System strengthening
JAR	Joint Annual Review
LSTM	Liverpool School of Tropical Medicine
MDGs	Millennium Development Goals
MMR	Maternal Mortality Ratio
MNCH	Maternal Neonatal and Child Health
MoHP	Ministry of Health and Population
NHSSP	Nepal Health Sector Support Programme
NSSD	Nursing and Social Security Division
OCA	Organizational Capacity Assessment
OCMC	One-stop Crisis Management Center
PHC	Primary Health Care
PPMD	Policy, Planning, and Monitoring Division
QI	Quality Improvement
RDQA	Routine Data Quality Assessment
SDGs	Sustainable Development Goals
TFR	Total Fertility Rate
THET	Tropical Health and Education Trust
UHC	Universal Health Coverage
UKPHS	UK Partnerships for Health Systems
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization

INTRODUCTION

A scoping assessment was conducted from 6th – 11th February 2020 to examine Nepal's Health System priorities in preparation for the implementation of the UK Partnerships for Health Systems (UKPHS) programme. The scoping assessment was carried out by a team from LSTM and THET, and included desk based research, interviews with key stakeholders, and engagement with the Ministry of Health of Nepal.

PURPOSE AND OBJECTIVES OF THE SCOPING ASSESSMENT

The overall purpose of the scoping assessments was to introduce the UKPHS programme and to consult with stakeholders to determine national health systems priorities and how Health Partnerships could contribute to addressing these and contribute to national health system strengthening (HSS) (see ToR in Annex 1).

The specific objectives were to:

- Introduce the UKPHS programme to key in-country stakeholders.
- Identify, validate and/or get consensus on national HSS issues, gaps and priorities, while considering gender equity and social inclusion (GESI), across the 6 Health System (HS) building blocks with key stakeholders.
- Explore the feasibility of the Health Partnership (HP) model (using selected criteria) to address the identified HSS priorities.
- Identify interventions that could be implemented through HPs and address these HSS priorities, as well as support the country's progress towards UHC.
- Review the UKPHS programme outcome statement and outcome indicators to ensure these are aligned with the identified priorities.
- Identify and understand the work of key actors supporting HSS in the country to ensure HPs build complementarity and synergies with these programmes and initiatives.
- Agree the way forward and national level mechanisms for ongoing programme oversight and monitoring.

ACTIVITIES UNDERTAKEN

DOCUMENT REVIEW

Prior to the scoping assessment, the team undertook a desk review of available secondary data (list of references in Annex 7) to produce an overview of the country context and the health system and to identify and document key health systems issues, gaps and priorities (findings are presented below). These secondary documents included policies and strategies such as the National Health Policy (2019), the Nepal Health Sector Strategy and Implementation Plan (2016-21), the Human Resources for Health Strategic Plan (2011-15), the Safe Motherhood and Newborn Health (SMNH) Road Map 2020, the Nepal Global Action Plan-2019, survey data from the Nepal Demographic and Health Survey and the Service Tracking Survey, government reports such as the Government of Nepal (GoN) National Review of Sustainable Development Goals and recent health sector reports such as the 2017/18 Department of Health Services Annual Report and the 2018/19 National Joint Annual Review Report, and the 2017 National Review of Sustainable Development Goals, analysis of equity gaps and other relevant GESI analysis and reports, as well as NHSSP/MOHP technical briefs, case studies and quarterly reports. A number of peer-reviewed articles with a focus on inequality and quality health systems were also reviewed.

Desk review findings and identified national priorities were summarised and presented in a PowerPoint presentation to frame and guide discussions on HSS issues, gaps and priorities, and were validated and further prioritised with key stakeholders during key informant interviews, group discussions, and in the stakeholder consultation workshop.

PRE-SCOPING VISIT COMMUNICATION AND DIALOGUE

Prior to the scoping visit, the Nepal team contextualised the generic programme template developed by LSTM to schedule meetings and stakeholder engagement approaches. Slide decks, the interview topic guide (Annex 5), and other materials for the conduct of the scoping assessment were adapted for the Nepal context.

The THET Nepal consultant, who is very familiar with the Nepal context and health systems and has well established relationships with key actors in the health sector, met with high level Ministry of Health and Population (MoHP) officials a number of times before the scoping visits to create awareness and build support for the UKPHS programme. He also shared information on the purpose and objectives of the scoping visit and sought the cooperation and endorsement of these senior MoHP leaders to schedule individual and group meetings with key MoHP Division Chiefs and managers, and other stakeholders.

COURTESY CALLS WITH MOHP LEADERSHIP

The scoping visit began with a courtesy call by the team, accompanied by the DFID Advisor, to the Health Secretary, Mr. Khaga Raj Baral at the MoHP, who was joined by the MoHP Chief of the Policy, Planning and Monitoring Division (PPMD), the focal person for external development partners (EDPs) from the MoHP Health Coordination Division (HCD), and the focal person for human resource for health (HRH). The Secretary welcomed the team and appreciated the detailed information on the UKPHS Programme that the team presented. Supplementary informational materials were also provided including the Programme Overview and a set of Frequently Asked Questions (FAQs) on the UKPHS programme. The overall purpose and expected outcomes of the scoping assessment were also outlined and the team explained that they would like to meet with MoHP officials and other relevant stakeholders to identify and validate national health system (HS) priorities and to explore interventions that could potentially be implemented through Health Partnerships (HPs) to address the identified HS priorities.

The team then invited questions and clarifications and responded to a number of queries raised by the Secretary and the other officials present, which related mainly to the role of the MoHP in the identification of priorities, and in the future monitoring and oversight of the programme; the overall value of the programme and of the individual grants, and funding mechanisms. The team provided information on the proposed national oversight mechanism (NOM) value and described the modalities of the UK-Nepal partnership and funding flows, as well as clarifying that the funding would be off-budget and off-treasury. Officials present were also invited to highlight any priorities they felt could be addressed by the HP model. In response to a query from the Chief of PPMD the team provided examples of previous Health Partnerships in Nepal, their achievements and lessons learned. The Secretary indicated that the team's MoH point of contact throughout the visit would be the EDP focal person.

This meeting was followed by a courtesy visit with the Chief HCD, during which the team shared programme information and elicited his support for the scoping visit. He explained that his current priority was the coordination of the human resources for health (HRH) readjustment process, which involved the (re)deployment of health workers across of all three tiers of government – to federal, provincial and local government or Palika levels.

The staff adjustment process is a challenging one for the MoH, with many health workers, especially from periphery health facilities, contesting their adjusted positions and new work posts. The process was reportedly leading to a high degree of absenteeism and disrupting service delivery, especially at the local levels.[1] The employee adjustment process was a constant topic throughout the week, with mitigating its impact on service delivery continuously cited as a priority and challenge by many stakeholders. The overall transition to federalism and the resultant changes to governance and coordination and the impact on the provision of essential services was also a common theme running through many of the discussions.

Another pressing issue for the MoHP at this time was the management of the Corona virus; many senior officials were occupied with this emergency and the evacuation of Nepali citizens from China.

IN-DEPTH INTERVIEWS AND INDIVIDUAL MEETINGS

After these initial courtesy meetings, the team met a range of officials from the MoHP, Division Directors from the MoHP Department of Health Services (DoHS), representatives from UN agencies – World Health Organization (WHO), United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA), and EDPs, as well as the DFID Advisors (see Annex 3 for the full list of people met). The team consulted key actors supporting HSS in the country to ensure potential HPs would contribute to complementarity and synergies and avoid duplication or overlap with these ongoing programmes and initiatives.

Interviews were conducted with health specialists who could provide more comprehensive insights on the identified priorities and focus area(s) to be supported through the HPs. The ongoing advice and guidance of the DFID health advisors was also sought, particularly to validate the priorities and ensure harmonisation with other DFID funded programmes in Nepal. An interview topic guide steered these discussions and enabled the validation of priorities, and exploration and assessment of the extent to which the HP model was fit for purpose.

Key objectives of these stakeholder consultations were to:

- Share information on the UKPHS and the HP model
- Share findings and priorities identified through the desk review
- Seek stakeholders' inputs and views to validate findings and agree priorities
- Collaboratively assess the potential of the HP model to address the identified priorities
- Get consensus on the interventions that could be implemented through HPs

STAKEHOLDER CONSULTATION MEETING

A half day workshop for MoHP stakeholders was organized in coordination with the MoHP EDP focal person. Participants included officials the team had already met as well as those who were not available during the week, such as representatives from other MoHP departments and Centres, and health professional councils. (See Annex 3 for a full list of participants).

[1] Nepal Health Sector Support Programme III – 2017 to 2020. *Quarterly Report, JULY 2019 – SEPTEMBER* 2019 Kathmandu, Nepal.

The team used a number of PowerPoint presentations (PPTs) to share information and facilitate brainstorming and discussions. These covered the following:

1. The UKPHS programme and HP model; including case studies, achievements, challenges and lessons learned from previous HPs
2. Findings and HS priorities identified through the desk review and stakeholder consultations
3. HPs and their contribution to Health Systems Strengthening

Various approaches and methods had been developed to facilitate participatory brainstorming and feedback sessions, however, due to the limited availability of participants, a plenary discussion was facilitated to seek stakeholders' inputs and views to validate findings and priorities and build consensus on the priorities and focus areas that could best be addressed by HP projects and interventions. The priorities and potential interventions identified are presented and discussed below.

As the stakeholder consultation workshop was held on the penultimate day of the scoping visit and designated officials were present, the MoH deemed a debriefing unnecessary.

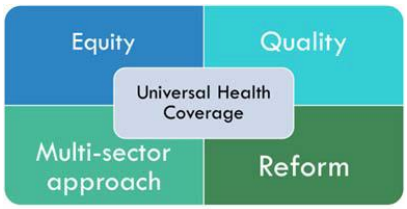
SUMMARY OF FINDINGS

DESK REVIEW FINDINGS

Documents were reviewed and data were extracted against the 6 building blocks of the WHO Health Systems Framework and as well as the Building Block Benchmarks for Gender[2] from the Rings "Guide on adopting a gender lens in health systems policy"[3]

International and national health commitments, strategies and plans

Nepal has embraced international commitments and continues to support interventions towards achieving the Sustainable Development Goals (SDG) and Universal Health Coverage (UHC). Under the leadership of the National Planning Commission, the cost implications of the SDGs and an accompanying financing strategy has been developed in order to meet Nepal's SDG targets.



The constitution of Nepal guarantees basic health services for all citizens as a fundamental right and the policy and programmes of the GoN envision equitable access to quality health services through the federal structure. The focus of the Nepal Health Sector Strategy (NHSS) 2015-20 is on achieving UHC across four strategic areas including:

1. Equitable access
2. Quality health services
3. Health systems reform
4. Multisectoral approach

[2] Research in Gender and Ethics (2019) Adopting a gender lens in health systems policy: A Guide for Policy Makers. https://www.ringsgenderresearch.org/wp-content/uploads/2020/01/Adopting-a-gender-lens-in-health-systems-policy.pdf

[3] https://ringsgenderresearch.org/resources/adopting-a-gender-lens-in-health-systems-policy-a-guide/

Nepal has also expressed its commitment to the global campaign of expanding people's access to quality primary health care (PHC) as per the Astana Declaration in 2018. The declaration commits to the provision of PHC services that will be *"accessible, equitable, safe, of high quality, comprehensive, efficient, acceptable, available and affordable, and will deliver continuous, integrated services that are people-centred and gender-sensitive."*

The GoN supports the Global Action Plan (GAP) for Healthy Lives and Well-being[4] and has developed its own GAP Country Road Map[5] to accelerate the health-related goals and targets of SDG with particular focus on Primary Health Care and Data management. This action plan outlines focus areas, key interventions and activities, implementation timelines, responsible agencies to execute the activities and progress monitoring indicators.

Since 2004, a sector-wide approach has been adopted in the health sector with most EDPs directing their support through the government's budget. The government and its partners hold joint annual reviews (JAR), and jointly monitor outputs and outcomes against investments. The government is increasing health financing to meet the evolving needs and demands of the population.

HEALTH OUTCOMES AND ACHIEVEMENTS

Nepal greatly reduced child mortality during the timeframe of the Millennium Development Goals (MDGs). During this period and beyond into the SDG era, neonatal mortality declined from 38/1000 live births in 2000 to 21 in 2019, and the aim is to reduce this to 10/1000 live births by 2030. The infant mortality rate declined from 64/1000 live births in 2000 to 32 in 2016 in the first year of the SDGs. The under-5 mortality rate reduced from 91/1000 live births in 2000 to 39 in 2019, which Nepal aims to reduce further to close to that of middle-income countries by 2030. Overall, the nutritional status of children (stunting) has improved, with the percentage of children under five years who are stunted (% below -2SD3) declining from 41% in 2011 to 35.8% in 2019.

Nepal has also made good progress in improving maternal and other health outcomes as shown below. The total fertility rate (TFR) of women aged 15-49 declined from 4.1 children in 2000 to 2.3 in 2019. Reducing the TFR has a multiplier effect on the health and wellbeing of women and children.[6]

[4]United Nations (2019) The Global Action Plan for Healthy Lives and Well-being for All. At a Glance https://www.who.int/docs/default-source/documents/global-action-plan-brochure.pdf?sfvrsn=9cd5c537_2 .

[5] Government of Nepal (2019) Global Action Plan for Healthy Lives and Well-being for all: "Uniting to accelerate progress towards the health related Sustainable Development Goals. COUNTRY ACTION PLAN – NEPAL.

[6] National Review of Sustainable Development Goals. Government of Nepal National Planning Commission, 2017.

Indicators	Achievement		
	2019	Source	2020 Target
Maternal mortality ratio (per 100,000 live births)	186	Estimates 2017 (WHO, 2019)	125
Under five mortality rate (per 1,000 live births)	39	NDHS 2016	28
Neonatal mortality rate (per 1,000 live births)	21	NDHS 2016	17.5
Total fertility rate (births per 1,000 women 15–19 yrs)	2.3	NDHS 2016	2.1
% of children under-5 years who are stunted	35.8	NDHS 2016	31
% of women aged 15-49 years with body mass index less than 18.5	17.3	NDHS 2016	12
Lives lost due to road traffic accidents per 100,000 population	9.5	Nepal Police 2075/76	17
Suicide rate per 100,000 population	19	Nepal Police, 2019	14.5
Disability adjusted life years lost to communicable, maternal and neonatal, non-communicable diseases & injuries	9,015,320	Nepal Burden of Disease, 2017	6,738,953
Incidence of impoverishment due to out-of-pocket expenditure in health	NA		Reduce by 20%

Source: 2018/19 NJAR Report

The proportion of pregnant women receiving antenatal care (ANC) increased from 28% in 2000 to 84% in 2016. The proportion of births taking place in health facilities increased from 9% in 2000 to 57% in 2016, while the proportion attended by a skilled attendant increased from 11% in 2001 to 58% in 2016. These improvements led to a decline in the maternal mortality ratio (MMR) from 281/100,000 live birth in 2005 to 186 in 2019. Nepal aims to reduce the MMR to 70 by 2030.[7] The UHC service coverage index for Nepal was estimated to be 52% in 2010 and has increased to 59% in

[7] National Review of Sustainable Development Goals. Government of Nepal National Planning Commission, 2017.

2019. In 2019, 10.7% of people spent more than 10% of their household's total expenditure on health care and access to essential medicines is 72%.[8]

Nepal has made good progress on reducing the disease burden. Polio has almost been eradicated while leprosy is in the elimination stage and 92.6% of one-year old children were immunized against measles in 2015. Considerable efforts have been made to halt and reverse TB, malaria and HIV/AIDS prevalence.

Leading cause of death	1990	2017
NCDs	31%	66%;
Injuries	6%	9%
Communicable, maternal, neonatal and nutritional (CMNN) diseases	63%	25%

The disease burden is shifting with a growing numbers of deaths from non-communicable diseases including cancer, heart attacks, diabetes and kidney disease. In response to the changing disease burden the health sector needs to: strengthen the provision of integrated preventive and promotive services at local level; improve the coordination between local and higher-level health facilities to provide curative services; while prioritising communicable, maternal, neonatal and nutritional (CMNN) interventions to safeguard gains in reducing the burden of CMNN diseases.

The GoN introduced a number of measures (introduced under the new Health Policy 2014 and the NHSS 2015-2020) to reduce inequality in access to health care services in Nepal and address the constitutional right to health care. These include the provision of free basic health care in health posts, primary health care centres and up to 25-bed district hospitals. Under the Amaa programme, all types of delivery and newborn care services are free nationwide and incentives are offered for attending 4 ANC visits and transport incentives are provided to encourage deliveries in a health facility. Poor and marginalized people receive free treatment for acute diseases such as heart disease and kidney failure. Private sector hospitals are expected to allocate 10% of their beds to poor and marginalized people. The government is implementing a retention policy for health workers in rural areas and a health insurance scheme is being piloted for nationwide scale up.[9]

ONGOING HEALTH SYSTEMS ISSUES, CHALLENGES AND PRIORITIES

SERVICE DELIVERY

Despite the steady progress in health outcomes, the country still has some way to go to achieve the 2030 SDG targets. Improvements are needed in the quality, coverage and take-up of services, especially for MNCH services - antenatal, delivery and postnatal care. During 2017/2018,the percentage of pregnant women who attended for 4 ANC visits decreased to 50% from 53% in 2016/2017. Similarly the institutional delivery slightly decreased to 54% in 2017/2018 from 55% in the previous year. The percentage of mothers who received three postnatal care visits as per the protocol also slightly decreased from 19% in 2017/2018 to 16 % in 2016/2017.[10] There is a declining trend in full immunization coverage nationally from 73% in 2016/17 to 68% in 2017/1. Stakeholders identified the need to safeguard the gains

[8] MoHP (2019) Progress of the Health and Population Sector, 2018/19 National Joint Annual Review Progress Report 2019.

[9] National Review of Sustainable Development Goals. Government of Nepal National Planning Commission, 2017.

[10] DoHS Annual Report 2074/75 (2017/2018).

made in MNCH, and maintain focus on improving MNCH health outcomes, ensuring that quality MNCH services are available and accessible to all mothers and babies.

Strengthening mental health services and improving the availability and access to suicide prevention and postvention services was another area highlighted in discussions with stakeholders. Suicide is a growing public health concern in Nepal and is often linked with mental health disorders, conflicts and life crisis situations[11]. Suicide increased almost two-fold in the last decade reaching a total of 5,754 suicide cases in 2018/19, with 16 people committing suicide every day. The suicide mortality rate is 19 per 100,000 population, with 40% of the suicides occurring in the 19-35-year-old age group.

'Systematic and sustained efforts from both government and development partners to embolden multisector planning, budgeting, implementation, monitoring, and evaluation are feasible and necessary.' (Lancet 2018)

Other stakeholders identified the need to improve the availability and accessibility of facility and community-based physiotherapy services, especially at primary health care levels. One stakeholder highlighted the difficulties many women with disabilities experience in accessing physiotherapy services, mainly as a result of financial constraints. In addition to the non-availability of services, in many cases, users are not aware of how and where to access physiotherapy services. Humanitarian Inclusion are currently developing the capacity of Health Assistants (HAs) and equipping them with the relevant knowledge and skills to provide basic physiotherapy care, make referrals and provide follow-up support. An evaluation of this project is yet to be completed, but initial signs are that health workers value these interventions, and the DoHS is interested in scaling them up. Community outreach is also required to make people aware of these services and to promote uptake.

HEALTH EDUCATION AND PROMOTION

Strengthening health education and promotion was perceived as key to improving public health and the uptake of health services at PHC level. Currently, there are over 50,000 Female Community Health Volunteers (FCHVs) in Nepal, who are highly accepted and utilised by the community, and who play a key role in the promotion of safe motherhood, and the uptake of maternal, newborn and child health, and family planning services as well as acting as a bridge between families and communities to periphery-level health facilities. Over the last 18 months, BBC Media Action working in collaboration with the Nursing and Social Security Division of the DoHS, has been piloting a mobile application which provides audio content on 13 health issues with over 800 FCHVs, who have also been trained in communication and behaviour change skills, in 3 provinces. Using a toll-free number FCHVs can access the content and use it for health education talks with mothers' groups and other community members. The programme will be evaluated in 2020, but already the DoHS is interested in expanding the topics covered e.g. to include family planning and/or ANC, and scaling it up nationwide, but currently lack the funding to do so. Discussions with BBC Media Action and DFID suggest that this intervention would be a good fit with the HP model, and would benefit from UK research expertise.

BUILDING QUALITY HEALTH SYSTEMS

Nepal was one of the nine national Commissions that participated in The Lancet Global Health Commission on high-quality health systems in the Sustainable Development Goal (SDGs) era, which highlighted the issue of systemic quality

[11] MoHP (2019) Progress of the Health and Population Sector, 2018/19 National Joint Annual Review Progress Report 2019.

deficits in health systems within the global health discourse. The HQSS Commission calls upon countries to make three interconnected commitments to reach the SDG goal of 'health for all by 2025'[12] as follows:

1. invest in health systems that enhance health
2. provide services valued by people;
3. remain accountable for delivering high-quality care.

A recent Lancet comment,[13] suggests that:

'High-quality health systems will lay the foundation for a healthier and more productive population.' (The Lancet 2018)

The same Lancet comment also highlights the opportunity that the transition to federalisation in Nepal provides to improve the quality of health systems:

'The current political juncture presents an opportune moment for Nepal to embark on the path to building a high-quality health system. Unwavering political commitment, structural innovations, and programmatic acceleration are essential for such policy reforms'. (The Lancet 2018)

Nepal has introduced a Minimum Service Standards (MSS) tool to assess hospitals' service readiness and availability to deliver quality health services. Implementation of the MSS at the health post level has reportedly contributed to:

- replenishment of required equipment and supplies,
- improvement in governance and management functions
- gradual impact on the quality of services delivered

However, the overall MSS score indicates poor service availability and readiness, and the need to improve service quality. The non-availability of basic equipment, human resources and weak managerial skills were some of the factors affecting readiness.

Stakeholders met identified the need to develop a national Quality Improvement (QI) Framework to guide implementation and measurement of QI interventions. They recognised that there are multiple QI interventions and available tools being implementation, none have been implemented at scale and there is limited information about their effectiveness. It was suggested that these interventions and tools should be mapped and assessed to inform scale up.

Other service delivery priorities identified from the document review and raised by stakeholders included:

- Strengthening reproductive, maternal, newborn, child and adolescent health (RMNCAH) services

[12] Envisioning a high-quality health system in Nepal: if not now, when? Published Online September 5, 2018 http://dx.doi.org/10.1016/.

S2214-109X(18)30322-X See The Lancet Global Health Commission page e1196.

[13] Envisioning a high-quality health system in Nepal: if not now, when? Published Online September 5, 2018 http://dx.doi.org/10.1016/.

S2214-109X(18)30322-X See The Lancet Global Health Commission page e1196.

- Development of a national Quality Improvement Framework and mapping and scale up of good QI practices and processes
- Tailoring health policies to inequality patterns to reduce inequality
- Harmonisation of MoHP plans and programmes to achieve more integrated service delivery at all levels
- Promoting prevention and awareness raising programmes e.g. public health education for behaviour change and prevention and management of NCDs
- Strengthening mental health services particularly the development of suicide monitoring and surveillance systems and capacity development for facility and community-based health workers in prevention and postvention services
- Strengthening physiotherapy services
- Balanced focus and investment in promotive, preventive and curative services
- Accessible and integrated health services to ensure efficient provision of services that meet the needs and rights of women, men, girls, boys and people of other genders

GOVERNANCE

In the last five years, Nepal has seen fundamental changes in the national administrative, legal and political systems. The constitutional amendment of 2015 redefined the structure of the government in Nepal and under the Federal system, the government is divided into three tiers - at the local/palika, provincial and federal level. There are currently 753 local governments, 7 provincial governments (subdivided into 77 districts) and 1 federal/central government. The 2015 Constitution provided these local and provincial authorities with greater political, fiscal and administrative powers, concurrently with the federal government. The new distribution of powers allows for greater participation at the local level.[14]

Under these governance arrangements, the MoHP is responsible for overall health policy formulation and strategic planning at the Federal level, while provincial and local government are responsible for the planning and delivery of health services. In addition, 7 provincial level health training centres and 77 health offices under the Health Directorate at district level have been established. Under the current governance arrangements for health service delivery, primary hospitals and health posts and community based health services are under local government, provincial governments are responsible for secondary hospitals, while tertiary and specialized hospitals are the responsibility of the federal government.

The 2019 National Joint Annual review noted that the transition to a federal structure demands systems reform in the sector and the:

'…need to build institutional, organizational and individual capacity at all levels of government, with special focus on the provincial and local levels to attain functional, sustainable, inclusive and accountable provincial and local governance'. (NJAR Report 2019)

The Lancet Comment recommends that the Ministry of Health:

[14] ECPAT International. (2020). ECPAT Country Overview: Nepal. Bangkok: ECPAT International. https://www.ecpat.org/wp-content/uploads/2020/01/ECPAT-Country-Overview-Report-Sexual-Exploitation-of-Children-in-Nepal-2020-ENG.pdf.

'The Ministry of Health should repurpose and reorient itself to push the envelope on governance and regulation by setting standards, producing guidelines, ensuring best practices, and strengthening the quality and cost-effectiveness of services offered by the health system.' (The Lancet 2018)

Several stakeholder acknowledged that capacity for planning and management at local levels was varied. There are some palikas that are functioning well, that are *'willing to learn'* but as one stakeholder advised '*Don't tell them what, tell them how'*. Some palika health coordinators are very active and are communicating and advocating well with the local leaders who are responsible for allocating the budget for health services. However, they also suggested that further capacity enhancement is needed for the palikas: *'we have to make them realise that health is as important as roads, etc.'* While the provinces were facilitating capacity development interventions, stakeholders felt that *'a training of 2-3 days is not going to increase capacity, when there are so many areas in health – including TB, Leprosy, tropical diseases, maternity services, newborn care - lots of areas that they need to be knowledgeable about'.*

The use of the 'learning lab' approach in seven rural/ municipalities across the seven provinces by the MoHP through the NHSSP project has produced interesting lessons and is improving understanding of health service delivery at the local level (i.e. leadership, governance and accountability, service quality, planning and budgeting, and monitoring of health interventions, reaching the unreached), however as one stakeholder commented: *'learning labs help with planning, and the guidelines are useful, but face to face orientation is what is needed'.*

Lessons learned from the organizational capacity assessments (OCA) facilitated in 2019 *'found overall capacity of Local Governments to manage delivery of basic healthcare services to be "weak'.* (NHSSP 2019)

Other areas where capacity development at local government level is needed as identified by stakeholders were as follows:

- Formulation and enactment of policies
- Planning, budgeting and delivery of quality integrated PHC services, including public health and community-based services
- Mobilisation, allocation and efficient use of resources
- Promotion and strengthening of community participation and accountability mechanisms (social audit, Health Facility Operation & Management Committees, CSOs and community groups)
- Management, generation and use of data for decision making
- Improving supply factors, including financial, human resources, drugs and supplies

Many of the stakeholders consulted and senior MoHP officials who participated in the stakeholder consultation meeting identified governance and leadership, especially at the local government/palika level as a key priority and an area which HPs could support. They felt that support could be provided in building and enhancing capacity in policy formulation and enactment; planning, budgeting and financial management; HRH planning and management; and with the monitoring and supervision of the delivery of integrated quality health services. Some identified the need to strengthen hospital/facility management and leadership to improve the quality of care at both secondary and primary hospitals and felt that HPs could also support with this type of intervention.

HUMAN RESOURCES FOR HEALTH

Currently the MoHP is developing an HRH strategic plan/roadmap and aligning it with the federal context to guide HR planning, management and development at all levels. A key HRH activity in the MoHP is the employee adjustment

process, with approximately 27,500 health workers 'adjusted' as per the Employee Adjustment Act (2074) by the end of 2019.

Several stakeholders perceived this adjustment process as a key challenge; it is affecting the availability of staff and skills mix at PHC level, with oversupply in some palika and facilities and undersupply in others; and disrupting both facility and community based service delivery; some MoHP officials cited a link between this process and the recent decline in vaccinations rates. Some gave examples of health workers being mismatched to posts, such as nurse anaesthetist and nurse/midwives being posted to administrative posts, which is affecting the functioning of CEOCs and BEOCs and birthing centres and creating a shortage of skilled providers for Caesarean Sections (CS). Others were concerned about LGs contracting MNCH health workers that are not adequately trained in deliveries and maternity services. LGs often recruit these health workers as a short-term fix, to fill vacant posts, and do not always consider the knowledge and skills required and other specifications for these posts. Guidance for the recruitment and distribution of newly appointed staff is needed to ensure LG recruit and deploy appropriately skilled health workers to where they are most needed.

They suggested that '*Government has to reverse this decision otherwise we can't run the birthing centres and we can't achieve our expected goals'*. Others reported that since the federal employee adjustment, health indicators have been worsening, but that *'there is no appetite amongst politicians to reverse this'.* Some felt that this would have *'to be spelt out once we get the results after one year, then this will reflect then what has to be done'.*

In the recent 6-monthly meeting between health officials from the provincial levels and federal levels, provincial stakeholders identified HRH related factors affecting service delivery, which included shortages of staff, lack of skills mix and staff absence.

Other challenges with HR supply and production were identified by stakeholders as follows:

- HRH projections, gaps and needs incomplete for new structure(s)
- Oversupply of some cadres, especially doctors and nurses
- Undersupply of other cadres including specialised nurses, ENT, ECH, lab technicians, midwives, physiotherapists, biomedical engineers, etc.
- Lack of clarity and progress on partnerships with academic health institutions
- Local contracting and short-term recruitment to fill HR gaps comprising quality, especially where those contracted do not have adequate or the appropriate skills

Many stakeholders raised issues about gaps in the quality of pre-service education (PSE), the need to revise and develop curricula, and the availability, retention and capacity of teaching faculty, especially for midwifery. The lack of lack of supervisors and clinical mentors/preceptors is also believed to be impacting on the quality of supervision and mentoring, especially for trainee nurses and midwives. Other felt that there was an overuse of in-service training address these gaps in PSE.

Other HRH priorities identified from the document review and the stakeholder consultations are as follows:

Strengthening HRH policy and planning in the following areas:

- MoHP to finalise and/or endorse the HRH strategy/roadmap
- MoHP to strengthen the generation and use of reliable information for workforce planning, recruitment and deployment at all levels

- Harmonise all health workforce strategies & plans across the MoHP, including the departments (e.g. the ongoing development of the Maternity & Nursing Strategy, Female Community Health Volunteer Strategy)
- MoHP to produce standardised guidelines for staff recruitment at Local Governments (LG) level
- Strengthen the HRH unit in the MoHP

Strengthening HRH supply/production

- Formulate HR policies and strategies that are evidenced based and match supply and skills mix with demand and requirements at all levels
- Strengthen partnerships with public and private academic health institutions to address HRH needs

Strengthening HRH management

- Review and finalise the staff adjustment process
- Ensure more equitable distribution across geographic areas, by skills mix and service levels, especially in remote and hard to reach areas

Strengthening HRH education, training and development

- Develop/revise PSE curricula, including for the midwifery bridging courses
- Improve availability and capacity of midwifery faculty, supervisors and clinical mentors/preceptors
- Design and deliver onsite and on the job in-service training and mentoring, and expand use of mHealth/online learning to meet identified needs at all levels

These HRH priorities were presented to different stakeholders and during the stakeholder consultation meeting and their views sought about which priorities could feasibly be addressed through the UKPHS programme. It was felt that many of these identified HRH priorities and issues would require government responses and action, for example the formalisation of recruitment guidelines, retention policies, etc., while others were already being supported by EDPs, for example, WHO is supporting the federal MoHP with the development of the HRH strategy and roadmap, workforce planning and projections, workload analysis and other strategic HRH interventions. However, stakeholders felt that there was a role for HPs in supporting a range of capacity development interventions, including the review and revision of curricula, and the design and delivery of specialised and advanced in-service and continuing professional development (CPD) courses for nurses and other cadres (i.e. operating theatre, ultrasound, ICU, Caesarean Section). Strengthening the capacity of nursing and midwifery faculty, clinical mentors, supervisors and preceptors was also identified as a critical area that could be supported through HPs.

Participants from the Nepal Nursing Council, who attended the stakeholder consultation meeting, suggested that the priorities HPs could support include overall organisational development of the Council, leadership development for nurses, as well as the design of a CPD system linked to the relicensing of nurses and midwives. Strengthening NHTC and the capacity of its training sites, including provincial health training centres were other areas identified during the stakeholder consultation meeting. As highlighted under the service delivery discussion above, mental health and suicide was also identified as a priority by several stakeholder, as well as the need to develop the capacity of facility and community-based health workers to provide prevention and postvention suicide services

GENDER EQUITY AND SOCIAL INCLUSION

The Sustainable Development Goals (SDG) and targets are firmly focused on the concept of "Leaving No-One Behind" (LNOB) and the Nepal health sector has a good track record in addressing exclusion related goals. The current national Nepal Health Sector Strategy (NHSS) (2015-2020) has equitable access as one of its four principles, with related disaggregated targets. The 2019 National Health Policy indicates that *'Universal and equitable access to health services shall be ensured with priority to population of various age groups, gender, classes and regions'.*

The MoHP has developed a number of GESI responsive and transformative policies, strategies, programmes and guidelines, including the Health Sector GESI Strategy, the National Strategy for Reaching the Unreached (2016-2030), the Aama Surakshya Programme, described above which promotes the utilisation and uptake of services, the Disability Inclusive Health Service Guidelines, Gender Responsive Budget Guidelines, and LNOB Budget Markers. In addition, free basic health care is available at PHC level, and fifty-five One-stop Crisis Management Centres are currently functional in fifty-four districts. The media has also played a role in raising awareness of some harmful practices e.g. mensuration huts. [15]

Despite the policy commitment to addressing inequality, inequality prevails, leading to the marginal exclusion of the disadvantaged and most vulnerable groups. Much more needs to be done, with the most recent data illustrating that differentials in knowledge, access and use still exist. For example, urban women are more likely to have four or more ANC visits than those living in rural areas (76% and 62% respectively), poor women and those with no education are even less likely to have four or more ANC visits (49% and 57% respectively). Nationally 42% of women took the full course of iron tablets during their last pregnancy which falls to 28% for women living in Province 2, which comprises the Terai districts of the former Eastern and Central Development regions. Inequitable access to and utilisation of services is a result of a combination of financial, sociocultural, and geographical barriers (NHSSP 2019)

"*Although Nepal is on track to achieve gender equality and women's empowerment, achievements vary with less equality among poorer women, while discrimination and violence against women and girls is still prevalent. Women's participation in public sector decision making is low". (*National Planning Commission 2017).

One stakeholder suggested that '*Given there are no one-stop crisis management centres (OCMCs) beyond primary hospital level, it would be useful to duplicate these at the lower levels. Frequent orientation around the OCMCs and GESI is required, however, along with a multi-sectoral approach'.*

The decentralization of healthcare to provincial and Palika levels should provide opportunities to increase the responsiveness of the health sector to frontline staff and the differential needs of men, women, girls, boys and people of other genders. In addition, local governments' understanding and knowledge of the local area and needs of the population in their areas should inform evidence-based planning and budgeting that focuses on reaching the un-reached and marginalized groups.

[15] Jennifer Thomson, Fran Amery, Melanie Channon & Mahesh Puri (2019) What's missing in MHM? Moving beyond hygiene in menstrual hygiene management, Sexual and Reproductive Health Matters, 27:1, 1215, DOI: 10.1080/26410397.2019.1684231

'*…early marriage, early pregnancy, frequent pregnancies, and the Chhaupadi tradition in the mid-western and far-western regions of banishing women during menstruation are the major causes of death of new mothers*'. (Family Welfare Division 2019).

The findings of the Organisational Capacity Assessments, supported by the MoHP though the NHSSP, however, found that local governments need further capacity in 'mapping communities deprived of mainstream service delivery' to understand their reasons for not visiting the health facilities' and to 'develop strategies accordingly in order to expand coverage and ensure access of services to the unreached.' (NHSSP 2019)

GESI priorities identified included the following:

- Implementation of GESI Strategy
- Establishment of GESI institutional mechanisms
- Support to province and local levels for the roll out of GESI strategy
- Advocacy for health services at local government and provincial levels to display data service coverage that is disaggregated
- Addressing social, economic, financial and cultural barriers to access and utilisation especially for disadvantaged caste and ethnic groups

HEALTH FINANCING

While there has been an increase in government spending on health as a share of gross domestic product (GDP) from 1.4 percent in FY 2014/15 to 1.9 percent in FY 2017/18. However, e*xternal funding for health has been* decreasing in relative terms in the recent years. O*ut-of-pocket (OOP) expenditure remains high at* 60.4%, with more than 10.7% of people spending over 10% of their total expenses on health. *In 2017* 1.67% of the population fells below the poverty line of PPP$ 1.90 per capita per day.(Health Financing Profile of Nepal-2017, WHO). There are disparities across Palikas in terms of resource mobilization at local level, and many stakeholders expressed concerns that service provision may be comprised in the more resourced constrained LGs. Another area of concern was the use of scare resources at Palika level on hospital infrastructure, with little regard for the resources needed to operationalise and staff these hospitals.

> *……., the government must reverse the declining investment in health and progressively increase the share of annual budget towards health to pay for high-quality care* (The Lancet 2018)

Health financing priorities identified through the document review and stakeholder consultations in were as follows:

- Strengthen Financial Information Management System across all three tiers of government (TABUCS, PLMBIS, SUTRA)
- Regularize overutilization of health insurance
- Tracking of public expenditures through Social Accountability Mechanisms
- Resources need to be reflected in Palikas Annual Work Plan and Budget (AWPB)
- Allocation of financial resources in a transparent manner that reflects the gendered dimensions of health
- Design equitable financing systems that minimize the risk of catastrophic health expenditures.

HEALTH INFORMATION SYSTEMS

Stakeholders indicated that online reporting from all health facilities was weak, with completeness and timeliness a problem e.g. 41% of health facilities reported in a timely manner in 2019. Data quality is also an issues raised by some

stakeholder who indicated that verification of facility data, previously the responsibility of the district statistical officer, is not being conducted in all Palikas. Electronic health records have been initiated in selected hospital but the availability of recording and reporting tools for HMIS & LMIS remains inadequate. In addition, more needs to be done to ensure that data is available and used to inform evidence-based decision making

The priorities identified through the desk review and stakeholder consultations are as follows:

- Training for all health facilities on DHIS2
- Generation and use of data for evidence-based service delivery planning and management at Palika and facility level
- Recruit and post dedicated staff for health information management
- Implement Routine Data Quality Assessment (RDQA) for quality improvement of Health Management Information System (HMIS) data
- Design of health information systems that identify gendered dimensions of health outcomes.
- Generation, collection and analysis of sex-disaggregated data and use of these data to address health inequities.

MEDICAL PRODUCTS AND TECHNOLOGIES

The information available and accessed by the Scoping team on medical products and technologies was limited. Issues and challenges identified through a review of the documentation available and raised by stakeholders included the ddevelopment of a mobile application for the Nepalese National Formulary; the initiation of online post-marketing surveillance; the need to regulate and quality assure pharmaceutical and pharmacy practices and reduce illegal pharmacies and the availability of unregistered medicines. The need for closer monitoring of the provision of 'free drugs without need assessment' was also highlighted.

Priorities identified in this area included:

- Regulation of health technology products (HTP);
- Revision of Drug Act introduced in 2035 BS (1978 AD).
- Antimicrobial stewardship

The findings and identified priorities from the desk review and stakeholder consultations findings and key informant interviews described above were presented and validated by stakeholder group comprising senior MoHP and DoHS officials. Those identified as key priorities and for which the HP model was deemed suitable and feasible are presented in the Theory of Change presented below.

UKPHS
UK Partnerships for Health Systems

NEPAL PRIORITIES | INITIAL THEORY OF CHANGE

	Human Resources for Health		Leadership & Governance	Health Information Systems	Community Health Promotion
	MNCH	Community Based Services			
Indicative Activities	Support for: · CPD and evaluation criteria for N/M registration and licensing · Specialist, advanced and leadership N/M training · CPD for C-section clinical mentorship for doctors, OT nurses and anaesthetists · Monitoring C-sections · Quality of N/M clinical learning environments · Provincial health training centres · Midwifery faculty	· Capacity development of facility and community-based health in the areas outlined in the narrative above · Development of suicide monitoring and surveillance systems and capacity development for facility and community-based health workers in prevention and postvention services	· Organizational support to Nursing Council Support to Palikas & provincial government in: · Policy formulation; Planning, budgeting and financial management; Planning & managing health workforce; Monitoring delivery of integrated services & quality of care; Hospital/facility planning, leadership and management; Establishing plan for public health emergency preparedness	· Generation and use of data for decision-making at Palika and facility level · Strengthen medical records · Strengthen the conduct and use of research/evidence for decision-making · Creation of a digitalised learning platform to assist municipalities in disease screening, remote surveillance and allow for remote support, technica advice and case management	· Support demand creation for MNCH services · Support implementation of community participation and accountability mechanisms · Orient health workers in the use of mobile health for health education
Indicative Outputs	· No. of N/Ms trained & deployed · No. of health workers trained in monitoring C-section · No. of midwifery tutors trained & mentored · CPD developed for N/M and C-Section clinical mentors · No. of clinical learning environments improved · Evaluation criteria for evaluating CPD linked to licensing developed	· No. of facility and community-based health workers trained in the areas outlinedin the narrative above · No. of One Stop Crisis Management Centres and other GBV services supported · Local facilities providing quality GBV services · Improved information, diagnosis and referrals available for local communities · Improved information, diagnosis and referrals available for local communities in NCDs, environmental health, services for aging populations, GESI, adolescent health, physiotherapy and mental health	· No. of Nursing Council representatives trained & processes strengthened Palikas/Provincial govt. no. of: · Policies/strategic plans produced · Systems/processes improved · Officials, health coordinators, hospital and health facility managers receiving support in planning, budgeting, and leadership and management · Provincial public health emergency preparedness plans	· No. of data collectors at HF level staff trained in data collection · No. of managers at HF, district and provincial level trained in use of data for decision making · No. of new information management tools/ platforms developed and embedded · No. of learning platforms operational and embedded within information management systems at a municipal level	· Community participation & accountability mechanisms reviewed and supported · No. of health workers trained in and with access to mobile health platforms · Greater community demand for, and accountability of, local health services · Mobile health platforms integrated into community health promotion
Indicative Outcomes	· Improved N/M availability and accessibility · Improved quality of C-sections · Improved quality of pre-service midwifery training · Quality clinical learning environments available and staffed with adequate number of skilled preceptors · Increased access to quality MNCH services for all		· Improved capacity of Nursing Council to monitor N/M training, regulation and licensing · Effective implementation of integrated PHC services · Improved link between health facilities, Palikas and national level · Palika/provincial gov. able to formulate and enact policies · Strengthened provincial systems for responding to public health emergencies	· Palikas/provincial governments able to generate, manage and use data for decision making · Municipalities able to utilise information through learning platforms contributing to increased consistency in case management, screening and data sharing	
Potential Impact	**improved MNCH outcomes through strengthened governance and leadership and use of evidence**				

NEXT STEPS AND WAY FORWARD

The THET Nepal consultant continued to facilitate discussions with DFID and other key stakeholders beyond the scoping visit, as follows:

1. Meeting with the Nursing and Social Security Division (NSSD) to validate key priorities: A follow-up meeting was conducted with NSSD officials. Discussion focused on the estimation and projection of midwives needed, and deployment of midwives in highly crowded hospitals where deliveries are more than 1500 per month. The officials also identified the need for Master level nursing courses with specialization.
2. Follow up meeting with the Chief of PPMD to feedback on the outcomes of the stakeholder consultation meeting, including the validation and identification of the priorities which are a best fit with the HP mode: A meeting was held with PPMD and HCD officials who agreed to having an MoHP representative on the NOM. Approval is now being sought from the Ministry.
3. Follow up with stakeholders to access additional documentation identified through the consultations e.g. Medical Education Act, Public Health Act, Minimum Services Standards, etc: THET Nepal Consultant is gathering the relevant policy and legal documents.
4. Sharing the Terms of Reference for the NOM with the DFID Health Advisor and the MoHP focal person to ensure understanding and the timelines for their inputs: Separate meetings were conducted by THET Nepal Consultant with the DFID Advisor, EDP Focal Person, and independent Health System Strengthening person to discuss the TOR for the NOM and the tentative timeline for reviewing the grant applications.
5. Seek the advice of the DFID Health Advisor for an independent Health Systems Strengthening member of the NOM, and approach with invite: After the meeting with the DFID adviser, an independent Health System Strengthening member for the of NOM was identified - Professor Shiv Adhikari, an economist from Tribhuvan University. The Nepal THET Consultant briefed him about the programme and his TOR.
6. Grant call notification: Once the grant call is out, the information will be circulated to a wide range of prospective applicants through use of email, social media, and other platforms.
7. The NOM will meet and review the grant applications as required and will send the review report to THET HQ London.
8. An Award Ceremony will be held probably in October and NOM member may participate with the THET secretariat.

LIST OF ANNEXES

ANNEX 1 - TERMS OF REFERENCE FOR SCOPING ASSESSMENT

DESIGN AND CONDUCT OF SCOPING ASSESSMENTS

BACKGROUND

UK Partnerships for Health Systems (UKPHS) is a DFID-funded grants programme that funds Health Partnerships (HPs) to improve health system performance and to enable progress towards Universal Health Coverage (UHC) in low- and lower-middle income countries (LMICs), especially for poor and vulnerable populations. The UKPHS will support the development of stronger health systems by promoting HPs that are aligned to national health priorities and strategies, focusing on quality, and gender equality and social inclusion (GESI). UKPHS will fund large strategic HPs in ten countries that explicitly focus on supporting LMIC health system priorities, complemented by smaller HP grants that test innovative approaches to specific health system challenges.

PURPOSE OF THE SCOPING ASSESSMENTS

From December 2019 to May 2020, THET and LSTM plan to undertake detailed scoping assessments in each of the 10 countries. The assessments will explore health systems issues, challenges and priorities, and identify and validate health systems priorities that HPs could potentially address and/or contribute to health system strengthening (HSS) or strengthen particular building blocks within the system, whilst ensuring a GESI perspective. These scoping assessments will consider the HP footprint in each country, as well as the potential supply of new and/or adapted HPs, ensuring the best fit between the priorities identified and the likely supply.

During the scoping visit, stakeholders will begin the process of constructing a Theory of Change (ToC) that maps out how HPs can address the identified health system priorities in that country context, contribute to HSS and UHC, and how the poorest and most vulnerable (from a GESI lens) can be supported in particular. All HPs will need to clearly demonstrate their contribution to this ToC. The assessment process will also contribute to stakeholder relationship building and promotion of the programme, and assessment findings will inform grant call design, overall UKPHS programme MEL processes, promote HP alignment with, and support of, national priorities and capacities, and ensure a good fit with the supply of UK expertise.

APPROACH AND METHODOLOGY

1. Desk review

The team will undertake a rapid desk review comprising mainly the review of country specific documents such as: health sector policies, strategies and plans including UHC, Quality Improvement, human resources for health, maternal, newborn, child and adolescent health; available HMIS data; and other relevant key government, donor and/or development partner reports/analyses, in order to construct an overview of health systems issues and priorities, and a stakeholder map for each country.

2. Design of assessment frameworks and tools

The team will draw on a number of frameworks to develop a flexible approach and tools for the scoping assessment that can be adapted to each country context. In addition to the key framework, which will be the WHO Health System

Framework and the 6 Building Blocks/core functions[16], the team will draw on a number of other assessment tools and guides, such as the USAID Health Systems Assessment Approach;[17] the Roberts, Hsiao, Berman, and Reich (2003) 'control knobs framework';[18] the DAC OECD Principles for Evaluation of Development Assistance;[19] the WHO five performance criteria for assessing a health system,[20] and the WHO Human Rights and Gender Equality in Health Sector Strategies: How to Assess Policy Coherence,[21] and the Building Block Benchmarks for Gender[22] to design the methodology, approach and assessment tools to identify health systems issues and priorities, and to assess the relevance of the HP model to address these.

3. Stakeholder engagement

Multidisciplinary and multi-stakeholder involvement to discuss potential HP projects is critical, as is engagement of key stakeholders affected by the implementation of these projects. MOH cooperation, collaboration and participation in the scoping process will be essential for generating high quality findings and outcomes that are acceptable to the government of each country. Country commitment will also be critical to increase the likelihood of HP interventions being implemented, achieving the expected results, and these results being sustained beyond the lifetime of the project.

Prior to the scoping visit, THET Country Directors (CDs) will meet with high level MOH officials, DFID Health Advisors and other development partner representatives to provide information and create awareness and build support for the UKPHS programme, outline the purpose of the scoping visit and level of cooperation expected from the MOH. These discussions will also provide opportunities for the initial exploration and validation of the country's health systems issues, challenges, and priorities, including GESI issues, and how the UKPHS programme can contribute to these, as well as support the government to achieve UHC and the SDGs.

In-depth interviews (IDIs) and key informant interviews (KIIs), meetings and workshops will be facilitated with a range of national and sub-national level stakeholders, identified in advance of the scoping visit through a stakeholder mapping exercise. These will include policymakers, representatives from the MoH and other strategic sectors and line ministries, in-country DFID teams, professional bodies and associations, including nursing, training institutions, NGOs, civil society,

[16] World Health Organization (2007) Everybody's Business: Strengthening health systems to improve health outcomes—WHO's Framework for Action. Geneva: WHO, 2007, p.3.

[17] Health Finance & Governance Project. September 2017. Health Systems Assessment Approach A How-To Manual. Version 3.0. Bethesda, MD: Health Finance & Governance Project, Abt Associates Inc.

[18] Roberts MJ, Hsiao WC, Berman P, Reich MR. 2003. Getting Health Reform Right. New York: Oxford University Press.* This conceptualized a health system as "a set of relationships where the structural components (means) and their interactions are associated and connected to the goals the system desires to achieve (ends)".The framework identifies five major "control knobs" of a health system which policymakers can use to achieve health system goals: financing, macro-organization, payment, regulation and education/persuasion.

[19] DAC Principles for Evaluation of Development Assistance, DEVELOPMENT ASSISTANCE COMMITTEE, OECD, PARIS, 1991 https://www.oecd.org/dac/evaluation/2755284.pdf.

[20] WHO (2007) Everybody's Business: Strengthening Health Systems to Improve Health Outcomes. Geneva, Switzerland: WHO.

[21] WHO (2011) Human Rights and Gender Equality in Health Sector Strategies: How to Assess Policy Coherence https://www.who.int/gender-equity-rights/knowledge/human_rights_tool/en/.

[22] Research in Gender and Ethics (2019) Adopting a gender lens in health systems policy: A Guide for Policy Makers. https://www.ringsgenderresearch.org/wp-content/uploads/2020/01/Adopting-a-gender-lens-in-health-systems-policy.pdf

women's, disability and faith-based organisations, development/funding partners, UN agencies, and private sector organisations.

The objectives of such stakeholder engagement are to:

- Share information on the UKPHS and the HP model
- Share findings and priorities identified through the desk review
- Seek stakeholders' inputs and views to validate findings and agree priorities
- Collaboratively assess the potential of the HP model to address the identified priorities
- Get consensus on the interventions that could be implemented through HPs

Debriefing sessions will be facilitated to provide an overview of the outputs and outcomes of the scoping visits and present priorities identified and validated. These sessions will provide opportunities for the team to build consensus on the draft country specific ToC, which will outline potential HP activities, outputs, outcome and impact. As part of this debriefing, teams will agree the way forward and the functioning of a national oversight mechanism. Beyond the scoping visits, the teams will continue to refine and finalise these country specific ToCs.

Summary country reports

Scoping visit reports, which provide an overview of the process and outcomes from each of the countries, will be produced. A summary of the agreed priorities that could potentially be addressed by HP projects and interventions and a draft Theory of Change will also be developed, which will be made available to guide grant applicants in the development of their applications and proposals. These outputs will be further refined and validated through the pre-commencement workshops and other planned stakeholder consultation fora in each country.

Specific activities

1. Conduct a rapid desk review of policies and country reports and other relevant documentation (national health sector plan and policies, strategies and plans for UHC, Quality Improvement, HRH, and relevant HMIS and surveillance data)
2. Map existing Health Partnerships and key stakeholders
3. Produce a draft situation analysis, including health system issues, challenges and priorities, including, progress on GESI, and identify priorities that could be potentially addressed through HPs
4. Develop standard frameworks and tools to be used across all countries to engage stakeholders in the identification and validation of health system issues, challenges and priorities, and in assessing the feasibility of the HP model to address identified HSS priorities
5. Conduct in-depth and key informant interviews and group discussions and workshops with a range of national and sub-national stakeholders to identify and validate health system issues, challenges and priorities, and elicit views and perceptions on the extent to which the HP model could address these
6. Facilitate a debriefing session with a representative group of stakeholders/gatekeepers to present and validate findings of the scoping assessment and agree the cope and functioning of national oversight mechanisms and way forward.

Expected Deliverables:

1. Desk review and situation analysis including map of stakeholders and health challenges and priorities
2. Country scoping assessment report, including an overview of the process, key findings, and a summary of agreed priorities to be addressed by HP projects
3. Draft country level TOC focusing on HP interventions, outputs and outcomes and broad indicators for each of the identified short-, medium- or long-term outcomes, including Gender Equality and Social Inclusion (GESI) indicators.

Composition of scoping team

Each scoping team will comprise up to two international specialists/leaders in HPs, HSS, and/or Gender, and a representative from the THET country offices.

Timeframe and duration of scoping assessment

The scoping assessments are expected to be undertaken between January and May 2020 and each country visit is expected to take up to 5 days. Country Reports and ToC will be completed for all countries by June 2020.

ANNEX 2 - FREQUENTLY ASKED QUESTIONS

WHAT IS THET?

THET is a global health charity operating in 7 countries across the world – the UK, Uganda, Tanzania, Zambia, Somaliland, Ethiopia and Myanmar. THET's primary aim is to address the statistic that one in seven people globally will never visit a qualified health worker. We do this primarily through health workforce development. We train support and educate health workers across Africa and Asia, working in partnership with organisations and volunteers from across the UK, Africa and Asia. We are the only UK charity with this focus. All of the work which THET does works within the Health Partnership model framework.

WHAT IS THE HEALTH PARTNERSHIP MODEL?

A Health Partnership is a partnership formed between a UK health institution, either a hospital, a trust, a professional association, or a health education facility like a university and their counterpart overseas. The aim of these partnerships is to deliver health worker training and peer to peer support, through utilising the skills and experience of each organisation. Partners co-develop programmes that address organisational and national priorities. The partnerships themselves are generally long term and sustainable, while the projects which they deliver are discrete and tailored to specific identified needs. The aim of all projects is sustainable impact and mutual benefit.

HOW DOES THET WORK WITHIN THE HEALTH PARTNERSHIP MODEL?

THET takes a 3-pronged approach to partnership work – we carry out policy, advocacy and research, we implement programmes directly, and we manage grants for donors. Our policy work involves advocating, mainly with the UK government, for support for Health Partnership work. In our country programmes work we work through our six country offices partnering with others (Mohs, hospitals, universities, professional associations and other organisations) both overseas and UK-based to deliver programmes that respond to local needs. Finally, THET acts as a fund manager for a number of donors. Historically we were grants manager for the Health Partnership Scheme – a 7 year, £32 million programmes funded by the Department for International Development. This programme supported 210 projects in over 30 countries and trained over 93,000 health workers. Currently, we are managing a number of grants, including the Johnson & Johnson Africa Grants Programme, which focuses on surgery and anaesthesia and community health, and the Commonwealth Partnerships for Antimicrobial Stewardship Programme, funded through the Department of Health's Fleming Fund. This supports partnerships with the aim of improving the detection and monitoring of resistant infections at the hospital level, taking measures to reduce infection and ensuring antibiotics' effective use.

WHAT IS THE UKPHS?

The UK Partnerships for Health (UKPHS) programme was announced by the UK Department for International Development as the successor to the HPS in 2018. After some delays, management of the programme was awarded to THET with technical input from the Liverpool School of Tropical Medicine, and the programme officially began on 2nd December 2019. The programme has a total budget of £28.5m and will run for 43 months until July 2023.

The programme aims to help LMICs build stronger, and more resilient health system, making progress towards universal health coverage through improved health service performance, particularly targeting poor and vulnerable populations. Some of the key aims are to:

- Support the development of stronger health systems through better governance, information, and management of health institutions
- Provide the health workforce with opportunities to improve skills and knowledge
- Build on the institutional capacity to decrease any reliance on external support.

WHAT KIND OF PROJECTS WILL BE FUNDED UNDER THE UKPHS?

There are two main strands under the UKPHS. The first focuses on 10 strategic countries which were identified by DFID – Bangladesh, Burma, Ethiopia, Ghana, Nepal, Sierra Leone, Somalia/Somaliland, Tanzania, Uganda and Zambia. Grants under this stream must address pre-identified health priorities, as identified by stakeholders within the country. The second strand will fund smaller projects and will have neither a pre-defined country nor a health theme.

All projects under this funding programme must be delivered by Health Partnerships and must address issues with the health workforce through activities such as training**,** leadership development, or protocol and curricula development. Unfortunately, this funding cannot be used for infrastructure work, including equipment procurement or refurbishment.

HOW MUCH FUNDING IS AVAILABLE FOR WORK IN UGANDA THROUGH THE UKPHS?

The programme has a total budget of £24m available for grants. There will be 6-8 large grants of up to £400k each being implemented in each of the strategic countries. There will be around £2m available for each strategic country, including Uganda, with the number of grants being decided on based on the number and quality of applications.

WHAT ARE THE MAIN OBJECTIVES AND PLANNED OUTCOMES OF THE GRANTS PROGRAMME?

The entirety of the programme aims to contribute to SDG 3 – ensuring healthier lives and promotion of well-being for all at all ages, with a focus on Universal Health Coverage. A key outcome will be improved health worker and health service performance including for the poor and most vulnerable populations. This will be measured through monitoring the number of facilities supported by UKPHS projects demonstrating positive outcomes in health service performance, with a focus on health worker performance. Projects funded under this programme should take an approach which enhances gender equality and social inclusion, focusing on targeting poor and vulnerable groups.

HOW WILL NATIONAL OWNERSHIP AND BUY-IN BE ENSURED?

It's crucial to the success of this programme and the sustainability of its outcomes that national stakeholders play a leading role in determining priorities. The key health priorities addressed by projects being implemented in strategic countries will be determined through a scoping visit undertaken specifically to engage with national stakeholders. Over the course of the scoping visit, national stakeholders will be asked to participate in workshops, focus groups and key informant interviews, aiming to draw out key priorities for those working in the health sector.

The priorities raised during these meetings will then be agreed upon and used to develop a country-specific Theory of Change, which will form the basis for all of the project interventions. Relevant stakeholders will then be invited to join a National Oversight Mechanism (NOM), which will play a key role throughout the programme in ensuring that projects remain aligned with national priorities and feed into the relevant national plans. The NOM will be asked to review and assess applications during the selection phase of the programme and then play an ongoing role in providing oversight on projects as they progress and attending annual national review events.

In addition to the NOM, THET's Country Director and associated country office staff will support funded Health Partnerships for the duration of the programme. They will be continuously engaging with national networks, the Ministry of Health and other relevant partners.

ANNEX 3 - LIST OF STAKEHOLDERS ENGAGED IN SCOPING TRIP

Designation	Organisation
Secretary	MoHP
Chief of Policy, Planning and Monitoring	MoHP
Chief of Health Coordination Division	MoHP
Focal person for External Development Partners (EDPs)	Health Coordination Division, MoHP
Director General	DoHS
Director of Family Welfare Division	DoHS
Director National Health Training Centre (NHTC)	MoHP, NHTC
Head of training section	MoHP, NHTC
Director, Nursing and Social Security Division	DoHS
Health Advisor	DFID
Health Advisor	DFID
Focal person Human Resources for Health (HRH)	Health Coordination Division, MoHP
Health Specialist	World Bank
Lead Advisor - Health Policy & Planning	Nepal Health Sector Support Programme (NHSSP)
Lead Advisor - Service Delivery	Nepal Health Sector Support Programme (NHSSP)
Deputy Chief of Party	USAID's Strengthening Systems for Better Health (SSBH)
Chief of Party	USAID's Strengthening Systems for Better Health (SSBH)
Principal Advisor	GIZ
Technical Advisor-Human Resources for Health,	Support to the Health Sector Programme (S2HSP), GIZ
Technical Advisor-Human Resources for Health,	Support to the Health Sector Programme (S2HSP), GIZ
Nationanl Professional Officer , Health Systems Development	WHO
Public Health Specialist	WHO
Health Specialist	UNICEF
Health Specialist	UNICEF
Deputy Representative	UNFPA

Nepal Country Director	BBC Action Media
Senior Project Manager	BBC Action Media
Chief/HCD	HCD
SPHA/HCD	HCD
Director	NHEICC
Director	NHTC
Chief/PPMD	PPMD
SHA	PPMD
Health Adviser	DFID Nepal
Director General	MoHP/DDA
Director	NCASC
Section Chief	NSSD
Registrar	NNC
Registrar	NHPC
Sr. H.E.O	MOHP
SPHA/HCD	MoHP/HCD

ANNEX 4 - SCOPING ASSESSMENT ITINERARY

Date	Activity	Designation
Wed, Feb 5	Courtesy call	Secretary
	Courtesy call	Chief Policy Planning and Monitoring
	Courtesy call	Chief Health Coordination Division
	Courtesy call	Focal person for EDPs (health coordination division)
	Courtesy call/KII	DG DOHS
	Courtesy call/KII	Director of Family Welfare Division
	Courtesy call/KII	Director NHTC
	Courtesy call/KII	Head of training section
	Courtesy call/KII	Nursing and Social Security Division
Thurs, Feb 6	KII	Focal person HRH (Health Coordination Division)
	KII	World Bank
	KII	Chief Policy Planning and Monitoring
Fri, Feb 7	KII	Lead Advisor - Health Policy & Planning
	Group Discussion	Health Advisor DFID
		Health Advisor DFID
	KII	Lead Advisor - Service Delivery, NHSSP
Mon, Feb 10	Group Discussion	Deputy Chief of Party, USAID's Strengthening Systems for Better Health (SSBH)
		Chief of Party, USAID's Strengthening Systems for Better Health
	Group Discussion	GIZ
		Technical Advisor-Human Resources for Health, Support to the Health Sector Programme (S2HSP), GIZ
		Technical Advisor-Human Resources for Health, Support to the Health Sector Programme (S2HSP), GIZ
	Group Discussion	WHO
		WHO
	Group Discussion	UNICEF
		UNICEF
		UNFPA
Tues, Feb 11	Consultation meeting	See separate list
Weds, Feb 12	Group discussion	Nepal Country Director, BBC Action Media
		Senior Project Manager BBC Action Media

ANNEX 5 - TOPIC GUIDE FOR COURTESY CALLS, IN-DEPTH AND KEY INFORMANT INTERVIEWS, AND SMALL GROUP MEETINGS

POTENTIAL RESPONDENTS

Ministry of Health policy makers and leaders; department heads and programme managers, including gender focal persons; official from other relevant ministries (education, gender finance/ treasury, national planning and development, labour, civil/public service commission or management agencies); representatives from regional and/or local government; professional councils and associations; health training and academic/research institutions; development partners and donors/funders; representatives from UN agencies, international and local NGOs, faith based organisations, civil society groups/organizations, private sector; and institutions (governmental or non-governmental) working on gender equity and social inclusion, including any disability organisations.

MATERIALS

KII guide, notepad, pens, Programme Overview, UKPHS FAQs, Rings Guide on adopting a gender lens in health systems policy, figure of WHO HS Framework; and country-specific desk review findings/priorities.

INTRODUCTIONS

1. All participants introduce themselves
2. Establish post title and roles and responsibilities of respondent(s), if unknown
    - For government officials and NGOs, ask them to describe their area of focus and/or programme(s) they are responsible
    - For DPs and UN agencies ask them to describe their area of focus and/or programme(s) they are supporting and/or implementing
3. Scoping Team provide an overview of the scoping visit, its purpose, objectives and expected outcomes
4. Scoping Team outline stakeholder engagement strategies/plans that will be adopted and seeks respondent's feedback and inputs
5. If a workshop has been agreed, Scoping Team share the workshop programme, and discuss and seek respondent's inputs on the approach, objectives and expected outputs

OVERVIEW OF UKPHS & HP MODEL

1. Scoping Team provide an overview of the UKPHS programme, including FAQs, and examples of any previous HPs in the country, including achievements, challenges and lessons learned
2. Scoping Team provide any informational materials e.g. Programme Overview, UKPHS FAQs, Share the Rings Guide on adopting a gender lens in health systems policy. [23]

DISCUSSION AND VALIDATION OF HEALTH SYSTEMS PRIORITIES

1. Scoping Team provide a brief overview of the health system priorities, including for GESI, identified through the desk review, and through previous stakeholder consultations, if appropriate.

[23] https://www.ringsgenderresearch.org/wp-content/uploads/2020/01/Adopting-a-gender-lens-in-health-systems-policy.pdf

2. Scoping Team seek inputs and validation on the identified priorities (share list of country-specific desk review findings/priorities) from respondents and probe for any additional priorities.
3. Scoping team explain that the UKPHS programme will seek to strengthen health systems and HPs will aim to support across the 6 building blocks or individual blocks as appropriate to the context and priorities identified. Check respondent's understanding of the WHO Health System Framework (share graphic in Annex if required) and map identified priorities against the building blocks as well as GESI.

APPROPRIATENESS AND FEASIBILITY OF HP MODEL TO ADDRESS IDENTIFIED PRIORITIES

1. Scoping Team Summarise the identified HSS priorities, check respondent's understanding of the HP model and invite respondent's views on how the HP model and HP projects or interventions could address the identified HSS priorities. *Probe for how HP projects could improve health service performance in terms of equity, efficiency, access, quality, and sustainability, and ultimately help the country to achieve UHC?*
2. Probe for 3-5 key priority areas that could be addressed by HPs projects, including indicative activities, outputs and outcome, and overall impact.

ADDRESSING GESI PRIORITIES THROUGH HPS

1. Discuss the identified GESI issues across the 6 building blocks, drawing on the Building Block Benchmarks for Gender[24] where appropriate (see Rings "Guide on adopting a gender lens in health systems policy").
2. Explore with the respondent how the identified HP projects/interventions could contribute to improving health sector performance in terms of equity (with a focus on gender equity, disability etc) and could help reach unreached and marginalised populations.

NATIONAL OVERSIGHT MECHANISM

- Provide an overview of the proposed national oversight mechanism and discuss functions and composition

Additional information:

1. Any other key stakeholders the respondent would recommend the team should consult
2. Any other key documents the respondent would recommend the team should review that were not available for review during the desk review

CLOSURE

- Ask if the respondent would like to add further comments
- Bring the meeting to a close by summarising the main points
- Check respondent's availability and agree a date for a debriefing session, if required
- Thank the participant for his/her time and active participation

[24] Research in Gender and Ethics (2019) Adopting a gender lens in health systems policy: A Guide for Policy Makers. https://www.ringsgenderresearch.org/wp-content/uploads/2020/01/Adopting-a-gender-lens-in-health-systems-policy.pdf

ANNEX 6 - GROUP WORK ACTIVITIES

GROUP WORK ACTIVITY 1: HSS PRIORITIES IDENTIFIED, VALIDATED AND RANKED

- Identified HSS priority areas and activities are distributed amongst the Groups, with each group allocated a different HS building block/core function.
- Each group will discuss the identified priorities and validate them, adding any that were omitted.
- Each group will rank each priority area and activity, with 1 being the highest ranked priority.
- Group work outputs, findings and conclusions can be captured and synthesized using Worksheet 1 below.

WORKSHEET 1

Building Block	HS Priority Area	Ranking	Priority Activity	Ranking
Governance	1. 2. 3.			
Health Financing				
Service Delivery				
Human Resources for Health (HRH)				
Medical Products, Vaccines, and Technologies				
Health Information System				

GROUP WORK ACTIVITY 2: POTENTIAL HP INTERVENTIONS AND PROJECTS TO ADDRESS IDENTIFIED PRIORITIES

- Groups will discuss and identify potential HP projects and interventions that could address the identified and ranked priority
- Groups will discuss how HPs could contribute to HSS within and across the 6 building blocks/core functions by addressing these priorities?
- Group work outputs, findings and conclusions can be captured and synthesized using Worksheet 2 below.

WORKSHEET 2

HS Priority Area/activity	Potential HP project/interventions
1. 2. 3.	

GROUP WORK ACTIVITY 3: ASSESSING HPS CONTRIBUTION TO THE HEALTH SYSTEM PERFORMANCE

- Groups will discuss how potential HP interventions/projects will contribute to improving health system performance.
- Groups will answer the questions related to the following criteria to assess contribution:
    - Coherence
    - Relevance
    - Effectiveness
    - Efficiency
    - Access
    - Quality
    - Equity, gender equality and social inclusion
    - Impact
    - Sustainability
- Group work outputs and findings can be synthesized using Worksheet 3.

WORKSHEET 3

HP interventions	Coherence	Relevance	Effectiveness	Efficiency	Access	Quality	Equity	Sustainability	Impact
1									
2									
3									
4									
5									

GROUP WORK ACTIVITY 4: SYNTHESIS OF GROUP WORK AND LINKAGES BETWEEN HP INTERVENTIONS AND OUTCOME/IMPACT

- Groups will discuss and describe the most feasible HP interventions to address the key priorities and the expected outcome(s) and impact.
- Group work outputs and findings can be synthesized using Worksheet 4.

WORKSHEET 4

Priority area	Description of HP Interventions	Expected output, outcome and impact

ANNEX 7 - REFERENCES

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