Social Assessment of the Nepal Health Sector Reform


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Appendix 6 Definition of SWAP

Abbreviations

ANM  Assistant Nurse Midwife
AP   Action Plan (Social Assessment of HSS)
BCC  Behaviour Change and Communication
BPEP Basic and Primary Education Programme
BPKIHS BP Koirala Institute of Health Sciences
DALY Disability Adjusted Life Years
DDC District Development Committees
EDP External Development Partners
EHCS Essential Health Care Services
EPI Expanded Programme for Immunization
FCHV Female Community Health Volunteer
FEDO Feminist Dalit Organization
FG  Focus Group
FGD  Focus Group Discussion
GDI  Gender Development Index
GIS  Geographical Information System
HDI  Human Development Index
HMGN His Majesty’s Government of Nepal
HMIS Health Management Information System
HHR Human Resource
HPI  Human Poverty Index
HSS Health Sector Strategy – An Agenda for Change (Reform)
IEC  Information, Education and Communication
ILO  International Labour Organisation
IMR  Infant Mortality Rate
IP  Indigenous People
IPO  Indigenous Peoples Organisations
LEB  Life Expectancy at Birth
LTHP Long Term Health Plan
MDG  Millennium Development Goal
MOF  Ministry of Finance
MOH  Ministry of Health
MTR  Mid-Term Review
NEFEN Nepal Federation of Nationalities
NDC Government National Dalit Commission
NHA  National Health Accounts
NHEA Nepal Health Economics Association
NLSS Nepal Living Standard Survey
NGO Non Government Organisation
NR Nepal Rupees
PDDP Participatory District Development Programme
PHC  Primary Health Care
PRSP Poverty Reduction Strategy Paper
RWSSP Rural Water Supply and Sanitation Fund Project
Executive Summary

A. Social impact and equity goals of HSS in a broad policy context

1. Long term perspective reform programs should be based on dialogue to encourage participation and ownership. Provision of consultation platforms for relevant stakeholders in the society - political as well as beneficiary representatives - will make the HSS robust to political change of mainly two reasons:

2. I) In the balance between insulation and acculturation the approach taken in the HSS is heavily biased towards acculturation to dominant society values. The outcome of an acculturation process depends on the acceptance vis à vis implied population groups of the elements of dominant and submissive cultures. A crucial step to achieve the required acceptance is provision of platforms for informed participation by indigenous people and Dalit communities. Mechanisms to ensure this is lacking in the approach taken in HSS.

3. II) In defining the equity goals in HSS organisations representing IP and vulnerable groups - who are often exposed to social exclusion - have not been consulted. When reaching the implementation stage of HSS this planning constraint can potentially impede local accountability, participation and ownership of the key PHC reform components.

4. By addressing maternal health and child mortality as key priorities in HSS a significant step has been taken towards policies aimed at mitigating mechanisms of differential health susceptibility. However, these goals lack focus on differential needs of disadvantaged population segments, and attention should be directed at forces of social stratification, differential exposure, differential susceptibility and differential social-economic consequences to optimize the health and social impact of HSS. By addressing the differential needs via dialogue approaches and integrated multi-sectoral interventions the HSS will become a much stronger policy tool for HMGN to reach the intended social goals (MDGs) via health care measures.

B. Multi-sectoral policies and the MDGs

5. In adopting MDGs as broad health targets in connection with PRSP, the HSS are addressing root causes of ill health by various PHC schemes aiming at decreasing vulnerability and preventing unequal consequences of social stratification. The
health sector has an important role to play for reaching the specific MDGs but
these goals will only be reached through coordinated multi-sectoral interventions
that take into account the forces of social stratification such as social exclusion.
To reach the MDGs remedies for interlinked problems of social and health
inequities must come not only via health sector policies but also from broad social
and infrastructural actions that addresses potential health gaps related to social
consequences of ill-health.

6. The most disadvantaged population groups live in remote rural areas primarily in
Far-West and Mid-Western regions and access barriers to health and social
services for these groups are mainly amenable to multi-sectoral intervention
schemes. Focus group discussions in Sipadol village revealed that local
willingness to apply multi-sectoral comprehensive actions - such as road
construction and women's education - in reaching local development goals in
health is highly present. This local awareness can potentially be stimulated and
focused at the specific MDGs by HSS thereby enhancing its social impact by
central support.

C. Health care finance and social impact

7. WHO has described the Nepalese health care finance mechanism as extremely
regressive and unfair because the prevailing payment method is user fees (out-of
pocket payment) that does not take into account differential health needs and
ability to pay. The costs of ill health for disadvantaged groups therefore need a
special focus in HSS. Especially in Far and Mid-Western regions (with high
density IP and vulnerable Dalit communities) a high percentage of reported unmet
needs combined with high poverty rates are found. Policy formulation and
technical specification of future finance schemes should aim at reducing the
potential risk of a downward spiral process into poverty and further illness
through the prevailing stratifying mechanisms.

8. The HSS proposes deduction schemes for vulnerable groups for specialised
hospital services. But the proposed mechanism is contradicting the financial basis
of running specialised services and therefore unsustainable. If this problem is left
unregulated experience from local management show that exemptions will be
provided only sparsely potentially causing adverse health effects in sub-
population groups.

9. A progressive mechanism should be identified in HSS that includes risk pooling
that merges the health risk for a group of people who have different health care
needs and different incomes. The group benefits of these arrangements will
therefore be provided on the basis of need allowing less healthy people and low
income households to benefit more.

D. Equity in resource allocation, payment method and health care benefits

10. Recent trend tendencies in MOH resource allocation on secondary and tertiary
care facilities and hospital construction indicate an urban vis-à-vis rural resource
allocation bias unfavourable for the most disadvantaged populations living in the
rural areas. This policy contradicts the stated political commitment to primary care since initiation of the National Health Policy of 1991. The pro-rich bias in overall government spending is observed to be much greater in Nepal than Bangladesh and Sri Lanka.

11. The primary health care system is the largest sub-sector of the health system in terms of capacity and personnel. However, the social impact of the primary health system has been low with an average of only 15 – 17% of the people utilising the system, and this average is only 11% in hill areas and 9% in mountain areas due to distance to the health posts and the poor quality of services.

12. NGO growth pattern in Nepal has been rewarding areas which have good facilities and are relatively more developed and penalising others which have fewer facilities and are less developed. In sum, the main beneficiaries of the NGO health sector programs are the middle income class families who constitute the dominant population group in urban areas.

13. Out of total burden of disease (total DALYs lost 7.68 million) in Nepal women lost 53.3 percent DALYs compared to men’s share of 46.7 per cent. Women’s share of the total health budget is estimated at 50 percent but maternal health problems form a very large proportion (11%) of the total disease burden which indicates a severe gender bias in potential needs. Gender difference in susceptibility, exposure and social consequences of ill health argues for an increased share in the health budget to be allocated for women health.

14. In 1996 a NHA analysis revealed that the urban poor were the only urban population segment who had little access to private medical care. The middle class was found to be the primary group using private health facilities, because of availability and accessibility of care. Though LTHP realises the reach of private sector services to be concentrated in urban area it does not consider the women’s economic status, their actual buying capacity and their ability to decide for own health. This concern is exacerbated for vulnerable population strata regarding LTHP, e.g. IP and Dalits.

15. Surveys of client satisfaction in Nepal and international evidence indicate that strategies aiming at increasing utilisation should focus on the following issues; current availability of essential drugs, current staffing, culturally sensitive service set-up at the facilities, training of health personnel with emphasis on dialogue and inclusion of local values, and finally, poor-friendly user fee systems.

16. Non-health factors constraining marginalised groups access, demand and utilisation of health care, such as ethnicity, caste and socio-economic status are not included as indicators in the existing information system. Due to priorities MOH has no plans to include dis-aggregated data on ethnicity, caste and gender in the future HMIS and NHA. If these indicators of constraining non-health factors are not included in the future HMIS and NHA in an operational way the
significance of NHA and HMIS to monitor the social impact of HSS will be significantly inflated.

17. HMGN has not yet listed or classified different Dalit Communities in the Nepal Gazette, though the establishment of the Government National Dalit Commission (NDC) is a very important step forward. The results of the NDC efforts should be utilised and included in monitoring and evaluation of the HSS program.

E. Decentralisation

18. In 1999, the local Self-Governance Act was amended, giving more power to the local government bodies (DDC and VDC) including the authority to protect, preserve and promote IPs language, religion and culture. Since 1999 no evaluations or assessments has been conducted on how the local bodies have managed the role as implementer of government policies towards vulnerable groups, including IP and Dalits. Such evaluations are highly needed in order to make assessments of the local bodies’ priority, ability and willingness to deal with issues such as utilisation, accessibility and participatory planning in local health care. Potentially, a high risk of negligence and social exclusion exist in local management of IP and Dalit programs as indicated by small scale studies.

19. Though the decentralisation process has been ongoing for some time, ownership has not shifted for the majority of the health posts. The country’s devolution of authority so far is not commensurate with the access to resources that would give it meaning. It must be accompanied by stronger institutional arrangements at the local level with technical support from the centre. Especially, technical support to DDC and VDC in order to develop concerted programmes that acts comprehensively to promote MDGs and other public health goals is needed. Additional, widespread lack of understanding what decentralisation means both at central and local level in combination with lack of HR capacity in the MOH to deal with the policy complexities of implementation support needs to be addressed.

20. Many of the newly established rural PHC facilities are undermanned and drug supplies only meet requirements for 3-5 months. The question arises if MOH has allocated its resources too thinly among too many health posts thereby creating an environment of considerable leakage and wastage. Additional, many health facilities in remote areas today appear as empty buildings without much qualitative service and essential drugs to come for. This situation reduces utilization. Fewer health facilities with regular basic quality services might increase efficiency, utilisation and equity. Especially the Far-West and Mid-Western regions are characterised by critical inadequacy of staffing and drug supplies. The situation is in some areas severely exacerbated by the Maoist insurgency.

21. The geographical distribution of life expectancy, income, educational level, poverty and women’s development strongly indicates strong correlations between
geographical distribution of human development and population health status. The unbalanced development status in the regions should be taken into account in the resource formula to be applied in HSS implying relatively higher resource allocations pr. capita to regions with most critical scores in relevant development indicators. Additional, concerted actions directed at geographical “social hot spots” characterised by combinations of low level human development and negative effects of the Maoist insurgency will have a highly supportive effect for the local health sector in delivering effective PHC services for vulnerable population segments.

F. HSS stakeholders: NGO, private sector, donors

22. Historically, lack of viable government NGO policies has had adverse effects on the development of several aspects of NGO performance: 1) Several NGOs are born virtually at the behest of donors, and their programs, priorities and operational modalities have been determined by the payers/financiers, and not always guided by national or local priorities and values. 2) As a consequence of the NGOs being very engrossed in their own activities and absence of government stewardship (central as well as local) duplication of functions and activities leading to unhealthy competition has become a widespread phenomenon. 3) Lack of NGO mapping in conformity with the topographical, economic and social determinants of underdevelopment in Nepal has resulted in a skewed distribution of health services provided by the NGOs.

23. 98 per cent of government physicians have additional private practices. It is believed that this seriously impacts the care accessible for the poor through hospital outpatients departments. The practice of double billing has eroded services provided by the public sector and thereby weakened effective and qualitative provision of health services to the poor population segments.

24. Improving the staffing situation in rural areas is key for meeting the staffing goals set out in the HSS. In order to improve the staffing situation government should develop regulation on partly mandatory arrangements and partly incentive schemes to station qualified health staff in remote areas. Incentives should be developed for private sector to include pro-poor schemes in their service provision and administration. These incentives could be tax, custom and duty exemptions in import of necessary goods and arrangement of financial credit and management support where needed. Additional, incentives as well as mandatory schemes for specialised health professionals to work in remote areas should be developed in close cooperation with the private sector and their organisations.

25. A change in donor attitudes can show to be a necessary precondition for effectively strengthening the overall effect of utilising total resources available in the Nepal health sector in concerted actions under the strategic auspices of government. Basket funding or SWApS approaches are viable strategies to minimize the administrative burden of multi donor projects and thereby provide degrees of freedom on strategic planning and monitoring by the central level.
26. Most donors are fully prepared to enter into a joint planning, programming and closer cooperation with government to achieve the goals of HSS - but not all are prepared for a SWAp approach. Partial programme components should be identified in order to make use of basket funding arrangements as the operational finance mechanism. These programs should be steered by government and targeted at high priority program components to ensure cohesiveness and stewardship regarding key equity issues of HSS, as for example the proposed package to address special needs in the geographical hot spots. In return for giving up their explicit role in running projects EDP will have a voice in the overall direction of sector policy regarding current dialogue about the appropriate policy approaches, monitoring and current evaluation. This will establish a necessary basis for that government can be held well on course on the stated policies in HSS and thereby ensure a higher degree of consistency between enunciated policy and actual implementation than experienced.

G. Traditional health systems
27. There is a strong tendency to view the problem of health care as involving two systems only: western and traditional medicine. Policy decisions based on assumptions that underlie this simplistic view may be unrealistic. An integrated approach with combination of traditional and western medicine has been successfully applied in Sri Lanka. HSS inclusion of traditional health practitioners as mind set change agents for immunization, family planning and other basic preventive and curative services is evident.

H. Community participation: Gender, caste and IP issues
28. Gained experience in the implementation phase of various government and donor projects aimed at IPs show problems in the communication and cooperation phase between district secretaries and local IPO organizations. District secretaries often neglect the specific needs of the IPOs and make their own judgments on behalf of IPOs without consultation.

29. Among women, 71% (compared to 57 percent of men) have little or no involvement in planning village health programmes and 67 per cent of women (compared to 59% of men) are only marginally involved in implementation. A sharper difference for gender is found among the Dalits: 75 per cent either do not participate or participate very little in the planning of village health services, compared to 58 per cent of the advantaged groups. This difference parallels that of implementation where non-participation is 74 per cent for Dalits compared to 56 per cent for the advantaged groups.

30. Representatives for the indigenous population groups (NEFEN) considers language as one the most severe access barriers experienced by indigenous people in accessing and utilising basic health care, - even bigger than barriers connected to economic and resource limitations. The language barrier is therefore perceived as leading to significant under-utilization of public health services.
1. Background

1.1 Introduction
Though Nepal is characterised as a low human development country it is very rich in ethnic diversity. This diverse population comprises more than 75 ethnic, caste, and linguistic groups and these population groups are often located in mountainous terrain with low level of infrastructure due to geographic conditions. These physical conditions often isolate the primarily rural population.

International comparisons show that combined with a low level of human development (Nepal ranks no. 129 in the Human Development Index) Nepal health care system is ranked as one of the most unfair financed health system in the world. Due to a highly patriarchal nature of society Nepal scores very low (121 out of 143 countries) on the Gender Development Index (GDI) reflecting that Nepal is one of few countries in the world where life expectancy has been recorded to be higher for men than for women.

The combination of these comparatively challenging factors constitutes the background for the implementation of the Health Sector Strategy – An Agenda for Change by His Majesty’s Government of Nepal (HMGN), through the Ministry of Health (MOH). The Health Sector Strategy Plan (HSS) has the following intended outputs:

(i) Delivery of the package of Essential Health Care Services (EHCS),
(ii) Decentralization of planning and management,
(iii) Human resource development and management,
(iv) Public private partnerships, and
(v) Sector management.

The issue of equality in access to the health services compounds the impact of the major components of the burden of disease in Nepal. The overall pattern of morbidity in Nepal is dominated by infectious disease, nutritional disorders and maternal and perinatal diseases, all characterising a population on a less developed level in the epidemiological transition. However non-communicable diseases (Group II) are increasing, especially in the urban centres. This development will place a severe future tension on resource allocation decisions between urban and rural health needs, which can result in epidemiological polarization that potentially will aggravate the current health disparities in Nepal.

Several barriers constitute significant deterrents to the poor accessing health care in remote areas. The HSS states that area of residence is the largest equity discrepancy existing for the Nepalese health care system.

Ensuring access for the poor and vulnerable groups to services of the public health system is therefore one of the stated main strategic implications of the reform. This will be done by directing public finance to poor and vulnerable population groups via the EHCS.
Another challenge for the health system - which the HSS intends to address - is coverage of the diverse population. The location of these population groups constitutes a significant barrier to overcome in providing and securing full, standardised and comprehensive health care coverage.

HMGN also intends to discontinue the multiple donor-assisted projects (NGOs and External Development Partners (EDP)) and replace these with a single coherent sector program now under preparation.

Despite a relatively low level of investment in health Nepal has achieved significant progress in central health indicators in the nineties, especially in reducing fertility and improving child survival which are two priority areas in the health sector strategy.

However, critical issues including broad social related health issues remain to be addressed. Difficult topography, inadequate financing, weak public sector capacity and coordination performance in combination with multiple donors each pursuing a separate agenda, constitute avoidable barriers for progress. Additionally, the background conditions relating to the reform implementation environment have been severely strained because of the political instability. During the study period this situation has improved since a ceasefire with related negotiations between HMGN and the Maoists has been established. At present stage the outcome of these initiatives is uncertain but promising.

In order to implement the HSS a number of tasks have been developed supplementary to this study in assisting effective execution of the process: analysis of decentralisation, financial management, institutional and economic assessment.

Mr. Lasse Chr. Nielsen, Danish consultant and public health economist, carried out this report with assistance from Mr. Sundar Man Shrestha. The team worked in close cooperation with the World Bank Office in Nepal in compiling data and literature on the study subject and in hosting a stakeholder workshop. The report includes inputs from field trips in January and February 2003 and comments from stakeholders to the draft report results from a workshop held in February 2003. The consultants wish to thank all officials, donors and individuals for the kind support and valuable information received during the mission.

1.2 Objective
The overall objective is to clarify the magnitude and character of barriers prohibiting disadvantaged groups to access essential health services.

This information will provide the background for a dialogue between the HMGN and the World Bank to achieve a more equitable allocation of resources and eventually improve the health status of the people of Nepal.

The scope of work includes:
A. Compile and synthesize information on impact of health services on society, especially on women, men, children, households, communities, Harijans, and indigenous population, obtaining information from existing studies and surveys and identifying information gaps

B. Conduct a stakeholder mapping and analysis and identify highly vulnerable groups that need special attention

C. Record and map NGOs working in the sector

D. Conduct a quick situation analysis of target population and social response through focus group discussions and rapid assessment to fill the information gaps on vulnerability and its impact

E. Review status of services provided by government, NGOs and community for the vulnerable groups; what are these services and whether they meet the needs of the these groups

F. Assess coordination at the local level among civil administration, local government and NGOs

G. Identify whether the culture/language of the vulnerable groups presents any special obstacles or barriers to their access to and utilization of health services.

1.3 Methodology
The report is based on a desk review of documents compiled and synthesized from Nepal and international sources related to the subjects. The methodology applied is a “top-down analytical process approach”: First, relevant official policy documents on macro-level related to the HSS have been reviewed and synthesized with the purpose of identifying an appropriate analytical framework for assessment and analysis. Second, interviews have been conducted with representatives for key stakeholders on various issues regarding e.g. relevant methods for monitoring, analytical approaches for a social assessment in Nepal, recent social, economic and political changes and their influence on vulnerable groups. See appendix 5 for synthesis of meetings and interviews held during two visits to Kathmandu (3 – 9 January 2003) and (6 – 20 February 2003). Third, results from focus group discussions held in Sipadol village are included as investigation of the micro implementation level according to local receiving abilities, awareness, willingness and readiness to work with the reform priorities and implied issues. The underlying analytical model applied for the assessment is illustrated in the figure at the front page that pictures the various determinants of individual health. Conditions that contribute positively – or work negatively – to the individual’s health status can be viewed as layers of the person’s health environment; from the general environmental conditions to the individual life style factors. Health policies aiming at reducing the society’s disease burden and promoting equity in health can therefore potentially take different entry points with various degrees of effect depending on the root causes at work. This social assessment therefore provide a framework for elucidating the pathways from social context to health outcomes and for identifying potential policy entry points to apply in HSS for meeting the social related health goals, see analysis framework in figure 2, appendix 1.
2. Equity in health and health care – ethical and social dimensions

Inequalities in health exist in every nation on earth. Some variations, e.g. biologically determined differences between men and women, are inevitable. But many inequalities are considered avoidable.

Figure 1. Judging the equity of health outcomes

Healthy inequalities exist largely because people have unequal access to society’s resources, including education, health care, job security and clean air and water – factors society can do something about.

Inequalities that are unfair (that arise from social injustices) and avoidable are considered inequities, see Figure 1 (WHO 1996, 1997a, Peter et al 2001). Health disparities within countries – industrial and developing – can be as great as disparities between the richest and poorest countries in the world. This is reflected in the current situation of Nepal, where life expectancy at birth (LEB) is 59 years but with considerable reported regional disparities. As an example the LEB in Kathmandu Valley is 74.4 years and comparable to that in Denmark (75.5 years) while LEB in Mugu in the Mid-Western Regions is just 37.4 years and comparable to 38 years for Zambia in Africa, which is severely hit by the HIV/AIDS epidemic (HDR 2002; WHO 2000). Neither overall increase in economic growth nor gains in aggregate health indicators are reliable proxies for improvements in equity related development goals (Diederichsen 2001). Nepal is no exception; during the last two and a half decades with an average economic growth rate of 4 per cent, the incidence of poverty has not decreased though distinct poverty alleviation programmes were part of the Seventh Plan and became one of the major objectives the Eight Plan and the sole goal of the Ninth and Tenth Plan (UNDP 2002). The NLSS data suggest that the rural poor suffer from insufficient and sub-standard health services and the relative high cost of medical treatment. The number of people below the poverty line has doubled from 4.7 million in 1976 to 9 million people now. New pro-poor and development policies therefore call strongly for elaborate reflections and evaluations of former policies in order to guide future policies (Panday 2000). Effective, efficient and equitable delivery of basic social services matters most to the poor, and hurts them most, when interventions fails or is lacking.

Precise definitions of equity are not available. Consensus on equity has eluded philosophers for at least 2500 years (WHO 1997a). Analysis of equity in health inevitably depends on many contentious issues, which can be resolved in very different ways that are thoroughly open to discussion. In other words; when applying the equity term as done in the HSS it necessarily implicates dialogue to make policies with equity goals operational and effective.
“Equity” means fairness and the term has a moral and ethical dimension. It refers to differences which are unnecessary and avoidable, but in addition are considered unfair and unjust. What is avoidable will vary with potentially available resources; people may disagree about what resources are potentially available at a given time (Whitehead 1990). Since notions of what is fair or just may vary among different societies each society must achieve a sufficient level of consensus about what equity means for that society in order to take effective action to reduce inequities (WHO 1996).

From the various official documents reviewed and meetings held with potential health reform stakeholders it is revealed that MOH had made no consultation with relevant organisations and institutions1 representing vulnerable sub-population groups from civil society in order to discuss the equity and participation components in HSS (MOH 2002ab, meeting summaries appendix 5). Ignoring dialogue with civil society organisation representing the population segments intended to be the main beneficiaries of policy reform activities constitute a serious caveat in reform preparation, that need to be dealt with in near future. Forums for these consultations should therefore be established as proposed in the action plan (AP) in appendix 7. Dialogue and participation should be the leading principles through all levels of HSS implementation starting from central level and MOH down to the community and sub-health post.

Often health care is financed and delivered by a mixture of systems and in the Nepal health system there are traces of both egalitarian and libertarian ideologies2. By launching the National Health Policy of 1991 in which the WHO “Health for all by the year 2000” is targeted HMGN’s priority on basic primary health care provision free of charge reflects egalitarian views but on the other hand the significant private share of total expenditure on health (77 per cent) gives the current health system a dominant libertarian characteristic. Nevertheless, The National Health Policy of 1991 marked a decisive shift

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1 As examples of potential bodies to consult can be mentioned: Representing the voice of indigenous people: Nepal Federation of Nationalities (NEFEN), representing the voice of women Dalits: Feminist Dalit Organisation (FEDO).

2 Two theories have tended to dominate discussions about equity, the libertarian versus the egalitarian view (DI 2000). The libertarian view holds that attention should be focused on the extent to which people are free to purchase the health care they want. State involvement should be minimal and limited to providing a minimum standard of care for the poor. Egalitarians focus on ensuring equality in access the health care and tend to favour a strong state sector role in the financing and provision of health care (DI 2000).
from an emphasis of health policy from curative to preventive service from a vertical programme approach to an integrated approach and from centralization to decentralisation, and by emphasising PHC and outreach health care free of charge HSS follows this strategic pro-poor egalitarian line thereby mitigating the negative health externalities emanating from the dominating libertarian traits of the government health sector (ADB 1996, MOH 2002B).

Remedies for health inequities must therefore come not only from the health sector but also from broad social policies that addresses potential health gaps related to equity e.g. by distribution of income (Diderichsen et al 2001, DI 2000):

- Gaps between socioeconomic groups
- Gaps between geographical groups
- Gender gaps
- Gaps between racial/ethnic groups
- Gaps between age groups

Establishing a consensus on societal values for policy may seem a daunting task, but through international agreements Nepal have already committed itself to health and health care policies with common equity objectives.

The HSS has adopted 5 MDG targets in the reform plan, and they are all characterized to be avoidable mainly to primary prevention intervention schemes addressing social root causes of ill-health (Rutstein 1976, Bjerregaard 1990, MOH 2002B). Application of a multi-sectoral framework for analysis of all relevant bottlenecks that have to be overcome to meet the MDGs are therefore apparently relevant when identifying appropriate policies that can contribute to the health MDGs if undertaken alongside health system interventions. Since people do not live their lives sector-wise health programmes must be developed in a comprehensive way to reach maximum effect (Gartoula, appendix 5).

2.1 Policy responses to health disparities

Figure 2, (appendix 1) reflects the social determinants framework that identifies 4 broad conceptual mechanisms that generates health inequalities. For each mechanism the possible policy entry points for interventions are identified. Below the 4 mechanisms are reviewed according to the Nepal health policy context.

2.1.1 Mechanism of social stratification

An important starting point for policies to reduce inequities in health is recognizing the importance of the social context and the hierarchical effects of social position (Diderichsen et al 2001).
The forces of social stratification, (see figure 2 appendix 1) is a mechanism leading to a separation of people into different social positions and, crucially, influence how wide the gulf is between these different sections of society. It is possible to influence the process of social stratification through economic, social and education policies that decrease (or increase) the divisions between different groups in society and also influence the ease with which social mobility can take place.

Although overt public forms of discrimination may be less visible in interactions of the urban elite, IPs and Dalits continue to face economic, educational, health and social disadvantages at all levels of society (Gurung 2002). Equity issues related to mechanisms of social stratification as e.g. social exclusion are considered a main source of equity discrepancy as compared to area of residence, since mechanisms of social stratification often is conditioning the area of residence implying more time and higher transportation cost to reach health services for the deprived (Sob appendix 5).

Although there has been cultural and religious cross influence between the two major racial groups found in Nepal, “Caucasoids” and “Mongoloids”, both cultural and religious systems of the two racial groups retain varying degrees of distinctness (Gurung 2002). Mongoloid groups, such as Magar, Tamang, Kiranti, Gurung tend to follow mostly Buddhism and animism, while most of the Caucasoid groups generally follow Hinduism. Hindus have “vertical” (hierarchical) social structure based on the idea of ritual purity. At the apex of the system are the Brahmins or Bahuns and at the bottom are the Dalits whose ritual impurity rendered them “untouchable” to the high caste. All Hindus are therefore members of some caste group (Jat), whether low or high. In contrast, Mongoloid groups tend to have more horizontal social structures and are recognised as Indigenous Nationalities (Janajatis) or Indigenous People (IP). In this study IP will be applied for this group.

Caste related biases have confined the so-called “untouchable castes” to the lowest-paying menial jobs, restricted or blocked their access to common resources, and limited or denied their access to government and public services (UNDP 2002). Some ethnic minorities and indigenous groups also face similar discrimination. Women face discrimination in almost all aspects of life.

Dominance in the power structure on the basis of the caste hierarchy is another aspect having an effect on the mechanism of social stratification. All but 8.8% of the individuals occupying the top political, bureaucratic and executive positions in Nepal in 1999 were recruited from high caste Hindu groups (92.2%) (Gurung 2002). People with IP and Dalit identity held respectively 8.4% and 0.3% of total top positions with potential influence on policy enunciation, prioritisation of resource allocation and not least implementation of governmental programs. Political marginalisation of IPs and Dalits based on social discrimination is therefore considered a main reason why these groups are deprived of economic, educational and overall social well-being (Gurung 2002).
The combination of poverty, the low status of women in the overall social structure, the household drudgery, the culture of son preference, legal age at marriage, women's low level of education and low nutritional status, have been found to trigger the low health status of women in Nepal and constituting a significant access barrier in rural women’s utilisation of publicly provided health care services due to lack of decision making power at household level (DHS 2002, MWCSW 2002, NCPWH 2001, WB 2001A).

As can be seen from table 1 below adult literacy and income are associated positively with one’s position in the social hierarchy. The Human Development Index (HDI) - a composite index of education, health (life expectancy at birth (LEB)), and income - is an indicator of overall well-being of the population. The HDI ranking in Nepal shows a close association with the caste hierarchy (Gurung 2002). Brahmans, Newars, and Chhetris are well above the national average while IPs (excluding Newars), Dalits and Muslims are below. Terai castes have lower literacy and income than the national average, however, their HDI rank is higher than that of the IPs.

Table 1. Human development indicators, 1996, for selected social, religious and ethnic groups.

<table>
<thead>
<tr>
<th>Social Group</th>
<th>Adult literacy rate</th>
<th>Per capita Income (NR)</th>
<th>Income Index</th>
<th>HDI Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caste group</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hill Bahun</td>
<td>58.0</td>
<td>9,921</td>
<td>0.237</td>
<td>0.441</td>
</tr>
<tr>
<td>Hill Chetri</td>
<td>42.0</td>
<td>7,744</td>
<td>0.181</td>
<td>0.348</td>
</tr>
<tr>
<td>Terai Castes</td>
<td>27.5</td>
<td>6,911</td>
<td>0.160</td>
<td>0.313</td>
</tr>
<tr>
<td>Artisan Castes (Dalits)</td>
<td>23.8</td>
<td>4,940</td>
<td>0.110</td>
<td>0.239</td>
</tr>
<tr>
<td>Language group</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Newar</td>
<td>54.8</td>
<td>11,953</td>
<td>0.289</td>
<td>0.457</td>
</tr>
<tr>
<td>Hill Ethnics (IP)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gurung, Limbu, Magar, Rai, Sherpa</td>
<td>35.2</td>
<td>6,603</td>
<td>0.152</td>
<td>0.299</td>
</tr>
<tr>
<td>Religious group</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Muslim</td>
<td>22.1</td>
<td>6,336</td>
<td>0.145</td>
<td>0.239</td>
</tr>
<tr>
<td>Others</td>
<td>27.6</td>
<td>7,312</td>
<td>0.170</td>
<td>0.295</td>
</tr>
<tr>
<td>Nepal</td>
<td>36.7</td>
<td>7,673</td>
<td>0.179</td>
<td>0.325</td>
</tr>
</tbody>
</table>

Source: Gurung 2002.

Table 2 shows disparities in various health outcome indicators when stratifying by consumption quintile. Households with highest consumption levels have the lowest incidence of stunting among children under 3 years (30%) while nearly two-thirds (59%) of all children from households with the lowest consumption levels suffer from stunting. Under five year mortality rate (U5MR) is two times higher in households with lowest consumption than households with highest consumption which is almost identical but less pronounced when stratifying the Infant Mortality Rate (IMR) by consumption group.

3 Consumption remains a more convincing indicator of well-being than income for two reasons: First, the various components of consumption are usually measured more accurately than certain components of income. Second, consumption may be a better proxy for long-term living standards because it may reflect the household’s ability to smooth out income fluctuations (NLSS 1997).
Table 2. Disparities in health outcome indicators by consumption quintile.

| Consumption Group | Stunting among children under 3 years (%) | Under five year mortality rate (U5MR) | Infant Mortality Rate  

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>(IMR)</th>
<th>Rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highest</td>
<td>31.8</td>
<td>82.7</td>
<td>63.9</td>
</tr>
<tr>
<td>Fourth</td>
<td>43.0</td>
<td>118.4</td>
<td>84.7</td>
</tr>
<tr>
<td>Third</td>
<td>48.1</td>
<td>154.8</td>
<td>103.6</td>
</tr>
<tr>
<td>Second</td>
<td>51.7</td>
<td>163.8</td>
<td>107.2</td>
</tr>
<tr>
<td>Lowest (poorest)</td>
<td>59.0</td>
<td>156.3</td>
<td>96.3</td>
</tr>
</tbody>
</table>

Source: UNDP 2002

In table 3 disparities in three central indicators for health outcome is presented stratified by caste/ethnic group. The indicators are LEB, IMR and U5MR. Data reveals significant disparities in health outcome between the various caste/ethnic groups. For example the difference in life expectancy between Brahmins and occupational caste is 10.6 years, and especially newborns of Brahmins have a much higher probability of survival (IMF: 52.5) than infants born by occupational caste population segments (IMF: 116.5). The U5MR – which is one of 5 MDG targets adopted in the HSS – indicates the greatest proportional disparities among the various caste/ethnic groups. The probability of dying for a 5 year child from an occupational caste is nearly three times as high as for a 5 year old Brahmin child.

Table 3. Disparities in health outcome indicators by caste/ethnic group. 1996.

<table>
<thead>
<tr>
<th>Caste/ethnic group</th>
<th>Life expectancy at birth (years)</th>
<th>Infant Mortality Rate</th>
<th>Under 5 year mortality Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occupational caste</td>
<td>50.8</td>
<td>116.5</td>
<td>171.2</td>
</tr>
<tr>
<td>Muslim</td>
<td>52.2</td>
<td>108.6</td>
<td>158.3</td>
</tr>
<tr>
<td>Yadav/Ahir</td>
<td>54.2</td>
<td>98.5</td>
<td>142.0</td>
</tr>
<tr>
<td>Tamang</td>
<td>54.2</td>
<td>98.0</td>
<td>141.2</td>
</tr>
<tr>
<td>Magar</td>
<td>54.9</td>
<td>94.7</td>
<td>135.9</td>
</tr>
<tr>
<td>Limbu</td>
<td>55.2</td>
<td>93.2</td>
<td>133.5</td>
</tr>
<tr>
<td>Rai</td>
<td>55.3</td>
<td>92.9</td>
<td>133.0</td>
</tr>
<tr>
<td>Gurung</td>
<td>56.1</td>
<td>88.6</td>
<td>126.3</td>
</tr>
<tr>
<td>Chhetri</td>
<td>58.4</td>
<td>77.8</td>
<td>109.1</td>
</tr>
<tr>
<td>Tharu</td>
<td>58.7</td>
<td>76.0</td>
<td>106.4</td>
</tr>
<tr>
<td>Brahmin</td>
<td>61.4</td>
<td>52.5</td>
<td>69.0</td>
</tr>
<tr>
<td>Newar</td>
<td>63.2</td>
<td>56.0</td>
<td>74.9</td>
</tr>
</tbody>
</table>

Source: UNDP 2002.

Taking into account the overall social structure of society is therefore key in formulating health interventions aiming at achieving aggregate health goals, like the MDG target 5 in HSS; reducing the under-five mortality rate by two-thirds between (1990 and 2015). Targeting sub-population groups sharing the following characteristics will therefore have the greatest health impact on IMR, U5MR and LEB: Occupational/Artist castes (Dalits),
ethnic minorities (hill IPs) and Muslims with lowest indicators of human development (HDI) living in households with the lowest consumption levels. According to relative levels of health outcomes these population segments indicate combinations lowest beneficial rates from public social services (education and health), the largest avoidable disease burden to reduce and the greatest potential health needs.

HMGN has not yet listed or classified different Dalit Communities in the Nepal Gazette, though the establishment of the Government National Dalit Commission (NDC) is a very important step forward. The NDC are currently working on definitions/classifications which will be operational for HMGN social and health programs. Only by identifying the Dalit communities, it will be possible for such communities to receive social and health programs, services and facilities provided by HMGN (Bhattachan 2002). Since classification and identification of Dalit households and communities is conditional for monitoring stratified utilisation rates of any social service provided by the government as well stratified outcome data for the vulnerable groups are not registered and published officially. The results of the NDC efforts are therefore central in filling this information gap and should be utilised and included in targeted HSS interventions.

Potential policy approaches related to health outcomes of social stratification: Two general approaches can be considered. First is the promotion of policies that diminish social inequalities (Entry Point A, Figure 2 appendix 1). Second are social and economic policies mitigating the effects on social stratification (Diderichsen et al 2001). Poverty Reduction Strategies are potentially effective policy instruments to influence systemic forces of social stratification. Per se, poverty reduction acts as highly potent promoting health and equity policy tool through decreasing exposures and vulnerability of marginalised and poor population segments to a majority of the social risk factors. Poverty reduction and the delivering of the MDGs are set out in the HMGNs Poverty Reduction Strategy Paper (PRSP) and potential synergies exist in interlinking health strategies into concerted actions with other sectors, e.g. education, water and sanitation and infrastructure thereby enhancing the effect in achieving the MDG.

Comprehensive empowerment policies aimed at diminishing overall gender disparities and influencing the position of women relative to men will therefore act positively on women’s health status. The potential effect of such policies will have marginally stronger health benefit for women from lower social positions due to a lower health status found e.g. among Dalits compared to non-Dalits (Koirala 2002, MWCSW 2002).

Finally, it is widely acknowledged among Nepal health experts that policy entry points must aim at addressing root causes related to mechanisms of social stratification and their distinctive set of health problems in order to effectively reduce the disease burden (Gartoula, Robertson, appendix 5, Pigg 1997).

2.1.2 Mechanism of differential exposure
A crucial feature of the linkage between social inequities and health is the mechanism differential exposure (II) and health-damaging conditions (see figure 2 appendix 1): Each social position encounters specific patterns of health risk. Exposures increasing with
decreasing social position contribute to the observed gradient in health across the social spectrum. Compounding this situation is a tendency for health-damaging exposures to cluster, e.g. illiteracy, poverty and polluted water as can be seen from tables 1-3 above.

In particular policies aimed at providing greater social, educational and economic opportunities to poor women is likely to have positive health outcomes as experienced in Bangladesh and Kerala in India (Bhuiya et al 2001, Östlin et al 2001). As can be seen in figure 3 the under-5-year mortality rates for children of uneducated mothers in Nepal is 121 per 1000 births, 64 per cent higher than for children of mothers who have some primary education and nearly double that of children of mothers who have some secondary education (DHS 2002). Compared with children of mothers with SLC and above children of uneducated mothers have 8 times higher risk of dying. Reducing one key social risk exposure - such as illiteracy - might decrease the vulnerability of women significantly to the effects of other health risks (WHO 1998, Östlin et al 2001). As shown in table 1 low literacy rates were recorded among Dalits, IPs and Muslims making these groups particularly vulnerable to child mortality. It has further been found that contrary to other population groups in Nepal Dalit women have not experienced the same rate of progress - or progress at all - in indicators like use of family planning devices, girls attending schools and increases in life expectancy in recent years (Koirala 2002).

Figure 3. Mother’s education and children under-5 year mortality rate

<table>
<thead>
<tr>
<th>Mothers educational background</th>
<th>Child mortality rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>No education</td>
<td></td>
</tr>
<tr>
<td>Primary</td>
<td></td>
</tr>
<tr>
<td>Some secondary</td>
<td></td>
</tr>
<tr>
<td>SLC and above</td>
<td></td>
</tr>
</tbody>
</table>


Increased education of women and their husbands was found to be positively correlated with increased utilisation of all health services in a World Bank study (WB 2001A). The same investigation revealed that lack of knowledge about illnesses contributed to rural women’s delay in seeking care also a factor found highly correlated with literacy rates and educational level in other developing countries (WB 2002). Literacy is key to ensure the basis for support to self care by information seeking at household level and provide an important factor in reducing the knowledge asymmetry between supplier and purchaser of drugs (Soucat 2002).
Potential policy approaches related to health outcomes of mechanisms of differential exposure. Beyond efforts to alter the social stratification process, policy makers might focus specifically on reducing the excess exposures to health hazards of those occupying lower social positions (Entry point B, Figure 2). Alternatively, a policy targeting the diminishing of one key exposure (entry point C) will potentially have effect when interacting exposures are diminished or relative social conditions improve significantly (Diderichsen et al 2001).

Comprehensive policies targeting illiteracy among women in deprived groups will significantly mitigate differential health exposures faced by these groups. In order to meet the MDG targets 5 and 6 interventions through this policy entry point will act strongly to reduce the related disease burden of targets 5 and 6 via health impacts of increased empowerment, awareness of utilising health services and act highly conducive for raising demands for social services.

In HSS a proposed Behaviour Change and Communication (BCC) program will be established to support the EHCS especially on the four priority areas, but also address alcohol and tobacco abuse. Smoking is very common among men and women in Nepal. Around 60-85% of the population over the age of 19 are smokers and the number of smokers in the hill and mountain regions - dominated by IP population groups - is higher than the national average (NCPWHD 2001). Likewise alcohol consumption in some ethnic groups in the rural population is more acceptable and lately become a symbol of higher status, and women and children whose family members drink excessively often suffer from domestic violence, stress and depression (NCPWHD 2001). This information indicates that IPs and Dalits face a comparatively high risk exposure from alcohol and tobacco abuse why the BCC on these issues should especially target these groups. IP also face a health risk due to low educational level why alternative communication approaches should be considered. Since health needs are diverse and differ by locality due to gender, socio-cultural, ethnic and ecological diversity variants of BCCs sensitive to district specific populations should be developed (WHO 1999, Cohen 1999, WB 2001A). Further, experience show that locally produced health information materials has the highest effect and opportunities at the local level should be encouraged and financially covered to provide or create these local intervention approaches, which could also include street theatre (Ghimire, appendix 5). In order to be more targeted at differential exposures to health-damaging conditions - and thereby increase intervention effectiveness - relative to the numerous ethnic and other population groups in Nepal adoption of a blanket approach in both the EHCS and the BCC should therefore be avoided in the HSS. An IP and Dalit sensitive approach to the BCC is suggested in the action plan, see appendix 7.

2.1.3. Mechanism of differential susceptibility
A third mechanism of differential susceptibility (III), [see figure 2, appendix 1] may sometimes come into play if two or more exposures act synergistically; that is they interact to produce an effect on health that is greater than the sum of their separate effects. Typically the health care equity literature argues for care according to need (Diderichsen 2001). One critical issue therefore is the definition of need. If need is defined with no sensitivity to the special needs of disadvantaged populations, it is likely that the implied lack of efficiency in the services provided will accentuate inequalities. Without special consideration, they may even be prone to prolonged disability and more complications (Diderichsen 2001, WB 2001E).

By addressing maternal health as one of the key priorities in HSS a significant step towards policies aimed at mitigating mechanisms of differential health susceptibility has been taking. However, in order to increase target focus policy enunciation should take a further step and adopt different policy approaches adapted to the specific needs of the various sub-populations of Nepal on a comprehensive basis (Ghimire, appendix 5). Mothers in Dalit and IP communities with no education and low literacy rates are the population groups most susceptible to risk factors connected to reproductive health. Therefore this group should become a core strategic target group in the HSS. Women in vulnerable sub-population groups should be identified in order to address and mitigate their multi-susceptibility of e.g. gender discrimination at household level, social stratification at community level and poverty by forces of macro-economic development.

At the national level in Nepal health policies and programs historically did not account for differences based on gender which creates various barriers that limit women’s demand (MWCSW 2002, WB 2001A). On the other hand policies aiming at promoting equity issues and gender mainstreaming can potentially collide with prevailing diversity in needs locally, why participatory planning becomes essential in formulation policies adequately addressing local needs (UNDP 2002, Bennett appendix 5). It is for example argued, that generic plans are often found to be of limited use in comparison with place and context-specific birth activism. To focus, for example, on the role played by the over 13,000 trained traditional birth attendants (TBA) is to overlook the fact that the main sources of maternal and child health problems are not located in the mismanagement of obstetrical crisis but in the lack of economic and social leverage that childbearing women have over their lives (Pigg 1997). Empowerment and health training programs therefore comes to the fore as strategic HSS tools. In designing these programs multicultural, multilingual and multiethnic representation and participation are considered essential in order to sensitize the current health care system to a multiethnic context (Limbu appendix 5). In its overall stewardship of HSS MOH should ensure that participation of Dalit and IP organizations are included in the design of training and empowerment programs.
It is widely acknowledged by evidence based facts that infrastructure interventions (water, sanitation, energy, transport and housing) are key inputs into the “production functions” for poverty, education, health and gender MDGs. Holistic and comprehensive approaches are therefore considered essential for effective decentralization of health care services in the context of Nepal (Chand et. al 2002; Gartoula appendix 5).

Today only 45% of rural women have access to basic health care although HMGN has reported 70% coverage in progress reporting on the Ninth Plan. Policy approaches aiming at improving infrastructure and transportation therefore comes to the fore. The critical delays that occur during child delivery for rural women in remote areas of Nepal can potentially be improved by securing better transportation facilities and infrastructure thereby mitigating differential susceptibility due to area of residence (WB 2001A).

However, the strategies applied to provide these women basic health care in a way that would transfer their objective needs into demand driven health seeking behaviour seems to be not well understood. More than one-fifth of the households in the rural areas prefer the traditional health care system and only 8 per cent of those seeking health care were content with the services they received (UNDP 2002). In order to sensitise the HSS more to the diversified target population consultation with civil society organisations representing marginalised groups on issues concerning health seeking behaviour - both a central and local levels - appear therefore highly relevant in order to identify approaches leading to increased utilisation of public health care services. As supplement to dialogue and consultation approaches household analysis and fields exercises are considered important preconditions for efficient policy implementation on all levels (Ghimire appendix 5).

**Potential policy approaches related to health outcomes of mechanisms of differential susceptibility.** Policy options must demand evidence for the range of interventions - disease specific and related to the broader social environment - that will reduce the likelihood of unequal consequences of ill health. Equity in resource allocation is not just a question of matching health care resources to need but also a question of whether they can be allocated specifically to reduce differentials in health outcomes (Diderichsen et al 2001).

Although access to health institutions has improved the quality of services leaves much to be desired. A 1998 survey found that household members seeking health care in government health institutions found lack of medicine, poor condition of facilities, bad attitude of staff and lack of staff as main problems in government health institutions in

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**Public opinion on government-run health services.**

"The doctor does not examine seriously in hospital, but the same doctor is very serious when I go to his private clinic". - *A literate Brahmin woman, Morang*

“Our health post is good-for-nothing. The building is nice, but we go to the health center of Bahuni VDC". - *An illiterate blacksmith woman, Morang*

“The health workers are usually unavailable. If they are present, instead of providing medicines, they prescribe medicines to be purchased from outside”.

* - *A Yadav woman, Siraha*

“Health post staff do not usually distribute medicines. But if we offer money, they do”.

* - *A Mahato woman, Siraha. (UNDP*
descending order (see table 4). Health workers tended to attribute the problems largely to shortcomings in medical supply, then staff inadequacies and poor facilities and finally lack of community support (UNDP 2002).

Table 4. Opinion on problems of government health institutions

<table>
<thead>
<tr>
<th>Problems</th>
<th>Households %</th>
<th>Health workers %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of medicine</td>
<td>59</td>
<td>84</td>
</tr>
<tr>
<td>Poor condition of facilities</td>
<td>40</td>
<td>61</td>
</tr>
<tr>
<td>Bad attitude of staff</td>
<td>35</td>
<td>-</td>
</tr>
<tr>
<td>Lack of staff</td>
<td>11</td>
<td>64</td>
</tr>
<tr>
<td>Lack of community support</td>
<td>-</td>
<td>13</td>
</tr>
</tbody>
</table>

Source: UNDP 2002

Latest international evidence confirms that current availability of essential drugs is a key factor for utilisation of health facilities especially in rural areas (Irwin 2003). The drugs distributed in the sub-health posts, health posts and primary health centres only meet requirements for 3-5 months though current drug supply are considered a key factor in clients incentives to attend rural health facilities (Shrestha, appendix 5).

The health care strategies to reach poor rural women are therefore not only a question of providing services to win over the women to demand the services. To generate the demand for health services will therefore imply the introduction of a multifaceted strategic approach implying (Soucat 2002; Alban 2003):

- that essential drugs are available all the time to fit the need of the catchments area
- including local women in every part of the processes at the health facility, including the choice of staff to ensure that the women are treated with respect, the services provided are relevant to them and that the facility is held accountable to the community it serves
- training of the health personnel to man the post to comply with the health needs and demands of the women
- provide infrastructure to physically ensure ability to reach the health facility and reducing other costs such as transport
- creating an enabling environment for the women according to traditions, culture and local circumstances, e.g. by training staff and develop manual/guidelines for NGO/MOH employees working in IP locations
- providing a poor friendly user fee system

See Action Plan in appendix 7 for activities related to the issues above.

2.1.4. Mechanism of differential social and economic consequences

Although social disadvantage is likely to lead to ill health, it is also important to point out that ill health through its differential social (and economic) outcomes (Irwin 2003). A study of China's poor rural areas - covering 150 million people - indicated that high medical expenses had become the primary cause of poverty. 18 per cent of the households that used any health services in 1993 had incurred health expenditures that exceeded their total household income. 47 per cent of the medically indebted households reported having suffered from hunger. The interaction between health and income could potentially start a vicious circle of illness, poverty.
economic) consequences (IV) may accentuate social stratification. In countries like Nepal without social safety nets, adult illness and death are often associated with the loss of household income-generating capacity.

These costs of ill health frequently precipitate a downward spiral into poverty and further risks of illness for an entire household.

In the Nepal Living Standards Survey Report from 1996 adequacy of foods and services – including health care – are reported. Respondents were asked to give their opinion about their consumption levels for various items by indicating if it was less than adequate, just adequate or more than adequate. The term "adequate" in the survey meant neither more nor less than what the respondent considers consumption needs of the family (NLSS 1997).

As can be seen from table 5 a clear difference exists between urban and rural Nepal according to households reporting on adequacy in consumption of health care services. Kathmandu has only 4

Table 5. Adequacy of health care services, urban and rural areas (percentage distribution)

<table>
<thead>
<tr>
<th>Adequacy level</th>
<th>Less than adequate</th>
<th>Just adequate</th>
<th>More than adequate</th>
<th>Not applicable</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>24.08</td>
<td>74.91</td>
<td>0.39</td>
<td>0.62</td>
<td>100.00</td>
</tr>
<tr>
<td>Kathmandu</td>
<td>4.44</td>
<td>95.56</td>
<td>0.00</td>
<td>0.00</td>
<td>100.00</td>
</tr>
<tr>
<td>Other urban</td>
<td>37.30</td>
<td>61.01</td>
<td>0.66</td>
<td>1.03</td>
<td>100.00</td>
</tr>
<tr>
<td>Rural</td>
<td>61.42</td>
<td>37.87</td>
<td>0.09</td>
<td>0.62</td>
<td>100.00</td>
</tr>
<tr>
<td>Western hill/mountain</td>
<td>67.28</td>
<td>32.57</td>
<td>0.14</td>
<td>0.00</td>
<td>100.00</td>
</tr>
<tr>
<td>Eastern hill/mountain</td>
<td>60.62</td>
<td>38.88</td>
<td>0.21</td>
<td>0.30</td>
<td>100.00</td>
</tr>
<tr>
<td>Western Terai</td>
<td>62.36</td>
<td>37.34</td>
<td>0.00</td>
<td>0.30</td>
<td>100.00</td>
</tr>
<tr>
<td>Eastern Terai</td>
<td>56.26</td>
<td>42.14</td>
<td>0.00</td>
<td>1.60</td>
<td>100.00</td>
</tr>
</tbody>
</table>


percent of the households indicating less than adequate health care and is comparatively low in contrast to Western hill/mountain where households reports nearly 70 percent inadequate health consumption relative to needs. The significant rural-urban disparity in unmet health care needs is indicative of social exclusion related to developmental, structural and geographical background variables. Compared with similar reporting on items like food consumption, housing, clothing, schooling and total income the same country profile of unmet needs appears. According to the last item, total income, 77 percent of the households in Western hill/mountain reports less than adequate total income compared to 35 percent in Kathmandu.

According to NLSS household expenditures gaining access to publicly provided health services vary substantially by income group, ranging from NR 470 a year for the poorest quarter to NR 5016 for the wealthiest quarter of population. Likewise regression results
have shown along with distance to a health facility, household economic status is a significant determinant of whether or not an individual seeks treatment.

These indications strongly suggest that the poor do not have the resources required to purchase needed health care or even face a barrier in ability to pay the travel expenses necessary to access care.

In a World Bank study it was found that the majority of the rural women had to consult family members – usually the head of the household/ and or whoever controlled the cash/family finances before seeking care (WB 2001A). Approximately half (51.2 percent) of women consulted their husbands, 44.5 percent consulted family members such as their mother in-law and 3 percent consulted neighbours and friends. Women who earned their own money through self-employment or micro credit arrangements sometimes used the limited amount of money they earned to pay for health care, but most women would only seek care on their own accord if services were free of charge. As prime care taker of household children women’s lack of decision making and inability to pay the low status of women also affects children (NCPWH 2001).

Generally, the majority of households in the rural areas are in a vulnerable position to be potentially captured by the vicious development circle of illness, poverty, and further illness. Because of very low ability to pay relative to health care needs the effect of the downward spiral constitutes potentially one of the main explanatory factors behind the wide geographical disparities found in health outcome in Nepal today. In combination with low scores in other development indicators many households in the rural areas - and especially households in the Western hill/mountain area - appear to be most vulnerable to the social risk of being exposed to a mainly libertarian health care system extensively based on 70 – 75 private household expenditures in the form of out-of pocket payment.

Potential policy approaches related to health outcomes of mechanisms of differential social consequences: In systems without insurance or equitable access to it, unreasonably high health-care costs associated with treatment for illness are a primary cause of household asset depletion. Importantly, each of these stratifying mechanisms may be countered by specific policies, outlined as policy entry points A to D in figure 2 appendix 1(Diderichsen et al 2001). According to ability to pay women are first and foremost in a vulnerable position when it comes to decision making at household level in all population strata. In general, policies should be pursued to improve status of women via empowerment approaches. Highly potent approaches include education and credit/income generating programs, like the Production Credit for Rural Women (PCRW) program. However, women from marginalised and deprived communities - mainly IP and Dalit communities in Western mountain, hill and terai - are found most vulnerable to costs related to ill health that could start a downward spiral into further poverty and increased risks of illness for the entire household. In order to support health seeking behaviour for these population segments initiatives to raise their overall status as well as introduction of income protection measures should be pursued, not least concerning design of future health insurance schemes. The prime goal to pursue politically will be
that women and men from highly marginalised groups should be ensured pay exemption when seeking health care as set out in the HSS.

See Action Plan appendix 7 on expert consultation in identifying appropriate models for future health insurance schemes and geographical social hot spot programme.

2.2 The HSS, PRSP and inter-sectoral collaboration

Meeting the MDGs as set out in the HMGNs Poverty Reduction Strategy Paper (PRSP) requires the support and collaboration of other sectors. Recent studies have shown that the effectiveness of social services increases when appropriate infrastructure supports them (WB 2001B). It is the intention stated in HSS that MOH will ensure that appropriate inter-sectoral coordination takes place, though HSS does not reveal how health strategies and poverty alleviation strategies are interlinked or should cooperate (Alban 2003). The PRSP sees improvements in health status as a reduction in poverty per se but it does not line out how different sector strategies complement general poverty reduction strategies such as empowerment of women and job creation. Since the Planning Commission regards the PRSP as a dynamic process these issues should be raised in the future process. Only in meeting the MDG targets 1, 5, 6, 7 and 8 intended coordination approaches are mentioned vaguely in HSS. It is strongly advised in literature and empirical studies that targeting root causes of ill health by inter-sectoral and holistic intervention schemes are highly relevant in the Nepal context due to barriers that can only be removed by assistance from sectors outside the health care sector and via community participation (Shah 2003; Panday 2000; Maskay 1998, Gartoula 1998).

However, international experience shows that multi-sectoral projects do not per se guarantee a holistic approach. Achieving outcomes and welfare impacts related to the MDGs requires, inter alia, ensuring an adequate and sustained supply of complementary inputs (e.g. teachers in schools, drugs in health facilities), and related investments (e.g., water supply in health clinics) (WB 2002). In Nepal experience shows when common programs are to be implemented line ministries often pursue their own narrow agendas mainly because of resource scarcities (Mathema, appendix 5). The PRSP is sector oriented and no concerted actions or coordination strategies across the poverty reduction strategies are proposed. If not appropriately addressed during the implementation period the country will not be able to harvest the full benefit of the resources spent as well as potential gains in income and health equality (Alban 2003).
The indications of historically weak inter-government coordination performance need to be addressed comprehensively to optimize the potential synergy effects between poverty alleviation and equity promoting efforts via the parallel health care reform and PRSP implementation. HSS should adopt approaches to package multi-sectoral interventions around the key health goals and ensure that health goals are met adequately by incorporating intermediate targets and goals (Chand et al 2002, Gartoula appendix 5). A guide for VDCs/DDCs on standard packages of potential multi-sectoral intervention schemes based on international evidence in meeting the MDGs could be developed alongside the implementation of the EHCS and the BCC, see Action Plan appendix 7.

3. Analysis of social impact and equity content in recent Nepal health policies

Health care financing is a means to an end. Concerning the social impact and equity of financing and expenditures, equal concern should be devoted to how a financing method is improving equity of health outcomes, social impact and general well-being (Hsiao et al 2001). Health care financing schemes are often designed to couple the source of funding with the party eligible to receive benefits. How effectively funds can be transformed into efficacious services depends, in part, on how the health delivery system is organized. The organisation of national health care systems is a product of complex components including national history, political culture, geography and etc., and the interactions of these factors determine the given method of financial mobilization (Field 1989). Each alternative has significant implications as to how efficient the funds are transformed into services and how services transform to social impact. While these logical relationships are clear, it is difficult to empirically study the impact of different combinations of these components of financing and equity (Hsiao et al 2001). An attempt has been made by WHO to measure the fairness of financial contribution to health systems for all WHO member states (WHO 2000). Most countries - particularly high income countries - are close to perfect equality, but great inequality characterises a few countries in the world in which nearly all health spending is out-of-pocket, notably China, Viet Nam and Nepal, where the latter is ranked no 186 out of 191 countries according to equality in financing.

Three components play a direct role in determining outcome of direct availability and distribution of health care:

- Method of financing
- Resource allocation
- Payment method

In sum, the financing scheme determines how much money will be mobilized, how the funds will be used and managed, how efficiently the services will be delivered, and what type of services will be available and to whom. (Hsiao et al 2001)

In Nepal health expenditures external to government is not reported (as much as 85%) and therefore significant donor contributions are not reflected in the government’s budget system (Maskay 2002). Nevertheless, HMGN is gradually incorporating more and more...
direct funding in the health budget why the percentage of unreported expenditures is slowly decreasing. This lack of transparency constitutes a major barrier when analysing the three components relative to impact, equity and outcome. However, some indicative studies have focused on partial subjects (Maskay et al 2002, WB 2000, DI 2000, NHEA 2002).

When measuring equity in resource mobilization the published literature generally measures how progressive - or fair - a system is. Different approaches can potentially be applied, but empirical work has been based on either the proportional method or an index approach (Hsiao et al 2001):

<table>
<thead>
<tr>
<th>Index of progressivity approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>A more comprehensive approach to measuring progressivity is to employ indices, particularly in relation to vertical equity. Recent work attempts to measure and compare both the vertical and horizontal effects.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>The proportional method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under the proportional method, the population is divided into income groups. The proportion of total health spending paid by an income group is compared with the proportion of national income received by that income group.</td>
</tr>
</tbody>
</table>

Below issues related to social impact, equity and sustainability will be analysed according to method of financing, resource allocation, payment method and health care benefits in Nepal mainly during the last decade with implications for the HSS.

3.1 Method of financing
It has been found that households in 1996 were responsible for 74 percent of total health expenditures in Nepal and donors provide funding for 13 percent while the government finances only 11% of total expenditure (Maskay et al 2002). This funding profile is the main reason for the low rank position of Nepal in the WHO rating of national health systems and their fairness in financing: The applied method of financing health services in Nepal is characterized as extreme inequality and ranked comparatively as one of the 6 most unfair financed health systems in the world (WHO 2000). This ranking was especially due to method of payment at door step of the health facility and high degree of out-of-pocket payment by households regardless of ability to pay, implying a low degree of progressiveness.

Studies have consistently found that user fees reduce utilization of health services by the poor more than the rich and therefore it is - in most part - characterised as a regressive finance form (Hsiao et al 2001). The prevailing regressiveness is also found to cause under-utilization of health services despite the high need for health services among rural women (WB 2001A). In Nepal findings support that - besides the rugged physical terrain - rate of illiteracy and its low per capita income constrain equitable access to health care, but also that patients are willing to pay when quality services are available (WB 2000). Out-of-pocket health care expense rises with the

HSS poverty focus in health financing and allocation imply:

- The establishment of a health economics group to analyse various health financing schemes.
- National Health Accounts (NHA) will be regularly produced to track out-of-pocket and EDP expenditure.
- Benefit incidence studies will be conducted to track who benefits from health expenditures.
- A comprehensive management information system (HMIS) will be developed and among other data include performance and impact data to be assessed at all levels.
- A resource formula will be developed.
level of facility as well as with seriousness of the ailment, and inpatient and out patient expenses at zonal hospitals were twice as high as they were at district hospitals. As verified in table 5 above income protection measures therefore become highly relevant in order to ensure the poorest population segments and with low ability to pay access to relevant specialised health care when needed.

In HSS a 50% deduction for vulnerable groups has been proposed to specialised hospital services. First, to be operational this requires a definition on which groups are to be classified as “vulnerable” and therefore to be exempted. In Bhaktapur hospital currently exemptions are managed in drugs for poor and destitute but exemptions is highly discouraged for more specialised services (laboratory tests etc.) Second, because exemptions have to be audited application of widely used exemption schemes imply extra additional administration costs on the tight hospital budget. Third, depending on the definition and thereby extent of exemptions, this mechanism is judged to be contradicting the financial basis of running specialised services and therefore unsustainable, e.g. in Bhaktapur hospital out-of-pocket payments are a significant source for financing current expenditures (Maskay 2002, Sharma [appendix 5]). To cover the poor effectively future health financing schemes should therefore include mechanisms that solve this potential contradiction between exemption schemes for poor and the financial basis of specialised hospitals. If decisions are left solely to the managers of the health facilities - often recruited from higher castes - examples of current practices show that the financial basis of the institution is devoted higher importance than social concerns in managing exempting schemes for the poor and destitute in the community.

The health economics group in MOH established to analyse various health financing schemes in HSS should address this contradictory reform issue with great care. If not appropriately addressed lack of ability to pay will constitute an effective access barrier and thereby a potential mechanism for social exclusion for the poorest segments and vulnerable groups in need for specialised health care. The negative social externalities of this unsolved financial problem can cause adverse health effects via the negative downward spiral process for sub-populations characterised by lacking or low ability to pay. Rural populations of Dalits and indigenous people in Western Mountain, Hill and Terai regions will be highly exposed to this unresolved problem because of their vulnerability measured as unmet health needs and potential ability to pay, cf. tables 1, 2 and 5 above.

3.2 Resource allocation

By comparing public expenditures on health by the sources of health services and hospital construction (as proxy for rural-urban focus) a recent shift in the relative priority has been experienced. MOH expenditure on secondary and tertiary care facilities increased from 14.6 percent of the health budget in 1991/92 to 37.5 percent in 1997/98 while the share of spending on primary care decreased from 76.8 percent to 57.25 percent over the same period. Additional, the portion or resources spent on hospital construction over the last five years has increased three times from 3% to 11% (Maskay et al 2002, NHEA 2002). These tendencies indicate an urban vis-à-vis rural resource allocation.
Since the most disadvantaged populations live in the rural areas this urban/rural allocation bias indicates a de facto policy which contradicts the stated political commitment to primary care since initiation of the National Health Policy of 1991.

MOH acknowledge this tendency as contradictory to stated political commitment and declares that this tendency has to be reversed in order to ensure coherence between political priority and actual allocation (MOH 2002B). Though the share of spending on primary care - according to MOH - has increased some since 1998 the described inconsistency indicates weak linkages between stated political enunciations and actual performed policy ex-post.

In a three country comparative study it was found that notably the disparity in government expenditures between the capital region and other regions is much greater in Nepal than in Sri Lanka and Bangladesh (DI 2000). In Bangladesh and Sri Lanka the peripheral regions all receive at least 80% of the national average, but in Nepal some districts are receiving only one tenth per capita subsidies of other districts. The large geographical disparities in subsidy levels in Nepal is therefore found to be associated with a much greater comparative pro-rich bias in overall government spending than observed in Bangladesh and Sri Lanka (DI 2000).

The public sector as the dominating health care provider while the households carry the financial burden will not be changed according to the intended reform plan (MOH 2002B). The HSS implies a mixed economy of health provision in developing a major new role for the MOH in working with the private sector, and NGO/INGOs. According to HSS the key in future work between MOH, private sector, NGOs and EDPs will be to work collaboratively rather than relying on regulation and control. This process will happen parallel to decentralisation implying transfer of budgets, responsibilities for planning and implementation of health service development within the districts. In other words HSS seeks to ensure local ownership and responsibility through decentralisation of the health service provision.

Though government is only responsible for a small fraction of total health expenditures, it remains the major, if in places the only, provider of health services for the poor especially those located in the remote areas of the country (Rana 2001).

The decentralisation process in the health services has been ongoing for some time and over the years 723 health posts have been created along side 3,175 sub-health posts to serve the poor. Since some of these new facilities are undermanned the question arise if,
MOH has allocated its resources too thinly among too many health posts thereby creating an environment of considerable leakage and wastage leading to under utilization. Fewer health facilities with regular basic quality services might increase both efficiency, utilisation and thereby equity (Alban 2003).

In HSS the organisational quality is being built through decentralisation of decision-making and eventually this is envisioned to create the much wanted social accountability and transparency in the delivery of health services.

Ownership is meant to imply citizen and community participation at all levels. Self-governance at community level along with mobilisation of the community to assert rightful claims to allocate resources and manage the resources of the state is though still to emerge (Alban 2003). Additional, a widespread lack of understanding what decentralisation means both at central and decentralised level in combination with lack of policy capacity in the MOH to deal the policy complexities of supporting the decentralisation needs to be addressed in the future decentralisation process (Chand et al 2002).

Though the decentralisation process has been ongoing for some time, ownership has not shifted for a majority of the health post. The country’s devolution of authority so far is not commensurate with the access to resources that would give it meaning (NHEA 2002, UNDP 2002, Chand et al 2002).

Voices has also been raised that decentralisation is motivated by the government’s fiscal deficit and not one for developing equity and overcoming poverty (Mulmi appendix 5, Chand et al 2002). In relation to resource allocation the possibility that decentralisation can also lead to further geographical inequity has been mentioned (Chand et al 2002). To avoid a scenario like this much depends on the form of local accountability developed, central resource allocation mechanisms and central planning guidelines (Chand et al 2002).

As a component of the poverty focus in the HSS MOH intends to develop a resource formula to augment the social impact of health financing and allocation. In identifying formula criteria for central resource allocation the following factors should preferably be considered included: the unbalanced social development of the regions; indicators on local population profile (stratified on ethnicity, caste and social groups), utilization rates, absorption capacity in health facilities, human resources (vacancy rates), and availability of other health care providers (private, NGO/INGO) and programme coverage rates.

Additional, urgent and special needs due to the negative effects of the insurgency should be addressed by special extra allocations, since the situation in provision of basic health care has deteriorated significantly in various regions due to the conflict situation. A regional analysis of the current state of health care provision indicates that delivery of PHC services in the Far Western and Mid Western Regions are worst affected areas, but
also hill and mountains districts throughout the country have experienced serious disruptions to PHC programs (Martinez et al. 2002). For example, in rural areas of hill districts in Far Western Region the provision of mobile PHC and EPI outreach activities has been reported less than adequate for the last 2-3 years due to the conflict. According to HMIS data the entire Far Western region had PHC outreach program coverage of 57.5% in 1999 while the other regions were above 60%. In 2000 the coverage was 62.7% while the Central and Eastern Regions had around 70%. According to field sources, the current PHC coverage is below previous statistics in most of the hill and mountain districts due to the deterioration of the security situation in 2001 and the imposition of the SoE (Martinez et al. 2002).

Allocating more resources to the Village- and District Development Committee does not necessarily mean better spending. It must be accompanied by stronger institutional arrangements at the local level with technical support from the centre based on clear regulatory setting providing a frame the aims of HSS (Alban 2003, Chand et al 2002). With only one clerical staff person for support, locally elected VDC chairpersons may not be able to use the available resources efficiently.

MOH will be responsible for co-ordinated and consistent sector management and ensuring equity issues in future resource allocation. A precondition for this to succeed will be a substantial higher level of transparency in allocation and expenditure that prevails today, where only 15 percent of contributions to the health sector are reported. In order to improve prevailing situation MOH must devote significant efforts and attention to this problem. If the intended efforts to improve prevailing deficiency of basic information fail, monitoring of the equity related components of the HSS will not be possible. Success of achieving the equity related components of the HSS will depend on the ability of MOH to establish monitoring tools as intended by the development of national health accounts (NHA). Data sources can be found in key household based studies such as the Demographic Health Survey and Living Standard Measurement which has been performed in Nepal in 1996 and the forthcoming NLSS II (DI 2000, DHS 2002). Also potential regularly gathered data from data bases from the Central Bureau of Statistics can be utilised (Prennushi 1997, WHO 2000, MOH 2002B). Two parallel initiatives are currently developing a NHA model to be applied in relation to the HSS: One initiative by MOH and one by NHEA (Chataut and Shrestha, appendix 5). Inclusion of variables for social stratification (caste, ethnicity and income brackets) will be evident for tracking the relative success of the equity components and social impact of the HSS (DI 2000; Shrestha, appendix 5). These initiatives to develop NHAs should be coordinated in order to avoid duplication and resource wastage and initiatives have been taken for this purpose (Chataut, appendix 5). Besides developing a

The sensitivity and technical complexity of measures must be weighted against the availability of reliable data and policymakers’ ability to readily interpret the results. (Anand, 2001; Gartoula, appendix 5)
NHA NHEA is currently involved in other equity related projects\(^5\) potentially useful for HSS.

### 3.3 Payment method

International evidence indicates that user fee schemes as payment method are very regressive unless the poorest segments are exempted. But user fee schemes can be made more or less equitable, see table 6 (Hsiao 2002).

User fees are the prevailing payment method in Nepal. Out-of-pocket expenditure constitutes 70 – 75 percent of total health care expenditures in Nepal. A significant part of the health expenditures is made by the private sector through private clinics, private hospitals, nursing homes etc. 59 percent of household expenditure takes place in health services that are provided by government and 25% on private providers (Maskay et al 2002). Of the approximately 75% of health care service expenditures that are paid as out-of-pocket user fees almost all money are paid on drugs either through cost sharing at public facilities or in the private sector (MOH 2002B).

Rural households are estimated to spend more on health care than urban households (ADB 1996). The reason for this seemingly unexpected finding is unclear, but one possible explanation is that rural areas lack the same degree of accessibility to modern health care as urban areas and, as a result, rural individuals may tend to delay treatment once they become ill. The delay in treatment may also result from a greater preference for traditional care among rural individuals; if traditional treatment does not cure an individual then treatment from modern practitioners may be sought, but at a time in which severity of the illness is greater and treatment costs are higher (ADB 1996). The findings indicate that the reliance of Nepali people on HMGN/Nepal health care facilities is substantial, and this reliance are almost the same between poorest and wealthiest quartiles of the population, both spending more than 50% of their health expenditures on care associated with public facilities (ADB 1996).

<table>
<thead>
<tr>
<th>Financing method</th>
<th>Mobilization of funds</th>
<th>Access to health care</th>
<th>Financial incentives</th>
</tr>
</thead>
<tbody>
<tr>
<td>General revenue</td>
<td>Highly varied. Income tax is progressive; value added tax</td>
<td>Depends on resource allocation; tends to be</td>
<td>Progressive when public hospitals provide free</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Developing countries</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>General revenue</td>
<td></td>
</tr>
</tbody>
</table>

\(^5\) Currently, NHEA is involved in the study of equity in health care financing, delivery and health status in Asia-Pacific Countries (EQUITAP), supported by the European Union. The aim in the micro-component of EQUITAP study is to assess and compare equity across the countries of Asia-Pacific region, (Shrestha, appendix 5).
is regressive unless food is exempted | regressive | services.
--- | --- | ---
**High-income countries** | Tends to be progressive | Other than the United States, all nations provide equal access | Equal under universal insurance or national health service (except in the United States)

**Social insurance**
- Proportional, slightly regressive when the taxable wage base is capped

**Developing countries**
- Covers only high- and middle-income classes; overall, it is regressive

**High-income countries**
- Progressive

**Private insurance**

<table>
<thead>
<tr>
<th>Type</th>
<th>Regressivity</th>
<th>Access</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual insurance</td>
<td>Very regressive</td>
<td>Insured have equal access</td>
</tr>
<tr>
<td>Group insurance</td>
<td>Regressive</td>
<td>Insured have equal access. Within group, tends to be progressive</td>
</tr>
<tr>
<td>Direct out-of-pocket and user fees</td>
<td>Very regressive unless the poor are exempted</td>
<td>Regressive</td>
</tr>
<tr>
<td>Community financing</td>
<td>Regressive unless significantly subsidized by general revenue</td>
<td>Equal access for members. Regressive when there is cost sharing</td>
</tr>
</tbody>
</table>

*Source: Hsiao et al 2001*

Availability of essential drugs at the primary health facilities leaves much to be desired since the allocation of drugs formula does not include the need of the population and the facilities quickly runs out of stock. There is a general shortage of drugs and suppliers in the country. The Community Drug Programme makes up for this in the communities where it is running, but data on its ability to reach out and effectively exempt the poorest of the poor is unclear. The way to provide access to affordable, essential drugs is not described in the HSS. Further, “proportion of population with access to affordable essential drugs at a sustainable basis” could be used as an indicator in the national health accounts (Alban 2003).

Health insurance in Nepal is not common (NHEA 2001). Few insurance companies actively encourage and/or publicise the availability and advantages of health insurance schemes and a majority of people do not seem to be aware of what insurance is all about (NHEA 2001). The government consider going ahead in the implementation either of the insurance schemes operated by BPKIHS or UMN along with some other interventions, and these have been evaluated for scale-up purpose in the context of Nepal.

Also, ILO (STEP) has been working with identifying various health insurance models suitable for the Nepal context (Stalpers appendix 5). The final choice of suitable models should nevertheless take due consideration for the content of equity and coverage of the

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**Risk pooling under social or private group insurances**

merges the health risk for a group of people who have different levels of health care need and different incomes. The benefits are therefore provided on the basis of need within that group. The less healthy people and the low-income households have the potential of benefiting more from risk pooling, and the expenditure side of this type of insurance is therefore progressive, see table 4. (Hsiao et al 2001)
poor and marginalised population segments judged by degree of progressiveness, impact of the scheme on health sector and whether the stakeholders are interested or not (NHEA 2001, Stalpers appendix 5, DI 2000).

Government has come some of the way by introducing Community Drug Programmes in 24 districts over the last six years. On providing drugs for the rural people is intended to cover another 35 districts during the Tenth Five-Year Plan (MOH 2001). The programme has been very successful in re-generating funds for drugs in the communities – in fact one of the problems mentioned in the last Yearly report is: Too much money accumulating in the revolving drug funds. The open question is therefore if this has occurred at the expense of unmet needs of poor and vulnerable sub-population groups who are not covered by the local funds in the communities.

The programme has so far been concentrating on implementing and the strategic choice at this time is if the programme should improve what has been implemented, monitoring if the poor are reached and sufficiently included and spend more resources on supervision to sustain quality (Alban 2003). However, a comprehensive and further developed community drug programme will be a main strategic approach to increase utilisation of health facilities since current availability of essential drugs is key to generate demand for health services cf. table 4 above (Soucat 2002).

3.4 Health care benefits
For developing nations, many studies have used a simple definition for equity in health care: Equal use of health care. Another major purpose of health care financing is the benefit from financial protection. The aim is to protect households from financial ruin arising from serious illness that may drive the family into poverty.

For Nepal the contribution of government public expenditures on health outcomes has been examined for the decade 1989/1990 to 1999/2000 by use of various statistical tests (Maskay 2002). The investigation indicated that the contribution of reported government public health expenditure in uplifting health outcomes (proxy by various summary health indicators) was insignificant. Further, the regression result indicated that “adult literacy” was the only variable with a significant effect for reducing infant mortality and child death rate respectively (Adhikari et al 2002). Though private sector input was not accounted for in the investigations, explanatory factors other than public health expenditures (total as well as government only) should be identified in explaining the significant progress in health status during the Ninth Plan. Various Nepalese public health planners support that improvements in adult literacy is a key factor in explanation of the progress in the summary health indicators (Amatya, Subedi, appendix 5).
A gender analysis of the total government health sector budget (1995 – 2002) revealed that nearly half of the health sector budget directly benefits women, meaning that Nepalese women’s share on the health sector budget is about 50 percent (MWCSW 2002). Although women’s share in the health budget is about 50 percent, it must be noted that maternal health problems form a very large proportion of the total burden of disease (WB 2000). Out of total burden of disease (total DALYs lost 7.68 million) Nepal women lost 4.09 million (53%) compared to men’s disease burden of 3.59 million DALYs (46.7). Accordingly it is argued that women’s share in the health budget should be greater than 50% to reflect the gender bias in relative disease burden, noting that maternal health problems (810,069 DALYs) form a very large proportion (app. 11%) of the total burden of disease (MWCSW 2002). Resource allocation (budgeted and actually spent) according to need (measured as relative disease burden) is therefore a highly relevant component in the HSS resource allocation formula to be developed.

A management information system for the health sector (HMIS) will be developed in a phased manner over the first five years as a strategic management tool in HSS. HMIS will include financial, personnel, logistics, facilities, maintenance, performance, and impact data. The development process will start with the information needs required to deliver the priority programme. At present a HMIS is applied by MOH to monitor program and system performance, but many health related personnel believe that the upcoming health statistics from HMIS will not reflect the reality of the delivery of PHC services in the country as some district figures have been inflated (Martinez et al. 2002). Most of the health workers are fearful of criticism if they report underperformance - even if the reasons for it are out of their control - while others have used the lack of monitoring to insert non-conducted activities within the statistics and therefore justify the use of resources and supplies. Additional, data collection and program management, especially in the western part of the country, has not been adequate for the last couple of years due to the conflict between government forces and the Maoists (Martinez et al. 2002). Today, detailed information are collected at hospital and health post level on caste, sex, but not by ethnic group and reporting is done on the aggregated form with only information segregated on age; under and above 5 years of age. Recently, the MIS division of the department has started to collect sex segregated information of disease pattern to be published. But non-health factors that e.g. constraining women’s access, demand and utilisation of health care, such as their socio-economic status, ethnicity and cultural factors are not included in the existing HMIS and inclusion of these in the future HMIS are not planned. No classification of patients on basis of ethnicity exists in aggregated form. In discussions with central persons dealing with HMIS from MOH it was revealed that HMGN have no plans to include disaggregated data on ethnicity and caste in the planned future HMIS, and even disaggregated data by sex may have to wait some time, “HMGN has other priorities due to scarcity of resources” (Chataut, appendix 5). The low priority by MOH on ensuring future ability to report and evaluate on HSS outcome and impact data segregated on ethnic and vulnerable sub-population groups is therefore significantly inflating the future HMIS as a “strategic management tool” and this priority will pose a great caveat on the social and equity profile of the HSS.
In connection to the establishment of the national health accounts (NHA) HSS will ensure benefit incidence studies to be conducted. These studies are supposed to track beneficiaries from health expenditures. For this purpose it will be essential to identify and define the various sub-population groups considered vulnerable, not least Dalits and ethnic populations living in remote rural areas. If current monitoring via HMIS is not ensured benefit studies risk to be conducted only on ad hoc basis, if done at all. Additional, without ability to track disaggregated population groups identified as vulnerable it will be difficult to conduct any social impact assessment of financial protection measures embedded in a future health care financing system. An essential tool for assessing equity in health care finance will thereby be omitted.

4. Vulnerable groups and backward areas

4.1 Geographical identification by health, gender development, education and poverty

As can be seen from table 7 clear social, economic and health disparities characterises the country. A significant rural-urban division in main central development indicators exist in Nepal. According

Table 7. Development indicators among geographic areas in Nepal, 2000

<table>
<thead>
<tr>
<th>Region</th>
<th>Life expectancy at birth</th>
<th>GDP per capita (PPP, US$)</th>
<th>Mean years of schooling</th>
<th>Human Poverty Index</th>
<th>Gender Related Development Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural</td>
<td>58.7</td>
<td>1094</td>
<td>2.5</td>
<td>41.4</td>
<td>0.426</td>
</tr>
<tr>
<td>Urban</td>
<td>71.1</td>
<td>2133</td>
<td>4.8</td>
<td>23.9</td>
<td>0.605</td>
</tr>
<tr>
<td>Mountains</td>
<td>49.8</td>
<td>698</td>
<td>2.5</td>
<td>48.1</td>
<td>0.355</td>
</tr>
<tr>
<td>Hills</td>
<td>65.1</td>
<td>1262</td>
<td>3.0</td>
<td>37.2</td>
<td>0.494</td>
</tr>
<tr>
<td>Terai</td>
<td>62.4</td>
<td>1267</td>
<td>2.8</td>
<td>40.2</td>
<td>0.456</td>
</tr>
<tr>
<td>Eastern</td>
<td>62.0</td>
<td>1073</td>
<td>2.7</td>
<td>42.0</td>
<td>0.465</td>
</tr>
<tr>
<td>Central</td>
<td>61.3</td>
<td>1713</td>
<td>2.9</td>
<td>40.7</td>
<td>0.476</td>
</tr>
<tr>
<td>Western</td>
<td>62.8</td>
<td>1022</td>
<td>3.3</td>
<td>39.9</td>
<td>0.463</td>
</tr>
<tr>
<td>Mid-west</td>
<td>53.2</td>
<td>881</td>
<td>2.7</td>
<td>43.4</td>
<td>0.376</td>
</tr>
<tr>
<td>Far-west</td>
<td>52.1</td>
<td>898</td>
<td>2.2</td>
<td>45.3</td>
<td>0.356</td>
</tr>
</tbody>
</table>

Sources: UNDP 2002

to life expectancy at birth (LEB) urban areas compares much more favourable than rural areas with Mountains having the lowest LEB, followed by Terai and hills. Distribution of mean years of schooling is shown as indicator for educational level. As expected, highest educational level is found in urban areas (4.8 years) with more than double years of schooling than rural areas (2.5 years). The poorest areas measured by the Human Poverty Index (HPI) are rural areas in Mountains with the Far-West as most poor region,

HPI: Composite index of 4 variables: 1) Chronic malnourishment among children, 2) adult illiteracy rate, 3) proportion of population with life expectancy less than 40 years, 4) population without access to safe water.
 sequenced by Mid-west, Eastern, Central and Western. GDP per capita in urban areas is twice the amount for rural areas, with Mountains having only 50% GDP per capita as populations in hills and Terai. Finally, Gender Related Development Index (GDI)\(^7\) shows the lowest levels of gender development in mountainous rural areas with Far-West as least developed region and urban areas and hills with Central as most developed region.

Judged by social, economic, health and gender development variables the most vulnerable areas in Nepal are *mountainous urban areas with Far-West and Mid-West regions* that on all indicators scores significantly under average.

The question therefore arises if there exist identifiable explanatory factors connected to this comparative backwardness apparently affecting health status of the population. A statistical investigation on the possible correlation between development in per capita income and health concludes that health variables are not sensitive to changes in per capita income *unless a*, as yet undetermined threshold, is passed (Adhikari et al 2002). However, relating to the geographical distribution of life expectancy, income, educational level, poverty and women's development the figures in table 5 strongly indicates a positive correlation between geographical distribution of human development and health. The best population health status emerge where all variables scores favourably. For some current Nepalese social scientists the indicators in table 7 illustrates that development on a national scale has failed in Nepal (Panday 2000, Maskay 1998). Information is needed to clarify how far a national health strategy significantly can work counter and mitigate the negative forces of a failed and uneven human development, unless simultaneously improving general human development factors. Concerted actions directed at geographical social “hot spots” characterised by low level human development like the mountainous areas in Far-West and Mid-West regions will therefore have the largest supportive effect for the health sector in improving health indicators amenable to primary prevention and health promotion as characterised by the MDGs adopted in HSS.

### 4.2 Geographical identification by ethnicity, caste and social stratification

#### 4.2.1 Definitions and classifications of indigenous people (IP) and caste groups

Various definitions on indigenous people exist (Cohen 1999, Gurung 2001). On basis of the National Academy for the Upliftment of Indigenous People/ Nationalities Act, 2058 (2001) the law has identified 59 indigenous peoples (Appendix 2), which may be changed after periodic review. Nepal Federation of Nationalities (NEFEN) is the largest IPO with 47 ethnic minority groups/organizations as members.

The 1991 census data is considered flawed by some because of the biased manner in which the different categories of the population were recorded, but it does provide some general picture of how the national cultural diversity is currently structured (Pradhan 2003). In terms of mother tongues spoken, 77 per cent use Indo-Aryan languages, 20 per cent speak Tibeto-Burman languages and three per cent speak other languages, including Munda and Dravidian. Speakers of Nepali as mother tongue constitute just over 50 per

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\(^7\) GDI: Composite index of 4 variables: 1) life expectancy at birth, 2) adult literacy rate, 3) mean years of schooling, 4) estimated earned income.
cent of the population, see appendix 2. In terms of caste and ethnic break-up, the country is essentially a conglomeration of minorities, with the two largest groups comprising but 16 per cent (Chhetri) and nearly 13 per cent (Bahun) of the total population. None of the other groups constitute more than 10 per cent of the population.

In terms of groupings, the 1991 census recorded 40.3 per cent of the population as hill-based Parbatiyas, Chhetri (16.1%), Bahun (12.9%) and the three “untouchable” and other service castes, Dalits (11.3%). The janajati ethnic groups, of both hill and plains taken together, constitute 35.5 per cent of the population, whereas the hill ethnic groups alone make up 26.5 per cent of all Nepalis. The major hill ethnic groups are the Magar, Newar, Tamang, Rai, Gurung and Limbu. The Tharu (6.5%) constitute the largest ethnic group in the plains.

Another way to stratify the population of the country is between the Pahadi and Medhesi, see appendix 2. The former is the term applied to the hill communities of Nepal, comprising both the caste-structured Parbatiya as well as the ethnic janajati. They constitute 66.8% of the population. As a counterpoint to the Pahadi are the Medhesi, people of the Terai origin, among whom are found caste, linguistic, religious as well as ethnic groups. Together the Madhesi make up the rest (32.1 per cent) of the population (Pradhan 2003).

### Definitions of indigenous people and caste

*World Bank study:* Definition on indigenous peoples relies on the three variables: 1) language, 2) self-perception, and 3) geographical concentration. These variables are used in different combinations and are given different priorities depending on the country under investigation. The definition has been applied in World Bank investigation on poverty among indigenous peoples of Latin America. (Cohen 1999)

*The National Academy for the Upliftment of Indigenous People/Nationalities Act, 2058 (2001):* has defined "Indigenous people/ Ethnic group" as a community that has its own mother tongue, and observes traditional customs, maintains a distinct identity, social structure and has its own history, written or unwritten". (Indigenous People/Nationalities Act 2001)

The National Dalit Commission is currently working on an operational definition on Dalits who comprises about 13 - 20 percent of total population in Nepal. (Sob appendix 5)

The high mountain regions of Nepal are inhabited by indigenous people only, and an interesting feature is that IPs still continue to live densely in their own traditional homelands whereas Hill Hindu castes such as Bahuns-Chhetris and Dalits such as Damai, Kami and Sarki live most densely in the Hills of the Far-Western Development region and also, being service oriented castes, they are scattered all over Nepal (Shrestha 2002).

### 4.2.2 Institutional arrangements for IP and acculturation in HSS

Beside 5 main functions (see text box below) the National Academy is also expected to implement special programs for promoting economic and social status of the poor and downtrodden IPs. The above functions will be carried out through a high level Council formed under
the Chairmanship of the Prime Minister, and an executing committee will be formed to implement its day-to-day works.

His Majesty's Government has assigned a Joint Secretary and a small unit under him in the Ministry of Local Development to look into the matters relating to the IPs in Nepal.

Despite the Constitution’s egalitarian provisions it is by some analysts seen as circumscribing the cultural pluralism with two important qualifications: first: its definition of Nepal as a “Hindu Kingdom” and second, its declaration of Nepali as the language of the nation (rastra bhasa) and

<table>
<thead>
<tr>
<th>As provisioned in the Act, the National Academy for the Upliftment of Indigenous People has been established with the following functions under the Chairmanship of the Prime Minister:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. formulate and implement programs related to social, educational, economic and cultural development of IP leading to their upliftment;</td>
</tr>
<tr>
<td>2. Preserve and promote their language, script, culture, literature art, and history;</td>
</tr>
<tr>
<td>3. maintain and promote traditional skills, techniques, and knowledge and put them in practical use;</td>
</tr>
<tr>
<td>4. maintain cordial relationship among various ethnic groups and bring them to the mainstream of development process; and</td>
</tr>
<tr>
<td>5. help establish an equitable society by developing and promoting IP's social, economic, religious and cultural status.</td>
</tr>
</tbody>
</table>

official language (Pradhan 2003). The primacy given to Hinduism and the Nepali language, is mainly due to pressure from Parbatiya Hindus from across the political spectrum indicated that the dominance of the Parbatiya ruling elite had continued into the modern democratic era. Thus, behind the official model of cultural pluralism and equality, a hierarchy of cultures of the dominance of one culture over others (through language and religion) can be discerned. The state does make efforts to promote the cultures and languages of the non-Parbatiya, but these tend to be more symbolic than real (Pradhan 2003).

Because of inattention to the multilingual context of Nepal and the ruling elites primacy of Nepali language (rastra bhasa) the balance between insulation or acculturation in the HSS policy approach is heavily biased towards acculturation to the dominant society values.

According to international experts in the field of indigenous people and cultural aspects of health care the outcome of an acculturation process depends of the acceptance vis a’ vis implied population groups of the elements of dominant and submissive cultures (Harvald 2000, Cohen 1999, Alderete 1996, Berry 1990). A crucial step to achieve this acceptance is provision of platforms for informed participation by the indigenous people

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8 *The insulation approach* is used when indigenous populations whose cultural and economic practices make it difficult for them to deal with powerful outside groups. The advantages of this approach are the special protections that are provided and the preservation of cultural distinctiveness; the costs are benefits foregone from development programs (OD 4.20).

9 *The process of acculturation* means “a process in which culture is transferred via contact between groups with different cultures” (Berry 1990, Harvald 2001)
themselves. Mechanisms to ensure this is lacking in the approach taken in HSS. Potential mitigating measures are; differential approaches in developing the EHSP, BCC and other central reform PHC components that take into account the prevailing plurality of languages and cultures.

Consultations with IPO representative, Balkrishna Mabuhang Limbu (BML), Secretary General, Nepal Federation of Nationalities (NEFEN) revealed that language is considered the most severe barrier according to indigenous people utilising basic health care in Nepal, - even bigger than barriers connected to economic and resource limitations (Limbu, appendix 5). IP utilisation of public health care services are severely constrained by the language barrier. However, from central planning level language is considered not to be a significant access barrier (Amatya, appendix 5). In Sipadol village FDG revealed that language and culture are considered to pose some barrier, but is considered not as serious as in the past by Tamang beneficiaries (FGD appendix 5).

Mostly Nepali is not spoken and understood by the various groups of indigenous people in Nepal. Since language is a very important precondition in communication regarding disease and illness inattention to the language barrier is considered leading to under-utilization of public health services by the various indigenous groups (Limbu, Gartoula appendix 5).

If the rastra bhasa approach in HSS is not accepted by the ethnic minority groups and their representatives adverse and unintended impacts of the HSS are potentially expected outcomes. Measures to increase the sensitivity and appropriateness in the intended health programs aiming at increasing indigenous people’s health status should be taken by MOH. Consultation platforms for informed participation should be established at both macro and micro implementation level of HSS. Inclusion of Indigenous people’s organisations should be encouraged. See proposal in Action Plan, Appendix 7.

4.2.3 IP and the Development Plan

Although the Constitution has clearly recognized Nepal as a country with multi-national minorities, the Eighth Plan (1992-1997) failed to incorporate programs for the development of disadvantaged IPs. The Ninth Plan was the first plan that explicitly made policies and programs targeting IPs though with only limited programs under the heading of Social Security. On social front, the plan envisioned for special priority to be accorded to the children of IPs while during enrolment in primary and vocational schools. Besides, personality development of IPs and ethnic minorities will be emphasized during the execution of education and health related programs.

The Tenth Plan/PRSP states that “government should play a lead role in poverty alleviation, uplifting and mainstreaming Dalits and indigenous groups, remote areas development, empowerment and development of women, empowerment of disables, and ensure security to senior citizen while it is the role of the local bodies (VDC and DDC) to effectively implement the related national programs (PRSP 2002). The Tenth Plan/PRSP has included sector oriented programs and strategies for the IPs. However, the programs are not planned on a comprehensive basis and only few sector strategies include
explicitly IP. The health sector strategy is not mentioning IP/Dalit specific health care issues such as accessibility and utilization. The Tenth Plan therefore lacks to describe potential measures to reduce the risk of social exclusion in health provision at local level.

In 1999, the local Self-Governance Act was amended, giving more power to the local government bodies (DDC and VDC) including the authority to protect, preserve and promote IPs language, religion and culture. Since 1999 no evaluations or assessments on how the local bodies have managed the role as implementer of government policies towards vulnerable groups, including IP and Dalits has been conducted. Such evaluations are highly needed in order to make assessments of the local bodies’ ability and willingness to deal with the above issues. Potentially, a high risk of negligence and social exclusion exist in local management of IP and Dalit programs. Until it is verified that local bodies are capable of effectively handling programs with due respect to IP and Dalit issues, HMGN should therefore take a much more active role in facilitating and monitoring targeted programs at highly deprived IP and Dalit communities to ensure that they will be reached with PHC at local at health post and sub- health posts. As a function of political marginalisation and low representation in governance elites low focus on IP/Dalit issues in previous HMGN development programs has prevailed. Therefore special targeted IP/Dalit programs should be developed, implemented and financed in close collaboration with EDPs and IPO to ensure a high IP/Dalit sensitive program profile including local participation and ownership, see proposal in chapter “donor participation”.

4.2.4 Geographical diversity among IP.
According to the 1991 census, the numbers of districts with IP majority are 27 districts as shown by table 8 below.

In the districts of Manang, Mustang and Rasuwa, each has IP percent of its population is over 76%. The other districts occupied by IP majority are Kathmandu Valley and districts in the eastern hill region. Districts with one-third IPs among its population are the mid hill and far-western Terai, and those with less than 24 percent IP population are mainly in the western hill and eastern Terai. Nine districts of Karnali each has IP at 5% of its population. The district of Darchula has the lowest percentage of IP among its population. In Terai, Dhanusha has less than 5% of its population as IP. The geographical diversity of IP in percentage is made on maps in Nepali and English language.

<table>
<thead>
<tr>
<th>Percentage of Indigenous People</th>
<th>Number of Districts</th>
</tr>
</thead>
<tbody>
<tr>
<td>76 – 86</td>
<td>3</td>
</tr>
<tr>
<td>51 – 75</td>
<td>24</td>
</tr>
<tr>
<td>34 – 50</td>
<td>17</td>
</tr>
<tr>
<td>25 – 35</td>
<td>5</td>
</tr>
<tr>
<td>0 - 24</td>
<td>26</td>
</tr>
</tbody>
</table>

*Source: Gurung 2002*
Region wise, there is Ethnic/Caste dominance by Tamangs in the Central Mountain and Inner Terai, by Newars in Central Hills, and by Tharu and Yadav in Western and Eastern Terai. Dominance by various Ethnic/Caste in percentage in given in Appendix 3.

In terms of regional distribution of IP, hill has the highest percentage, 50.5% (3,249,622 persons with ethnic identity) of total IP, followed by Terai with 30.5% (1,963,677 persons). The detailed list of IP region-wise is presented in appendix 4.

4.2.5 Geographical priority areas for HSS in relation to vulnerable groups
As indicated in table 5 above population in the rural western hill/mountain areas nearly 70% reported less than adequate consumption of health services (NLSS 1997). The geographical distribution of self-reported unmet health care needs coincided with unfavourable indicators on social, economic and gender related development found to be at the lowest in mountain areas in Far-Western and Mid-Western regions. Here life-expectancy is between 49.8 and 53.2 years thereby significantly below national average of 59 years. The social impact of the primary health system is low with an average of only 15 – 17% of the people utilising the system, and this average is only 11% in hill areas and 9% in mountain areas and due to distance to the health posts and the poor quality of services (UNDP 2002).

In Far-Western and Mid-Western regions income levels are found to be at the lowest compared with all other regions in the country, e.g. constituting only 50 percent of the income level in Central region. (cf. table 7). Since income level is a good proxy for ability to pay for needed health care services this buying capacity is significantly low in these areas. Additional, negative effects of the Maoist insurgency on local health care in the mountainous areas in Far-West and Mid-West regions are more severe than other regions in the country and have exacerbated the critical state of health care provision in recent years. In these areas ethnic groups comprises around 31.8% of total population with dominating groups like Tamang, Magar, Limbu, Rai and Gurung revealing the most critical health indicators such as life expectancy and U5MR (cf. table 3). Communities of occupational and artisan castes (Dalits) in these regions are displaying the most critical values on all available health indicators apparently making Dalits in Far-Western and Mid-Western regions one of the most vulnerable sub-population groups in the country. Due to comparatively low status women in these sub-populations are characterised by the lowest indicators of gender development (health, literacy, education level and income) in the country.

Therefore women and children in Far-Western and Mid-Western from the identified ethnic population groups and especially women in Dalit communities in all country regions should be considered a special priority in HSS. Areas where these groups are located should be devoted a special concern in the resource allocating formula developed in connection to HSS.

Geographical Information System (GIS) is a highly supportive planning tool in connection to identifying areas with combinations of low human development,
availability of public social and health institutions and distance to these for vulnerable
groups (PDDP 2002ab). GIS is widely used by PDDP to identify local issues for
participatory district development and input data in GIS include also stratification of
district population according to ethnicity, caste and socio economic status. Since current
initiatives in PDDP are monitoring correlation between local political instability and
relative availability of government social/health services PDDP are a highly relevant
partner for MOH regarding efforts to identifying, mapping and monitoring “geographical
hot spots” in planning efforts to strengthening the social profile of HSS (Adhikari,
appendix 5).

5. Stakeholder analysis
5.1 Stakeholders in the health care sector
As table 9 indicates over 58% of all health rupees were in 1994/1995 used for services
associated with the government sector. Most of the expenditure, even if made to a private pharmacy
or medical supply store, followed a visit to a government health facility. In addition, 11% of
rupees were used for care provided by INGOs and other international donors, and 30% of rupees were used
for services directly by pharmacies and other private providers. Moreover, 4% of care was used for
traditional medicine (both public and private) (ADB 1996).

Table 9. National health accounts by uses & sources of funds, 1994/95 (as proportion
of total)

<table>
<thead>
<tr>
<th>Use of fund</th>
<th>Donors</th>
<th>HMGN/MOF</th>
<th>Pvt. company</th>
<th>Households</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Donors</td>
<td>4.7</td>
<td></td>
<td></td>
<td></td>
<td>4.7</td>
</tr>
<tr>
<td>INGO</td>
<td>1.6</td>
<td></td>
<td></td>
<td>0.6</td>
<td>2.3</td>
</tr>
<tr>
<td>NGO</td>
<td>4.3</td>
<td></td>
<td></td>
<td></td>
<td>4.3</td>
</tr>
<tr>
<td>Other ministry/ HMGN</td>
<td>1.0</td>
<td>0.7</td>
<td></td>
<td></td>
<td>1.7</td>
</tr>
<tr>
<td>MOH/HMGN</td>
<td>4.3</td>
<td>9.2</td>
<td></td>
<td>42.6</td>
<td>56.2</td>
</tr>
<tr>
<td>Private</td>
<td></td>
<td></td>
<td></td>
<td>20.5</td>
<td>20.5</td>
</tr>
<tr>
<td>Pharmacies</td>
<td></td>
<td></td>
<td></td>
<td>4.8</td>
<td>4.8</td>
</tr>
<tr>
<td>Traditional</td>
<td></td>
<td></td>
<td>0.4</td>
<td>3.7</td>
<td>4.2</td>
</tr>
<tr>
<td>Unknown</td>
<td></td>
<td></td>
<td></td>
<td>1.5</td>
<td>1.5</td>
</tr>
<tr>
<td>Total</td>
<td>15.9</td>
<td>10.4</td>
<td>1.5</td>
<td>72.3</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Source: ADB 1996

5.2 Stakeholder analysis and HSS participation issues
5.2.1 NGO and INGOs
There has been a significant growth in the number of NGOs in Nepal following the
restoration of multi party democracy in 1990. Of the total NGOs registered with the
Social Welfare Council (SWC), about 6% was in 1996 estimated to be involved in the
health sector (GTZ 1996). On the pattern of NGO growth in Nepal, it can be said with
certitude that this growth has been patterned in uneven ways, rewarding areas which have good facilities and are relatively more developed and penalising others which have less facilities and are less developed (Maskay 1998). This means that the main beneficiaries of the NGO health sector programs are the middle income class families, as this class constitutes the dominant group in urban areas. Further, though a large number of NGOs have been registered only a limited number of these have been found gone into operation, because incentives exist to “garner foreign funds through the name of noble sounding organisations”. This is found to be one of the main reasons for the non-operation of a large number of registered NGOs (GTZ 1996). The issue needs to be thoroughly investigated and addressed when implementing the health care reform, especially concerning the participatory and training components in remote areas.

NGOs need not register with MOH, (or in fact, with any official authority) so there is no accurate picture of INGOs/NGOs in the health field (Kansakar 1999, GTZ 1996). Nevertheless, MOH has recently made inventories and overviews of partners (NGOs, INGO/EDPs) working in the health sector on partial intervention areas, such as reproductive health. An example is the comprehensive inventory of “Partners Support for Reproductive Health Activities in Nepal in the 75 districts for the year 2002”.

Only partial studies have been conducted of NGOs/INGOs involved in the health sector (Kansakar 1999). Such partial indication from a 1996 study revealed that some 256 NGOs and 43 INGOs were engaged in the health sector (GTZ 1996).

Table 10 provides an overview of the distribution of NGOs by regions. Though the investigation was made in 1996 the data indicates that NGOs are not spread across all the 75 districts of the country (GTZ 1996). Of the 256 NGOs, 152 (59%) were concentrated in the central region, and Kathmandu alone had 63 NGOs (41% of regional total). Next to Central region were Eastern and Western regions which have almost the same number of NGOs; 42 and 41 respectively, each accounting for 16% out of total NGOs operating in Nepal. The Mid-Western region had 15 NGOs (6% of total) and the Far-Western had only 6 NGOs (2%).

<table>
<thead>
<tr>
<th>Development Region</th>
<th>Total no. of Districts</th>
<th>No. of Districts served by NGOs</th>
<th>Total no. of NGOs in the development regions</th>
<th>Concentration ratio of NGOs. Percentage (%) out of total NGOs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern</td>
<td>16</td>
<td>12</td>
<td>42</td>
<td>16%</td>
</tr>
<tr>
<td>Central</td>
<td>19</td>
<td>16</td>
<td>152</td>
<td>59%</td>
</tr>
<tr>
<td>Western</td>
<td>16</td>
<td>14</td>
<td>41</td>
<td>16%</td>
</tr>
<tr>
<td>Mid-Western</td>
<td>15</td>
<td>5</td>
<td>15</td>
<td>6%</td>
</tr>
<tr>
<td>Far-Western</td>
<td>9</td>
<td>4</td>
<td>6</td>
<td>2%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>75</strong></td>
<td><strong>51</strong></td>
<td><strong>256</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

Source: GTZ 1996

Those who travel through the difficult parts of Nepal will return to the capital with a stinging impression that something has gone wrong in planning for development, including the NGO interventions. (Maskay 1998)
The information presented in table 10 did not, however, present a total picture of district coverage in 1996 as some districts served by INGOs were not recorded. However, in 1996 INGOs were found to be operating in at least 28 districts (GTZ 1996).

The major health areas in which the NGOs have made a significant contribution include control of TB and leprosy, family planning, immunization, eye care, rehabilitation of disabled, health education and awareness programs (GTZ 1996). The majority of National NGOs are engaged in providing particular health care services. The health activities of the INGOs range from the provision of specialized medical services to work in a specific sector to multi-sectional programs. A majority of INGOs implement their programs by themselves and to a small extent through national and local NGOs. Some INGOs also provide technical support to local NGOs and local bodies.

With the exception of a few cases, the health services being provided by the NGOs generally lack participatory support of the community, government district health offices and local authorities (DDC/VDC) (GTZ 1996). Most of the NGOs/INGOs have a tendency of implementing the project directly rather than through the grass root organisations and thereby lacking to facilitate the beneficiaries to participate in the planning and implementation process. This raises two concerns: First, it questions the sustainability of the NGO activities. Second, while working in regions with high IP density lack of understanding - or willingness - to adapt to IP sensitive participatory implementation approaches I/NGOs are at risk of creating a barrier for IP participation. IPs have their own traditional organisations and most IPs have now transformed some of their traditional organisations into ethnic or community-based organisations (Shrestha 2002). When I/NGO therefore become participatory implementers of the HSS in regions with IPs it is important for MOH to ensure that the operating I/NGOs possess the necessary social, technical and legal skills needed for carrying out the IP sensitive health programs in a participatory manner with due respect of local culture and customs. Certifications for I/NGOs issued by MOH - achieved after review of gained experience and applied implementation approaches - could be one potential approach to ensure I/NGO actually being capable of operating among IPs. Establishment of introductory courses for I/NGOs working in IPs are another - more costly - approach.

According to the World Bank OD 4.20 is therefore highly appropriate that I/NGOs working in the regions with high density of ethnic populations - like Manang, Mustang and Rasuwa - receive training and knowledge when working with IP (WB 2001E). This leaves the question of MOH being capable of professionally performing this activities connected to certification procedures. The institutional capacity and expertise in MOH are generally weak on ethnic and minority issues. Institutionalisation of certification procedures will therefore need adequate external support based on dialogue with IP organisations. An instruction programme to sensitise I/NGOs operating in IP areas are therefore proposed in the Action Plan in Appendix 7.

Another problem is that INGOs cannot be expected to work in Nepal for good and when they wrap up their activities, a big jerk might be felt in the local health care system. On the other hand the challenge is to avoid dependency and attachments in working with
communities (Dhakal, appendix 5). The sustainability issue becomes particularly serious in the case of INGOs and a balanced approach should be applied when INGOs become implementing partners in HSS.

Though it is widely acknowledged that NGOs play a major role in provision of health and social services in Nepal the quality of the performance is widely questioned in various assessments.

The performance of level of Nepalese NGO in general - on each parameter assessed - was found to be below the average in an investigation (Maskay 1998). On the other hand the health services provided by the NGOs are usually rated to be of better quality than those by the district health offices, although district hospitals are clearly in a superior position with regard to back-up services (GTZ 1996).

Despite that NGOs are interacting and collaborating with the Ministry of Health, local bodies and other NGOs, there is no permanent formal mechanism of coordination. The coordination is described as mostly ad-hoc and issue specific (GTZ 1996). However, in the absence of supportive activities impact of the attempts made by NGOs to raise awareness of the rural poor regarding health and sanitation has remained considerable low (GTZ 1996).

Regarding co-ordination among NGOs, there exist formal as informal structure of regulating and co-ordinating the activities of NGOs (GTZ 1996). The SWC is the national authority to act both as a regulatory body (to register NGOs, to coordinate their activities and to prevent duplication of program) and as an NGO support agency. It also has the authority to formulate criteria about membership and issue guidelines on accounting, auditing and other procedural matters in relation to NGOs affiliated with it.

The SWC was created in connection with the legislation of the Social Welfare Act 2049 (1993) to meet the increasing demand for NGO participation in making decisions on matters that affect them. But as things have turned out, the SWC appears to be just an extended arm of the government (Maskay 1998). Although a provision has been made to compose the SWC predominantly with social workers, almost all are officials and the SWC is characterised as a "technocratic council with government yes-men who will ever dare make decisions inconvenient to the government" (Maskay 1998).

The tug of war on interest between the government and NGO for a redefinition of the poser base seems to go on for some length of time, and the probability of non-occurrence of such an event must be said to be very low under the present circumstances (Maskay 1998). Nevertheless, HSS is seen as representing a complete change of basic planning characteristics and approaches compared to former practices of government central planning with the open attitude from HMGN to cooperation with NGOs and donors (Moffatt, appendix 5). This "new beginning" therefore seems to be balancing between ensuring necessary uniformity in I/NGO service provision and IP sensitive approaches on one side and - on the other side - ensure an attractive and motivated environment for I/NGOs to work in remote areas by still leaving enough operational space and degree of freedom allowing them to work on basis of their organisational values and philosophies.
Since there is little consensus between NGOs relating to training approaches, HMGN should provide guiding principles and exert quality control for NGOs working with training of health workers to ensure qualitative uniformity and IP sensitivity in provisions from NGOs (Maskay 1998; Mulmi appendix 5). Sustainable decentralised health training and education approaches hinge on two main issues: 1) Ownership of local people and 2) Local people must be trained locally. If these two preconditions are not met in decentralisation there will always exist the question of inadequate health care man power in rural areas. If the preconditions are met adequately in HSS, it is more a question of managing available resources than providing extra resources (Mulmi appendix 5).

5.2.2 Private sector and participation in HSS
Following the establishment of democracy in Nepal there has been a significant growth in the number of Nursing homes and private hospitals. In 1996 there were registered 60 private hospitals and nursing homes all in Kathmandu valley or other urban areas. The growth of the private sector is considered to have had both good and bad equity effects. Most government physicians (an estimated 98%) also have private practices, and many believe that this seriously impacts the care available to the poor through hospital outpatients departments. By using National Health Accounts analysis it was in 1996 found that the urban poor were the only segment who had little access to private medical care. The middle class was found to be the primary group using private health facilities, because of availability of care (ADB 1996). This practice of double billing therefore has a risk of eroding services available from the public sector, though the supply of doctors increased during the past 10 years.

Likewise the promotion of the private sector in the health services may lead to further marginalization of women in having access to specialised services. This concern is mainly due to the functions of women’s lack of property rights, men’s greater control of household resources and consequent greater say in the household decision–making (MWCSW 2002).

The Ninth Five Year Plan 1997-2001 introduced the role of private sector for provision of tertiary and super tertiary care. Due to absence of proper regulations and lack of clear policy in the matter of private sector and NGO provisions of health services was not well assured for quality of care.
This was reported in the mid term review (MTR) of the Ninth five year plan (Rana 2001). MTR recommended certain strategic actions to deal with the imbalance of health service by regional distribution.

The private sector participation is one of the guiding principles of the Long Term Health Plan (1997-2017). Though it realises the reach of private sector services to be concentrated in urban area it does not consider the women’s economic status, her actual buying capacity and her ability to decide for own health (MWCSW 2002). This also goes for other vulnerable population strata of Nepal in the LTHP, e.g. IP and Dalits.
Especially the staffing situation in rural areas is of great concern in HSS. In order to improve the staffing situation government should develop regulation on partly mandatory arrangements and partly incentive schemes to station specialised health staff in remote areas (Rijal Appendix 5).

This current situation of no regulation and no incentives for specialised health staff to work in remote areas are seen by representatives from private sector as a main obstacle to reach the staffing and recruitment goals in HSS (Rijal appendix 5).

As suggested by chairman of the Association of Private Health Institutions of Nepal, Dr. Bhola Rijal, a precondition for obtaining a doctors license to practise in urban areas should be 2-4 years mandatory work practise in remote areas (Rijal appendix 5). This mandatory scheme should be managed by HMGN. Alongside mandatory arrangements HMGN should create incentives for highly educated staff to work in the remote areas. HMGN should facilitate refresher courses - e.g. by outsourcing to private sector education capacity - and thereby provide upgrading for health staff so they are kept up to date with current knowledge and best practise in their respective professional fields. These arrangements could be provided by the private sector by outsourcing and on contract basis in different remote localities.

Previously MOH has been suggesting cooperation with private sector on a non-mutual beneficial basis. MOH only asks for participation from private sector without offering anything in return. This MOH attitude has led to a low motivation situation for private sector participation in government plans for the health care system (Rijal appendix 5).

According to private health provision and participation in health reform incentives should be provided for private sector to include pro-poor schemes in their service supply. These incentives could potentially be tax, custom and duty exemption in import of necessary goods and arrangement of financial credit and management support where needed. Additional, incentive as well as mandatory schemes for specialised health professionals to work in remote areas should be developed in close cooperation with the private sector and their organisations.

Government should delegate responsibility of total health care of a particular geographical area and should take advantage of private sector manpower training institutions by establishing appropriate environment for expansion of service coverage by such institutions in remote areas. Delegation and outsourcing should be on a well defined contractual basis - preferably in a package form - taking into consideration components of social equity and IP sensitivity related to vulnerable groups in the specific areas.

5.2.3 External Donors and participation in HSS
Local implementers must act as catalysts for local participatory and sustainable development processes and seek to avoid the mutual risk of dependency. Donors and NGOs should be kept in line not to be too attached to the given projects and the local communities. Government should ideally steward the process and set limits for donor
projects and should be willing to continue projects by ensuring that sustainability conditions are in place when donors are handing over projects to the local communities (Dhakal, appendix 5).

Analytically, it is essential to view the health sector as a market place where consumer choices are one of the most important factors in terms of the utilisation of the service be that public or private, traditional or allopathic and preventive or curative. Not least in poor countries like Nepal where the needs far exceed the public financing available. How government, or in a more pluralistic perspective society, can influence the consumption of health services in the entire market and thereby the resulting health outcomes remains a critical issue not least according to EDP participation in HSS.

The vision must be to enable the society in question to take their own decisions on which goals to strive for and on how to organise their health sector to achieve them, rather than to force upon them blueprint models from outside.

The Sector Wide Approach (SWAp) is fitting well with these key problems, see definition of SWAp in appendix 6. It does not mean that donors as co-financers should not contribute to political changes. On the contrary, the foundation of the SWAp is the allocation of resources, the fundamental aspect of politics. But it is indeed a difficult balance between on one hand to be a change agent, with a specific mandate of e.g. poverty alleviation, and on the other to respect that a society may choose solutions that the donor finds less appropriate. It is deemed not only the most effective way of supporting established good policies and plans but even more the most efficient modality for furthering change in less perfect and more ambiguous circumstances (Baldwin et al 2002). Finally, by increasing transparency of actual priorities and by strengthening sustainable systems, the SWAp could contribute significantly not only to health development but also to good governance10.

However, a few of the bilateral and UN donors are not prepared to enter into a SWAp-agreement, but are fully prepared to enter into a joint planning, programming and closer cooperation with Government to achieve the goals of the HSS (Alban 2003). The donors welcome the devolution of authority to local government and are prepared to support local health initiatives such as building capacity at the district level and beyond. Therefore, if not a fully SWAp can be agreed upon basket funding approaches on partial health reform projects can be applied as the one applied in the education sector - see example below - as a model to follow regarding EDP participation in HSS.

Small projects do not face much difficulty in arranging funding modality. They involve comparatively few activities (components) and small scale of finance. Mobilizing funding from one donor may be enough for financing such projects. Of course, the counterpart funds would normally come from the government of the recipient country.

10 Useful information on SWAp can be found on: http://www.ihsd.org/swaps
For a larger project, funding from a single country or donor will generally not be enough to undertake the project. But, as each donor has its own mandate and philosophy in extending assistance to other recipient country or government, joint financing of a project by many donors will not definitely be as simple as financing from a single donor situation. So, critical examination of the funding mechanism must be done before the project is ready for implementation.

Two possibilities of financing from multiple donors exist, namely, parallel financing and joint financing. The situation of parallel financing appears when certain components of a project will be carried out fully or partly under the funding of a donor. Procurement and payment (reimbursement) are done according to the procedures of the donor.

If government is the executing agency, the undertaking of a multiple donor financed project usually calls for a very cumbersome task implying use of significant administrative resources. It has to prepare separate financial and physical progress reports to each donor for the component it has supported, and audit of transactions is to be carried out for the components financed from each donor. Since the recipient government has its own system of accounting and procurement procedures, reconciliation is a demanding job for the personnel working for the implementing agency. It is for the above reasons that consensus is required among the donor communities for application of uniform rules and regulations, to the extent possible the government rules and regulations, for procurement of goods and services and also for the accounting, reporting and auditing purposes.

Consensus among the donor communities for applying a standard rules and regulations for accounting, reporting and auditing purpose solves many of the above mentioned problems. However, some problems still persist. For example, the project office still needs to keep separate accounts for each donor, prepare separate reports and do separate audits. To do away with these sorts of problems, a "basket funding mechanism" has been introduced. This funding modality does away with many inconsistencies prevalent with the parallel funding mechanism. However, the mechanism is not without problems. In appendix 6 an example of an applied basket funding project is presented namely The Basic and Primary Education Programme, Second Phase (BPEP II) and its deficiencies are presented and examined.

Basket funding approaches, which is also commonly known as “joint funding” is a mechanism applicable under a multi-donors financing scheme. In basket funding arrangements strong mechanisms for monitoring and supervision are prerequisite. Because of the vastness of programme all over the country, this job should be delegated to local bodies, e.g. DDCs.

According to policies and programmes aimed at IPs and vulnerable groups basket funding and SWAs and basket funded projects are regarded a most efficient tool. MOH should preferably provide leadership for the special pro-poor policies to these groups to ensure priority as a potential counterweight to prevailing local social power balance. Basket funded programmes towards IPs/vulnerable groups are fitting well in the SWAp
approach as a single policy and expenditure program. Since the "implicit bargain" that EDP agree to give up their explicit role in running projects in return for a voice in the overall direction of sector policy the process of SWAp bring together development partners in dialogue about the appropriate policy approaches, monitoring and current evaluation. This will ensure that government can be held well on course on the stated policies ensuring the HSS targets on social impact and equity are actually operationalised.

Above all, the capacity building of the implementing agency is vital for successful implementation of programme assistance under basket funding mechanism. Frequent turn over of the key staff and trained staff in MOH should be retained for the project period regarding the intended basket funded projects in HSS. A programme for capacity building in MOH to manage and steward basket funded projects is therefore suggested in the Action Plan, appendix 7.

Some donors cannot join the basket mechanism, because of their own mandate. The success of the basket funding largely depends on the firm commitment among the donors for the standard procedures to be applied for procurement and disbursement. If such commitment falters, the whole mechanism is bound to fail.

5.2.4 Community participation issues: Gender, IP and caste/social class

5.2.4.1. Gender and caste/social class

The primary health care system is the largest sub-sector of the health system in terms of capacity and personnel. However, the social impact of the primary health system has been low with an average of only 15 - 17% of the people utilising the system, and this average is only 9% in mountain areas and 11% in hill areas due to distance to the health posts and the poor quality of services (UNDP 2002).

Access to health services is determined not only by physical access, but also by ownership in the planning and delivery of health services. Among women, 71% (compared to 57 percent of men) have little or no involvement in planning village health programmes and 67 per cent of women (compared to 59% of men) are only marginally involved in implementation (UNDP 2002).

Similar trends in lack of engagement become evident when the participation of Dalits is compared with that of advantaged groups, a difference sharper than that for gender. Among the Dalits, 75 per cent either do not participate or participate very little in the planning of village health services, compared to 58 per cent of the advantaged groups. This difference parallels that of implementation where non-participation is 74 per cent for Dalits compared to 56 per cent for the advantaged groups (UNDP 2002).
International experience had shown that avoidance of the three delays 1. delay in seeking care, 2. delay in reaching care and 3. delay in receiving care was imperative to achieve the goal of reduction of maternal mortality (NSMP 2002).

In 1996 the Family Health Division of the Department of Health Services (DoHS) initiated the Maternal Mortality and Morbidity Study (MMMS). This study gave a better understanding of the causes of maternal deaths to be 71% and 29% by indirect causes and fortuitous. With 90% of the deliveries occurring at home, most of the deaths occur in the community (79%) and only 21% in the health institution. Similarly, since antenatal coverage is low and since most deliveries occur outside a health institution and only 10% of most deliveries are attended by trained personnel (most being attended by friends and relatives), most deaths take place during the post partum period (62%). In this context the current strategy of MOH is to increase access to services at hospitals and primary health care centres through establishment of basic and comprehensive essential obstetric care and skilled attendance through trained Maternal and Child Health Workers (MCHW).

Government introduction of various social and health packages should include components of parallel information packages that aim at changing gender power relations at household level.

*Household analysis* and fields exercises are important preconditions for ensuring future consistency between policy formulation and implementation. As an example family planning is targeted against women not taking into account the prevailing power balance between sexes and relatives in the households (MWCSW 2002). Women take often a lower position in decision making according to birth control in families, which constitutes a basic factor not accounted for in family planning campaigns, constituting one of the main reasons for the frequent failures of these campaigns. The relative status of women is often lower among Hindu sub-population groups than among Buddhist population groups, where less gender inequality has been experienced (Ghimire, appendix 5).

Other potential barriers for women utilization health services: Indiscrete treatment and diagnostic environments where diagnose often implies exposure to male health personal. One of the reasons behind the decision of constructing a new 4-room SHP in Sipadol was indiscrete diagnostic and treatment environment in the old one-room SHP (FGD appendix 5). In a 1996 investigation it was found that of 22 health offices visited 11% of staff was women, and of the staff below the officer level, 36% were women (ADB 1996). This issue needs to be addressed in the training of para-professional staff and in recruitment of officers in the health care system.

*Lead groups* should preferably be established to conduct training and information use among local health workers. Information packages should preferably be developed in the communities for which the information is intended to be directed at by means of focus group discussions, because of the highly diversified communities in Nepal.
The reproductive health (RH) strategies of MOH include human rights approach at the centre. Though democracy was introduced in 1990 people are not used to raise their voice in demands for public health services, and women - in particular rural women - often isolated and kept in houses why they are generally not aware of their rights and potential possibilities according to seeking health services (MWCSW 2002, Bennett, appendix 5). Teaching democracy and rights awareness therefore become a central issue to raise demands and thereby participation and utilisation. The Female Community Health Volunteer (FCHV) programme – described as one of the most effective health programmes in the rural areas of Nepal (MWCSW 2002). The principal objectives of the FCHV set by MOH includes mainly empowerment of local women with basic knowledge of primary health care, particularly health of mothers and children; enhance community self-help in primary health care through increased knowledge and mobilisation of local women and promote community participation by creating awareness of the maximum utilisation of available health and family planning services in order to reduce infant child and maternal mortality. The strategies for achieving these objectives are geared towards community orientation and mobilisation at the grass root level.

Despite the effectiveness of the programme, the FCHV programme is besieged by a myriad of problems such as delay in the release of the programme budget, lack of adequate budget to replace dropout FCHVs, institutional inability to hold FCHV district review and FCHV refresher review meetings effectively in many places. Additional, training of FCHV still lacks the development of their ability to identify individual health needs and understand their perceptions with a view to delivering services with a rights-based approach. The attitude demonstrated by a provider at the first point of contact determines the whole cycle of interaction - and further influencing the health decisions to be taken. From a gender perspective it is therefore regarded of utmost importance to ensure inclusion of the rights based demand approach for all kinds of community level first line health service providers (MWCSW 2002).

Continuation, improvement and strengthening of the FCHV programme therefore appear as a key strategic priority for HSS. Regarding the importance of first line health workers in rural and remote areas a strengthened FCHV programme will act as a powerful booster for the social impact of HSS not least according to gender, IP and Dalit communities. In order to strengthen its social impact and to support the MDG goals of HSS a review of the FCHV programme is therefore needed in order to identify issues to be corrected. A review should deal with the following issues: i) why only female volunteers?, ii) level of support provided to FCHV to improve their performance, iii) selection criteria and process of FCHV selection, iv) supervision and follow-up of FCHV, v) whether awareness of issues related to gender, IP, and vulnerable groups are included in the training curriculum of FHSV. A review of the FCHV programme is included in the Action Plan, appendix 7.

5.2.4.2 Community health insurance schemes
It is a core issue to increase local community understanding of maternal health care and create understanding of generating and raising money. Creation of unit groups can be a viable way to enhance access of poor women to local health care services at hospital level. Groups can consist of 20 – 40 – 60 households. In order to prevent social exclusion help and guidance are needed to identify groups that are not included in the schemes, e.g.
Dalit groups in local communities, and clarify the reason why these groups are not included in the community schemes. Donor/Partner mandates are important to ensure that no discriminatory approaches are applied in forming household groups. A potential 2 phase strategy in forming household groups can be: 1) In the first phase: create groups in average communities situated by more homogenous population groups. 2) In phase 2 take into account class/ethnicity/caste when defining groups. Taking social stratification into consideration will work better and create more harmonious group constellations (Subedi, appendix 5). The group formation process will depend partly on the facilitator who make the groups and also on the local community, how stratified it is and so forth. The more equal a community (all households close to community average) the better group performances can be expected. This approach is expected to lead to holistic approaches and a precondition is thinking in potential needs.

Health services are beyond the reach of most rural women in Nepal. Today only 45% of rural women have access to basic health care. In order to enhance women’s ability to access and utilize health services in rural areas in Nepal the existing micro finance programs could include a women’s health component focused on compulsory health insurance financed from the participant’s savings (WB 2001A).

Gender mainstreaming projects to raise savings and microfinance need to take into account the prevailing gender power balance in the households (Ghimire, appendix 5). Before implementation of various community insurance schemes discussions between programme implementers and receivers should preferably be held according to a process approach. The initial gender power balance analysis on micro level must be carried out through the entire project process as input to current corrections according to experienced behaviour and outcome.

Cross sectoral committees should internalize community defined health needs into local plans. Likewise monitoring tools should be developed e.g. by applying interviews about experienced barriers to health care in the community. This could be regarding perceptions and like access barriers. This monitoring should be performed by the VDC. It is key to make group formation a self sustaining factor. This can be supported by internally evaluations (Subedi, appendix 5).

5.2.4.3 Traditional medicine and IP participation issues
Although the literature is scarce, the phenomenon of ethnomedicine and other alternative medication practices is wide spread in Nepal. Despite the health facilities provided by the government, more than 50 per cent of health problems never reach the established government health services. They are treated through a system of ethnomedicine and other alternative practices which are based on home remedies, commercial sales of traditional and modern medicine in over-the-counter sale (OTC) often combined with religious practices (Gartoula 1998).

There exist about 400,000 traditional service providers (dhami, jhankris, faith healers, sudenis and others) who are the first contact in
most of the rural settings and are practising from decades (Ayurvedic Dpt. Appendix 5; Rana 2001). There are indigenous system practitioners as Ayurvedic service providers, homeopaths and yunani system ones. FDG revealed that in Sipadol village an increasing tendency among faith healers referred patients to modern health facilities (FGD appendix 5). It is estimated that about 200,000 faith healers are operating in Nepal (Ayurvedic Dpt. appendix 5).

The Ayurvedic practitioners are closely related to the society in which they live and practise (Gartoula 1998). Their advices as elders are much sought after in all village activities, whether cultural, social, economic and political. They are often not merely regarded as a physician but considered as a friend, philosopher and guide by the community. Even today in rural areas these physicians remain the first contact of the villagers in times of illness and difficulties (Gartoula 1998).

There is a strong tendency to view the problem of health care as involving two systems only: western and traditional medicine. The problem - as it has been seen - does not fully fit in with any strait jacket classification. Policy decisions based on assumptions that underline this simplistic view may be unrealistic (Gartoula 1998). One of the most striking things about the contemporary alternative health care scene is the vitality displayed by traditional systems and their practitioners. By not in carrying on in an unchanged fashion traditional faith healers adapt their aetiologies, therapies, and rituals to meet the expectations of their traditional (and new) clients. This flexibility of the traditional faith healers in adapting to the modern world in its ways can be very useful for HSS in its outreach and referral strategies. Therefore faith healers should be integrated in HSS as a first line referral agency for the modern health system. A pilot project to investigate the possibilities to start up a combined traditional/western medicine education programme in the formalised education system is proposed in the ACTION PLAN (appendix 7).

Perception of health and illness varies with respect to the various groups or ethnicity. Nepal is an ethnic mosaic of a nation state. Though the multicultural perspective is accentuated socially, the dominant Hindu Religion in the 'local' context and western medicine and value in the name of 'developed' persist in every sector including the health (Limbu, appendix 5). Similarly the health personnel in massive number are of the dominant Brahmin community. None of the health personnel are reoriented towards the multiethnic, multi-religious social situation of the country. In addressing health seeking behaviour and treatment - either preventive or curative - the multilingual and multicultural reality must be realised by the State. This discrepancy in perception of health and illness leads to significant barriers in health seeking behaviour of indigenous people (Limbu, appendix 5).

In the village of Sipadol people still believe that illness is the result of rage of the spirit or god and a majority of the village people go to the traditional faith healer or “Jhankri”. However, with increasing awareness among people, the Sipadol village people practise both traditional and modern health seeking behaviour (FGD appendix 5).
Especially the caste/ethnic gender dimension should be addressed and monitored according to equity outcomes of health care reform, since most rural women are kept isolated in houses and therefore generally not aware of their potential possibilities and rights (Limbu, Ghimire, Bennett appendix 5). In monitoring progress of the health reform, use of benchmarks relative to base-line approaches - are advisable since application of benchmarks include a totality picture of all information and therefore support holistic policy approaches (Gartoula, appendix 5).

In order to provide sustainable health service provision in remote areas where local people are situated and where health post are only transitory staffed, educational programs to educate local (married) women with minimum 8 grade education level should be introduced alongside implementation of the essential health care package. This training program would produce low level health workers recruited from the same indigenous groups that could service their own indigenous communities. These trained health workers of local origin should provide basic health information and advice to local people. Education and training programs should be provided by government and NGOs (Limbu, appendix 5).

The proposed training program could be a starting point in a perspective process ending up with a model like the one applied in Sri Lanka. Sri Lanka has an old and well-established system of indigenous medicine which is supported by government (DI 2000). Some government health facilities provide indigenous medical services and government universities train indigenous medical practitioners up to degree level. The formalised education system in Sri Lanka has applied an integrated approach with integration of traditional and western oriented medicine. Today the rural-urban discrepancy in death rates is eliminated in Sri Lanka (DI 2000). A similar integrated system has been suggested for Nepal in order to use traditional health practitioners as mind set change agents for immunization, family planning and other basic preventive, promotive and curative services (Ayurvedic Dpt appendix 5; Rana 2001; Gartoula appendix 5).

**IP participation issues in implementation of HSS**

Important in the planning phase before implementation: The NEFEN can be a general agency to consult for the health care reform planning bodies, but at local implementation level it is a precondition for success that local indigenous people’s organisations will be integrated with their consultancy in local implementation bodies and local community representation (Limbu, appendix 5).

*Gained experience* in the implementation phase of various government and donor projects aimed at Indigenous Peoples Organisations (IPOs) show problems in the communication and cooperation phase between district secretaries and local IPO organizations. District secretaries often neglect the specific needs of the IPOs and make their own judgments on behalf of IPOs without consulting the local IPOs. A mechanism needs to be identified/developed to overcome this barrier and ensure better cooperation and this should be sought for in cooperation between IP organisations (e.g. NEFEN), government and NGOs.
Official statistics. Representatives for indigenous people states that MOH when publishing national figures do not take into account the wide geographic health disparities and stratify health indicators according to ethnicity (Limbu, appendix 5). Also research related to the health often generalises the population across the region, place of residence, and sex rather than the Dalit, ethnic or indigenous group specific. Research studies very seldom consult the group specific perception, health-seeking behaviour, and their traditional medicinal practices.

In meetings with ministries and government institutions NEFEN has on several occasions emphasized the need for calculating vital statistics (e.g. life expectancies and death rates) on different indigenous groups to be included in official databases administered by government and published together with national statistics. This also includes vital statistics for Dalit groups with information's on place of residence.

Involuntary resettlement and displacements. It was during the assessment study found that there were no indications of displacement (involuntary resettlement) or losses of land or livelihood implied for local people due to implementation of the HSS (WB 2001C,D). Currently, involuntary resettlement and displacements in connection with government provision of health care services is considered not to constitute any significant problems for indigenous people in Nepal according to Balkrishna Mabuhang Limbu (BML), Secretary General, Nepal Federation of Nationalities (NEFEN).

Potential issues to address according to indigenous people to promote participation (WHO 1999; Cohen 1999):
- mapping and documenting existing institutional arrangements for health care available to marginalized ethnic populations (traditional and allopathic medicine)
- identifying and exploring methods of overcoming cultural barriers to access to care
- encouraging closer links between traditional and allopathic health systems
- training programs of community health workers from marginalized ethnic populations
- reducing financial barriers by decreasing or waiving charges for health care
- establishing appropriate staffed and equipped health centres in areas with large poor and underserved ethnic populations
- strengthening incentives for private service provision in underserved locations
- training health professionals in cultural sensitivity.

6. Recommendations
A. Social impact and equity goals of HSS in a broad policy context
1. Long term perspective reform programs – such as the HSS – should be based on broad political consensus and international declarations to make the core program components robust to political change. To ensure sustainability of sensitive core reform issues related to debatable value oriented definitions consultation platforms including main stakeholders - political as well as beneficiary representatives - should be established. Consultations on this issue are proposed in the Action Plan in appendix 7.
2. The approach taken in the HSS is heavily biased towards acculturation to the dominant society values, including a pro rastra bhasa approach. As a function of political marginalisation and low representation in governance elites focus on IP/Dalit issues in previous HMGN development programs has been insignificant. Intended pro-IP/Dalit policies had been more symbolic than practical measured ex-post.

3. The outcome of an acculturation process depends of the acceptance vis a’ vis implied population groups of the elements of dominant and submissive cultures. A crucial step to achieve this acceptance is provision of platforms for informed participation by the indigenous people themselves. Mechanisms to ensure this are lacking in the approach taken in HSS and platforms for IP consultations on core issues are adopted in the Action Plan.

4. To reach HSS targets of MDGs in disadvantaged groups blanket versions of both the EHCS and the BCC should be avoided. BCC versions on issues relevant for IP with cultural and linguistic sensitivity to IP and disadvantaged groups in social hot spot areas are proposed in the Action Plan.

B. Multi-sectoral policies and the MDGs
5. In order to reach the MDGs remedies for interlinked problems of social and health inequities must come via combined policies. MOH should develop a standard instruction manual for packaging local health interventions with multi-sectoral approaches. Focus on infrastructure, education and empowerment of women is essential. A standard instruction manual on potential health supportive multi-sectoral interventions is included in the Action Plan.

C. Health care finance and social impact
6. Sustainable models of equitable schemes for financing, payment deductions and exemptions should be analysed comprehensively to ensure consistency. In search for alternative future schemes for finance, payment, and insurance degree of progressiveness is a relevant criterion when assessing potential social impacts.

7. The pro-poor exemption mechanism for specialised health services needs to be specified to ensure viable operationalisation (e.g. definition of criteria for vulnerability in pay deduction/exemption), practical administration (ensure mechanisms to prevent social exclusion and low administration cost). “Health cards” (a form of voucher for purchasing specialised health care services) issued to the poor and vulnerable groups can be potentially applied. The entitlement to the cards should be determined jointly by the governments and local representatives.

8. In search for future health insurance models experience from the community drug program can be used. To ensure progressive social impact mechanisms including risk pooling should be identified. Risk pooling merges the health risk for a group of people who have different health care needs and different incomes.
9. Since expertise on designing equitable insurance schemes in MOH is very limited, external expert consultations on future health insurance schemes are highly needed. A potential risk for developing health insurance schemes without adequately considering negative social externalities exists. To avoid a negative downward spiral process leading to adverse health impacts of disadvantaged groups, it must be technically ensured that future health insurance schemes are selected according to appropriate social criteria and measures of income protection to poor population segments. External consultancy on future health insurance schemes is included in the Action Plan.

D. Equity in resource allocation, payment method and health care benefits

10. To enhance utilisation of government health facilities by poor and marginalised groups, a combined policy strategy should be pursued. Surveys on client satisfaction in Nepal and international evidence emphasise the following strategies to increase utilisation: current availability of essential drugs, current staffing, culturally sensitive service set-up at the facilities, training of health personnel with emphasis on dialogue and inclusion of local values, and finally, poor-friendly user fee systems. Since Nepal has population groups characterised by extreme poverty with no ability to pay, HMGN should consider essential medicines available to the poorest population segments free of charge.

11. Due to priorities regarding HMIS and NHA, MOH will not be able to disaggregate data according to ethnicity, caste, and even gender. Monitoring and reporting of any potential adverse effects of HSS will not be possible on a current basis, thereby critically inflating the equity profile of HSS. A second best solution will be regular monitoring by benefit studies on spot survey basis. Though MOH should preferably be the prime agent to perform the benefit studies supporting its stewardship of HSS, it is advised that organisations independent of MOH will be conducting these benefit studies. This is due to partly low level of expertise in MOH on issues related to stratified and differential health outcomes and partly because of low attention on and priority of IP, low caste and gender issues in health policy historically.

12. Women are characterised by higher health risks due to mechanisms of stratification, differential susceptibility/exposures and economic consequences of ill health compared to men. Inclusion of gender-related allocation criteria based on differential health needs (measured as relative disease burden) are therefore a highly relevant component in the resource allocation formula to be developed in HSS. Further, criteria for central resource allocation to districts should be developed by MOH, including as a minimum: population characteristics (size, ethnicity, castes, and socio-economic groups), indicators of human and gender development (e.g., HDI and GDI), and availability of local health and social service institutions per population size. Finally, geographical equity-related concerns on "social hot spots" should be included in the resource allocation formula. GIS mapping is a highly supportive planning tool in identifying,
mapping and monitoring “geographical social hot spots” requiring extra support from MOH.

E. Decentralisation:
13. Due to lack of adequate resources and to prevent leakage and wastage leading to under utilisation MOH should concentrate allocation of its scarce resources to fewer health posts. Fewer health facilities with regular basic quality services and drug supplies for all year requirements might significantly increase efficiency, utilisation and equity. Especially the Far-Western and Mid-Western regions are characterised by critical inadequacy of staffing and drug supplies, a situation exacerbated by the Maoist insurgence.

14. The geographical distribution of life expectancy, income, educational level, poverty and women’s development strongly indicates a positive correlation between geographical distribution of human development and health status. Concerted and focused actions directed at geographical “social hot spots” will therefore have the largest supportive effect for the health sector in improving local population health status. The rural and remote rural areas in Far-Western and Mid-Western regions suffering from combinations of significant low level of human development, critical state of PHC facilities and with the most severe negative effects of the Maoist insurgence should have a special and high priority in HSS according to extra decentralisation support.

15. In 1999, the local Self-Governance Act was amended, giving more power to the local government bodies (DDC and VDC) including the authority to protect, preserve and promote IPs language, religion and culture. Since 1999 no evaluations or assessments on how the local bodies have managed the role as implementer of government policies towards vulnerable groups, including IP and Dalits has been conducted. An evaluation on how the local bodies have managed the role as implementer and local coordinator of government policies since 1999 towards disadvantaged groups, including IP and Dalits is included in the Action Plan (appendix 7).

F. Efforts to strengthen the social impact of HSS
16. A social hot spot program package should be developed in connection to HSS. This special programme should target identified vulnerable communities in mainly rural and remote rural areas in Far-Western and Mid-Western regions and most marginalised Dalit communities in other regions. This program package should take a holistic approach applying concerted multi-sectoral interventions. Access barriers for receiving health services should be minimised for the beneficiaries of this special intervention PHC package and include income protection measures such as effective exemption schemes for all user charges for health services and drugs.

17. Strong indications of wide health gaps among different population groups exist. HMGN should promote development of operational classification and definitions.
of the various sub-population groups enabling MOH to track and monitor development in HSS key social goals. The HMGN establishment of NDC in April 2002 represents a promising step forward towards operational classification on Dalit population segments and the NDC definitions should be applied to monitor health impact and other stratified beneficiary data in HMIS, NHA and benefit studies.

18. A primary success criterion for the HSS will be the ability to track and monitor impact and outcome of the PHC programs (EHCS and BCC) for vulnerable and marginalised population segments that are most in need, not least women in Dalit and IP communities. This should be ensured via NHAs and HMIS allowing monitoring and evaluation of HSS impact on main social stratification brackets (gender, caste, class, ethnicity, and geography/topography).

G. NGOs and participation in HSS

19. Historically, lack of viable government NGO policies has had adverse effects on the development of several aspects of NGO performance. Government stewardship of NGO activities should be strengthened by development of guidelines for NGO activities and focus on the following issues: 1) Design programs based on needs assessment, 2) implement programs in proper and effective ways avoiding duplication (e.g. by use of GIS mapping), 3) enhance professionalism and cultural sensitivity among the NGO workers through government training programs, 4) cooperate from day one with local people to ensure participation in projects they implement, 5) assist in instituting grassroots/IP organisations and strengthen their participatory skills, 6) open up career opportunities in the health sector for the young generation 7) include teaching of democracy and rights awareness in NGO programs to increase demand and utilisation. A workshop on IP related issues as a lead up to production of an instruction manual/social safe guard is included in the Action Plan.

20. The health services being provided by the NGOs generally lack participatory support of the community, government district health offices and local authorities (DDC/VDC). Most of the NGOs/INGO have a tendency of implementing the project directly rather than through the grass root organisations and thereby lacking to facilitate the beneficiaries to participate in the planning and implementation process. When INGO therefore become participatory implementers of the HSS in regions with IPs it is important for MOH and local governments to ensure that the operating I/NGOs possess the necessary social, technical and legal skills needed for carrying out the health programs sensitive to IPs and marginalised groups in a participatory manner with due respect of local culture and customs. Certifications for I/NGOs issued by MOH - achieved after review of gained experience and applied implementation approaches - could be one potential approach to ensure I/NGO actually being capable of operating among IPs. Establishment of introductory courses for I/NGOs working in IPs are another - more costly - approach. Development of a pilot introductory training
program (TOT) for INGOs working in Far- and Mid Western Region is proposed in the Action Plan.

21. In order to keep track of the NGOs and INGOs working in Nepal, registration as well as coordination, monitoring and evaluation should be given to the concerned District Development Office. This will enhance the overall planning requisites at disposal for the DDC. Strategies to enhance the managerial capability of DDC/VDCs to plan and implement interventions aimed at marginalized groups are proposed in the Action Plan.

H. Private sector and participation in HSS
22. In order to strengthen the effective and qualitative supply of health services to the poor population segments the widespread practice of double billing by government physicians should be limited by regulations.

23. Improving the staffing situation in rural areas is key for meeting the staffing goals set out in the HSS. In order to improve the staffing situation in remote rural areas government should develop regulation on schemes based on both regulatory arrangements and incentive settings. Mandatory approaches are welcomed by the private sector if appropriate arrangements are made alongside (education facilities for children of the remote stationed staff, refresher courses and upgrading etc.). Incentive as well as mandatory schemes for specialised health professionals to work in remote areas should be developed in close cooperation with the private sector and their organisations.

24. All activities in the private sector are based on business criteria and HSS participation implying costs should be compensated either directly or indirectly. To include pro-poor schemes in private sector service supply and administration viable indirect HMGN compensation arrangements are: Tax, custom and duty exemption in import of necessary medico instruments and supplies, financial credit and management support where needed. Participation based on mutual benefit ("give and take") should be a key principle in collaboration between HMGN and the private sector.

I. Donors and participation in HSS
25. The social hot spot program package should technically be operationalised by a basket funded program between MOH and EDPs. In order to prevent social exclusion locally and ensure utmost benefit of the pro-poor arrangements in HSS MOH should take on the full responsibility and stewardship of the social hot spot programme package. On the other hand the basket fund approach will enable EDPs current evaluating on MOHs performance and allow correction if the targeted interventions are not meeting social impact and equity goals. Organisations of IP and vulnerable groups should be included in the design, implementation and current evaluation of the social hot spot program package.
26. Above all, the capacity building of the implementing agency is vital for successful implementation of programme assistance, also under basket funding mechanism. Frequent turnover of key staff and trained staff should be retained for the project period. A programme for capacity building in MOH to manage and steward basket funded projects is suggested in the Action Plan.

J. Traditional health systems and participation in HSS
27. 400,000 traditional health service providers are often the first line client contact in most rural settings. An integrated approach combining traditional and western medicine in order to use traditional health practitioners as mind set change agents for immunization, family planning and other basic preventive and curative services are key in HSS to reach IP and marginalised groups. Additional, faith healers can be integrated in HSS as first line referral agent to modern health facilities. A pilot project to investigate the possibilities to start up a combined traditional/western medicine education programme in the formalised education system is proposed in the Action Plan.

K. Communities: Gender, caste and IP participation in HSS
28. To prevent social exclusion locally, all education, training and empowerment programs directed at beneficiaries in social hot spots and other extremely deprived communities should be provided with joint intervention schemes delivered by government and NGOs. In its overall stewardship of HSS MOH should ensure that participation of Dalit and IP organizations are included in designing of training and empowerment programs and that participation of local IP organizations and Dalit community representatives are included in all stages of program implementation and evaluation.

29. A mechanism is needed that overcomes the barriers of communication and collaboration between district secretaries and local IP organizations when implementing health intervention schemes. IP organisations (e.g. NEFEN), representatives from local government and NGOs should commonly develop a manual including a check list/safe guard for NGO and government employees operating in IP populated rural areas. A platform for consultation on this issue is suggested in the Action Plan.

30. Preferably, training programs on maternal health should begin with the knowledge, values, and concerns of the women involved instead of with the assumptions that their understandings are inadequate and deficient. An approach respecting local knowledge and norms will create an appropriate basis for mutual understanding and communication, not least among IP and population segments for which a culturally sensitive approach is conducive for utilization of government health services. Inclusion of issues related to gender, IP and vulnerable groups in the training curriculum of FCHV as component in a comprehensive review of the FCHV programme is suggested in the Action Plan.
31. Compared to health staff with cultural origin different from the local community they serve health workers of local origin are the best community agents to provide basic health information/promotion and assistance in referral to modern specialised health services. Educational programs to educate local (married) IP women with minimum 8 grade education level should be introduced alongside implementation of the essential health care package in HSS. This training program would produce low level health workers recruited from the indigenous groups servicing their own indigenous communities. Selection criteria and process of FCHV selection are suggested as review component of the FHCV programme in the Action Plan.

32. Household analysis and fields exercises should be carried out as a necessary precondition before implementation of pro-poor projects to increase savings in revolving funds or microfinance schemes. These analyses should take into account the prevailing gender power balance in the community households by discussions between programme implementers and receivers. Implementation should follow a process approach. The initial gender power balance analysis on household level must be continued through the entire project process as input to current evaluations and corrections according to experienced behaviour and outcome.

33. In order to prevent social exclusion in future community health insurance schemes HMGN should provide regulation, assistance and guidance on how local bodies can identify and include groups that are at risk of being excluded from given schemes. Concretization of these issues is included as discussion issues for the consultation platforms proposed in the Action Plan.

34. NEFEN considers language as one the most severe access barriers by indigenous people to basic health care, - even bigger than barriers connected to economic and resource limitations. Language is by NEFEN perceived as leading to significant under-utilization of public health services by the various indigenous groups. The acculturation approach followed in HSS is not agreed upon by representatives from NEFEN.

L. Future research needs and information gaps

35. Research reveals that other factors than public health expenditures have been in play causing the significant progress in health status during the Ninth Plan. Further research is crucially needed that identify the root causes (significant explanatory factors) behind the observed improvement of the central health indicators during the Ninth Plan period. Identification and reinforcement of the positive underlying factors are potentially significant inputs to develop comprehensive intervention schemes meeting the MDGs and research should take a comprehensive stratified approach to identify which population groups have been experiencing net health benefits in the Ninth Plan period.
36. The community drug program should be reviewed according to coverage, equity and social impact. In scaling up the drug program experience on preliminary program strength and weaknesses are necessary to ensure social inclusion and coverage of the program. A review of the community drug scheme is included in the Action Plan.

37. No comprehensive research analysis taking a stratified approach of health status and impact of health services have ever been conducted for Nepal. Investigation of these subjects should be conducted for various population groups, not least IPs and Dalits and focus on indicators of health outcome and social impact of health care provision.

38. There exist a large information gap on how the local bodies (DDC ad VDC) have managed the role as implementer of government health policies towards vulnerable groups, including IP and Dalits since the local Self-Governance Act was amended in 1999. Evaluations and social assessments are highly needed in order to evaluate the local bodies’ ability and willingness to deal with related concerns and to identify issues for support or regulation.

39. According to NGOs the following information gaps should be filled in future: 1) Evaluation and mapping of the present I/NGOs and their health activities in Nepal. 2) Impact study of the I/NGOs on the local health related efforts of Nepal. 3) Ways and means of coordinating I/NGO activities with those of the VDC and DDCs. 4) Extent of local resource mobilization and people’s participation by the I/NGOs in Nepal.

40. Continuation, improvement and strengthening of the FCHV programme are a key strategic priority for HSS. Regarding the importance of first line health workers in rural and remote areas a strengthened FCHV programme will act as a powerful booster for the social impact of HSS. In order to strengthen its social impact and sensitivity to gender, IP and Dalit issues a review of the FCHV programme are highly needed in order to identify issues to be enforced and improved. A review of the FCHV programme is included in the Action Plan in appendix 7.

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PDDP, 


Appendices

Appendix 1

Figure 2. A framework for elucidating the pathways from the social context to health outcomes and for introducing policy interventions
Appendix - 2

Caste and ethnic groups, languages and religions

<table>
<thead>
<tr>
<th>Major classifications</th>
<th>Major caste/ethnic</th>
<th>Language</th>
<th>Religion</th>
</tr>
</thead>
</table>

Source: Diderichsen et al 2001
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<th>Group</th>
<th>Family</th>
<th>Source: Pradhan 2003</th>
</tr>
</thead>
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<tr>
<td><strong>Hills and mountains:</strong> Pahadi 66.8%</td>
<td><strong>Ethnic communities</strong> 26.5%</td>
<td><strong>Tibeto-Burman=20% Tamang (4.5%) Newari (3.7%)</strong></td>
</tr>
<tr>
<td></td>
<td>Magar (7.2%)</td>
<td>Buddhism, animism etc. Buddhists (7.8%)</td>
</tr>
<tr>
<td></td>
<td>Newar (5.5%)</td>
<td>Hinduism Hindus (86.5%)</td>
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<td></td>
<td>Tamang (5.5%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rai (2.8%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Gurung (2.4%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Limbu (1.6%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sherpa (0.6%)</td>
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<tr>
<td><strong>Parbatiya castes</strong> 40.3%</td>
<td>Chhetri (4.1%)</td>
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<tr>
<td></td>
<td>Bahun (12.9%)</td>
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<tr>
<td></td>
<td>Various service castes (11.3%)</td>
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</tr>
<tr>
<td><strong>Other people living in the hills/mountains 1%</strong></td>
<td><strong>Castes 15.9%</strong></td>
<td><strong>Indo-Aryan=80% Nepali speakers (50.3%, including people from non-Indo-Aryan communities). Others: Maithili (11.8%) Bhojpuri (7.5%) Tharu (5.4%) Awadhi (2.0%)</strong></td>
</tr>
<tr>
<td>Plains: Madhesi 32.1%</td>
<td>Yadav (4.1%)</td>
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</tr>
<tr>
<td></td>
<td>Brahmins (0.9%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Various Kshatriya castes (0.8%)</td>
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</tr>
<tr>
<td></td>
<td>Kalawar and other “impure” castes (3.2%)</td>
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</tr>
<tr>
<td></td>
<td>Musahar and other “untouchable” castes</td>
<td></td>
</tr>
<tr>
<td><strong>Ethnic communities 9%</strong></td>
<td>Tharu (6.5%)</td>
<td></td>
</tr>
<tr>
<td><strong>Others 7.2%</strong></td>
<td>Muslims, Sikhs, Marwaris and other groups listed as “Others”</td>
<td>Other religions Muslims (3.5%)</td>
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99.9% 99.9% 99.9% 99.9% 99.9%

List of Indigenous People
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<th>Kumal</th>
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<td>Dhanuk (Rajbansi)</td>
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<td>Dhimal</td>
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<td>59</td>
<td>Hyolmo</td>
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*Source: NG 2001*
## Ethnic/Caste Dominance by Geographic Region

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<tr>
<th>Elevation Zone</th>
<th>Group</th>
<th>% of West</th>
<th>Group</th>
<th>% of Central</th>
<th>Group</th>
<th>% of East</th>
<th>Group</th>
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<tbody>
<tr>
<td>Mountain</td>
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<td>53.0</td>
<td>1. Tamang</td>
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<td>1. Chhetri</td>
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<td></td>
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<td>2. Gurung</td>
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<td>2. Rai</td>
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<td>1. Tamang</td>
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<td>1. Chhetri</td>
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<td>Terai</td>
<td>1. Tharu</td>
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<td>1. Yadav</td>
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<tr>
<td></td>
<td>2. Chhetri</td>
<td>15.4</td>
<td>2. Tharu</td>
<td>9.2</td>
<td>2. Muslim</td>
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*Source: Gurung 2001*

## Appendix - 4

### Ethnic Population by Regions, 1991

<table>
<thead>
<tr>
<th>Geographic Region</th>
<th>Population</th>
<th>% of Total</th>
<th>% of Regional Population</th>
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<tbody>
<tr>
<td>A. Mountain</td>
<td>375,811</td>
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<td>31.8</td>
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<tr>
<td>1. West</td>
<td>23,755</td>
<td>0.4</td>
<td>4.0</td>
</tr>
<tr>
<td>2. Central</td>
<td>44,161</td>
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<td>87.4</td>
</tr>
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<td>3. East</td>
<td>307,895</td>
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<td>57.4</td>
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<td>B. Hill</td>
<td>3,249,622</td>
<td>50.5</td>
<td>42.2</td>
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<td>4. West</td>
<td>23,848</td>
<td>4.1</td>
<td>15.6</td>
</tr>
<tr>
<td>5. Central</td>
<td>1,208,767</td>
<td>18.8</td>
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<tr>
<td>6. Kathmandu Valley</td>
<td>649,993</td>
<td>10.1</td>
<td>58.8</td>
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<td>7. East</td>
<td>1,127,014</td>
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<td>C. Inner Terai</td>
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<td>8. West</td>
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<td>37.9</td>
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<td>9. Central</td>
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Field report, Kathmandu 3 – 9 January 2003

Meeting summaries

Meeting schedule:

**Sunday 5 January**
12:00 Nepal Health Economics Association (NHEA). B.R. Shrestha, economist NHEA treasurer
14:00 – 15:00 Meeting with Padma Methema, senior Social Sector Development Economist, Social Service Division, National Planning Commission Secretariat. p.t UNFPA
15:30 – 17:30 pm Meeting with Balkrishna Mabuhang Limbu, Secretary General, Nepal Federation of Nationalities (NEFEN)

**Monday 6 January**
9:30 AM. Meeting at the Resource Centre For Primary Health Care (RECPHEC), Shanta Lall Mulmi (SLM), Executive Director.
11:30 – 13:30 Stupa Health Care Centre Co-operative Ltd (SHCCC), Chairman Associate Professor Dr. Ritu P. Gartoula.
14:00 – 16:00 PM UNDP, Mainstreaming Gender Equity Programme, Indu Pant Ghimire (IPG), National Programme Manager.

**Tuesday 7 January**
10:00 AM District Health Strengthening Project (DHSP), HMGN/DFID, Hugh Moffatt, team leader and Dr. S. Robertson
12:00 Dr. Chatra Amatya, Director, Ministry of Health
14:00 UNDP/ HMGN Nepal Participatory District Development Programme (PDDP) NEP /95/008. Sanjaya Adhikari, National Programme Manager.

**Wednesday 8 January**
10:00 AM Red Cross Society. Umesh Prasad Dhakal, Director and DEV Ratna Dhakhwa (RD), Secretary General.
11:30 AM. Nepal Safer Motherhood (SM) Project – a part of HMGN Safe Motherhood Programme, Hom Nath Subedi, Social Development Manager.
14:00 - 16:00 Community Drug Programme, Department of Health Services, Navin Shrestha, Chief Community Drug Programme

**Thursday 9 January**
11:00 – 13:00 Bhaktapur Hospital, interview with Mr. JN Sharma, Accounting Officer
14:00 – 15:30 AM World Bank, Yak & Yeti Hotel, Dr. Lynn Bennett, Sector Director, Social Development, South Asia Region.
16:00 – 16:30 Dr. Celia Male, Anthropologist, Social Advisor (vacancy), DFID.

**Sunday 5. January**

12.00 Nepal Health Economics Association (NHEA). B.R. Shrestha, economist
NHEA treasurer.

**The meeting had the following conclusions:**

1. NHEA is at present developing a model for National Health Accounts (NHA) for Nepal. The model is inspired by the NHA approach used in Sri Lanka (guidelines) and follows the OECD manual for developing country NHAs.

2. Regarding inclusion of data on social stratification, income and ethnicity, these are at present not built into the pilot model. Inclusion in NHA of these variables is technically feasible and if included this will enable monitoring development according to the equity targets of the health care reform (stratifying on vulnerable groups and other social sub population groups).

3. Introductory training programs to ensure ability to interpret and use NHA outputs at central as well as local level are highly needed to make full use of the NHA planning tool.

4. Currently, NHEA is involved in the study of equity in health care financing, delivery and health status in Asia-Pacific Countries (EQUITAP), supported by the European Union. The aim in the micro-component of EQUITAP study is to assess and compare equity across the countries of Asia-Pacific region.

14.00 – 15.00. Meeting with Padma Methema, senior Social Sector Development Economist, Social Service Division, National Planning Commission Secretariat. p.t. UNFPA.

**The meeting had the following conclusions:**

1. In the planning phase inter ministerial cooperation usually works quite well.

2. When implementing common programs line ministries often pursue their own agendas because of resource scarcities.

3. Successful cross ministerial coordinated policies has also been experienced.

15.30 – 17.30 pm Meeting with Balkrishna Mabuhang Limbu, Secretary General, Nepal Federation of Nationalities (NEFEN)
The meeting had the following conclusions:

1. The main discrepancy in the health sector among indigenous population lies in the involuntary shifting of indigenous peoples from their traditional practices to the inaccessible - so called modern - health services;
2. The main gap in the health services provided to indigenous peoples is the insensitivity of the State to the indigenous peoples' culture, language, and way of living, since the health system is entirely run by dominant population groups with their value settings;
3. The multicultural, multilingual and multiethnic representation and participation are essential in and a milestone to designing the health system in Nepal;
4. Massive health training services must be provided to the Indigenous Peoples, communities and individuals to improve the health situation in their respective groups;
5. The scholarships for the study and training must be given to the respective indigenous peoples groups in consultation with their own organization; and
6. To ensure regular calculation and publishing of vital statistics and health surveys for the various indigenous population groups participation with their organisation is necessary to reveal their severe health status.

Monday 6 January

9.30 AM. Meeting at the Resource Centre For Primary Health Care (RECPHEC), Shanta Lall Mulmi, Executive Director.

The meeting had the following conclusions:

1. Health data are difficult to require from ministries though legal rights to require officially compiled data exists. A transparency mechanism is needed which can show light on issues of how are resources utilized? This should published by Govt. thereby providing transparency.
2. Unless Govt. ensures the basis for ownership and equal participation by local people in decentralizing Govt. is de facto trying to escape responsibility for providing primary health care to the vulnerable groups locally. Govt. bears the moral responsibility to provide basic health care and should not escape this by decentralizing.
3. Local group organization and capacity building should be based on local organization and sub population groups, e.g. local married women.
4. Govt. should provide guiding principles for NGOs working with training of health workers to ensure uniformity in provision from NGOs, since there is little consensus between NGOs relating to training approaches.
5. Experience show that health information (and education) directed at the policy making level is difficult to provide so that health knowledge internalizes in policy making.
6. Sustainable decentralised approaches hinge on two main issues: 1. Ownership of local people 2. Local people must be trained locally. If these two preconditions are not met in decentralisation there will always exist the
question of inadequate health care man power. If the preconditions are met adequately in health reform, it is more a question of managing available resources than providing extra resources.

7. According to implementation of Govt. policies Nepal has comparatively lack of resources in 1) political stability, 2) Administrative efficiency and 3) historical bureaucracy preference for top-down (vertical) policy implementation approaches.

11.30 AM Stupa Health Care Centre Co-operative Ltd (SHCCC), Chairman Associate Professor Dr. Ritu P. Gartoula.

The meeting had the following conclusions:

1. Programmes must be developed in a comprehensive way. Health is not a single but multiple factor concept and policies to enhance population health must take comprehensive approaches. “People do not live sector-wise”.
2. The comprehensive philosophy is simple: Ensure the provision of food to people 3 times a day and (e.g. by growing naturally house garden food). This philosophy has been successfully pursued in Sri Lanka.
3. Policy entry points must first of all address root causes of ill health, meaning respect and understanding of characteristics of specific cultural habits, language and social stratification of the local communities where intervention programmes are intended to take place.
4. Polypathy systems as practised in Sri Lanka can act as models for Nepal.
5. Often donors pursue narrow profit oriented interests which works counter to comprehensive/holistic health promoting intervention approaches. Often big pharmaceutical companies are operating though donors.
6. In monitoring progress of health care reform: use benchmarks not baselines. Benchmarks include a totality picture of all information and therefore support holistic approaches.
7. NHA should ideally include 1. stratification (Nepal has 7 classes according to Blackie & Cameron et al), 2. Topography 3. Other physical resources than health care facilities 4. rural/urban issues.
8. Comprehensive analysis of social stratification and health is much needed in Nepal. No comprehensive analysis has been made until now.
9. Participation strategies: The Sisterhood method can be an applicable method in ensuring participation and local experience and capacity building when implementing health care reform (Essential health care package and the intended Behaviour Change and Communication Program).

14.00 PM UNDP, Mainstreaming Gender Equity Programme, Indu Pant Ghimire, National Programme Manager.

The meeting had the following conclusions:
1. Going beyond equity and simply addressing equality is more appropriate at the present stage in Nepal. First equality -> then equity.

2. Discrepancy in policy enunciation and ex-post performance: Govt. has put mainstreaming of gender equity on the political agenda since the 6th Plan and it is still an agenda issue in the 10th Plan without much change in women’s situation has actually taken place.

3. Politicians have deeply inherited beliefs of the gender mainstreaming that works counter to the enunciated policies in the Plans.

4. Household analysis and fields exercises are important preconditions for ensuring future consistency between policy formulation and implementation.

5. Besides gender aspects intervention outcomes should be monitored according to ethnicity, caste, geography and topography. Caste/ethnic differences in gender relation are important.

6. General barriers for women utilization health services: Indiscrete treatment and diagnostic environments where diagnose often implies exposure to male health personal.

7. Experience show, that use of locally produced health information materials has the highest effect.

8. According to the introduction of community health insurance schemes the gender factors has to be taken into consideration when deciding between the various models of insurance schemes.

9. An equitable health care system will become reality in Nepal only when evidence of gender based imbalances in health is taken into account and gender issues are consciously considered and addressed in policies, programmes, Acts and monitored in against expected results.

10. Readdressing should start with legislative and financial measures.

Tuesday 7 January

10:00 AM District Health Strengthening Project (DHSP), HMGN/DFID, Hugh Moffatt, team leader, Dr. S. Robertson.

The meeting had the following conclusions:

1. HSS represents a complete change of basic planning characteristics and approaches compared to former practices of Govt. central planning.

2. Holistic approaches in addressing health issues are needed: “people are not living their lives sector wise”. Though at district level equity is not on the agenda. Mind set has to be changed at the local level too.

3. In order to address root causes of social exclusion need to be addressed along with implementing of holistic approaches. A precondition for this is the creating of the best attainable receiving environments for
dealing with decentralisation as well as equity issues given the present local opportunities. This can be done with a stepwise approach.

4. Ad hoc planning approaches that take into account practice based experience will be a viable approach to prevent inappropriate uniform/blanket policy entries due to lack of managerial planning experience and professionalism at district level.

5. A change in donor attitudes can show to be a necessary precondition for effectively strengthening the overall effect of applying total resources available in the Nepal health sector in concerted actions under the strategic auspices of Govt.

6. Bureaucrats are often politically appointed, why this loyalty bias often creates barriers in inter-sectoral cooperation at central level - affecting concerted actions at lower level as well. In more successful cases Govt. cooperation are often due to personal connections between line ministries and via other informal ways.

7. Gender is a key social stratifier and prioritizing women in the HSS can show up to be a gateway to address other stratification issues in society, such as caste, ethnicity etc.

12:00 Dr. Chatra Amatya, Director, Ministry of Health.

The meeting had the following conclusions:

1. Education is the main explanatory factor for the experienced progress in vital statistics during the last 10 years (the Ninth Plan period).
2. MOH is not the sole actor that has potential influence on population health, other ministries and sectors play important roles, too.
3. Language does not constitute a significant access barrier. Nearly 80% understand or speak Nepali. Besides, village health workers are recruited from local environment and they speak local languages, therefore language is not a significant access barrier problem

14:00 PM. UNDP/ HMGN Nepal Participatory District Development Programme (PDDP) NEP /95/008. Sanjaya Adhikari, National Programme Manager.

The meeting had the following conclusions:

1. GIS (Geographical Information System) has been introduced by PDDP in many districts allowing local planning bodies to achieve better overview of where are the services provided and where are the beneficiaries located. GIS are used to map location of roads, health care facilities, agriculture etc.
2. The input data in GIS on beneficiaries include also stratification of district population according to caste, and other socio economic characteristics. Such overview will provide a basis for optimizing local planning.
3. To encourage further decentralisation activities PDDP intends to map and estimate – with use of GIS – the potential correlation between the relative supply
of Govt. social/health services and the prevalence of local political instability in order to guide social and health policy.

**Wednesday 8 January**

10:00 AM Red Cross Society. Umesh Prasad Dhakal, Director and DEV Ratna Dhakhwa, Secretary General.

**The meeting had the following conclusions:**

1. The strategic point is to enter into different communities -> work with them in a participatory way with the clear objective of handing over responsibility after finishing capacity building.

2. The challenge is to avoid dependency and attachments in working with communities. Local implementers must act as catalysts for local participatory and sustainable development processes and seek to avoid the mutual risk of dependency.

3. Donors should be kept in line not to be attached to the project and the local communities. Govt. should ideally take on the agency role that set the limits for donor projects.

4. On the other hand Govt. should be kept responsible for continuation of projects and should ensure that continuity factors are in place when donors are handing over projects to the local communities.

5. Often a controversy emerges between applying interventions to diversified and uniform communities applying the same intervention scheme. A demand based approach (bottom -up approach) in identifying the right composition of intervention components in diversified community environments is an applicable way to implement development and health projects that match local characteristics and needs.

11:00 AM. Nepal Safer Motherhood (SM) Project – a part of HMGN Safe Motherhood Programme, Hom Nath Subedi, Social Development Manager.

**The meeting had the following conclusions:**

1. Different remunerations for training by donors distort incentives to attend training programs.

2. User fees constitute one significant type of barrier in accessing hospital services. But user fees are necessary for financing hospitals, because they are under budgeted. A framework is needed for ensuring sustainable availability of health services and ensuring pro poor access simultaneously.
3. It is a core issue that parallel to increase local community understanding of maternal health also to create understanding of raising money in unit groups in the local community.


5. In preventing social exclusion assistance is needed to identify groups that are not included in the schemes, e.g. Dalit groups in local communities, and clarify the reason behind why these groups are not included in the community schemes.

6. The group formation process will depend partly on the facilitator who make the groups and also on the local community, how stratified it is and so forth. Taking class into consideration will work better and create more harmonious group constellations.

7. A precondition is thinking in potential needs. Cross sectoral committees should internalize community defined local needs and internalize these into local plans.

8. Monitoring tools should be performed by the VDC and developed by using interviews about factors concerning barriers and satisfaction in community.

9. To factors are core explanatory factors in explaining improvement in vital statistics during the Ninth Health Plan: 1) Increased adult literacy rates, especially among women and 2) poverty alleviation programs. A cofactor in this process has been decentralising. Key in future is how to empower VDCs to further this positive progress.

14:00 - 16:00 Community Drug Programme, Department of Health Services, Navin Shrestha, Chief Community Drug Programme

**The meeting had the following conclusions:**

1. The drugs are distributed in the sub-health posts, health posts, the primary health centers free of costs. But the drugs are not enough to run the healthcare centers for the whole year. It is hardly enough for 3 to 5 months.

2. People do not intend to come to the healthcare centers when there is no medicine. This is especially the case in rural areas.

3. Several observations show that people are willing to pay for drugs.

4. Under the Community drug schemes, drugs are not free of charge, but are sold at subsidized prices. Drug prices at the health facilities are therefore cheaper than in the drug stores.

5. Under the Community Drug Scheme, there is the element of free provision (pay exemption) for the poor and destitute, but the management committee is very much hesitant to make use of it. Exemption is provided to a very limited amount of persons (1-2% of patients) though 42 % of population live under the poverty line.

6. In 48 health facilities where CDP is being implemented, the total amount in the Revolving Drug Fund has reached over Rs.5.4 million. Thus, on the average, one health facility has about Rs100,000 at its disposal for drugs and pro poor exemption provision.
7. Community Drug Scheme can be taken as a part of health insurance scheme.
8. Though the Community Drug Scheme and the work in developing insurance models.
9. Government has paid very little importance on developing community drug scheme. Only limited staffs have been provided to the division that also will be developing different models for pro poor community insurance schemes.

Thursday 9 January

11:00 am 12:30 Bhaktapur Hospital, interview with Mr. JN Sharma, Accounting Officer

The meeting had the following conclusions:

1. The hospital is financed via two main sources; 60% from government and 30% from out-of pocket payments.
2. The government underbudgetting generates a situation, where the hospital must rely on alternative financial sources to meet basic current expenditures. The scope of facilities provided by the hospital is therefore gradually contracting, which in turn, is limiting the internal revenue of the hospital.
3. Everybody, including the poor and destitute, is fully exempted in drugs.
4. Government's quota for drugs is enough for the first quarter only. The residual hospital drug supplies are procured by the hospital managing committee for the internal revenue, which is also financing staff in supporting functions.
5. The poor and destitute can be partially or fully exempted from laboratory test or x-ray. In the last six months, only three persons have been so far exempted. Exemption is highly discouraged because the exemption has to be audited. Besides, out-of pocket payments are a significant revenue source for financing the hospitals current expenditures.

14:00 – 15.30 AM World Bank, Yak & Yeti Hotel, Dr. Lynn Bennett, Sector Director, Social Development, South Asia Region.

The meeting had the following conclusions:

1. Women – and in particular rural women – are often isolated and kept in houses and are therefore generally not aware of their potential possibilities (including rights) according to receiving health services.
2. Though democracy was introduced in 1990 people are not used to raise their voice in demands for public health services, so teaching democracy is key in developing bottom-up demand driven policy approaches.
3. Policies aiming at promoting equality and equity issues can also potentially collide with the prevailing diversity in needs locally. Participatory planning is therefore essential in formulation of policies adequately addressing local needs.
4. Comparative approaches can be applied in analysing health post that has not yet been decentralised compared to decentralised health post that has voluntary local funding as financial base. According to this experiences from voluntary funds can be of potential use.

16:00 – 16.30 Dr. Celia Male, Anthropologist, Social advisor (vacancy), DFID.

The meeting had the following conclusions:

1. Military has stopped for all drug supplies to various districts where DFID are working, and the present situation constitutes a severe barrier in the implementing environment of any Govt. policy concerning district planning and decentralisation.
2. Analysis of all Govt. policy planning for the coming 2-3 years ahead must take into account the present political instability as a substantial barrier for enunciated policy at central level.
3. The Maoist pursues a destructive and non-cooperative strategy to Govt. and donors/INGOs.
4. Larger donors and INGOs have been threatened by the Maoists in performing their work locally, and are considering withdrawing from several projects in Maoist controlled areas because of security reasons.

Field report, Kathmandu 6 – 20 February 2003

Meeting summaries, Focus group discussions and Work Shop

Friday 7 February

9:30 – 11:00 AM. His Majesty’s Government National Dalit Commission (NDC), Durga Sob, Member Secretary

The meeting had the following conclusions:

1. NDC established on Government initiative in April 2002. It is the first organisation/association of this kind in Nepal.
2. Dalits constitutes around 20% of total population in Nepal, but this perecentage is depending on the definition applied. This population group is regarded having no formal representation in formal decision making at any level in Nepal society.
3. Only 15% of the Dalit oriented programs in the Ninth 5 year plan was implemented.
4. Equality comes before equity. Social exclusion of Dalits in local participation is one main barrier according to access to social services including health.
5. Essential for programmes directed at Dalits are clear definitions. NDC is working currently on definitions which are operational. A provisional definition list will be ready by the end of February 2003.

6. Stigmatization constitutes one large barrier in outreach intervention directed at Dalits. But poverty mapping - as done by PDDP by use of GIS - are one viable way to identify Dalit groups.

7. Social exclusion is considered a larger source of inequity in health than area of residence.

11:15 AM – 12:30 PM. HMGN Ministry of Health. Dr. B.D. Chataut, Chief Specialist

The meeting had the following conclusions:

1. Previous experiences show severe weaknesses when large Govt. programs have reached the implementation phase. These experiences will be taking into account when implementing the current HSS.

2. Political situation is now improving with the on-going cease-fire negotiations between HMGN and the Maoists. Nevertheless, before these negotiations the political instability did not cause severe obstacles for running health care services in the districts with Maoist activity. MOH had made local agreements with Maoists about drug supplies to local districts. On the other hand the military had stopped drug supplies to districts with strong Maoist activity.

3. MOH is developing a model for a National Health Accounts to be applied in HSS. This work goes parallel to the development of NHA in NHEA. Dr. Chataut has taken initiative to integrate the two initiatives in order to avoid duplication and enhance best use of resources. Dr. Chataut had called for a meeting on this subject Tuesday 11 February to clarify status on the two parallel NHA development initiatives.

4. HMGN have no plans to include disaggregated data on ethnicity and caste in the planned future HMIS, and even disaggregated data by sex may have to wait some time, “HMGN has other priorities due to scarcity of resources”.

Sunday 9 February

6:00 PM - 8:00 PM. Meeting with Chairman of Association of Private Health Institution of Nepal, Dr. Bhola Rijal. Rjani Rijal, Marketing Director, Dr. Hari Kishor Shrestha, Managing Director. OM Hospital and Research Center (P.) LTD.

The meeting had the following conclusions:

1. Staffing situation in rural areas: Government should develop regulation on partly mandatory arrangements and partly incentive schemes to station specialised health staff in remote areas.

2. This current situation of no regulation and no incentives for specialised health staff to work in remote areas are seen as a main obstacle to reach the staffing and recruitment goals in HSS.
3. Mandatory schemes could potentially be, that a precondition for obtaining doctors license to practise in urban areas should be 2-4 years mandatory work practise in remote areas.

4. Alongside mandatory arrangements HMGN should create incentives for highly educated staff to work in the remote areas, e.g. in providing appropriate education facilities for children of the staff. HMGN should organise refresher courses and upgrading for health staff so they are kept up to date with current knowledge and best practise in their respective professional fields. These arrangements could be provided by the private sector by outsourcing and on contract basis in different remote localities.

5. Previously MOH has been suggesting cooperation with private sector on a non-mutual beneficial basis. MOH only asked for participation from private sector without offering anything in return. This MOH attitude has led to a low motivation situation for private sector participation in HSS, and Dr. Bhola Rijal have on this basis denied to cooperate with HMGN in developing the 10th Plan despite invitation to do so from HMGN.

6. Future cooperation should be based on mutual benefit incentive schemes. HMGN could e.g. provide tax and custom exemptions on imported instruments to the private health care sector in return for private sector HSS participation in reaching the poor in urban areas.

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**Monday 10 February**

10:00 AM – 12:00 AM. Meeting with Maheshwar Shrestha, Senior Public Health Officer, District Public Health Office, Bakhtapur

The meeting had the following conclusions:

1. Preparation for the focus group discussions to be held including selection of village in the district.
2. Collecting main information on the village, Sipadol, where to conduct FG discussions:
   - One of 16 VDCs of Bhaktapur district.
   - Arniko Highway is the northern border.
   - Altogether 7 of its 9 wards are accessible by motorable fair weather road.
   - There are 1160 households and population is 7,000.
   - 25 percent of households has toilet facilities.
   - Sipadol population consists mainly of Chhetri, Brahmin, Newar, Tamang and Sarki.
   - The sub-health post is accommodated in one room of a school which is 4 km distant from the Bhaktapur municipality.
   - The village has drinking water, electricity and telephone lines.
3. Due to the present political situation, VDCs and DDC are currently dissolved and awaits new elections to be held. This situation constitutes an unusual period in respect to investigate current functional relations between the different actors involved with SHP.

12:30 – 15:00 PM. Meeting with representatives from the VDC, Sipadol and SHP workers. Sipadol Village.

The meeting had the following conclusions:

- Talking with local people, including the medical staff, FCHVs and the local leaders on arrangement and preparation of the FG discussions to be held Wednesday 12 February.
- Familiarizing with the local situation, including the composition of the population, facility situation: electric power, transport and communication etc.
- Collecting information about the prevailing health situation.

Wednesday 12 February

10:00 AM - 16:00 PM Focus Group Discussions (FGD) in Sipadol village.

Main findings:

1) Findings from FG discussion with local leaders (former VDC-members): 4 persons

VDC support for the SHP:

- VDC has allocated land for construction of a new SHP.
- VDC has already spent over Rs.200,000 for construction of a new 4 room SHP.
- Additional VDC has allocated additional Rs.200,000 for its construction and are currently trying to raise more funds for equipping it.
- The 7 member SHP Management Committee is chaired by VDC chairperson. Registration fee, charge on certain medicine and other service charges are fixed by the Committee.
- VDC had allocated Rs.25,000 for CDP making drugs available at 15% lower than the market price. At present, it is non-functional.
- Literacy rate among women is very low. The VDC did not get a single qualified (grade 8 pass) lady for ANM training quota allocated to the village.

Some other VDC schemes:

- VDC has schemes for providing relief to vulnerable groups.
- VDC has launched literacy program for newly wedded illiterate brides of the village.
- VDC has no plan for community health insurance right now. It has financial constraint due to its heavy involvement in road construction, which it considers is the fundamental for any development effort, including health.

2) Findings from FG discussion with Medical Staff and FCHVs (8 persons)

- TBAs have had no refresher training for long. Some TBAs have received no training for the last 15 years.
- SHP medical staff strongly requires periodic skill upgrading training as an incentive and also to meet community's needs.
- Plan International is helping to raise awareness on sanitation by organizing a women's awareness committee and also by providing financial assistance to Tamang community to build toilets.
- Alcoholism and gambling have been reduced considerably. However, alcoholism is still a problem in some community, e.g., the Tamang and Sarki communities.

3) Findings from FG discussion with Patients and Caretakers (4 persons)
The SHP is (under)utilized with only 3-4 patients a day for the following reasons:

- There are limited medical services available. (SHP is providing FP, General health check-ups, immunization, First Aid, outreach treatment, and school health program).
- People have the increasing tendency of seeking consultation from the qualified doctors. SHP is available for only 4 hours for checkup, whereas a patient can be serious at any time of the day.
- Limited drugs are available (only for the first 2-3 months of year consumption). The patients have to go to Bhaktapur to buy drugs.
- Transport is easily available for going to Kathmandu or Bhaktapur Hospitals.

4) Findings from separate focus group meeting with Tamang community (3 persons).

Perceptions of health and health care:

- People still believe that illness is the result of rage of the spirit or god.
A majority of the village people go to the traditional faith healer or “Jhankri” first. However, with increasing awareness among people, they practice both traditional and modern health seeking behavior such as - before going to health facilities - to set aside some rice and flower to appease the evil spirits. There is also increasing tendency among faith healers in referring the patients to health facilities.

Accessibility and significance of potential access barriers

- Women’s accessibility to health care does not seem to be a problem. SHP has a MCH female health worker. Women are however often accompanied by family members.
- Language and culture are considered to pose some barrier, but it is not as serious as in the past.

Thursday 13 February

11:00 AM - 12:00 Meeting with B.K. Bista, Head of Department, HMG MOH, Department of Health Services

The meeting had the following conclusions:

1. Preparation on notice on participants, date and time for holding the workshop to present preliminary findings from the Social Assessment of the HSS.
2. Discussions of some of the main results of the Social Assessment Study.
3. Long perspective reform programs - like the HSS - should be based on broad political consensus to make the core program components resistant to political change.

12:00 AM – 13:00 Meeting with various representative from the Department of Ayurvedic Medicine, MOH Department of Health Services.

The meeting had the following conclusions:

1. Important lessons can be learned from the experiences made in Sri Lanka on combination of traditional medicine and modern medicine and on integration approaches to include traditional faith healers into cooperation with modern health care system.
2. The typical Nepal health seeking patient most often meets the traditional faith healer (estimated to be at least around 200,000) as the primary health institution.
3. The traditional faith healer is a de-facto key agent in referring patients to further treatment.
4. Since the traditional faith healer is a key front-line agent in people’s health seeking behaviour programs should be established to integrate the traditional faith healers to become an agent for mind set change.
Friday 14 February

14:30 PM – 16:30 PM  Meeting with Isméne R.A.C. Stalpers, Associate Expert on Social Protection, Strategies and Tools against Social Exclusion and Poverty (STEP), ILO

The meeting had the following conclusions:

1. ILO and STEPS are involved in developing health insurance models for application in Nepal.
2. A model must be configured for a local context and the national strategy must embrace a range of models.
3. At least 4 models potentially applicable for the Nepal context have been identified.
4. Insurance models must be judged according to degree of progressiveness.

Monday 17 February

14:00 – 16:00 Workshop presentation of preliminary findings of the Social Assessment study and focus group discussions.

Power point presentations were made on 1) Introduction and scope of work 2) Preliminary findings from the broad analysis 3) Findings from the focus group discussions.

Stakeholder responses were made on the following main subjects:

1. The necessity of broad political and stakeholder support on key areas in HSS regarding equity and core HSS components by establishing broad (round table) discussions in order to sustainability and making HSS resistant to political change. It was suggested that - regarding the present stage of planning - time for this had passed and that MOH should carry on its planning work opening for discussions on value related issues in HSS.
2. General development plans and MOH’s ability to influence these regarding broad health and poverty issues. It was regarded that MOH was not the Ministry in Government to push for the development of general comprehensive development plans. Other line Ministries, e.g. Ministry of Finance (MOF) - had to enunciate the necessity for the development of these broad and comprehensive development strategies.
3. Gender mainstreaming and potential policy entry points to fight discrimination at all levels in society. It was suggested that HSS should take into account the general prevailing discrimination against women starting at the household level. The presentation showed that among women wide gaps between socioeconomic sub population groups existed and policies to address these gaps were necessary. HSS should identify these groups in order to centrally support the development of local level comprehensive activities and interventions directed at mitigating the
differential exposure, susceptibility and economic consequences of especially uneducated women.

4. Priorities made on local level by the VDC and commitment and ability to raise financial means to secure local priorities. It was found that the decision made by VDC on construction of a new 4-room SHP was not a correct priority decision according to the relative short distance to higher qualitative health care services. On the other hand, by setting priorities out of locally on judged necessities and pursue these by raising local funds and allocate land to set these priorities through the VDC signalled commitment and high level of concern to develop the local facilities as a response to the underutilisation of the existing SHP. The VDC was acting responsively and future will show if the new SHP construction was a correct response leading to increased utility.

Appendix 6

Definition of SWAp.

There is no single definition of SWAp, the following useful characteristic is used in the training seminars sponsored by the Inter-Agency Group on Sector Wide Approaches for Health Development:

The sector wide approach defines a method of working between government and development partners, a mechanism for co-ordinating support to public expenditure programmes, and for improving the efficiency and effectiveness with which resources are used in the sector.

The defining characteristics are that:

- All significant funding for the sector supports a single policy and expenditure program
- Government provides leadership for the programme
- Common implementation and management approaches are applied across the sector by all partners
- Over time, the programme progresses towards relying on government procedures to disburse and account for all funds
- The SWAP is an approach rather than a blueprint, flexible and adaptable to a changing environment. Most programmes, even well established ones, are in the process of moving towards broadening support to all sources of funding, making the coverage of the sector more comprehensive, bringing ongoing projects into line with the SWAp, and developing common procedures and increased reliance on
government. The working definition thus focuses on the intended direction of change.

The process of a SWAp brings together development partners in dialogue on sector policy issues. The "implicit bargain" is that the External Development Partner agree to give up their explicit role in running projects (or small fragments of the sector), in return for a voice in the overall direction of sector policy and its management.

An early "definition" was:
- Sustained partnership between development actors, led by government
- Goal of achieving health improvement
- Coherent sector defined by a collaborative programme of work, an appropriate institutional structure and national financing programme
- Processes and structures for negotiating strategic and management issues, and for reviewing sectoral performance against jointly agreed milestones and targets

Short version based on A.Cassels: “A guide to sector wide approaches for health development”, WHO 1997 (Sponsored by WHO, Danida, DfID and European Commission)

Source for both: Orientation and training seminars for agency staff: sector-wide approaches for health in a changing environment (Sandra Baldwin and Adrienne Brown. IHSD, 2002).

Other useful information can be found on: http://www.ihsd.org/swaps

Basket funding – experiences from BPEP II, Nepal

Basket funding mechanism applied in the Basic and Primary Education Programme, Second Phase (BPEP II) and its deficiencies.

The Basic and Primary Education Programme, Second Phase (BPEP II) consists of 17 components corresponding to three major goals: access and retention improvement (8 components), quality improvement (4 components), and institutional strengthening (5 components). BPEP II has adopted a 'basket' approach to programme funding.

In order to implement the basket funding the development activities is divided into core and non-core investment programmes. The core investment programme is the essential part of the whole programme. The purpose for dividing project activities into core and non-core is not simply for segregating essential and not-so-much essential parts, but to guarantee full financing of the essential portion of the project. Unless financing for the core investment programme part is not guaranteed, implementation of project may be hampered.
The donors who join the core basket programme have to agree on a standard procurement rules and regulations and agree on a standard accounting; reporting and auditing procedures (The World Bank procedures for procurement have been agreed upon by all basket donors). For BPEP II, such donors are European Commission, Norway, Denmark, Finland and the World Bank. Technical assistance provided by donors like Denmark, Finland, EC, Norway and UNICEF are lumped together as sub-basket. Each participating donor in the sub-basket programme has its own rules and regulations for procurement, withdrawal and audit etc. Other donors financing the essential portions of the programme outside the basket are Asian Development Bank and Japan.

Total BPEP II budget for 5 years, 1999/01 to 2003/04, is estimated at NRs 29030 million. The major source of funding is the HMG Regular Budget which accounts for 65 percent of the total budget. The Core Investment Programme (CIP) 'basket' funding (consisting of Denmark, IDA, Norway, EU, and Finland) accounts for 26 percent of the total budget.

Under the basket funding mechanism, there is a certain percentage of commitment from each donor to the total basket. Initial advance is released from the government treasury on trimester basis. After all the expenditures against the advance being consolidated and scrutinized by the Department of Education, the statement is forwarded to the World Bank. After the scrutiny from the World Bank, each donor replenishes specified percentage contribution it had committed for the basket.

As mentioned earlier, Denmark, EC, Finland and Norway are providing technical assistance outside the CIP under the donor/HMG agreements. Such free standing TA contribution of the donors has been referred to as the sub-basket. JICA and ADB are providing earmarked support under separate agreements. In addition to regular HMG monitoring and assessment of implementation programme, it has been agreed between HMG and the donors that review mission to be undertaken jointly twice in a year to ensure co-ordination between all partners involved, one in March/April for planning and budgeting and one in November for monitoring and follow-up.

BPEP II involves 95 cost centers in all over the country. If the statement of accounts does not come from one district, the Department of Education cannot process for reimbursement from the donor’s account. In such situation, the objectives of the programme may not be achieved.