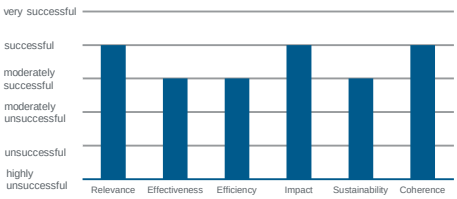
KfW Development Bank

Ex-post evaluation of the Health and Family Planning Sectoral Programme, Nepal

Title	Health and Family Planning Sectoral Programme		
Sector and CRS code	Health policy and administrative management (CRS code 12110)		
Project number	BMZ No.: 2006 66 305		
Commissioned by	German Federal Ministry for Economic Cooperation and Development		
Recipient/Executing agency	Ministry of Finance (MoF) / Ministry of Health and Population (MoHP)		
Project volume/ Financing instrument	*EUR 9.99 million budget funds, EUR 0.97 million study and consultancy fund, EUR 0.38 million residual funds*		
Project duration	*07/08–12/19*		
Reporting year	2024	**Year of random sample**	2023

Overall rating:
moderately successful



Objectives and project outline

The FC/TC cooperation programme served to support the Nepalese government's first national sectoral programme, which included all measures in the health sector from 2005–2010 that were financed by Nepal and the donor community. It contributed to increasing the use of health services, particularly by disadvantaged population groups (outcome objective), and thereby contributed to improving the health situation of the population and achieving the health-related MDGs (impact objective).

Key findings

Embedded as parallel financing in the national sectoral programme, the programme achieved the objectives and indicators set during the programme appraisal in parts. As a result, we evaluate the FC programme as moderately successful overall.

The FC programme contributed to increasing the availability of basic medicines and contraceptives in Nepal. By incorporating social marketing approaches, a wide range of contraceptives was provided, even in remote regions. The programme also supported innovative approaches in the field of maintenance, whereby the Ministry of Health commissioned private companies to maintain medical devices. This contractual involvement of non-state actors by the Ministry of Health represents a “best practice” case, for which German DC has gained high recognition. However, this maintenance component was discontinued in 2019 due to decentralisation in the health care sector and subsequent jurisdiction disputes. It was also not possible to implement the infrastructure component as originally planned, with only three of the eight planned warehouses being built.

Nevertheless, the objectives of the FC measure were largely achieved. It therefore made an important developmental contribution not only to improving the health situation of the population, but also to the country’s efforts to harmonise external support in the health care sector.

Conclusions

- In case of a sectoral programme, the policy dialogue linked to external financing may have good leverage regarding national ownership and the harmonisation of external assistance.
- Taking demand-side components (such as health insurance) into account could further increase the sectoral programme's efficiency and sustainability.
- A maintenance system for medical equipment can only work in a decentralised system if the responsibilities are clarified and sufficient training and funds are provided.

Ex-post evaluation – rating according to OECD-DAC criteria

Overall context

The landlocked country of the Federal Democratic Republic of Nepal is still one of the poorest countries in Asia, but the situation has shown positive development trends in recent years in several aspects. In 2010, Nepal was still one of the low-income countries with a GDP of USD 589 per capita, while it is now one of the lower-middle income countries with a gross domestic product (GDP) of USD 1,336 per capita per year (2022). The Human Development Index (HDI) also rose from 0.56 to 0.60 from 2014 to 2022. As a result, GDP per capita and the HDI are lower than in all neighbouring countries, but the trend is positive.[1] Meanwhile, Nepal ranks 79th out of 163 places in the Global Peace Index and, with an index of 12.006, has a better value than its neighbouring countries, but with a deteriorating trend.[2] Nepal's governance indicators are also still significantly below the South Asian average, meaning that the country is classified as a "highly defective democracy". However, the trend is considered as ascending. The ranking in the Fragile State Index improved from 95 to 81 from 2006 to 2022.[3]

Nepal is highly dependent on development aid, with the United Kingdom, the USA, Japan and China being the main bilateral donors. Nepal is home to 125 ethnic groups, who in the past had unequal access to basic services, resources and opportunities, which poses risks to social cohesion. Indeed, significant differences in development between individual ethnic and social groups on a national level have not yet been overcome. The severe earthquake in 2015 significantly reversed the country's development, with serious impacts on the health sector. In the 14 districts most affected by the earthquake, 363 healthcare facilities were completely destroyed and 294 were partially destroyed. Among other players, German Development Cooperation (DC) is involved in the reconstruction of the destroyed infrastructure, a process which is not yet complete.

The health of the population continues to be a high priority in national policy, which is also reflected in the fact that a succession of large-scale national programmes has been implemented since the turn of the millennium. The National Health Sector Programme I (NHSP-I from 2005–2010) was followed by NHSP-II (2010–2016) as well as by the National Health Sector Strategy (NHSS 2016–2022).[4] However, these efforts to improve health take place in a dynamic environment. In addition to external shocks (earthquakes on 25 February and 12 May 2015; coronavirus 2020–2022), globalisation as well as the demographic and epidemiological transition are posing constant challenges for the healthcare system in Nepal, which requires repeated adjustment of strategies and measures.[5] Education and training of medical and nursing staff (e.g. for chronic degenerative diseases), changing catchment areas due to mobility shifts and migratory movements require repeated adjustment of health policies.

Over the past two decades, Nepal has made remarkable progress in improving general health metrics. For example, maternal mortality (MDG 5) and child mortality (MDG 4) were reduced by about 50% in the years 2000–2015, and further improvements have been made since then.

As part of the decentralisation that has been taking place since 2015, a new administrative structure was established in Nepal with seven provinces, 77 districts and over 753 municipalities. Since then, the federal system has been developing. In order to adapt the health system to the new federal structure, the responsibility for the administration of basic care has been decentralised. This has resulted in new responsibilities and challenges, as the local levels are often not yet familiar with their new tasks.

The right of citizens to free basic medical care by the state was enshrined in Article 35 of the 2015 Nepalese Constitution and legitimised by the Public Health Service Act, 2075 (2018). Nevertheless, Nepal's healthcare sector remains underfinanced and lacks a sustainable financing strategy. In 2022/23, the share of the health budget

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1 World Bank. *World Development Indicators*. 2024 [cited 2024 18 March 2024]; https://databank.worldbank.org/source/world-development-indicators. UNDP. *Human Development Index*. 2024 [2024 18 March 2024]; : https://hdr.undp.org/data-center/human-development-index#/indicies/HDI.

2 Institute for Economics & Peace, *Global Peace Index 2023*. 2023, Institute for Economics & Peace: Sydney.

3 The Fund for Peace. *Fragile States Index*. 2024 [cited 2024 18 September 2024]; Available from: https://fragilestatesindex.org/.

4 Ministry of Health, *Nepal Health Sector Programme Implementation Plan 2004-2009*, M.o. Health, Editor. 2004, Government of Nepal: Kathmandu.

5 Adhikari, B., S.R. Mishra, and R. Schwarz, Transforming Nepal's primary health care delivery system in global health era: addressing historical and current implementation challenges. Globalization and Health, 2022. 18 (1): p. 1–12.

in the total national budget was 6.9% and thereby remained low. In 2020, users' own financial contribution amounted to more than half of the total healthcare expenditure (54%), which still represents a high burden for the poor population in the event of illness. Around half a million Nepalese people are pushed below the poverty line every year due to expensive health care alone.[6]

Project Summary

Designed as an open programme, the FC/TC cooperation project (CP) "Health and Family Planning Sectoral Programme" aimed to contribute to improving the health situation of the population and achieving the health-related Millennium Development Goals (MDGs) in Nepal. The programme was designed as parallel financing within the first Nepalese National Health Programme (NHSP-I) of 2005–2010. The NHSP-I was the first sectoral programme of the Nepalese government in the health sector, which was jointly financed by Nepal and other donors. It covered all measures in the health sector from 2005–2010. When this FC programme was assessed in 2006, only the World Bank and British development cooperation (DFID) had pool financing within NHSP-I, i.e. they provided financing via a shared account. At this time, all other donors provided financing as part of parallel financing, i.e. individual components from NHSP-I. The target group of the NHSP-I – and therefore also of the FC programme – was the entire population of Nepal. As part of NHSP-I, which was designed to reduce group-specific disadvantages, the FC contribution was also aimed at benefiting disadvantaged population groups.

This FC programme financed basic medicines, contraceptives for the public, NGO and social marketing sectors, social franchise approaches[7] in the area of sexual and reproductive health, the maintenance of medical equipment involving the private sector, smaller infrastructure measures, the construction of warehouses to expand a decentralised, demand-oriented logistics system and accompanying consulting services. The TC measures support decentralisation and quality improvement in health care, improving access to health care and promoting sexual and reproductive health. The FC contribution amounted to EUR 11,3 million, while the TC contribution amounted to EUR 4.7 million.

Breakdown of total costs

It was originally planned that USAID would co-finance the programme with EUR 10.8 million. However, due to other priorities, USAID withdrew its financing after the programme appraisal, resulting in altered total costs and financing:

In EUR million	Investment (planned)	Investment (actual)
Costs (total)	**24.7**	**15.2**
Counterpart contribution	3.9	3.9
Financing	20.8	11.3
of which BMZ budget funds	10.0	11.3

Map/Satellite image of the project country including project areas/locations

[6] MoHP: Nepal National Health Accounts 2017/18
[7] Social Franchising is a business model in which certain activities are outsourced from the franchisor to the franchisee.

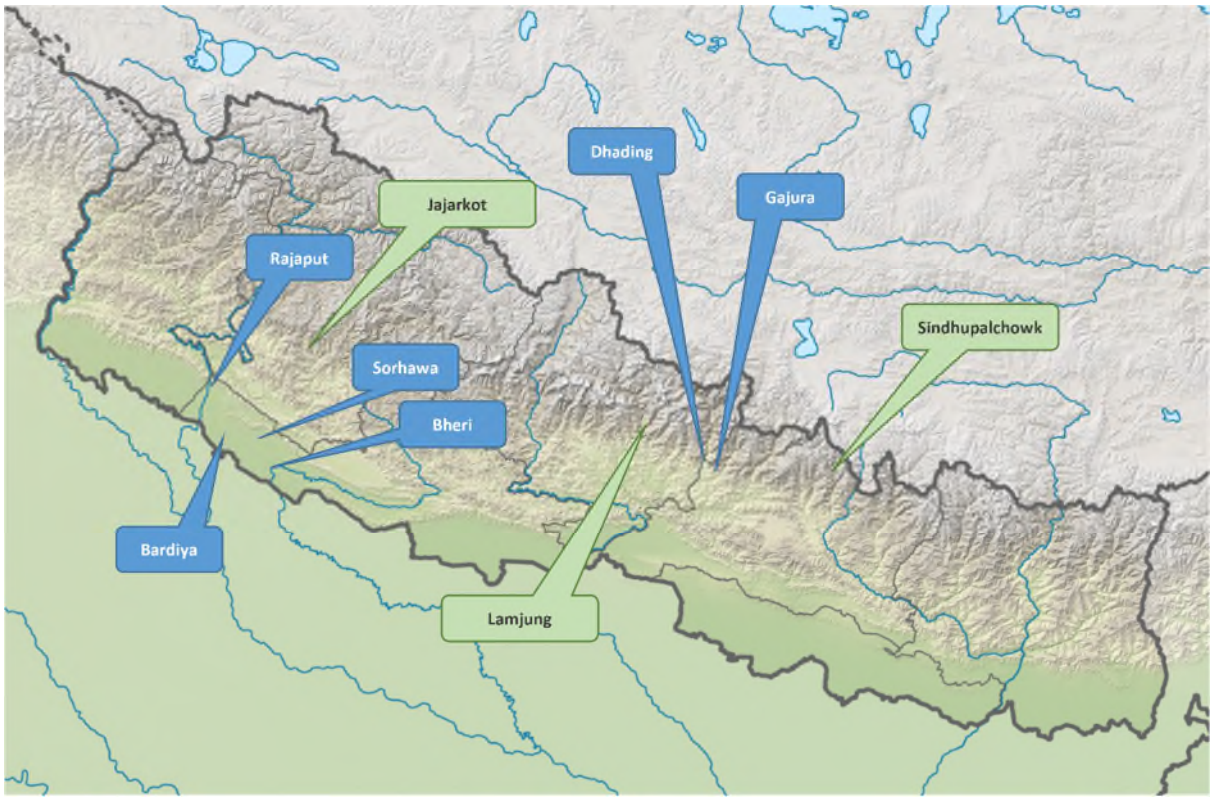

Figure 1: Map of Nepal with the hospitals, primary healthcare centres and warehouses visited as part of the evaluation mission, where the availability of medicines and contraceptives was checked on a random basis. [8]

Rating according to OECD-DAC criteria

Relevance

Alignment with policies and priorities

At the time of the appraisal in 2006, improving health care was one of the three agreed priorities of German-Nepalese development cooperation. Nepal was already pursuing an expedient health policy in the years before that. In its 1991 National Health Policy, Nepal set itself the objective of improving access to basic health care, particularly for the rural population and disadvantaged groups, and of focussing on the provision of essential health services, including those pertaining to reproductive health. Among a number of relevant sector strategy and policy documents, the Second Long Term Health Plan (1997–2017) and the implementation plan of the Nepal Health Sector Programme (NHSP-IP), which provided detailed specifications for the implementation of the Health Sector Strategy for a first phase (2005–2010), are of particular importance. These documents are essential elements of the national poverty reduction strategy.

After ten years of conflict between the Kingdom rulers and the Maoist rebels, the king stepped down in 2006 and made way for a democratic multi-party system, into which the Maoists were also incorporated. This had stabilised the political conditions by the time of the appraisal and thereby laid the foundation for the effective implementation of the programmes in Nepal. At that time, the Nepalese government had set up the sector-wide, comprehensive Nepal Health Sector Programme (NHSP-I) for the period 2005–2010, which was co-financed by almost all donors within the framework of pool or parallel financing. This was the first Sector Wide Approach (SWAp) in the healthcare sector in Nepal. Previously, donor projects had been split into individual finance, which had led to high transaction costs for the Ministry of Finance, Health and Population as well as for the donors. At the time, the total cost in the healthcare sector for the period 2005–2015 were estimated at up to USD 2.6 billion. Overall, in the Nepalese healthcare sector, there was a shortfall of around 50% in investments and ongoing financing.

[8] Commons, W. *Nepal rel location map.svg*. 2024 [2024 18 March 2024]; https://commons.wikimedia.org/wiki/File:Nepal_rel_location_map.svg?uselang=de

The joint NHSP I addressed this urgent need through a sector-wide approach (SWAp), which also aligns with the Paris Declaration for the effective implementation of international aid and a response to the widespread dissatisfaction with fragmented donor-funded projects. The SWAp aimed to achieve the Millennium Development Goals to reduce maternal and child mortality (MDGs 5 and 4), to reduce fertility rates and to combat infectious diseases (MDG 6) in order to improve the health of the Nepalese population. It aimed to improve access to basic health services for the entire population as a guiding principle of the country's overall health policy. The focus on vulnerable population groups (women, children, remote areas) was appropriate in the light of national and international guidelines. By focusing on the vulnerable, it aligned with the global and German objectives of alleviating poverty and reducing inequality as well as gender equality and inclusion.

Alignment with needs and capacities of persons concerned

The fundamental problem in Nepal is related to guaranteeing basic medical care, in particular for vulnerable people, i.e. the provision of essential medical services, especially for people who would otherwise not be able to access these services, either because they would be too far away, of too poor quality or not affordable. This was the main focus of the Nepalese health policy and of the donors.

The government's declared goal was to increasingly process external donor support as SWAp. At the time of the programme appraisal in 2006, the FC initially advocated for continuing the FC support in form of parallel financing (i.e. financing of individual components from the sectoral programme), but not yet as pool financing via a joint account, mainly due to the uncertainties regarding the future orientation of health policy and the still existing weaknesses in financial management and procurement.

Via several components, it addressed the inherent need for basic medicines in 2006 (availability of less than 50%), contraceptives (unmet need of 25%) and corresponding storage facilities. A maintenance component aimed to eliminate a serious bottleneck, as at the time of the 2006 programme appraisal, maintenance contracts only existed with suppliers of the most complex, high-quality equipment such as MRT and CT. There were no maintenance contracts for other complex equipment such as X-ray and ultrasound machines. There was also a serious shortage of qualified technicians and biomedical engineers for preventive and corrective maintenance of medical equipment.

The target group of the NHSP-I and therefore also of the FC programme was the entire population of Nepal, with a focus on disadvantaged population groups (e.g. poor people, women). The core problem was the inadequate performance of the public health sector, which was characterised by a number of supply bottlenecks. Existing bottlenecks had been amplified by inadequate maintenance of the healthcare infrastructure. Overall, low attractiveness of public health facilities combined with access barriers led to unsatisfactory utilisation. Adequate provision of services, particularly for disadvantaged population groups, was not guaranteed at the time of the appraisal. In addition, the unbalanced geographical distribution of the population in the three ecological zones of the country of Nepal (lowland, hilly region and high mountain region) made it difficult to equally distribute medical services nationwide. In the high mountain regions, the network of health stations is much thinner, access is more difficult and the population is poorer.

A fundamental problem of the healthcare system in Nepal has been and still is the fact that even though services should be free, user fees are still accounting for more than half of the expenditure in the entire healthcare sector. Although Nepal clearly defined the "essential package of healthcare services" in 2015 and these services are essentially free of charge, numerous studies have shown that user fees that are incurred in the event of illness often lead to poverty and over-indebtedness. According to this, there are still significant disparities between income groups and provinces and vulnerable groups.[9]

Gender perspective

A relevant proportion of the NHSP-I measures concerned women of childbearing age. This is what the FC programme was geared towards. Additionally, the Basic Package, which was introduced later in 2015 clearly focused on the health of mothers and children.[10] Adequate mother-child care is one of the main priorities of the

[9] UNICEF, *Health Expenditure Brief*. 2018, UNICEF Nepal: Kathmandu.

[10] Thapa, A.K., An Assessment of Household's Out of Pocket Healthcare Payment and Impoverishment in Nepal: Evidence from Nepal Living Standard Survey III. Journal of Development and Social Engineering, 2017. **3**(1): pp. 17–24.

Nepalese MoHP. Gender impact potential was adequately addressed in the NHSP and therefore also in this FC programme.

Suitability of project concept

The aim of NHSP-I was to improve access to more effective health care, especially for disadvantaged population groups. This objective was supported by the co-financing FC programme.

In view of the fact that "*access*" is aimed at the *output* level, but the *use* of the created capacities is aimed at the *outcome* level, we have adapted the original programme objective to: “The objective adjusted as part of the EPE was to improve the *use* of health services, particularly for disadvantaged population groups”. This objective was to be achieved by addressing the aforementioned sectoral bottlenecks and thereby making a direct contribution to four of the eight results at output level of the NHSP-I. Given that insufficient availability of medicines constitutes a significant access barrier to healthcare facilities, better availability and storage of basic medicines and contraceptives should increase the quality and acceptance of public health care. In addition, the maintenance component should enable improved and longer use of the medical equipment. Overall, this should contribute to improving the health situation of the population and achieving the health-related development goals (formerly MDGs) in Nepal. The theory of change of improving healthcare facilities’ ability to better prevent, diagnose and treat diseases as well as meet the need for sexual and reproductive health services is plausible. Improved quality and availability generally increase the attractiveness and utilisation of healthcare facilities, contributing to improved health of the population.

Indicators for measuring target achievement at outcome level were the increase in the proportion of women in the 15 to 49-year-old age group who use a modern contraceptive method (contraceptive prevalence rate for modern methods – mCYP), the improvement in availability of medicines in basic healthcare facilities and the improvement in the quality of care evaluated by user surveys. The outcome target indicators were largely consistent with the indicators of the third phase of the TC programme. With the exception of the latter outcome target indicator (improved quality of care), which the GIZ stopped measuring as part of the third phase of the TC programme, which ran in parallel, all indicators were part of the more comprehensive target and indicator system of NHSP-I. The indicators that appeared to be most suitable for evaluating the FC contribution were selected from this to measure target achievement. Indicators for measuring the impact target achievement were the reduction in mortality rates of mothers, infants and children under the age of five years as well as the reduction in the fertility rate. We consider these indicators to be suitable for measuring the programme's success.

NHSP-I was the first sectoral programme co-financed by the World Bank and DFID via pool financing. At the time of the programme appraisal in 2006, German DC had not yet had any experience with pool financing in the Nepalese health sector. In this respect, the cautious approach of parallel financing on the part of German FC at the time of the appraisal makes sense in retrospect. Once pool financing had proven itself, German FC also switched towards this in the subsequent programme (SWAp, BMZ no. 2010 65 440). In principle, the programme was appropriately designed from the point of view of the time to adequately address the core problem of inadequate use of health services.

Reaction to changes/adaptability

Except for the omission of the N-MARC component (social marketing and social franchising of family planning), the FC programme was not adapted during implementation.

Rating summary:

Overall, the programme is highly relevant. All objectives and indicators of the FC/TC cooperation programme aligned with the national objectives of NHSP-I. It is clear that the programme fully aligns with the Sustainable Development Goals (SDGs). This was confirmed by the National Planning Commission in the National Review of Sustainable Development Goals 2020.[11]

Relevance: 2

Coherence

Internal coherence

The German DC has been involved in Nepal's health sector with various FC and TC programmes since the first half of the '90s. This FC programme is a continuation, merge and expansion of the previous FC projects for the supply of basic medicines (Basic Health Programmes I, II and III; BMZ nos. 1993 66 063, 1999 65 104 and 2004 65 971) and contraceptives (Family Planning Programmes I and II; BMZ no. 1996 65 381 and 2001 65 068) and to improve health infrastructure (District Health; BMZ no. 2002 65 959). It was implemented in cooperation with the third promotional phase of the TC programme "CP Programme for the Promotion of the Health Sector – PN 2006.2180.5", which focused on decentralisation and quality improvement, improved access to healthcare facilities and the improvement of sexual and reproductive health. As part of the cooperation programme, Ministry of Health developed with TC national guidelines and standards for quality management in healthcare facilities.The improvement of sexual and reproductive health was promoted by the FC through the FC programmes "District Health" (BMZ no. 2002 65 959) and "Mother-child care in remote regions" (BMZ no. 2014 68 248) by building or rehabilitating and equipping the healthcare facilities for the provision of emergency care with regard to mother-child health (e.g. treatment of complications in pregnancy and childbirth) in particular. German TC has been active in this field since 2014 and has primarily supported the training of obstetricians and midwives. In addition, the FC component strengthened the start-up fund originally financed from TC funds for minor repairs and medical equipment in healthcare facilities, which was designed as a starting point for strengthening the decentralisation process.

Under the umbrella of NHSP-II (2010–2016), the FC and TC pursued a common strategy and complemented each other. With regard to the quality and acceptance of health services, the provision of basic medicines and contraceptives by the FC plays a key role. This also strengthened the TC's effectiveness in terms of improved access to health facilities for disadvantaged population groups. The start-up fund originally set up by TC received further financing from FC funds for the implementation of small infrastructure measures, which supported the effect of the TC measures. The capacity-building and policy-advising TC measures, in particular in the areas of quality improvement and decentralisation as well as maintenance, in turn improved the conditions for the efficient use and effectiveness of the FC measures. With regard to social security in the event of illness and fair health financing, the TC participated in the restructuring of the health financing system in conjunction with other donors in order to be able to expand and sustainably finance social security in the event of illness – especially for the poor and marginalised population. In this respect, the TC also supported the FC project's focus on the vulnerable population.

The FC programme aimed to improve the provision of high-quality health services, with a focus on equal opportunities for all population groups. The components of the programme were fully aligned with international and Nepalese health policy guidelines as well as those of German development cooperation. The measures are fundamentally suitable for achieving the objective of universal health coverage (UHC), in which access to basic health services is improved, in particular on the supply side. Consequently, the programme aligns with the principles of the Declaration of Alma-Ata, the Ottawa Charter, the corresponding focus on universal health coverage and the Sustainable Development Goals (SDGs; in particular no. 3 but also no. 1, 2 and 5).[12] By focusing on the vulnerable population, it aligned with the German and international objectives of alleviating poverty and reducing inequality as well as gender equality and inclusion. The programme explicitly addresses the health and health care of the following vulnerable groups: mothers, small children, the population in peripheral rural regions, the lower castes and religious groups.

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11 Government of Nepal, *National Review of Sustainable Development Goals. Report. 2020*, N.P. Commission, Editor. 2021, Government of Nepal: Kathmandu.

12 Government of Nepal, *National Review of Sustainable Development Goals. Report. 2020*, N.P. Commission, Editor. 2021, Government of Nepal: Kathmandu.

External coherence

A SWAp, i.e. a sectoral programme, requires consistent coordination between donors and recipients, as called for in the Paris and Accra declarations. Like the successor programmes NHSP-II and NHSS, the first SWAp in Nepal's healthcare system (NHSP-I) aimed to increase the participation and ownership of the government of Nepal[13] and to align Nepal's health policy with the standards of international development policy, increasing the efficiency of the development cooperation in the healthcare system and reducing transaction costs.[14]

At the beginning of 2004, 11 donors, including the German DC, signed a Statement of Intent on cooperation in the health sector with the Nepalese partner. The main donors of the subsequent first sectoral programme NHSP (2005–2010) were the World Bank and the UK development cooperation DFID (now FCDO), which initially participated as the only one in a joint pool financing, followed initially by parallel financing by USAID, GFATM, UNICEF and GAVI. Although this FC programme was not yet designed as a pool financing mechanism with joint account management, it also fit well into the overall framework of the SWAP of NHSP-I (2005–2010) as parallel financing, as the objectives and measures of the FC/TC cooperation programme aligned with those of NHSP-I. Donor harmonisation had already taken place during the programme appraisal of the CP in regular semi-annual and annual meetings (Joint Annual Reviews/JAR), which FC and TC joined on a case-by-case basis.

The main objectives of the SWAp in health care in Nepal (NHSP-I, NHSP-II, NHSS) are to increase the ownership of the government of Nepal,[15] to align Nepal's health policy with international development policy standards, increase the efficiency of the development cooperation in public health, reduce transaction costs and increase mutual accountability.[16]

The interviews with donors involved in the NHSP showed that the SWAp during NHSP-I can be declared as a learning phase in which many ways first had to be paved and structures and processes developed. It was particularly important to get contact persons in the ministries (MoHP, MoF) in order to be able to maintain continuous dialogue. The successor programme NHSP-II (2011–2016), on the other hand, seems to have been based on these experiences and benefited from them right from the beginning and onwards. Overall, the interviewees highlighted a high level of satisfaction with the dialogue during NHSP-I and II. Donors with relatively little involvement in the SWAp (e.g. KfW with around 1% of the total budget) could thereby be fully integrated, were accepted as equal partners and were able to contribute their ideas to an extent that would not have been possible without the SWAp.

We got the impression that donor coordination under the thematic leadership of DFID and the financial leadership of the World Bank worked very well overall. All donors surveyed benefited from the structures established as part of the SWAp (Joint Consultative Meetings and Joint Annual Reviews), which created mutual trust between MoHP and donors. This accelerated the joint decisions taken in the interests of the beneficiary, the Democratic Republic of Nepal, represented by the Ministry of Health.

The family planning component of this FC project was originally intended to be carried out in cooperation with the Nepal Social Marketing and Franchise Project: AIDS, Reproductive Health and Child Survival (N-MARC) supported by USAID. The N-MARC program aimed to improve the range, reach and effectiveness of private social marketing and social franchise offerings in the areas of family planning, mother-child health and HIV/AIDS prevention. However, for budgetary reasons on the part of USAID, the originally planned cooperation in this area did not take place – the EUR 10.8 million earmarked by USAID were withdrawn following the programme appraisal.

Rating summary:

The measures of this FC programme were consistent with the efforts of the Nepalese government within the framework of the overarching sectoral programme NHSP-I. The comprehensive approach with numerous donors

13 Department of Health Services, *Annual Report* D.o.H. Services, Editor. 2020, Government of Nepal Kathmandu.
14 Ministry of Health and Population, Report on stocktaking the health policies of Nepal, Nepal Health Sector Support Programme III. 2018, Government of Nepal, UKAid: Kathmandu.
15 Rabinowitz, G. *Literature Review on aid ownership and participation*. 2015 [cited 2024 19 April 2024]; https://www.powerofownership.org/wp-content/uploads/2017/06/ODI-Literature-Review-aid-ownership-and-participation-formated-for-web.pdf.
16 Ministry of Finance, *An Assessment of Sector Wide Approach (SWAp) in Health and Education Sectors of Nepal*, I.E.C.C.D.I. Ministry of Finance, Editor. 2018, Government of Nepal: Kathmandu.

showed a high degree of coherence, which was further consolidated during the successor programme NHSP-II. One consequence of this was the incredibly rapid and effective response of the donor community after the 2015 earthquake.

The fact that this FC project was not yet designed as basket funding as part of the predecessor programme NHSP-I is understandable in the light of the fact that this approach was new in Nepal at the time. This changed in the follow-up programme NHSP-II from 2011–2016, which was co-financed by the FC programme "Support for the National Sectoral Programme for Health, BMZ no.: 2010 65 440" as part of basket funding. We rate the coherence of the programme as successful overall.

Coherence: 2

Effectiveness

Achievement of (intended) goals

The objective adjusted as part of the EPE was to improve the use of health services, particularly for disadvantaged population groups.

The achievement of the targets at outcome level can be summarised as follows:

Indicator	Status at PA (2006)	Target value PA	Actual value at final inspection (optional)	Actual value at EPE (2023)
(1) Increase in the proportion of women in the 15–49 age group who use a modern contraceptive method (contraceptive prevalence rate)	44%	Increase	46% (2019)	43% (NDHS 2022) Value not achieved
(2) Improvement in drug availability in basic healthcare facilities	Approx. 50%	Improvement	92.4 (WHO, 2014)	> 90% (NHFS 2021 and on-site spot checks) Value achieved
(3) In min. 80% of healthcare facilities, the quality of care has improved compared to the preliminary examination in 2004 as evaluated by means of user surveys (GTC survey in 2010)	No data available		Achieved according to baseline GIZ 2011: 22% satisfied 71% very satisfied 7% exceptionally satisfied users	79-89% (NHFS 2021 and on-site spot checks) Indicator is not evaluated, see rationale below

Contribution to goal achievement

The following outputs were provided as part of this FC programme:

Component I: Improving basic health

(1) Procurement of essential **medicines and oral rehydration salts** (ORS) for public sector needs for up to three years for sub health posts (SHP), health posts (HP) and primary healthcare centres (PHCC). This measure was carried out – slightly late – to our complete satisfaction (see chapter on Efficiency).

(2) Construction and basic equipment of **three district warehouses** for medicines and medical equipment according to a decentralised demand-controlled pull system (up to **eight** planned). The warehouses could only be built at three locations (Jajarkot, Lamjung and Sindhupalchowk) instead of eight. The reasons for this were the unexpectedly challenging terrain and cost increases. There is a significant deviation from the plan here.

In the predecessor programmes Basic Health I–III, 41 warehouses had already been built or rehabilitated with FC funds. Insofar as the warehouses are adequately stocked, which was mainly the case at the facilities visited as part of the mission, they contribute to efficient medicine logistics and therefore to improved health care.

(3) Continuation of a **start-up fund** for smaller investments in basic health infrastructure in selected districts.

Under the start-up fund, numerous smaller primary-level healthcare facilities in several districts were rehabilitated and equipped by the end of 2012. In order to strengthen institutional capacity at local level, the fund was integrated into the corresponding district development funds.

Component II: Improving reproductive health

(4) Social marketing[17] and procurement of **contraceptives** via the MoHP and the NGO Family Planning Association of Nepal (FPAN) over a period of three years. This was carried out – slightly delayed – to our complete satisfaction (see Efficiency section).

(5) Support for social franchise approaches in the field of family planning as well as sexual and reproductive health, including the development and, if necessary, pilot testing of a voucher system. The distribution of **oral contraceptives, emergency contraceptive pills**, and other products and services in the field of sexual and reproductive health took place via the Nepal CRS Company. The originally planned pilot project, a voucher system for contraceptives, which was also to be implemented via CRS, was not realised due to the limited capacity for this new component. The originally planned cooperation with USAID's N-MARC programme and its franchise activities also failed due to other priorities of USAID and a reallocation of the originally planned budget. In this respect, component II was not implemented as originally planned.

With regard to the procurement of components I and II, a correlating positive aspect that should be mentioned is that regular quality checks for all deliveries were an integral part of the process, both in the form of pre- and post-shipment inspections. This approach has now been institutionalised for all public health procurement in Nepal.

Component III: Outsourcing of maintenance/repair of medical equipment to the private sector

(6) Establishment of a management system for the maintenance of medical equipment (e.g. X-ray and ultrasound machines) and award of contracts for maintenance to private sector concessionaires. This contractual involvement of non-state actors by the Ministry of Health (PPP approaches, initially piloted in some districts, later nationwide via three large maintenance contractors, which were financed nationwide by the Nepalese government) represented a best practice case for which German FC has gained high recognition. Accompanying, biomedical engineers and technicians were trained in Nepal to take over the specific maintenance tasks on site. Unfortunately, the MoHP stopped providing further financing for nationwide maintenance contracts in 2019, as the decentralisation strategy resulted in uncertainties regarding the respective responsibilities and their financing.

[17] Social marketing refers to the dissemination of ideas, values and behaviours as well as the marketing of price-subsidised products in order to achieve the desired goals.

(7) Consulting services

Indicators – status at ex-post evaluation

1. Increase in the **contraceptive prevalence rate** (modern contraceptive prevalence rate = mCPR; in relation to modern methods) in the group of women aged 14–49 years. The individual measures of the FC programme primarily concern the increase in availability and diversification of the supply even in remote regions, accompanied by measures to increase demand (social marketing and franchises) in order to also reach poorer population groups. The development of the demand side appears to be insufficient as of yet, with FC measures only forming a subset of national efforts. On the other hand, the fertility rate in Nepal has fallen significantly and reached the target of 2.1 children per family (see section Impact). An increase in the mCPR was observed from 1996 (27 %) to 2006 (44 %). The mCPR has been stagnating in Nepal for several years, for several reasons, which have been discussed in the Joint Annual Reviews (JAR), the National Health Sector Programme (NHSP) reports and by other organisations (such as the United Nations Fund for Population (UNFPA)). The high number of men spending long periods of time abroad as migrant workers could be an explanation[18] along with an increasing abortion rate and a rising proportion of sterilisations. Additionally, negative perceptions about the risks and side effects of the individual contraceptive methods are widespread among women of reproductive age.

2. The **availability of essential medicines** in basic healthcare facilities has improved significantly from approximately 50 % in 2006 to over 90 % (NHFS 2021 and spot checks in 2023). Here, a wide range of essential medicines was also provided in remote regions, which meets the target objective (taking into account the disadvantaged population). Here, too, the continuous quality control is a positive aspect that should be mentioned. The target for indicator 2 was set at 95 % during implementation, which we consider to be too high, as it would mean approximately doubling the availability compared to the initial value of about 50 % at programme appraisal. The evaluation concludes that the availability of medicines has improved significantly. The published data of the NHSS 2021 is used as a measure of essential medicines. These attest to a very good availability of the frequently used medicines at the different levels of the Nepalese health system of over 90 % (e.g. of paracetamol, antibiotics such as amoxicillin, metronidazole, ciprofloxacin, ORS, iron supplements as well as oxytocin and magnesium sulphate). We were also able to observe this during our random on-site visits to different healthcare facilities at different levels.

3. Increase of patient satisfaction: According to the 2011 GIZ evaluation, patient satisfaction was as follows: 22 % of patients were satisfied, 71 % were very satisfied and 7 % were extremely satisfied. The appropriateness of this indicator appears questionable in retrospect, as the baseline values were already in line with the target. Consequently, this indicator was not assessed at final inspection.

As an approximation, the following monitoring data can be used for this evaluation: the 2021 Nepal Health Facility Survey (NHFS) found that of 546 post-partum women in healthcare facilities, between 79 and 89 % were satisfied (NHFS 2021, Table 7.30). However, these more recent values only indicate that this proportion of patients were satisfied. We do not have a sample representing all patients and corresponding comparison values from the past to attest to a significant increase in satisfaction. This indicator is therefore not included in the evaluation of this appraisal – as their was not in the final inspection.

Quality of implementation

The MoHP was responsible for the NHSP-I and the FC programme financed as part of this, with implementation at national level being carried out by the Department of Health Services (DoHS) that reports to the Ministry. At district level, the relevant District development committees (DDCs) and the district health offices were responsible. As part of the ongoing decentralisation strategy, which has not yet been completed, there have been repeated overlaps of competence in areas such as staff management, procurement and logistics since 2015, which has sometimes had an adverse impact on the quality and speed of implementation.

Gender aspects were already taken into account by selecting the package of measures under the aforementioned component II (family planning).

[18] About half of married women stop using contraceptives if the husband works abroad for a longer period of time (Khanal P. 2022)

Unintended effects (positive or negative)

Not all population groups were able to benefit equally from this programme. Although discrimination based on caste, ethnicity, gender, place of residence or religion is officially prohibited in Nepal, there is still great social inequality and the level of health care received by different parts of the population varies hugely. This is shown by the 2022 Demographic and Health Survey for the indicators of fertility, teenage pregnancy, contraceptive use, child mortality, childcare, vaccinations and nutritional status of children (e.g. seetable 11).[19]. Even these few examples make it clear that caste, ethnicity and religion still play a major role. For example, in case of the Dalit caste (lowest caste), teenage pregnancies are almost three times higher than in case of the Brahmin caste (highest caste). Caste continues to play a major role in the region, especially in the use of health services, even in the capital.

Regarding modern contraceptives, usage among Muslims is far below that of other ethnicities or religious groups, while at the same time the proportion of pregnancies among girls under 20 is significantly higher. The place of residence also plays a role. Rural regions tend to have poorer indicators, as do mountain regions. However, there are also exceptions with regard to this. For example, the use of modern contraceptives is higher in the mountain regions than in the lowlands, which is probably related to religious affiliation. Additionally, the proportion of fully immunised children is higher in the mountain regions.

Looking at the provinces, differences can be seen for various parameters. Karnali Province has the highest proportion of teenage pregnancies, Gandaki Province has the lowest use of contraceptives and Madhesh Province has the lowest proportion of fully vaccinated children. Therefore, it is also evident that the parameters are not uniform, i.e. there is no “worst” province in which everything is far below average. Rather, provinces report significant variations for different parameters.

The importance of education and income is substantial for almost all parameters. However, it is surprising here that the use of contraceptives decreases as the level of education increases. Whether this result is attributable to intensive education or poverty (“cannot afford children”) cannot be assessed at this time.

MoHP statistics show that gender still plays a role. When girls fall ill, parents are less likely to visit healthcare facilities, they spend less money on health care and are less likely to get the right diagnosis.[20]

Rating summary:

The FC programme certainly contributed to increasing the availability of basic medicines and contraceptives. By incorporating social marketing approaches via the public sector (CRS) and via non-governmental organisations (FPAN), a wide range of contraceptives can be provided even in remote regions. However, the contraceptive prevalence rate with modern methods (mCPR) has stagnated for several years in Nepal, probably for several reasons that cannot be attributed to the increased availability of contraceptives alone. For example, there is a high number of men staying abroad as migrant workers and a high proportion of sterilisations. The abortion rate is also increasing.

Overall, we evaluate the effectiveness of this programme as moderately successful, as not all FC measures could be implemented as planned (see above). Components I and II were only implemented partially, and the maintenance component III was not further financed after decentralisation in 2019. Of the three outcome indicators, conclusions can only be drawn from two. One of these has not been achieved.

Effectiveness: 3

Efficiency

Production efficiency

With regard to production efficiency, the picture is different for the individual components:

[19] Ministry of Health and Population, Demographic and Health Survey 2022. Key Indicators Report. 2022, Nepal: Kathmandu.

[20] Shrestha, B., et al., Determinants affecting utilisation of health services and treatment for children under-5 in rural Nepali health centres: a cross-sectional study. BMC Public Health, 2022. 22 (1): pp. 1–15.

Components I and II: The procurement of important **medicines and contraceptives** took place on time within the planned three years 2008–2011, and the costs for components I and II remained largely within the scope of the original design. Efficient procurement of contraceptives enables savings to be made in the amount of around EUR 0.3 million, which made it possible to procure additional contraceptives. According to interviews, the programme paved the way for a cost-efficient procurement process. It established procurement channels, which were subsequently institutionalised in the Ministry of Health and Population. We consider the efficiency of these components to be high.

We evaluate the efficiency of the **warehouse component** to be significantly lower: As assumed in the PP, the warehouses could not be constructed at eight locations, but only at three (Jajarkot, Lamjung and Sindhupalchowk). The main reasons for this were unexpectedly difficult terrain (limited availability of flat construction land) and the alterations in the design that this necessitated. Part of the cost increases was also due to larger dimensions related to increased space requirements for the warehouses, as well as general price increases and an unfavourable exchange rate development. This component was completed in 2012.

Component III: The outsourcing of maintenance contracts to public private partnerships (PPPs) and the establishment of a management system for the maintenance of medical equipment were completely new measures in the Nepalese context at the time of the programme appraisal. Until now, regular maintenance was only known to be carried out for the most complex, high-priced equipment such as magnetic resonance tomographs (MRI) and computer tomographs (CT), and was usually part of the supply contracts at the time of procurement. As part of this FC programme, a nationwide system consisting of three maintenance contractors (MCs) was set up from 2009 to 2019. The process was supervised by trained biomedical technicians and gradually came to be financed entirely from state funds until 2019. The task of the three MCs was the preventive and corrective maintenance of more demanding equipment such as ultrasound and X-ray machines. This PPP came with extensive advisory support, which was financed from FC funds and accounted for more than 30 % of this programme's total budget (approx. EUR 3 million instead of the originally planned EUR 0.7 million). In terms of the amount of the consulting costs, it must be taken into account that this involved "all-round support" of the MoHP over a period of almost 10 years. In light of this, the costs seem reasonable, but their efficiency is now questionable, as the contracts with the MCs ceased to be continued from 2019 (see chapter on Sustainability).

Allocation efficiency

From today's perspective, a number of factors stand out that could have been adjusted to further improve the effectiveness of this FC programme:

- The focus area of the measures was on improving **mother-infant health**. This aligns with international health policy, as these groups are considered vulnerable. However, the increasing relevance of chronic degenerative diseases – including those suffered by men – (non-communicable diseases, NCD) should have been taken more into account. Nevertheless, this was not reflected in the measures of NHSP-I and the FC programme, but only in the successor sectoral programme NHSS from 2016.
- The measures are almost entirely focused on the **supply side**, while the demand side and, in particular, the filtering effect of purchasing power have been neglected. It is worth considering whether strengthening the demand side of the healthcare market would have made the patient a customer. If this were the case, they could have made the decision themselves as to where they would receive the best service in relation to direct and indirect costs they would bear. The allocation of resources would then have taken place entirely automatically in the market. The possibility of introducing health insurance was not yet considered at the time and was only included in the last NHSS sectoral programme (2016–2020).

Some of these gaps were closed in the successor programme NHSS from 2016, a basic health insurance was introduced. However, the positive effects of NHSP-I (2005–2010), including this FC progeramme and the successor programme NHSP-II (2010–2016), could have been optimised by closing these gaps even earlier.

Until 2019, the new maintenance system proved to be efficient from the point of view of a scientific accompanying measure implemented by the University of Heidelberg. It was found that the annual contract costs for the maintenance companies are less than 10 % of the estimated replacement value, making the chosen outsourcing approach comparatively cost effective given Nepal's topographical and logistical challenges. Cost efficiency increased with the duration of maintenance and the size of the geographical catchment area. Compared to purely in-house maintenance, there was a clear cost advantage of around 20 %. Unfortunately, the MoHP stopped extending the maintenance contracts with the MCs after 2019, as federalisation was gradually being introduced in

the healthcare sector from 2015. However, some of the biomedical technicians we interviewed are still being financed from decentralised budgets, partly through temporary contracts.

As parallel financing, this FC programme was part of the overarching first SWAp in Nepal (NHSP-I).
Looking at NHSP-I as a whole, it should have contributed to increasing efficiency by reducing transaction costs. The harmonised financing mechanism also entailed uniform follow-up and reporting. This meant that coordination (e.g. with regard to priorities) was no longer done in parallel, complex meetings, but could instead be carried out in a concentrated and joint manner. The bilateral dialogue was replaced by a joint exchange. The interviewees saw a significant (efficiency) advantage. Although at first this was not down to the FC contribution in this project completely, as it was still a parallel financing mechanism (with non-uniform account management by the World Bank as trustee), this changed with the implementation of the successor programme NHSP-II, which the German FC co-financed with the SWAP under BMZ no. 2010 666 305.

Rating summary:

Efficiency: Efficiency is evaluated separately by component. For procurement, it is rated as successful, as the cost savings in the procurement of medicines and contraceptives have enabled the purchase of more consumables. The cost-efficient procurement processes and quality controls established as part of the FC programme have now also been institutionalised.

The time efficiency seems negative at first glance. However, the long term must be assessed in the light of the novel approach of awarding three nationwide maintenance contracts to the private sector. This – financed by the MoHP's annual budget and supplemented by the training of technicians at public hospitals – led to positive systemic effects until the end of the maintenance contracts with the contractors in 2019, which, however, must now be reorganised appropriately as part of the decentralisation in the healthcare sector.

Despite all this, it is not possible to quantitatively determine allocation efficiency within the scope of this report. Nevertheless, there are numerous approaches that, when viewed ex-post, would have led to an increase in efficiency. However, this should not imply that serious errors were made in the programme's design.
More decisive is the fact that the partners have learned from developments and misjudgements. These learning points have been incorporated in the design of the last successor NHSS programme (e.g. the increased consideration of non-communicable diseases and the introduction of health insurance). On this basis, the overall efficiency can be evaluated as satisfactory.

Efficiency: 3

Impact

Overarching (intended) developmental changes

The overarching developmental objective (impact), as defined in the appraisal, was to contribute to improving the health status of the population and achieving the MDGs in the health sector in Nepal.

Target achievement at the impact level can be summarised as follows.

Indicator	Status at PA (2006)	Target value at PA	Actual value at Final Inspection	Actual value at EPE 2023
(1) Reduction in maternal mortality (MDG 5 or SDG 3.1) per 100,000 live births	281	**Reduction, otherwise n/a in PA.** Target value added later, only during NHSP II (2010–16): 134	239 (NDHS 2016) 190 (WHO estimate)	151 (National Population and Housing Census 2021) 174 (WHO) Significant reduction, but not yet up to the NHSP II level added later

(2) Reduction in infant mortality per 1,000 live births	48	**Reduction, otherwise n/a in PA.** Target value added later, only during NHSP II (2010–16): 16	23 (NDHS 2016)	28 (NDHS 2022) Significant reduction, but not yet up to the NHSP II level added later
(3) Reduction in child mortality (under 5 years of age) per 1,000 live births	61	**Reduction, otherwise n/a in PA.** Target value added later, only during NHSP II (2010–16): 38	38 (NDHS 2016), already achieved in 2014 according to JAR	33 (NDHS 2022) Value achieved
(4) Decrease in fertility rate	3.1	**Reduction, otherwise n/a in PA.** Target value added later, only during NHSP II (2010–16): 2.3	2.3 (NDHS 2016)	2.1 (NDHS 2022) Value achieved

ad (1): Maternal mortality ratio (MMR): Against the background of high maternal and neonatal mortality rates, the programme aimed in particular to improve access to health services for this previously under-served group. At national level, there is a significant increase in births in healthcare institutions: while in 1996, only 8 % of Nepalese women gave birth in a healthcare facility, it was possible to increase the rate nearly tenfold (80 %) by 2021. The MMR has decreased, probably due to NHSP-I and its strong focus on reproductive health. The target was a maternal mortality ratio of 134 in 2015; this target was not achieved. However, the most recent figures are significantly better than in 2006. The most recent 2021 census (MoHP and NSO 2022) found that the MMR was 151 per 100,000 live births in Nepal. This positive trend is, among other things, due to the increase in births in healthcare facilities and the increasing use of family planning services. Nepal is also a signatory of the Sustainable Development Goals (SDGs) and has committed to reducing the maternal mortality rate to below 70 per 100,000 live births by 2030.

ad (2), (3): Infant mortality rates: These parameters measure the number of deaths of children under 1 year of age and under 5 years of age per 1,000 live births. All these parameters are meaningful indicators of the health system's functioning, with a focus on vulnerable groups of young children.

ad (4): Fertility rate: The statistics show the number of children per woman. The figure has fallen sharply, from 3.94 children per woman in 2000 to 2.1 in 2022. The value of 2.1 corresponds to a fertility rate at which a constant population is possible in the long term (replacement rate). This value has a high relevance for the economic and political stability of the country. This is a great success. The declining birth rate is seen as a key contributing factor to the improved poverty situation, underlining the importance of effective family planning.

Contribution to overarching (intended) developmental changes

With its focus on women's and children's health, the FC programme has contributed to improving the living conditions of this vulnerable target group. However, this programme accounts for less than 1 % of the total volume of the sectoral programme, so its contribution to the overarching development policy changes may at most be limited. Overall, the 2022 SDG report for Nepal (https://dashboards.sdgindex.org/profiles/nepal) shows a positive development for most indicators of SDG 3. In 2023, Nepal fully met MDG 4 targets and almost met MDG 5 targets.[21] Regarding MDG 6, target achievement was somewhat stable. Only with regard to mortality due to NCDs, environmental pollution and traffic accidents clearly negative values can be found – i.e. in the areas that NHSP-I neglected.

Inequality undoubtedly remains a central problem for Nepal. It can be assumed that NHSP-I made a contribution here, but this cannot be fully identified. As part of the overall NHSP programme, which was poverty-oriented and which was focused on eliminating disadvantages experienced by specific groups, it can be assumed that the FC

[21] MoHP and NSO, *National Population and Housing Census 2021: Nepal Maternal Mortality Study 2021.*, N.S. Office, Editor. 2022, Ministry of Health and Population: Kathmandu.

contribution also particularly benefited disadvantaged groups. This is also reflected in the improvement in the income-related GINI coefficient in Nepal from 0.41 to 0.32 between 2006 and 2015.[22]

Contribution to overarching (unintended) developmental changes

The question of whether the sectoral programme NHSP-I and the FC parallel financing contained therein also had an impact on stability, security and democracy is not easy to answer. According to some interviewees, even after the 2015 constitutional reform, some people and social groups in Nepal do not feel sufficiently recognised, and the delineation of the new provinces is criticised. Nepal's stability is fragile. This makes it all the more important that healthcare is completely reliable, i.e. basic care must be provided to every citizen – regardless of ethnicity, caste, religion, gender, place of residence, etc. In Nepal, the "free drug initiative", according to which every citizen receives a free basic health package, was introduced in 2015. Support for democracy depends upon whether the quality of life of citizens is improving, i.e. the government of Nepal is assessed accordingly. The healthcare sector (and therefore also NSHP-I and the German DC contribution) makes a contribution towards this. However, this contribution cannot be recorded quantitatively. Overall, the German FC contribution to the NHSP was less than 1 %.

Rating summary:

In summary, we can note that the FC programme's impact indicators, which were taken from the overarching sectoral programme NHSP-I, showed clearly positive developments between the time of the programme appraisal in 2006 and the evaluation in 2023. Promoting vulnerable people is likely to have contributed to the country's political stability and to citizens identifying with their state, although it has not been possible to prove this. We therefore evaluate the overarching developmental impact as successful.

Impact: 2

Sustainability

Capacities of persons concerned

Since the MoHP did not have any lists of the medicines, contraceptives, equipment and systems ordered during the programme, it is difficult to evaluate whether they are functioning and sustainable. In this regard, we can therefore only make assessments of the healthcare departments and warehouses visited. In this respect, it was found that all the facilities still fulfil their original function. No facility has been closed or converted resulting in a discontinuation of the provision of public healthcare. In many cases, the original capacities were expanded, partly using own resources.

With regard to staffing, there is a high turnover, especially among doctors. However, we got the impression that this applies to facilities on an individual basis and not to the overall public health system, i.e. structural sustainability appears to be at risk at the level of the individual facilities, but not at the system-wide level.

However, an inadequate management system is resulting in doubts being cast regarding the permanent functionality of the healthcare system: there are no cost accounting systems at the level of the individual facilities or for the overall system. Epidemiological data is often inconsistent, i.e. data from facilities and the health management information system (HMIS) do not align. Therefore, it is uncertain as to whether the maintenance of service provision in the event of increasing complexity and decentralisation can be ensured.

Contribution to support for sustainable capacities

Limited sustainability was anticipated for the medicines and contraceptives procured as part of the programme due to their limited life expectancy. The promotion of an efficient procurement system (demand-based pull system with quality controls) paved the way for its permanent institutionalisation in the MoHP. In the course of the

[22] National Planning Commission, *Nepal and the Millennium Development Goals. Final Status Report 2000–2015.* 2016, Government of Nepal: Kathmandu. Values not available since.

free drug distribution introduced in 2015 and the associated increased requirements for decentralised medication logistics, the introduction of the pull system supported by the German DC gained additional significance.

The start-up fund, initially financed from TC funds and later from FC funds, was integrated into the decentralised structures and thereby made more sustainable. However, following the adoption of the Local Government Operation Act in 2017, ongoing uncertainty regarding the competences and financing at this level has arisen.

The construction of the warehouses proved to be largely sustainable – all warehouses visited were used as intended for the storage of equipment and important medicines. All buildings were solidly constructed and showed no major defects. In some cases, the organisation of storage needs to be improved, in particular in places where expired and even unexpired medicines were stacked outside the warehouse.

By 2019, 178 hospitals across all provinces were involved in the preventive maintenance system for more sophisticated equipment, with a total of over 5,000 pieces of equipment. The seven provinces were divided into three lots and regular visits by the respective MC were agreed every six months. The total costs, which were fully provided by the MoHP, amounted to NPR 536.36 million (around EUR 4.26 million) when the contract was concluded. This is to be regarded as a comparatively high own contribution, which unfortunately was not continued at decentralised level after 2019. Consultant support had been provided from FC funds for 10 years.

Durability of effects over time

With regard to maintenance, the programme had led to a fundamental change in the healthcare sector over the course of its implementation between 2008 and 2019: the relevance of medical device maintenance increased, with several suppliers of this equipment creating new jobs for engineers.
Their income had risen and higher demand had led to an increase of study places for future biomedical engineers. Unfortunately, the MoHP discontinued financing of the three nationwide maintenance contracts with the maintenance contractors (MCs) after 2019 due to disagreements regarding the responsibilities for further financing (central or decentralised level).

However, training of maintenance personnel (e.g. biomedical technicians) already carried out in previous years was continued. We saw some of the personnel on site in the larger hospitals. The MCs are still responsible for the operation and maintenance of more sophisticated medical equipment such as ultrasound and X-ray machines, but they often only have temporary contracts.

The structures established during NHSP-I are to be assessed in the continuity of the sector programmes NHSP-I (2005–2010), NHSP-II (2011–2016) and NHSS (2016–2022). Forums, reviews, consultations, etc. developed during NHSP-I matured according to the interview partners in NHSP-II and were continued (at least initially) in NHSS. However, the coronavirus pandemic had resulted in many processes being interrupted and subsequently no longer being continued by new decision-makers. For example, interview partners reported that key people no longer visited the forums.

Furthermore, there are uncertainties with regard to the future design of key processes, such as procurement, financing, etc., due to decentralisation (federalisation) being implemented. The Nepalese healthcare sector is still undergoing a structural adjustment with regard to the transition to federalism. In the coming years, the supply network for medical facilities will require adjustment to federal requirements. Adjustments have already been initiated with, for example, a newly introduced classification of healthcare facilities. In this context, this primarily means balancing the number of planned facilities with the number of available health care staff that can be anticipated as well as the financing of operation. As a result, there are restructuring requirements for personnel, finances, medical technology and digital equipment.

Although the budget of the Nepalese Ministry of Health has increased in absolute terms in recent years, relatively speaking, a decrease in the health budget in relation to the state budget can be seen. Whereas in the years 2002–2008, a rate of more than 5 % was achieved (maximum: 7.58 % in 2006), the figures thereafter were below 5 % until 2013 (minimum: 4.69 % in 2012). They then rose again to reach a global minimum of 3.81 % in 2018. In the last year for which data is available (2020), a value of 5.67 % was reached due to the coronavirus, but this seems to be an exceptional situation. Overall, public health financing is insufficient and not very sustainable.

Although the absorption capacity in the healthcare sector improved from 76.2 % in 2014/2015 to 78.7 % in 2015/2016 and 94.0 % in 2016/2017, this positive trend could not be continued due to the upcoming decentralisation efforts (80.4 % in 2017/2018). We do not have any more recent figures on this.

Rating summary:

In summary, the sustainability of this FC project can be assessed as moderately successful: it was successful in terms of quality assurance achieved in procurement and the sustainable capacity of the warehouses – and needs improvement in terms of the necessary adjustment of the maintenance component to the specific design of the decentralisation process.

Sustainability: 3

Overall rating: 3

Embedded as parallel financing in the successful NHSP sectoral programme in the health sector, the FC programme partially achieved the objectives and indicators set during the programme appraisal. As a result, we evaluate the project as moderately successful overall.

The durability of its effects depends on the nature of the inputs – the medicines and contraceptives provided are naturally less sustainability than, for example, the built warehouses. The initially very successful maintenance component had been extended from piloting in one district to application at national level – and thereby contributed to a rethink taking place in the healthcare sector. Unfortunately, its nationwide financing was discontinued in 2019, as questions regarding responsibilities that arose in the course of decentralisation could not yet be definitively clarified. It would be great to see this component establishing itself in the newly created decentralised structures with locally hired biomedical technicians.

Contributions to the Agenda 2030

NHSP-I and the German DC contribution were directly focused on MDG 4 (Reduce child mortality), MDG 5 (Improve maternal health) and MDG 6 (Combat HIV/AIDS, malaria and other diseases) as well as SDG 3 (Good health and well-being), i.e. ensuring a healthy life for all people of all ages and the promotion of their well-being. The corresponding indicators are mainly positive.[23] The focus area of vulnerable groups also aligns with the 2030 Agenda.[24] The SWAp used the national systems, implemented national routines and coordinated the donors.

NHSP-I has not yet been explicitly aligned with ecological objectives. The intent is that this will first take place as part of SWAp IV, as global warming has a significant impact on Nepal, which experiences a monsoon season. In this regard, the country has experienced heavy rain and flooding.

Project specific strengths/weaknesses and general conclusions/lessons learned

The project had the following strengths and weaknesses, in particular:

The project supported procurement processes for basic medicines and contraceptives as well as innovative PPP approaches for maintenance processes (Ministry of Health commissions private companies with the maintenance of medical equipment with framework contracts). This contractual involvement of non-state actors by the Ministry of Health represented a “best practice” case, for which German DC has gained high recognition.

The government's implementation of the decentralisation approach, in which the necessary detailed plans have not yet been concluded, over a very short period of time and in a very forced manner, was worrying. Uncertainties regarding responsibilities and financing in the new system led, among other things, to the originally very promising maintenance component being discontinued by the Nepalese government from 2019 onwards.

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23 Report on Social Development Goals, *SDG Nepal*. 2023 [cited 2024 19 July 2024]; https://dashboards.sdgindex.org/profiles/nepal. National Planning Commission, *Nepal and the Millennium Development Goals. Final Status Report 2000–2015.* 2016, Government of Nepal: Kathmandu.

24 National Planning Commission, Nepal and the Millennium Development Goals. Final Status Report 2000–2015. 2016, Kathmandu: Government of Nepal.

The impact of this programme on the contraceptive prevalence rate was limited. Overall, there was no increase in the contraceptive prevalence rate in Nepal during the implementation period starting in 2006. This was probably due to the fact that other factors are at least as important as the actual availability of contraceptives.

In contrast, the availability of essential medicines in basic healthcare facilities increased from around 50 % in 2006 to over 90 % in 2023. In our opinion, this programme played a role here through the establishment of the pull system and quality assurance.

General conclusions and lessons learned:

The Government of Nepal developed ownership for the NHSP-I sectoral programme, which was further strengthened in the subsequent NHSP-II programme (2011–2016). The sector dialogue led to mutual trust, which contributed to improved implementation of the measures. The FC measure not only makes an important development policy contribution to improving the health situation of the population, but also to the country's efforts to harmonise external support (via integration in the sectoral programme NHSP-I).

However, implementation in a federal system is a new approach that requires fundamental adjustment that has not yet taken place. Demand-oriented measures (such as the introduction of health insurance) were mostly lacking in NHSP-I, but were implemented as part of the successor programme NHSS.

A maintenance system for medical equipment can only work in a decentralised system if the responsibilities are clarified and if sufficient training and funds are provided. In short, successful implementation of the subsidiarity principle is only possible if the corresponding capacities and finances are available at all levels.

Evaluation approach and methodology

Ex-post-evaluation methodology

Ex-post-evaluations follow the approach of a rapid appraisal, i.e. a data-supported, qualitative contribution analysis resulting in an expert opinion. Effects are attributed to the project considering plausibilities, based on thorough analysis of documents, facts and impressions. This includes – if possible – the use of advanced technology (e.g. satellite imagery, online interviews, geocoding). There is a follow-up on possible conflicting information, attempting to eliminate inconsistencies and to base the rating on information that – to the extent possible – has been confirmed through different sources (triangulation).

Data sources and tools for analysis: Literature (see appendices and notes in the respective footnotes), BE 2007–2022, PA and Final Inspection, various databases (e.g. World Development Indicators).
Interview partners[25]: Interview partners online before the mission: ten interviews of 60 minutes each, mainly with former employees of the Ministry of Health, donors and consultants; interview partners during the mission: Ministry of Health (4), Ministry of Finance (1), Family Welfare Division (3), GIZ (3), managers of health facilities (24), managers of district warehouses (6), other (6).

The analysis of project effects is based on the theory of change defined at project appraisal and documented within the impact matrix, which may be updated for the purposes of the evaluation. The evaluation report argues which factors contributed to the observed effects and why – as well as the probable extent of the project's contribution (contribution analysis). The context of the project is taken into account concerning its influence on the results. The conclusions are put into perspective regarding the availability and accuracy of the available data. The framework of the evaluation was established by the evaluation conception.

This method provides a balance between cost and usefulness, generating evaluation findings with appropriate effort and expense. Also, it allows for a systematic success rating across the FC projects. Thus, an isolated ex post evaluation cannot fulfil the requirements of a scientific assessment in the sense of a strict causality analysis.

The following aspects limit the evaluation: No budgets and revenue surplus calculations could be obtained for health care facilities.

The analysis of project effects is based on the theory of change defined at project appraisal and documented within the impact matrix, which may be updated for the purposes of the evaluation. The evaluation report argues which factors contributed to the observed effects and why – as well as the probable extent of the project's contribution (contribution analysis). The context of the project is taken into account concerning its influence on the results. The conclusions are put into perspective regarding the availability and accuracy of the available data. The framework of the evaluation is established by the evaluation conception.

This method provides a balance between cost and usefulness, generating evaluation findings with appropriate effort and expense. Also, it allows for a systematic success rating across the FC projects. Thus, an isolated ex-post-evaluation cannot fulfil the requirements of a scientific assessment in the sense of a strict causality analysis.

[25] Numbers in brackets indicate the number of interviewees.

Rating methodology

Projects are rated on a six-point scale for each of the OECD DAC criteria. The scale is as follows:

Level 1 very successful: result that clearly exceeds expectations

Level 2 successful: fully in line with expectations and without any significant shortcomings

Level 3 moderately successful: project falls short of expectations but the positive results dominate

Level 4 moderately unsuccessful: significantly below expectations, with negative results dominating despite discernible positive results

Level 5 unsuccessful: despite some positive partial results, the negative results clearly dominate

Level 6 highly unsuccessful: the project has no impact or the situation has actually deteriorated

The overall rating on the six-point scale is compiled from a weighting of all six individual criteria as appropriate to the project in question. Rating levels 1-3 of the overall rating denote a “successful” project while rating levels 4-6 denote an “unsuccessful” project. It should be noted that a project can generally be considered developmentally “successful” only if the achievement of the project objective (“Effectiveness”), the impact on the overall objective (“Impact”) and the sustainability are rated at least “moderately successful” (level 3).

The annex to this report is available upon request.

List of abbreviations:

FI	Final inspection
BMZ	German Federal Ministry for Economic Cooperation and Development
GDP	Gross domestic product
CT	Computed tomography
CRS	CRS Company Nepal
DAC	Development Assistance Committee
DFID	Department for International Development
EUR	Euro
FC	Financial Cooperation
FPAN	Family Planning Association Nepal
FC E	FC evaluation
HDI	Human Development Index
JAR	Joint annual review
JCM	Joint consultative meetings
CP	Cooperative project
MDG	Millennium Development Goal
MoF	Ministry of Finance
MoHP	Ministry of Health and Population
MRI	Magnetic resonance imaging
NCD	Non-communicable diseases
NGO	Non-governmental organisation
NHSP	National Health Sector Programme
NHSS	National Health Sector Strategy
ODA	Official development assistance
OOP	Out-of-pocket
PPP	Public-private partnership
PP	Programme proposal
PHCC	Primary health care centres
PM	Process management

QM	Quality management
SDGs	Sustainable Development Goals
SWAp	Sector-wide approach
TB	Tuberculosis
UHC	Universal health coverage
WB	World Bank

About this publication

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