

Ex-post evaluation SWAp II, Nepal

Title	Support for the National Sector Programme for Health (basket funding), Nepal		
Sector and CRS code	Health policy and administrative management (CRS code 12110)		
Project number	BMZ no.: 2010 65 440		
Commissioned by	German Federal Ministry for Economic Cooperation and Development		
Recipient/Project-executing agency	Ministry of Finance (MoF) / Ministry of Health and Population (MoHP)		
Project volume/ Financing instrument	EUR 9.98 million / budget grant via basket funding		
Project duration	July 2011– June 2016		
Year of report	2023	Year of random sample	2023

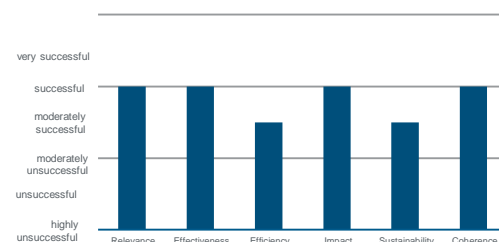
Objectives and project outline

The FC project supported the second phase of the “National Sector Programme for Health” (NHSP-II, 2011–2016) by means of basket funding. To this end, measures to improve healthservices (reproductive health, child health, nutrition, HIV/AIDS, TB and malaria) and to strengthen the health system (infrastructure, finance, procurement, strengthening the management capacities of decentralised structures, education and training, social inclusion and equality, in-depth studies) were financed. The indicators were adjusted several times.

Key findings

- The objectives of the FC measure were largely achieved. It thus 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. The policy dialogue linked to basket funding resulted in good coherence, strengthened the executing agency’s position and ensured greater participation of partners in the formulation of sector policies and the implementation of reforms.
- Although the share of German FC in the total budget of NHSP-II was low at around 1%, the impact of the measure was significantly stronger due to the improved sector dialogue. German FC was involved in the policy dialogue, while NHSP-II was a recognised partner on an equal footing that clearly contributed the values of German DC. This significantly increased the efficiency, effectiveness and visibility of the German commitment.
- Efficiency and sustainability of the measures would have been reduced by taking certain components into account (e.g. maintenance services, disposal/waste management, combating non-communicable diseases). Demand-oriented measures (such as health insurance and rescue services) were mainly lacking in NHSP-II, but were included in the successor programme NHSS (2016–2020).

Overall rating:
successful



Conclusions

- The SWAp made an important contribution to the harmonisation of external support. Basket funding is a suitable instrument for this, as it strengthens the responsibility taken by the partner country’s government.
- However, implementation in a federal system is new territory and requires fundamental adjustment.
- The sector-wide approach (SWAp) appears to be suitable for increasing the speed and effectiveness of the implementation of individual measures via the moderator effect. This was particularly evident in times of crisis (earthquakes 2015, coronavirus 2020/21).
- Efficiency and sustainability of the measures would have been reduced by taking certain components into account (e.g. maintenance services, disposal/waste management, combating non-communicable diseases).

Ex post evaluation – rating according to OECD-DAC criteria

List of abbreviations

Aama	Aama Surakshya Programme
ANC	Antenatal care
AusAID	Australian Agency for International Development
GDP	Gross Domestic Product
CEOs	Chief Executive Officers
CHE	Catastrophic health expenditure
CMNN	Communicable, maternal, neonatal and nutritional diseases
DALYs	Disability-adjusted life years lost
DFID	Department for International Development
eLMIS	Electronic Logistics Management Information System
GAVI	Global Alliance for Vaccines and Immunization
GESI	Gender Equality and Social Inclusion Strategy
HALE	Healthy Life Expectancy
HDI	Human Development Index
HEART	Health & Education Advice and Resource Team
HP	Health post
IDA	International Development Association
IECCD	International Economic Cooperation Coordination Division
JAR	Joint Annual Health Review
JAR	Joint Annual Review
JCM	Joint Consultative Meetings
M&E	Monitoring & Evaluation
MCH	Mother and Child Health Care
mCPR	Modern method contraceptive prevalence rate
MDG	Millennium Development Goal
MIS	Maternity Incentive Scheme
MoF	Ministry of Finance
MoHP	Ministry of Health and Population
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
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

General conditions and classification of the project

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. With a gross domestic product (GDP) of USD 1,208 per capita and year (2020), it is one of the lower-middle income countries, but in 2010 Nepal was still counted as a low-income country with a GDP of USD 589 p.a. The Human Development Index (HDI) also rose from 0.56 to 0.60 from 2014 to 2021. As a result, GDP per capita and the HDI value are lower than in all neighbouring countries, but the trend is clearly positive [1, 2].

Some changes can also be noted from a political perspective. As part of the Nepalese decentralisation process (federalisation), the constitution from 20 September 2015¹ enabled the establishment of seven provinces, which, like the peace treaty (Comprehensive Peace Accord, November 2006) and the subsequent peace process, contributed to the political stabilisation of the country. Today, Nepal is 73rd out of 161 countries [3] in the Global Peace Index and achieves a better score than any of its neighbouring countries with an index of 1.947. However,

¹ The Constitution of the Kingdom of Nepal, 2015. Date of Red Seal and Gazette publication: 2015/11/01 (Section 8, additional issue 32).

Nepal's governance indicators are still significantly below the South Asian average.² But here too, the trend must be seen as positive. The ranking in the Fragile State Index improved from 95 to 81 from 2006 to 2022 [4].

The major disparities in the country still seem problematic, i.e. there are major differences between provinces, urban and rural areas, social groups, ethnic groups, caste and gender, which are reflected in income, educational opportunities, quality of life and health [5–7].

The health of the population continues to be a high priority in national policy, which is also reflected in the constant succession of large national programmes since the turn of the millennium. National Health Sector Programme I (NHSP-I from 2005–2010) [8] was followed by NHSP-II (2010–2016), followed by the National Health Sector Strategy (NHSS 2016–2022). However, these efforts to improve health take place in a dynamic environment. Firstly, two external shocks challenged healthcare (two earthquakes in 2015; coronavirus pandemic 2020–2022). Secondly, the demographic and epidemiological transition, the change in mobility and settlement structures required changes in healthcare, i.e. the strategies and measures had to be constantly adjusted [9]. Education and training of medical and nursing staff (e.g. for chronic degenerative diseases such as cancer, cardiovascular diseases and diabetes) and changed catchment areas require dynamic adjustment of the current health policy in each case.

NHSP-II was a response from the government of Nepal and the donor community to the comparatively poor state of public health in Nepal. The programme was originally planned from mid-July 2010 to mid-July 2015 but was then extended until mid-July 2016 in order to stave off issues during the phase following the 2015 earthquakes on the one hand and to ensure a connection to the NHSS (2016–2022) follow-up programme on the other.

Brief description of the project

The FC measure co-financed the second phase of the “National Health Sector Programme” (NHSP-II from 2010–2016). The first phase ran from 2005–2010. NHSP-II aims to ensure equal opportunities in the access to and use of high-quality healthcare services, with particular attention paid to poor and socially disadvantaged population groups. Comprehensive investments and training measures were planned for this purpose. The total costs of NHSP-II were estimated at EUR 1 billion. The Ministry of Health provided financing of approx. EUR 515 million. The intent was for the donor community to provide the remaining financing. In order to harmonise the diverse financing modalities of external support, a basket was set up for programme support in which German FC participated with EUR 9.98 million. The World Bank, DFID, AusAid and Gavi played a key role in basket funding. Basket funding accounted for around 25% of total donor financing during NHSP-II, with FC contributing around 5% of this.

Map/satellite image of the project country including project areas

The project's target area was the entire country, with priority placed on vulnerable groups, especially in peripheral regions. Figure 1 shows the locations of health facilities visited during the evaluation. However, these are not focal points of NHSP-II, as it operated nationwide.

² “Governance in Nepal remains problematic, even though the pandemic has provided some impetus for improvement”, so Nepal is classified as a “highly defective democracy” [4].

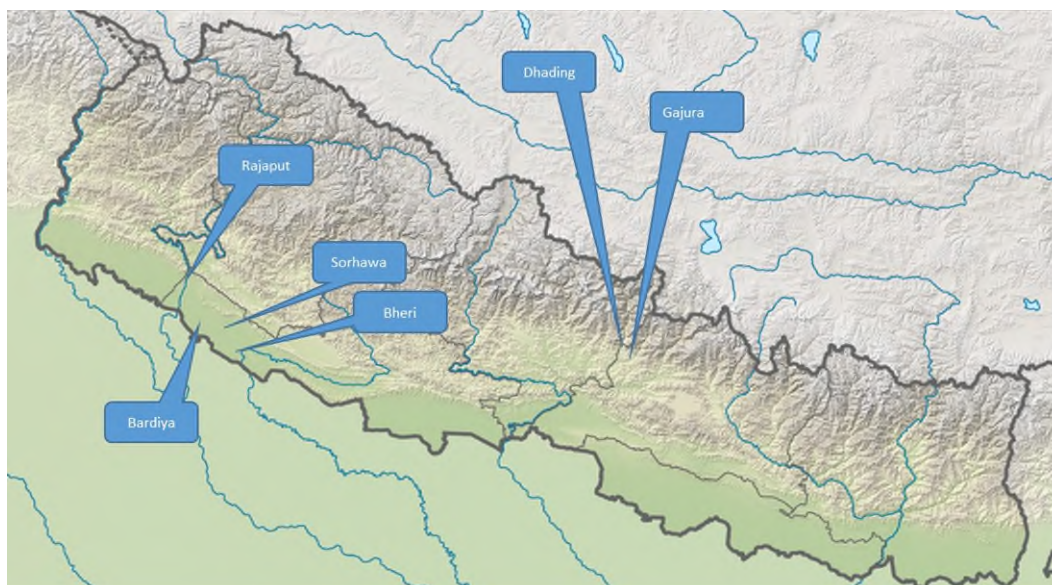


Figure 1: Map of Nepal with the hospitals and primary health care centres visited as part of the mission (health posts were not marked). Source: [10]

Breakdown of total costs

The total costs of NHSP-II amounted to approx. EUR 1.1 billion, of which EUR 9.98 million was provided via basket funding (deposit via a joint financing mechanism between the Nepalese government and donors, see sections on Effectiveness and Coherence). The exact actual costs of NHSP II could not be quantified, even during the final inspection. This is partly due to exchange rate fluctuations and the unplanned extension until 2016, but also partly due to incomplete documentation in the reports.

		Inv. (planned)	Inv. (actual)
Investment costs (total)	EUR million	1,000.00	1,109.98
Counterpart contribution	EUR million	515.00	716.00
Debt financing	EUR million	485.00	393.98
of which BMZ budget funds	EUR million	10.00	9.98

Rating according to OECD-DAC criteria

Relevance

Policy and priority focus

NHSP-II comprised two components, each with several fields of action and numerous measures and sub-measures: **Component 1 (improvement of health services)** includes reproductive health, child health and nutrition, as well as the fight against infectious diseases (malaria, TB, HIV/AIDS) and **Component 2 (strengthening of the health system)**, the strengthening of staff capacities and the construction or upgrading of health facilities, the improvement of management (administration, finance, procurement, decentralised structures) and inclusion. A breakdown of the components can be found in the annexes.

The “double structure” of the FC project (co-financing NHSP-II) shows that its relevance must be assessed in two dimensions. Firstly, it must be questioned whether the **measures** were suitable for achieving the desired objectives. Secondly, analysis is required as to whether the **sector-wide approach (SWAp)**³ and the basket funding

³ The SWAp is ...an approach to a locally-owned programme for a coherent sector in a comprehensive and coordinated manner, moving towards the use of country systems. SWAps represent a ...shift in the focus, relationship and behaviour of donors and

instrument selected were suitable for the measures to achieve the set objectives. Assessment is therefore about evaluating the measures themselves as well as assessing the suitability of the SWAp and the financing methodology of the basket.

The SWAp was the sectoral programme (NHSP-II) 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 2010–2016. The FC project participated in this in the form of basket funding (payment to a jointly managed account from which the Ministry of Health's expenses were reimbursed). Around a quarter of all SWAp measures were accounted for via basket funding, three quarters via direct financing and individual measures.

As part of NHSP II, the FC project aimed to improve the provision of high-quality healthcare services, taking into account equal opportunities for all population groups. The components of the project were suitable for this purpose and were fully in line with the guidelines of the international health policy and that of Nepal as well as German development cooperation. The measures are fundamentally suitable for achieving the objectives of Universal Health Coverage (UHC), in which access to basic health services is improved, in particular on the supply side. The project therefore complies with the principles of the Declaration of Alma-Ata, the Ottawa Declaration and the corresponding focus on UHC. It is also obvious that the project was fully committed to the Sustainable Development Goals (SDGs; in particular no. 3 but also no. 1, 2, 5), as determined by the National Planning Commission in the 2020 National Review of Sustainable Development Goals [12]. By focusing on the vulnerable, it was in line with the global and German objectives of alleviating poverty and reducing inequality as well as gender equality and inclusion. The programme explicitly addressed the health and health care of mothers, small children, the population in peripheral rural regions, the lower castes and religious groups as vulnerable people. Even though parts of the measures are relevant for the entire population, a large part of the measures are explicitly aimed at these groups.

Over the last two decades, Nepal has developed strategies and guidelines to assess the direction of the country's health policies. In addition to numerous disease-specific laws (e.g. Tuberculosis Act, Safe Motherhood Act), the Public Health Service Act, the Nepal Health Sector Strategy 2015/16–2020/21 and the Social Health Insurance Act are key milestones [13].

The updated Health Sector Strategy is currently in the parliamentary process and – according to the interviewees – is eagerly awaited as it takes into account current developments (e.g. staffing, non-communicable disease, etc.). NHSP-II is in line with the country's objectives regarding international cooperation (Foreign Aid Policy, Development Cooperation Policy, National Health Policy) [8, 14] and the principles of donors (e.g. WHO Country Cooperation Strategy, [15, 16]) and the United National Development Assistance Framework [17].

Focus on needs and capacities of participants and stakeholders

A fundamental problem in Nepal's healthcare sector continues to be the high user fees that result despite “free” services. Although Nepal has clearly defined the “essential package of healthcare services” and these services are free of charge in principle [18], numerous studies have shown that fees, transport costs and opportunity costs can place a high degree of strain on households [19]. Significant disparities between the provinces and the income groups can be observed here [20]. In principle, the proportion of direct user fees in healthcare expenditure is not exceptionally high, but exhibited the tendency to increase over the years (from USD 19 to 21 per capita from 2011–2017) [21].

Insufficient supply and the poor health of vulnerable groups continue to pose major health problems in Nepal. For example, UNICEF's Health Expenditure Brief identifies general disparities in the distribution of healthcare services, which has an impact on indicators with a high degree of deviation [21]. Deviating performance indicators include the distribution of public hospitals (city/country; centres/periphery), the accessibility of public hospitals, the distribution of public health centres (city/country; centres/periphery), health expenditure per capita and direct user fees (out-of-pocket spending) in relation to household income, resulting in excessive health expenditure, particularly for vulnerable groups (catastrophic health expenditure) [22].

As a result, the health and demographic indicators differ significantly between castes, ethnic groups and income segments. This is how Umesh et al. compared the results of the 2011 and 2016 Demographic and Health Surveys

governments. They involve high levels of donor and country coordination for the achievement of programme goals, and can be financed through parallel financing, pooled financing, general budget support, or a combination” [11].

and presented disparities in terms of fertility (above-average reproduction rate for Dalit⁴ and Muslims), contraceptives (below-average frequency of use amongst Newars, Terai/Madhesi⁵ Brahmin/Chhetri and Hill Brahmins; the Dalit caste shows the highest number of children per woman and the lowest incomes), vaccinations (vaccination rates and drop-out rates differ significantly between regions), obstetrics (comparable results to those with the use of contraceptives), child mortality (2–3 times higher than the national average among Terai/Madhesi Dalits) and undernutrition (especially strong among Terai/Madhesi Dalit and Terai/Madhesi) [23]. In particular, the Annual Report 2020/21 [22] shows on numerous maps (e.g. vaccination rate), how severe the disparity still is, which is expressed not only by the geographical location with regard to the centre or periphery, but above all by belonging to a certain caste.

We consider the project's potential impact on gender to be positive. A relevant proportion of SWAp components concern women, especially of childbearing age. The Basic Package [18] also clearly focuses on the health of mothers and children. The MoHP has also developed a "Gender Equality and Social Inclusion Strategy" (GESI). The aim of GESI is to embed a strategy with regard to gender equality and social inclusion at all levels. In-depth studies are intended to provide further information on the causes of social exclusion in order to respond more effectively.

Appropriateness of design

Figure 2 shows an outline of the impact system. Due to the numerous measures and indicators (cf. Result Framework, [24]), a complete graphical or verbal assignment of causes and effects is not possible at this point. The figure distinguishes between five levels. The two upper levels relate to the use of health services (outcome) and their health impacts (impact). The lower levels specify the input, the resulting outputs and the consequences of the outputs (induced outputs). The orange activities refer to processes as they appear in every (partially) donor-financed health programme, while the green activities refer to specifics of basket funding or the SWAp. The basic principle here is the will to engage in political dialogue between development partners and the government. This can lead to formats, forums and regulations, but also to trust and harmonisation within the sector, which in turn enables rapid coordination. Conversely, the success of the SWAp or basket can increase the government's ownership of the entire programme and the visibility of healthcare in the government.

The central factor here is that the political dialogue on trust, speed and ownership as a moderator influences the success of the measures. The measures would actually stand on their own, i.e. be possible without sector dialogue within the framework of the SWAp, but the moderator increases their impact and accelerates their effectiveness.

Fundamentally, it should be noted that the components were appropriately selected to achieve the objectives of Nepal's health and development policy and the set indicators. However, the choice of indicators (and thus sub-objectives) appears relatively inconsistent. The programme proposal defined: "The indicators are identical to the NHSP-II indicators defined in the Result Framework. [...] Once a year, the programme progress is evaluated with regard to target achievement, measured by the indicators defined for this purpose. This is carried out jointly by the Ministry of Health and all donors (Joint Annual Health Review, JAR). An integral part of this is also the evaluation of the progress in implementing the measures agreed in the action plan to guarantee good governance and accountability. The results determine the policy dialogue on the strategic direction of the programme for the following year. This is specified in the form of the annual work and budget plans. Comprehensive external evaluations of the programme progress are planned after half of the term and in the last year of implementation (final evaluation)." Unfortunately, this final evaluation of NHSP-II, which was planned at the time, never took place and could have provided valuable information for this evaluation.

⁴ Dalit is the lowest group in the Hindu caste system and has been considered "impure" or "untouchable" in traditional society. They have also been discriminated against in Nepal for centuries (<https://www.hurights.or.jp/archives/focus/section2/2002/12/dalits-in-nepal-story-of-discrimination.html>).

⁵ Terai ("wet land") is the name for the fertile lowlands south of the Himalayas. It covers India, Nepal and Bhutan. The inhabitants of Terai in the southern lowlands of Nepal are called Madhesi. They are ethnically inhomogeneous and make up about half of Nepal's population. The inhabitants of the Nepal hill and mountain regions are called Pahari.

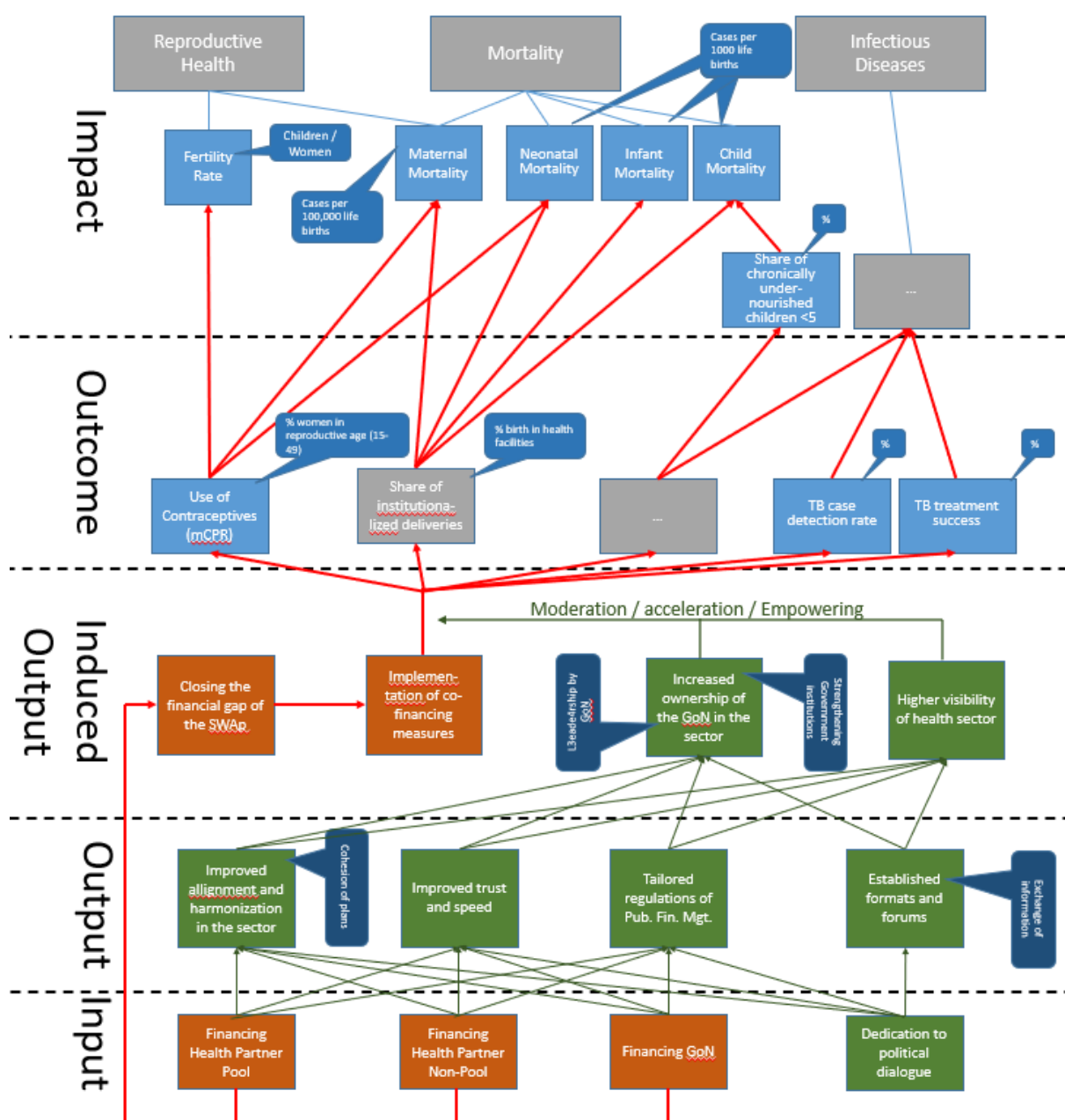


Figure 2 Impact and indicator system. Source: Own data.

The Result Framework (Annex 2 of the appraisal report) distinguishes between 57 indicators (11 Impact and 46 Outcome). However, no indicator was specifically defined for the method (basket funding). In the original form, this is a key figure list, but not a key figure system. In addition, it was not specified whether action was taken at outcome or impact level.

In 2011, KfW-specific indicators were agreed with the Policy Planning & International Cooperation department of the MoHP and used for the first time in the 2012 reporting. “Simply” 10 of the 11 impact indicators were used for the KfW impact objective. From this moment on, these ten impact indicators were largely adopted for KfW’s contribution to SWAp II. Outcome indicators were not defined.

In the mid-term review, 15 February 2013, the indicators were defined differently. HEART (co-financing donor DFID’s Health & Education Advice and Resource Team) presented a mid-term review of Nepal Health Sector Programme II (2010–2015) on 15 February 2013 [24]. Here, no distinction was made between outcomes and impacts. Instead distinctions were made between goal, purpose, outcome and output, whereby an impact logic (outputs → outcomes → purpose → goal) was assumed. A total of 87 indicators were defined (goal: 12, purpose: 14, outcomes: 19, outputs: 42). Based on this structure, we can talk about a consistent key figure system.

At this point, it is important to ask whether FC financing made sense as basket funding as part of the SWAp. The objective was already described in great detail in the initial concepts of a sector-wide programme [25–30]. It is fundamentally about consistent coordination between donors and recipients, as called for in the Paris and Accra declarations. 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 [31], to align Nepal’s health policy with international development policy standards [13], to increase the efficiency of development cooperation in public health [13], to reduce transaction costs [13] and to increase mutual accountability [13].

On this basis, it can be stated that the individual measures contribute to achieving the overall objective, but there is a lack of instruments for evaluating the SWAp, in particular for the FC indicators. It is not clear why no SWAp-specific indicator was defined. Overall, it would have been possible to incorporate a more precise indicator of the relevance and functionality of the SWAp, such as the share of basket funding in NHSP-II (cf. also [13]).

The comprehensive **design** of the sector-wide programme takes into account numerous dimensions of social and economic sustainability insofar as they affect health. Explicit emphasis on environmental sustainability (e.g. waste management) did not take place. From the point of view of 2023, some gaps in the bundle of measures are noticeable, which could have further improved the effectiveness of the overall project. These include neglecting hospital management, hospital autonomy, emergency services, and insufficient consideration of male breadwinners of the family and chronic-degenerative diseases (e.g. cancer, cardiovascular diseases and diabetes). Health insurance has also not yet been introduced. It is particularly clear that 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. Demand-side effects were taken into account in particular in the Aama and 4ANC programmes,⁶ but this hardly plays a role in relation to the total volume and other measures beyond Aama [33]. The gaps in NHSP-II were partly closed in the successor programme NHSS, and health insurance was introduced. However, the success of the NHSP-II measures could have been increased by taking these gaps into account even earlier in the overall concept.

Looking at the current MoHP statistics [23, 34, 35], some characteristics stand out. In particular, occupancy rates are very low in some cases, hospital stays are very short and differences between institutions and regions are enormous. For example, the average length of stay in the hospitals in Madhesh province (southern Kathmandu on the border with India) was only one day, and the occupancy rate was only 14%. The question arises as to whether there is even a functioning hospital in this province. In principle, the measures of the project are suitable for increasing quality and accessibility, so that heavier procedures with longer lengths of stay and a higher number of patients should also be possible. A stronger focus on these statistics could have increased the relevance of the individual measures.

Response to changes/adaptability

NHSP-II and the FC project demonstrated a high level of flexibility during the earthquakes in 2015. The response was quick, and the term was extended by one year. Agreements between donors and the government of Nepal were swift and smooth. Health insurance was also introduced relatively quickly and today covers around 25% of the population – despite some setbacks. It will intervene (with an upper limit of NPR 100,000 per year/≈ EUR 680) if the required services go beyond the free basic package. The primary health care centres and hospital offerings are covered, with each facility visited stressing the high importance of this income from health insurance.

According to all the interviewees, trust and the jointly introduced formats were critical for the speed and effectiveness of the measures in the aforementioned situations (earthquakes 2015, health insurance, COVID 2020/21). Without mutual knowledge, these rapid responses would not have been possible. This leads to the conclusion that the connection outlined in Figure 2 (in particular the moderator effect) is highly relevant.

Summary of the rating:

In summary, it can be concluded that the measures and objectives of NHSP II – and thus also of the basket-funding FC project – are still relevant. The selected basket funding instrument – involved in the SWAp of NHSP II –

⁶ The “Aama Surakshya Programme” (abbreviated: Aama) is the official programme of the government of Nepal to improve the health of pregnant women and mothers. It includes free institutional delivery, payment of transport costs and an incentive to pay for four ANC (antenatal care) visits. As early as 2005, the Maternity Incentive Scheme (MIS) was initiated, and in 2009 maternity fees were abolished nationwide. In 2012, MIS merged with the programme for four ANC visits to become the Aama programme. It is an essential component of NHSP-I, NHSP-II and NHSS [32].

was of great importance as an amplifier and accelerator, which proved particularly effective during the crisis periods in 2015 and 2020/21. The missing components (e.g. health insurance, training, management, telemedicine, emergency rescue, greater consideration of chronic degenerative diseases) were largely addressed in the follow-up programme NHSS (2016–2020), but could have increased the good relevance of NHSP-II even further.

Relevance: 2

Coherence

Internal coherence

At the same time as the basket funding under NHSP-II to be evaluated here, several individual German development cooperation projects were financed and implemented (cf. Annex 1, Table 3). It can be seen that most FC and TC projects before, during and after NHSP-II are consistent with the measures and objectives of NHSP-II (with the exception of the specific support with regard to relief for the effects of the earthquakes in 2015). District health, family health, strategy development, etc. are all also found in NHSP-II, so it can be assumed that there is a high level of coherence between the programme evaluated here and the other German DC activities. The annex contains the other German DC projects and programmes, whereby it is clear that the individual FC and TC instruments are well-dovetailed and complementary. At the time of NHSP-II, most of the German cooperation with Nepal was still carried out as part of individual projects.

External coherence

As mentioned above, the financing of a SWAp is a common instrument for harmonisation and coordination at sectoral level [30]. In 2009, the World Bank presented an evaluation of health SWAps from Bangladesh, Ghana, the Kyrgyz Republic, Malawi, Nepal and Tanzania [11] and showed that the SWAp in Nepal was comparatively successful, i.e. harmonisation and alignment were improved at a good level, but there were still problems in the area of Monitoring & Evaluation (M&E) and efficiency. It is important to note that the primary goal of improved coherence by the health SWAp in Nepal was already achieved by 2009.

The interviews with development partners showed that the SWAp could be viewed as a learning phase during the precursor phase NHSP-I (2005–2010), in which many paths first had to be paved and processes developed. It was particularly important to win over contact persons as focal points in the ministries (MoHP, MoF) in order to be able to maintain continuous dialogue. NHSP-II appears to have been based on and benefited from these NHSP-I experiences from the outset.

In 2018, Nepal's Ministry of Finance (MoF) presented an evaluation of the two SWAps in health and education [13]. It was found that the International Economic Cooperation Coordination Division (IECCD) worked successfully in the MoF and, in particular, led coordination and standardisation efforts.⁷ Furthermore, the constitutional reform from 20 September 2015 led to federalist reform and decentralisation in the healthcare sector in the following years, i.e. the shift of responsibility to lower levels. This led to an increase in inequality between regions, as the lower levels in the regions managed the modalities of the SWAps differently. The phenomenon of increasing inequality as a result of federalisation has already been generally proven in the literature [36] and can therefore not be attributed to the SWAp. Overall, the analysis provides the SWAp with a very good report as an instrument, especially since the actual objective (increasing the health budget, improving relevant health statistics) was largely achieved in the period under review [13].

All interview partners (donor organisations, MoHP and MoF employees, employees of health institutions, donors before and during the mission) stressed the particular importance of the SWAps for good cooperation between the government and donors, especially during the earthquakes and coronavirus crisis. At the same time, its functioning within a federal system was called into question. It is still too early for a final empirical evaluation. However, it can be stated that federalisation poses new challenges for the future SWAp, while very high coherence was still to be assumed for the NHSP-II phase (2010–2016).

⁷ Coordination and unification were based on the "Government of Nepal's Development Cooperation Policy 2014", which "sets out its preferences in terms of aid modalities, and encourages Development Partners to harmonise their support in a given sector by setting up pooled funds and providing their assistance through Programme-Based Approaches or Sector-wide Approaches (SWAp)" [13].

The core of the SWAp is the sectoral dialogue that the external development partners have entered into with each other and with the government of Nepal. This dialogue consisted of constant exchange and a number of institutions and processes. The most important are:

- **Donor Forum:** The donors met regularly to exchange information, coordinate and set joint priorities.
- **JCM and JAR:** Joint Consultative Meetings (JCM) were held every six months for two days. The first meeting took place in February/March so that the partners could contribute to the planning and budget for the next financial year. The second meeting was held in July to consider the consequences of the budget adopted by Parliament for the coming financial year. The Joint Annual Review (JAR) usually took place in November/December for three days in order to analyse the progress of the past financial year and discuss priorities for the current financial year. JCM and JAR were the main formal platform for dialogue between the donors and the government in Nepal.
- **Fiduciary risk control:** As part of the fiduciary risk control, procurement and financial management were closely monitored by the World Bank on behalf of all financiers. The implementation of the reform measures in the sector was monitored and inspected with the help of annual financial and operational audits. According to all interviewees, all participants were informed quickly and comprehensively on this basis.

Management of the SWAp (sector lead) changed every six months, with KfW being only the deputy lead on the basis of the comparatively low staff capacity. GIZ, on the other hand, was able to take over the lead once during NHSP-II. Overall, the interviewees highlighted a high level of satisfaction with the dialogue during NHSP-II. Donors with relatively little involvement in the SWAp (e.g. FC with around 1% of the total budget) could thus 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.

Overall, financing from external donors, including German DC, is considered necessary because the state health sector in Nepal is still operating inadequately to ensure health care for all population groups that meets the United Nations standard and global human rights. However, the Nepalese government's own share of the total budget in the healthcare sector has continuously increased from 2010 (58%) to 79% in 2019/20 until the coronavirus pandemic, after which it suffered a slight downturn, cf. diagrams and tables in the annexes.⁸

Summary of the rating:

In summary, the NHSP-II measures were consistent with the government of Nepal's own efforts. The extensive approach with numerous donors and the instruments and processes implemented implied⁹ a high level of cohesion during NHSP-II. One benefit of this was the exceptionally rapid and effective response from the donor community after the 2015 earthquakes, which was highlighted by almost all interviewees. We assume that basket funding has intensified the beneficial effects of the SWAp.

Coherence: 1

Effectiveness

Achievement of (intended) targets

The programme aimed to ensure equal opportunities in access and the use of high-quality healthcare services, with particular attention paid to poor and socially disadvantaged population groups. This target is maintained as an outcome objective.

However, no concrete outcome indicators were specified during the programme appraisal, only 56 indicators were specified at impact level as part of the results framework. Only in the course of project implementation up to 2011 did ten of these indicators become concrete, four of which can be directly influenced by the measures of NHSP-II (see the Project Measures annex) and have a major (expected) effect on the impacts.

⁸ The statistics for 2020–2022 were heavily distorted by the coronavirus pandemic. For example, Nepal received significant amounts for combating the disease, which led to a significant increase in the donor share. However, this must be treated as an externality and excluded from the analysis. It can be assumed that the figures will fall back to pre-coronavirus times starting in 2023.

⁹ Pooling partners supported the basket together. These included the Australian Agency for International Development (AusAID), the British Department for International Development (DFID), the Global Alliance for Vaccines and Immunisation (Gavi), the International Development Association (IDA) for the World Bank (WB) and German FC. UNICEF, UNFPA and USAID supported measures and projects in the health sector as non-pooling partners. Other organisations were associated, e.g. TC.

Table 1 Effectiveness – outcomes

Indicator	Status during PA	Target value PA	Actual value at final inspection	Actual value at EPE
(1) Use of contraceptives (modern methods)	45.1% ¹⁰	55%	46.7%	42.7% (not achieved)
(2) TB case detection rate	75.8%	85%	83%	95% (achieved)
(3) TB treatment success rate	89.7%	90%	90%	91 (achieved)
(4) Institutionalised births [NEW]	18%	40%	–	65% (achieved)

Source: [1, 35, 37–40]

The target achievement at outcome level is summarised in the table below:

Re (1): The proportion of women [%] in reproductive age (15–49 years) who use a modern contraceptive method is an important prerequisite for reducing the fertility rate (impact indicator). According to the PA and PCR this figure rose from 45.1% at the time of the project appraisal to 46.7% in 2019. However, the original target of 55.0% was not achieved. However, the values do not match the data from the Demographic and Health Survey (2002). This is where modern methods of contraception (mCPR) are used: “steady at 43% from 2011 through 2022”. However, the development has been excellent since 1996, when the figure was still 26%. This indicator was originally declared as an impact indicator, but appears to be more meaningful at the usage or outcome level.

Re (2): TB case detection rate is the proportion of estimated new or relapsed cases of tuberculosis (TB) detected within a given year [%] [41]. It increased in the period between the PP and PCR from 75.8% to 83.0% and to 95% by the EPE, thus above the target value of 85%. This rate was also originally assigned to the impact, but corresponds to a (use-related) outcome indicator.

Re (3): The TB treatment success rate reflects the proportion of TB cases registered in a specific year that have successfully completed treatment (without bacteriological evidence of treatment failure) [%] [42]. The value reached the target of 90.0% exactly, with the value of 89.7% already being almost identical at appraisal. Since then, the already relatively good value has only increased slightly. This rate was also originally attributed to the impact indicators.

Re (4): The proportion of institutionalised births (i.e. of births in a healthcare facility) was added in the EPE as it is an important outcome for measure Component I (reproductive health). NHSP-II assumed 18% (2011) and set a target of 40%. In 2020/21, it rose to 65%.

Contribution to achieving targets

The programme focused on the health of mothers and children. The significant increase in institutionalised births (from 18% to 65%) shows that the capacities created are actually being used, but on the other hand there is still room for improvement. There is no doubt that the measures of NHSP-II and this FC project contributed significantly to this success. However, there are still significant differences, especially in institutionalised obstetrics. While on national average 65% of all births took place in healthcare facilities, in Karnali province this was 87% and in Gandaki province 42% [35]. There is no breakdown by caste or religious affiliation, but it can be assumed that the rates are likely to differ significantly.

There is also a close correlation between measures, outputs and outcomes for the other outcomes. The unequal distribution within the provinces can be verified in most cases (example TB case notification rate in Karnali: 65, Lumbini 115 / 100,000 pop. [35]). This suggests inequality between social groups. NHSP-II’s focus on vulnerable groups is well suited to reducing this inequality. The following are some of the reasons for a positive distribution effect:

- **Focus on the poor:** The institutions supported by NHSP-II (e.g. health posts, primary health care centres) are still the first contact point for the poor population, as transport costs to the cities have the effect of reducing demand on them.
- **Focusing on maternal and child health (MCH¹¹)** also makes sense when considering that men generally have a significantly lower life expectancy than women. Adult men in particular generally have significantly more resources, are more mobile and can mobilise more support than women or (younger) children. The focus on

¹⁰ The values from the PA and PCR cannot be reproduced. According to the Household and Health Survey (2022), the use of modern methods of contraception (mCPR) “held steady at 43% from 2011 through 2022”.

¹¹ MCH: mother and child health care.

mother and child health therefore certainly led to the intended strengthening of vulnerable sections of the population.

- **Accessibility:** physical accessibility is particularly important in Nepal. In peripheral regions in particular, even well-equipped healthcare providers with high quality develop only a low significance, as they are simply not accessible. Added to this are quality deficits, official and unofficial user fees, discrimination against different sociocultural population groups and a lack of knowledge of one's own rights, so it is little surprise that healthcare providers are sometimes very poorly utilised. It can be assumed that the investments of NHSP-II have generally improved the appeal.

The extent to which inequality in Nepal was mitigated by NHSP-II cannot be conclusively substantiated during the EPE. The basic package is free of charge, but it was not possible to check on-site whether basic free services still have to be paid for. Likewise, there is no insight into whether paid services ultimately lead to the exclusion of vulnerable groups. It is clear, however, that the positive effects of the programme were not only achieved through the improvement for small groups. Rather, the majority of the population must have benefited from it, including vulnerable people.

Overall, the successes – on average – are considerable, which is due to the following factors, among other things: (1) high political will by Nepal to implement the programme, (2) continuous increase in the allocation of funds to the health sector, (3) consistent implementation of the programme to ensure a safe pregnancy and professionally accompanied births (*Aama programme*, see the section on Relevance), cf. [43], (4) consistent implementation of the programme for community-based management of childhood disease (Integrated Management of Childhood Illness), cf. [44].

However, some of the successes can also be attributed to measures introduced in parallel or afterwards, especially in the area of demand-related factors. There is no doubt that the introduction of health insurance has contributed to achieving the above indicators, cf. [45].

Quality of implementation

First of all, it should be noted that the government of Nepal (and in particular the MoHP) has initiated and in some cases implemented numerous laws, strategies and reforms in recent years (see above). There was undoubtedly a will to improve, although the speed of implementation was sometimes unsatisfactory – and the principle of the SWAp has not yet permeated all departments of the ministries.

One positive thing to mention is the establishment of a “Health Sector Reform Unit” and a “Health Economics and Financing Unit” as a part of the Department of Health Services’ reorganisation. These departments formed the basis for the implementation of NHSP-II. A comprehensive analysis of budget allocation and expenditures was carried out in 2015 [46]. This showed that health expenditure has increased fivefold during the period 2005–2015 and more than doubled during the period 2011–2015 (see Figure 2 in Annex “Tables and diagrams”). The absorption rate, on the other hand, was below average for most years, i.e. it was not possible to actually use all available financial resources.

The processing of basket funding appears to be largely in accordance with the rules – insofar as this can be verified as part of an EPE. The World Bank, DFID, Gavi, AusAid and German FC acted as basket financiers. The World Bank managed the basket and managed the fiduciary risks. The basket partners’ payments to a non-interest-bearing US dollar foreign currency account and the coordinated, standardised disbursement procedure worked to the greatest extent possible. This was done in the reimbursement procedure, i.e. the Ministry of Health paid the expenditures for the individual measures in advance. These were reimbursed by a jointly used special account into which the pooling partners had paid according to their financing share of the total volume. The annual, coordinated work and budget plans established within the framework of the JAR were decisive for the amount of the contributions.

As illustrated, the objective of a SWAp is to improve the implementation and impact of the measures through sector dialogue and the development of trust (moderator effect). Empirical measurement is not possible here either, so reliance on the perception of the interviewees is required. They unanimously stressed that during the NHSP-I phase, moderation was initially low, but then increased, while during the NHSS phase, sector dialogue and probably also trust between donors and the Nepalese government decreased. One interviewee described the phase of NHSP-II as “the golden age” – when the exchange of information, coordination, harmonisation and joint prioritisation worked comparatively well. Specifically, this was demonstrated by the examples of the earthquakes in 2015, the development of health insurance and the rapid reactions during the coronavirus pandemic. Protocols can also be used to demonstrate that the processes of the SWAp improved until the end of NHSP-II. The transaction costs

are likely to be significantly lower than for individual measures. It is also likely, but not empirically verifiable, that the indicators have also improved due to the moderator effect.

Unintended consequences (positive or negative)

The above-mentioned federalisation contributes to the fact that the moderator effect of the SWAp is no longer as strong as it was during the NHSP-II phase. In addition, the executing agency's cooperation with donors in the healthcare sector promoted digitalisation – several monitoring programmes were established during NHSP-II (e.g. Electronic Logistics Management Information System, eLMIS).

Summary of the rating:

As part of NHSP-II, the FC project predominantly achieved the outcome objectives. In this phase, the SWAp developed its moderator effect in the best possible way, so good overall effectiveness can be assumed. For the previous roll-out phase of NHSP-I (2005–2010) and NHSS (2016–21) this assessment would probably look different, but is not the subject of this examination.

Effectiveness: 2

Efficiency

Production efficiency

The NHSP-II measures mainly had a direct impact on the provision of services in healthcare facilities. The most important inputs of a healthcare facility are personnel, buildings, equipment and materials (drugs, medical supplies, vaccines). The visits showed that the facilities are adequately equipped compared to former times and other countries. Drug bottlenecks are less common than in the past, and health posts (HP) and primary health care centres (PHCC) in particular appear to be relatively reliable. Hospitals sometimes have the problem that they receive deliveries of drugs that are more needed at lower levels of care, but this problem seems logistically manageable.

The equipment required for the individual supply levels appears acceptable, even if certain bottlenecks occur in some cases. The capacity situation is somewhat more complex, as some facilities have seen significantly increasing numbers of patients in recent years and are reaching their limits, especially in the emergency and outpatient departments. Bed utilisation, on the other hand, is frighteningly low in the facilities, so there is no need to assume a general shortage of space. Investments in infrastructure still seem sensible, but they are not the biggest bottleneck.

Staffing presents a mixed picture. First of all, it should be noted that the number of sanctioned posts was generally insufficient to operate the facilities. This was identified and a remedy was created in the form of employee positions with temporary contracts. This led to a satisfactory staffing level, but is not a permanent solution. Particularly where these temporary contracts are less funded than permanent positions, this division implies horizontal wage inequality with a tendency to demotivate. Compared to other countries, the facilities appear to be relatively well staffed with medical professionals. However, the number of nurses is comparatively low. The survey did not allow for in-depth analysis, but it seems to be a fundamental problem that tasks that could easily be performed by nurses need to be performed by more qualified staff (e.g. doctors) – or not performed at all – due to the low number of employees. Furthermore, a high staff turnover rate is noticeable. In most facilities, our interviewees were in management positions for a comparatively short period of time (1–3 years).¹²

In summary, it turns out that the inputs of healthcare facilities are no longer the biggest bottleneck in the production process. Rather, the transformation of inputs into the right health outputs is of utmost relevance for determining efficiency, i.e. the management of the facility. As expected, all facility managers were professionals with a medical (or nursing) background. In hospitals, the Chief Executive Officers (CEOs) are generally physicians.

¹² The economic viability of institutions can also be strengthened by rational management if they are non-profit organisations with no intention of making a profit. For example, in a hospital we learned that medicines beyond the list of essential, free medicines are sold with a markup (especially to patients with insurance), which was used to pay for minor improvement measures (e.g. canopies). The concept appeared to be well thought-out (including a separation of the pharmacy for the two patient groups) and shows that innovative ideas can strengthen profitability even under the conditions in rural non-profit hospitals. The way unusable equipment in a hospital was dealt with was just as creative. While in most facilities there were “waste dumps” of old equipment, this hospital had sold the old equipment. In fact, it turns out that the administrative process of selling old equipment is extremely complex, which most facility managers try to avoid.

While there is a pilot program for hospitals to recruit hospital administrators, this is only just starting, so no experience has been gained yet. In principle, there is a great need for training and action in all areas of management, including procurement, quality management (QM), process management (PM), disposal/waste management, marketing, financing, investment, logistics, accounting and information management. The lack of training in management-related issues, including planning, organisation, personnel selection, personnel management and control systems, appears to be particularly problematic. There is probably a willingness to learn here – although our sample was small and not very reliable – but these courses are currently not available for “normal” managers in healthcare facilities. None of the facility managers we interviewed had completed management training. In the current situation, management will certainly be in the hands of a medical or nursing care professional for years to come. However, this implies a loss of efficiency in two dimensions. On the one hand, this person does not have the training for this and, with very few exceptions, cannot use the entrusted resources as efficiently as a professional manager. On the other hand, the medical or nursing professional is then missing from their original target area if they take on management tasks as a layperson. This inefficiency can be minimised by using administrative assistants across the board, particularly for hospitals. These assistants can take over tasks such as procurement, disposal/waste management and hygiene and thus relieve the manager.

Overall, it appears that the structural quality no longer represents a bottleneck. Rather, the system has already progressed so that aspects of process quality are now becoming more important. This makes maintenance, application of standards, waste management and administration the main topics for increasing efficiency. Structured quality management could not be verified in any facility.

While maintenance must later be considered again from a sustainability perspective, the efficiency effect should be analysed here. The budgets for maintenance are insufficient and the intended purpose is not controlled. The facilities lack maintenance schedules. The maintenance personnel are either not available or only rudimentary (e.g. one-year course). Above all, however, there is a lack of a mentality for maintenance. Overall, the lack of maintenance seems to be a relevant cause of technical inefficiency of medical equipment. Any contribution (e.g. hiring technicians to support maintenance) would improve their efficiency. A lack of hygiene also affects efficiency, as it increases waiting times and implies additional personnel and material costs.

In Nepal, there are several factors that have a fundamental impact on efficiency. First and foremost, this includes corruption. Corruption is a major problem in health care. 17% of patients worldwide report having to bribe at least once to receive health care [47]. Corruption is particularly detrimental because it systematically disadvantages the poor who cannot afford the corresponding payments. The determination with which a government fights corruption thus also determines life and death and thus also efficiency in healthcare. In 2022, Nepal ranked 110th out of 180 [47] on the Corruption Perceptions Index. Only Bangladesh was worse in the region (rank 147). However, this is already a very strong improvement compared to previous years (e.g. 2010: 146th place; 2016: 131st), but also means that corruption is still a problem.¹³ Corruption destroys efficiency, as the system’s necessary inputs increase without any output being increased. Anti-corruption in healthcare thus implies an increase in efficiency. Secondly, inequality is significant for efficiency. The continuing inequality of health care and health status between different regions and population groups has already been highlighted. In fact, this also has a significant impact on efficiency. Hospitals, for example, can only operate with sufficient utilisation (e.g. occupancy rate of 80–90%) (international standard), as these are fixed-cost-intensive businesses. If specific patient groups are systematically excluded from the supply (e.g. due to discrimination, further travel distances, user fees, etc.), this automatically implies lower capacity utilisation and thus lower efficiency of the facilities. This happens regularly in the Nepalese healthcare system with extensive fees and long distances and leads to efficiency losses.

Discontinuity also plays a role in efficiency. The phase, lasting until the federal system has stabilised at all levels, represents a discontinuity and implies new administrative processes. This leads to higher costs and inefficiency in the short term. Similarly, the comparatively high staff turnover (especially among doctors) leads to loss of productivity. Managers in particular must either be in a company for a longer period of time or be able to rely on institutional memory. In many instances, this does not seem to be the case, which threatens to reduce efficiency. Discontinuity can also be observed at ministerial level, which is detrimental to the above-mentioned moderator effect of the SWAp and threatens to limit efficiency.

Looking at the SWAp as a whole, it should have actually contributed to increasing efficiency by reducing transaction costs. The harmonised financing mechanism also implied uniform follow-up and reporting. This meant that

¹³ The Himalayan Times quite rightly states, “Corruption is so rampant in Nepal’s health system that we accept it as a norm. Nepalis are deprived of quality healthcare services due to the unwritten rules of corruption. Healthcare corruption threatens accessibility, utilisation and quality of healthcare service and ultimately paralyses the healthcare system. Nepali women have lost their lives during childbirth owing to consequences of corruption.” (<https://thehimalayantimes.com/opinion/corruption-in-healthcare-its-killing-nepalis>).

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 delayed bilateral dialogue with various donors, which used to be very time-consuming for the executing agency, was replaced with mutual cooperation. The interviewees saw a significant (efficiency) advantage from the SWAp.

Allocation efficiency

The SWAp itself can also be analysed from an efficiency perspective. As no specific indicators were defined at outcome level, the analysis remains rudimentary. First of all, it should be noted that the basket was managed by the World Bank, which also bore a significant part of the fiduciary risks. This meant that the World Bank also accounted for a large part of the transaction costs. The procedure corresponds to a stabilised standard from SWAps in other countries as well as NHSP-I. A non-interest-bearing USD account was set up with the Ministry of Health, into which the pooling partners paid after confirmation by the World Bank. Only funds already spent by the MoHP were reimbursed. From our point of view, the World Bank's assumption of the trustee role was extremely effective.

The aim of NHSP II and the developmental objective of this FC project was to improve the health of the population. This can be measured by increasing quality of life (measured in DALYs¹⁴) or by increasing life expectancy, reducing mortality and healthy life expectancy (measured in HALE). This raises the question of whether a different choice of measures could have achieved more "health" with the same funds. First of all, it should be noted that the "Nepal Burden of Disease" [48] makes very clear that the health situation has largely improved since 1990 and also during the duration of the NHSP-II programme: Death rate, mortality, loss as well as DALYs and HALE have improved significantly during this period, whereby the composition (e.g. percentage of deaths) from infectious diseases has shifted to chronic degenerative diseases (non-communicable diseases / NCDs, such as cancer, cardiovascular diseases, diabetes, accidents). In 2019, 71% of the deaths and 61.2% of the losses from DALYs were attributable to NCD, but only 21% and 29.3%, respectively, were due to the diseases that were the focus of NHSP II and the FC project, i.e. infectious diseases and the diagnoses associated with MCH.¹⁵ The increasing significance of accidents was completely ignored until the start of the successor programme NHSS in 2021.¹⁶

In summary, it can be concluded that the measures of NHSP II and the FC project contained therein did not adequately address the predominant health problems of the country's average population. By focusing more on these diseases, more "health" could have been achieved with the resources deployed, i.e. increased allocation efficiency. The aforementioned components, which were subsequently added to the NHSS successor programme (health insurance, telemedicine, hospital management, etc.), could also have further improved the allocative efficiency of NHSP-II.

The healthcare facilities in Nepal are comparatively small, especially in terms of the number of beds. This has consequences that are relevant for allocative efficiency. On the one hand, the principles of fixed cost degression must be observed, which all speak in favour of concentrating services on larger units. All other things being equal, the case costs for small units are inevitably higher than for large units. On the other hand, guaranteeing high-quality results in the healthcare sector also depends on practice and thus on the repetition of processes, especially in the case of rare complications. Of course, small units are also at a disadvantage here. If a midwife only performs three births per month, the last complication was so long ago that she can lose proficiency in handling it.

Mobility has increased significantly in Nepal. Tuk tuks, motorcycles and local public transport are much more available than during/at the start of NHSP-II. As a result, the establishment of micro-hospitals (with 15 beds) in each municipality, which was politically desired as part of the decentralisation process, is likely to be problematic from two perspectives. On the one hand, they are increasingly unnecessary, as patients prefer to go to the more efficient facilities. On the other hand, they are inefficient because no economies of scale can be achieved. From this ex post perspective, the guiding principle enshrined in NHSP-II, that the entire country should be covered with maternity clinics (ideal: in every ward), appears to be inefficient. At the same time, the small units (healthcare facilities with basic health services) are indispensable for the increasing incidence of NCDs. Regional planning of the healthcare facilities that establishes efficient location planning on the basis of catchment area analyses would

¹⁴ Disability Adjusted Life Years lost (DALYs) are a measure of quality of life that has been a standard of international quality of life assessment since the 1993 World Development Report. Healthy Life Expectancy (HALE) expresses the number of years a person can expect to live in full health (<https://www.who.int/data/gho/indicator-metadata-registry>).

¹⁵ CMNN: communicable, maternal, neonatal and nutritional diseases. NCDs: non-communicable disease. NCDs are generally chronic degenerative diseases such as cancer, heart attack, stroke or type 2 diabetes. Communicable diseases are infections such as malaria, measles or tuberculosis.

¹⁶ Goal indicator no. 6 of NHSS: "Life lost due to road and traffic accident (RTA) per 100,000".

be important and could improve allocative efficiency. We have learned about examples of innovative communities (municipalities) that are trend-setting. For example, instead of building and operating their own micro-hospital, one community has decided to provide financial support to the existing district hospital. This is very welcome from the point of view of allocative efficiency, as it lowers case costs and improves quality. But this example is rare.

It is striking that NHSP-II focuses exclusively on the public sector, despite the fact that private and non-profit organisations play a major role in health care in Nepal [49]. Public health expenditure accounted for 24.81% of total health expenditure in 2019 [1], i.e. private households predominantly determine the healthcare provider, with some services even increasing the share of private and non-profit providers (e.g. obstetrics) [50, 51]. Even services that are (should be) generally offered free of charge in public institutions are increasingly in demand and paid for in private institutions.¹⁷ NGOs (e.g. religious communities) also operate hospitals, leprosy centres, educational programmes, etc.¹⁸ Given the great importance of expenditure in the private and NGO sectors of 75% of total healthcare costs, it must be questioned here whether NHSP-II's concentration on the public sector was in line with the diversity of healthcare providers in Nepal or whether the involvement of these service providers in particular in remote areas (e.g. leprosy relief work in remote areas) could have increased allocation efficiency. However, this is speculative and cannot be assessed based on evidence. Allocation efficiency could have been further increased by strengthening telemedicine, rescue services, training, hospital management and operational autonomy.

During our on-site visits, we found that federalism in many institutions had a positive effect on the ownership of managers in the institutions and municipalities. However, there is also a risk of inefficiency due to the involvement of a further provincial level and the delegation of decision-making to lower levels. The procurement of medicines, medical materials and vaccines is an example of this. These consumer goods are of great importance for healthcare service output. Accordingly, planning (incl. design of the standard drug lists), competitive bidding, procurement, quality control, storage, inventory withdrawal, order picking, inventory, logistics/transport, etc. are carried out with great professionalism to prevent theft, delivery bottlenecks, expiry, etc. and thus avoid inefficiency. In addition, some materials (e.g. vaccines) require special precautions, such as cold chains, dust-free conditions and protection against (solar) radiation. As a result of federalisation (transfer of competences to the provinces), materials can be procured independently at almost all levels. As a result, there are comparatively longer distribution routes for centrally procured materials (e.g. contraceptives, vitamin A). But lower-level procurement also implies two disadvantages for the decentralised system. Firstly, material management and in particular procurement are divided into different levels and institutions. This implies higher costs. The central system was able to achieve economies of scale (e.g. discounts, low fixed costs per unit) compared to the decentralised system. Secondly, there is an inherent quality problem, as the central system was also able to control quality centrally, whereas this is no longer possible at a decentralised level due to a lack of time and expertise. As a result, there is a risk that procurement will become increasingly inefficient. However, the introduction of the digital logistics information system eLMIS in particular also created the basis for keeping material logistics lean despite decentralisation. However, this is not a matter of course, but requires leadership and decision-making. Overall, it is still too early to assess whether federalisation has increased or reduced efficiency. However, the expectation that it would automatically lead to efficiency gains was incorrect.

Summary of the rating:

Overall, we are of the opinion that basket funding achieved higher allocation efficiency than a classic investment approach by strengthening the executing agency's ownership and harmonising donor approaches.

However, it is not possible to quantitatively determine this within the framework of this report. However, there are numerous approaches that, when viewed ex post, would have led to an increase in efficiency. The key aspect here is that the partners have learned from the developments and misjudgements. This is reflected in the further development of the SWAp as part of the NHSS successor programme (integration of health insurance, telemedicine, management, etc.).

Overall, we rate the efficiency as moderately successful.

Efficiency: 3

¹⁷ A study showed that the share of MCH services in the private sector increased from 2006 to 2016, although these services are generally free of charge. Women with higher education and higher incomes in particular prefer to give birth in private clinics [50].

¹⁸ The NGO associations provide an overview at <https://www.ngofederation.org/> and <https://www.ain.org.np/>.

Impact

Overarching developmental changes (intended)

The development policy objective of the project is to improve the health status of the population. Table 2 summarises the achievement of the objectives at impact level.¹⁹

Table 2 Impact indicators

Indicator	PA status (Data from 2011)	Target value at PA	Actual value at final inspection	Actual value at EPE (Data from 2020)
(1) Maternal mortality	229	134	258	151 (2021) – not achieved
(2) Fertility	2.9	2.5	2.0	2.1 – achieved
(3) Child mortality	55	38	28	28.2 – achieved
(4) Infant mortality rate	79	32	25	23.6 – achieved
(5) Neonatal mortality	50	16	16	16.20 (2021) – achieved
(6) Underweight	39%	34%		31.5% (2019) – achieved

Source: [1, 24, 35, 52–54]

Re (1): maternal mortality rate. It indicates the mortality rate of mothers per 100,000 live births as a standard indicator. Compared to the status in 2011, mortality has decreased, but the original target has not been achieved. Accordingly, the Annual Report of the MoHP from 2020/21 also complains about the “slow pace of decrease in maternal mortality ratio” [22].²⁰

Re (2): fertility rate. This statistic shows the number of children per woman as a standard indicator. The value has decreased significantly and is now quite close to the replacement value of 2.1, i.e. the original target has been achieved.

Re (3): child mortality. This measures the number of deaths of children under the age of five per 1,000 live births as a standard indicator. This indicator also shows great success in every respect.

Re (4): infant mortality (younger than one year old). The statistics measure the number of deaths of children under one year per 1,000 live births as a standard indicator. The result was significantly lower than the target and the positive trend has continued since the end of the project.

Re (5): neonatal mortality. The last mortality indicator considers neonatal mortality, i.e. the number of deaths in children in the first 28 days of life in relation to the number of live births as a standard statistic. Here, too, the goal was achieved. The downward trend from 58 (1990) to 16.2 (2021) is a great success. Overall, indicators (3), (4) and (5) are strong proxies for the functioning of the healthcare system, with a focus on the particularly vulnerable groups of (young) children.

Re (6): underweight. Here, the standard indicator “height in relation to age < 2 SD” is used for the rate of chronically underweight children under five years of age.²¹ PA and PCR still used the definition for acute malnutrition, while the interim report used both parameters. However, chronic malnutrition seems more meaningful for evaluating the nutritional situation. There is a clear improvement.

¹⁹ HIV prevalence was also originally defined as an indicator. The indicator was not included in the evaluation for several reasons, stated below. Firstly, the definition is inconsistent. The impact indicator in the original Results Framework was the HIV prevalence in pregnant women between the ages of 15–24 without a baseline value. The interim report [24] assessed the HIV prevalence among men and women between the ages of 15–24 (cases per 100,000 inhabitants). In the PCR, HIV prevalence among young women between the ages of 15–24 was used as cases in this target group per 100,000 inhabitants, with the data used being identical to those from the interim report despite a different population. Secondly, NHSP-II barely focuses on this parameter, so that it is hardly possible to attribute successes. Thirdly, HIV prevalence in Nepal is relatively low and stable compared to other countries in the region.

²⁰ The 2021 National Population and Housing Census indicates a value of 151 deaths per 100,000 live births [55], but also explicitly points to very different statistics in the provinces. The value in Lumbini and in Karnali province was 207 and 172, respectively, while it was 98 in Bagmati province. In total, 12,976 women of reproductive age (15–49 years old) died in 2021, 653 of which were deaths due to pregnancy and birth, i.e. approximately 5%.

²¹ Stunting (chronic malnutrition): height-for-age <-2 standard deviation of the WHO Child growth standards median; Wasting (acute malnutrition): weight-for-height <-2 standard deviation of the WHO Child growth standards median; underweight: weight-for-age <-2 standard deviations of the WHO Child growth standards median. <https://www.who.int/data/nutrition/nlis/info/malnutrition-in-children>.

Although Figure 2 suggests a clear link between intervention and impact factors, clear allocation is not possible. In the period since the PA, there have been many changes macropolitically and for individual parameters. The result is that any attempt to calculate the statistical significance of NHSP-II's influence on this development would fail. The impact of German DC's comparatively small contribution to this of around one percent of the NHSP-II budget can be determined even less.

Contribution to overarching developmental changes (intended)

Nepal's key health indicators (e.g. life expectancy, maternal mortality, infant mortality, child mortality, birth rate) have shown a positive trend since the start of NHSP-II [1]. This clearly positive development is a strong indication that important foundations for improving the health situation were created during NHSP-II. Although discrimination based on caste, ethnicity, gender, place of residence or religion is officially prohibited in Nepal, there is still – as shown above – a great deal of social inequality, and the distribution of health parameters is very large. The 2022 Demographic and Health Survey [37] shows this for the indicators of fertility, teenage pregnancy, contraceptive use, child mortality, childcare, vaccinations and nutritional status of children. For example, teenage pregnancies in the Dalit caste (lowest caste) are almost three times higher than in the Brahmin caste (highest caste). When using modern contraceptives, Muslims are far below the comparable values of other ethnicities or religious affiliations, while the proportion of pregnancies among girls under 20 is significantly higher. The place of residence also plays a role. Rural regions tend to have poor indicators, as do mountain regions. However, there are also exceptions here. Consequently, the use of modern contraceptives is higher in the mountain regions than in the lowlands, which is probably related to religious affiliation. But the proportion of fully immunised children is also higher in the mountain regions. MoHP statistics show that gender still plays a role. Parents visit health care facilities less often in the event of illness for girls, spend less money on this and are less likely to get the right diagnosis [56].

Overall, although health indicators improved on average during NHSP-II, inequality did not decrease evenly. Inequality will undoubtedly remain a central problem for Nepal. Caste continues to play a major role in the region, especially in the use of health services [6], even in the capital [57]. It must be stressed here that the majority of countries around the world do not allow a more detailed analysis of vulnerable groups because disaggregated data is not published. Nepal is a remarkable exception here [58].

Contribution to (unintended) overarching developmental changes

The question of whether NHSP II or basket funding has 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. This makes it all the more important that healthcare represent an ultimate reliability i.e. basic care must be provided to every citizen – regardless of ethnicity, caste, religion, gender, place of residence, etc. The state is also assessed accordingly, and identification with democracy stands and falls with the question of whether the citizens' quality of life is constantly improving. NHSP-II makes an important contribution here.

Summary of the rating:

In summary, it can be stated that the impact indicators of the NHSP-II and the FC project show clearly positive developments during the term of NHSP-II and beyond. The health-related MDGs have also improved to a large extent during this period. The support of vulnerable people implied by NHSP-II is likely to have contributed to the country's political stability and to the identification of citizens with their nation, although this could not be quantitatively assessed, and it was not possible to fully eliminate the inequality. Overall, the overarching developmental impacts can therefore be assessed as successful.

Impact: 2

Sustainability

Capacities of participants and stakeholders

Looking at the sustainability of NHSP-II and the SWAp over time, it can be noted that the financial and personnel capacities of the ministries and the sector have developed positively. The share of donor financing fell from 41% at the start of NHSP-II (2010/11) to 28% (2015/16), and continued to fall to 21% by the financial year 2019/20.

Although the coronavirus years 2020–2022 led to significantly higher donor shares, this can only be assessed as pandemic-related distortion [21, 22, 35]. The growth rates of the health budget are also positive when deflated. In fact, the share of donors steadily decreased until the coronavirus pandemic reversed this development, which is likely to be a temporary effect. Looking at NHSP-II alone, the importance of the government of Nepal's own share is also increasing.²²

Contribution to supporting sustainable capacities

The SWAp would be as sustainable as possible if it had developed into a comprehensive basket with an increasing number of pooling partners and finally into budget financing until a point when no external support would have been necessary. However, according to the interview partners, this “natural chain” was interrupted and the development is declining. For SWAp IV currently being negotiated, there is currently only one donor who would generally like to support the basket funding instrument; all others evaluate the SWAp positively, but not the basket funding. Each individual partner seems to want to take advantage of the benefits of the SWAp, but shies away from the administrative burden of the central basket funding instrument. The many efforts to strengthen basket funding during NHSP II were therefore unsustainable.

The absorption rate can also be considered an indicator of sustainability. The target of 95% has never been reached. In 2018/19 it was 80.4%, corresponding to the long-term funds [59, 60]. It seems that programmes are generally somewhat overbudgeted, so that the lack of absorption may not necessarily be the result of weakness in implementation management, but rather of caution. Budget absorption was even selected as indicator OC 5.1 in the NHSS. It would have been good to have already agreed on this SWAp-related indicator during NHSP-II, but the inclusion in the NHSS catalogue once again shows the ability of the system to learn.

Durability of impacts over time

The investments in Nepal's healthcare system made during NHSP-II are on average more than ten years ago. Accordingly, it is to be expected that purchased **equipment** has predominantly exceeded its economic life. In fact, no complete NHSP-II procurement list could be found, so a final evaluation is not possible. However, based on the visits to the healthcare facilities, it can generally be concluded that the equipment appears appropriate. In addition, almost everywhere unusable equipment was seen which, although still present, is no longer functional and was not disposed of.

Buildings have a longer useful life, so investments from the time of NHSP-II could be viewed. They are used for the original purpose. No facility has been closed or converted to stop providing public health care. In many cases, however, further development took place in the sense of the inclusion of additional functionalities. The high proportion of extensions financed from resources contributed by the institutions themselves was remarkable.

However, some buildings show significant degradation. In some cases, roofs were in need of urgent repairs, power lines were repaired unprofessionally and water damage was not eliminated. The technical service life has not yet been reached, but in some cases the actual service life is likely to be less than the technical service life because they have not been adequately maintained. Consequently, sustainability can be verified, which could have gained significantly through better maintenance.

With regard to **staffing**, there is the impression that the high staff turnover, especially at the medical level, applies to the individual institution, but not to the overall public health system, i.e. structural sustainability appears to be at risk at the level of the individual institutions, but not at the system-wide level.

The **structures in the form of forums, reviews, consultations**, etc. developed during NHSP-I matured according to the interview partners in NHSP-II and were continued (at least initially) in the NHSS. However, the coronavirus pandemic meant that many routines and processes were interrupted and no longer continued (especially by new decision-makers in different positions). For example, interview partners reported that key people no longer visited the forums. The long-standing fiduciary administration of the SWAp was also transferred from the World Bank to DFID.

It is striking that the **steering options** for the facilities and the overall system are limited, which calls into question the permanent functionality. There are no cost accounting systems or cost studies at the level of the individual

²² Unfortunately, the data for the year 2015/16 are not available. It appears to be a fundamental problem; when switching from one programme to another (e.g. NHSP-II to NHSS) the follow-up is changed exclusively to the new programme, so that statistics for the year 2015/16 are scarcely available.

institution or for the overall system. Epidemiological data are often inconsistent, i.e. Facility and Health Management Information System (HMIS) data do not match. Whether the maintenance of service provision can be ensured with increasing complexity of the facilities on this basis would have to be analysed more precisely at another point. Overall, sustainability at the system level is excluded from the analysis. For level of the individual facilities, the sustainability is described as moderate. *Wie stabil ist der Kontext der Maßnahme) (z.B. soziale Gerechtigkeit, wirtschaftliche Leistungsfähigkeit, politische Stabilität, ökologisches Gleichgewicht) (Lern-/Hilfsfrage)*

Summary of the rating:

Zusammenfassung der ausschlaggebenden Aspekte, die auf Ebene der Bewertungsdimensionen in die Benotung des Nachhaltigkeitskriteriums einfließen (Nachvollziehbarkeit der Notenfindung) entlang der Notenskala (sehr erfolgreich, erfolgreich, eingeschränkt erfolgreich, eher nicht erfolgreich, überwiegend nicht erfolgreich, gänzlich erfolglos).

In summary, the picture is very mixed. At the facility level, sustainability appears to be average. In the case of the SWAp per se and the processes established for its implementation, the evaluation requires a time reference. If we look at the 2016–2018 phase, i.e. until the start of the implementation of federalisation in the healthcare sector before the coronavirus pandemic, good sustainability can be observed. Looking at the last five years, many processes seem to have been abandoned. It is currently not feasible to assess whether it will be possible to resume these processes. The distinction between the SWAp and basket funding seems extremely difficult. It is likely that the sector-wide approach (i.e. the coordinated financing of various components in the health sector) will also be decisive in the new programme and will be supported by (almost) everyone, but not the basket's financing instrument. Taking these dimensions into account, sustainability is assessed as moderately successful.

Sustainability: 3

Overall rating:

On the basis of the above, it can be concluded that the impacts of NHSP-II were of great importance for the population of Nepal. Health-related indicators have improved significantly from 2010–2016 and beyond. It is to be assumed that this will continue to be the case for a longer period of time. It can also be stated that they were also successful for the SWAp instrument and basket funding. How this may still be the case under the changed conditions of federalisation should be discussed in more detail beyond this evaluation.

Overall rating: 2

Contributions to the 2030 Agenda

NHSP-II 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) and SDG 3 (Good health and well-being), respectively 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 [61, 62]. The focus on vulnerable groups is also in line with the 2030 Agenda [63]. The SWAp used the national systems by definition, implemented national routines and coordinated the donors.

NHSP-II 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 had a significant impact on Nepal's monsoon country with heavy rainfall and flooding.

Project-specific strengths and weaknesses as well as cross-project conclusions and lessons learned

The project had the following strengths and weaknesses in particular:

- The SWAp during NHSP-II is classified by many interviewees as the “golden age” of cooperation between donors and with the government of Nepal. Coordination, harmonisation, joint planning and learning worked better than before and after.
- The government of Nepal developed ownership for the SWAp and basket during the NHSP-II phase. To this day, there are still employees in the ministries who also consider the basket to be essential and would very much like to continue along this path, even up to the point of budget support.

- The sector dialogue led to mutual trust, which served as a moderator for improved implementation of the measures. Speed and effectiveness were significantly increased through close cooperation. This was also reflected in the extremely rapid response after the 2015 earthquakes.
- The system can be described as resilient. During the crises (earthquakes 2015, coronavirus pandemic 2020/21) the stabilised system reacted quickly, effectively and efficiently. Furthermore, the system quickly returned to a stable phase.
- The healthcare sector as a whole and the SWAp in particular were not prepared for federalisation. The implementation of a SWAp in a federal system will require further adjustments and new processes.
- (Preventive) maintenance is a fundamental problem that requires, above all, cultural change.

Conclusions and lessons learned(mindestens 3): 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. The policy dialogue linked to basket funding also ensures greater participation in the formulation of sectoral policies and the implementation of reforms. This significantly increased the efficiency, effectiveness and visibility of the German commitment. The SWAp has the potential for moderation, i.e. it can strengthen the effect of individual measures and significantly increase their speed of implementation. Basket funding is a particularly suitable instrument for this, as it strengthens the responsibility of the partner country's government. However, implementation in a federal system is new territory and requires a fundamental adjustment that has not yet taken place. Demand-oriented measures were lacking for the most part in NHSP-II, but were implemented in the NHSS successor programme.

Evaluation approach and methods

Methodology of the ex post evaluation

The ex post evaluation follows the methodology of a rapid appraisal, which is a data-supported qualitative contribution analysis and constitutes an expert judgement. This approach ascribes impacts to the project through plausibility considerations which are based on a careful analysis of documents, data, facts and impressions. This also includes – when possible – the use of digital data sources and the use of modern technologies (e.g. satellite data, online surveys, geocoding). The reasons for any contradicting information are investigated and attempts are made to clarify such issues and base the evaluation on statements that can be confirmed by several sources of information wherever possible (triangulation).

Data sources and analysis tools: Literature (see annexes), BE 2007–2022, PA and PCR, various databases (e.g. World Development Indicators).

Interview partners: interview partners online before the mission: ten interviews of 60 minutes each, mainly with former employees of the Ministry of Health, donors and consultants; conversation partners during the mission: Ministry of Health (four)²³, Ministry of Finance (one), Family Welfare Division (three), GIZ (three), managers of health facilities (24), managers of district warehouses (six), other (six).

The analysis of impacts is based on assumed causal relationships, documented in the results matrix developed during the project appraisal and, if necessary, updated during the ex post evaluation. The evaluation report sets out arguments as to why the influencing factors in question were identified for the experienced effects and why the project under investigation was likely to make the contribution that it did (contribution analysis). The context of the development measure and its influence on results is taken into account. The conclusions are reported in relation to the availability and quality of the data. An evaluation concept is the frame of reference for the evaluation.

On average, the methods offer a balanced cost-benefit ratio for project evaluations that maintains a balance between the knowledge gained and the evaluation costs, and allows an assessment of the effectiveness of FC projects across all project evaluations. The individual ex post evaluation therefore does not meet the requirements of a scientific assessment in line with a clear causal analysis.

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

²³ Numbers in brackets indicate the number of interviewees.

Methods used to evaluate project success

A six-point scale is used to evaluate the project according to 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).

Publication details

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List of annexes:

Annex 1: Tables and figures

Annex 2: Target system and indicators

Annex 3: Risk analysis

Annex 4: Project measures and results

Annex 5: Recommendations for operation

Annex 6: Evaluation questions in line with OECD DAC criteria/ex post evaluation matrix

Annex 7: List of references annex (main section and annexes)

Tables and figures
Table 1 Indicators for the provinces

Indicator	National	Koshi	Madhesh	Bagmati	Gandaki	Lumbini	Karnali	Sudurpashchim
Public hospitals [number]	201	31	16	63	19	30	27	15
Primary Health Care Centres [number]	189	39	33	36	25	38	12	16
Health posts [number]	3794	639	743	368	486	569	342	377
Non-public institutions [number]	2082	141	172	1406	96	168	57	42
MR2 coverage (12–23 months) [%]	87	74	83	63	80	94	92	85
Underweight children (12–23 months) [%]	3.4	1.4	6.5	1.5	0.9	3.1	4.5	3.8
Institutionalised births [%]	65	60	54	62	42	80	87	83
Contraceptive Prevalence Rate [%]	39	41	44	35	34	40	37	41

Source: [22]

The 2020/21 Annual Report shows through numerous maps (e.g. vaccination rate), how severe the regional disparity still is, which results not only from the periphery, but above all from belonging to castes and religions (e.g. vaccinations p. 36 Map, Measles, p. 42, p. 43, Nutrition: p. 65, Institutionalised births p. 93, Contraceptives p. 101 ff.). Figure 1 shows the disparities for some indicators, in particular Number of healthcare facilities per province, nutritional situation, births in healthcare facilities and availability of contraceptives.

Table 2 Facilities visited

	Bagmati Province	Lumbini Province
National Hospital		Bheri National Hospital
District Hospital	Dhading District Hospital	Bardiya District Hospital
Primary Health Care Centre	Gajuri PHCC	Rajapur PHCC, Sorhawa PHCC
Health posts		Saurahawa HP, Kalika HP, Sanoshree HP, Khairapu HP
District Medical Store	Tanahu	Bardia MS, Banke MS

Source: own data.

Table 3 Other German DC projects and programmes during NHSP-II

Project/Programme	BMZ No.	Org.	Time	Amount [EUR million]
Family planning programme II / HIV/AIDS prevention	2001 56 068	KfW	2001-09	4.1
District Health Programme	2002 65 959	KfW	2004-21	2.5
Basic health programme III	2004 65 971	KfW	2005-09	3.3
Health and family planning sector programme	2006 66 305	KfW	2008-21	10.0
Programme improvement of mother and child care in remote areas	2014 68 248	KfW	2015-23	10.0
National Health Sector Programme III	2014 67 851	KfW	2016-21	10.0
FC Recovery Nepal – Health Component	2015 10 244	KfW	2015-23	20.0
FC Recovery Nepal, health component	2015 68 112	KfW	2015-25	20.0
Supporting mother-child care in the urban area – Paropakar Maternity and Women’s Hospital Kathmandu	2018 67 613 2018 70 153	KfW	2022-29	7.3
Supporting mother-child care in the urban area – Paropakar Maternity and Women’s Hospital Kathmandu II	2020 67 775	KfW	2022-29	5.3
Emergency coronavirus aid support for the National Sector Programme Health IV	2020 68 450	KfW	2020-23	10.0

Cooperative programme for health sector support	2006.2180.5	GIZ		4.7
Health Sector Support Programme	2006.2180.5	GIZ	2007-14	9.6
HIV-Prevention for the High Risk Group of Injecting Drug User	2010.2246.6	GIZ	2011-14	2.0
Health Sector Support Programme	2012.2202.5	GIZ	2014-16	5.9
Support to Health Sector Strategy	2014.2134.6	GIZ	2016-22	18.8
Support of primary health care in selected districts after the earthquakes in Nepal	2015.1827.3	GIZ	2015-15	0.5
Recovery Programme Nepal	2015.2105.3	GIZ	2015-18	10.1
Support to Health Sector Strategy	2020.2133.5	GIZ	2021-24	7.6

Source: GIZ and KfW.

Table 4 Development of health expenditure and absorption rate

Criterion	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Gross Domestic Product	1367	1527	1693	1929	2120	2248
National budget	338	385	405	517	618	819
Ministry of Health budget	24	25	20	30	33.51	36.7
National expenditure	295	339	359	450	531	601
Ministry of Health expenditure	18	20	19	23	24.53	29.2
National absorption rate [%]	87.4	88.1	88.6	87.0	85.92	73.34
Ministry of Health absorption rate [%]	76.3	81.2	94.1	75.1	73.9	79.6

Source: [46]

Table 5 Financing sources during NHSP-II [percentage of budget]

Source	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Government	58.40%	60.80%	57.92%	86.67%	65.67%	78.68%
Basket funding	25.21%	24.80%	28.71%	2.47%	20.00%	4.60%
Direct financing	16.39%	14.40%	13.37%	10.86%	14.33%	16.72%
Total MoHP	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

Source: [46]

Figure 5 shows the MoHP's funding sources during NHSP-II from 2010/11 to 2015/16 (no longer shown in other reports). The government share increased significantly during this period. At the same time, the financial importance of basket funding saw a downward trend. The outlier in 2015/16 is due to the special programmes following the earthquakes, the low value of basket funding in 2013/14 is an error [46].

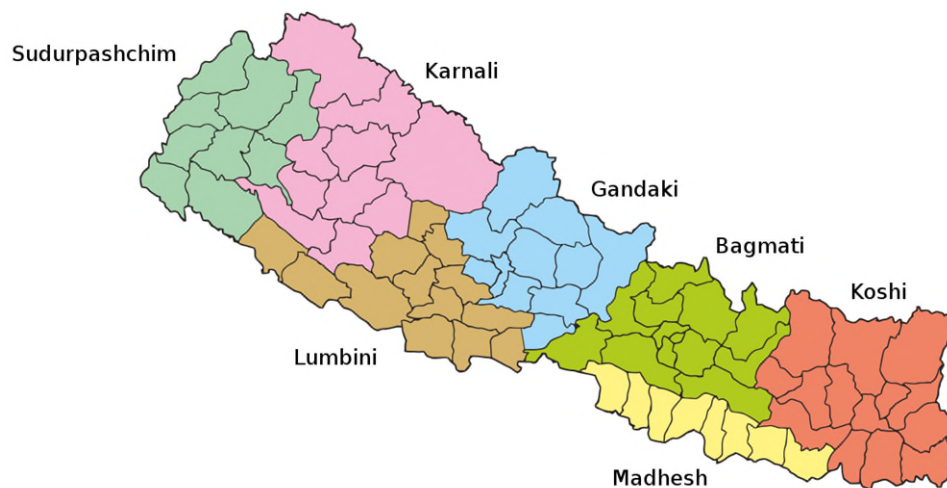
Table 6 Vulnerable groups and selected indicators

Indicator	grade	Teenage pregnancy [%]	Use of modern contraceptives	Children fully immunised
Ethnicity/ caste/ Religion	Brahmin/Chhetri	5.7	39.6	
	Dalit	15.5	44.0	
	Janajati	9.2	45.4	
	Madhesi	8.4	44.6	
	Muslim	15.5	27.6	
Place of resi- dence	Urban	8.6	40.7	52.6
	Rural	11.6	46.8	51.1
Zone	Mountain	13.6	50.1	60.3
	Hill	9.3	41.1	58.7
	Terai	9.4	43.0	47.7
Province	Koshi	10.9	43.5	45.0
	Madhesh Province	12.4	40.5	41.9
	Bagmati Province	4.8	44.6	60.3
	Gandaki Province	11.5	35.1	79.2
	Lumbini Province	6.3	43.0	57.6
	Karnali Province	16.6	45.9	55.8
	Sudurpashchim Province	8.8	47.0	54.0
Educa- tion	No school education	27.5	54.3	38.8
	Primary school (1–8)	14.1	42.4	50.6
	Secondary school (9–12)	5.4	32.9	58.8
Income quin- tile	Lowest	14.8	44.7	50.0
	Second	13.3	46.9	45.1
	Middle	10.5	44.4	55.1
	Fourth	6.1	38.7	57.1
	Highest	2.1	39.0	55.9

Source: [37]

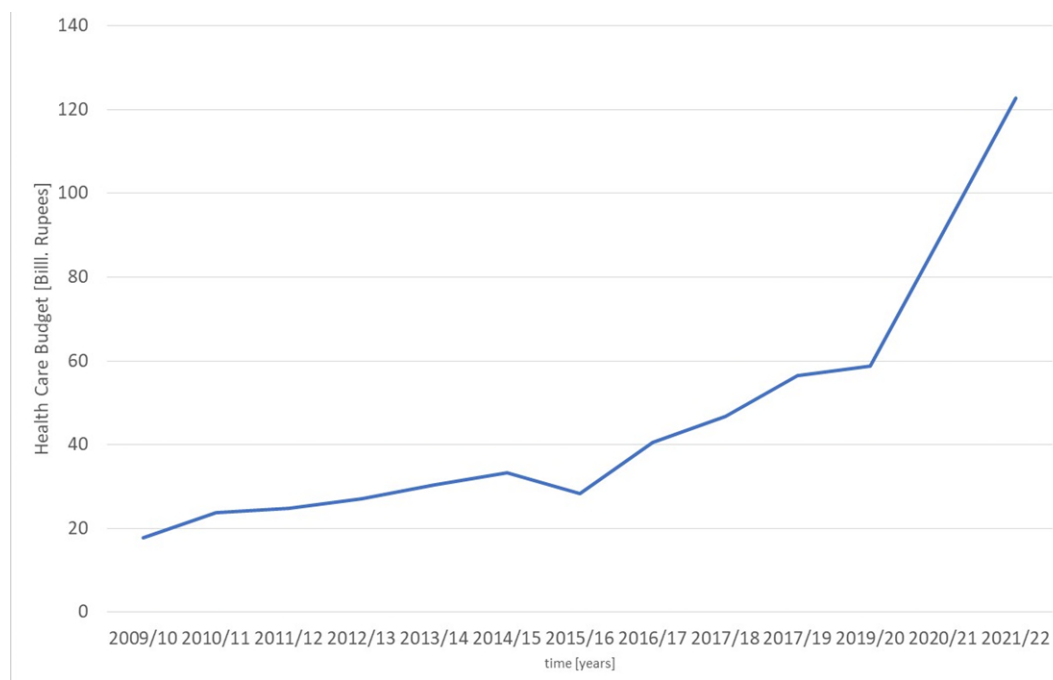
Figures

Figure 1 Provinces of Nepal



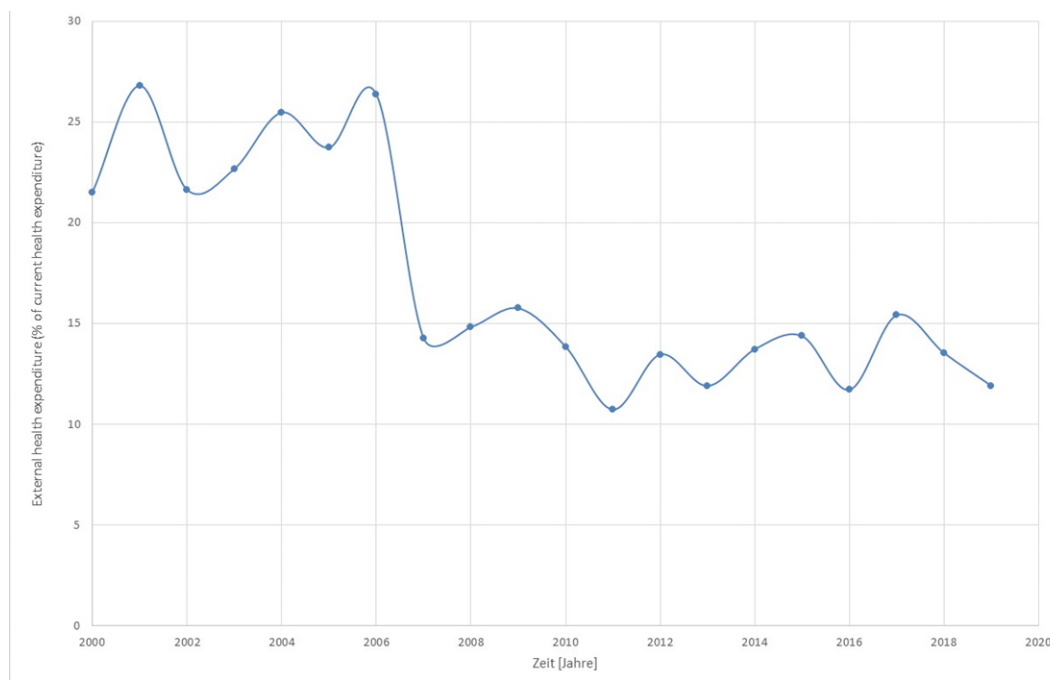
Source: https://commons.wikimedia.org/wiki/File:Provinces_of_Nepal_german_2018.svg

Figure 2 Nepal's health budget



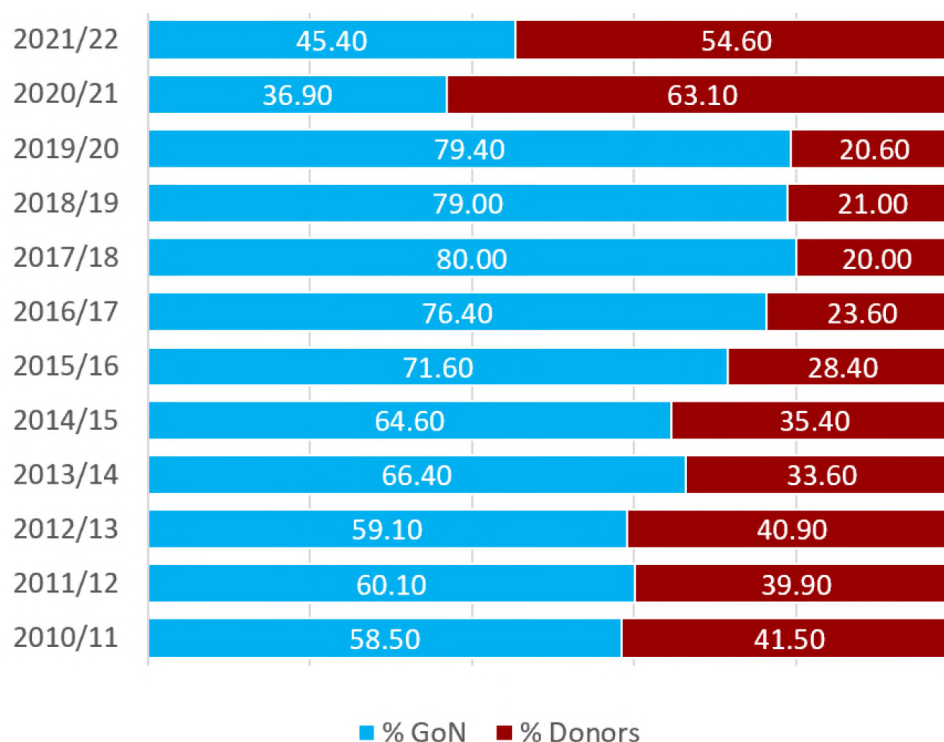
Source: [21]. See also Table 4.

Figure 3 Share of external financing in health expenditure



Source: [1]. See also Table 4 and Table 5.

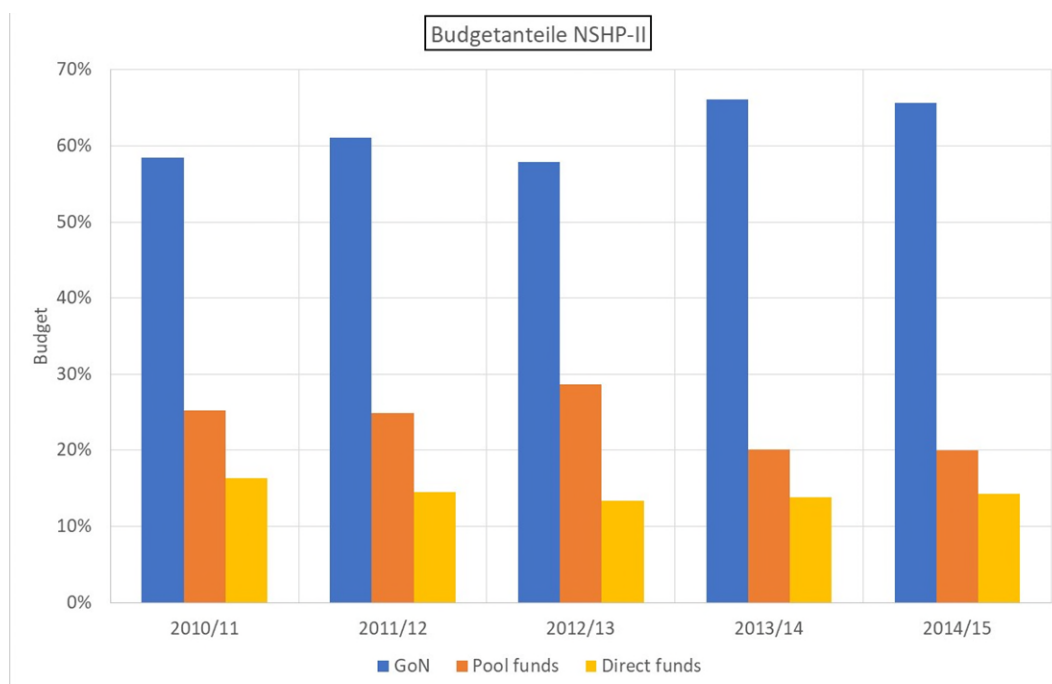
Figure 4 Donor contributions to Nepal's health budget



■ % GoN ■ % Donors

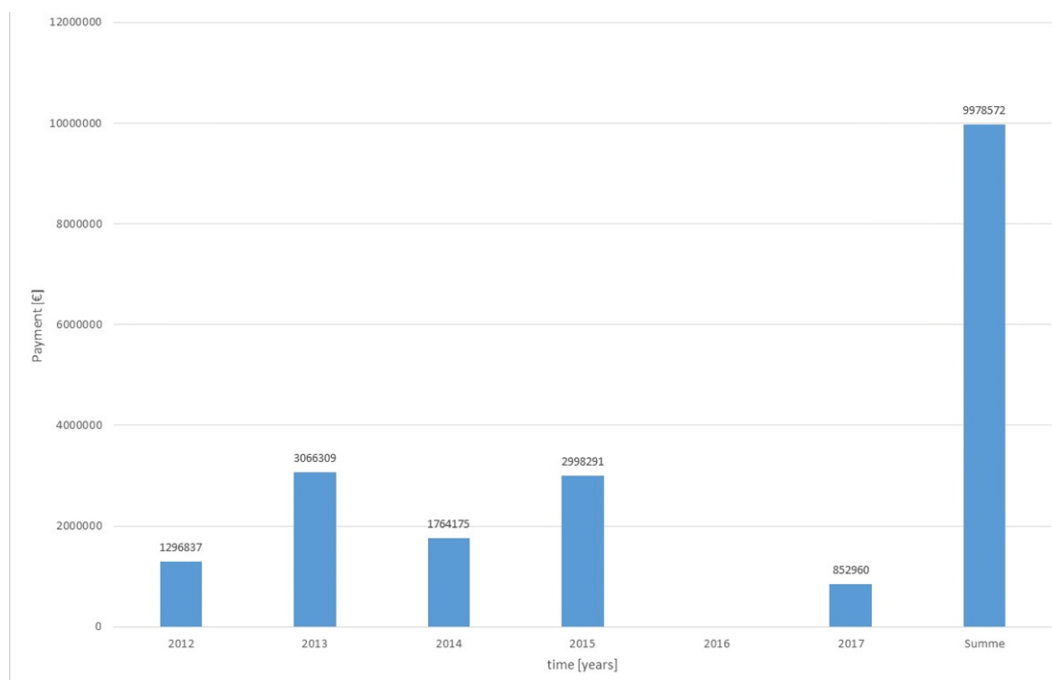
Source: [21]. See also Table 5.

Figure 5 NHSP-II budget shares (2010–2015)



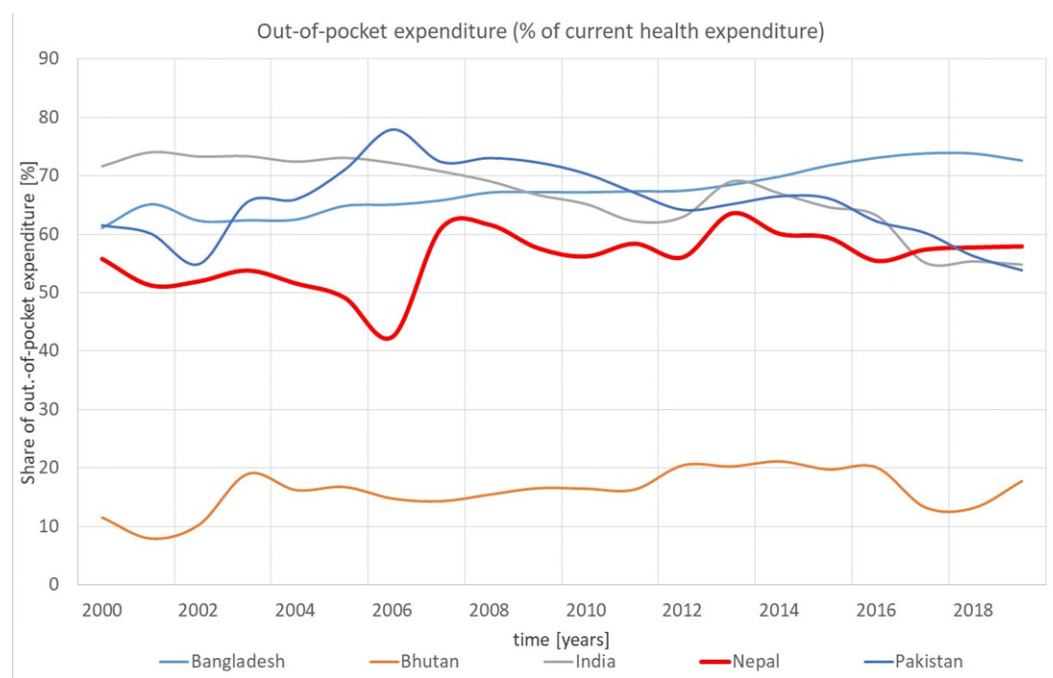
Source: [64]. See also Table 5.

Figure 6 KfW disbursements for NHSP-II (2010–2017)



Source: KfW.

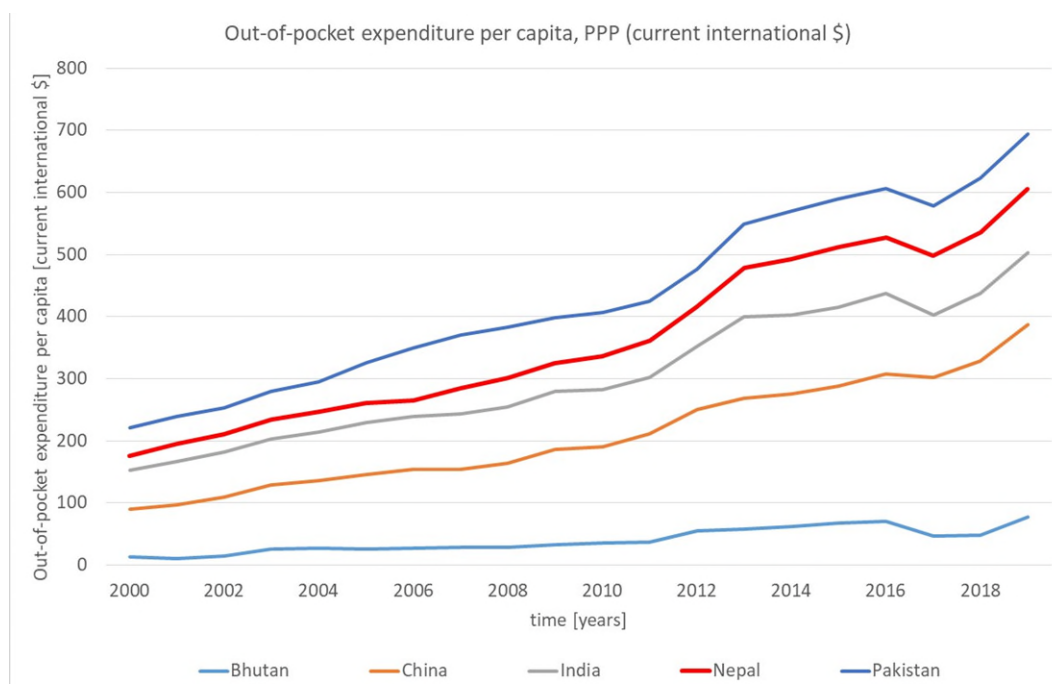
Figure 7 Share of direct user fees



Source: Own representation based on [1].

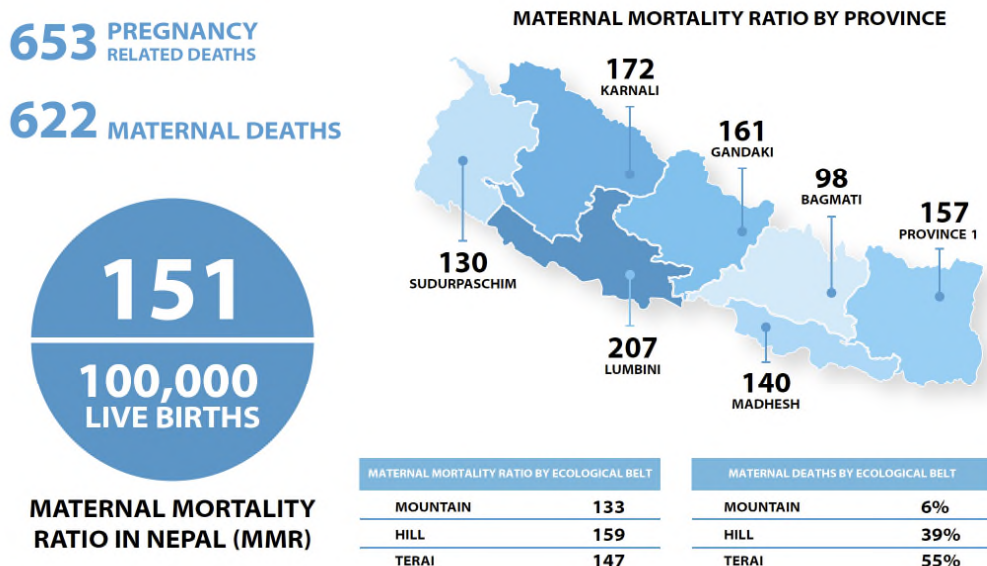
Figure 7 shows the share of out-of-pocket expenditure in total health expenditure. It is clear that Nepal (with the exception of Bhutan) does not have an unusually high share in the region, but this has increased in recent years. Figure 8 shows the absolute values, with costs continuously increasing and Nepal having comparatively high user fees for the households using private services. Similar results are found in the more recent literature. Gartaula et al. [65] shows that accessibility and budgetary costs remain the biggest problem in institutionalised obstetrics. Sapkota et al. [66] indicate the proportion of catastrophic health expenditure at 10.7% and 5.2% (10% and 40% threshold) and point in particular to the informal sector as a risk group. Rai et al. [67] come to similar conclusions, highlighting the elderly population and people with chronic degenerative diseases as risk groups in particular.

Figure 8 Direct user fees per capita



Source: Own representation based on [1].

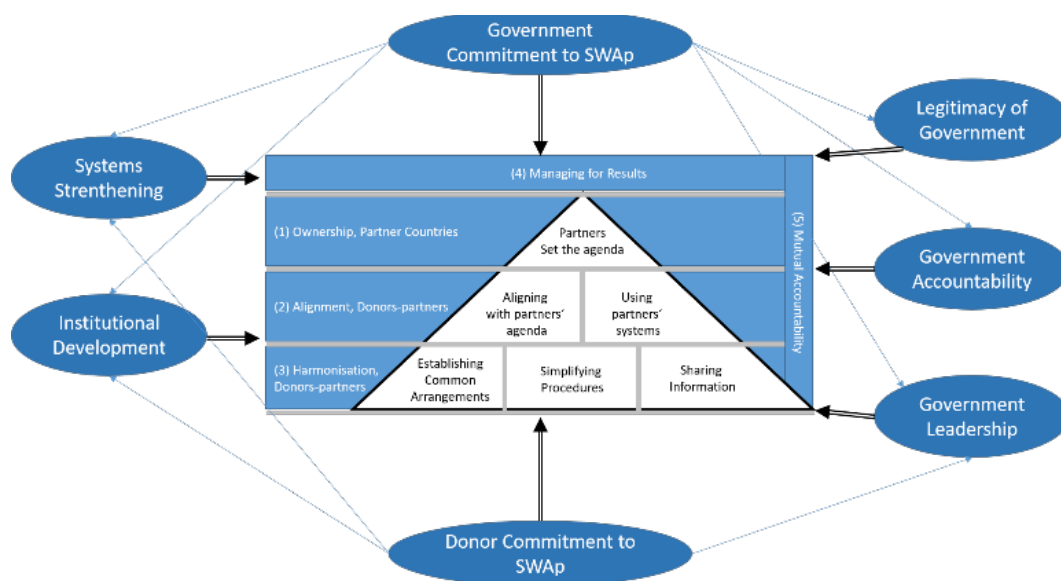
Figure 9 Regional disparity in maternal mortality



Source: [55].

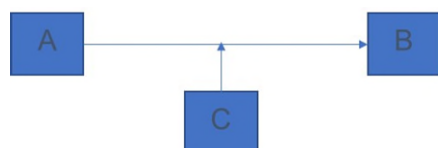
Figure 9 shows the regional disparity using the example of maternal mortality.

Figure 10 SWAp design



Source: Own data.

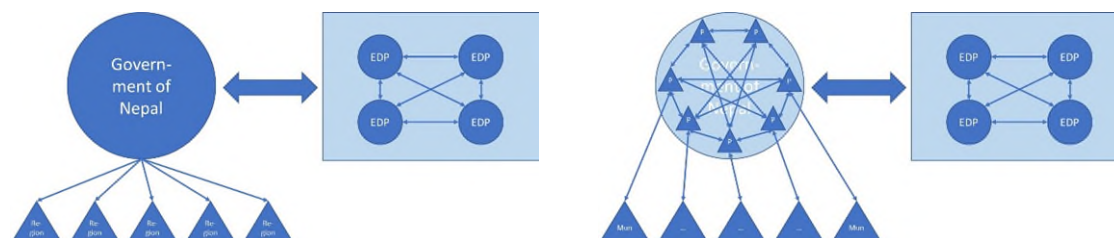
Figure 11 Moderator model



Source: Own data.

Figure 11 outlines the moderator effect. The endogenous (B) is determined by the exogenous (A), but the direction of action, the intensity of action and the speed of action are determined by the moderator (C). For example, income (exogenous, A) determines quality of life (B), whereby the strength of the effect depends on age (moderator, C). Hence, age is not only an exogenous factor that determines quality of life, but age also determines the impact of income on quality of life. This moderation can pertain to the intensity, direction and speed of the impact.

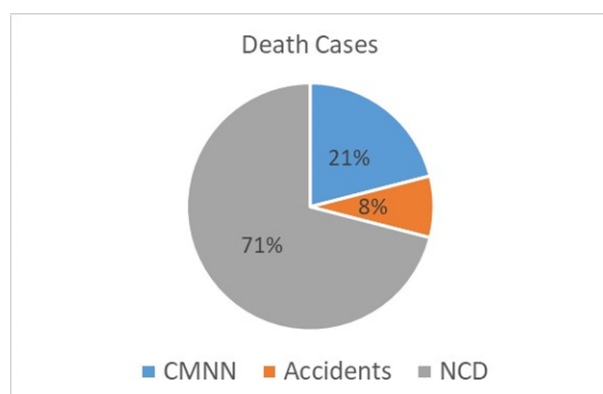
Figure 12 Interaction between government and donors before (left) and after (right) federalisation



Source: own data.

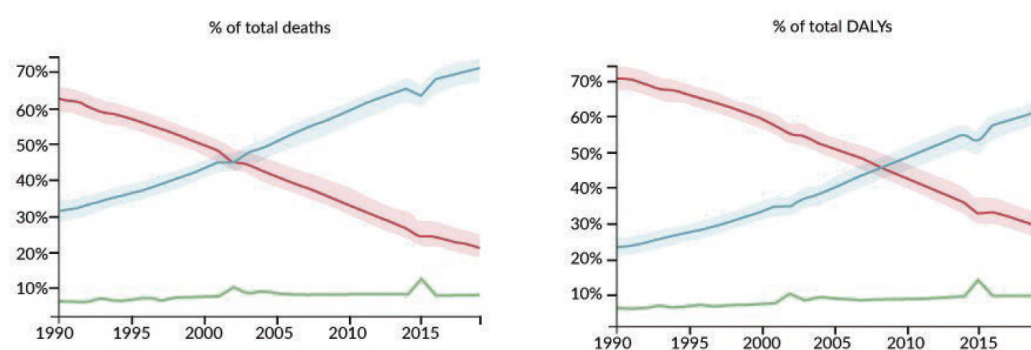
Figure 12 shows that before federalisation, donors only had to negotiate with the government of Nepal (national level), while after federalisation, the seven ministers of the provinces also became negotiating partners in addition to the federal minister.

Figure 13 Percentage of deaths in 2019



Source: [48]¹.

Figure 14 Percentage of deaths and loss of QALYs over time

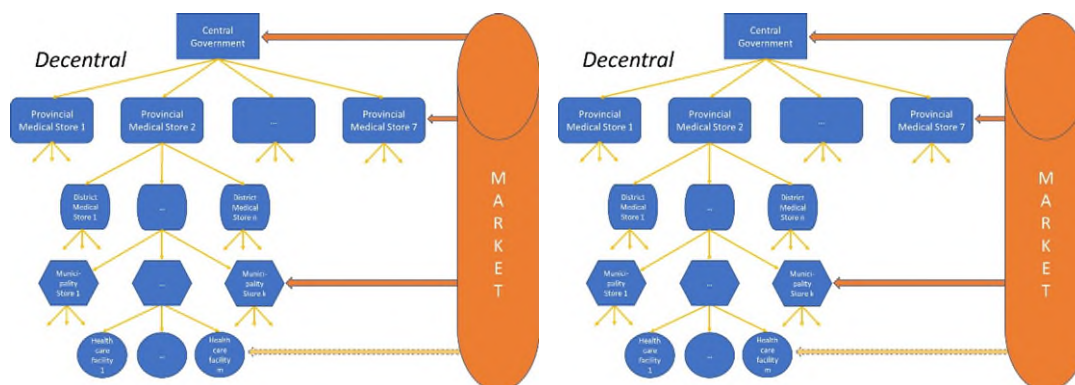


Source: [48].

Figure 14 shows that, even at the beginning of NHSP-II, the NCDs were in the majority. In fact, the country entered the third phase of the epidemiological transition as early as 2002/2003, when NCDs became the main cause of death. However, this argument only corresponds to the average. If specific vulnerable groups are observed, the distribution looks different. The above-mentioned report states that the percentage of deaths due to CMNN diseases among women is still higher than the percentage among men (2019: 22.7 vs. 19.7). As a result, the average allocation efficiency of NHSP-II and the BMZ project could have made gains through a general re-allocation of funds to NCDs, but the explicit and intended focus on vulnerable groups would have been damaged as a result. However, more measures against accidents (strengthening rescue services and their favourable pricing) would have been possible and would have benefited all target groups.

¹ CMNN: communicable, maternal, neonatal and nutritional diseases. NCDs: non-communicable disease.

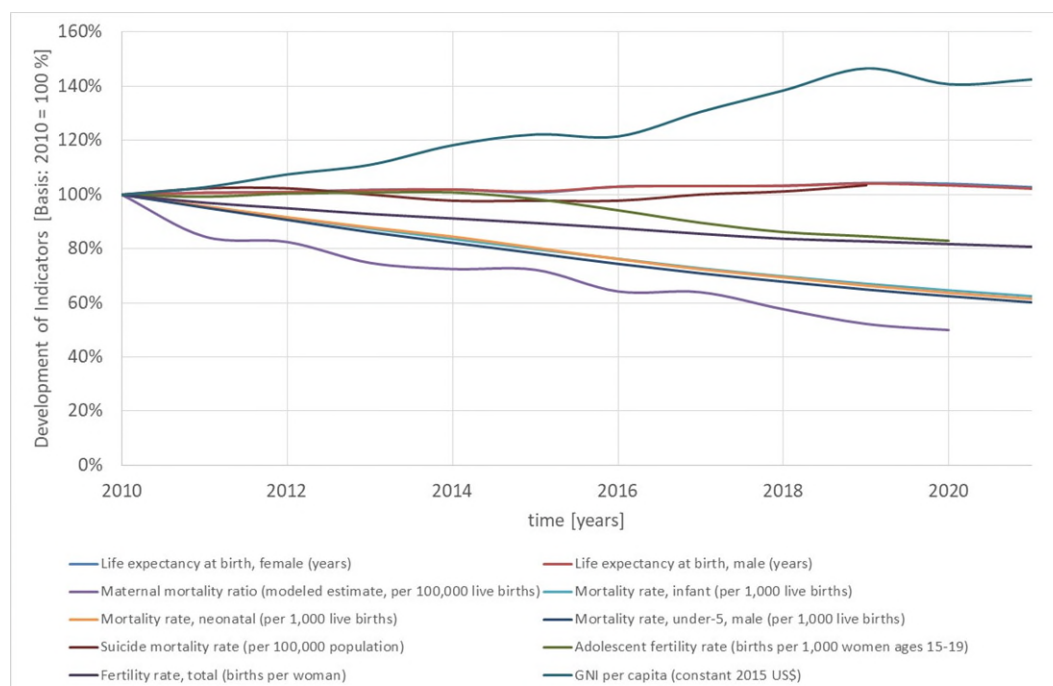
Figure 15 Material flow



Source: Own data.

Figure 15 shows the past and present flow of medical consumables in Nepal. Traditionally, they were purchased at the upper level and channelled to lower levels in a push system (i.e. materials were picked independently based on demand), whereby parameters such as the population of a region were decisive for the quantity of delivery. The logistics chain went from the central government to the five regions, then to the districts and finally to the healthcare facility.

Figure 16 Selected indicators



Source: [1].

Target system and indicators

The FC measure is intended to support the second phase of the Nepalese Health Sector Programme (NHSP II) by means of basket funding. NHSP II aimed at equal opportunities for access to and use of high-quality healthcare services, with particular regard to poor and socially disadvantaged groups. This requires extensive investments and training measures.

Defining the target system and in particular the indicators was more difficult than usual because they have changed several times. The programme proposal defined: "Once a year, the programme's progress is evaluated in terms of target achievement, measured against the indicators defined for this purpose. This is carried out jointly by the Ministry of Health and all donors (Joint Annual Health Review, JAR). An integral part of this is also the evaluation of the progress in implementing the measures agreed in the action plan to guarantee good governance and accountability. The results determine the policy dialogue on the strategic direction of the programme for the following year. This is specified in the form of the annual work and budget plans. Comprehensive external evaluations of the programme progress are planned after half of the term and in the last year of implementation (final evaluation)."

Based on the fact that it is not possible to clearly attribute the various target indicators, we have developed a different proposal for the EPE for improved subdivision of the indicators under impact and outcome. The outcome indicator "Proportion of institutionalised births" was added because it was also defined in the original framework and is a good indication of the use of the created resources of the reproductive health action area, which is a focus area of the SWAp. The derivation of the target system can be found in the main section.

Project objective at outcome level		Rating of appropriateness (former and current view)			
<p>During project appraisal: “The FC measure serves to support the second phase of the “National Sector Programme for Health” (NHSP-II) in the form of basket funding. NHSP-II aims at equal opportunities for access to and use of high-quality healthcare services, with particular attention paid to poor and socially disadvantaged groups. This requires extensive investments and training measures.”</p>		<p>Still fully appropriate, as access to and quality of health services are the key barriers to fair and equal health care.</p>			
Indicator	Rating of appropriateness	Target level PA / EPE (new)	PA status (2011)	Status at final inspection (2021, 2014 data)	EPE status (2023, data from 2021)
(1) Use of contraceptives (modern methods) (PA)	The use of contraceptives is a very good indicator of the effectiveness and efficiency of family planning as an essential component of NHSP-II.	55%	45.1%	46.7%	42.7%
(2) TB Case Detection Rate (PA)	This indicator provides important information on the successes in combating infectious diseases as a central component of NHSP-II	85%	75.8	83%	95%
(3) TB treatment success rate (PA)	This indicator provides important information on the successes in combating infectious diseases as a central component of NHSP-II	90%	89.7%	90%	91%
NEW: (4) Institutionalised births	This indicator was added to analyse the results of the Aama programme as a key component of NHSP-II.				65%

Source: [1, 35, 37–40]

Project objective at impact level		Rating of appropriateness (former and current view)			
During project appraisal: The aim of the FC measure is to improve the health situation of the population		Still fully appropriate, as improving the health of the population is a central objective of international and Nepalese policies, a resource for the country's economic and social development and a guarantee of stability and peace.			
Indicator	Rating of appropriateness	Target level PA / EPE (new)	PA status (2011)	Status at final inspection (2021, 2014 data)	EPE status (2023, data from 2021)
(1) Maternal mortality (PA)	Good impact indicator for component I	134	229	258	151 (2021)
(2) Fertility (PA)	Good impact indicator for component I	2.5	2.9	2.0	2.1
(3) Child mortality (PA)	Good impact indicator for component I	38	55	28	28.2
(4) Infant mortality rate (PA)	Good impact indicator for component I	32	79	25	23.6
(5) Neonatal mortality rate (PP)	Good impact indicator for component I	16	50	16	16.20 (2021)
(6) HIV prevalence in young women between the ages of 15–24 (PA)	Hardly possible to influence with measures, ignored during EPE	0.06	–	0.03	0.03
NEW: (7) Underweight, % of chronically underweight children	better indicator than acute undernourishment	34%	39%		31.5% (2019)

Source: [1, 24, 35, 52–54]

All risks should be included in the following table as described above:

Risk	Relevant OECD-DAC criterion	Evaluation
Improper use of the funds as part of the SWAp	Efficiency	Risks largely did not occur due to: separate administration and supervision of donor and Nepalese budget funds (deposit of donor contributions to a special account) Comprehensive follow-up of programme progress Regular financial audits Good cooperation from the MoHP in the clarification of all audit requests
Implementation capacities of the Ministry of Health	Efficiency	Risk occurred to a limited extent: the speed of implementation could have been improved, but this ultimately delayed implementation without preventing it.

Project measures and their results.....Annex 4

It is not possible as part of an EPE to carry out a complete analysis of all NHSP-II measures that were carried out in the amount of USD 1 billion from 2011 to 2016. Therefore, only a few focal points are to be discussed here. **Table** and **Table 7** provide a rough overview of the measures.

Table 7 Components and measures of the project, Component I

Compo-nents	Action area	Measure	Sub-measure
Component 1: Improving healthcare services	Reproductive health	Reduction of maternal mortality	Geographical expansion of the Aama programme
		Training	Training of an additional 3,000 female community health volunteers
			10,000 obstetricians trained in remote regions
			Strengthening professional care for home births
		Infrastruc-ture	Building additional healthcare facilities
			Sub health posts and all health posts have a maternity ward
			All health care centres and district hospitals have equipment to handle mater-nity-related emergencies
		Costs	Free institutional births
			Reimbursement of corresponding transport costs will continue
		Increased use of con-traceptives	Comprehensive awareness-raising measures
			Provision of a mix of methods
			Stronger involvement of women's groups and NGOs
	Adolescent-friendly services: for young people and adolescents		
	Child health	Reduction of child mortality	
		Communi-city-based manage-ment of childhood diseases	Preventive and curative measures for the most significant childhood diseases
			Municipal level: Awareness-raising measures
			Easy-to-implement therapies (including for diarrhoea).
			Comprehensive refresher courses for healthcare professionals
			Enhanced supervision
			Periodic evaluations
	Nutrition	Improving the nutri-tional situ-ation	of children under the age of five of women of reproductive age – top priority
		Community-based nutrition programme	
		Multisectoral ap-proach	Involvement of further ministries
			Expansion of successfully implemented measures
			<ul style="list-style-type: none"> ▪ Community-based rehabilitation of acutely malnour-ished children ▪ Administering micronutrients to pregnant women and children ▪ Deworming campaigns
	HIV/AIDS	Intensification of awareness-raising campaigns	
		Provision of condoms	
		Arrangements for voluntary advice	
		Conducting tests	
		Intensification of measures to prevent “mother-to-child transmission” during pregnancy and birth	
Involvement of NGOs contracted by the Ministry of Health			
TB	Prevalence and incidence, knowledge, treatment		
Malaria	Prevalence and incidence, knowledge, treatment		

Table 7 Components and measures of the project, Component II

Compo-nents	Action area	Measure	Sub-measure
Component II: Strengthening the health care system	Human resource capacities	Recruitment of additional staff	
		Consideration of representatives from socially disadvantaged groups	
		Incentive systems for recruiting in remote regions	
		Improving the qualifications of medical staff	
		Multidisciplinary training	
		Introduction of incentive systems for high-quality service provision	
	Build-ing/up-grading healthcare facilities	Focus on remote regions	
		Repair and maintenance of buildings and equipment	Binding specifications developed
			Budgeting
	Financial system	Implementation of a computerised financial management information system	
		Data evaluation with regard to poor and socially disadvantaged groups	
		Simplification of the complex budget structure to facilitate allocation of funds and appraisal of the use	
		Implementation of alternative control mechanisms such as performance and social audits	
		Public announcement of financial information (budget, audits, etc.) as well as the services to be provided, including their costs.	
		Committee that accelerates the response to findings in the context of financial audits	
	Procurement	Implementation of international procurement standards	
		Publication of all tender documents on the Ministry's website	
		Introduction of the central bidding/local purchasing concept for decentralised procurement	
		Conclusion of contracts covering deliveries over several years, e.g. for basic medicines to be procured annually	
		Introduction of quality control mechanisms for medicines and medical equipment	
		Expansion of the distribution network by building additional district warehouses and increasing the fleet	
	Strengthening the management capacities of decentralised structures	Increased private sector involvement	
		Developing a health finance strategy	
		Gender	
		Gender Equality and Social Inclusion Strategy	
	Gender Equality and Social Inclusion Strategy, GESI	Anchoring the topic in all policies, programmes and their budgeting	
		Establishment of dedicated units at both central and decentral level	
		Raising awareness among healthcare professionals of the needs of disadvantaged populations	
Raising awareness about their rights and how they can be exercised			
More detailed studies			

In **Component I (improvement of health services)**, the following is particularly noticeable:

- Studies: over 30 studies and surveys have been conducted. On the one hand, this meant that it was possible to base decisions within NHSP-II on evidence from other programmes (e.g. introduction of health insurance, NHSS). On the other hand, this implies an increase ability of the management to steer the health system, in particular the Ministry of Health, as fact-based decision-making was practised.

- Maternal health: The Aama program has been rolled out nationwide.¹ Female community health volunteers and obstetricians were trained, and the infrastructure in sub-health posts and health posts was expanded to include a maternity ward. The introduction of free delivery is also central to this. In contrast to all other measures of NHSP-II, demand-side intervention in the form of the assumption of transport costs was also taken into account here. The bundle also included the provision of different contraceptives.
- Child health: *Integrated Management of Childhood Illness* was introduced across the board for the prevention and cure of respiratory diseases, diarrhoea, malaria and malnutrition in children. The indicators show the positive impact. The approach to improving nutrition must be mentioned particularly positively.
- (Other) infectious diseases: The fight against malaria is very successful overall and follows the international trend. However, the “get-to-zero” malaria programme aimed at eradicating malaria in 2025 is likely to remain a utopia, as reinfection cannot be prevented. The tuberculosis situation is still difficult; values vary depending on the survey. For example, the National TB Prevalence Survey (2020) showed prevalence increased by a factor of 1.6 compared to previous studies.

For **component II (strengthening of the healthcare system)**, the following should be noted:

- Human resource capacity: Basically, the training and hiring activities are successful. However, there is an urgent need for employment analysis to create new positions. Currently, many additional employees are only in temporary positions with lower salaries, to some extent, which increases staff turnover and reduces motivation.
- Infrastructure: Numerous new institutions or buildings were created or renovated, especially in remote areas. Binding requirements have also been developed, such as standard plans for healthcare facilities of a certain size. However, the number of facilities in some areas is already likely to be too large, i.e. increasing mobility will lead to concentrations.
- Financing: To improve financing and the financial system, a financial management information system, the accounting software TABUCS (Transaction Accounting and Budget Control System) and a Financial Management Improvement Plan (FMIP) were introduced. In fact, this has little significance for the institutions which often do not operate with financial key figures. Management – including financial management – is often rudimentary.
- Materials handling: Procurement (incl. competitive bidding), warehousing and provision of goods have been improved. Some of NHSP-II’s “acquisitions” (e.g. “*central bidding / local purchasing*”) became obsolete due to federalisation.
- Gender Equality and Social Inclusion Strategy (GESI): In many cases, equality has become the guiding principle of the GoN and the DONOR. As the programme has always placed a major focus on MCH,² this was to be expected. However, social inclusion of other groups, including people with disabilities, played a significant subordinate role.

It is regrettable that no SWAp or basket-specific measures and indicators have been defined, so that a review of the moderator effect described in the main part would be possible. Here, reference can only be made to the interviews with the overall very good evaluation of SWAp and the basket by the interviewees.

¹ The “Aama Surakshya Programme” (abbreviated: Aama) is the official programme of the government of Nepal to improve the health of pregnant women and mothers. It includes free institutional delivery, payment of transport costs and an incentive to pay for four ANC (antenatal care) visits. As early as 2005, the Maternity Incentive Scheme (MIS) was initiated, and in 2009 maternity fees were abolished nationwide. In 2012, MIS merged with the programme for four ANC visits to become the Aama programme. It is an essential component of NHSP-I, NHSP-II and NHSS [32].

² MCH: mother and child health care.

Recommendations for operation

Annex 5

No recommendations were made for operation in the project completion report. It is important to question how basket funding and the SWAp can be carried out in a federal system in the future. One interviewee said: “Instead of coordinating with one Ministry of Health, we now have eight ministries,” he said, referring to the Federal Ministry and the respective ministries of health in the seven provinces. Since the provinces have a comparatively high level of independence, it no longer makes sense to agree on top-down regulations and measures. Rather, programmes must come from the provinces in a bottom-up manner, which calls into question the previous SWAp processes.

As mentioned in the main section, Nepal is facing significant changes due to demographic change and the mobility transition. As a result, the importance of small units decreases, particularly in the case of interventions that can be planned (at least to a limited extent) (e.g. birth). The planned investment in 15-bed hospitals in each province as part of decentralisation requires considerations at a national level about how to finance their sustainable operation.

Relevance

Evaluation questions	Specification of the question for the present project	Data source (or rationale if the question is not relevant/applicable)	Rating	Weighting (- / o / +)	Reason for weighting
Evaluation dimension: Policy and priority focus			2	0	
Are the objectives of the programme aligned with the (global, regional and country-specific) policies and priorities, in particular those of the (development policy) partners involved and affected and the BMZ? This is about the objective of the measure.	Do the measures correspond to the state-of-the-art of international health policy (Primary Health Care, Health Promotion, Accessibility, Paris and Accra Declaration, Universal Health Coverage, UHC)? Are the measures compatible with the SDGs and Nepal's health policy? Are the measures in line with the donors in Nepal? How do they fit with the Federal Ministry for Economic Cooperation and Development (BMZ) guidelines?	The question is definitely relevant, but in the case of a SWAp it is self-explanatory to some extent. Primary health care, alignment with vulnerable groups, improved accessibility, donor harmonisation and strengthening of the healthcare work force continue to be the foundations of national and international health policy, but also of the Federal Ministry for Economic Cooperation and Development (BMZ), donors in Nepal and all relevant stakeholders.			
Do the objectives of the programme take into account the relevant political and institutional framework conditions (e.g. legislation, administrative capacity, actual power structures (including those related to ethnicity, gender, etc.))?	Are the measures in line with Nepal's health legislation? Can they be implemented at all with existing management capacities in the state administration, but above all in the healthcare facilities? Are the vulnerable groups without a lobby or power adequately taken into account?	The objective of the programme explicitly focuses on vulnerable groups (women, ethnic groups, remote areas).			
Other evaluation question 1	To what extent have the dimensions of the Paris Declaration been taken into account and implemented?	The SWAp fully takes into account the dimensions of the Paris Declaration. [25–30]			

Other evaluation question 2	Has the coronavirus pandemic changed something fundamental about the relevance of the measures taken and objectives set?	No.			
Evaluation dimension: Focus on needs and capacities of participants and stakeholders			2	0	
Are the programme objectives focused on the developmental needs and capacities of the target group? Was the core problem identified correctly?	What are the differences between the needs of the total population and vulnerable groups (e.g. remote regions of the country, women, indigenous ethnic groups (e.g. Janajati), low-lying countries (e.g. Dalit), non-Hindu religious communities (Muslims), Indian-descent lowland residents (Madhesi)? Are the indicators set out in NHSP-II appropriate?	Interview with MoHP and donors, but also in the healthcare facilities			
Were the needs and capacities of particularly disadvantaged or vulnerable parts of the target group taken into account (possible differentiation according to age, income, gender, ethnicity, etc.)? How was the target group selected?	What problems prevent vulnerable groups from gaining access (e.g. transport costs)? What does the programme have to overcome this? Were these target groups adequately taken into account in the programme?	Based on the PA, primarily construction of new facilities and improvement of the quality of facilities in remote regions as well as training of additional personnel and the AAMA system as an integral part of NHSP-II (incl. assumption of transport costs)			
Would the programme (from an ex post perspective) have had other significant gender impact potentials if the concept had been designed differently? (FC-E-specific question)	Accessibility is likely to be a major problem in this country. In which regions is this particularly difficult and what has been done to improve it (transport)? What role do rescue services play? How is the population supplied in border regions? Are there areas where a facility is necessary, but cannot be financed due to the low population density? Which measures were actually applied to "GESI" (Gender Equality and Social Inclusion Strategy)?	[24, 68, 69]			

Other evaluation question 1	What role does decentralisation play? What has been decentralised in the healthcare sector (responsibilities, personnel, finance)? What impact does this have on the supply? Do the provinces even have the staff?	Interviews with donors and facilities			
Evaluation dimension: Appropriateness of design			2	0	
Was the design of the programme appropriate and realistic (technically, organisationally and financially) and in principle suitable for contributing to solving the core problem?	What does the impact matrix look like? Is it logical and coherent? Is it still true today? Was it at all realistic to expect an impact with an FC component of only EUR 10 million?	Here, a clear distinction must be made between NHSP II and the FC component. The impact of the FC component can only be assumed, but not proven.			
Is the programme design sufficiently precise and plausible (transparency and verifiability of the target system and the underlying impact assumptions)?	Is the assumption that investments in infrastructure, procurement, management, personnel, etc. with a focus on vulnerable groups lead to an improvement in the health status of the population, realistic?	Clearly yes according to the MDGs and SDGs.			
Please describe the results chain, incl. complementary measures, if necessary in the form of a graphical representation. Is this plausible? As well as specifying the original and, if necessary, adjusted target system, taking into account the impact levels (outcome and impact). The (adjusted) target system can also be displayed graphically. (<i>FC-E-specific question</i>)	Which measures should lead to which outcomes and how would these affect impacts? Example: Training of personnel leads to better qualification. This, in turn, should induce improved treatment quality, which in turn should increase the health of the population.	No results chain or results matrix was defined in the PP. The interim report of NHSP-II distinguishes between outputs, outcomes, purpose and goals and shows that the previous component is a necessary but insufficient condition for the subsequent one. The relationship is also shown by way of example in the above evaluation model, as well as described in the main section.			
To what extent is the design of the programme based on a holistic approach to sustainable development	What significance does NHSP-II's environmental sustainability have? What significance does economic sustainability have in terms of long-term strengthening of economic output? How is the measure	On-site visits to the clinics and health stations did not result in an environmental programme, but waste management has a certain role to play. This could have been strengthened.			

(interplay of the social, environmental and economic dimensions of sustainability)?	likely to have affected society's cohesion, the peace process and democratisation?			
For projects within the scope of DC programmes: is the programme, based on its design, suitable for achieving the objectives of the DC programme? To what extent is the impact level of the FC module meaningfully linked to the DC programme (e.g. outcome impact or output outcome)? <i>(FC-E-specific question)</i>	What other DC measures are there? What was the basket funding able to do in particular to ensure that the DC objectives (especially the health of the population) could be achieved?	Interviews with KfW and GIZ		
Other evaluation question 1	A devastating earthquake occurred in April 2015. Was the healthcare system prepared for this ("resilient healthcare system (HS)")? What could have been done under NHSP-II to strengthen the HS' capacity for disasters (both self-preservation and maintenance as well as expansion of services in the event of a disaster)?	Interviews (MoH, donors) showed that the trusting cooperation has increased resilience for future possible crises as part of the SWAp.		
Other evaluation question 2	What effects did the COVID-19 pandemic have on the HS in Nepal (especially treatment capacity for patients, protection of in-house staff, resources)? Could preparations for this have been made?	Interviews revealed that the healthcare sector was able to cope relatively well with the consequences of the pandemic, especially on the basis of the management processes of the SWAp. Long-term consequences are limited.		
Other evaluation questions		2	0	
Other evaluation question 1	Specifically for the SWAp: Why is the SWAp and, in particular, the basket especially suitable for achieving the above effects?	[13] [23]		

Other evaluation question 2	<p>Effectiveness could have been increased by considering the following aspects:</p> <p>Alternative elements of medicine</p> <ul style="list-style-type: none"> - Telemedicine - Hygiene, especially central sterilisation and waste management - Rescue services - Obesity <p>Alternative training elements</p> <ul style="list-style-type: none"> - Interdisciplinary training, cooperation as teams - Importance of hospital managers <p>Strong focus on maternal and child health</p> <ul style="list-style-type: none"> - And what about the bread winners? <p>System options</p> <ul style="list-style-type: none"> - Financing system: Health insurance, user fees, exemptions, etc. - Autonomy of hospitals 	Interviews with MoHP and donors
Other evaluation question 3	<p>Why are some indicators noteworthy?</p> <ul style="list-style-type: none"> - Low occupancy rates - Short hospitalisations <p>High regional differences</p>	[34] [23]

Coherence

Evaluation question	Specification of the question for the present project	Data source (or rationale if the question is not relevant/applicable)	Rating	Weighting (- / 0 / +)	Reason for weighting
<p>Evaluation dimension: Internal coherence (division of tasks and synergies within German development cooperation):</p>			2	0	
<p>To what extent is the programme designed in a complementary and collaborative manner within the German development cooperation (e.g. integration into DC programme, country/sector strategy)?</p>	<p>The SWAp is per se a coherent measure, which has been closely coordinated with the partners (Nepal, donors) and is even completely integrated. The role of the two other programmes running simultaneously</p>	<p>Results from the documents of the two other programmes or from the joint programme in Nepal. FC very specifically accomplished what was envisaged in NHSP-II as a whole with the two programmes. The GIZ programmes are fully complementary to the NHSP-II measures.</p>			

<p>This concerns the design and implementation of the measure.</p>	<p>(district health and family planning) appears to be unclear. How do they work together? The role of GIZ and its programmes is also unclear. What exactly did they do and how did they cooperate?</p>				
<p>Do the instruments of the German development cooperation dovetail in a conceptually meaningful way as well as in implementation, and are synergies put to use?</p>	<p>How do basket funding and individual programmes work together? How do FC and TC work together? How much consulting did our programme generally contain (nothing according to the current state of knowledge)? Should this be taken into account in the future or can it be left entirely to TC?</p>	<p>Interviews with GIZ and KfW in Nepal</p>			
<p>Is the programme consistent with international norms and standards to which the German development cooperation is committed (e.g. human rights, Paris Climate Agreement, etc.)?</p>	<p>Is the primary care approach in line with health as a human right? What role does equity play here? How are the Paris Declaration and Accra Agenda taken into account? Contribution to the SDGs? Why were climate targets not explicitly taken into account?</p>	<p>Primary Care in Nepal is entirely based on the Alma Ata, Ottawa, Paris and Accra declarations. The contribution to the SDGs (see main section) must be assessed positively, in particular SDG 3 (Good health and well-being)</p>			
<p>Other evaluation question 1</p>	<p>If the individual dimensions of the Paris Declaration have not already been taken into account, they could be brought up again here.</p>	<p>[25–30]</p>			
<p>Evaluation dimension: External coherence (complementarity and co-ordination with actors external to German DC):</p>			<p>1</p>	<p>+</p>	<p>Good donor coordination is central to basket funding</p>
<p>To what extent does the programme complement and support the partner's own efforts (subsidiarity principle)?</p>	<p>How was the cooperation with the national partners in NHSP-II? How were decisions made? How has it been ensured that decisions are in line with national strategies? How were the partner's own efforts strengthened?</p>	<p>The mid-term review [24] provides some information on this, including interviews. Otherwise, Nepal is so central to the SWAp that subsidiarity and coherence are actually self-explanatory.</p>			

		Strengthening healthcare management: Interview Strengthening of MoF capacity: Mid-term review [24], also PCR
Is the design of the programme and its implementation coordinated with the activities of other donors?	ditto	The nature of the SWAp does not need to be explained several times.
Was the programme designed to use the existing systems and structures (of partners/other donors/international organisations) for the implementation of its activities and to what extent are these used?	What is the significance of the individual donors in NHSP? Who was the pooling and non-pooling partner? Who is missing? How did the coordination processes work? How do the Joint Annual Review (JAR) and Joint Financing Agreement (JFA) work?	See PCR on pooling; coordination processes: interviews with donors and MoH/MoF JAR and JFA documents.
Are common systems (of partners/other donors/international organisations) used for monitoring/evaluation, learning and accountability?	Which follow-up and evaluation system was used by NHSP-II? How did this work? Are there systemic gaps (e.g. measurement of accessibility)? What has been learned? How was the Governance and Accountability Action Plan implemented?	Gaps: Quality and accessibility are difficult to measure. Is there a common understanding of quality and accessibility? Have instruments been developed to measure them?
Other evaluation question 1	What did effective donor coordination mean in connection with basket funding? Did it work?	Interviews with donors, MoHP and MoF: Yes.
Other evaluation question 2	Is the SWAp even suitable for achieving a leveraging effect?	Dto.: Yes.

Effectiveness

Evaluation question	Specification of the question for the present project	Data source (or rationale if the question is not relevant/applicable)	Rating	Weighting (- / 0 / +)	Reason for weighting
Evaluation dimension: Achievement of (intended) targets			2	0	
Were the (if necessary, adjusted) objectives of the programme (incl. capacity development measures) achieved? (Target/actual comparison indicator table)	Which objectives of the FC measure were achieved (see table above)? What is the chronological sequence (e.g. 2016/2021/2023 achievement), if data is available?	Predominantly yes, see the table in the main section, in the section on Effectiveness			
Other evaluation question 1	Why were NHSP indicators changed and what relevance does this have for FC indicators?	Mid-term review [24]			
Evaluation dimension: Contribution to achieving objectives:			2	0	
To what extent were the outputs of the programme delivered as planned (or adapted to new developments)? (<i>Learning/help question</i>)	What outputs did the programme really deliver?	Mid-term review [24], in particular percentage of indicators achieved. What was adjusted? Why?			
Are the outputs provided and the capacities created used?	What are the utilisation statistics? Number of inpatient and outpatient cases, vaccinations, use of contraceptives, etc.	Utilisation is generally very low, varies significantly between regions [22, 35]			
To what extent is equal access to the outputs provided and the capacities created guaranteed (e.g. non-discriminatory, physically accessible, financially affordable, qualitatively, socially and culturally acceptable)?	Accessibility plays a key role in the programme. What are the results for the individual vulnerable groups (see above)? How is the accessibility (if not already in the foreground)? What other barriers and filters are present?	Statistics for vulnerable groups show clear differences. [22, 35]			

<p>To what extent did the programme contribute to achieving the objectives?</p>	<p>What is the significance of the 1% share in NHSP-II from the FC component? Is this more or less than 1%?</p>	<p>All interviewees agree that the leveraging effect is significant. German FC's contribution to the moderator effect is significantly higher than the financial share.</p>
<p>To what extent did the programme contribute to achieving the objectives at the level of the intended beneficiaries?</p>	<p>How has the health of the entire population developed? How about that of the vulnerable groups? What has FC contributed to this?</p>	<p>Significant improvement in the health status across (almost) all population groups; NHSP-II is likely to play a major role in this.</p>
<p>Did the programme contribute to the achievement of objectives at the level of the particularly disadvantaged or vulnerable groups involved and affected (potential differentiation according to age, income, gender, ethnicity, etc.)?</p>	<p>See above</p>	
<p>Were there measures that specifically addressed gender impact potential (e.g. through the involvement of women in project committees, water committees, use of social workers for women, etc.)? <i>(FC-E-specific question)</i></p>	<p>What exactly is "Gender Equality and Social Inclusion" in this context? What were the results?</p>	<p>The GESI concept has already been implemented by focusing solely on MCH. MCH remains a central focus of German FC [24, 68, 69].</p>
<p>Which project-internal factors (technical, organisational or financial) were decisive for the achievement or non-achievement of the intended objectives of the programme? <i>(Learning/help question)</i></p>	<p>Has KfW positively influenced the SWAp through its contribution and made processes feasible? Has KfW been a relevant partner with its relatively small contribution? Was it able to introduce specific DC priorities (e.g. vulnerable groups, equity)?</p>	<p>Interviews with KfW, donors, MoHP, MoF</p>
<p>Which external factors were decisive for the achievement or non-achievement of the intended objectives of the programme (also taking into account the risks anticipated</p>	<p>What were the risks? How were these risks to be mitigated? What led to them not materialising? What led to them occurring? What could have been done better?</p>	<p>PCR, interviews with KfW, donor, MoHP, MoF</p>

beforehand)? (<i>Learning/help question</i>)				
Evaluation dimension: Quality of implementation			2	0
How is the quality of the management and implementation of the programme (e.g. project-executing agency, taking into account ethnicity and gender in decision-making committees) evaluated with regard to the achievement of objectives?	Were there any FC activities beyond financing at all? Accompanying research? How are the committees structured (e.g. parity according to gender, parts of the country, professional groups)?	According to the project completion report, no FC consultant, but DFID and others provided advice. Interviews, in particular with donor in KfW Country Office		
How is the quality of the management, implementation and participation in the programme by the partners/sponsors evaluated?	What is the management and administrative capacity of the MoHP and the MoF? What is the minister's absorptive capacity? Were the health facilities and programmes able to implement the programmes?	Mid-term review of HEART, interviews with MoF, donor		
Were gender results and relevant risks in/through the project (gender-based violence, e.g. in the context of infrastructure or empowerment projects) regularly monitored or otherwise taken into account during implementation? Have corresponding measures (e.g. as part of a CM) been implemented in a timely manner? (<i>FC-E-specific question</i>)	See gender explanations above	[69]		
Evaluation dimension: Unintended consequences (positive or negative)			2	0
Can unintended positive/negative direct impacts (social, economic, ecological and, where applicable,	What unintended effects did the programme have on employees in the healthcare sector (e.g. identification with the profession, length of time spent in the profession; level of training)? How has the attitude of health	Interviews in healthcare facilities, literature		

those affecting vulnerable groups) be seen (or are they foreseeable)?	workers changed? What significance did the programme have for the successful introduction of health insurance?	Increased quality leads to acceptance of the insurance?			
What potential/risks arise from the positive/negative unintended effects and how should they be evaluated?	Was the programme able to increase resilience during the earthquakes and pandemics (see above)? Is there anything to be learned from this?	Interview with healthcare facilities and MoHP			
How did the programme respond to the potential/risks of the positive/negative unintended effects?		Comprehensive, regular discussions and adjustments as part of the SWAp dialogue.			
Other evaluation questions			3	0	
Other evaluation question 1	How has the situation in the country generally developed? What part of this is due to NHSP?	Problem: positive until 2018, then increasingly difficult.			

Efficiency

Evaluation question	Specification of the question for the present project	Data source (or rationale if the question is not relevant/applicable)	Rating	Weighting (- / 0 / +)	Reason for weighting
Evaluation dimension: Production efficiency			3	0	
How are the inputs (financial and material resources) of the programme distributed (e.g. by instruments, sectors, sub-measures, also taking into account the cost contributions of the partners/executing agency/other participants and affected parties, etc.)? (Learning and help question)	What were the NHSP-II funds ultimately spent on? For which parts of the country? For which projects?	See tables in the Project measures annex. We were also unable to obtain a more precise breakdown from the MoHP as part of their mid-term review			

<p>To what extent were the inputs of the programme used sparingly in relation to the outputs produced (products, capital goods and services) (if possible in a comparison with data from other evaluations of a region, sector, etc.)? For example, comparison of specific costs.</p>	<p>Which measures were generally invested in? Infrastructure, training, ...? What evidence of this can be seen in the individual healthcare facilities? What is the condition of the buildings? What is the condition of the equipment? How large is the staff? What is the level of qualification and motivation of the personnel?</p>	<p>As shown in the main section, investments in tangible assets are made as part of NHSP-II. Eight years after the end of the project term, however, only part of it remains within its technical useful life. In principle, however, the visit has repeatedly found that equipment and buildings are being used for their intended purpose, even if maintenance is a problem.</p>
<p>If necessary, as a complementary perspective: To what extent could the outputs of the programme have been increased by an alternative use of inputs (if possible in a comparison with data from other evaluations of a region, sector, etc.)?</p>	<p>What was missing from the measures that could have significantly improved efficiency?</p>	<p>Hygiene example: Disposal, central sterile supply department (CSSD) and other forms of hygiene are inadequate in all facilities visited. Equipment example: the equipment of the facilities visited is consistently at an appropriate level. Building example: the buildings of the facilities visited are appropriate. Maintenance: Expenditures for maintenance, availability of qualified maintenance personnel and maintenance planning need to be improved in all facilities visited.</p>
<p>Were the outputs produced on time and within the planned period?</p>	<p>What delays occurred during implementation? What could be absorbed by NHSS?</p>	<p>Mostly interviews, partly from the PCR: one-year delay of NHSP-II from 2015 to 2016 due to the earthquakes. Possible delays do not play a major role as NHSS followed immediately.</p>
<p>Were the coordination and management costs reasonable (e.g. implementation consultant's cost component)? (FC-E-specific question)</p>	<p>How high were the coordination and management costs in NHSP and FC?</p>	<p>No source found</p>
<p>Other evaluation question 1</p>	<p>Do we know the general cost of healthcare? Has costing ever been done?</p>	<p>No costing was carried out. Costs are only known at macro level, e.g. [1]</p>

Evaluation dimension: Allocation efficiency			3	0	
In what other ways and at what costs could the effects achieved (outcome/impact) have been attained? <i>(Learning/help question)</i>	Could the infrastructure have been renovated instead of rebuilt? Should it have been built "better"? Was the right equipment supplied? Should the maintenance contracts have been paid for? Have the right people received training for the right professions? How long do the trainees stay in the profession or at the institution?	Interviews with MoHP employees and visits showed that the right buildings and equipment were supplied. Staff turnover figures are not available.			
To what extent could the effects achieved have been attained in a more cost-effective manner, compared with an alternatively designed programme?	Are there areas in which we could have saved?	Interviews at the facilities showed that the measures are regarded as appropriate throughout.			
If necessary, as a complementary perspective: To what extent could the positive effects have been increased with the resources available, compared to an alternatively designed programme?	What could have been done better? Would the use of funds have improved through additional management expertise in the facilities, MoHP and MoF?	A focus on hospital management was clearly lacking.			

Impact

Evaluation question	Specification of the question for the present project	Data source (or rationale if the question is not relevant/applicable)	Rating	Weighting (- / o / +)	Reason for weighting
Evaluation dimension: Overarching developmental changes (intended)			1	0	
Is it possible to identify overarching developmental changes to	Has the measure contributed to increasing the importance of health within policy? Did the measure strengthen the government and its management? Have national programmes been modified or further	These are mainly assessment questions, based on interviews with MoHP, MoF and donors. Overall, it is clear that the impact of the			

<p>which the programme should contribute? (Or if foreseeable, please be as specific as possible in terms of time.)</p>	<p>developed? What significance did NHSP-II have for the development of health insurance (HI)?</p>	<p>measures was extremely positive. NHSP-II is the “golden age” of co-operation, especially in terms of impact.</p>			
<p>Is it possible to identify overarching developmental changes (social, economic, environmental and their interactions) at the level of the intended beneficiaries? (Or if foreseeable, please be as specific as possible in terms of time).</p>	<p>How did the general health of the population improve during the programme? How has the situation of vulnerable groups improved? Which aspects of this can be directly attributed to NHSP-II?</p>	<p>Here again, assignment is the biggest problem. The impacts of NHSP-II on the health of the population are very likely, but not 100% attributable. The impact of 1% of the FC measure contained in NHSP-II is hardly attributable any more; the generally positive assessment was therefore queried in interviews. See above.</p>			
<p>To what extent can overarching developmental changes be identified at the level of particularly disadvantaged or vulnerable parts of the target group to which the programme should contribute? (Or, if foreseeable, please be as specific as possible in terms of time).</p>	<p>As vulnerable groups are part of the target group, they are always documented.</p>	<p>As described in the main section, the programme explicitly addresses vulnerable groups. These include mothers, children, the population in remote and rural regions, the poor, members of lower castes and certain religious affiliations.</p>			
<p>Other evaluation question 1</p>	<p>Do the facilities generally have the personnel to implement all the reforms and changes (e.g. new equipment, new tasks)? If not, what could be done? If so, how could this be strengthened?</p>	<p>The “ideas” and reforms from Kathmandu may be adequate within NHSP-II, but the population only benefits if there are people on the ground who can implement this. Their training in management is insufficient.</p>			
<p>Evaluation dimension: Contribution to overarching developmental changes (intended)</p>			<p>2</p>	<p>0</p>	
<p>To what extent did the programme actually contribute to the</p>	<p>Can a connection between health and politics establish stability and peace? If yes, what significance did NHSP-II have in this regard?</p>	<p>Health creates satisfaction and thus reduces the potential for conflict. Literature analysis and interviews (MoHP, MoF, donors)</p>			

<p>identified or foreseeable overarching developmental changes (also taking into account the political stability) to which the programme should contribute?</p>		
<p>To what extent did the programme achieve its intended (possibly adjusted) developmental objectives? In other words, are the project impacts sufficiently tangible not only at outcome level but at impact level? (e.g. drinking water supply/health effects)</p>	<p>Which of the above-mentioned health effects are particularly relevant for the population? Which of these have a special priority in the government?</p>	<p>Here, too, there is a question of attributability. The indicators have improved over the course of programme implementation. But it is not clearly proven that they improved due to NHSP-II.).</p>
<p>Did the programme contribute to achieving its (possibly adjusted) developmental objectives at the level of the intended beneficiaries?</p>	<p>Did the programme contribute to achieving its (possibly adjusted) developmental objectives at the level of the intended beneficiaries?</p>	<p>The intended beneficiaries are the vulnerable groups. As shown, they were explicitly promoted. Overall, inequality in the country has not improved. However, it is questionable what would have happened if NHSP-II had not explicitly focused on these groups.</p>
<p>Has the programme contributed to overarching developmental changes or changes in life situations at the level of particularly disadvantaged or vulnerable parts of the target group (potential differentiation according to age, income, gender, ethnicity, etc.) to which the programme was intended to contribute?</p>	<p>ditto</p>	<p>ditto</p>
<p>Which project-internal factors (technical, organisational or financial) were decisive for the achievement or non-achievement</p>	<p>How did basket funding help to achieve the development policy objectives? Which processes should have been improved? How good was the absorption capacity of the ministries?</p>	<p>See HEART mid-term review and PCR for details on system capacity. Overall, the basket in particular contributed to the success of the SWAp.</p>

<p>of the intended developmental objectives of the programme? (<i>Learning/help question</i>)</p>		
<p>Which external factors were decisive for the achievement or non-achievement of the intended developmental objectives of the programme? (<i>Learning/help question</i>)</p>	<p>What role did the earthquakes in 2015 play in achieving the goals? What role did the peace process and the new constitution play in the achievement of objectives?</p>	<p>The earthquakes extended NHSP-II by one year. Subsequently, the reconstruction measures took up a great deal of resources, meaning that some objectives were neglected after 2016. The new constitution implies federalisation and thus a more complex decision-making situation for the SWAp.</p>
<p>Does the project have a broad-based impact?</p> <ul style="list-style-type: none"> - To what extent have the programme led to structural or institutional changes (e.g.in organisations, systems and regulations)? (Structure formation) - Was the programme exemplary and/or broadly effective and is it reproducible? (Model character) 	<p>What role did NHSP-II and basket funding play in the development of health insurance? What has changed and improved due to NHSS? What does NHSP-II have to do with this? Can anything be learned from this that goes beyond Nepal?</p>	<p>According to the interviewees, the created trust provided a basis for further measures, including health insurance. Initial studies on this were carried out during NHSP-II. NHSS has filled the gaps of NHSP-II.</p> <p>Learning: see "Lessons learned" in the main section.</p>
<p>How would the development have gone without the programme (developmental additionality)?</p>	<p>What would the situation be like today without NHSP-II? Since there would have been state support in any case, the question must be more precise: if there had been no money from abroad? And what if it had been individual projects, i.e. without cooperation? How would that have affected the "partner provinces" vs. vulnerable groups?</p>	<p>Speculation, interviews. It is clear that individual projects do not have a complete overview and that there is a risk that certain groups and regions will be neglected.</p>

Other evaluation question 1	Has donor harmonisation really worked? Did the FC measure only have a 1% impact, or did it have more due to a “leveraging effect”?	The interviewees placed great importance on the fact that harmonisation worked well and that KfW was a significant partner whose impact went far beyond its financial share.
Other evaluation question 2	What significance does corruption have for the transformation of development cooperation in health?	On a macro level, the Corruption Perception Index shows an improvement in Nepal while maintaining a high level; in the healthcare sector, this implies a destruction of efficiency.

Evaluation dimension: Contribution to (unintended) overarching developmental changes			3	0	
To what extent can unintended overarching developmental changes (also taking into account political stability) be identified (or, if foreseeable, please be as specific as possible in terms of time)?	Which unintended overarching developmental changes happened that could be related to NHSP-II? Stability, democracy, corruption?	Corresponding indices; interviews with donors, MoHP and MoF for correlations. Difficult to identify. The majority of interviewees believe that social justice and reliable health care are essential for stability and democracy.			
Did the programme noticeably or foreseeably contribute to unintended (positive and/or negative) overarching developmental impacts?	Exactly in this wording.	Not measurable.			
Did the programme noticeably (or foreseeably) contribute to unintended (positive or negative) overarching developmental changes at the level of particularly disadvantaged or vulnerable groups (within or outside the target group) (do no harm, e.g. no	Equity: Has gender equality (equity) changed? Not only in terms of figures, but also in the minds of decision makers?	Interviews with donors, MoHP and MoF: overall, awareness of equality may have increased, but this cannot be demonstrated in this study.			

strengthening of inequality (gender/ethnicity)?		
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Sustainability

Evaluation question	Specification of the question for the present project	Data source (or rationale if the question is not relevant/applicable)			
Evaluation dimension: Capacities of participants and stakeholders			3	0	
Are the target group, executing agencies and partners institutionally, personally and financially able and willing (ownership) to maintain the positive effects of the programme over time (after the end of the promotion)?	Which equipment that was promoted during the NHSP-II phase is still being used for its intended purpose, is fully functional, and well maintained? Which buildings promoted during the NHSP-II phase are still being used for their intended purpose, are fully functional and well maintained? Which employees who received training during the NHSP-II phase are still working today?	As there were no procurement lists, this survey could not be carried out. However, other programmes and visits to health facilities concluded that the use was indeed relatively suitable for the purposes.			
To what extent do the target group, executing agencies and partners demonstrate resilience to future risks that could jeopardise the impact of the programme?	If not already discussed above: How resilient were the buildings and facilities in terms of earthquakes in 2015? How resilient were the health services during the coronavirus pandemic? What is staff turnover like?	MoHP, donors and facility management interviews provide a positive assessment, with the exception of the frequent personnel changes			
Other evaluation question 1	What was learned from NHSP-II for NHSS? How successful was NHSS, and what significance did NHSP-II have in this context, in particular the alignment harmonisation process in SWAp?	The PCR for NHSS (Phase III) and interviews with the MoHP and donors revealed that harmonisation worked well, especially during NHSP-II. NHSS started with this social capital. Gaps have been closed. [13]			

Other evaluation question 2	How did the budget financing in the health sector develop from 2010–2022 (own contribution budget, own contribution user / loan application, donor pooling, donors' individual projects)? What trends can be determined and why?	See Health Budget Brief (UNICEF 2020), Budget Analysis of Health Sector, or Figure 2, Figure 3.			
Evaluation dimension: Contribution to supporting sustainable capacities:			3	0	
Did the programme contribute to the target group, executing agencies and partners being institutionally, staffing-wise and financially able and willing (ownership) to maintain the positive effects of the programme over time and, where necessary, to curb negative effects?	How has the willingness of the government of Nepal changed with regard to prioritising the health of the population and, in particular, that of vulnerable groups? How has the ability of the MoHP and MoF to manage these large-scale programs developed? How has ownership developed?	The mid-term review [24] and interviews showed that the capacity of the ministry had increased sharply at first. However, after federalisation, the SWAp was no longer the priority. Furthermore, the restriction of communication during the coronavirus pandemic and the departure of decision-makers led to a loss of trust.			
Did the programme contribute to strengthening the resilience of the target group, executing agencies and partners to risks that could jeopardise the effects of the programme?	How many staff in the MoHP, MoF and facilities that had responsibilities during the NHSP-III phase are still working in the healthcare sector today?	Interviews with the MoHP, donors and facility management confirmed high fluctuation			
Did the programme contribute to strengthening the resilience of particularly disadvantaged groups to risks that could jeopardise the effects of the programme?	Was it possible to improve the health of women and children and other vulnerable groups in the long term? Has this resulted in long-term benefits (e.g. education of children, employability) that go beyond the end of NHSP-III?	Interviews with the MoHP, donor and facility management: to be assumed.			
Other evaluation question 1	What experience have the managers gained from the crises (earthquakes, coronavirus)? Would specific training in management, change management and crisis management have made a difference?	Interviews with the MoHP, donors and facility management have shown that Nepal has survived the crisis relatively well. It			

		was stressed that the basis of shared experience facilitated very close and rapid cooperation.			
Other evaluation question 2	How can demand-side factors be overcome?	Sustainable financing of HS (donor, own share, user/insurance): developments, coverage, affordable for the poor			
Evaluation dimension: Durability of impacts over time			2	0	
How stable is the context of the programme (e.g. social justice, economic performance, political stability, environmental balance)? (<i>Learning/help question</i>)	What has changed for better or for worse in the sector since the end of NHSP-II? Have previous problems weakened or new ones emerged?	Interview, NHSS PCR, health indicators since 2016: generally good development of the SWAp indicators.			
To what extent is the durability of the positive effects of the programme influenced by the context? (<i>Learning/help question</i>)	If not already done: What role did the 2015 earthquakes, coronavirus, democratisation, decentralisation and the peace process play in improving the health of the population?	Please see above.			
To what extent are the positive and, where applicable, the negative effects of the programme likely to be long-lasting?	If not already considered above: how functional are the investments in buildings, equipment and personnel after seven years?	Please see above.			
To what extent can the gender results of the intervention be considered permanent (ownership, capacities, etc.)? (FC-E-specific question)	How did the stakeholders rate gender mainstreaming and the mainstreaming of vulnerable groups?	Interviews, assessment questions: interviewees are aware of both parameters, but a measurement is not possible.			
Other evaluation questions			2	0	
Other evaluation question 1	Basically, how have health and economic statistics developed since the end of NHSP-II? What significance could the SWAp have in this context?	Interviews, assessment questions. Generally positive development. Contribution of SWAp not verifiable.			

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