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Report No: PAD5264

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROGRAM APPRAISAL DOCUMENT

ON A

PROPOSED CREDIT ON SHORT MATURITY LOAN TERMS

IN THE AMOUNT OF SDR 60.3 MILLION
(US$80 MILLION EQUIVALENT)

AND A

PROPOSED CREDIT

IN THE AMOUNT OF SDR 15.1 MILLION
(US$20 MILLION EQUIVALENT)

TO

NEPAL

FOR A

NEPAL QUALITY HEALTH SYSTEMS PROGRAM-FOR-RESULTS

April 7, 2023

Health, Nutrition & Population Global Practice
South Asia Region

This document is being made publicly available prior to Board consideration. This does not imply a presumed outcome. This document may be updated following Board consideration and the updated document will be made publicly available in accordance with the Bank's policy on Access to Information.

CURRENCY EQUIVALENTS

Exchange Rate Effective {February 28, 2023}

Currency Unit =	Nepalese Rupee (NPR)
NPR 132.27 =	US$1
US$1.33 =	SDR 1

FISCAL YEAR
July 16 – July 15

Regional Vice President:	Martin Raiser
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ABBREVIATIONS AND ACRONYMS

ACG	Anti-Corruption Guidelines
ANC	Antenatal Care
AWPB	Annual Work Plan and Budget
BEK	British Embassy in Kathmandu
BHS	Basic Healthcare Services
CAD	Current Account Deficit
CG	Conditional Grant
CGAS	Computerized Government Accounting System
CIAA	Commission for Investigation of Abuse of Authority
CPF	Country Partnership Framework
CSD	Curative Service Division
DLI	Disbursement Linked Indicator
DLR	Disbursement Linked Result
DoHS	Department of Health Services
DP	Development Partner
E&S	Environmental and Social
EDCD	Epidemiology and Disease Control Division
e-GP	Electronic Government Procurement
EMR	Electronic Medical Record
ESSA	Environmental and Social Systems Assessment
FDI	Foreign Direct Investment
FY	Fiscal Year
GCRF	Global Crisis Response Framework
GDI	Gender Development Index
GDP	Gross Domestic Product
GESI	Gender Equality and Social Inclusion
GIZ	German International Cooperation
GoN	Government of Nepal
GRID	Green, Resilient, and Inclusive Development
GRM	Grievance Redress Mechanism
H1FY2023	First Half of Fiscal Year 2023
HCI	Human Capital Index
HEOC	Health Emergency Operation Centre
HIB	Health Insurance Board
HMIS	Health Management Information System
IDA	International Development Association
IHIMS	Integrated Health Information Management Section
IMF	International Monetary Fund
IMIS	Insurance Management Information System
IRI	Intermediate Results Indicator
IVA	Independent Verification Agent

KPI	Key Performance Indicator
LL	Local Level
MoHP	Ministry of Health and Population
NHSMRP	Nepal Health Sector Management Reform Program
NHS-SP	Nepal Health Sector Strategic Plan
NPR	Nepalese Rupees
OAG	Office of the Auditor General
PEF	Program Expenditure Framework
PforR	Program for Results
PGLL	Provincial Government and Local Level
PPMD	Policy Planning and Monitoring Division
QSRD	Quality, Standards and Regulations Division
RA	Results Area
RRT	Rapid Response Team
SML	Short Maturity Loan
SuTRA	Sub-national Treasury Regulatory Application
UHC	Universal Health Coverage
UNICEF	United Nations Children's Fund
US$	United States Dollar
USAID	United States Aid for International Development
WHO	World Health Organization
Y-O-Y	Year on Year

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DATASHEET

BASIC INFORMATION

Country(ies)	Project Name	
Nepal	Nepal Quality Health Systems Program-for-Results	
Project ID	Financing Instrument	Does this operation have an IPF component?
P177389	Program-for-Results Financing	No

Financing & Implementation Modalities

[ ] Multiphase Programmatic Approach (MPA)	[ ] Fragile State(s)
[ ] Contingent Emergency Response Component (CERC)	[ ] Fragile within a non-fragile Country
[ ] Small State(s)	[ ] Conflict
[ ] Alternate Procurement Arrangements (APA)	[ ] Responding to Natural or Man-made Disaster
[ ] Hands-on Enhanced Implementation Support (HEIS)	

Expected Project Approval Date	Expected Closing Date
28-Apr-2023	15-Jul-2028

Bank/IFC Collaboration
No

Proposed Program Development Objective(s)

To improve quality of healthcare, enhance health insurance coverage for poor, and strengthen health emergency preparedness in the Selected Provinces.

Organizations

Borrower :	Nepal
Implementing Agency :	Ministry of Health and Population
Contact:	The Secretary

Title: Ministry of Health and Population
Telephone No: 00977-1-4262590
Email: info@mohp.gov.np

COST & FINANCING

SUMMARY

Government program Cost	7,424.00
Total Operation Cost	1,513.00
Total Program Cost	1,513.00
Total Financing	1,513.00
Financing Gap	0.00

Financing (USD Millions)

Counterpart Funding	**1,409.16**
Borrower/Recipient	1,409.16
International Development Association (IDA)	**100.00**
IDA Credit	20.00
IDA Shorter Maturity Loan (SML)	80.00
Trust Funds	**3.84**
Health Emergency Preparedness and Response Multi-Donor Trust	3.84

IDA Resources (in US$, Millions)

	Credit Amount	Grant Amount	SML Amount	Total Amount
Nepal	20.00	0.00	80.00	100.00
National Performance-Based Allocations (PBA)	20.00	0.00	80.00	100.00
Total	**20.00**	**0.00**	**80.00**	**100.00**

Expected Disbursements (USD Millions)

Fiscal Year	2023	2024	2025	2026	2027	2028	2029
Absolute	0.00	7.00	5.00	12.94	36.65	9.82	32.43
Cumulative	0.00	7.00	12.00	24.94	61.59	71.41	103.84

INSTITUTIONAL DATA

Practice Area (Lead)
Health, Nutrition & Population

Contributing Practice Areas

Climate Change and Disaster Screening
This operation has been screened for short and long-term climate change and disaster risks

SYSTEMATIC OPERATIONS RISK-RATING TOOL (SORT)

Risk Category	Rating
1. Political and Governance	High
2. Macroeconomic	Substantial
3. Sector Strategies and Policies	Moderate
4. Technical Design of Project or Program	Moderate
5. Institutional Capacity for Implementation and Sustainability	Substantial
6. Fiduciary	Substantial
7. Environment and Social	Moderate
8. Stakeholders	Moderate
9. Other	
10. Overall	Substantial

COMPLIANCE

Policy
Does the program depart from the CPF in content or in other significant respects?
[ ] Yes [✓] No

Does the program require any waivers of Bank policies?

[ ] Yes [✓] No

Legal Operational Policies

	Triggered
Projects on International Waterways OP/BP 7.50	No
Projects in Disputed Areas OP/BP 7.60	No

Legal Covenants

Sections and Description

The Recipient shall establish, within two (2) months from the Effective Date, and thereafter maintain throughout the period of implementation of the Program, a Program Management Unit, comprising of, inter alia, representatives of relevant divisions and centers of MoHP, HIB and Selected Provinces, assisted by competent staff, all with experience, qualification and terms of reference satisfactory to the Association, for ensuring day-to-day oversight, implementation and monitoring of results.

Sections and Description

The Recipient shall establish, within two (2) months from the Effective Date, and thereafter maintain throughout the period of implementation of the Program, a Program Steering Committee, chaired by the Secretary of Health and comprising of high-level officials from MoHP, including from its Policy, Planning and Monitoring Division, Health Coordination Division, Administration Division and DoHS, and HIB, assisted by competent staff, all with experience, qualification and terms of reference satisfactory to the Association, for supervising and guiding the Program Management Unit in Program implementation.

Sections and Description

The Recipient shall: (a) prepare, adopt and issue the Operating Guidelines within three (3) months from the Effective Date, and include in the Operating Guidelines, appropriate provisions to ensure that the terms of this Agreement are passed down to all PGs and LLs as special conditions for their respective Conditional Grants; (b) ensure that all PGs and LLs receive all relevant documents describing in detail their responsibilities in relation to the implementation of their respective activities under the Program in accordance with this Agreement; and (c) include in the Operating Guidelines the protocol for the application of the Anti-corruption Guidelines and procedures for the collection, storage, usage, and/or processing of Personal Data, in accordance with the provisions set forth in in Section V of Schedule 2 of the Financing Agreement.

Sections and Description

The Recipient shall appoint, within six (6) months from the Effective Date, and thereafter maintain, throughout the

period of implementation of the Program, the Independent Verification Agent in accordance with the terms of the MOU between the MoHP and the Independent Verification Agent.

Conditions

Type	Financing source	Description
Disbursement	IBRD/IDA	No withdrawal shall be made: on basis of DLRs achieved prior to the Signature Date, except that withdrawals up to an aggregate amount not to exceed SDR3,044,050 may ne made on the basis of DLRs achieved prior to this date but on or after July 16, 2022.
Disbursement	IBRD/IDA	No withdrawals shall be made: on basis of DLRs achieved prior to the Signature Date, except that withdrawals up to an aggregate amount not to exceed SDR1,510,410 may be made on the basis of DLRs achieved prior to this date but on or after July 16, 2022.
Disbursement	Trust Funds	No withdrawals shall be made: on basis of DLRs achieved prior to the Signature Date, except that withdrawals up to an aggregate amount not to exceed USD960,000 may be made on the basis of DLRs achieved prior to this date but on or after July 15, 2022.

I. STRATEGIC CONTEXT

A. Country Context

1. **Nepal is a landlocked country in the South Asia Region with an estimated population of 29 million** (2021). Nepal's gross national income stands at US$1,230 per capita (in 2021)[1], and it is classified as a lower-middle income country by the World Bank. Nepal has made good progress in reducing the poverty from 46 percent in 1996 to 18.7 percent in 2019, one of the fastest reductions in South Asia. The Government of Nepal (GoN) has set an ambitious target of reducing the national poverty rate to 4.9 percent by FY2030 and eliminate by FY2043.[2] These targets, however, are challenged in the present context as one-third of the population is at risk of falling back into extreme poverty mainly as the result of COVID-19 pandemic.[3]

2. **Over the past decade, Nepal's economy has demonstrated impressive growth and resilience when faced with a wide variety of economic shocks.** Movement restrictions and the almost complete shut-down of tourism during the COVID-19 pandemic resulted in Nepal's first economic contraction in almost 40 years in FY2020 (-2.4 percent). A decisive vaccine roll-out and reopening of the borders have supported the economy's recovery, with growth inching up to 4.2 percent in FY2021.

3. **The growth momentum continued in FY2022, with industries and services expanding by 10.2 and 5.9 percent, respectively.** The industrial sector benefited from higher investment rates, accompanied by a 52 percent growth in the number of new businesses registered and substantial credit expansion focused on investment. Services sub-sectors impacted by the pandemic, including transportation and accommodation services, started recovering as domestic and international air passenger numbers increased, and international tourists began to return. Higher demand and the availability of credit also drove a 42 percent increase in real-estate sales, raising real estate services. However, agricultural growth decelerated slightly from 2.8 percent in FY2021 to 2.3 percent in FY2022, reflecting a fall in main season rice paddy production following unseasonal rains in October 2021.

4. **However, the economy grew at a slower pace in the first half of FY2023 (H1FY2023).** This reflects tighter monetary policy, higher international prices, and the continuation of import restriction measures. The central bank raised the policy repo rate in February 2022 and again in August 2022, and the measures were effective at cooling credit growth and inflation. Import restriction measures were first imposed on December 29, 2021 and were continued until January 19, 2023. On the supply side, growth was driven by the services sector. Increased activity in accommodations, food services, and finance and insurance contributed to growth in the services sector, although at a slower pace than in H1FY2022. The agricultural sector also grew with an expansion in main season rice paddy production. However, industrial sector growth declined as construction activities slowed.

[1] World Bank. 2022. World Development Indicators 2022. Washington, DC: World Bank.
[2] National Planning Commission, Fifteenth Plan. (The national poverty line for Nepal estimated at NPR 19,262 per person per year in 2010, is an absolute poverty line based on the cost of basic food and non-food needs.)
[3] The World Bank, 2021. Federalism and Public Expenditure for Human Development in Nepal: An Emerging Agenda, World Bank.

5. **An uneven and slow jobs recovery poses risks to poverty reduction and can exacerbate existing inequalities.** New analysis from the second round of the World Bank's SAR COVID-19 phone monitoring survey conducted at the end of 2021 suggests that the economic contraction induced by the pandemic had continued impacts on the labor market, with 22 percent of jobs lost during 2020 still not being recovered at the end of 2021.

6. **Average consumer inflation accelerated to 6.3 percent in FY2022, buoyed by non-food and services inflation.** The average inflation increased further to 8.2 percent year-on-year (y-o-y) in H1FY2023, above the central bank's ceiling of 7 percent and the highest inflation registered since H1FY2016. Inflation has become broad-based, with food prices expanding by 7.5 percent y-o-y in H1FY2023 from 3.8 percent in the same period of FY2022, reflecting higher vegetable prices associated in part with supply shocks in India, and cereal grain prices triggered by India's export ban on wheat and rice. Similarly, non-food price inflation increased to 8.7 percent (y-o-y) in H1FY2023, primarily due to higher transportation prices associated with the increase in global energy prices, and housing and utility prices.

7. **The Nepali economy imports much more than it exports and over half of all fiscal revenues are trade related**. Expansive monetary policy and sluggish remittances following the pandemic led to a wide current account deficit (CAD) of 12.8 percent of GDP in FY2022. Although reserves are deemed adequate, as they approached the policy floor of 7 months of import cover the government raised the policy rate, imposed a ban on the import of selected goods in April 2022, and raised letter of credit and cash backing requirements on imports. These import restrictions reduced the CAD and stabilized foreign exchange reserve stocks as intended in H1FY2023. The unintended consequences include a steep drop in fiscal revenues and slower growth in H1FY2023 as capital goods imports fell below FY2021 pandemic levels. Import restrictions were gradually lifted, with the final restrictions removed in January 2023. Worker migration has recovered, and H1FY2023 remittances were 13.9 percent higher in nominal dollar terms than during H1FY2022.

8. **The fiscal deficit narrowed to 3.5 percent of GDP in FY2022, driven by capital budget under-execution, delayed passage of the FY2022 budget, and greater trade-related revenues associated with elevated imports**. This trend changed quickly as the fiscal balance turned negative in H1FY2023 for the first time in five years. Fiscal revenues fell and expenditures were driven by one-off electoral spending and higher public wages. Consecutive fiscal deficits have increased the debt to GDP ratio from 22.7 to 41.5 percent from FY2017 to FY2022, roughly half of which is highly concessional external debt. The risk of debt distress is assessed as low per the Joint Bank-Fund Debt Sustainability Analysis of December 2021.

9. **As growth underperformed in H1FY2023, the baseline forecast has been adjusted downwards**. The forecast projects growth declining to 4.1 percent in FY2023 before accelerating once again to 4.9 percent growth in FY2024 and further to 5.5 percent growth by FY2025, close to the country's long-term potential growth rate. The services sector is expected to continue to be the primary driver of real GDP growth over the medium term, slowing to 5.2 percent in FY2023 then averaging 5.8 percent in FY2024-FY2025. Agricultural sector growth is projected to average 2.6 percent per year over FY2023-FY2025 reflecting increased rice paddy production in FY2023 and a five-year agreement on the supply of chemical fertilizers between the governments of India and Nepal signed in February 2022. Industrial sector growth is envisioned to pick up as newly commissioned hydroelectric power plants drive electricity production higher and boost industrial growth in the medium term.

B. Sectoral (or Multi-Sectoral) and Institutional Context

10. **Nepal has achieved some gains in human capital over the past decades.** Besides improvement in learning outcomes, these gains are attributed to improvement in child and adult survival rates and reduction in stunting of under five children. Life expectancy at birth has increased to 69 years in 2020, up from 39 years in 1960, and fertility rate decreased from 5.2 per woman in 1990 to 2.1 in 2020.[4] Under five mortality rate has declined from 91 in 2001 to 33 per 1,000 live births in 2022 and maternal mortality ratio declined from 553 in 2000 to 186 per 100,000 live births in 2017. Stunting of under five children declined from 57 percent in 1990 to 36 percent in 2016 and further to 25 percent in 2022.[5] The gains are reflected in Nepal's Human Capital Index (HCI) score which is at 0.505 in 2020, an improvement from 0.49 in 2018. This means that a child born today in Nepal will be half as productive as she would otherwise be with full health and education when she reaches the age of eighteen years. On HCI, Nepal stands in second position in South Asia after Sri Lanka (0.598). Success in addressing gender disparity is reflected is Nepal's gender development index (GDI) which is 0.886.[6] In 2018, for which cross country comparable data are available, Nepal's GDI was higher than that of average of South Asia (0.828) and least development countries (0.869).[7]

11. **Access to some basic reproductive, maternal, neonatal and child health services has improved over the last decades.** Eighty-one percent of women had at least 4 antenatal care (ANC) visits for their most recent live births in 2022 compared to 9 percent in 1996. Access to ANC from a skilled provider increased from 25 percent in 1996 to 94 percent in 2022. The percentage of women whose most recent live birth was protected against neonatal tetanus increased from 84 percent in 2006 to 93 percent in 2022. The percentage of live births assisted by a skilled provider increased markedly, from 10 percent in 1996 to 80 percent in 2022. Eighty percent of 12-23 months children were fully vaccinated with basic antigens[8] in 2022.

12. **Although significant progress in healthcare services is evident, challenges remain.** Some indicators have stagnated or only slightly improved or even declined in the recent past. For example, although the use of modern methods of contraception increased from 26 percent in 1996 to 44 percent in 2006, it remained steady at 43 percent from 2011 to 2022. Neonatal mortality stands at 21 per 1,000 live births from 2016 to 2022. Exclusive breastfeeding of children under six months declined from 66 percent to 56 percent between 2016 to 2022. Prevalence of anemia in children 6-59 months is still high at 43 percent in 2022, only down from 48 percent in 2006. Moreover, there are variations in healthcare access and outcomes by Provinces, income quintiles, rural-urban location and educational attainment of mothers. Overall, health indicators are poorer in lower income quintiles, women with no education, and in the Madhesh Province (**Table 1**).

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[4] https://data.worldbank.org
[5] Nepal Demographic and Health Survey 2022 Key Indicators Report
[6] National Planning Commission, 2020. Nepal Human Development Report 2020, Beyond Graduation: Productive Transformation and Prosperity.
[7] UNDP, 2019. Human Development Report 2019, Beyond income, beyond averages, beyond today: Inequalities in human development in the 21st century, UNDP, New York.
[8] One dose of BCG vaccine, which protects against tuberculosis ▪ Three doses of polio vaccine given as oral polio vaccine (OPV) ▪ Three doses of DPT-containing vaccine, which protects against diphtheria, pertussis (whooping cough), and tetanus ▪ One dose of measles-containing vaccine given as measles rubella (MR)

13. **Despite increased availability of services in the past few decades, the management of delivering quality healthcare remains poor.** Nepal Health Facility Survey in 2015 and 2021 showed that adherence to tracer standards for delivering quality care did not improve, with less than one percent of facilities having each of the nine tracer items in both years.[9] Maintenance of biomedical equipment has been a challenge. Insufficient knowledge about operating devices, lack of maintenance experts, inappropriate referral systems for repair and lack of spare parts influence the availability, functionality, and utilization of equipment.[10] The MoHP introduced the minimum service standards in 2015 as a framework for continuous improvement of quality at the point of delivery. Minimum service standards implementation was initiated in 2018 in secondary hospitals and has been expanded covering nearly all existing hospitals at different levels; however, the pace of roll out at primary level facilities (LL hospitals and health posts[11]) is quite slow, and with a rapidly increasing number of these facilities, the coverage gap is likely to increase.

Table 1: Key health indicators by urban-rural, Provinces, wealth quintiles and educational status

Variables	Modern contraceptive prevalence rate (percent)	4 ANC check-ups (percent)	Gap between 1 ANC and 4 ANC visits (percent)*	Delivered by a skilled health provider (percent)	Women with a postnatal check during the first 2 days after birth (percent)	Treated with complete dose of gentamicin for possible severe bacterial infection in 0-2 months children (percent)*	Full immunization- basic antigens (percent)	Stunting of under five children (percent)	Advice or treatment sought for children with fever (percent)
Residence									
Urban	40.7	79.5		81.4	71.6		79.8	21.5	79.9
Rural	46.8	82.4		77.5	67.6		80.3	31	74.3
Provinces									
Koshi	43.5	78.8	21.4	81.8	77.3	37.8	80.8	20	76.2
Madhesh	40.5	68.4	33.8	67.9	57.8	16.6	67.7	29.3	88.7
Bagmati	44.6	88.8	11.6	86.6	73.9	25.2	83.4	17.6	75.5
Gandaki	35.1	84.6	9	89.2	76.4	22.8	93.4	19.7	72.1
Lumbini	43	86.9	19.3	86.9	77.2	61.9	85.3	25.1	78.5
Karnali	45.9	79.1	16.5	72.3	57.9	65.2	84.3	35.8	70.2
Sudurpaschim	47	90	18	87.8	77.7	69	88.8	28.4	70.5
Wealth quintiles									
Lowest	44.7	74.5		67	55.5		75.8	36.9	68.4
Second	46.9	76.7		73.1	65.4		74.1	28.4	73.7
Third	44.4	77.7		81.2	71.4		85	22.3	82.4
Fourth	38.7	84.5		88	77.7		85.2	17.7	88.5
Highest	39	92.6		97.4	87.1		82.8	13.1	79.1
Educational status									

[9] Those items were related to soap and water, waste disposal, trained staff, QA guidelines, clinical protocols, basic amenities, waiting room and tracer medicines.
[10] Thapa, R., Yih, A., Chauhan, A. et al. Effect of deploying biomedical equipment technician on the functionality of medical equipment in the Government hospitals of rural Nepal. Hum Resour Health 20, 21 (2022). https://doi.org/10.1186/s12960-022-00719-y.
[11] Health Post: Primary level health facility below a hospital staffed by paramedics and nurses providing basic healthcare services and has been recategorized as Basic Health Service Centre.

No education	54.3	67.2		60.9	55.9		65.8	36.3	82
Basic education	42.4	75.7		74.8	64.4		80.5	27.5	77
Secondary	32.9	88.6		90.9	78.6		86.3	17.6	77.5
More than secondary	32.7	93.4		96.2	91.9		84.1	12	72.8
Total	**42.7**	**80.5**	**19.9**	**80.1**	**70.2**	**50**	**80**	**24.8**	**78**

Source: Nepal Demographic Health Survey 2022 and *derived from annual Report of Department of Health Services 2021

14. **Nepal started digitization of its Health Management Information System (HMIS) in 2014 and introduced District Health Information Software (DHIS2) platform in 2017.** Currently, all 753 municipalities and 2,164 health facilities (around one-third of all) report monthly online on DHIS2.[12] An e-Health Strategy-2017 and its Implementation Roadmap have emphasized MoHP's ambition to digitize health data systematically and comprehensively by introducing and expanding an Electronic Medical Record (EMR) and Electronic Health Record for hospitals and electronic health database for recording and reporting at the lower-level facilities. Though most secondary and higher hospitals have digitalized their information system and implemented EMR using different proprietary software, in the absence of standards, these are not uniform in terms of the services and information they capture, and the individual hospital systems are also not linked. Health sector needs to ensure interoperability of the existing management information systems (electronic logistic management information system (eLMIS) and HMIS) and EMR for generating comprehensive evidence to inform policies and implementation.

15. **With low levels of public spending[13] on health, Nepal's health system financing is reliant on household out of pocket (OOP) expenditure** -- representing 58 percent of current health expenditure -- greater than the recommended Universal Health Coverage (UHC) benchmark of 15–20 percent of current health spending.[14] The share of OOP spending on health is highest among the low quintile households. In 2016, 10.7 percent of the population spent more than 10 percent of their household's total income on healthcare putting them at high risk of financial catastrophe and 2 percent of the population were pushed into poverty (at Purchasing Power Parity of US$1.90 per day level)[15] due to spending in health.

16. **Under the new Federal structure, health is a concurrent function between the three levels of Government – Federal, Provincial, and Local-- and conditional grant (CG) is a constant financial source for the Provincial Government and Local Levels (PGLLs) to finance the healthcare services.** The primary function of the Federal Government is to set national level goals, policies, legal framework and standards for the health sector, finance basic healthcare services (BHS) and provide tertiary level services. Provinces also perform similar functions to the Federal level but within their own territory and under the policy and legal provisions defined by the Federal level. Delivering BHS free of charge to users is an exclusive function of the Local Levels (LLs). With the Federal restructuring, public health facilities are being expanded up to the ward level, but their functionality, quality and efficiency remain poor. The MoHP developed a guidance document for LLs to facilitate designing of health programs aligned with national targets and tailored to the local context as per available evidence while promoting a participatory

[12] DoHS Annual Report, 2021.

[13] Government spending in health stood at 1.1 percent of GDP or 24 percent of current health expenditure, equivalent to 13.21 US$ per capita in 2019.

[14] World Health Organization. 2010. World Health Report: Health Systems Financing: The Path to Universal Coverage. Geneva: WHO.

[15] WHO, 2021. Monitoring progress on universal health coverage and the health-related Sustainable Development Goals in the South- East Asia Region: 2021 Update, WHO South-East Asia Region.

approach for a seven-step planning process.[16] Currently, Nepal's public sector healthcare delivery system has nearly 7,000 healthcare facilities[17] offering different levels of care, in addition to those in the non-public sector.[18]

17. **The MoHP has developed the fourth medium-term strategy: Nepal Health Sector Strategic Plan (NHS-SP; 2022-2030), in consultation with development partners (DPs).** It recognizes the shortcomings in the system, and based on lessons from the pandemic, among others, it strives to build a more resilient health system. Similarly, the MoHP has drafted the National Health Financing Strategy 2021-2031 with a two-pronged aim to ensure financial resources for healthcare services and reduce financial risks of the citizen's while seeking healthcare – quite aligned with the priorities in the NHS-SP.

18. **The National Health Insurance Scheme, introduced in 2016, is a major initiative of the GoN to improve access to healthcare services as well as financial protection in health, but its implementation is slow and marred with challenges.** Despite being mandatory by the Health Insurance Act and implemented across 77 districts, the total population coverage by the insurance scheme is only 23 percent. Renewal rates are between 50 to 85 percent amongst Provinces. The national health insurance scheme's benefits package has been designed to cover secondary outpatient and some inpatient healthcare services but has yet to be clearly distinguished from the BHS and other vertical programs. The Health Insurance Board (HIB) requires annual premiums to be paid by households which are neither poor nor belong to exempted categories of ultra-poor families, families of individuals with medical conditions of multi-drug resistant tuberculosis, HIV, leprosy, severe disability, and population >70 years of age and provides health services as defined in the benefits package equivalent to 27.6 percent of average household consumption in Nepal.[19] Poor people are subsidized by the Government, however absence of timely identification and verification of ultra-poor households has led to low enrollment of these households which are most likely to either incur catastrophic OOP expenditure or forgo care due to medical costs. The HIB lacks a well-organized institutional structure to deliver on its mandate. Requisite and well capacitated human resource is lacking. Claims are not digitized, and slow and low settlement of claims have led to a payment backlog of millions of US$ equivalent to be paid to hospitals at the end of FY2022. As a result, some large hospitals have begun suspending their services for the insured resulting in poor coverage of healthcare services through the insurance scheme.

19. **Nepal's diverse geo-climatic system makes it vulnerable to a myriad of climatic-related risks, including increased outbreaks of water and vector borne diseases.** However, the health system's preparedness and capacity to manage changes in hazards, exposure, and susceptibility impacting health outcomes is low. Nepal's geo-climatic system, which combines heavy monsoons, steep terrain, and remoteness, renders the country vulnerable to natural disasters.[20] Millions of Nepalese are estimated to be at risk from the impacts of climate change including reductions in agricultural production, food insecurity, strained water resources, loss of forests and biodiversity, reduced tourism and damaged

[16] MoHP, 2018. Guidelines for health sector annual planning and budgeting at the local level, MoHP, Kathmandu.

[17] There are 30 hospitals managed by Federal Government, 69 hospitals by Provincial Government, and 79 primary hospitals, 267 primary healthcare centers and 6,319 other types of primary healthcare facilities under the LLs. (Annual Report 2019-20, Ministry of Health and Population / Department of Health Services, Nepal)

[18] There are 2,519 hospitals and healthcare facilities run by private entities, and communities and cooperatives. (DOHS Annual Report 2019-20)

[19] The annual average consumption of a Nepalese household is NPR. 362,617. Data source- Annual Household Survey FY2017

[20] *https://climateknowledgeportal.worldbank.org/country/nepal/vulnerability#:~:text=Nepal's percent20diverse percent20geo percent2Dclimatic percent20system,hampered percent20by percent20poverty %20and percent20disempowerment.* Accessed on Aug 02, 2022.

infrastructure and their associated impacts on health.[21] Climate change is expected to increase temperatures in the country, driving increases in vector and water borne diseases. Vectors– in particular mosquitoes – are highly sensitive to climate. Analyses estimate that climate change will put an additional 600,000 people at risk of malaria and an additional 400,000 at risk of dengue. This is on top of an already very high burden of vector-borne diseases that are endemic in the lowland Terai and hills of Nepal with an estimated 80 percent of the population at risk.[22] Risks to health outcomes from climate are not evenly distributed in the population, with some groups, especially the poor and marginalized, at greater risk than others. Epidemic crises, usually exacerbated by climate change, are frequent demanding permanent institutional arrangements for epidemic response.[23] Given Nepal's high exposure to climate risks and that the nation's health infrastructure is not adequately prepared to effectively adapt to climate change – there is a need to strengthen climate change adaptation. In response the Government developed the National Climate Change Policy (2019), which identifies health, drinking water, and sanitation as one of the priority sectors for climate change adaptation, as well as mechanisms for preparedness, forecasting and prevention to avoid the epidemic of vector-borne and communicable diseases induced by climate change.[24] The policy implementation is, however, far from complete, requiring greater strengthening of capacities and coordination and accountability arrangements at the Federal, Provincial and LLs and increased integration of adaptive actions into the Provincial and Local plans.

20. **The COVID-19 pandemic exposed inadequacies in Nepal's health system, particularly in its readiness to mitigate the impact of the unprecedented health crisis.** The health system was badly affected due to the disruption in global supply chain of medical products, including closure of the borders and restrictions on internal movements, during the COVID-19 pandemic.[25, 26] Hospitals were overstretched and not able to cater to increased demand. Although existing institutional structures such as health emergency operations centres (HEOC) and health desks at point of entry were made functional and Rapid Response Teams (RRT) were formed, their capacity and functionality remained relatively poor due to limited resources.

21. **Nepal's overall health emergency preparedness capacities are low.** The institutions, structures, policies, and plans related to health emergency preparedness and response remain quite limited, and the priority and resources accorded are quite low, at the PGLLs. Nepal's current multi-disease surveillance is largely limited to an Early Warning and Reporting System, and a hospital-based sentinel surveillance system, with 118 sentinel sites reporting.[27] Apart from disease specific surveillance implemented by responsible agencies (e.g., for HIV and tuberculosis), there are also some efforts on event-based surveillance which relies on internet based, facility based and community-based reporting. The MoHP aims to integrate disease surveillance and expand its network to LLs and communities to make it more comprehensive, efficient, and effective. Given the impact of climate change on shifting disease patterns, the MoHP proposes to initiate a climate sensitive prioritized disease surveillance system. In 2021, 12 percent of the facilities had a rapid response team while only 6 percent of facilities reported

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https://climate. MoHP.gov.np/34-scroll/index.php?option=com_content&view=article&id=160&catid=2.

[22] Dhimal. M, et al, (2015). Climate Change and Spatiotemporal Distributions of Vector-Borne Diseases in Nepal – A Systematic Synthesis of Literature. PLoS One 10(6): e0129869.

[23] MoHP. Progress of the Health and Population Sector: National Joint Annual Review Report 2021.

[24] GoN. National Climate Change Policy, 2019,

[25] MoHP 2022. Health Sector Response to COVID-19 Pandemic in Nepal.

[26] https://www.theguardian.com/world/2021/may/10/hopeless-situation-oxygen-shortage-fuels-nepal-covid-crisis

[27] DoHS Annual Report, 2021

having an outbreak management plan.[28] The World Health Organization (WHO) proposes strengthening of the laboratory network in Nepal, including information systems in support of NHS-SP's vision of at least 90 percent of the district labs having a facility for blood culture and viral/ anti-microbial resistance testing.

C. Relationship to the CPF and Rationale for Use of Instrument

22. **The Program is aligned with the World Bank Group's Nepal Country Partnership Framework (CPF) FY2019–FY2023 (Report No. 83148-NP) discussed by the Board of Executive Directors on August 7, 2018 and extended to FY2024 by the corresponding Performance and Learning Review (Report No. 168048-NP).** By improving health facilities readiness for providing quality healthcare services, the proposed operation is aligned with 'Strengthened institutions for public sector management and service delivery' (Objective 1.2) under 'Public Institutions' Focus Area 1 of the CPF. The Program also contributes to 'Improved access to services and support for the well-being of the vulnerable groups' (Objective 3.2) and 'Increased resilience to health shocks, natural disasters, and climate change' (Objective 3.3) under 'Inclusion and Resilience' Focus Area 3 of the CPF. It will improve health insurance coverage for the poor and vulnerable and strengthen health systems preparedness and response during health emergencies. The Program is also aligned with the World Bank Nepal Country Climate and Development Report 2022, which highlights the importance of engaging communities in climate and health assessments and health emergency planning and strengthening health information and surveillance systems to reduce climate-related health risks.

23. **The proposed Program will contribute to the green, resilient, and inclusive development (GRID) agenda in Nepal.** The technical design offers potential opportunities for (i) initiatives that will lead to positive impact for a greener environment, (ii) climate change actions at health systems level contributing to resilience, and (iii) addressing the disparities in access to health benefits and promoting inclusion. The opportunities have been exemplified in the proposed interventions and results under the three results areas of the Program.

24. **Finally, the Program is aligned with the World Bank Group's Global Crisis Response Framework (GCRF), Pillar 2: Protecting People and Protecting Jobs, and Pillar 3: Strengthening Resilience.** Under Pillar 2, DLI 1 will ensure quality of healthcare service delivery (US$39million), DLI 2 will digitize health information on patient centric electronic medical record system for provision of informed healthcare (US$8 million), DLI 3 will enhance enrollment of poor and vulnerable population into health insurance scheme and ensure equity of healthcare (US$27 million) and DLI 4 will improve efficiency of insurance systems by timely settlement of claims (US$6 million). Under Pillar 3, DLI 5 will support crisis and pandemic preparedness and healthcare response during disasters and public health emergencies (US$20 million), and DLI 6 will support climate sensitive prioritized disease surveillance system (US$3.84 million).

25. **Rationale for use of instrument:** The Program for Results (PforR) has been considered as the appropriate financing instrument for this operation for the following reasons:

   a. The Disbursement Linked Indicators (DLIs) of the Program can provide a stronger focus on accountability for results and outcomes, incentivize Government's ownership, and accelerate implementation of critical reforms and policies in the health sector;

[28] Nepal Health Facility Survey 2021.

b. The instrument further strengthens the use of multi-level country systems supporting the operationalization of federalism in line with the CPF priorities;
c. The MoHP is already experienced with DLI-based operations funded by the Bank and other DPs; and
d. The PforR provides several advantages over Investment Project Financing (IPF) instrument in terms of flexibility and efficiency in supporting a fairly large national program, which is built on the foundation of successful sector programs that the Bank has financed.

II. PROGRAM DESCRIPTION

A. Government program ("p")

26. **The Government program ("p") is defined in the NHS-SP, the major vehicle to implement the National Health Policy 2019 to achieve Sustainable Development Goals by 2030.** The NHS-SP is the first sector plan after the federal restructuring and is envisaged as a strategic instrument to address major unfinished health system agendas towards achieving UHC in the federalized structure of Nepal. The NHS-SP has been devised carrying on the aspirations of the constitution, the Fifteenth Plan, and Nepal Public Health Service Act 2018 among others, and it builds on successes of and incorporates learnings from prior sector programs and the COVID-19 pandemic response. Outcomes and Outputs under each NHS-SP objective mapped to Program Result Areas are detailed in Annex 3.

B. Theory of Change

27. **The Nepal Quality Health Systems Program for Results (PforR) aims to support the MoHP in implementing the NHS-SP 2022-2030,** by providing support to improve quality of healthcare, enhance health insurance coverage, and strengthen health emergency preparedness for the period of five years, FY2024-2028. The Program's Theory of Change illustrates select health systems challenges (which have been considered critical in having a collective impact on the health systems performance) as well as the Program inputs required to achieve the expected outputs and outcomes leading to the long-term outcomes (**Table 2**).

Table 2: Program Theory of Change

Priority Issues/challenges for the Program	Inputs	Outputs and Intermediate Results	Outcomes	Long Term Outcomes
RA1: Improving readiness of healthcare delivery system and quality of care				
Inadequate readiness of health facilities to deliver quality health services Lack of unified patient centric	Conduct analysis of minimum service standards of Provincial hospitals Provide support (supplies, medicines, training, SOPs, infrastructure, bio-medical equipment maintenance, health care waste management) to health	Program-Supported Health Facilities are implementing minimum service standards **(Intermediate Results Indicator (IRI) 1.1/ Disbursement Linked Result (DLR) 1.1)** Provincial public health facilities in Selected Provinces have minimum service standards score of at least 85% **(IRI 1.2/DLR 1.2)**	Average reduced gap for pregnant women with 1 ANC visit and 4 ANC visits in Selected Provinces **(Key Performance Indicator – KPI-**	▪ Health outcomes with improved quality and equity

data for integrated care	facilities to improve minimum service standards score Strengthen Nepal Drug limited to scale up manufacturing of essential drugs Selected health facilities provided with training, IT equipment, internet connectivity, and training for EMR Resources (expertise, financing) for developing electronic medical record system compatible with DHIS2/HMIS Ensure interoperability of existing MIS (HMIS, eLMIS, EMR)-integrated HMIS	Bio-medical equipment repair and maintenance system established and functional in two Selected Provinces **(IRI 1.3/ DLR 1.3)** Hospitals in the two Selected Provinces have functional healthcare waste management system **(IRI 1.4/ DLR 1.4)** Memorandum of understanding signed between MoHP and Nepal Drug Limited for purchase of essential medicines **(IRI 1.5/DLR 1.5)** Local Levels in each Selected Province have implemented social audits (**IRI 1.6/DLR 1.6**) EMR standards adopted by MoHP **(IRI 1.7/DLR 2.1)** EMR implemented by Program-Supported Health Facilities **(IRI 1.8/ DLR 2.2)**	**1)** Average percentage of children 0-2 months of age suspected of severe bacterial infection treated with complete doses of gentamicin injection **(KPI 2)** In-patients in Program-Supported Health Facilities have EMR records **(KPI 3/ DLR 2.3)**	
RA2: Improving health insurance coverage and effectiveness				
Low and inequitable enrollment in health insurance Inefficient health insurance management	Develop a framework for identification of poor and vulnerable households into health insurance Activation and mobilization of Provincial and LLs Insurance Coordination Committee to identify and enroll poor households into Health Insurance program Enhanced communication and citizen engagement for enrollment of population into health insurance Improve the readiness of LL health facilities to be empaneled in the insurance Operationalize inclusion of formal sector as per policy/regulations	Framework for identification of poor and vulnerable households developed and adopted by MoHP (**IRI2.1/DLR 3.1**) Program supported LLs have identified to enroll poor and vulnerable population as per the framework into the health insurance program LLs are engaged in enhanced enrollment drive through communication outreach and citizen engagement LLs have at least one empaneled health facility Health insurance claims from Selected Provinces settled in time **(IRI 2.2/DLR 4.1)**	Poor and vulnerable households in Selected Provinces enrolled in the health insurance program (with share of female headed households) **(KPI 4/ DLR 3.2)**	▪ Reduced impoverishment due to healthcare spending

	Provision of required human resource and capacity enhancement Digitize benefit package for claims management Capacity building measures to enhance organizational capacity of HIB, including Provincial and LLs /facilities, including digitization of claims.			
RA3: Enhancing health emergency preparedness and response capacity at Province and Local Levels				
Province and LLs structures and systems for health emergency preparedness and response are inadequate	Provide trainings and capacity enhancement to selected Provinces and LLs to develop, implement, and monitor health emergency preparedness plans, including healthcare waste management, life and fire safety Establish and expand integrated disease surveillance system- real time, indicator and event based Pilot climate sensitive prioritized disease surveillance system Form RRT at PGLLs	Selected Provinces and Local Levels have developed health emergency preparedness and response plans **(IRI 3.1/ DLR 5.1)** Climate sensitive prioritized disease surveillance system established in two Selected Provinces **(IRI 3.2/DLI 6)**	Functional rapid response teams established in Selected Provinces and Local Levels **(KPI 5/ DLR 5.2)**	▪ Resilient public health systems

C. PforR Program Scope

28. **The proposed PforR Program ("P") comprises of selective systems strengthening interventions and results aimed at contributing to the first five years of the NHS-SP, the Government program.** NHS-SP and Program objectives and results areas are described in Table 3. The proposed Program will support outcomes/results associated with three of the five strategic objectives of NHS-SP (Strategic Objectives 1, 3 and 4).

29. **To achieve the PDO, the Program will support selected components of health systems, not only to provide impetus to ongoing but slow-moving reforms from the current sector program, but also to introduce critical new reforms for stronger and more resilient healthcare system.** The Program has three interlinked Results Areas (RA) that reinforce their individual contributions to the high-level outcomes and development objectives. The areas are – RA1: Improving readiness of healthcare delivery system and quality of care; RA2: Improving health insurance coverage and effectiveness; and RA3: Enhancing health emergency preparedness and response capacity at PGLLs.

Table 3. Scope of Government program and Program supported by the PforR

Areas	Government program	Program supported by the PforR	Reasons for non-alignment
Objective	To improve the health status of every Nepali citizen.	To improve quality of healthcare, enhance health insurance coverage for poor, and strengthen health emergency preparedness in the selected Provinces	Fully aligned to the Government program but supporting select objectives (a sub-set) and selected Provinces only.
Duration	2022-2030	2024-2028	Supporting first phase of the program.
Geographic coverage	National	- Interventions at the Federal level to develop policy guidelines, tools, processes and mechanisms essential to deliver Program results. These can benefit the whole country. - Testing and scaling up of health system interventions to deliver Program results in two of the seven Provinces: Koshi and Gandaki	The Provinces were selected strategically to demonstrate Program results.
Results areas	Defined by five Strategic Objectives of NHS-SP	Three results areas of the Program contributing to Strategic Objectives 1, 3 and 4 of NHS-SP	The Program focuses on key health sector related determinants, namely quality and equitable access to health services reflected in Strategic Objectives 1,3, and 4.
Overall Financing	US$7.42 billion for the first five years of the program	US$1.51 billion (Bank's financing: US$100 million IDA concessional credits and US$3.84 million Trust Fund grant)	Program boundary and expenditure framework are a defined as sub-set of Government program.

RA 1: Improving readiness of healthcare delivery system and quality of care (US$46 million equivalent)

30. **This RA will support the GoN's prioritized and inter-related reform areas to improve health facility readiness for quality healthcare service delivery at public sector health facilities.** It will focus on minimum service standards to ensure that key inputs (for example, equipment, instrument, and supplies to carry out services are available and functioning; required training for healthcare workers; standard operating procedures; etc.) are in place for the provision of quality health services (DLRs 1.1 and 1.2). Minimum service standards ensure the supply side readiness in maternal and neonatal and childcare. RA

1 will also support: the establishment of biomedical equipment repair and maintenance systems in selected Provinces (DLR 1.3); the establishment of a functional health care waste management system in selected Provinces (DLR 1.4); promoting the availability of drugs through a memorandum of understanding between the MoHP and the Nepal Drug Limited (DLR 1.5); and social audits in selected Provinces (DLR 1.6). These interventions will help the public sector health facilities in the selected two Provinces to universally adopt and implement the nationally defined minimum service standards framework to ultimately improve the quality of healthcare delivery.

31. **Timely, reliable, actionable data is essential for delivering interventions to improve the health of populations.** This RA will also build on the momentum of health data systems strengthening, mainly with regards to digitizing health data to increase data quality and use, enhance efficiency of health systems, and improve quality of healthcare. RA1 will support designing, developing, and implementing an EMR system, according to MoHP guidelines, in public hospitals of selected Provinces (DLRs 2.1, 2.2 and 2.3). The collection, use and processing (including transfers to third parties) of any personal data collected under the Program will be done in accordance with the national law and best international practices, and legitimate, appropriate, and proportionate treatment of such data will be ensured.

RA 2: Improving health insurance coverage and effectiveness (US$33 million equivalent)

32. **This RA will focus on both demand and supply side interventions for increased and sustained coverage of health insurance particularly among poor and vulnerable population groups, while pursuing institutional reforms to strengthen the insurance system.** The Program will support reforms such as development/adoption by MoHP of a Health Financing Strategy (prior result) and a Standard Framework to be deployed by LLs in selected Provinces to identify and enroll poor and vulnerable households into the health insurance scheme (DLR 3.1). Targeting mechanisms, and communication and mobilization strategies to identify and enroll poor and vulnerable households into the Program, including those at great risk of climate-induced outbreaks and events, will be defined by and implemented through the LLs in the interim until the identification of ultra-poor households by other GoN ministries is completed fully. The Program will also support targeted capacity building measures to enhance organizational capacity of HIB. Timely settlement of health insurance claims will be incentivized (DLR 4). The insurance management information system will be strengthened and, to boost its efficiency, interlinked with EMR where the latter is implemented (linked to RA 1). Health insurance staff and mobilizers will be trained for effective operations (such as on enrollment, claim review, data handling, motivating clients), as well as advocacy with PGLLs (for example, to activate/ functionalize coordination and support committees at their level, to implement and finance targeting strategies, etc.) and communication interventions and campaigns targeted at beneficiaries to create demand and enhance population enrollment. Pro-poor targeting and intensive advocacy and communication efforts will reduce attrition and incentivize beneficiaries to enroll in the health insurance scheme while more efficient systems and timely settlement of claims will attract more providers in the scheme, thereby helping expedite and sustain the population coverage of the national health insurance scheme. This will ensure increased demand for maternal, neonatal and child healthcare services and through RA 1 help improve the lagging indicators.

RA 3: Enhancing health emergency preparedness and response capacity at Province and Local Levels (US$24.84 million)

33. **RA 3 will support targeted actions at selected Provinces and LLs, ensuring effective and sustainable structures and mechanisms for health emergency preparedness and response.** This will ensure that health emergency preparedness at Provincial and LLs is strengthened through trainings and capacity building activities to develop, implement, monitor their preparedness plans. RA3 will focus on establishing and expanding both breadth and depth of the disease surveillance system. The number and types of diseases and events covered for surveillance will be expanded under one system (reducing fragmentation) and contextualized to ecological zones and Provinces, while the reach of the surveillance will be expanded from limited sentinel sites to all LLs. Selected Provinces and LLs will develop health emergency preparedness and response plans (DLR 5.1). It will also ensure functional RRTs have been established in selected Provinces and LLs (DLR 5.2). The simulation drill will entail a prior table-top exercise which will take into account the evolving climate -sensitive diseases and the tools needed to respond to it. The interventions under this area will support systematic formation, capacity building, equipping and deployment of RRTs as per the new national guidelines at Provincial and LLs in the two Provinces. This will be backed by pre-positioning of essential equipment, medical commodities and supplies for emergency mobilization as well as regular simulation exercises to sustain the capacity built. It will also support establishment of climate sensitive prioritized disease surveillance system at two sites of selected Provinces (DLI 6). It consists of developing and integrating climate sensitive prioritized disease surveillance into the existing surveillance and early warning systems.

34. **The geographic focus of the Program is on two of Nepal's seven Provinces – Koshi and Gandaki – to deliver key results of the Program while Federal level interventions will benefit the whole country.** Interventions at the Federal level, such as the development of policy guidelines, tools, structures and mechanisms essential to deliver Program results can be used nationally, benefiting the whole country. In the two selected Provinces, testing and scaling up of health system interventions will be undertaken to deliver Program results. Koshi and Gandaki have been selected because they cover 25 percent of country's population, house more than 25 percent of health facilities, score low on multi-dimensional poverty index, contribute to 25 percent of GDP,[29] cover all three ecological zones and have better health systems strength (human resources) to demonstrate reforms stipulated in the Program.

Program Expenditure

35. **Of the US$7.42 billion of the Government program cost, the Program is costed at US$1.51 billion for the period of FY2024 to FY2028.** Federal Government is the main financier of the Program, with US$103.84 million contribution from the Bank comprising an IDA Short Maturity Loan (SML) of US$80 million, IDA concessional loan of US$20 million and a Health Emergency Preparedness and Response (HEPR) Trust Fund Program grant of US$3.84 million (**Table 4**). The scope of the Program is supporting all federally funded and executed activities to be implemented directly by Federal spending units and federally funded health CGs to the two selected PGLLs as far as they relate to the Program results areas. These have been identified in the Program Expenditure Framework (PEF) (discussed in the Technical Assessment section and in Annex 3).

Table 4: Program Financing by Source of Financing

Source	Amount (US$ Million)	percent of Total
Government financing	1,409.16	93.1

[29] Census 2021, Nepal.

International Development Association (IDA)	**100.00**	
IDA SML	80.00	5.3
IDA Credit	100.00	1.3
Trust Funds		
Health Emergency Preparedness and Response Multi-Donor Trust	4.00	3.85
Total Program Financing	**1,513.00**	**100.00**

*IDA fund amounts are based on the prevailing exchange rate SDR/US$ at time of negotiations.

Ongoing Relevant Projects of the World Bank and Development Partners

36. **The World Bank has developed a strong partnership with the GoN in the health sector over the past two decades and, as one the largest financiers to the sector, has supported Nepal's efforts to reform and strengthen health systems and promote good governance to improve health outcomes.** The Bank has supported GoN's health sector reform programs since 2004.[30] In addition, the Bank has been at the forefront of supporting the GoN in its health response to the COVID-19 pandemic. The proposed Program is a follow up to the recently closed Nepal Health Sector Management Reform PforR (NHSMRP, P160207), continuing to support one of its four key results areas: Strengthening data for decision making by expediting some existing reforms (digitalizing data systems for primary level facilities) and introducing new reforms too (linking hospitals' data systems through electronic medical and health records). It will also support the areas of public financial management, procurement system and social accountability – through fiduciary and social action plans. Similarly, the Program will complement the Bank financed COVID-19 Emergency Response and Health Systems Preparedness Project (CERHSP, P173760), which focuses on strengthening health systems to prevent and effectively manage potential surges of COVID-19 outbreak. Similarly, the Program will build on the technical assistance provided to the MoHP to develop the Health Financing Strategy and ensure implementation of select critical elements of the strategy.

37. **The nature of reforms proposed under this Program are relatively upstream and relevant in the context of Nepal graduating to a middle-income country over the Program period.** The reforms tested and implemented in these two Provinces have the potential to be scaled-up to Provinces which have lagged but are expected to catch up through extensive support from other DPs. The British Embassy Kathmandu (BEK), the United States Agency for International Development (USAID), and the United Nations (UN) agencies are expected to provide their support in other Provinces as well.

D. Program Development Objective(s) (PDO) and PDO Level Results Indicators

38. The Program Development Objectives are to improve quality of healthcare, enhance health insurance coverage for poor, and strengthen health emergency preparedness in the Selected Provinces.

39. Key outcome indicators are included in **Table 5**.

[30] (i) Nepal Health Sector Strategy: An Agenda for Reform (NHSS, 2004-2009); (ii) Nepal Health Sector Strategy II (NHSS II, 2010-2015); and (iii) Nepal Health Sector Strategy III (NHSS III, 2016-2022).

Table 5: Mapping of PDO level results indicators by elements of PDO

PDO level results indicators	Elements of PDO		
	Quality of healthcare	Health insurance coverage	Health emergency preparedness and response
1. Average reduced gap for pregnant women with 1 ANC visit and 4 ANC visits in Selected Provinces	√		
2. Average percentage of children 0-2 months of age suspected of severe bacterial infection treated with complete doses of Gentamycin injection	√		
3. In-patients in Program-Supported Health Facilities have EMR records (DLR 2.3)	√		
4. Poor and vulnerable households in Selected Provinces enrolled in the health insurance program (DLR 3.2) (with share of female headed households)	√	√	
5. Functional rapid response teams established in Selected Provinces and Local Levels (DLR 5.2)			√

E. Disbursement Linked Indicators and Verification Protocols

40. **The Program focuses on three Results Areas and will incentivize achievement of corresponding DLIs.** The allocations against DLIs will allow for a regular disbursement flow through the Program period. Annex 2 details each DLI and corresponding verification protocol, and identifies which ones are timebound and scalable. The DLIs for the Program—a combination of outcome and intermediate results—are outlined in **Table 6**.

Table 6: Overview of DLIs

Results Areas	Disbursement Linked Indicators	PDO	IR	GCRF		Allocations (US$ million)					
					Total	**FY23**	**FY24**	**FY25**	**FY26**	**FY27**	**FY28**
RA1: Improving readiness of healthcare delivery system and quality of care	**DLI 1:** Implementation of minimum service standards including biomedical equipment maintenance		IRI 1.1 1.2, 1.3, 1.4 1.5 and 1.6	Pillar 2	39.00	2.00	0.00	4.50	14.75	1.00	16.75
	DLI 2: Patients enrolled in EMR as per MoHP standards	PDO3	IRI 1.5 and 1.6	Pillar 2	8.00	0.00	0.00	3.00	2.75	0.00	2.25
RA 2: Improving health insurance coverage and effectiveness	**DLI 3:** Increased enrollment of poor and vulnerable households in the health insurance program	PDO4	IRI 2.1	Pillar 2	27.04	2.04	5.00	0.00	13.44	0.00	6.56
	DLI 4: Timely settlement of health insurance claims		IRI 2.2	Pillar 2	5.96	0.00	0.00	0.00	4.26	0.00	1.70
RA 3: Enhancing health emergency preparedness and response capacity at PGLLs	**DLI 5:** Provincial Governments and Local Levels have adequate capacity for health emergency preparedness and response	PDO5	IRI 3.1	Pillar 3	20.00	2.00	0	4.00		8.83	5.17

Results Areas	Disbursement Linked Indicators	PDO	IR	GCRF		Allocations (US$ million)					
					Total	FY23	FY24	FY25	FY26	FY27	FY28
	DLI 6: Climate sensitive prioritized disease surveillance system established		IRI 3.2	Pillar 3	3.84	0.96		1.44	1.44		

41. **The achievement of DLIs will be verified by an independent institution based on a detailed DLI verification protocol endorsed by the MoHP and the World Bank.** The MoHP will identify and deploy an Independent Verification Agent (IVA) based on established selection criteria within six months of the effectiveness of the Program. A Memorandum of Understanding (MOU)/contractual arrangement outlining the specific responsibilities of the IVA with respect to the verification of achieved DLIs will be signed between the MoHP and the IVA prior to implementation of the Program. Any cost related to IVA's work will be borne by GoN.

III. PROGRAM IMPLEMENTATION

A. Institutional and Implementation Arrangements

42. **The PforR will use Government systems for Program implementation, oversight, financial management, procurement, safeguards, monitoring and evaluation and reporting arrangements**. A robust implementation arrangement has been agreed in line with the federalism principle to improve accountability and coordination among Federal ministries, Provincial and LLs, and health facilities. MoHP will serve as the implementing agency which remains responsible for providing policy guidance, ensuring an enabling environment, allocating adequate resources, overseeing implementation, and accountability to the Bank with regards to the Program. Provincial and LLs will implement the Program according to their mandates. A Program Management Unit (PMU) under the leadership of a director level senior official will be formed. The PMU will include directors/representatives of relevant MoHP's divisions and centers, including directors of Curative Service Division (CSD); Management Division (MD); Policy, Planning and Monitoring Division (PPMD); Epidemiology and Disease Control Division (EDCD); Administration Division; and Quality Standard and Regulation Division (QSRD). Representatives from HIB, Selected Provinces, Municipal Association of Nepal and National Association of Rural Municipalities in Nepal will also be in the PMU. The PMU will ensure day-to-day oversight, implementation and monitoring of results in the Program under the responsibility of: QSRD and CSD for minimum service standards - related DLIs; MD and CSD for HMIS and EMR related DLIs; MD for equipment-related DLIs; HIB for health insurance related DLIs; and EDCD health emergency-related DLIs. A Program Steering Committee, chaired by the Secretary of Health and constituted of high-level officials will supervise and guide the PMU for Program implementation and accountability.

43. **The selected PGLLs will bear the responsibility for implementing interventions at Province and LLs**. The two Provinces and LLs under these Provinces will be issued Operating Guidelines with information on the implementation arrangements of the Program, including conditions for using CGs meant for the activities under this Program, PGLLs' responsibilities for management and basic functions of financial management, procurement, application of anti-corruption guidelines, data protection and environmental and social management associated with their respective activities under the Program. At

the Provincial Level, a focal unit in the Provincial Ministry of Health will be assigned for day-to-day oversight, implementation, and monitoring of results in the Program results areas. At the LL, the health section of the municipality headed by the health coordinator will be designated as the focal unit for day-to-day oversight, implementation and monitoring of results in the Program results areas. These units can be strengthened by hiring required experts and specialists as needed.

44. **The activities and budget required to deliver the Program will be incorporated in the annual workplan and budget of MoHP for each year of Program implementation**. This will also include CG resources to the Provincial and LLs in the two selected Provinces which will follow the same budgeting, fund flow and reporting arrangements as with other health programs funded with CGs by MoHP. The fund transfers will be authorized and disbursed through the Treasury system, and upward reporting done through the PGLLs financial management information systems. Though not currently in practice, the MoHP will establish procedures to ensure physical and financial progress reporting from the PGLLs implementing the Program. For Federal level implementing agencies, existing health and financial information management systems, structures and mechanisms will be used for physical and financial reporting. MoHP will submit annual audits for agencies implementing the Program, i.e., the Federal level agencies as well as the PGLLs in the two selected Provinces. [31] The Bank will provide supervision and implementation support through regular engagement with the MoHP and bi-annual implementation support and review missions. To the extent feasible, the review missions will be aligned to the joint consultative meetings and annual reviews between MoHP and DPs.

B. Results Monitoring and Evaluation

45. **The Bank will engage with MoHP in the preparation of the annual workplan and budget, monitoring of the implementation progress, achievement of Program results, monitoring adequacy of systems performance, changes in risks and compliance with the Legal Agreement, and implementation of the Program Action Plan (PAP).** The Bank will conduct field visits to collect direct feedback from beneficiaries. In addition, the MoHP will also compile best practices and lessons gathered through reviews and regular supervisory visits.

46. **The Program will use the existing routine management information systems, structures and mechanisms within the MoHP and its entities for monitoring of the physical and financial progress of the Program.** There are no formal arrangements from Province and LLs to the Federal Government on physical reporting of health programs. To monitor data not captured in the routine information systems, the MoHP will agree on the reporting requirements and formats with the PGLLs receiving support through the CGs, enabling MoHP to regularly present a compiled update and report to the Bank. Towards this, the MoHP will communicate the bi-annual progress on the Program – implementation of activities, Program expenditures, bottlenecks, and progress toward results as outlined in the Program Results Framework. In addition, the MoHP may commission surveys, reviews and assessments for the relevant DLIs, PDO indicators, and intermediate results indicators, if necessary.

47. **The MoHP will communicate to the Bank the DLI achievements with supporting evidence, which will then be verified by the IVA using the agreed verification protocols.** The communication

[31] Audits of entities at all three levels of Government and state funded organizations are carried out annually by the Office of the Auditor General.

process between the MoHP and the Bank with regards to DLI achievements and their allocations is explained in Annex 2 and under the Disbursement section below.

48. **The MoHP will share lessons of the Program with various stakeholders including those from other Provinces during the institutionalized Joint Annual Reviews of the Health Sector program.**

C. Disbursement Arrangements

49. **Disbursements will be made based on achievement of results (DLRs) under each DLI.** The GoN will prefinance expenditures for the Program using its own budgetary resources through the identified budget lines of the Program Expenditure Framework (PEF). The MoHP will prepare technical reports to document the achievement of DLIs that will be verified by the designated IVA, except for agreed prior results under DLI 1, DLI 3, DLI 5 and DLI 6 (US$7.02 million), which will be verified by an independent entity and confirmed by the Bank. Upon verification of the prior results and DLI targets by the IVA, the MoHP will communicate their achievement with and corresponding allocations to the World Bank along with the supporting documents requesting disbursement. The MoHP will then submit a withdrawal application of said amount with supporting documents to the World Bank for reimbursement into the Government's Treasury Account in NPR. Withdrawal applications are to be above US$10,000, based on the amount in the disbursement letter. The DLIs for this Program, except for prior results, are non-timebound and, hence, if the DLI targets are not achieved in the anticipated year, disbursement may be rolled over to the future years till such time the DLI target is achieved within the Program Closing Date. For non-scalable DLIs, the World Bank will disburse the DLI value only upon full achievement of the DLI result. For scalable DLIs, the World Bank will disburse the DLI allocation in proportion to its verified achievement and targets as set out in the DLI matrix.

50. **Reconciliation of Program Expenditures.** Within six months of the Closing Date, a reconciliation of expenditures financed under the Program and disbursements made by the Bank under the three financing sources will be conducted by MoHP and reviewed by the Bank. To facilitate this reconciliation, the expenditures with budget codes that can be financed under the Program will be considered from audited statements. The aggregate disbursements under the Program should not exceed the total Program expenditures by the Government, considering other sources of financing, if any. If Bank financing under the three financing sources exceeds the total amount of Program expenditures, the Government is required to refund the difference to the Bank.

D. Capacity Building

51. **Capacity-building support will be critical for achieving the transformational results envisaged under the Program**. Continuous hands-on engagement, including need-based, just-in-time analytical and diagnostic support, knowledge exchange and robust implementation support, will be mobilized by the World Bank for each RA. This will include knowledge sharing of global best practices especially on national health insurance and health emergency preparedness.

52. **Some of the DPs active in the health sector have confirmed their intent to engage in and provide technical assistance to the MoHP on one or more results areas of the Program** (**Table 7**). The team expects that intensive technical assistance will be required to deliver on RA 3. The WHO has been active in this area, and there are potential partners like BEK and USAID to provide support in this area. The Bank

will also seek additional grant resources from within the Bank to provide hands-on technical assistance to the GoN, and work closely with DPs to promote collaboration and complementarities during implementation.

Table 7: Mapping of Development Partners Engagement in the Program results areas

Results Area	Development Partners*
RA1: Improving readiness of healthcare delivery system and quality of care	BEK, GIZ, NSI, UNICEF, USAID, WHO, JICA
RA2: Improving health insurance coverage and effectiveness	GIZ, KfW, ADB, WHO
RA3: Enhancing health emergency preparedness and response capacity at Province and Local Levels	BEK, USAID, WHO

*ADB: Asian Development Bank; GIZ: German Agency for International Cooperation; JICA: Japan International Cooperation Agency; KfW: German Development Bank; NSI: Nick Simons Institute; TGF: The Global Fund; UNICEF: United Nations Children's Fund.

IV. ASSESSMENT SUMMARY

A. Technical (including program economic evaluation)

53. **In the NHS-SP, the Government has put a renewed focus on strengthening health system which is necessary to improve quality and affordability of healthcare services.** Although the GoN ensures availability of healthcare services, access to quality healthcare services remains a challenge. Absence of quality in healthcare services challenge both improved health outcomes and financial protection of citizens in health, both important to achieve UHC. Consequently, three out of five strategic objectives of the NHS-SP are related to improving coverage of quality healthcare services and enhancing financial protection in health. The Program will contribute to NHS-SP achieving its stated objectives.

54. **The PEF is defined within the boundary of the NHS-SP**. It includes costs related to human resources for the selected PGLLs to implement NHS-SP, health protection targeted for the poor and priority population groups in the selected PGLLs, and other cost as shown in **Table 8**, adjusting for the Program support areas. PEF is estimated at US$1,513 million over five years in the Federal and the selected two Provinces and their LLs.

Table 8: Composition of Program expenditure by economic classification (in million US$)

Outcome Area	Year 1	Year 2	Year 3	Year 4	Year 5	Total	
						Amount	Percent
Wages and salaries	82	93	110	123	146	554	36.6
Capacity building	5	6	7	8	10	36	2.4
Medicines and supplies	20	22	24	26	29	121	8.0
Capital goods and maintenance	8	9	11	13	14	55	3.6
Grants and social security	62	81	81	88	98	410	27.0
Program activities	52	60	67	75	83	337	22.4
Total	229	271	300	333	380	1,513	100.0

Note: The relevant PforR Expenditure Framework budget codes include: Wages and Salaries (21111, 21112, 21121, 21122, 21131, 21132, 21123); Capacity Building (22511, 22512); Medicines and Supplies (27213); Capital Goods and Maintenance (22213, 31123, 31161, 31134); Program Activities (22522, 22529, 22611, 22612, 22311, 22313, 22314, 22315, 22411, 22412, 22413, 22111, 22112, 22211)
Note: Conditional Grant (26332, 26336) of the two Provinces and their LLs is accounted for in all the outcome areas.

55. **Adequate institutional arrangements are in place to implement the Program**. The MoHP in coordination with PGLLs and HIB will be responsible for the implementation and the achievement of

agreed DLRs. The selected Provinces and LLs will bear the overall responsibility for implementing interventions at Province and LLs.

56. **Planning, monitoring and evaluation capacity.** The MoHP's PPMD is tasked with developing evidence informed budgets to its relevant cost units based on the sector program. Its Monitoring and Evaluation Section conducts regular monitoring and evaluation of the sector program including through Joint Annual Reviews and supports similar exercises at the Province and LLs. The Results Framework of the proposed Program falls within the Government's own sector program. There are divisions and sections of MoHP and DoHS responsible for different results areas of the Program. Capacity of the PGLLs will require strengthening to deliver the Program. The MoHP is expected to support capacity building of the implementing PGLLs. Further, technical assistance is being envisioned through different DPs.

57. **Recognizing the global nature of health emergencies, in June 2020 the World Bank's Board of Executive Directors, approved the creation of a new umbrella trust fund program, the Health Emergency Preparedness and Response (HEPR) Program.** The development objective of the HEPR Program is to support eligible countries and territories to improve their capacities to prepare for, prevent, respond and mitigate the impact of epidemics on populations. It is set up as a flexible mechanism to provide catalytic, upfront and rapid financing at times that other sources of funding are not available for health emergency preparedness and to fill specific gaps in terms of health emergency responses. Activities eligible for HEPR Program financing focus on two pillars: (a) preparedness for future health emergencies, and (b) responses to emerging and current health emergencies. The HEPR Multi-donor Trust Fund (MDTF) is the anchor Trust Fund of the HEPR Program. Nepal has been allocated a HEPR MDTF grant in the value of US$3.84 million to strengthen health emergency preparedness, on the condition that these resources are not used to purchase COVID-19 vaccines.

58. **The economic analysis shows that the Program will generate positive returns.** The minimum service standards promote the right mix of inputs for improved quality of care which has potential to enhance efficiency in service provision and effectiveness of service delivery. Similarly pro-poor features of the Program are explicit in health insurance which has provision of Government sponsored enrollment of the poor and targeted population groups. Moreover, the Program's focus on quality data systems and improved planning at the LL will enhance efficiency through evidence-based decision making and prioritization of cost-effective interventions. Net benefits were calculated in reference to PEF and expected benefits from the Program. After adjusting for 10 percent contingency margin in gross benefits, the net present value was calculated using a 12 percent discount rate. Net benefits over the five-year period are estimated to be US$1.38 billion which is equivalent to US$923 million net present value (**Table 9**).

Table 9: Summary of Economic and Financial Analysis (in million US$)

Cost/benefits	2024	2025	2026	2027	2028	Total
Costs	229	271	301	333	379	1,513
Gross benefits	230	418	612	834	1,121	3,215
Contingency (10 percent)	23	42	61	83	112	321
Net benefits	(22)	105	250	417	629	1,380
Net present value						923

B. Fiduciary

59. **The Fiduciary Systems Assessment (FSA) concluded that the extant fiduciary systems, capacity, and performance of the implementing agencies are adequate to provide reasonable assurance, subject to timely and material implementation of agreed mitigation measures for risks identified, that the Program funds will be used for the intended purposes, with due attention to the principles of economy, efficiency, effectiveness, transparency, and accountability.** The FSA covered the MoHP, DoHS, HIB (an autonomous agency), and the two Provincial Governments. Based on the FSA and given the inherent risks in a multi-agency engagement with different systems on the operation and execution of the Program, the fiduciary risk is assessed as "Substantial." The Program would use Government systems and procedures. The Program audit will be conducted by the Office of the Auditor General (OAG) and the report will be submitted to the Bank within nine months from the end of fiscal year. Program fiduciary systems will be documented in the Operating Guidelines.

60. **The Program considered the weaknesses in the current fiduciary systems in respect of budgeting, accounting, financial reporting, and audit.** Fiduciary risk is higher as health services are under the domain of Provincial Governments and basic health and sanitation services under the jurisdiction of the LLs. There are shortcomings in preparing annual work plans, applying internal controls, timely reconciliations, timely delivery of audits, executive responses to audit findings and recommendations, adequacy of internal audits, and capacity of fiduciary staff. There are significant in-year budgetary transfers from one budget code to another. On procurement, the electronic Government procurement (e-GP) system is used only for collecting bids while it could be utilized for bid evaluation and wider procurement management; model bid documents are not adequate to address health equipment and medicine procurement.

61. **Mitigation measures to address the risks have been included in the PAP.** These include compiling the annual plans of the implementing agencies and adequate allocation by the Government based on annual workplans; timely closing of accounts by implementing agencies; strict implementation of internal controls including reconciliation according to the Internal Control Guidelines, 2014; full use of e-GP system for the entire procurement cycle; development of model bidding documents for medicines; and establishing the framework and process for compliant handling. These risks are mitigated by good practices of GoN such as timeliness, classification, and execution control by Treasury, operation through a Treasury Single Account (and minimizing use of bank accounts) androlling out of CGAS and Sub-national Treasury Regulatory Application (SuTRA). This activity-wise budgeting has enhanced reliability, tracking of expenditures and financial reporting. Constitution of an audit committee to follow up on resolution of audits issues will also mitigate risks. GoN may also consider implementing performance-based budgeting and developing a medium-term expenditure framework for the health sector. For improving internal audit practices, the GoN has recently developed a separate pool of internal auditors; internal audit guidelines equally applicable for health sector have also been prepared.

62. **Fraud and Corruption**. The assessment concludes that Fraud and Corruption risks are Substantial. Nepal has taken significant policy level steps to combat corruption, and it is a punishable offence under the Prevention of Corruption Act, 2002 and the Commission for Investigation of Abuse of Authority Act (CIAA), 1991. Despite these efforts, corruption remains an issue. According to the CIAA, FY2021, there are a significant number of complaints related to the health sector, making it one of the five most vulnerable sectors to corruption.

63. **The Bank's Guidelines on Preventing and Combating Fraud and Corruption (ACG) in Program-for-Results Financing" dated July 1, 2012 and revised on July 10, 2015 will apply to the Program and a protocol for operationalizing these will be agreed with MoHP**. Requirements under these guidelines include but are not limited to (a) The MoHP will share with the World Bank information on allegations of corruption received from the public and its own investigation every year, (b) the World Bank's right to conduct administrative inquiries through its Institutional Integrity Vice Presidency (INT) as well as the role of the CIAA to investigate corruption allegations, and (c) use of the World Bank's debarment list of firms and individuals for the Program. Specific measures include maintaining a grievance redressal system, reporting complaints or alleged cases of fraud or corruption, and verification that no contracts under the Program have been awarded to vendors that are on the Bank's debarment list (https://www.worldbank.org/en/projects-operations/procurement/debarred-firms). The agencies will ensure that the contract documents include a clause that the vendors will follow the Bank's ACG.

C. Environmental and Social

64. **An Environmental and Social Systems Assessment (ESSA) was undertaken to: (a) identify risks and impacts associated with the Program; (b) assess the strengths and weaknesses of the legal, institutional, and implementation frameworks; and (c) recommend measures to strengthen national systems and capacity to deliver the PforR in a sustainable manner.** In addition, the ESSA assessed the adequacy of environmental and social systems in the context of the Program's boundary.

65. **The ESSA concludes that the Program has moderate environmental and social risks.** The associated environmental risks identified may relate to impacts like healthcare waste management, noise and dust pollution from minor civil works required for bio-medical equipment, and support to hospitals with repair and maintenance. Management of e-waste from medical equipment and digital system may be another area which will require attention. On social risks, the ESSA noted the need to extend the existing health insurance coverage to ultra-poor households, digitize system management with availability of disaggregated data and ensure poor and excluded are adequately covered. The previous World Bank operation (NHSMRP, P160207) had supported the development and implementation of social audit guideline of the MoHP in selected LLs. ESSA recommends that social audits are rolled out in the two PGLLs under this Program for enhanced citizen and stakeholder engagement.

66. **The ESSA finds that the existing legal and regulatory frameworks governing the sector are satisfactory for managing environmental and social risks.** The Federal Government has introduced new legislation, provisions, standards, guidelines, and programs such as national Health care waste management, standards, and operating procedures (2020), Public health service acts (2019), and other provisions[32] for more effective management of healthcare waste, occupational health safety and targeted programs for enhancing the access of poor and vulnerable groups to health services. However, the implementation of these legal and regulatory provisions at the PGLLs faces challenges due to regulatory deficiencies, shortage of human resource, inadequate institutional capacity and budget allocation and low priority. The PGLLs lack adequate supervision and monitoring of implementation of safeguard policies to manage environmental or social risks of the Program.

[32] The GESI strategy (2023) for the health sector is in the process of approval from the Cabinet. This is expected to institutionalize gender and inclusion in the health sector systems and procedures by ensuring equitable access and utilization of basic health services to the poor, vulnerable and socially excluded population.

67. **The ESSA suggests that these challenges be addressed through the following activities:** (a) develop/establish mechanism for coordination between MoHP/DoHS, selected municipalities and health facilities to manage and dispose healthcare waste; (b) prepare and endorse Sector wide Environment and Social Framework (ESF) (or guideline) for all activities including civil works executed by MoHP under the Program; (c) outreach and enrollment of ultra-poor households in the health insurance scheme; (d) Health Emergency Preparedness and Response plans to include community participation and healthcare waste management (2019); and (e) enhance existing GRM to make it comprehensive and; (f) roll out of GESI strategy once approved by the cabinet. Some of these measures/actions are included in the PA.

D. Gender

68. ***Gaps and analysis*****:** Women and children in poorer households and living in remote areas have worse health indicators compared to others. Further, only nine percent of the estimated poor households are enrolled into the health insurance scheme. Due to high care costs of secondary care, poorer households have less access. Further, female headed households are likely to be poorer and more vulnerable to foregone healthcare. In addition to the cost of care, female headed households also face higher opportunity costs related to losing daily wages and transportation costs that are incurred when visiting services. In addition to the concern of female headed households, there are also alarming gaps in poorer women's access to healthcare, particularly during their pregnancies. Many poorer women still do not access the minimum recommended four antenatal care check-ups, which are provided free of cost. Only 75 percent of lowest quintile complete 4+ ANCs compared to 93 percent of highest quintile and only 67 percent of women with no education avail 4+ ANCs compared to 93 percent of women with more than higher secondary education. The gaps in usage of antenatal care among the poorest women are concerning because low antenatal care is associated with poorer maternal and child health outcomes contributing to increased child and maternal mortality. Failure to reach the poorest women with care during their pregnancies continues to perpetuate inter-generational cycles of disadvantage.

69. ***Program interventions:*** The Program intends to focus on delivering quality healthcare through public health facilities, enroll poor and vulnerable people into the health insurance scheme, giving special attention to female headed households, to improve their affordability of higher levels of healthcare. A standardized framework will be developed to identify poor and vulnerable households including female headed households and LLs will use the framework to enroll them by conducting door to door assessment. HIB will also empanel health facilities into health insurance scheme which are closer to these communities for ease of access. There will be extensive outreach activities including peer-to-peer counselling at the community level to reach these low educated and marginalized women, including dedicated outreach to enroll female headed households into the scheme and to improve health-seeking behavior among pregnant women. These sessions will empower women to make informed decisions about their right to health, work with gatekeepers of women's health to encourage good health-seeking behaviors, guide women and their households to enroll into health insurance scheme for free to avoid high costs of care, and even avail the health outreach activities through female community health volunteers if they are not able to come to health facilities.

70. ***Measurement:*** The Program will measure success in addressing identified gender gaps by *analyzing* reduction in gap between women with 1 ANC and 4+ ANC visits, and increased enrollment of poor households (share of which female headed) into the health insurance scheme.

E. Citizen Engagement

71. **Implementation of the minimum service standards at select Provincial and LL hospitals in Koshi and Gandaki, complemented with the roll out of annual social audits will facilitate improved citizen engagement and accountability**. The minimum service standards module on Governance and Management assesses functionality and responsiveness of citizen engagement through citizen charters, notices of public concern and functional public contact information centers. Performance of grievance redressal and complaint handling, and resolution/follow-up on issues identified during social audits is also assessed. The Program will expand the coverage of social audits already piloted in two LLs of Koshi under the previous PforR (NHSMRP, P160207), to cover Program supported health facilities. In accordance with the guidelines for the conduct of social audits (June 21, 2020), key stakeholders including representatives of beneficiaries, general public and local representatives will participate in each social audit. The feedback and findings of the social audit will inform the minimum service standards assessment and quality improvement program of respective health facility.

72. **The Program has extensive community outreach activities to reach the intended poor beneficiaries and encourage them to enroll into and remain within the health insurance scheme to avail healthcare and financial protection.** Additionally, citizens will also be involved in community surveillance of diseases and development and deployment of emergency preparedness and response plans at the LLs. Finally, the call centers 1133 and 1115 established to communicate, educate, and address grievances of citizens with respect to the health sector, including health response to epidemics/pandemics will continue to be strengthened for greater citizen satisfaction.

73. **All Program supported health facilities in Koshi and Gandaki will have operational mechanisms for grievance redressal and complaint handling.** The functionality of these systems will be assessed annually through social audits and MSS assessments and strengthened based on the findings. Additionally, call centers 1133 and 1115 will continue to operate at the national level to address grievances related to the health sector, including ongoing assessment of satisfaction of callers with services provided.

F. Climate

74. **Future climate is expected to be warmer and wetter in Nepal and annual precipitation is likely to increase.** Increase in precipitation will increase floods and landslides risks, with the far Western Region expected to experience some of the highest increases. The risk of floods is greatest in the lower elevation and more populated Provinces of the country, with the estimated population exposed to extreme flood increasing to nearly 370,000 by 2035-2044. Rising temperatures could also impact snow stability, contributing to avalanches and landslides. The projected increase in the temperature indicates a higher risk of outbreak of new and re-emerging diseases, including vector-borne diseases, water-borne diseases, heat-related morbidity and mortality, nutrition risks, and the increased burden of non-communicable diseases in Nepal. These diseases are expected to put additional burden on the country’s healthcare system.

75. **The Program has been screened for climate change and disaster risks.** The Program intends to address these climate-related health impacts by improving supply-side readiness, especially by strengthening climate change and disaster resilience measures in the health facilities of the Provinces, among others. The Program will strengthen health emergency preparedness and response by establishing and expanding climate-sensitive prioritized disease surveillance system which will account for climate-induced diseases in the selected Provinces, as listed in Table 10.

Table 10. Climate-Related Actions

<table>
<tr><th>DLI</th><th>DLR</th><th>Climate-Related Actions</th><th>Financing Amount of the Climate-Related Actions</th></tr>
<tr><td rowspan="4">DLI 1: Implementation of minimum service standards including biomedical equipment maintenance (US$39 million)</td><td>DLR 1.1: Program supported health facilities are implementing minimum service standards (US$9 million- including prior result)</td><td rowspan="4">Activities in the Program seek to improve health facility readiness by enhancing minimum service standards scores of health facilities which will facilitate those facilities for quality healthcare service delivery, including during climate-related disaster, and contributes to enhancing the climate resilience of health services that benefit climate-vulnerable populations. Specifically:

Health facilities disaster preparedness and mitigation system—one of the pillars in the minimum service standards scoring system—will be improved by- (a) providing disaster preparedness orientation to all staff yearly
(b) ensuring basic readiness of the health facilities including:
- ensuring exit signs are displayed to escape during disaster and climate-induced events in all departments and wards
- ensuring that assembly zone has been specified for disaster/climate induced events,
- presence of functional RRT in health facilities; and
- availability of medicine stock for post disaster response.

Furthermore, as climate change is expected to heighten risks of floods and landslides due to an increase in precipitation and snow instability, especially in the western region and in lower elevation, measures will be put in place to ensure use of weather resistant materials by revising procurement and facility infrastructure guidelines and to ensure bio-medical equipment stay secure in case of heavy precipitation and to reduce heat in buildings by incorporating them in the equipment installation guidelines, training curriculum, and supervision checklists.

Under health care waste management, reduction of carbon-footprint will be enhanced through a well-prepared action plan and awareness of health providers which aim for suppression of waste generation; waste reuse; promotion of waste recycling; energy recovery; and appropriate disposal</td><td rowspan="2">US$4.8 million

Expected amount to contribute to addressing climate related events is 20 percent</td></tr>
<tr><td>DLR 1.2: Provincial public health facilities in selected Provinces have minimum service standards score of at least 85%
(US$14 million)</td></tr>
<tr><td>DLR 1.3: Bio-medical equipment repair and maintenance system established and functional in two selected Provinces
(US$6 million)</td><td>US$0.9 million

Assuming 15 percent additional cost over standard building to adapt to climate including procurement of energy efficient equipment</td></tr>
<tr><td>DLR 1.4: Three hospitals in one of the two Selected Provinces have functional health care waste management
(US$3 million)</td><td>US$0.9 million

Assuming 30 percent additional cost over standard to adapt to climate change</td></tr>
<tr><td rowspan="2">DLI 2: Patients enrolled in EMR as per MoHP standards (US$8 million)</td><td>DLR 2.1: EMR standards adopted by MoHP (US$3 million)</td><td rowspan="2">The implementation and expansion of standard EMR will be strengthened to enhance the capacity of health facilities to digitize recording and monitoring of the incidence and prevalence, on a regular basis, of vector-borne/climate-sensitive diseases, including early detection of vector-borne and water-borne disease outbreaks, heat-related morbidity,</td><td rowspan="2">US$0.4 million

Assuming 5 percent of the financing would be related to</td></tr>
<tr><td>DLR 2.2: EMR implemented by 6</td></tr>
</table>

	Program-Supported Health Facilities (US$3 million)	famine, re-emerging diseases, and plan evidence-based interventions. The digitalized data would also help to better understand the relationship between vector-borne and water-borne disease and climate change, by overlaying this new data with meteorologic data. This evidence will enable the health managers and providers to better target and reach communities who are most vulnerable and advocate for additional resources.	addressing climate events (linked to DLI 5)
	DLR 2.3: In-patients in Program supported health facilities with Electronic Medical Records (US$2 million)		
DLI 3: Increased enrollment of poor and vulnerable households in the health insurance program (US$27 million)	**DLR 3.1:** Framework for identification of poor and vulnerable households developed and adopted by MoHP (US$5 million)	The framework will establish climate-vulnerability as one of the criteria of vulnerability. Climate vulnerability will be identified using climate vulnerability maps, which will break down the vulnerability of specific locations to climate shocks. This will be included in the targeting criteria for vulnerable households. The targeting will be initiated in the 2 select Provinces. The targeting will ensure that the groups of population disproportionately affected by climate-induced health risks have access to health services when they need those services the most. To support the targeting, the Program will also strengthen HIB capacity to improve health insurance coverage by using criteria developed in the framework and the vulnerability maps. This will be carried out in coordination with PGLLs.	**US$2.5 million** Assuming 10 percent of the financing is used for addressing climate related events
	DLR 3.2: 50% of poor and vulnerable households in Selected Provinces enrolled in the health insurance program (US$20 million)		
DLI5: Provincial Governments and Local Levels have adequate capacity for health emergency preparedness and response (US$20 million)	**DLR 5.1:** The Selected Provinces have developed health emergency preparedness and response plans (US$8 million)	The Provinces will be capacitated via orientations and trainings to respond to outbreaks of vector and waterborne diseases, such as malaria and diarrheal diseases, which are climate related in Nepal. This will include training and technical support on surveillance and monitoring and capacity development to develop plans to influence care for the vulnerable population in climate-risk areas and climate-sensitive conditions. Formation and deployment of health RRTs will serve as a major pillar of epidemic preparedness and emergency response to natural disasters. Training and specific protocols on response to climate-sensitive diseases and climate shock response will be conducted.	**US$4 million** Assuming 50 percent of it is specifically going to address climate related events
	DLR 5.2: Functional rapid response teams established in Selected Provinces (US$9.9 million including prior result)		**US$6 million** Assuming 50 percent of it is specifically going to address climate related events
DLI 6: Climate sensitive prioritized disease surveillance system established (US$3.84 million)		The climate sensitive prioritized disease surveillance system established and strengthened to integrate early warning system and disease surveillance which will help in timely response to outbreaks of climate-sensitive diseases (ex: Malaria, Japanese Encephalitis, Yellow Fever, and Zika) during monsoons, extreme heat events, and famine (nutritional risks).	**US$3.84 million**

76. ***Grievance Redress.*** Communities and individuals who believe that they are adversely affected as a result of a Bank supported PforR operation, as defined by the applicable policy and procedures, may submit complaints to the existing program grievance mechanism or the Bank's Grievance Redress Service (GRS). The GRS ensures that complaints received are promptly reviewed in order to address pertinent concerns. Project affected communities and individuals may submit their complaint to the Bank's independent Accountability Mechanism (AM). The AM houses the Inspection Panel, which determines whether harm occurred, or could occur, as a result of Bank non-compliance with its policies and procedures, and the Dispute Resolution Service, which provides communities and borrowers with the opportunity to address complaints through dispute resolution. Complaints may be submitted at any time after concerns have been brought directly to the Bank's attention, and Bank Management has been given an opportunity to respond. For information on how to submit complaints to the Bank's Grievance Redress Service (GRS), please visit http://www.worldbank.org/GRS. For information on how to submit complaints to the Bank's Accountability Mechanism, please visit https://accountability.worldbank.org.

V. RISK

77. **The overall residual Program risk is Substantial.** The main risks to achieving the intended results are political and governance risks, macroeconomic risks and the risks related to the institutional capacity and fiduciary environment for implementation of the Program.

78. **Political and Governance risks are High.** A new coalition Government will take time to form and settle down at the Federal and Provincial levels. The Federal system provides opportunities to decentralize development benefits and make service delivery more effective and accountable. The pandemic also underscored the role of LLs, especially in deploying social programs. Nevertheless, the risks of political uncertainty, jurisdictional overlap between the three tiers of Government, and need for more clarity and coherence between policies and devolved powers will remain in the coming period. While the extent to which political risks can be mitigated through project-specific measures is limited, the World Bank will maintain continuity in policy dialogue with the new Government, and project design includes specific actions to build public support through broader stakeholder participation, strategic communication, and outreach.

79. **Macroeconomic risks are Substantial.** No new shocks are included in the forecast; given the increasing frequency of shocks in recent years, this may be optimistic. Political stability remains important to manage the economy and ensure continued pursuit of development priorities. Political stability may not be achieved in the forecast period. Higher than expected inflation would reduce household purchasing power and drag growth. Welfare recovery remains uncertain due to rising inflation and risks to agricultural production. Reduced investments in human capital, especially amongst those yet to recover from a job loss following COVID-19, also impose risks to rising inequality.

80. **Institutional Capacity for Implementation and Sustainability risks are Substantial.** This Program involves working through and supporting the new Federal structures. Though the capacity of the Federal Government is modest, that of the PGLLs is low and systems for intergovernmental coordination and accountability are poor. The Program design includes working through the existing intergovernmental

program and financial management systems and has capacity building measures particularly targeted at LLs. The Program provisions formation of PMU for day-to-day implementation and monitoring with certain coordination and focal entities to be formed at each level and mechanisms to be developed to ensure accountability for Program results. Technical assistance is also expected from DPs who plan to be engaged in some of the activities under the Program's results areas. These will help to minimize the risk to a certain degree.

81. **Fiduciary risks are Substantial.** Program planning and budgeting are fragmented across the three Government levels. The systems and practices for financial management, including internal controls, at the PGLLs are relatively new and weak. Accountability arrangements between Federal and Provinces and LLs for the federally funded programs are limited, while its absent for those funded by PGLLs own resources. The capacity building measures targeted at the LLs will incorporate basics of financial management, procurement and governance. In addition, targeted measures at strengthening fiduciary systems will be enforced through the PAP.

ANNEX 1. RESULTS FRAMEWORK MATRIX

Results Framework
COUNTRY: Nepal
Nepal Quality Health Systems Program-for-Results

Program Development Objective(s)

To improve quality of healthcare, enhance health insurance coverage for poor, and strengthen health emergency preparedness in the Selected Provinces.

Program Development Objective Indicators by Objectives/Outcomes

Indicator Name	DLI	Baseline	Intermediate Targets				End Target
			1	2	3	4	
Improving readiness and efficiency of healthcare delivery system and quality of care							
Average reduced gap for pregnant women with 1 ANC visit and 4 ANC visits in Selected Provinces (Percentage)		17.80	15.00	14.00	13.00	9.00	7.00
Average percentage of children 0-2 months of age suspected of severe bacterial infection treated with complete doses of Gentamycin injection (Percentage)		30.30	35.00	40.00	45.00	55.00	60.00
In-patients in Program-	DLI 2	0.00	20.00	35.00	50.00	70.00	80.00

Indicator Name	DLI	Baseline	Intermediate Targets				End Target
			1	2	3	4	
Supported Health Facilities have EMR Records (Percentage)							
Improving health insurance coverage and effectiveness							
Poor and vulnerable households in Selected Provinces enrolled in the health insurance program (with share of female headed households) (Percentage)	DLI 3	9.00		30.00	50.00	60.00	70.00
Enhancing health emergency preparedness and response capacity at province and local levels							
Functional Rapid Response Teams established in Selected Provinces (Number)	DLI 5	0.00		2.00		70.00	113.00

Intermediate Results Indicator by Results Areas

Indicator Name	DLI	Baseline	Intermediate Targets				End Target
			1	2	3	4	
Improving Readiness of Health Care Delivery System and Quality of Care							
Program supported health facilities are implementing minimum service standards (Percentage)		36.00	40.00	45.00	60.00	70.00	80.00
Provincial public health facilities in Selected Provinces have minimum service standards score of at least 85% (Text)		TBD		50 percent Provincial facilities have MSS score of at least 85 percent			50 percent Provincial facilities have MSS score of at least 90 percent,
Biomedical equipment repair and maintenance system established and functional in two Selected Provinces (Number)		0.00	0.00	1.00	2.00	2.00	2.00
Memorandum of Understanding signed between MoHP and Nepal Drug Limited for purchase of essential medicines (Text)		No MOU		MOU established			MOU established
EMR standards adopted by MoHP (Text)		No	No	Yes	Yes	Yes	Yes
EMR implemented by Program-Supported Health Facilities (Number)		0.00			6.00	10.00	12.00

Indicator Name	DLI	Baseline	Intermediate Targets				End Target
			1	2	3	4	
Hospitals in the two Selected Provinces have functional healthcare waste management system (Number)		0.00		3.00	6.00		6.00
Local Levels in each Selected Province have implemented social audits (Number)		0.00		5.00	10.00		15.00
Improving health insurance coverage and effectiveness							
Framework for identification of poor and vulnerable households developed and adopted by MoHP (Text)		No		Yes	Yes	Yes	Yes
Health insurance claims from Selected Provinces settled in time (Percentage)	DLI 4	0.00	20.00	30.00	50.00	60.00	70.00
Enhancing health emergency preparedness and response capacity at province and local levels							
Selected Provinces and Local Levels have developed health emergency preparedness and response plans (Number)		0.00		2.00	52.00	72.00	113.00
Climate sensitive prioritized disease surveillance system established in two Selected Provinces (Number)		0.00	0.00	1.00	2.00	2.00	2.00

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Monitoring & Evaluation Plan: PDO Indicators					
Indicator Name	**Definition/Description**	**Frequency**	**Datasource**	**Methodology for Data Collection**	**Responsibility for Data Collection**
Average reduced gap for pregnant women with 1 ANC visit and 4 ANC visits in Selected Provinces	Numerator= Women with birth in last one year with 1 ANC visit in Koshi and Gandaki minus women with birth in last one year with 4 ANC visits in Koshi and Gandaki Denominator= Women with birth in last one year with 1 ANC visit in Koshi and Gandaki	Annual	DoHS Annual report	DoHS annual report	MoHP
Average percentage of children 0-2 months of age suspected of severe bacterial infection treated with complete doses of Gentamycin injection	Numerator= Children 0-2 months of age in Koshi and Gandaki with severe bacterial infection treated with complete doses of gentamycin injection Denominator= Children 0-2 months of age in Koshi and Gandaki with severe bacterial infection	Annual	DoHS Annual Report	DoHS Annual Report	MoHP
In-patients in Program-Supported Health Facilities have EMR Records	Numerator: No: of inpatients (of three wards) in Program supported health facilities in selected Provinces with EMR in the assessment year	Annual	EMR and DHIS2	Review of EMR and DHIS2	DoHS

	Denominator: Total no: of inpatients (of three wards) in Program supported health facilities in selected Provinces in the assessment year				
Poor and vulnerable households in Selected Provinces enrolled in the health insurance program (with share of female headed households)	Numerator: Total number of households enrolled in insurance scheme in assessment year Denominator: Total poor and vulnerable households in the assessment year	Annual	Annual Report of HIB	Insurance Management Information System (IMIS) review	HIB
Functional Rapid Response Teams established in Selected Provinces	Cumulative number of Provinces + LL with RRTs having received one training and conducted at least one simulation exercise in assessment year	Annual	Annual Report of EDCD	Review of Annual Report of EDCD	EDCD

Monitoring & Evaluation Plan: Intermediate Results Indicators					
Indicator Name	**Definition/Description**	**Frequency**	**Datasource**	**Methodology for Data Collection**	**Responsibility for Data Collection**
Program supported health facilities are implementing minimum service standards	Numerator: No: of Program supported health facilities conducted minimum service standards exercise as per the guideline in the assessment year Denominator: Total number of health facilities eligible to participate in Program	Annual	Minimum service standards dat abase	Review of minimum service standards database	Curative Services Division/QSRD
Provincial public health facilities in Selected Provinces have minimum service standards score of at least 85%	Numerator: No: of Program supported public health facilities that conducted minimum service standards exercise as per the guideline in the assessment Year and scored = or >85 percent; Denominator: Total number of Program supported public health facilities that conducted the minimum service standards exercise as per the guidelines in the assessment Year	Annual	Minimum service standards database	Review of minimum service standards database	Curative Services Division/QSRD
Biomedical equipment repair and	Biomedical equipment	Annual	Physical Asset	Review of Physical Asset	Management Division

maintenance system established and functional in two Selected Provinces	repair and maintenance system established and functional with staffing, equipment, training and operations		Management System of DoHS	Management System of DoHS	
Memorandum of Understanding signed between MoHP and Nepal Drug Limited for purchase of essential medicines	Memorandum of Understanding between MoHP and Nepal Drug Limited signed.	Once	MoHP	Report from MoHP	MoHP
EMR standards adopted by MoHP	Electronic Medical Records standards framework developed and adopted by MoHP-ensure interoperability of the existing management information systems (eLMIS, HMIS, IMIS)	Annual	DoHS Annual Report	Review of DoHS Annual Report	Integrated Health Information Management Section (IHIMS)
EMR implemented by Program-Supported Health Facilities	Cumulative number of Program supported health facilities implementing Electronic Medical Records	Annual	Annual Report of DoHS	Review of Annual Report of DoHS	IHIMS
Hospitals in the two Selected Provinces have functional healthcare waste management system	Three district level hospitals, each in Koshi and Gandaki Province equipped with i) functional technology ii) trained and dedicated HR and iii) adequate budget to complete end disposal of health care waste as per standards	Continuous	DoHS/MD-report back	Monitoring by DoHS/MD of the selected hospitals at least twice a year	DoHS/MD in coordination with selected hospitals.

Local Levels in each Selected Province have implemented social audits	Cumulative number of LLs implement social audits as per the guidelines developed by the MoHP	Annual	Report of DoHS/CSD	DoHS/CSD collects social audit reports from the LLs who have implemented social audits and verifies it.	DoHS/CSD in coordination with LLs.
Framework for identification of poor and vulnerable households developed and adopted by MoHP	Framework for identification of poor and vulnerable households adopted by HIB/MoHP	Annual	Annual Report of HIB	Review of Annual Report of HIB	HIB
Health insurance claims from Selected Provinces settled in time	Numerator: Total no: of claims settled within 60 days in assessment year Denominator: Total no: of claims in the assessment year	Annual	Annual Report of HIB	Review of Annual Report of HIB	HIB
Selected Provinces and Local Levels have developed health emergency preparedness and response plans	Cumulative number of Provinces and LLs that have developed health emergency preparedness and response plans	Annual	Annual Report of EDCD	Review of Annual Report of EDCD	EDCD
Climate sensitive prioritized disease surveillance system established in two Selected Provinces	Cumulative number of surveillance sites reporting on climate induced outbreaks/diseases in the assessment year	Annual	Annual Report of EDCD	Review of Annual Report of EDCD	EDCD

ANNEX 2. DISBURSEMENT LINKED INDICATORS, DISBURSEMENT ARRANGEMENTS AND VERIFICATION PROTOCOLS

Table A2.1 DLIs and Allocation Formula

Disbursement Linked Indicators	Total DLI value	Baseline	Prior Results	Year 1	Year 2	Year 3	Year 4	Year 5
DLI 1: Implementation of minimum service standards including biomedical equipment maintenance	**SDR29,400,000** **(IDA SML)**	Percentage of Provincial and Local Level public health facilities in the two Provinces implementing minimum service standards =XX Biomedical equipment repair and maintenance system/Lab in Province= 0	Minimum service standards implemented in 20 Local Level hospitals in the two Selected Provinces (SDR1,509,800) *Non- scalable, no rollover*	**DLR 1.1:** Program supported health facilities are implementing minimum service standards *Targets*- Year 3- 60 percent, Year 5- 80 percent *Scalable, non-timebound* *Disbursement rule:* Year 3: SDR226,000 for every percentage point increase above 50% up to a total amount of SDR2,260,000 Year 5: SDR226,000 for every per percentage point increase above 60% up to a total amount of SDR4,520,000 **DLR 1.2:** Provincial public health facilities in Selected Provinces have minimum service standards score of at least 85% *Targets*- Year 3- 50% of Provincial public health facilities in Selected Proinces have minimum service standards score of at least 85%, Year 5- 50% of Provincial public health facilities in Selected Provinces have minimum service standards score at least 90% *Scalable, non-timebound* *Disbursement rule:* Year 3: SDR71,600 for every percentage point increase in Provincial public health facilities meeting the target, up to a total amount of SDR3,580,000 Year 5: SDR139,400 for every percentage point increase in Provincial public health facilities meeting the target, up to a total amount of SDR6,970,000 **DLR 1.3:** Bio-medical equipment repair and maintenance system established and functional in two Selected Provinces *Targets*- Year 2- Biomedical equipment repair and maintenance system established and functional in 1 of the two Selected Provinces Year 3- Biomedical equipment repair and maintenance system established and functional in the other of the two Selected Provinces *Non-scalable, non-timebound* *Disbursement rule-* Year 2: 1 workshop per Province: SDR2,250,000 Year 3: 1 additional workshop in next Province: SDR2,260,000 **DLR1.4:** Three hospitals in one of the two Selected Provinces have functional healthcare waste management system *Targets*- Year 2- Three hospitals in one of the two Selected Provinces have functional healthcare waste management system, Year 3- Three hospitals in the other of the two Selected Provinces have functional				

Disbursement Linked Indicators	Total DLI value	Baseline	Prior Results	Year 1	Year 2	Year 3	Year 4	Year 5
				healthcare waste management system *Scalable, non-timebound* *Disbursement rule-* Year 2: SDR376,700 for each hospital up to a total amount of SDR1,130,100 Year 3: SDR376,700 for each hospital up to a total amount of SDR1,130,100 **DLR 1.5:** Memorandum of Understanding signed between MoHP and Nepal Drug Limited for purchase of essential medicines *Targets*- Year 3- Memorandum of Understanding signed between MoHP and Nepal Drug Limited for purchase of essential medicines *Non-scalable, non-timebound* *Disbursement rule*- SDR1,510,000 **DLR 1.6**: Five LLs in each Selected Province have implemented social audits *Targets*- Year 3- Five LLs in each Selected Province have implemented social audits, Year 4- Ten additional LLs in each Selected Province have implemented social audits, Year 5- Fifteen additional LLs in each Selected Province have implemented social audits *Scalable, non-timebound* *Disbursement rule-* Year 3- SDR38,000 for each LL meeting the target, up to a total amount of SDR380,000 Year 4- SDR38,000 for each LL meeting the target, up to a total amount of SDR760,000 Year 5- SDR38,000 for each LL meeting the target, up to a total amount of SDR1,140,000				
DLI 2: Patients enrolled in EMR as per MoHP standards	**SDR6,050,000** **(IDA SML)**	Standardized EMR in selected public health facilities= 0 Percentage of patients with EMR records in selected health facilities= 0		**DLR 2.1:** EMR standards adopted by MoHP Target- Year 2- EMR standards adopted by MoHP Non- scalable, non-timebound Disbursement rule- SDR2,269,200 **DLR 2.2:** EMR implemented by 6 Program-Supported Health Facilities *Targets*- Year 3- EMR implemented by 6 Program-Supported Health Facilities, Year 5- EMR implemented by an additional 6 Program-Supported Health Facilities *Scalable, non-timebound* *Disbursement rule:* Year 3: SDR188,400 for each facility meeting the target, up to a total amount of SDR 1,130,400 Year 5: SDR188,400 for each additional facility meeting the target, up to a total amount of SDR1,130,400 **DLR2.3:** In-patients in Program supported health facilities with Electronic Medical Records *Targets*- Year 3- 50 percent, Year 5- 80 percent *Scalable, non-timebound* *Disbursement rule:*				

Disbursement Linked Indicators	Total DLI value	Baseline	Prior Results	Year 1	Year 2	Year 3	Year 4	Year 5
				Year 3: US$25,000 per percentage point up to a maximum of 50 percent (US$25,000 X 50 percent) = US$1,250,000 Year 5: US$25,000 per percentage point above 50 percent up to a maximum of 80 percent (30 percent X US$25,000) = US$750,000				
DLI 3: Increased enrollment of poor and vulnerable households in the health insurance program	**SDR20,350,000** **(IDA SML)**	Percentage of identified poor and vulnerable households in the health insurance scheme = 9 percent of poor population which is estimated to be 17 percent of the total population	Health Financing Strategy adopted by MoHP (SDR1,534,250) *Non- scalable, no rollover*	**DLR 3.1: Framework for identification of poor and vulnerable households developed and adopted by MoHP** *Targets*- Year 1- **Framework for identification of poor and vulnerable households developed and adopted by MoHP** *Non-timebound, non-scalable* *Disbursement rule:* SDR3,764,000 **DLR 3.2:** 50% of poor and vulnerable households in Selected Provinces enrolled in the health insurance program *Targets*- Year 3- 50% of poor and vulnerable households in Selected Provinces enrolled in the health insurance program, Year 5- 70% of poor and vulnerable households in Selected Provinces enrolled in the health insurance program *Scalable, non-timebound* *Disbursement rule:* Year 3: SDR246,750 for every percentage point increase above 9%, up to a total amount of SDR10,116,750 Year 5: SDR246,750 for every percentage point increase above 50%, up to a total amount of SDR4,935,000				
DLI 4: Timely settlement of health insurance claims	**SDR4,500,000** **(IDA SML)**	(5 months backlog of claims settlement)		**DLR 4: 50% of** health insurance claims from Selected Provinces settled in time *Targets*- Year 3- **50% of** health insurance claims from Selected Provinces settled in time, Year 5- 70% **of** health insurance claims from Selected Provinces settled in time *Scalable, non-timebound* *Disbursement rule:* Year 3: SDR64,284 for every percentage point, up to a total amount of SDR3,214,200 Year 5: SDR64,290 for every percentage point increase above 50%, up to a total amount of SDR1,285,800				
DLI 5: Provincial Governments and Local Levels have adequate capacity for health emergency preparedness and response	**SDR15,100,000** **(IDA Regular Terms Credit)**	PGLLs with health emergency preparedness and response plans= 0 Functional RRT as per the RRT national guidelines at	Rapid Response Team guideline adopted by MoHP (SDR1,510,410) *Non- scalable, no rollover*	**DLR 5.1:** The Selected Provinces have developed health emergency preparedness and response plans *Targets*- Year 2- The Selected Provinces have developed health emergency preparedness and response plans, Year 4- 70 Selected LLs have developed health emergency preparedness and response plans, Year 5- 111 (cumulative) Selected LLs have developed health emergency preparedness and response plans *Scalable, non-timebound* *Disbursement rule:* Year 2: SDR753,100 for each Province that meets the target, up to a total amount of SDR1,506,200 Year 4: SDR40,860 for each LL that meets the target, up to a total amount of SDR2,860,200Year 5: SDR40,860 for each LL that meets the target, up to a total amount of SDR1,675,260				

Disbursement Linked Indicators	Total DLI value	Baseline	Prior Results	Year 1	Year 2	Year 3	Year 4	Year 5
		PGLLs=0		**DLR 5.2:** Functional **r**apid response teams established in Selected Provinces and Local Levels *Targets*- Year 2- Functional **r**apid response teams established in Selected Provinces, Year 4- Functional **r**apid response teams established by 70 Selected LLs, Year 5- Functional **r**apid response teams established by 111 (cumulative) Selected LLs *Scalable, non-timebound* *Disbursement rule:* Year 2: SDR753,100 for each Province that meets the target, up to a total amount of SDR1,506,200 Year 4: SDR54,430 for each LL that meets the target, up to a total amount of SDR3,810,100 Year 5: SDR54,430 for each additional LL that meets the target, up to a total amount of SDR2,231,630				
DLI 6: Climate sensitive prioritized disease surveillance system established	**US$3.84 million** **(HEPR TF)**	Not established	Memorandum of Understanding entered into between MoHP and Department of Hydrology and Meteorology for climate sensitive surveillance system (US$960,000) *Non- scalable, no rollover*	**DLR 6.1**: Climate sensitive prioritized disease surveillance system established in one site in one of the two Selected Provinces *Targets*- Year 2- Climate sensitive prioritized disease surveillance system established in one site in one of the two Selected Provinces , Year 3- Climate sensitive prioritized disease surveillance system established in one site in the other Selected Province *Non-Scalable, non-timebound* *Disbursement rule:* Year 2: US$1,440,000 per site Year 3: US$1,440,000 per maximum one additional site: US$1,440,000				

Disbursement Linked Indicators Matrix				
DLI 1	Implementation of minimum service standards including biomedical equipment maintenance			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Output	Yes	Text	39,000,000.00	37.56
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	Not all selected public health facilities implement minimum service standards regularly			

Prior Results	Minimum service standards implemented in 20 local level hospitals in two Selected Provinces	2,000,000.00	Table A2.1 (Annex 2)
July 15, 2023 to July 15, 2024	0.00	0.00	NA
July 15, 2024 to July 15, 2025	(i) Biomedical equipment repair and maintenance system established and functional in one of the two Selected Provinces (ii) 3 hospitals in one of the two Selected Provinces have functional healthcare waste management system	10,000,000.00	Table A2.1 (Annex 2)
July 15, 2025 to July 15, 2026	(i) 60% of Program-Supported Health Facilities are implementing minimum service standards (ii) 50% of Provincial public health facilities in Selected Provinces have minimum service standards score of at least 85% (iii) Biomedical equipment repair and maintenance system established and functional in the other of the two Selected Provinces (iv) 3 hospitals in the other of the two Selected Provinces have functional healthcare waste management system (v) Memorandum of understanding signed between MoHP and Nepal Drug Limited for purchase of essential medicines (vi) 5 LLs in each Selected Province have implemented social audits	9,250,000.00	Table A2.1 (Annex 2)
July 15, 2026 to July 15, 2027	10 additional LLs in each Selected Province have implemented social audits	1,500,000.00	Table A2.1 (Annex 2)
July 15, 2027 to July 15, 2028	(i) 80% (cumulative) of Program-Supported Health Facilities are implementing minimum	16,250,000.00	Table A2.1 (Annex 2)

	service standards (ii) 50% of provincial public health facilities in Selected Provinces have minimum service standards score of at least 90% (iii) 15 additional LLs in each Selected Province have implemented social audits		

DLI 2	Patients enrolled in EMR as per MoHP standards			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Outcome	Yes	Text	8,000,000.00	7.70

Period	**Value**	**Allocated Amount (USD)**	**Formula**
Baseline	No		
Prior Results	NA	0.00	NA
July 15, 2023 to July 15, 2024	NA	0.00	NA
July 15, 2024 to July 15, 2025	EMR standards adopted by MoHP	3,000,000.00	Table A2.1 (Annex 2)
July 15, 2025 to July 15, 2026	(i) EMR implemented by 6 Program-Supported Health Facilities (ii) 50% of in-patients in Program-Supported Health Facilities have EMR records	2,750,000.00	Table A2.1 (Annex 2)
July 15, 2026 to July 15, 2027	NA	0.00	NA
July 15, 2027 to July 15, 2028	(i) EMR implemented by additional 6 Program-Supported Health Facilities (ii) 80% (cumulative) of in-patients in Program-Supported Health Facilities have EMR records	2,250,000.00	Table A2.1 (Annex 2)

DLI 3	Increased enrollment of poor and vulnerable households in the health insurance program			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Outcome	Yes	Text	27,037,820.00	26.00
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	9% of estimated poor enrolled in the health insurance scheme			
Prior Results	Health financing strategy adopted by MoHP		2,037,811.00	Table A2.1 (Annex 2)
July 15, 2023 to July 15, 2024	Framework for identification of poor and vulnerable households developed and adopted by MoHP		5,000,000.00	Table A2.1 (Annex 2)
July 15, 2024 to July 15, 2025	NA		0.00	NA
July 15, 2025 to July 15, 2026	50% of poor and vulnerable households in Selected Provinces enrolled in the health insurance program		13,442,629.00	Table A2.1 (Annex 2)
July 15, 2026 to July 15, 2027	NA		0.00	NA
July 15, 2027 to July 15, 2028	70% of poor and vulnerable households in Selected Provinces enrolled in the health insurance program		6,557,380.00	Table A2.1 (Annex 2)

DLI 4	Timely settlement of health insurance claims			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Outcome	Yes	Percentage	5,962,180.00	5.70
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	0.00			
Prior Results	0.00		0.00	NA
July 15, 2023 to July 15, 2024	0.00		0.00	NA
July 15, 2024 to July 15, 2025	0.00		0.00	NA
July 15, 2025 to July 15, 2026	50.00		4,258,700.00	Table A2.1 (Annex 2)
July 15, 2026 to July 15, 2027	0.00		0.00	NA
July 15, 2027 to July 15, 2028	70.00		1,703,480.00	Table A2.1 (Annex 2)

DLI 5	Provincial Governments and Local Levels have adequate capacity for health emergency preparedness and response			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Outcome	Yes	Text	20,000,000.00	19.26
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	PGLLs with health emergency preparedness and response plans= 0Functional RRT as per the RRT national guidelines at PLLs=0			

Prior Results	Rapid response team guideline adopted by MoHP	2,000,125.00	Table A2.1 (Annex 2)
July 15, 2023 to July 15, 2024	NA	0.00	NA
July 15, 2024 to July 15, 2025	(i) The Selected Provinces have developed health emergency preparedness and response plans (ii) Functional rapid response teams established in Selected Provinces	4,000,000.00	Table A2.1 (Annex 2)
July 15, 2025 to July 15, 2026	NA	0.00	NA
July 15, 2026 to July 15, 2027	(i) 70 Selected LLs have developed health emergency preparedness and response plans (ii) Functional rapid response teams established by 70 Selected LLs	8,828,750.00	Table A2.1 (Annex 2)
July 15, 2027 to July 15, 2028	(i) 111 (cumulative) Selected LLs have developed health emergency preparedness and response plans (ii) Functional rapid response teams established by 111 (cumulative) Selected LLs	5,171,125.00	Table A2.1 (Annex 2)

DLI 6	Climate sensitive prioritized disease surveillance system established			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Output	No	Text	3,840,000.00	0.04
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	0.00			
Prior Results	Memorandum of Understanding (MoU) entered into between MoHP and Department of		960,000.00	Table A2.1 (Annex 2)

	Hydrology and Meteorology for climate sensitive surveillance system		
July 15, 2023 to July 15, 2024	NA	0.00	NA
July 15, 2024 to July 15, 2025	Climate sensitive prioritized disease surveillance system established in one site in one of the two Selected Provinces	1,440,000.00	Table A2.1 (Annex 2)
July 15, 2025 to July 15, 2026	Climate sensitive prioritized disease surveillance system established in one site in the other Selected Province	1,440,000.00	Table A2.1 (Annex 2)
July 15, 2026 to July 15, 2027	NA	0.00	NA
July 15, 2027 to July 15, 2028	NA	0.00	NA

Verification Protocol Table: Disbursement Linked Indicators	
DLI 1	Implementation of minimum service standards including biomedical equipment maintenance
Description	Biomedical equipment repair and maintenance system established and functional in two Selected Provinces --- Biomedical equipment repair and maintenance system established and functional with staffing, equipment, training and operations Memorandum of Understanding (MoU) with Nepal Drug Limited (NDL) for purchase of essential medicines --- Agreement between MoHP and NDL for purchase of essential medicines from NDL is established in an MoU Program supported public health facilities have functional healthcare waste management system --- Number of selected 3 district level hospitals in each province have healthcare waste management established Program supported health facilities implementing Minimum service standards --- Numerator: No: of Program supported health facilities conducted minimum service standards exercise as per the guideline in the assessment year; Denominator: Total number of health facilities eligible to participate in Program Percentage of provincial public health facilities in Selected Provinces have minimum service standards score of at least 85% --- Numerator: No: of Program supported health facilities that conducted minimum service standards exercise as per the

	guideline in the assessment Year and scored = or 85 percent; Denominator: Total number of Program supported health facilities that conducted the minimum service standards exercise as per the guidelines in the assessment Year LLs implement social audit ----Number of LLs implementing social audit
Data source/ Agency	Minimum service standards database; Curative Services Division Biomedical equipment/ Healthcare waste; Provincial and DoHS/MD reports MoU of MoHP and NDL: MoHP record Social audits: LLs report and CSD report
Verification Entity	World Bank for the Prior Results Independent Verification Agent (IVA)
Procedure	Minimum service standards implemented in 20 local level hospitals in two Selected Provinces -- World Bank reviews the report submitted by DoHS/CSD and verifies it by gaining access through the HMIS. Biomedical equipment repair and maintenance system established and functional in two Selected Provinces --- IVA verifies through onsite visit- checks presence of agreed number of staff and equipment, annual training of staff and operations as evidenced by inventory of equipment maintained. MoU with Nepal Drug Limited (NDL) for purchase of essential medicines --- IVA reviews and verifies with MoHP that an MoU has been signed between MoHP and NDL for purchase of essential medicines from NDL Program supported public health facilities have functional healthcare waste management system ---- IVA verifies with onsite visits-the presence of three district level hospitals, each in Koshi and Gandaki province equipped with i) functional technology ii) trained and dedicated HR and iii) adequate budget to complete end disposal of health care waste as per standards Program supported health facilities implementing Minimum Service Standards ---IVA verifies that MSS assessment has been conducted as per the guideline (from HMIS/CSD report) and reports are available for the preceding year (20 percent sample checks of the reports from the hospitals). Percentage of provincial and local level public health facilities in Selected Provinces have minimum service standards score of at least XX percent --- IVA verifies the HMIS/CSD report and if required through provincial health office Local Levels implement social audit --- IVA reviews submission by CSD in coordination with selected local levels and verifies it by checking minutes, report signed by competent authority
DLI 2	Patients enrolled in EMR as per MoHP standards
Description	Electronic Medical Records standards framework developed and endorsed and implemented by Selected Provincial health facilities. In-patients record in EMR --- Numerator: No: of inpatients in Program supported health facilities in Selected Provinces with EMR in the assessment year ---Denominator: Total no: of inpatients in Program supported health facilities in

	Selected Provinces with EMR in the assessment year
Data source/ Agency	DoHS Annual Report/ IHIMS in coordination with Provincial health office EMR records of selected hospitals implementing EMR
Verification Entity	Independent Verification Agent
Procedure	EMR Standard adopted by MoHP--- IVA reviews the standard developed for the EMR which would include details of API requirement, interoperability between DHIS2/HMIS and health insurance MIS, etc. EMR implemented by selected facilities---- IVA reviews the EMR of the identified Province hospitals and checks whether it fulfills the criteria established as per the standard. In-patients in Program-Supported Public Health Facilities have EMR records----IVA reviews the report submitted CSD/HMIS section, conducts onsite visit and verifies that at least 3 specialty wards have in-patient records in the EMR
DLI 3	Increased enrollment of poor and vulnerable households in the health insurance program
Description	Health financing strategy available Endorsement of framework for identification of poor and vulnerable households LLs enroll poor and vulnerable households in Selected Provinces as per the framework
Data source/ Agency	Annual Report of HIB, insurance management information system
Verification Entity	Independent Verification Agent
Procedure	World Bank verifies that a Health Financing Strategy has been endorsed by a competent authority of the MoHP and submitted to Cabinet IVA verifies that a framework for identification of poor and vulnerable households to be enrolled in the health insurance scheme has been adopted by a competent authority (HIB/MoHP) IVA reviews the report submitted by HIB related to enrolment of poor and vulnerable population, conducts checks by gaining access through insurance MIS and verifies the number.
DLI 4	Timely settlement of health insurance claims
Description	Numerator: Total no: of claims settled within 60 days in assessment year Denominator: Total no: of claims in the assessment year
Data source/ Agency	Annual Report of HIB; HIB

Verification Entity	Independent Verification Agent
Procedure	IVA reviews the report submitted by the HIB. Conducts sample checks through gaining access to the health insurance MIS.

DLI 5	Provincial Governments and Local Levels have adequate capacity for health emergency preparedness and response
Description	Rapid response team guideline adopted by MoHP Cumulative number of PGLLs that have developed health emergency preparedness and response plans Cumulative number of PGLLs that have established functional rapid response teams
Data source/ Agency	EDCD/DoHS
Verification Entity	World Bank for the Prior Results Independent Verification Agent
Procedure	Rapid response team (RRT) guideline adopted by MoHP-- World Bank reviews and verifies that the RRT guideline has been drafted and adopted by the MoHP The Selected Provinces have developed health emergency preparedness and response plans- IVA reviews and verifies that the preparedness and response plans exist as defined and includes aspects of citizen engagement, healthcare waste management, life and fire safety. Functional rapid response teams established in Selected Provinces- IVA reviews and verifies the report, conducts sample checks with PGLLs (20 percent) of the reported number of the assessment year- with functional RRT meaning- annual trained human resources and at least one tabletop/ simulation exercise conducted annually

DLI 6	Climate sensitive prioritized disease surveillance system established
Description	(i) MoU entered into between MoHP and Department of Hydrology and Meteorology for climate sensitive prioritized disease surveillance system (ii) Sites where climate sensitive prioritized disease surveillance system established
Data source/ Agency	EDCD/DoHS
Verification Entity	World Bank for the Prior Results Independent Verification Agent for DLI 6
Procedure	(i) MoU entered into between MoHP and Department of Hydrology and Meteorology for climate sensitive prioritized disease surveillance system- World Bank reviews and verifies the signing of the said MOU (ii) Sites where climate sensitive prioritized disease surveillance system established- IVA reviews the report submitted and verifies by conducting field visits such surveillance system exists

ANNEX 3. (SUMMARY) TECHNICAL ASSESSMENT

1. The Program Development Objective of the proposed operation is to improve quality of healthcare, enhance health insurance coverage for poor, and strengthen health emergency preparedness in the selected Provinces.

Strategic Relevance and Technical Soundness

2. **Nepal's health system continues to be challenged by some critical and systemic performance issues.** The NHS-SP includes institutional and system reforms necessary to improve health system readiness and quality of health service delivery. This NHS-SP is the first sector plan after the Federal restructuring, serves also as an operational plan of the national health policy (2019), and builds on the Government's long-term vision of 'Prosperous Nepal, Happy Nepali' to achieve effective UHC. Strategic objectives of the NHS-SP are aimed to improve overall health system's performance required to deliver quality of care to all without exposing population, especially to the poor and vulnerable, to financial hardship.

3. **NHS-SP sets the overall boundary of Government program ('p').** It espouses five strategic objectives: (1) strengthening of health systems components; (2) addressing wider determinants of health; (3) enhancing financial protection in health; (4) improving quality and equity in access; and (5) management of population and migration to be achieved from 2023-2030.

4. **The Program ('P') will support a subset of objectives for a period of five years as defined under the Government's NHS-SP.** The Program will focus on three RAs as described in the main section of the PAD to align with the three objectives of the NHS-SP. The three RAs were chosen since they are supported with relevant policy and guidelines for implementation, are critical for quality of and equity in healthcare services (reaching the last mile), and are necessary to enhance health systems resilience in the aftermath of pandemic and propensity for being impacted by climate hazards.

Program boundary and expenditure framework

5. **Program boundary.** The proposed PforR is a well-defined subset of the NSS-SP. An overview of the objectives, outcomes and outputs of the NHS-SP along with mapping of the results areas of the Program is presented in the table below (Table A3.1).

Table A3.1: Mapping of outcomes and outputs of NHS-SP against Program Results Area

Results Area (RA)	Output	Outcome	Strategic Objective
NA	*Competent human resources for health produced based on projections*	1.1 Skill-mixed human resources for health produced and mobilized	Enhance efficiency and responsiveness of health system
RA 1	Human resources for health mobilized effectively		
RA 1 & 2	Evidence generated, analyzed and used at all levels leveraging technology	1.2 Evidence- and equity-based planning	
RA 1	Promoted high-quality health research in priority areas		
NA	*Physical infrastructure of health institutions strengthened*	1.3 Safe and people friendly health infrastructures	
RA 1	Health facilities equipped with bio-medical and other equipment, and regularly repaired and maintained		
RA 1	Domestic production of medicines, diagnostic and health products promoted and regulated	1.4 Ensured uninterrupted availability of quality medicine and supplies	
RA 2	Procurement and supply chain management of medicines and supplies strengthened		
RA 1, 2 & 3	Governance and leadership performance improved at all levels	1.5 Improved governance, leadership and accountability	
RA 1 & 2	Citizen engagement platforms enhanced and institutionalized		
RA 1	Ethical health practice and rational use of services promoted		
RA 2	Improved public financial management		

RA 3	Strengthened preparedness for public health emergencies	1.6 Public health emergencies managed effectively	
RA 3	Public health emergencies responded effectively and timely		
NA	*Institutional and policy arrangements governing wider determinants developed and/or reformed*	*2.1 Reduced adverse effects of wider determinants on health*	*Address wider determinants of health*
NA	*Operationalized multi-sectoral collaboration by establishing institutional mechanism*		
NA	*Modified behavior of citizens for a healthier lifestyle*	*2.2 Citizens responsible for their own, family and community health*	
RA 1 & 2	Increased domestic financing and efficiency in health sector	3.1 Improved public investment in health sector	Promote sustainable financing and social protection in health
RA 1	Improved management of development cooperation in health sector		
RA 2	Free basic health services ensured in urban and rural settings	3.2 Improved social protection in health	
RA 2	Reformed health insurance system		
NA	*Streamlined social health protection schemes*		
RA 1	Quality assurance mechanism for health services strengthened	4.1 Improved quality of health services	Promote equitable access to quality health services
RA 1	Quality of care improved at the point of delivery		
RA 1 & 2	Improved access to quality health services	4.2 Reduced inequity in health services	
RA 2	Drivers of inequities in health services addressed		
NA	*Strengthened population information management system and research*	*Maximized demographic dividend and managed demographic transitions in development process*	*Manage population and migration*
NA	*Enabling environment created for demographic dividend and transition management*		
NA	*Safe migration and planned settlement promoted*	*Systematic migration and planned settlement practiced*	

Expenditure Framework

6. **The overall expenditure framework of the Government program ("p") is US$7.42 billion while the proposed Program ("P") is estimated at US$1,513 million.** The Program Expenditure Framework is premised on the existing expenditure pattern of the MoHP and cost scenario of the NHS-SP. Composition of the health sector budget (MoHP, inclusive of health sector CGs for Province and LLs) is presented in the table below (**Table A3.2**).

Table A3.2: Trend and composition of the Federal health budget by line items

Description	2019	2020	2021	2022	2019	2020	2021	2022
	Million US$				Percent			
Wages and salaries	122	130	157	153	24.5	22.0	20.4	13.8
Support services	14	8	20	5	2.8	1.4	2.6	0.4
Capacity building	8	4	6	5	1.5	0.7	0.8	0.5
Program activities	42	57	87	126	8.4	9.7	11.4	11.3
Medicines and supplies	47	54	48	374	9.4	9.2	6.3	33.7
Grants and social security	187	261	317	329	37.4	44.2	41.4	29.7
Capital construction	68	68	124	112	13.7	11.5	16.2	10.1
Capital goods	12	8	8	6	2.4	1.3	1.0	0.5
Total	500	591	767	1,109	100.0	100.0	100.0	100.0

Source: Nepal Health Sector Support Programme (NHSSP)/ MoHP, Budget Analysis Report, 2022.

7. **The Federal MoHP has projected the implementation cost of the NHS-SP for the first five years of implementation.** A total of US$7.42 billion has been estimated for the implementation of the health sector programs at the Federal, Provincial and LLs during the first five years.

8. Total cost of the Program boundary was defined by including relevant outcomes and outputs, and by applying reasonable weightage given the nature of proposed Program components. Accordingly, estimated Program cost is presented in Table A3.3 by outcome areas of the NHS-SP.

Table A3.3: Composition of the total cost within the scope Program boundary in US$ million

Outcome Area	2024	2025	2026	2027	2028	Total	
						Amount	Percent
Outcome 1.1	109	123	147	164	194	738	48.8
Outcome 1.2	7	10	12	15	17	61	4.0
Outcome 1.3	8	9	11	13	14	54	3.6
Outcome 1.4	20	22	24	26	29	120	7.9
Outcome 1.5	1	1	1	1	1	5	0.3
Outcome 1. 6	2	3	3	3	3	13	0.9
Outcome 2.1	-	-	-	-	-	-	0.0
Outcome 2.2	-	-	-	-	-	-	0.0
Outcome 3.1	11	13	16	18	20	79	5.2
Outcome 3.2	51	69	66	71	78	335	22.2
Outcome 4.1	13	13	13	13	13	67	4.4
Outcome 4.2	7	8	8	9	10	41	2.7
Outcome 5.1	-	-	-	-	-	-	0.0
Outcome 5.2	-	-	-	-	-	-	0.0
Total	229	271	301	333	379	1,513	100.0

Source: estimated based on NHS-SP cost scenario.

Program Results Framework and Monitoring and Evaluation

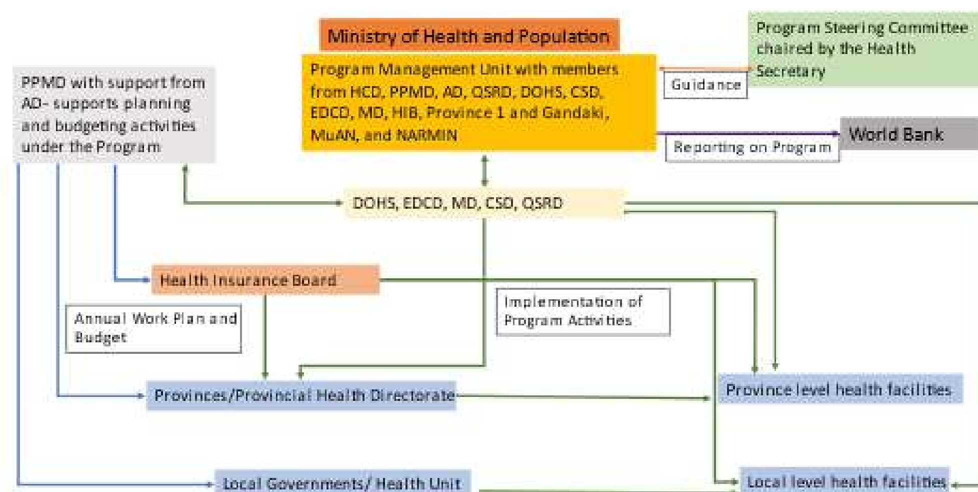
9. Program Results Framework and indicators are built on the theory of change to tackle the underlying issues regarding the three results areas. These are the areas prioritized by the Government under its own program and are part of the monitoring and evaluation framework of the NHS-SP. The rationale for choosing the DLIs under each Results Area of the Program is described under the PforR Program Scope and Disbursement Linked Indicators. The Program's results framework and monitoring and evaluation are described in the main section of the PAD.

10. **Program's Governance Structure and Institutional Arrangements** as described under Section III. A of the main PAD are adequate for delivering the Program results areas. Table A3.4 below depicts the roles and responsibilities of national and PGLLs with respect to the DLIs and Figure A3.1 shows the overall institutional arrangement.

Table A3.4. Roles and responsibilities of national and PGLLs with respect to DLIs

DLIs	Responsibility for achieving results	Implementing agencies	
		National	PGLLs
DLI1: Implementation of minimum service standards including biomedical equipment maintenance	National + PGLLs	- QSRD and CSD - MD - PPMD	- Provincial Health Directorate - Health Section of LLs
DLI2: Patients enrolled in EMR as per MoHP standards	National + PGLLs	- MD - CSD - PPMD	- Provincial Health Directorate - Health section of LL - Hospitals
DLI3: Increased enrollment of poor and vulnerable households in the health insurance program	National +PGLLs	- HIB - MoHP	- LLs
DLI4: Timely settlement of health insurance claims	National + PGLLs	- HIB	- Health Section of LLs - Empaneled hospitals
DLI5: Provincial Governments and Local Levels have adequate capacity for health emergency preparedness and response	National + PGLLs	- EDCD	- Provincial HEOC - Hospitals - Health Section of LLs
DLI 6: Climate sensitive prioritized disease surveillance system established	National + Provinces	-EDCD	- Provincial Health Directorate

Figure A3.1. Institutional Arrangement



Economic Justification

11. **The proposed Program is supporting three critical RAs that directly contribute to improving service quality and access, and health systems' resilience.**

- RA1 has the potential to strengthen the health facility services and contribute to efficiency through the effective roll out of minimum service standards. Strengthening of the data systems as proposed in the RA1, can contribute to improve allocative efficiency of the health systems through appropriate evidence-based prioritization of resources. Improved functionality of the biomedical equipment can contribute to enhancing the efficiency of hospitals and improving patient outcomes. It is estimated that 60 percent of deaths from conditions amenable to health care are due to poor-quality care, whereas the remaining deaths result from non-utilization of the health system. In a separate study conducted in 2008, economic value of the total annual DALY for Nepal was estimated to be 0.93 percent of the GDP which is equivalent to nearly half of the annual budget of Federal MoHP. The proposed Program has included minimum service standards as a component of RA1 for strengthening health systems. The effective roll out of the minimum service standards through this Program has potential to contribute to enhance quality of care by facilitating for the right mix of inputs and adherence of the processes at service delivery points.

- RA2 envisions reducing the burden of OOP expenditures which is considered one of the most regressive approaches for financing health services. Widening the scope of health insurance scheme in terms of its population and service coverage, especially among the poor and vulnerable populations, along with enhancement of institutional capacity can yield multiple benefits in the health sector in terms of reduced rates for package than usual market price, compliance to quality protocols linking to the reimbursement and gains from scale of economy in program management.

- RA 3 will make the health system resilient to health emergencies and enhance the capacity of the health sector to manage exogenous shocks. Benefits of investments in pandemic preparedness are multiple times than investments. In the most conservative scenario, it is estimated that US$3.25 of benefit is generated for every US$1 spent, and this increases as high as US$5.31 of benefit for every US$1 spent in the least conservative.[1]

12. Considering each of the components of the Program, costs and benefits were analyzed in

[1] Kellet, J. & Peters, K. 2014. Dare to prepare: taking risk seriously. Financing emergency preparedness: from fighting crisis to managing risk. ODI. Accessed on 29th September at: http://cdn-odi-production.s3-website-eu-west-1.amazonaws.com/media/documents/8748.pdf.

monetary terms to understand the benefits of the Program against the estimated costs. In doing so, benefits are estimated under direct cost saving and indirect benefits to the health systems by applying a specific discount rate. Although discounting is important in economic evaluation, there is wide discrepancy in terms of specific rates being practiced[2] and discount rates of 0 to 5 percent were found to have been commonly applied in the health sector.[3] For this evaluation, uniform rate of discounting throughout the years on the annualized benefits of the investment was used. Cost benefit analysis was conducted for five years period mainly basing on the PEF and relating that to the total expenditure estimated for the Government program, i.e., NHS-SP.

13. Since the cost scenario was defined in constant value so was done for the benefits mainly by linking the benefit to the cost amount based on assumptions tailored to the country context. Therefore, no adjustments were made for the inflation, instead estimated annual benefits were contracted by 10 percent as the contingency margin. Moreover, net present value of net annual benefit was calculated using 12 percent. Analysis of the cost and benefit was disaggregated by Results Area of the Program as well as strategic objectives of the program (NHS-SP) which are presented in the following tables. Net benefit becomes positive from the second year of the implementation and successively increases over the years. During the entire phase of Program implementation, a net benefit of US$923 million is expected. Given the Program's nature of focusing on strengthening of the Government systems and their institutionalization, substantial benefits can be expected beyond the Program phase which however have not been accounted in this analysis.

Table A3.5: Cost benefit analysis of the Program by Results Areas

Results Area	Costs and benefits	2024	2025	2026	2027	2028	Total
RA 1: Improving readiness of healthcare delivery systems and quality of care	Costs	117	133	156	173	199	779
	Benefits	115	217	339	482	666	1,818
	Net benefits	(3)	84	183	308	467	1,039
RA 2: Improving health insurance coverage and effectiveness	Costs	77	98	99	108	119	500
	Benefits	84	130	157	189	226	786
	Net benefits	7	32	59	81	107	287
RA 3: Enhancing health emergency preparedness and response capacity at Province and Local Levels	Costs	35	40	47	52	61	235
	Benefits	31	70	116	164	229	610
	Net benefits	(4)	31	69	112	167	376
Total	Costs	229	271	301	333	379	1,513
	Gross benefits	230	418	612	834	1,121	3,215
	Contingency (10 percent)	23	42	61	83	112	321
	Net benefits	(22)	105	250	417	629	1,380
Net present value (at 12 percent discount rate)							923

Note: Amount in million US$

[2] Hultkrantz, L. Discounting in economic evaluation of healthcare interventions: what about the risk term?. Eur J Health Econ 22, 357–363 (2021). https://doi.org/10.1007/s10198-020-01257-x.
[3] Attema, A.E., Brouwer, W.B.F., Claxton, K.: Discounting in economic evaluations. PharmacoEconomics (2018).

ANNEX 4. (SUMMARY) FIDUCIARY SYSTEMS ASSESSMENT

Reasonable Assurance

1. **As part of Program preparation, a Fiduciary Systems Assessment (FSA) of all the implementing agencies (IA) has been carried out by the World Bank in accordance with Bank Policy and Directive for Program for Results (PforR) financing.** The focus on the agencies was impacted by the level of Program expenditure expected to be incurred at the individual agency-level: MoHP 24 percent, DoHS 14 percent, HIB 2 percent and the two Provincial Governments, including their LLs 60 percent. The FSA concludes that the extant fiduciary systems, capacity, and performance of the IAs are adequate to provide reasonable assurance, subject to timely and material implementation of agreed mitigation measures for risks identified, that the Program funds will be used for the intended purposes, with due attention to the principles to economy, efficiency, effectiveness, transparency, and accountability. The mitigation measures are included in the PAP or as legal covenants or incentivized through a DLI. Further, based on the procurement profile of the Program, no high-value contracts are expected.

2. The audit report for the recently closed Nepal Health Sector Management Reform Program-for-Results, which is due on April 15, 2023, is yet to be received. Since it is unlikely that the audit report would be received by the proposed Board date, an exception request was approved.

Risk Assessment

3. **Based on the FSA and given the multi-agency engagement for operation and execution of the Program, the fiduciary risk is assessed as "Substantial."** There is an inherent risk associated with variations in fiduciary capacity to comply with agreed fiduciary arrangements. The key risks to which the Program may be subject to that led to assessment of fiduciary risk as Substantial are mentioned below (Table A4.1) along with the mitigation measures.

Table A4.1. Risks and Mitigation

Area	Risks Identified	Proposed Mitigation
Planning and Budgeting	▪ The Annual Work Plan and Bundget (AWPB) is highly influenced by MoHP and its departments on health priorities. Hence contracting down the PGLL's discretion in determining their health plans, programs and service delivery contextualized to their own needs, priorities, and capacity is limited ▪ Medium Term Expenditure and Budget Frameworks is not considered during budget preparation and there is risk of the Program activities being underfunded	▪ The activities and budget required to deliver the Program and achieve DLIs, and other results will be incorporated in the AWPB of MoHP, and CG resources to the Provincial and LLs in the two selected Provinces which will follow the same budgeting, fund flow and reporting arrangements as with other health programs funded with CGs by MoHP.
Accounting, Internal Controls, and Financial Reporting	▪ Shortcomings in the implementation of the internal control framework within MoHP pose a risk that Bank proceeds might be expensed in contradiction with the legal and regulatory framework. ▪ Timely accounts reconciliation is not made.	▪ MoHP will ensure in the Operating Guidelines of the Program that the Internal Control Guidelines are adhered to by the Program implementing agencies. ▪ MoHP will provide financial management report (FMR) every six month, within 60 days of the close of fiscal semester. ▪ Financial reporting will be strengthened to enhance internal control measures.
Internal Audit	▪ Inadequate Internal Audit	▪ Ensure internal audit every quarter for all cost centers and establish a mechanism under the Program to devise action plan for internal audit observation and regularize its' follow-up.
External Audit	▪ Timely audit and follow up on audit issues	▪ The Program Financial Statements will be

Area	Risks Identified	Proposed Mitigation
	pose a challenge	audited annually by the OAG and audit report submitted to the Bank within nine months from close of the fiscal year. ▪ The World Bank has discussed with the leadership at OAG for timely audit, and OAG issued an internal circular on the same.
Procurement	▪ e-GP system is used only for collecting bids and no significant progress observed to utilize the system for wider procurement management. ▪ Model bid documents are not adequately developed to address health equipment and medicine procurement.	▪ MoHP will develop model bidding documents for health specific items and medicines. ▪ Use e-GP system for all the procurable items of the program irrespective of any thresholds and for the full procurement cycle and potential of the electronic procurement system of the country.
Staff Capacity	▪ Staff for financial management and procurement management are not adequately arranged ▪ Financial Management staff at the MoHP are stretched with routine jobs	▪ Develop the capacity of human resources in all three tiers of Government especially at the provinces and LLs on financial management, procurement, and governance. ▪ Update and conduct rollout/ refresher courses for all cost centers under the Program on FM related policy documents and guidelines. ▪ A FM Consultant and Procurement Specialist will be appointed in the program support unit at MoHP. Additionally, one procurement specialist in the health ministry of each of the participating provinces will be placed.
Fraud & Corruption	▪ MoHP has a mechanism to receive fraud and corruption related complaints, however, has shortcomings in relation to recording, monitoring and acting against the complaints received	▪ MoHP will ensure in the Operating Guidelines to a mechanism to redress Fraud and Corruption issues under the Program to be implemented by all cost centers and provide periodic reports to the Bank on allegations of fraud and corruption related to the Program.

Program Expenditure Framework (PEF)

4. **The PEF comprises of wages and salaries, capacity building, goods, health insurance and social security expenses and Program operational costs.** Almost 25 percent of the Program's Expenditure is estimated to be procurable. Details of the nature of Program Expenditure are provided in Table A4.2. The Program is not expected to include any large-value contracts based on the inherent definition of Program boundaries as explained in the main text of the PAD.

Table A4.2: Description of Program Expenditure

Category	Description	Agency
Goods	Machinery, equipment, and supplies for health, IT hardware, software, and office equipment	Participating departments/divisions of MoHP and PGLLs
Non-consulting services	IT system, upgrading and/or new management information system for recording and reporting of health data for enhancing monitoring and evaluation	Participating departments/divisions of MoHP and PGLLs
Works	Construction of bio-medical equipment workshops, minor repairs	Participating Provinces
Consultancy	For design and quality assurance of bio-medical equipment workshops, modernization of the health facilities/institutes and training of staff, support for unified database	Participating departments/divisions of MoHP and PGLLs
Program Operational Expenses	Wages and salaries, health insurance subsidies, and other recurrent costs	Participating departments/divisions of MoHP and PGLLs

5. **The majority of the Program Expenditure will be incurred at the two Provinces Gandaki and Koshi and their LLs for about 60 percent and at the level of the MoHP and DoHS, 24 percent and 14 percent respectively.** The agency-wise Framework is summarized in Table A4.3.

Table A4.3: Implementing Agency-wise Program Expenditure and share

Agency	PforR Program ("P") - US$ million	Percent of expenditure to total P
MoHP	363.12	24
DoHS	211.82	14
HIB	30.26	2
Provincial Governments and Lls therein	907.8	60
TOTAL US$ million "P"	**1,513**	**100**

Source: Calculations based on NHS-SP costing

6. **The Program is expected to incur 37 percent on wages and salaries followed by Grants and Social Security at 27 percent (Table 8 in the main body of the PAD).** There are district budget heads linked to the expenditure which will facilitate easy identification and quantum of Program Expenditure. Funding predictability is reasonably high as health is a priority sector for GoN and agencies know in advance their allocations to allow planning.

Program Fiduciary Oversight Mechanisms and Arrangements

7. **Legal & Regulatory Aspects.** The legal and institutional basis for public financial management is comprehensive with adequate systems and procedures in guiding public entities in the management of public funds. The 2015 constitution defines the responsibilities of different government ministries and agencies for the three tiers of government in the budget formulation and implementation process. The Intergovernmental Fiscal Arrangement Act 2017 (IFAA) and the Financial Procedures and Fiscal Responsibility Act 2019 (FPFRA) assign the responsibilities for public entities on planning, budgeting, execution and oversight. Audits are regulated through the Audit Act (2019) and public procurement is regulated by the Public Procurement Act (PPA) (2007) with subsequent amendments. For Provincial and LL planning, budgeting, execution and oversight, the Federal Government has issued detailed model guidelines to facilitate Provinces and LLs in formulation of their policies. The OAG mandate also includes audit of PGLLs. As per the Local Government Operation Act (2017) there are to be Public Accounts Committees at all LLs.

8. **The fiduciary systems for the Program will be predicated on the extant systems of GoN and the implementing entities.** The budget for the Program will be consolidated by MoHP and proposed in the Line Ministry Budgetary Information system based on administrative and economic classification and with segregation of activities for each entity. The budget of each Province and LL will be budgeted as fiscal transfers (CGs) in the Federal budget. All funds will be through the government systems and there will be no use of bank accounts. Computerized Government Accounting System (CGAS) at Federal and provincial levels, and SuTRA at LLs will be used for accounting and reporting on a real-time basis. The MoHP will continuously monitor that the accounts are locked and reconciled timely. All agencies will follow the Internal Control Guidelines (2014) of the GoN including the financial management improvement plan. The GoN and MoHP will ensure that these are rolled out to all PGLLs. The internal audit unit of the Financial Comptroller General Office (FCGO) is responsible for conducting internal audit function in all offices at the Federal and Provincial Treasury Controller Office conducts it for Provincial Governments. The LLs as per the autonomy provided by Local Governance Operations Act can either conduct internal audit through their own internal audit unit or through District Treasury Controller Office or any other appropriate way. These mechanisms will apply to the Program and the MoHP will share periodic Program internal audits with the Bank on agreed terms of reference. The MoHP will prepare the Program annual financial statements as per agreed format and present in a timely manner to the OAG for audit. The audit will be conducted by the OAG and an audit report along with audited financial statements will be submitted to the Bank within nine months of closing the fiscal year. MoHP will follow up on audit issues and submit a remedial action plan.

9. All the implementing entities will use Nepal e-GP system, National Public Procurement Act and Public Procurement Regulations and standard procurement documents of Public Procurement Monitoring Office. They will continue the practice of preparation of annual procurement plan in the beginning of fiscal year, and publication of contract awards information with quoted prices of awarded and participating bidders.

Anti-corruption Measures

10. **The Bank's Anti-Corruption Guidelines (ACG)[4] will apply to all activities under the Program and a detailed protocol for operationalizing these will be agreed with MoHP**.

Implementation Support

11. **The Bank will carry out regular implementation support missions supplemented by need-based thematic missions to support the implementing entities to implement the agreed fiduciary arrangements, and the PAP, compliance with legal covenants and achievement of results.** The progress on agreed PAPs will be reviewed and any changes required will be made during the implementation phase. The MoHP will regularly share reports with the Bank to monitor the fiduciary performance, identify gaps and recommend actions including the key performance indicators as below. These reports will be reviewed, and issues identified will be addressed appropriately. Program expenditure will be reviewed regularly including through the Program Audit Reports. The Bank team will work with the implementing entities for need-based institutional capacity building and training. Further, during Program Implementation, continued compliance regarding the exclusion of high-value contract(s) would be ensured through reporting by the implementing entities, reviews by the Bank and the Program's internal and external audits.

Key Performance Indicators

12. **Fiduciary Performance Indicators have been identified in the FSA and will be monitored during Program implementation.** In addition to the above-mentioned risks mitigated through actions agreed as, the following indicators will be monitored by the IAs and reports (in an agreed format) will be shared with the World Bank every half-year during the Program's life.

a) Disclosure of contract award at implementing entities respective websites for contracts within 15 days of the award of the contract.
b) Consolidated Annual Procurement Plan prepared by October.
c) Procurement-related complaints lodged, resolved, and reported (percent resolved).
d) Program annual financial statements audited within the agreed timelines.
e) Continuing adequate budgetary provision made by GoN towards Program funding requirements with adequate coordination among implementing entities and MoF.

[4] "Guidelines on Preventing and Combating Fraud and Corruption in Program-for-Results Financing" dated July 1, 2012 and revised on July 10, 2015

ANNEX 5. SUMMARY ENVIRONMENTAL AND SOCIAL SYSTEMS ASSESSMENT

1. The Program-for-Results (PforR) lending instrument to be applied for the implementation of the proposed Nepal Quality Health System Program (NQHSP) requires a thorough assessment of the country's environmental and social (E&S) risks, opportunities, and capacity to support the proposed investment. Accordingly, an Environmental and Social Assessment (ESSA) was carried out with the overall objective of comprehensively reviewing and analyzing the existing environmental and social systems, and procedures of various implementing agencies (IAs) and stakeholders within the health sector. The specific objectives of the ESSA were to:

    i. review legal and policy frameworks and provisions for the environment and social (E&S) risk management in the health sector;
    ii. identify E&S issues, gaps, and challenges in E&S compliance and management within the remit of the PforR Program;
    iii. assess institutional systems and capacities of implementing agencies to implement the Program;
    iv. recommend and develop of a PAP to address the E&S gaps and improve the current risk management system; and
    v. carry out multi-stakeholder consultations and disclosure.

2. The ESSA primarily relied on a desk review of existing information and data sources, complemented by primary data collection and assessment through consultations, interviews, and interactions with key stakeholders. Field visits were made in Gandaki and Koshi Provinces for interactions with Provincial and local stakeholders including healthcare workers. The study also consulted with key stakeholders on the findings of the draft ESSA report, including proposed measures to strengthen program risk management capabilities that have been identified through the assessment. After the initial E&S risk assessment, follow up with stakeholders were done in particular with concerned health ministry and departments to triangulate findings from desk reviews, field visits, and interviews and agree on proposed actions to further enhance the E&S risk management during program implementation.

Recipient's Systems Relative to Core Principles

3. Based on the assessment and stakeholder consultations, the ESSA determined that the following three of the six Core Principles apply to the Program:

Core Principle # 1: Promote environmental and social sustainability in the Program design; avoid, minimize, or mitigate adverse impacts, and promote informed decision-making relating to the Program's environmental and social impacts.

4. The capacity to manage E&S risks exists at MoHP but needs to be strengthened in terms of human resources and budget. The sector has developed a set of guidelines and good practices but at present, there is a lack of a sector-wide and integrated framework for screening, identifying potential environmental and social issues/risks, and proposing adequate measures to address the risks before undertaking any works. There is a low capacity to look into E&S risks, particularly with regard to healthcare waste management (HCWM), emergency health preparedness, quality health care services, and insurance coverage.

5. Program design promotes environmental and social sustainability in several ways. This is evident in terms of the following results that the Program is expected to generate. For instance, an improved digital database for minimum service standards related to HCWM & occupational health safety (OHS) will contribute towards better design and planning of HCWM and OHS in health care facilities (HCFs). The proposed Program will contribute to the GRID agenda in Nepal in the procurement and upkeep of medical equipment. Improved bio-medical technical capacity to support

hospitals with repair and maintenance will reduce medical equipment waste. The systematic formation, capacity building, equipping, and deployment of RRTs as per the new RRT at Provincial and LLs, will result in effective and sustainable structures and mechanisms for preparedness and response from the bottom of the pyramid.

6. Likewise, the Program will contribute toward promoting sustainable social benefits in several ways. For instance, the improvement in readiness and service provision at the public hospitals and primary level facilities, as per minimum service standards, will benefit the poor and marginalized communities that lack alternative options for accessing health services. Poor and vulnerable groups' access to quality health care will significantly improve due to the Program's support of wider and sustained coverage by the health insurance program, particularly among poor and vulnerable populations. There will be more coherent, objective and evidence-based allocations for public health activities and basic health care delivery customized to local circumstances and needs. Gaps identified through minimum service standards assessments will be addressed to improve quality of health care as well as to mobilize resources for deploying RRTs during health emergency events. This will not only increase the efficiency of the local health system but is also expected to enhance equity through more nuanced targeting of poor, vulnerable and out-of-reach (geographically remote or marginalized) communities. Furthermore, relevant equity indicators will be incorporated into the HMIS to help LLs to improve equity. The Program's sub-results area on health data systems, strengthened LL planning and emergency health preparedness will include gender and inclusion considerations as per the MoHP's GESI strategy: for example, disaggregation of data, and addressing the needs of women, poor and vulnerable populations.

Core Principle # 3: Protect public and worker safety against the potential risks associated with: (i) construction or operations of facilities or other operational practices under the Program; (ii) exposure to toxic chemicals, hazardous wastes, and other dangerous materials under the Program; and (iii) reconstruction or rehabilitation of infrastructure located in areas prone to natural hazards.

7. Provisions for safety at work have been made in national regulatory and policy frameworks; but in the absence of separate legislation on OHS, these provisions have failed to adequately to address OHS issues. Although the Program will not support any major civil works, there are issues related to infection control and good operating practices by health care workers and other workers dealing with chemicals, medical equipment, and risks from infectious diseases. The provisions in Core Principle 3 are considered as part of the OHS issues related to chemicals usage, medical equipment and handling infectious waste and medical waste. However, challenges in implementation and monitoring compliance with E&S safeguards persist due to shortcomings in institutional capacities (often involving insufficient dedicated human resources and budget), particularly at the PGLLs.

8. The Environmental and Social Management Framework (ESMF), applied by the MoHP in earlier projects, needs to be updated, contextualized, and uniformly applied across all sectoral projects and programs to address the E&S risk of the entire health sector. This updated ESMF needs to incorporate relevant provisions in GoN's legislation, standards, and programs for more effective management of E&S concerns such as HCWM, OHS, life and fire safety, and targeted approaches and frameworks for enhancing the access of poor and vulnerable groups to health services, with clear institutional roles and responsibilities.

Core Principle # 5: Give due consideration to the cultural appropriateness of, and equitable access to Program benefits, giving special attention to the rights and interests of the Indigenous Peoples and to the needs or concerns of vulnerable groups.

9. In recent times, political commitment to gender equality and social inclusion (GESI) has led to integration of GESI into the GoN systems. This is evident in terms of the high priority accorded to GESI integration in GoN's policy and regulatory regimes. Special legal/regulatory provisions are in place for

safeguarding the interests and concerns of Indigenous People (IP) and vulnerable people; this is amply reflected in the ESMFs applied by the MoHP in earlier projects, particularly in the recent COVID-19 Emergency Response and Health Systems Preparedness Project. An Indigenous People Management Framework (IPMF) has been built into this framework to (i) ensure inclusion of targeted communities in the consultation process of the Program; (ii) avoid, minimize, and mitigate any potential adverse impacts on indigenous and vulnerable communities; and (iii) ensure vulnerable peoples' participation in the process of planning, implementation, and monitoring of the sub-program facilities. There is a need to update the existing ESMF with clear procedures for comprehensive consultations with vulnerable groups, women, disabilities and indigenous people, as well as proper access to a functional Grievance Redress Mechanism (GRM).

10. Furthermore, the MoHP, through its GESI Strategy, is focused on mainstreaming GESI in the Health Sector policies, strategies, system, plans, programs, budget and monitoring and evaluation of the Federal, Provincial, and LLs. It envisages promoting equitable access to health services by increasing targeted communities' access to and utilization of basic health services. The GESI Strategy of 2018 has been revised and a new strategy, which is in the final process of approval by the Cabinet, has been developed in the context of the new Federal structure of the health sector. Effective rollout and implementation of the Strategy at all levels of the Federal structure will be critical for delivery of GESI-responsive health services.

Key Gaps and Challenges Requiring Immediate Actions

11. The ESSA has identified key gaps and challenges requiring immediate action: these have been listed under the following broad headings: A) Institutional arrangement; B) Capacity to manage and implement E&S safeguards; and C) Monitoring compliance of implementing agencies across the three levels of the Federal structure. The Program will require increased coordination among various departments and Ministries and with PGLLs and stakeholders on environmental and social aspects to support implementation.

A. Institutional Arrangement

- The Provincial and LLs lack adequate policies and systems, and limited implementation mechanisms for the management of potential environmental and social risks for the program. A dedicated unit or focal person has not been designated at the Provincial and LLs. This includes a lack of mandate and coordination to roll out national health insurance programs, integrated surveillance, disaster, and emergency response plans, coordination on healthcare GESI strategy, and management of healthcare waste.
- Lack of an E&S framework for the health sector that can be uniformly applied across all sectoral projects/programs.
- Lack of effective mechanism for coordination among Federal, Provincial, and LL line agencies for managing the implementation of E&S measures.
- Lack of GESI responsive structure and adequate resources for implementation in IAs at the Provincial and Federal levels. Though few Provinces have taken initiatives to integrate the GESI strategy on their own it is not uniformly adopted. The approval from the Government would enable the implementation of the GESI strategy at the LL more coherently.

B. Capacity to manage and implement E&S risk management measures

- The capacity of the Provincial and LLs and healthcare facilities for managing E&S risks is inadequate and needs strengthening in terms of knowledge/skill and financial resources. There is a shortage of dedicated human resources for the management and implementation of safeguard measures and for the implementation of the GESI strategy.
- Managing wastes generated from healthcare facilities, including e-waste, has emerged as one of the serious health issues in Nepal. There are also capacity and resource gaps in

managing OHS risk related to HCW handling. Given that the Program focuses on expediting the reforms to improve health facility readiness for quality healthcare at all public sector health facilities, proper management of HCW in line with the minimum service standards is also important to improve the provision of health services.

- Maintenance and operation of equipment related to disinfection and treatment of healthcare waste are also challenging due to a shortage of skilled technical resources and a lack of budget.
- Inadequate and/or ineffective identification and outreach to ultra-poor families has resulted in their low coverage by the health insurance program and challenges in rapid response or emergency response.
- Lack of enabling and accessible quality services for the public and in particular for the poor and vulnerable population including accountable services that promote service-seeking behavior of excluded and vulnerable people.

C. Monitoring Compliance

- Environment and social performance/compliance monitoring and verification audit procedures for meeting minimum conditions related to environmental and social safeguards at all levels of Government are inadequate.
- The Federal and PGLLs lack adequate budget for environmental & social management including monitoring safeguards measures.
- The lack of integrated HMIS and EMR results in proper monitoring mechanism and GESI strategy.

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ANNEX 6. PROGRAM ACTION PLAN

Action Description	Source	DLI#	Responsibility	Timing		Completion Measurement
Three district level hospitals, each in Koshi and Gandaki province equipped with i) functional technology ii) trained and dedicated HR and iii) adequate budget to complete end disposal of health care waste as per standards	Environmental and Social Systems	DLI 6	Provincial Hospitals and LLs	Due Date	15-Jul-2025	National health care waste management, standards and operating procedures 2020 implemented for end disposal of healthcare waste in Program health facilities
MoHP's GESI Strategy rolled out to LLs	Environmental and Social Systems		LLs and Health Facilities	Due Date	15-Jul-2024	MoHP's GESI Strategy implemented at LLs in Program areas
Prepare and endorse Sector wide ESF (or guideline) for all the activities including civil works executed by MoHP	Environmental and Social Systems		MoHP	Due Date	15-Jul-2025	ESF endorsed
Outreach and enrollment of ultra-poor households in the health insurance scheme	Technical	DLI 3	Health Insurance Board and Local Levels	Due Date	15-Jul-2025	Achievement of DLI targets as defined under DLI matrix
Health Emergency Preparedness and Response plans to include community participation and healthcare waste management	Environmental and Social Systems	DLI 5	EDCD and LLs	Due Date	16-Jul-2025	Achievement of DLI targets as described under DLI matrix
Use of eGP system throughout the procurement cycle	Fiduciary Systems		DoHS	Recurrent	Yearly	At least 10 percent of annual procurement packages of DoHS to be tested to be channeled through e-GP system in entirety, by 2nd year. To be scaled up depending on the lessons.

Implement internal control guidelines	Fiduciary Systems		MoHP and cost centers	Recurrent	Yearly	Provision of guidelines, trainings, conduct of audit committees and resolution of audit queries
Enhance the existing GRM to make it more systemic and digitized	Environmental and Social Systems		MoHP, DoHS, PGLL	Recurrent	Yearly	GRM digitized & functional