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Introduction

Over the past years, poverty reduction has been explicitly driving the development agenda. In 1999, World Bank and IMF agreed that nationally owned participatory poverty reduction strategies should provide the basis for all concessional lending and for debt relief under the enhanced Heavily Indebted Poor Countries (HIPC) Initiative. The Poverty Reduction Strategy Papers (PRSPs) put this approach into effect and describe a country's macroeconomic, structural and social policies and programs to promote economic growth and reduce poverty.

At the turn of the millenium world leaders agreed on ambitious targets for reducing poverty and improving lives by 2015: the Millennium Development Goals (MDGs). In summary the MDGs focus on poverty eradication, improving access to primary education, enhancing gender equity, improving health (notably by reducing child mortality, improving maternal health and combating HIV/AIDS, TB, malaria and other diseases) and ensuring environmental sustainability. Since then most of the bilateral donor agencies also made poverty reduction and reaching the MDGs the main area for their support.

The publication of the Report of the Commission on Macroeconomics and Health (CMH) in December 2001 marked a renewed interest in the specific relationship between poverty and disease, and inversely between economic growth and health. The Commission recommended that substantial investments be made in low and middle income countries, predicting that this would yield important economic returns.

The additional investment should be used to scale up essential health care and health-related services, and in particular reach the poor with these services. The

Commission emphasised the need to simultaneously invest in the health systems of these countries, because many constraints that inhibit scaling up services are due to inadequately developed health systems. The additional investment, according to the CMH, should be financed both through increased domestic investment and increased donor support.

All these initiatives have been kick-started by the United Nations (UN), the International Financing Institutions (IFIs) and the bilateral donors at the global level. But the plans and activities necessary to access the funds and to reach the targets have to be produced at the national level or below. There is no blueprint for doing this, given the diversity of opportunities and constraints in countries.

WHO is supporting countries interested in embarking on a process towards poverty reduction by increasing cost-effective spending on health in ways which improve outcomes for the poor. This assistance aims to support:

- increased political support for investment in health
- strengthening of the health section in the poverty reduction strategy, medium term expenditure framework and other national development plans
- development of a comprehensive health sector strategy addressing the achievement of the MDGs and other essential health targets
- improving aid-effectiveness through development of sector-wide approaches (SWAps) and more effective management of global initiatives
- health policies and systems that better address the needs of the poor

While WHO is providing financial and technical support, countries themselves are driving the process, and will decide on priority investments, partnerships, health system changes and financing mechanisms.

The poverty reduction agenda is particularly relevant for Nepal, being the poorest country on the Eurasian continent.

Nepal is receiving support from WHO and the Royal Tropical Institute in Amsterdam for pro-poor health planning in the context of macroeconomics and health work.

This report describes and discusses the work done in Nepal during the preparatory phase. It addresses in particular the opportunities and constraints expected to influence the work during the planning and implementation phase. It also describes how Nepal intends to overcome the constraints and use the opportunities in planning for implementation. It is hoped that countries, wishing to embark on a similar exercise, can make use of the Nepali approach and experience.



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The living goddess Kumari being taken to the Hanuman Dhoka Durbar;
this is done every year, before the Indra Jatra festival, Sep. 25, 2004

Key information for Macroeconomics and Health work in countries

Main findings of the Commission for Macroeconomics and Health

- Disease creates poverty
- Health will create economic growth
- Investing in health will result in high economic returns
- Especially when investment is targeted at the poor

Macroeconomics and Health Agenda focuses on

- Achieving better health for the poor, thereby reducing poverty and stimulating economic growth
- Eliminating financial constraints by increasing domestic and external investments in health
- Eliminating non-financial constraints to providing a package of essential interventions to the poor

From Global to Local Action

- CMH does not provide a blueprint
- Each country has to translate the findings of the CMH to its own context
- Assess the health and poverty status
- Develop a strategy to scale up essential health interventions and reach the poor
- Cost the strategy à investment plan
- Mobilise sufficient funds to implement it

Three phases of Macroeconomics and Health work

- Preparatory Phase 6 months: mid 2004
- Planning Phase 12-18 months: end 2005
- Implementation Phase 10 years: end 2015

General activities during the Preparatory Phase

- Advocacy on CMH findings
- Set up institutional mechanisms to take Macroeconomics and Health work forward
- Situational analysis on health and poverty
- Identify financial and non-financial constraints
- Make proposal for planning phase

Macroeconomics and Health process in Nepal

His Majesty's Government of Nepal (HMG of Nepal) is committed to a pro-poor development policy and reaching the poor with essential health services, as is evident from the Tenth Development Plan, the PRSP and specifically for the health sector, the Nepal Health Sector Programme - Implementation Plan (NHSP-IP). Nepal also subscribes to the Millennium Development Goals.

The Macroeconomics and Health agenda strengthens this approach, as it provides a framework for scaling up essential health services and reaching the poor. HMG of Nepal therefore welcomed the challenges that the CMH Report posed and the support WHO offered to look closely into the opportunities and constraints Nepal faces vis-à-vis increasing the coverage of essential health services and implementing its plans.

In February 2002, only 2 months after the official presentation of the the CMH Report, the MoH in Nepal organised a National Seminar on Health and Poverty Reduction, sponsored by WHO/SEARO, attended by 76 people from the Ministry of Health (MoH), the Ministry of Finance (MoF), National Planning Commission (NPC), Parliament, External Development Partners (EDPs), NGOs, Tribhuvan University and the WHO secretariat.

A delegation from Nepal attended both WHO consultations on Macroeconomics and Health in Geneva in June 2002 and October 2003, as well as the Regional Consultation on Macroeconomics and Health, organised by SEARO in August 2003.

In December 2002 HMG of Nepal established a Subcommittee on Macroeconomics and Health (SCMH) under the already existing high-level National Commission on Sustainable Development (chaired by the Prime

Minister). The SCMH is chaired by the Minister of Health. Besides other key officials from the MoH, the SCMH includes members from the MoF and NPC and from 2 NGOs. In order to facilitate quick progress a 3 people working committee was formed, consisting of one representative each from the MoH, MoF and NPC.

This Subcommittee endorsed a Plan of Action for the preparatory phase in September 2003, which was submitted for funding to WHO (see box). The Royal Tropical Institute (KIT) in Amsterdam was separately contracted by WHO to give technical support for the activities during the preparatory phase.

The KIT consultant conducted a situational analysis, which was discussed with stakeholders in January 2004. As an outcome of this analysis, the working committee of the SCMH agreed to a district approach as being the best strategy to guarantee access to essential health services to all, in particular the poor, in particular as much work in terms of policy analysis and planning at the central level had already been achieved. So it is a high now time to translate it into districtwise operational plan Because Nepal is so fragmented and diverse no national investment plan can cater for the whole country. A district approach also aligns well with the ongoing decentralisation process. Nepal therefore decided to produce **Pro-Poor District Health Investment Plans** (PPDHIPs).

In that context two studies were done during the preparatory phase to review which information, necessary for pro-poor district planning, was already available, both in the form of research outcomes and in the form of routinely available information. Gaps in information were also identified. Both studies were done by the Nepal Health Research Council

(NHRC) during the first half year of 2004.

The first study was a desk review of research relevant to Macroeconomics and Health. Studies done between 1999-2004 were identified, their quality assessed and the results summarised. A report is available from the NHRC. The outcome of the desk review feeded into the proposal for the planning phase, during which studies to fill the identified gaps will be undertaken.

The second study focused on information that is already routinely available. In order to tailor operational planning to the needs

of the district population, District Health and Poverty Profiles were compiled for each district, using various information sources. Included in the profiles are important health indicators and targets, demographic features, indicators on poverty, unemployment and education levels, data on health facilities, human resources and utilisation, NGO and donor presence, presence of special programmes and information on health financing. These health and poverty profiles will form an important input for making the PPDHIPS during the planning phase.

The following activities have been implemented during the preparatory phase in Nepal

1. A situation analysis has been made.
2. A desk review of relevant studies has been done by the Nepal Health Research Council.
3. A format for District Health and Poverty Profiles has been developed and data have been collected for all 75 districts by the Nepal Health Research Council.
4. The Summary Brochure *Investing in Health* has been translated into Nepali
5. A planning workshop has been held to discuss a proposal for a Plan of Work for the planning phase of the Macroeconomics and Health work.

A national advocacy meeting, which was planned for the preparatory phase has been postponed until the political and security situation will allow such a meeting to be conducted.

Nepal Context

Nepal is a relatively small (population 24 million) land-locked country, bordered by the two biggest countries in the world, India and China. Its renowned physical beauty makes it very fragmented and many parts are difficult to access by modern transport and suffer from a lack of communication facilities. There are few cities and 86% of the population live in rural areas. The country is divided into 5 development regions, 14 zones and 75 districts, almost 4000 Village Development Committees (VDCs) and 58 municipalities.

Nepal was never colonised, is a constitutional Hindu monarchy and has a multiparty bicameral parliamentary democracy. However, since 1996 an increasingly violent Maoist insurgency has thrown the country into civil war. Road blocks, abductions, forced protection and fighting are increasingly compromising security and negatively affecting social and economic developments. In October 2002 His Majesty the King dissolved parliament and appointed an interim cabinet. Elections have not yet been held and people have taken to the streets to demand the restoration of democracy.



Their Majesties King Gyanendra and Queen Komal gracing the chariot procession of Kumari, the living Goddess on the occasion of Indra Jatra, Sep. 27, 2004

Underlying the insurgency is (among other things) a pervasive poverty. The country's GDP per capita is only \$250 and 38% of the population live below the

poverty line. There are large inequalities. Ninety percent of the poor live in the rural areas. The poorest people belong to the lowest caste (Dalits) or live in the remote mountainous areas in the Western part of the country. This is also the part where the Maoists are strongest. While only 15% of households is connected to the electricity grid, 80% have access to water supply. Unemployment is a big problem, and many work abroad. The remittances they send home bring more money into the economy than tourism, foreign aid and export together. Illiteracy is very high, with around 40% of men and 75% of women not able to read or write.

Nepal is still a very traditional country with strong religious and family ties, although this is changing. Strict hierarchies are linked to a caste system, challenged by the Maoist movement. Nepal takes a 90th place on the 2004 Corruption Perception Index by Transparency International. On the positive side civil society is well developed with numerous NGOs, including human rights organisations, and a diverse and free press. Two broad ethnic groups can be subdivided into some 60 different groups, with their own culture and language, but there is only one official language: Nepali.

According to the MoF Budget Speech 2003 total government expenditure over FY 2002/2003 was \$48 per capita, being 19% of Gross Domestic Product (GDP). Two-thirds of that was regular budget, one third development budget. Eleven percent of government expenditure was used for debt repayment. Nepal does not qualify for World Bank/IMF debt relief under the Heavily Indebted Poor Country (HIPC) scheme. The government budget for FY 2003/2004 is almost 20% higher than for the previous year. Around 60% of that comes from domestic revenues, 15% is

expected to come in as foreign aid and 25% will be borrowed. The real percentage of foreign aid to Nepal is much higher, as a substantial percentage does not go through the MoF.

In the health sector only 10% of foreign aid was accounted for through the MoF. The

expected government expenditure 2003/2004 for the health sector is low, both compared to the education sector, which receives three times as much, and as compared to other countries: only 5.1% of total government budget, being \$2,94 per capita and 1.18% of GDP, is spent on health.



People's Front Nepal in an anti-Maoist rally at Bhotahity, as part of nationwide protest against Maoist atrocities, Sep. 15, 2004

The Health Sector

Policies and plans

The central section of the MoH is responsible for policy making, planning, financing, international cooperation, human resources, as well as for monitoring and evaluation.

Over the years many health policies and plans have been produced. The basis for present activities is the National Health Policy of 1991 and the *Second Long Term Health Plan 1997-2017*. Over the past years the MoH, together with the external development partners, made a *Strategic Analysis*, on which the *Nepal Health Sector Strategy* and the *Nepal Health Sector Programme-Implementation Plan (NHSP-IP)* are based. Specific strategic plans were made to develop health sector decentralisation and human resources for health. More or less simultaneously the

NPC produced the *Tenth 5-year Development Plan* and its *Medium Term Expenditure Framework (MTEF)*, as well as the *Poverty Reduction Strategy Paper*, all of which contain sections on health.

All these plans include clear commitments to poverty reduction and view health as a major driving force for economic growth. The MoH has identified essential health care services and the main objective of the health sector relates to scaling these up to reach more people. The Essential Health Care Services (EHCS) package is very similar to the globally agreed priorities of maternal and child care, reproductive health and infectious diseases, consistent with the MDGs and the package that the CMH advised.



photo Dr Jim Matiko

Provision

The Department of Health Services (DoHS) in the MoH is responsible for the provision of all health services at the district level and below and produces very informative annual reports. Regional Health Directors are responsible for technical backstopping as well as programme supervision.

Although Nepal has an impressive coverage of health facilities, from Sub Health Posts to Teaching hospitals, geographical access is still limited: only 29% of the poor can reach a health facility within half an hour. Also quality of care is compromised, in particular in the rural areas, because of lack of equipment, drugs, and staff. There is one public hospital bed for every 2000 people. The public sector has only one medical doctor for every 18,500 inhabitants (more of them specialists than medical officers!), one nurse for 4000 people, one paramedic or health assistant for 4500 people, one Village Health Worker for 6000 people, and one Maternal Child Health Worker for 7500 people. These figures are national averages and conceal great geographical disparities. Health workers in Nepal earn relatively well (as compared with the average per capita income and with health worker salaries in other low-income countries), but even so it has been difficult to find providers who are willing to serve in remote areas. Monetary incentives alone have not worked, but a combination of training and monetary incentives has been effective. Staff is offered full-time higher education after 5 years of service, of which one year in a very remote area or two years in a near remote area.

There is a growing and unregulated private-for-profit sector, that cannot be clearly distinguished from the public sector, as many doctors working in the public sector have a private practice on the side. A permission is necessary, but easily

granted, in order to keep doctors in public service. As usual private practitioners are most dense in the urban areas. The MoH has objectives to partner with the private and NGO sector and to improve quality of services.

Public services are mostly used by the middle and low-middle income groups, while the rich go to the private sector and most poor don't go anywhere. The public sector provides 60% of the total number of beds, the private sector 40%. According to the Annual Report 2001/2002 by the DoHS the occupancy rate in the public sector is higher than in the private sector (72% vs 50%).

With the Local Self Governance Act of 1999 HMG of Nepal decided to decentralise management responsibility to lower levels. The mode of decentralisation is **devolution**. The devolution process is phased in. Government has decided to transfer property, equipment and staff of all Health Posts and Sub Health Posts to the Village Development Committees by 2007, making local authorities completely responsible for the delivery of public services, including health. Currently this is not fully functioning due to absence of locally elected bodies in many places.

The delivery of health services has been affected by the Maoist insurgency. Experts informally estimate absenteeism to reach 50% and many health workers cannot carry out their duties without harassment, intimidation and interference by both Maoist and government forces. There are sporadic reports of destruction of SHPs, blockades and looting of essential drugs, difficulties in supervision and monitoring visits by regional and district health officers, and disruption of the cold chain, all of which impact negatively on the delivery of the EHCS.

Financing

The Health Economics and Financing Unit (HEFU) in the MoH is responsible for all issues related to the financing of public sector health services. Provision is basically financed from taxes and user fees. Both are regressive, as the taxes are mainly indirect (VAT) and the user fees are a fixed amount, meaning that the poor pay relatively more than the rich, if and when they make use of public services at all. There are virtually no insurance schemes in place, except for civil servants. Community health insurance for people not formally employed is being piloted and exemption schemes for user fees will be developed. People pay around \$10 per capita out-of-pocket per annum for health care, with government contributing \$3.1 and donors \$2. The share of locally raised funds by district and village development committees is still low, but growing.

A system of National Health Accounts (NHA) is being set up. In order to collect data that were not available through existing information systems, HEFU has commissioned health expenditure surveys among (I)NGOs, private companies, private health providers, and public health facilities, as well as a drug expenditure survey. The results feed into the NHA.

According to the Public Expenditure Review, done by HEFU for the Health Sector in 2003 over the preceding 3 years, capital costs make up one-fourth of all public health expenditures. Of the recurrent costs 55% is spent on salaries. Of all expenditures directly related to health care 60% is spent at the district level and below. The share of funding going to Priority I programmes (as defined in the Tenth Development Plan and MTEF) has decreased over the last three years, while expenditures on Priority III programmes has increased, contrary to intentions. And although people in the rural areas are likely to have higher health needs than the urban population, the trend is one of decreasing expenditures in rural and

increasing expenditures in urban areas. The share of reproductive health in total public expenditures decreased drastically from 14% to 3%, due to the closure of a big donor funded project, illustrating the risks involved in project-based financing systems. The share of health expenditures for children under 5, being more than 12% of the population, is only 4.7%, while they bear more than 50% of the burden of disease.

Nepal will need to allocate more domestic resources to health and/or raise additional external resources to be able to reach the MDG targets on health and provide the poor with other health services considered essential. Assuming that the calculations by the CMH are also valid for Nepal total health expenditures in Nepal would have to double by 2007. HMG of Nepal would at least need to double its investment in health before 2007 and the donors would need to increase their share with \$17 per capita, an eighth-fold increase from the present \$2. Possibilities to channel the \$10 that people now spend on health care out-of-pocket into pre-paid schemes need to be studied.

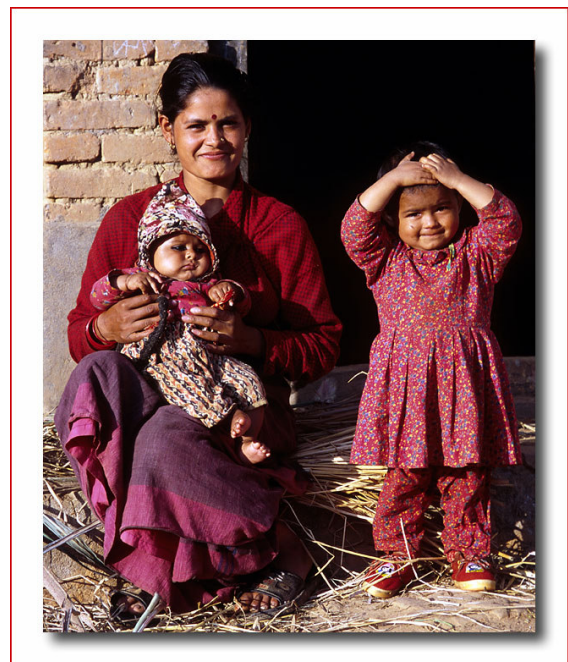


Photo Dr Jim Matiko

Health indicators, targets and priorities

A burden of disease study, done in 1996, showed that infectious diseases, maternal and perinatal conditions and nutritional deficiencies (Group 1 diseases) accounted for 69%, degenerative and non-communicable diseases for 23% and injuries and accidents for 9% of the total burden. The number of DALYs lost per person is higher than in India or China,

and higher for females than for males. Half the burden falls on children under 5. Projections for the next 10 years show that Group 1 diseases will continue to cause the highest burden. An overview of selected indicators and targets is given in the table from the Tenth Plan (the alternative growth scenario is the most realistic).

Tenth Plan Chapter 24 - Health (May 2003)

Table No. 24.2 Quantitative goals

S. No.	Health indicators	Status of 2002	Targets of 10 th Plan	
			General growth	Alternative growth
1	Availability of essential health services (%)	70	90	88
2	Availability of the stipulated essential medicines in the specific institutions (%)	80	90	89
3	Provide essential health services with all health workers required (%)	60 ^{ns}	80	78
4	Percent of women receiving prenatal service for four times	14.3	18	17
5	Women of 15-44 age group receiving TT vaccines (%)	45.3 ^{ns}	50	49
6	Birth attendance by the trained health workers (%)	13 [*]	18	17
7	Contraceptive prevalence rate (%)	39	47	46
8	Use of condoms for safe sex (14-35 years) (%)	-	35	35
9	Total fertility rate (women of 15-49 years)	4.1	3.5	3.6
10	Crude birth rate (per 1000)	34	30	30
11	Maternal mortality rate (per 100 thousand)	415 [#]	300	315
12	Newly born infant mortality (per 1000 live birth)	39	32	33
13	Infant mortality (per 1000 live birth)	64	45	47
14	Child mortality (below 5 years old) (per 1000 live birth)	91	72	74
15	Crude mortality rate (per 1000)	10	7	7
16	Life expectancy at birth (years)	61.9	65	64
	* Included are the attendance by the trained <i>sudenis</i> (female childbirth attendant with short orientations) but the status and goals afterwards do not include them as per the understanding with the World Health Organization.			

Realisation of scarce resources led to priority setting on the basis of the burden of disease study. Based on this the EHCS package was approved in 1999. By 2017 this package should be available to 90% of the population within 30 minutes travel time. Twenty broad areas of intervention were identified, with the bold intent to '*redirect resources from high-cost-low-impact interventions to those that can substantially reduce mortality, morbidity and disability without increasing expenditures*'. Because this package was still found to be too

ambitious, given the limited resources, it was decided to initially focus on four main areas of essential care: safe motherhood and family planning, child health, control of communicable diseases, and strengthened out patient care, supported by a national programme to increase knowledge about common illnesses and cost effective interventions. Preliminary costing of the package has been done, but more detailed work is needed, based on actual local costs and including costs to scale up the health system.

Poverty and Health

Routine data on the relationship between poverty and health are not available in Nepal, but information from the Nepal Family Health Survey revealed great disparities in both health outcomes and intermediate indicators. Differences between the richest and poorest income quintiles in attended delivery, antenatal care, immunization coverage, malnutrition, total fertility rate and use of modern contraceptives are 2-10 fold. Infant and child mortality rates are much higher in rural areas and in particular in the mountains, coinciding with income differentials. A relation between the educational level of the mother (often in itself income related) and major health indicators has also been clearly established, as well as a relation between health care seeking behaviour and poverty. Geographical focus of reaching the poor should be on the Mid-and Far-West Regions, where 22% of the population live, who have the worst health indicators of the country and where hence great health gains can be made. As these are also the strongholds of the Maoist groups, this is far from simple.

As part of a multi-country study on equity catastrophic health care costs have also been studied in Nepal, but more needs to be done.



photos: Dr Jim Matiko

External Development Partners (EDPs)

In Nepal 6% of external aid is spent on health. Donor expenditure in the health sector has more than tripled over the last 3 years and amount to about 40% of total public health expenditures, translating in \$2 per capita per annum. While the regular budget of HMG was fully used, only 27% of EDP development budget was used in 2001/2002 (from 61% two years earlier). EDPs channel 90% of their support for the health sector directly to the MoH, and only 10% through the Ministry of Finance. The biggest donors at the moment in the health sector are Japan, the World Bank and the UK, together good for more than half the external aid, with UNICEF, WHO, UNFPA, Germany, the US and Switzerland making up most of the remainder. The financial inputs by indigenous and international NGOs are less well documented.

The EDPs and the MoH have jointly developed the Health Sector Strategy and its Implementation Plan. Although this plan is a move towards a sector-wide approach, most donors are not in favour of fundpooling (yet), except DFID and the WB. At present all support is still organised in the form of projects or programmes and almost all funds go directly to the MoH or are self-executed by partners. The bulk of the donor funds go to essential health care programmes or to system development and strengthening.

During pre-consultative meetings of the Nepal Development Forum in April 2004 most donors have made restoration of democracy and conflict resolution

conditionalities to future aid. Some donors advocated co-operating with the rebels in order for service delivery to continue. Therefore the present political situation could hamper scaling up efforts, in as far as both HMG of Nepal and donors do not seem willing and/or able to put more resources into health in the current situation.



Opposition party supporters in a torch rally against 'regression', Sep. 24, 2004

Relatively few international NGOs are active in the health sector in Nepal, as well as some national NGOs, among which the Nepal Red Cross Society, the Family Planning Association, the Nepal Health Economics Association and New Era. The coordination between the MOH and I/NGO needs to be further strengthened to reduce the duplication of activities and maximise intended output. Because few I/NGOs report to the MOH or to the district health office the HMIS has been affected, as services provided by other providers than the MOH are not included.

Constraints

Nepal has problems implementing their policies and plans due to many kinds of constraints. Some of these are specific to Nepal, others will be recognizable to many low-income countries. They will be described on the next pages, categorised into financial and non-financial constraints that hamper pro-poor planning, scaling up

of essential services and reaching the poor.

But first an astonishingly candid and comprehensive summary of the health status of the population and its determinants, which can be found on the MoH website.

Summary of problem analysis on MoH website

“The Mortality and morbidity rates especially among women and children are alarmingly high.

Acute, preventable childhood diseases, complications of child birth, nutritional disorders and endemic diseases such as malaria, tuberculosis, leprosy, STDs, rabies, and vector borne diseases continue to prevail at a high rate.

Determinants of such conditions are associated with pervasive poverty, low literacy rates, poor mass education, rough terrain and difficult communications, low levels of hygiene and sanitary facilities, and limited availability of safe drinking water.

These problems are further exacerbated by under-utilization of resources; shortages of adequately trained personnel; underdeveloped infrastructure; poor public sector management; and weak intra- and inter-sectoral co-ordination”.

Non-financial constraints

Geographical constraints exist because Nepal is very fragmented, hampering transport and communication. Because of this there are relatively many remote areas in the country, although the distances in kilometers are not that great. And it is in those remote areas that most of the poor live.

Institutional constraints include a lack of planning and coordination capacity within the Ministry of Health, lack of clarity of roles and responsibilities between the MoH and the Directorate of Health Services, the need to strengthen intersectoral collaboration, and the need to integrate several disease based programmes. Absorptive capacity is weak; utilisation of funds has been lower than in other ministries, especially for the development budget. There are four underlying factors exacerbating all the above:

- The frequent changes in the civil service, which lead to lack of institutional memory and ownership, as well as lack of continuity in policy making and planning; but also the lack of proper skills for any particular job, because by the time an officer has acquired the knowledge for a specific job and is becoming productive, s/he is being transferred again.
- The Tenth Plan and the PRSP contain somewhat different objectives, strategies and activities than those mentioned in the NHSP-IP. The main government document in force is the Tenth Plan, the health chapter and budget of which are organised by priority programme and/or organisational centre, following present budget lines. All programmes have been assigned priority I, II or III status. The NHSP-IP is organised by priority objectives, outputs and activities in a logical framework and its budget is based on the costs of

those activities. This different method of prioritising and budgeting could in practice lead to conflicting points of view for the main partners, being the MoH, the MoF, the NPC and the EDPs.

- The lack of capacity at the district level and below to translate national policies and plans into operational plans with detailed activities, to set priorities, reallocate resources and to manage implementation of such plans. In particular there is a lack of knowledge on how to identify the poor, how to reach them with services, and on financing options.
- Organisational management is weak. Accountability and responsibility by those in managing positions could be improved. More interest to work in teams, rather than individually, is needed. More attention should be paid to systematic follow-up on recommendations by workshops, seminars and studies, thereby also avoiding duplication of efforts.

Supply side constraints include a lack of staff in rural and remote areas (because of irrational distribution), weak supervision of service delivery, a need for quality assurance, but also for improving attitudes of staff. Facilities need to be upgraded and supply of drugs and medical supplies ensured. Whether the present supply of health care services reaches the poor cannot be established, because the HMIS does not allow disaggregation of key indicators by income or poverty status.

Demand side constraints include lack of awareness among the public, in particular the poor, about health and disease, and inability to pay the user fees, while exemption schemes do not work well. Supply and demand side constraints together lead to a low utilisation of the public facilities, in particular by those groups that could benefit most.

Partnership constraints include the lack of mechanisms to regulate the private sector and assure quality of work, as well as lack of coordination with international and national NGOs. A particular issue is collaboration between HMGN and the EDPs. This has improved over recent years but there is still considerable work to do in increasing coordination of donor resources within a national strategy. In particular not all EDP expenditure is notified to the Government.

EDPs in Nepal are concerned about potential duplication of macroeconomics and health work and past and ongoing planning efforts they have all been involved in. In particular the production

of a health investment plan is seen as superfluous.

Political constraints include the present political instability, due to the Maoist insurgency. The implications of the insurgency on the delivery of health services are increasing, with reports of destruction of SHPs, blockades of essential drugs, difficulties in supervision and monitoring visits by regional and district health officers, disruption of the cold chain etc. The conflict makes it even more difficult to find staff willing to serve in remote areas, as these are mostly under control of the Maoists. Support of EDPs to districts is also jeopardised.

Financial constraints

Constraints related to sources of funds

HMG of Nepal is very committed to poverty reduction, as is evident from all major policy and planning documents, but less so to health, as is evident from the low and even decreasing budget made available for the health sector (which might be related to the increased flows of funding from the donors directly to the MoH). As all low-income countries, HMG of Nepal has problems raising revenues. Therefore the government cannot invest enough money in basic services to make an impact on health status: the national government spends only \$2.65 per capita or 1.06% of GDP on health. This is little compared to other low-income countries, and also compares unfavourably to the education sector, since the health budget 2003/2004 was only one-third of the education budget. Moreover, the health budget has increased less than the general budget over the last years and has even decreased with 4.5% in real terms since 2001/2002. The EDP contribution to the health sector is around \$2 per capita per year.

Together with a small percentage of local revenues, the total domestic budget for health was around \$3, which is only one-fifth of the \$15 the CMH thinks low-

income countries should be able to raise domestically for health (around 5% of per capital income). Fortunately in FY 2004/05 the budget for the MoH increased by 26% which is a positive step and aligns with the proclaimed commitment to invest more in health. Actual health expenditures will be under pressure, because of the insurgency. First, the insurgency requires more money for defence, police and security. Second, it has a negative influence on economic production, including tourism, meaning less government revenues.

With such a small contribution from the public coffers, people pay 3-4 times more out-of-pocket for health than the government does (\$10 per capita per year). Being the poorest country on the Eurasian continent with 38% of the population living below the poverty line and an average per capita income of just \$250 per annum, poorer Nepalis just do not have enough money to buy health services. Pre-paid plans hardly exist. Because health services are mostly financed from indirect taxes and user fees, which are regressive, the poor pay relatively more for health services than the rich and often get less.

Constraints related to expenditures

While the MoH is on paper committed to reaching the poor with health services, the main problem on the expenditure side is that money does not follow agreed policies. While the Tenth Plan allocated 70% of the budget for Priority-1 programmes, the Public Expenditure Review of the health sector showed that actual funding going to Priority-1 programmes decreased from 58% to 50% over the last 3 years, while funding for Priority-3 programmes increased. Also running counter to plans, the share of the funding going to rural areas decreased,

the expenditures for RH drastically decreased, and the share of health expenditures specifically for children under 5 was only 4.7%, while they bear around 50% of the burden of disease. There also seems to be a problem with the timely release of funds to the periphery.

These changes in expenditure patterns will also impact negatively on the achievement of the health goals in the MDGs. It is therefore unlikely that these goals will be met by 2015, unless much more money is invested and absorption capacity is increased at all levels of the health system.

Opportunities

There are many achievements and developments in Nepal that forebode well on the possibility to scale up essential health interventions and reach the poor:

Strong pro-poor policies and plans are in place, both at central government level and in the Ministry of Health, reflecting commitment to poverty reduction. HMG of Nepal believes that improving the health of the people can substantially contribute to economic growth. Disparities in health outcomes between income groups are big, indicating that great health gains can be made by focusing on the health of the poor.

Nepal has a well-developed and in principle functional administrative structure and a good coverage of public health facilities. The ongoing **devolution** process will mean more local ownership and possibilities to target interventions to local needs and vulnerable groups. This will also increase absorption capacity. If local political commitment to poverty reduction is present and health is seen as an important issue, local communities could decide to use a larger part of their resources for health and provide higher quality health services in better facilities.

With the right incentive structure and the intended upgrading of medical personnel, it seems possible to staff health facilities in remote areas.

At the national level **Essential Health Care Services** have been identified on the basis of a burden of disease study and have been further prioritised. They are in line with the internationally agreed MDGs and with packages identified in the past by the World Bank, WHO and the Commission on Macroeconomics and Health. The Second Long Term Health Plan specifically mentions that resources will be redirected from high-cost low-impact interventions to the low-cost high-impact EHCS.

The **HMIS** is relatively well developed and the DoHS produces useful data on key indicators per district, which can be used to monitor progress towards targets. It has already been decided that the system will be adapted in such a way that the impact of the health strategy on the health status of the poor can be monitored.

The MoH has a strong **health economics and financing unit** (HEFU). A first public expenditure review of the health sector has been made and a system of health accounts is being set up, improving availability of data on financial flows, necessary to monitor macroeconomic and health work. New community financing schemes for those informally employed are being piloted in 2004. The Nepal Health Economics Association, is an active partner for the MoH in conducting studies on equity in financing and delivery of health services, tobacco economics, health insurance, vital registration etc.

Results of a **Living Standard Survey** will soon be available, including information on health facilities, personnel and health care seeking behaviour. It will be possible to link the data to income and poverty statistics at district level. This will be a very powerful data source for detailed planning, necessary to reach the poor with essential services.

Nepal has recently received a grant from the World Bank for its **Poverty Alleviation Fund** (PAF). The fund aims to improve access to income-generation projects and community infrastructure, as well as to basic social services (including health) for the groups that have tended to be excluded for reasons of gender, ethnicity and caste, as well as for the poorest groups in rural communities. The approach is community-centered and demand-driven. Activities will initially be implemented in six districts, and expanded in subsequent phases.

Government revenue from **excise duty** on tobacco and alcohol is more than the entire health budget that comes from domestic revenue sources. At present very little of this is going to the MoH, although the health sector is bearing the brunt of the societal burden caused by alcohol and tobacco, which makes a strong case for a

much higher share of the excise duty going to the MoH, increasing its budget.

Donors are willing to support Nepal and have also indicated their willingness to increase their support, albeit dependent on restoration of democracy and establishing peace.

Available information to facilitate pro-poor planning

- Annual reports from the DoHS, including information from the HMIS
- Public Expenditure Review (2003)
- National Health Accounts (since 2004)
- Nepal Living Standard Survey (2004)
- District Poverty and Health Profiles (2004)
- Desk review of studies relevant for planning pro-poor services

Pro-Poor District Health Investment Plans

All the information collected for the situational analysis, the desk review and the district health and poverty profiles was discussed in a 4-day planning workshop, that was held to prepare a proposal for the planning phase of the macroeconomics and health work. During the planning phase Pro-Poor District Health Investment Plans will be produced and costed. Participants discussed **guiding principles** for the production of such a PPDHIP, a potential **outline**, the **process** to arrive at them, which **information** will be needed and whether this information is already available or could be collected, the need for **technical assistance**, how much **time** it would take to produce the PPDHIPS and how much it would **cost** to produce them.

Representatives from the following organisations participated in the workshop: Ministry of Health, Department of Health Services, Nepal Health Research Council, BP Koirala Institute of Health Sciences, the Nepal Red Cross Society, the Nepal Health Economics Association, New Era, GTZ and WHO. Representatives from the Federations of District and Village Development Committees, DFID and the World Bank attended part of the workshop.

Guiding principles

PPDHIP will be part of government planning cycle

The PPDHIPs will be guided by and build on the or Second Long Term Health Plan, the Health Chapter in the Tenth Development Plan and the NHSP-IP. As such the PPDHIPs will be a subset of the existing NHSP-IP, in line the recommendation of the Joint Review of the Nepal Health Sector Programme to produce district health plans, rather than duplicating past planning efforts. The PPDHIPs will follow the government annual planning cycle and feed into the the overall District Development Plan and finally into the 11th Development Plan.

PPDHIP production will be in line with devolution process

In line with the decentralisation process, national strategies will be adapted to the local situation (using the District Health and Poverty Profiles) and operationalised into concrete activities. In this way PPDHIPs will target the specific health needs of identified vulnerable groups in the district. Planning of provision and financing of essential services can take into account the presence of special government programmes, NGOs and EDPs or the lack thereof.

PPDHIP production will be participatory

In each district a District Planning Group will be responsible for drafting the PPDHIP. The group will also be responsible for seeking advice and consultation from beneficiaries and other stakeholders, in particular from representatives of the poor and other vulnerable groups. This participatory approach to planning will ensure local ownership and make local governments directly responsible and accountable for health care in their district.

Municipalities (> some 50,000 inhabitants) in Nepal are autonomous administrative bodies. There can be 1 or more municipalities in a district. Each municipality will set up its own planning group and collaborate with the district planning group in developing its Urban health programme, which will be part of the overall district health plan.

A multisectoral approach will be strongly encouraged

There are many important health determinants outside the health sector, in particular food, nutrition, water & sanitation and education. Community health especially depends on the above factors. Activities related to these factors outside the health sector can/should be incorporated in the plan.

Communities will be empowered to increase demand

Health utilisation, in particular by the poor, is low because of lack of awareness. Therefore they don't seek health care and many have unhealthy lifestyles. They will be empowered by providing them with information and skills to increase their demand for health services and their sense of ownership.

Government will engage in partnerships with the private sector

The public sector alone cannot provide the necessary services to meet all health needs of the community. NGOs and private-for-profit professionals can make an important contribution. The limited government resources should be used cost-effectively and be mainly targeted to serve the poor with quality services. Different types of partnerships with NGOs and the private sector will be sought in order to increase access to the EHCS and increase the number of staff in remote areas.

Outline of a PPDHIP

A detailed outline for a PPDHIP was discussed. A PPDHIP will be made every 5 years in preparation for the 5-year development plans in 2007, 2012 and 2017, with yearly operational plans. The central focus in all sections of the plan will be pro-poor. For that purpose operational definitions of poverty will have to be agreed at different levels.

1. The Government of Nepal monitors **national** poverty rates once every 5 years by means of the Nepal Living Standard Survey. Because data are based on a nationally valid sample, the NLSS does not provide reliable data at the district level. However, poverty mapping has been done by the Integrated Centre for Mountain Development, UNDP and CBS. These data can be used by the national government in a resource allocation formula for the districts.
2. For planning purposes at the **district** level, it is important to find out which groups in the district are relatively poor, where they are, and how they can be reached with services. It is therefore important to identify a few key indicators and collect these data by VDC (for example income ranges, access to safe drinking water and/or sanitation, utilisation of available health services, percentage of people who are not earning a living wage etc.). From a ranking of VDCs on these key indicators it will become apparent which areas in the district host the most vulnerable populations and therefore need more inputs.
3. For implementation purposes at the **VDC** level it is necessary to assess the poverty status of individual households, in order to implement exemption schemes for user fees or insurance premium. Because households can move in and out of poverty over time the poverty status of a household needs to be periodically re-assessed.

1. Overall and Specific Objectives

The overall objective will be the same as the national objective: *“to ensure universal access to quality essential health services, with special attention to the poor and vulnerable populations by 2017”*.

Each district will identify their own specific objectives depending on their situation analysis, constraints and opportunities.

2. Specific district targets for 2007, 2012 and 2017

The PPDHIP will specify final targets for key health indicators by 2017 and intermediate targets for 2007 and 2012. These will take into account the MDGs, but specify MDG targets for the poor.

3. Guiding principles

These will be based on the general guiding principles mentioned above.

4. Pro-poor situation analysis

Each District Planning Group will make a pro-poor situation analysis based on data in key areas that are already routinely collected or available from surveys. Districts can use the Health and Poverty Profiles produced by the NHRC for each district, which cover most of the indicators. See Annex 2a. Data on key indicators not available at the district level, will be collected using a simple survey methodology. Support for this survey/study will be given from the national level.

The situation analysis will contain the following areas:

- General information
- Security
- Poverty
- Decentralisation status
- Organisation and management of District Development Committee/District Health Office
- Health facilities
- Drugs and supplies
- Human resources
- Health service utilisation
- Health financing
- Nutrition status
- Child health
- Family planning
- Safe motherhood
- Top 5 causes of mortality
- Poverty related diseases
- Coordination with other sectors/EDPs
- (I)NGO and EDP activities/special government programmes

5. Opportunities

Based on the situation analysis, describe the opportunities there are in the district or the municipality that will support or enable reaching the objectives and specific targets.

For example:

- High interest of the DDC committee for investing more in health
- Willingness of the better off population to buy insurance
- Good planning capacity at the district level
- Existing poverty reduction activities, either in the health sector or other sectors
-

6. Constraints/challenges

Based on the situation analysis describe the constraints or challenges that will hamper reaching the objectives and specific targets: problem analysis.

For example:

- Lack of sufficiently trained human resources or problems retaining them
- Supervision hampered by bad infrastructure and lack of transport
- Badly maintained facilities
- Low health care utilization, due to.....
- Lack of capacity for planning
-

7. Planning for Service Delivery

On the basis of analysis of the collected information, opportunities and constraints a service delivery plan will be made. The plan will be needs-based, with the objective to scale up essential services impacting on health towards universal coverage, with extra activities to reach the poor. The plan will not only include scaling up and improving health services, but will also include health related services of other sectors, such as production of nutritious food, improving sewage and sanitary facilities, education etc. Districts will have to be creative and look into innovative possibilities to reach the poor with services, such as operating

outreach/mobile services, organise transport to health facilities or setting up telemedicine systems.

8. Planning for Health Financing

Scaling up of essential health services and making them available to all at an affordable price requires more investment. Using the assessment of the existing government and other health care financing mechanisms in the situation analysis, the district will develop a Fair Financing Mechanism addressing the poor people's health needs in line with MDGs. The district will plan how:

1. to promote existing government financing mechanism to ensure the poorer people get the right share of resources and benefits
2. to develop community based health insurance (prepaid) scheme involving community participation at planning and management level
3. to develop exemption and subsidization criteria for poor people as per wealth ranking exercise at the community level
4. to promote the Community Drug Program as a supplementary financing scheme to community based insurance

9. Planning for Monitoring & Evaluation

As the overall objective of the PPDHIPs is to ensure universal access to quality essential health services, with special attention to the poor and vulnerable populations by 2017, in order to improve health status, reduce poverty and increase economic productivity, data on utilisation, health status, poverty status and economic productivity are needed for planning, monitoring and evaluation purposes. These will be based on the indicators as proposed by the joint review of NHSP-IP and on the key indicators used in the 5-year development plans, but need to be adapted as necessary to specifically monitor the health status and utilisation patterns of the poor/vulnerable groups. Special attention will be paid to disaggregation of key indicators (used in the Tenth Plan, the MDGs and the NSHP-IP) by poverty/income status or proxies thereof. In collaboration with the HMIS Unit in the DoHS districts will also study how they can include utilisation of private and NGO services more fully into the HMIS system.

A rapid appraisal or Lots study among the poor/vulnerable groups in the districts will be designed and conducted to generate baseline data for key indicators that are not (yet) routinely available. This study can be repeated every 5 years to evaluate the **impact** of the programme.

An **annual performance review** can give important inputs for the next annual planning exercise. A periodic **third party evaluation**, combining internal evaluators and independent consultants from outside the system, focusing more on outcome and impact should be an option to get the optimum level of feedback for the programme. These could be done once every 5 years, timed to enable the results to be used for the next 5 year development plan planning cycle.

Although the present HMIS generates an impressive amount of information, important information for pro-poor district planning is not available, because relevant indicators are not available for the district level and below, or because available indicators are not disaggregated for vulnerable groups. For the future the **HMIS system will be adapted** on the basis of the planning experience in the pilot districts. Key indicators to monitor and measure utilisation of services by the poor,

their health and poverty status and their economic activity, at the district level, will then be included in the routinely used management information systems and in the periodic Nepal Living Standard Survey and DHS survey.

10. Planning for Coordination, Consultation and Collaboration

The District Planning Group will coordinate, consult and collaborate with all stakeholders in the district on all aspects and in all phases of the planning process: community representatives, other government sectors, NGOs and EDPS, as well as the private-for-profit sector. They will plan how this will be organised, which partners and stakeholders will be included, how often they will be consulted etc. The group will also identify what other sectors do for the poor and which coordination mechanism will be most appropriate. Using already existing coordination mechanisms at the district level is preferable, rather than creating new ones.

11. Creating the evidence base

Although much information can be gathered through the HMIS and other routine data collection systems, some issues have to be specifically studied. Special surveys/studies will be done as part of the district planning process to fill the gaps in information in order to be able to produce the PPDHIPs. This work can be done by the districts themselves, if capacity is available in the district, or by academic institutions, research firms or NGOs, such as the Nepal Health Economics Association. In some cases external technical assistance will be required. Examples of such studies are:

- Simple survey to collect remaining information in the District Health and Poverty Profiles
- Document success & failure stories of pro-poor activities in the health sector or other sectors on the basis of a literature study
- Calculate programme cost at cluster level in order to properly budget for expansion
- Study cost sharing at the local level
 - Study willingness and ability to pay for health services by the poor and disadvantaged
 - Evaluate the fee level of user charges for different types of services
 - Evaluate community based insurance
 - Assess alternative financing mechanisms, such as contribution in kind or labour to pay for health services
 - Assess the local experiences with micro-financing in health
- Assess the opportunity to enhance health services with community participation
- Assess awareness of poor and vulnerable populations about health, healthy food, lifestyles etc.
- Study the health and treatment seeking behaviour of the poor and vulnerable
- Look into possibilities to link up with community based organisations outside the health sector, such as micro-credit schemes, farmers groups, forestry user groups, interest groups etc. that also focus on the poor or certain vulnerable groups

Process

A National Task Force will be set up

In order to facilitate the planning process in the districts a National Task Force will be set up, consisting of members from the MoH Planning Unit, HEFU, HMIS, disease control and other relevant departments, Ministry of Local Development, NPC, and some EDP and NGO representatives working in district strengthening. At least one local expert will be full-time appointed to coordinate the work and maintain and augment the momentum.

District Planning Groups will be established

The District Planning Group will consist of the District Health Officer, District Public Health Officer, Local Development Officer, Women Development Officer & Planning Officer (all members of the District Health Management Committee), representatives of the VDC Federation, Health and Social Coordination Committee, the NGO Coordination Committee and the donor(s) active in the district (if any).

External technical assistance will support the planning process

The lack of planning capacity at the district level and below, identified as an institutional constraint, will be taken care of by providing intensive support. Because planning capacity is also lacking at the national level, external technical assistance by international planning and financing experts is foreseen. The external planning expert will train a group of national planning facilitators and will pilot the planning outline and process in a few districts together with them. S/he will support the whole planning process, setting up monitoring systems, as well as the studies necessary to generate additional information. The external health financing expert will support the introduction and evaluation of Community Based Insurance and costing of the PPDHIPs (together with HEFU and local consultants). They will work closely with the National Task Force and the Expert Coordinator, in order to increase ownership and sustainability.

10 districts will be included in the first planning round

There are 75 districts in Nepal and 59 municipalities. In order to gain experience and be able to document lessons learned, HMG of Nepal will choose 10 districts to be included in the first round of producing PPDHIPs, together with the municipalities that are located in those districts. The workshop participants prepared a shortlist using the following criteria: an Overall Composite (Development) Index, a Health and Development Index and a Road Density Index (as a proxy for accessibility), all available for 2003 from the Central Bureau of Statistics. The 20 shortlisted districts scored low on development and health, but high on road density. This method guarantees that the most needy districts, that are still accessible, will be served first, but also allows policy makers to use additional criteria in their final choice. Undoubtedly the security situation will be taken into account at that point in time.

PPDHIP production will be piloted in 2 districts

Two of the 10 chosen districts will serve as pilot districts. The usefulness of the District Health and Poverty Profiles will be assessed in these districts and the survey methodology to collect additional information piloted. Planning workshops with all stakeholders will be conducted in the districts and the PPDHIPs will be drafted and finalised after the necessary rounds of comments. The plans will be costed on the basis of real local costs. The whole process will be facilitated by members of the National Task Force and the external consultants.

Lessons learned will be documented and guidelines produced

The experience gathered during planning process in the 2 pilot districts will be documented, problems identified and solutions sought. Necessary changes in the outline for the PPDHIPs and/or the planning process itself will be made on the basis of the lessons learned and guidelines for correct data collection, planning and costing will be produced.

Facilitators will be trained and planning workshops conducted in remaining districts

Using the experience and lessons learned from the two pilot districts a pool of facilitators will be trained who in turn will facilitate the planning workshops in the remaining districts (initially the remaining 8 districts in this phase, but later also in the other 65 districts of Nepal). This ToT will be conducted by the national and international experts who facilitated the planning workshops in the pilot districts. The remaining districts and municipalities therein will collect the necessary information and planning workshops will be conducted to produce the PPDHIPs.

Draft PPDHIPs will be reviewed and adapted

Draft PPDHIPs will be peer reviewed by the other districts in pairs. The next version will then be sent to SCM, Ministry of Local Development, Federations of District, Village and Municipal Development Committees, as well as to the external consultants, WHO and other EDPs. On the basis of the comments received the District Planning Group will adapt the PPDHIPs as needed.

A regional/national component will be added

On the basis of the 10 PPDHIPs a workshop will be conducted at the national level to assess the need for additional investments at regional/national level to support the implementation of the district plans. In particular the need for system changes and scaling up of supporting structures will be assessed, as well as research and evaluation. The necessary activities will be described and costed.

PPD/MHIPs and national component will be presented to donor community and HMG of Nepal for funding

The national component together with the District and Municipal Pro-Poor Health investment Plans will be presented to the National Planning Commission for clearance. After clearance by the NPC a national donor meeting will be organised (or a regularly planned development forum meeting utilised) to discuss funding of the implementation of the 10 PPDHIPs, as well as funding for the planning process in the remaining 65 districts of Nepal.

Timeframe

It will take at least 6 months after funds have become available for this planning exercise to pilot and produce 10 PPDHIPs and the concomittant PPMHIPs. If enough funds can be generated timely and the security situation allows, Nepal plans to have developed pro-poor health investment plans for all 75 districts and 59 municipalities in time for them to feed into the next 5-year development plan, i.e. early 2007. This will give the country 10 years to implement the plans.