Save the Children

Midterm Review Report on

Tackling Human Resources for Health (HRH) Crisis in Nepal through Informed Policy Decisions and Actions

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Abbreviations

CCF	Country Coordination and Facilitation (MOHP initiatives for developing national HRH strategy)
CMA	Community Medical Auxiliary
CSO	Civil Society Organisation
DDC	District Development Committee
DHO	District Health Office/Officer
DPHO	District Public Health Office/Officer
HP	Health Post
HRH	Human Resources for Health
HRM	Human Resource Management
LSGA	Local Self Governance Act
MoHP	Ministry of Health and Population
MoU	Memorandum of Understanding
NGDO	Non Governmental Development Organisation
NHRC	National Health Research Council
NSA	Non State Actors
PAT	Project Advisory Team
SBA	Skilled Birth Attendants
SC	Save the Children
SHP	Sub Health Post
VDC	Village Development Committee

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Executive summary

This midterm review was conducted during the month of September – October 2012 after the completion of 18 months of implementation of a 30 month long EU funded project titled **"Tackling Human Resources for Health (HRH) Crisis in Nepal through Informed Policy Decisions and Actions"**, and implemented by the Save the Children country office Nepal. The overall objective of the project is "to set the issue of HRH into the wider context of health system reform by engaging civil society organizations (CSOs) and non-state actors (NSAs) towards building the knowledge base for all and policy advocacy".

The review process consisted of reviewing the documents, meetings with partners at the project districts, with key officials of MoHP and other stakeholders and obtaining critical information from Save the Children team particularly the HRH team. The review findings in this report are structured around the key result areas as defined in the project document.

Findings of midterm review

In view of issues and challenges facing national HRH situation, the current project is very relevant and its launch was received very positively by stakeholders including the MoHP. Moreover, up until now HRH issue had not been a serious agenda of action among the non-governmental actors, this project along with other has established the fact that HRH in public sectors should be and can be a developmental agenda of NGOs.

National Strategy on Human Resource for Health had already begun since the project was designed in 2010 and related activities were progressing basically in the same direction as the project had anticipated. The challenges therefore for project management was to carefully align the project activities to avoid duplication with ongoing activities while at the same time spending the resources where there is best value for money. The implication of delay in project start up date and the time taken to speed up the implementation has reflected on various areas of project activities.

Despite number of achievements made over the period of one and half years, considering the relatively short project duration of 30 months, some of the project targets are ambitious, particularly in the new concepts like Diaspora engagement, setting up ombudsperson for HRH and role of (and expectation from) CSO/NSA Alliance.

Of the total budget for 2012 (EURO 329,927) nearly 70% is allocated to central level activities which also included research and trainings to district Alliance members and 30% to specifically to project districts. In 2012 (as of September) the overall programme spending (excluding salary of project staff) was 31%. At the beginning the spending was quite low, but over the period steady progress was recorded.

Alliance of CSOs and NSAs for HRH

The first period of the project focused on preparatory work and the formation of Alliance of CSO and NSA for HRH at three project districts and at the centre followed by number of capacity building inputs for its members. During the same period, series of meetings and

dialogue were conducted by SC HRH team and Alliances with government officials towards national HRH strategy development process.

Alliances (central and district Alliance) have started conducting monitoring (at district level) and advocacy activities at different levels. Its presence has been felt and there are mixed responses and reactions to its role in HRH. Alliances have developed its work plan or working guideline – but resources required for implementation is not yet identified and all are expecting SC to provide it. Leadership and group dynamics (including group management) is emerging but did not indicate strong enough (Siraha, Bardiya and Doti) to be able to organise and drive the Alliance. The diverse representation in Alliance is certainly strength, but institutionalising and managing such diversity into a functional group and driving it after the project inputs are over in June 2013 is a challenge.

Knowledge base on HRH issues through operational research

HRH situation (three districts specific) and a national assessment were completed and findings disseminated. Mostly based on secondary data (almost all from MOHP or DHO data) these documents are good resource of compiled data on health and HRH. Utilisation of data and findings at local and at central level appeared limited to nonexistent. Despite delay, HRH research has begun with new partner (Development Research Centre) for which inputs and support for research design and training was received from NHRC. The project document has a plan for conducting operational research on HRH, but so far research of standalone nature has been conducted due to lack of clarity in the project document in operational research.

Continue policy dialogue on HRH at different level

Alliances at the districts have made some efforts to initiate dialogue with District Health Office, and to a limited extent to DDC/VDC. National Alliance was regularly engaged in CCF during national HRH strategy development process where there was opportunity to influence the strategy development process. Similarly, central Alliance conducted number of sessions with policy makers of the Ministry of Health and other stakeholders. The impact of such advocacy effort is difficult to measure or even if the impact is seen, that cannot be easily attributed to any particular advocacy effort.

Advocacy and dialogue with policy makers by default appeared to have largely remained the responsibility of Alliance. Given the current organisational structure and lack of funding, Alliances particularly the district Alliance so far has limited results in its advocacy effort. HRH team at centre were regularly involved in national HRH Strategy development process where Save the Children was asked to review the content of the strategy.

Capacity of public sector for HRH

The project is supporting salary of locally recruited health workers in the project districts. In Bardiya district there is cost sharing mechanism whereas other districts are fully dependant on the project. Funding support for local recruitment is much appreciated and has certainly ameliorated some of the problems of shortage of HRH in the short run, but in the long run this is not an answer to HRH issue in the country. There is already a policy and practices to recruit health workers locally with support from DDC/VDC or from other local sources.

The project also supported the most needed training of Skill Birth Attendants in the project areas. Similarly, a number of trainings (HRH management, research, advocacy skills) were organised for government and non government partners, international training and exposure was organised for HRH team and govt officials.

Inputs were also provided to HuRIS at the Ministry of Health making its web search interface user friendly and interactive. This is much appreciated by MoHP officials. A Human Resource portal is being developed with the aim of linking it with existing HuRIS. The portal is being designed to provide details of HR working under MoHP in all 75 districts.

Towards sustainability, the project had anticipated a Critical mass of CSO/NSA – leading to local and decentralised management of HRH. Despite training inputs and supports provided by SC, district Alliances are fully dependant on Save the Children for coordination and other functions. Some form of collective leadership and group dynamics is emerging, but it is yet to demonstrate its strength, credibility and sustainability.

Signing MoU with MoHP, bringing NHRC on board and engaging representative of Ministry of Federal Affairs and Local Development are strategically well placed as these agencies have strong influencing role in policy making and monitoring its implementation.

Major recommendations

- Given the delay in initiation of the project and some ambitiously planned activities, coupled with slow spending rate, consideration should be given for extension of project period beyond June 2013.
- An exit strategy needs to be developed, while so doing, Save the Children should explore the possibility of linking this project (i.e. Alliance of CSO/NSA) into its other ongoing projects so as to ensure continuity.
- More facilitation and mobilisation support to Alliance members is required to build its group dynamics and leadership. Some financial support is needed to conduct district level activities and help leverage additional resource mobilisation by Alliance.
- The current ongoing research is a standalone activity in nature, though according to project document and logframe it is part of operational research. Clarity on current standalone research and operational research is necessary
- Explore for more sustainable funding support for local recruitment of health staff under DHO. Build cost sharing elements in Doti and Siraha as well
- GIS in district – ensure it is not a burden and does not clash with district IT need and is aligned with MoHP plan.
- Ombudsperson and Diaspora engagement – preliminary exploration and concept paper could be possible in remaining period

CHAPTER 1: INTRODUCTION

1.1 Introduction

Save the Children with financial support from EU has been implementing the Human Resource for Health Project in coordination with the Ministry of Health and Population at the central level, District Health Offices, District Development Committees at the district level (Siraha, Doti, and Bardiya), and civil society organizations and non state actors at both the national and the district levels. The overall objective of the HRH project is to set the issue of HRH into the wider context of health system reform by engaging civil society organizations and non-state actors towards building the knowledge base for all and policy advocacy. The 30 months long project was signed with EU on December 2010 and subsequent activities were started from January 2011.

Specific objectives of the HRH project are:

1. To enhance HRH research and policy advocacy capacity of CSOs and NSAs
2. To promote research for building knowledge base on HRH issues in-country, relating it to regional and global context
3. To instigate and propagate national and sub-national debates and advocacy campaigns on HRH issues through strategic Alliance led by CSO
4. To strengthen capacity of public sector authorities for better and evidence-based design, implementation and monitoring of policies related to HRH management

1.2 Objectives and methods of the midterm review

A. Objectives

The main objective of this review is to share learning and challenges among HRH partners and stakeholders, look over the progress and process of intervention, the efficiency and effectiveness of the project team in implementation to achieve results.

- To review the activities that are being implemented according to the work plan and within the planned budget
- To verify the expected results of the project as specified by the indicators and targets are being achieved
- To identify shortcomings and challenges to allow for immediate measures to rectify them in timely manner
- To make availability of documentation and lessons learnt
- To identify the level of effectiveness and efficiency of the project
- To review the processes of intervention, quality and sustainability of the actions
- To assess the relevancy of action at activity level and contribution to achieve results

B. Methodology

Following methods and steps were followed during the midterm review process and three project districts were visited.

- Reviewed related programme documents/agreements/progress reports and field report etc.
- Conducted key informant interviews and discussions with relevant key stakeholders, CSO/NSA members and public sector authorities at both level.
- Carried out Focus Group Discussions (FGDs) with the CSO/NSA Alliance members, partners and beneficiaries.
- Personal observation of the programme sites. Two health facilities in each district visited: one facility where locally recruited staff with SC support and another without SC support.
- Stakeholders meeting (DDC officials) held, feedbacks, comments collected
- Project Advisory Team meeting was held to obtain views and suggestions regarding the HRH project and number of meetings with relevant officials at MoHP and other partners were held.

C. Areas of Assessment

The mid-term review report focused on the following areas:

- Level of CSOs/NSAs Alliance members' participation in programme planning and implementation on HRH.
- Effectiveness of the project and level of awareness, knowledge and skills of the CSO/NSA Alliance members, beneficiaries of HRH project.
- Successful cases/stories of the programme, which can be replicated in other areas/ programmes, and failure cases and the lesson learn (best practices) in HRH
- Sustainability and cross cutting component- the process and strategy of intervention.
- Coordination, networking and collaboration among stakeholders, beneficiaries and public authorities.
- Identify the key challenges, issues, strategies and gaps.
- Analyse achievements and outcomes based on each of five results of project frames.

1.3 HRH situation in Nepal

The situation assessment conducted earlier by Save the Children as part of project activity has summarised the HRH situation in Nepal. The challenges in HRM include mal-distribution, retention, irregularities in promotions, capacity building and transfers of health workers and maintaining the right kind of skill-mix of health workers in facilities. Producers and users (academia, Ministry of Education, MoHP, professional councils, Ministry of General Administration, Public Service Commission, etc) and inadequate monitoring and evaluation framework and HuRIS makes it difficult for effective monitoring of both the qualitative and quantitative benefits. Yet others include non-implementation of retention and motivation scheme for the health workers posted to the remote areas, insufficient planning of capacity development for in-service training and provision of continuous medical education opportunities and the inability of authority to enforce recruitment in sanctioned posts (National situation analysis on human resources for health – Save the Children 2011-12).

The assessment also highlighted some interesting fact about the overall availability of health workers in the country.

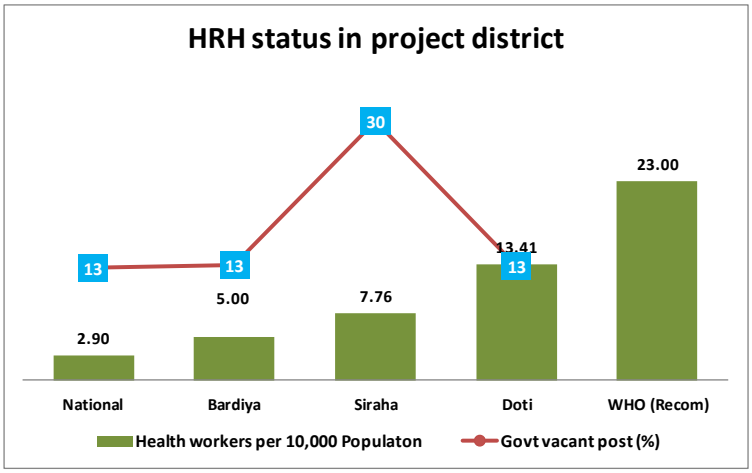
On the production side, a stock and trend analysis of various categories of HRH in the country over a period of last 10 years (1999 – 2009) shows a significant increase in the production of medical graduates (MBBS) - by 16.4% - and a decrease by 1.32% in the production of graduates in public health category. Moreover, there are over 97,000 health professionals registered with different professional councils (cited in the Save the children 2012). On the supply side, 18 medical colleges, recognized by Nepal Medical Council are engaged in the production of medical graduates in various semesters, and many more from three dental colleges.

A recent report further highlighted data inconsistency regarding workforce availability (supply, distribution and skill mix). Medical and Nursing Council shows 16 registered health workforces per 10,000 populations (including public and private sectors). Public sector has a ratio of only 2.9 health workers (including doctors, nurses, and midwives) per 10,000 population which is far below the WHO standards of 23 health workers per 10,000 population to meet health related MDGs (SOLID and Merlin Nepal 2012).

Clearly, there is discord between supply and demand. Despite the good supply of human resources locally, due to government policy and practices demand for HRH in public sector has not been met. Health workforce in public sector has not been able to keep pace with demand and population growth in the country. Moreover, for long, health workforce in general has not been updated and equipped to respond to changing need or newly emerging threats (e.g. HIV, Kalazar, Dengue) and Non Communicable Diseases. Some categories of health workforce are worst hit by this imbalance.

The project districts shows better situation than the national average on health workers population ratio (Figure 1)[1]. Doti has better distribution of health workers largely due to local employment through VDC and low overall population compared to Tarai districts like Siraha and Bardiya. But the government vacant position is similar to national average across the district. The message is clear – there is a need for a better recruitment and retention at the district level.

Figure 1: Health workforce in project district



[1] Data source: National and WHO – cited in NHSP IP 2, project district – collected by SC team from DHOs (as of October 2012)

CHAPTER 2: MIDTERM REVIEW FINDINGS

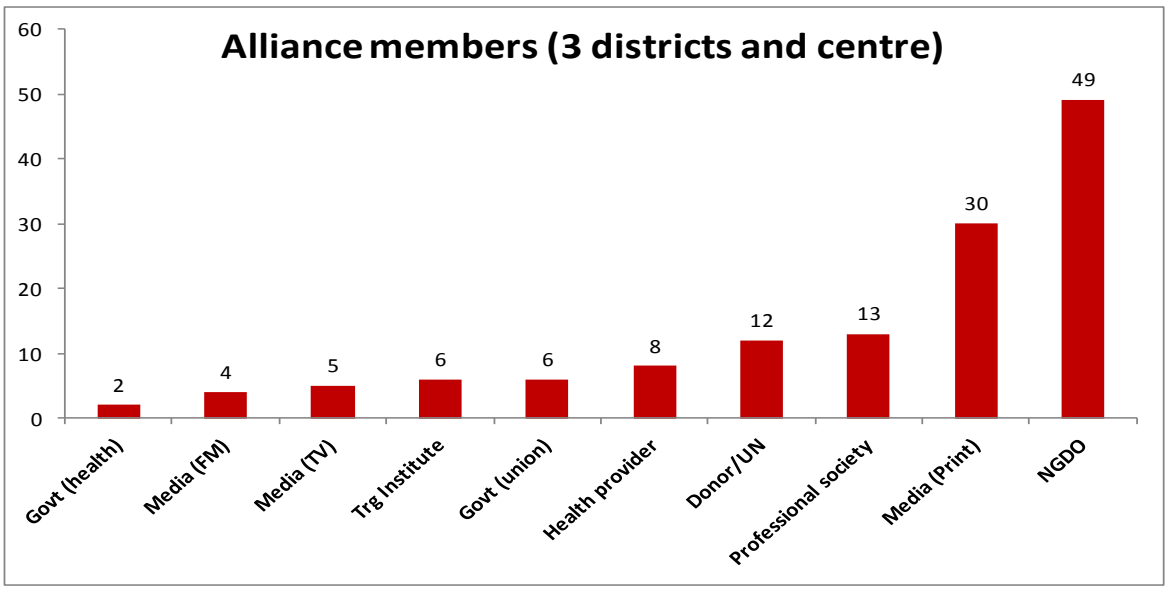
2.1 Alliance of CSOs and NSAs for HRH

Profile of Alliance members

Composition of Alliance (Alliance of CSO and NSA for HRH) consisted of representations from wide varieties of institutions and expertise. Potentially this is a depository of different skills, knowledge and expertise needed for HRH advocacy. Number of institutions and the memberships in the Alliance varied by district apparently guided by the expertise available and interest of the participating organisations at the local level. The representing institutions from three programme districts and centre were arbitrarily grouped into ten different categories for the purpose of analysing and interpreting the data. The highest number of representations is from NGDO (Non Governmental Development Organisations) and the lowest from Media (FM). The Alliance was also represented by government institutions and union of health workers working in different government health facilities. Likewise, professional associations (e.g. Nepal Medical Association) are also member of Alliance (Figure 2).

Representation from trade union of health workers working in government facility (for example, in Siraha and Bardiya there are three different trade unions of health workers) and other health staff in Alliance can potentially influence the activities and decision of Alliance. In a practical term, Alliance is a body to lobby and advocate against the current establishment (which includes attitude of health workers, policy and practices, working modality and so on). In a body where there are representatives of the establishment itself the discussion and decision it takes on or about establishment can be bias. This is a clear case of conflict of interest and potentially can put Alliance in complex situation. Similar concerns were expressed as a potential risk during CSO/NSA consultation organised by Save the Children in August 2011 Kathmandu.

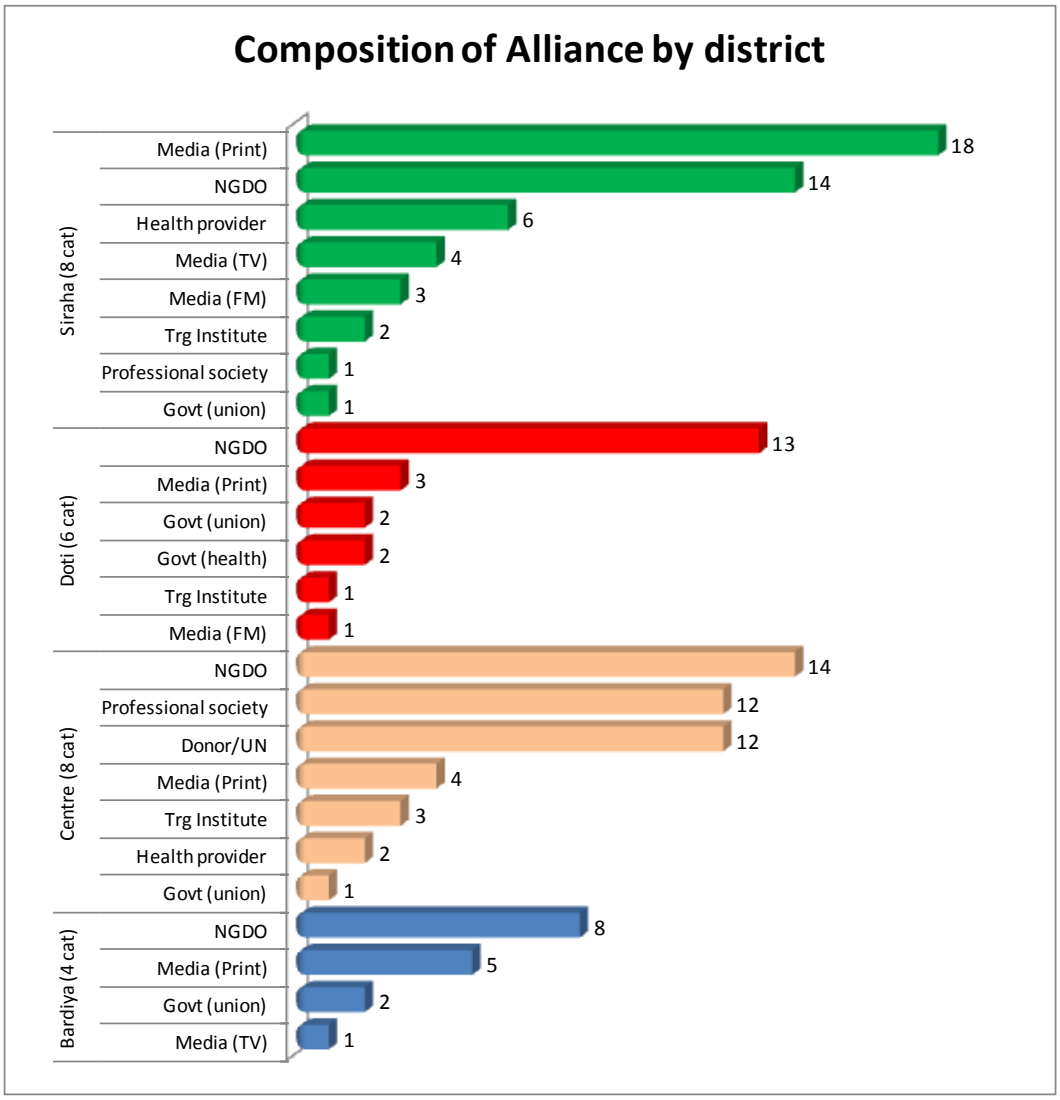
Figure 2: Alliance members



There is however consensus voice among the Alliance members and stakeholders that without active engagement of such unions, moving forward on HRH issue would not be possible. Therefore Alliance would continue as it is (with trade union of health workers as member) but would be careful on any conflict of interest that may arise.

Number and composition of Alliance members differs by district. Predominantly there are more members from NGOs (NGDOs) followed by representative from media. The presence of representatives of professional organisations both at district and centre is strength. **The diverse representation in Alliance is certainly strength, but institutionalising and managing such diversity into a functional group and driving it after the project inputs are over in June 2013 is a challenge**. Similarly, number of meetings, types of agenda discussed in the meeting and number of activities conducted are broadly the same in all district Alliance, which is often guided and initiated by the Save the Children staff (Table 1).

Figure 3: Composition of Alliance by district



Early indicator of change

Health workers and others stakeholders are aware about existence of Alliance; but few are not clear about its role. There is already a subtle tension building up between Alliance and health worker (Siraha), during initial monitoring visit to health facility (Bardiya) health worker refused to cooperate and was asked to produce introductory letter of DHO. There is a feeling that the monitoring and watch dog role of Alliance may overlap with the role of DHO and create conflict (Siraha). At centre also, as reported by central Alliance members, initial response of MoHP officials towards Alliance activities was not very positive.

Alliance as an independent body watching and questioning the performance of health workers who were left unwatched and unquestioned for long will certainly face resistance particularly from those who are not performing. But at the same time, it was reported that health workers have become self conscious because of the presence of Alliance and its monitoring role and have improved their performance (i.e. opening health facility in time, staying full time in the health facility). Many health workers, as reported, also expected that since their request for HRH improvements is not often heard by the authority, but if their voice is raised by Alliance that may be heard and action taken by the authority to improve HR situation in their particular health facility.

There is strong view from the PAT members; particularly from representatives of MoHP that Central Alliance should be merged with CCF as most of the members of central Alliance are member of CCF anyway.

Central Alliance needs to make its own decision on its dual role as a CCF member and choose a position they that is most effective in policy influencing.

Looking at the time line of major activities (Table 1), in the period between 2011 and 2012 after its formation Alliances (and its members) were primarily engaged in capacity building process and conducting district situation assessment. During the same period, some meetings and dialogue were conducted with government officials.

Figure 4: Lesson learned (working with media)

Working with the media has proven a great success in the advocacy of Human Resources for Health. The project has been doing press releases and publishing articles whenever there are opportunities to make news and dissemination of views. Journalists have been oriented to the HRH issues at the national and the district levels to report accurately on HRH issues and they have been taken out on the field to report the issues. Journalists have also been encouraged to report on HRH with the establishment of an award to the best write-up on HRH. Journalist Associations are also an integral part of the CSO/NSA alliance on HRH.

These interventions of the project has produced several news reports and articles, including some on television which means the general people and policy makers are aware of what ails Human Resources for Health. These media write-ups have prompted bureaucrats to expedite the process of working on the HRH strategy and now the HRH strategy is with the cabinet of ministers waiting to be endorsed *(source: Save the Children, HRH team)*

Table 1: Timeline of Major activities

Date (months)	Save the Children	Central Alliance	Bardiya Alliance	Doti Alliance	Siraha Alliance
Mar – June 2011	Meetings with HRH partners- BNMT and Merlin and other stakeholders (MoHP, CTEVT). PAT formed	3 Consultative meeting with stakeholders			
July – Sept 2011	Meetings (PAT, EDPs), MoU with NHRC	Meeting for Alliance formation	Meeting for the formation of Alliance	Meeting for the formation of Alliance	
Oct - Dec 2011	Participation in HRH course (Scotland, Philippines) Journalist orientation	Preparation of advocacy strategy and communication strategy of Alliance	Alliance formation meeting. Agreement with DHO and DDC for local hiring, Alliance formed	Pre-consensus letter to implement activities Alliance formed. Agreement with DHO and DDC for local hiring	Pre-consensus letter to implement activities Alliance formed Agreement with DHO and DDC for local hiring.
Jan – Mar 2012	MoU with MoHP Participation in Conference (Prince Mahidol)		Journalist orientation		Orientation to Alliance members
Apr 2012	Participation in HRH Management Training				
May 2012	International HRH Management Training	Assessment Alliance members on research and advocacy	Research and advocacy training need assessment	Training need assessment (research and advocacy)	Training need assessment (research and advocacy)
June 2012	3rd PAT meeting	Research Training, by	Training on research	Training on research	Training on research

Date (months)	Save the Children	Central Alliance	Bardiya Alliance	Doti Alliance	Siraha Alliance
		NHRC Secretariat and coordinator identified.	method by NHRC	method by NHRC	method by NHRC
July 2012			Situation assessment and dissemination		Situation assessment started
Aug 2012	Extension of MoU with MoHP Research agency selected	Advocacy Training Working guidelines and broad activity prepared		Situation assessment disseminated	Taskforce meeting Advocacy training
Sept 2012	1st phase upgrading of HURDIS		SBA training to local health workers		Advocacy message design
Oct 2012	4th PAT meeting Research team in the field for data collection				

2.2 Capacity of CSOs and NSAs for HRH research and advocacy

Capacity of Alliance

Alliance members (particularly the task force members) have received training on advocacy, research, and also receive onsite support from project team. Training was designed following the training need assessment conducted by NHRC.

Alliance members are aware about the objectives and the role of the Alliance. But written TOR was not available to members, it was expected that Save the Children will prepare it and circulate to the members. Though some differences exist in specificity of activities across the districts, Alliance members broadly share the same views in terms of their role in information collection and advocacy at the district level. Almost all the members in the district Alliance are local residents and are fairly aware about health care providers' work style, attitude, quality of service they provide and overall staffing situation in hospitals and health posts. Alliance members are also conscious about their 'position' and the consequences of their presence and 'presentation' in the district, particularly among the health workers and the local policy makers (i.e., DDC officials). Alliance members have received training on research, advocacy and a general orientation.

Out of total member, a task force/task team consisting of 9-11 members are formed to carry out specific task and to regularly communicate with Save the Children. Communication between 'task team' and general member is not adequate. Task team members are involved in all activities, trainings and monitoring visits. General members often do not get timely communication and updates from task team members therefore do not feel engaged or part of the team. At the initial phase, in order to initiate activities and drive the Alliance formation of task team was a useful step.

Once a task is completed, the task team is redundant, but distinctions still exist between task team and general members. But once the Alliance is more matured and have better group dynamics such difference should be avoided. All members should be equally involved and opportunity is made available to all to engage in the process.

> *We know the overall health workers' situation in the district and we want to improve the current situation. Previously there was no such forum where we can openly and collectively discuss the issue. Now the Alliance has offered us a forum and opportunity where we can discuss and plan activities towards improving the current situation. -* ***A participant in Siraha***

Structure and working modality of Alliance differs by districts. Most of the coordination and communication role is taken by Save the Children HRH project staff both at the district and at the centre. Leadership and group dynamics (including group management) is emerging but did not indicate strong enough (Siraha, Bardiya and Doti) to be able to organise and drive the Alliance. In Siraha, there is no coordinator or communication person/institution identified for Alliance, in Bardiya a coordinating agency and organisation for secretariat is identified, in Doti also a coordinating agency (FPAN) is identified but secretariat is not yet identified. But whatever is the case, the communication and coordination role and keeping documentation of Alliance activities up until now is being carried out by SC staff. One of the

challenges within the Alliance is same individual from representing organisation do not attend all the meetings and all the members are not regular at the meetings. Members attending the meeting often do not share back the decisions with their respective organisation; therefore there is regular gap on updates and understanding.

Work plan of district Alliance is available where types of activities and responsibilities are stipulated. But for the budget and other resource requirements for implementing the work plan, it is fully dependent on Save the Children. There is no clarity on the resource generation for the Alliance activities though some ideas and possibilities of obtaining funding support from INGOs are being discussed. But there is no any indication of efforts made towards this. Alliance members felt that their visibility is not yet strong to create an impact. District member expressed that central Alliance needs to pick up advocacy issue raised by district Alliance and complement if through advocacy at the centre.

Central Alliance (also called national Alliance) is relatively better organised, role of secretariat and coordinator's role is taken by Britain Nepal Medical Trust and SOLID respectively (both organisations are recipients of EU HRH grant). It has developed a working guideline and identified broad activities areas for advocacy. Central Alliance is also struggling to be clearer for its long term sustainability, mobilising resources for its advocacy activities and for routine activities. Defining its 'national' form (with or without representation from districts); and defining and agreeing its legality and working modality i.e. register as an organisation or continuing its current form of loose network are other unresolved agenda of central Alliance.

Communication and linkage between district and central Alliance is nonexistent. In a context where most HR related decision is taken by Ministry of Health or Department of Health Services, district advocacy efforts needs to be complemented by central advocacy initiatives. Alliance member at Doti suggested Central Alliance to be registered where district members will be its member. This creates an umbrella structure that makes the central Alliance bigger and more 'powerful' structure. A visible and powerful structure is essential to have an impact of advocacy work.

Linkage and communication of district Alliances to central Alliance needs to be explored and promoted. Some possibilities (not limited to) are;

1. District Alliance sends one or two representative formally in the Central Alliance as member to participate in all central level meetings and other activities. This means central Alliance needs to be more structured (and may be registered) with clear working modality with district team.
2. Centre and district Alliance agree a joint action plan and conducts activities accordingly in coordinated and mutually reinforcing manner.
3. Centre and district agrees to respects each other's differences, identities and strengths; and establish a mechanism for regular communication and agree to work jointly as and when needed on agreed issues.

Rotating leadership and rotating responsibility in housing the Alliance secretariat and hosting the meetings will improve the leadership and strengthen the ownership. This should be promoted in next phase.

Additional guidance, trainings and mentoring is necessary to strengthen the Alliance. Inputs on leadership development and group dynamic to the Alliance members appeared crucial.

Alliance at district and centre needs to be provided with some financial support (on task basis) as a part of HRH project to carry out its plan of advocacy. In such financial support, cost sharing should be encouraged so that Alliance will be exploring other funding sources to complement SC contribution. This kind of task based funding will not only create visibility and credibility of Alliance but also promotes ownership, builds group dynamics and promotes collective leadership culture.

2.3 Knowledge base on HRH issues through action research

National and district HRH situation assessment was completed and finding disseminated. National and district situation assessment were conducted in parallel, therefore each report is a standalone report with limited data comparability and comparisons between and among districts. Mostly based on secondary data (almost all from MOHP or DHO data) these documents are good resource of compiled data on health and HRH in a single document which otherwise was not readily available in the districts. Other than district level dissemination, utilisation of data and findings at local and at central level is limited or nonexistent.

Additional data were collected by members of Alliance (4 teams were formed to collect data from health facility) in Bardiya and data was handed to SC for compilation. As of midterm review SC had not compiled it and shared it back to Alliance members. Siraha Alliance has a plan to visit health facility to collect data.

Fact sheet preparation and distribution to the central and district authority is in the next year plan, although there was an opportunity to prepare district fact sheet along with district situation assessment task for better impact. This would also add to the advocacy and policy dialogue that Alliance aim to conduct in future.

After some delay in the selection of partner, HRH research at district has just begun with new partner (DRC) and it is hoped that by January the finding of HR research will be available. Inputs for research design and research training was received from NHRC. Ongoing research is designed to be a standalone research rather than in the operational research format. The project document has a plan to carry out operational research on HRH. Normally, the duration for operational research particularly in HR field require longer time period, therefore it highly unlikely to be able to design and successfully implement a operatinal research in the remaining months (9 months) of the project duration. Besides, the project document is also not specific on operational research vs stand alone research. **Notwithstanding, there is opportunity to explore the possibilities in operationalising the research findings made so far**.

Certain cases however can be fine tuned to operational research format. For example, financial support to Alliances to carry out its advocacy activity can be an operational research to see the effect of financial support in terms of improving Alliance ability to leverage additional resources, ability to attract attention of wider stakeholders and policy makers in HRH related issues and ability of Alliance to sustain its effort independently with no or little support from Save the Children.

2.4 Continue policy dialogue on HRH at different level

Alliances at the districts and centre have made some efforts to initiate dialogue with District Health Office, Ministry of Health and Population and to a limited extent to DDC/VDC. DHO/DPHOs in the district do have fairly good understanding about Alliance and the issue around HRH, whereas other officials and staff in DHO do not have same level of understanding about Alliance.

DDC officials on the other hand are not fully aware about existence of Alliance and its role (most DDC officials met had recently joined the office, therefore the gap in information). There are difference on views among DDC officials about the Alliance and its possible roles. Some expect Alliance to monitor all that happens in the health sector where as some expect Alliance to monitor NGOs activities related to health. DHO and staff are fairly satisfied by the current level of coordination maintained with them though some improvements are expected, whereas DDC officials see greater need of improved coordination between Alliance and DDC.

After the introduction of LSGA (1998), VDCs have been a continuous and reliable resource to many health facilities both for budgetary support and input in overall functioning of the health facility. Though Alliance member do see the need to initiate dialogue with VDC, no concrete action was initiated so far. In Doti where VDC is already supporting over 50 staff to set up Birthing Centre, need for advocacy for additional HR is hard to justify locally. Similarly, since most DDC told that they do not have much internal revenue source and are heavily dependent to central government grant, allocation of additional resource for HRH is highly unlikely unless government changes its resource allocation guidelines and authority to DDC/VDC.

National Alliance was regularly engaged in CCF during national HRH strategy development process where there was opportunity to influence the strategy development process. Similarly, central Alliance conducted number of sessions with policy makers of the ministry of health and other stakeholders.

> *Diverse groups and expertise were pulled together to form the Alliance. This in itself is an achievement as this process made all of us from different organisation realise how important it was for us to engage in HRH issues in the district. –* ***Participants in Bardiya Alliance***

Advocacy and dialogue with policy makers appeared to have remained the responsibility of Alliance in the HRH project. Given the current weak organisational structure and lack of funding, Alliance so far have not been very active and successful in its effort of advocacy. District level dissemination of situation assessment report is one initial step towards

advocacy and policy dialogue at the district. Alliance member felt that this kind of simple advocacy does not produce much impact, therefore suggested that district efforts needs to be picked up and complemented by the central Alliance.

There are number of recommendations made in the situation assessment and further ideas were generated by Alliance for policy dialogue. At the district level – Alliance members highlighted the issue like, late opening of the health facility and health workers not staying full time in the facility; absenteeism among the health workers and health worker giving priority to their personal pharmacy or drug shops. But agenda/issue for advocacy is yet to be prioritised for policy dialogue.

2.5 Capacity of public sector for HRH improved

Shortage of health worker is critical and chronic issue at all level. SC in partnership with DDC/DHO is supporting salary of locally recruited health worker in the district. In Bardiya the cost sharing mechanism is inbuilt in such local recruitment from the very beginning (currently SC contribution is 73% of total salary of 15 locally hired staff) but in Doti and Siraha do not have such cost sharing mechanism. In Doti however, local employment of health workers from VDC sources is highest among three districts, therefore leveraging additional resources from VDC is unlikely.

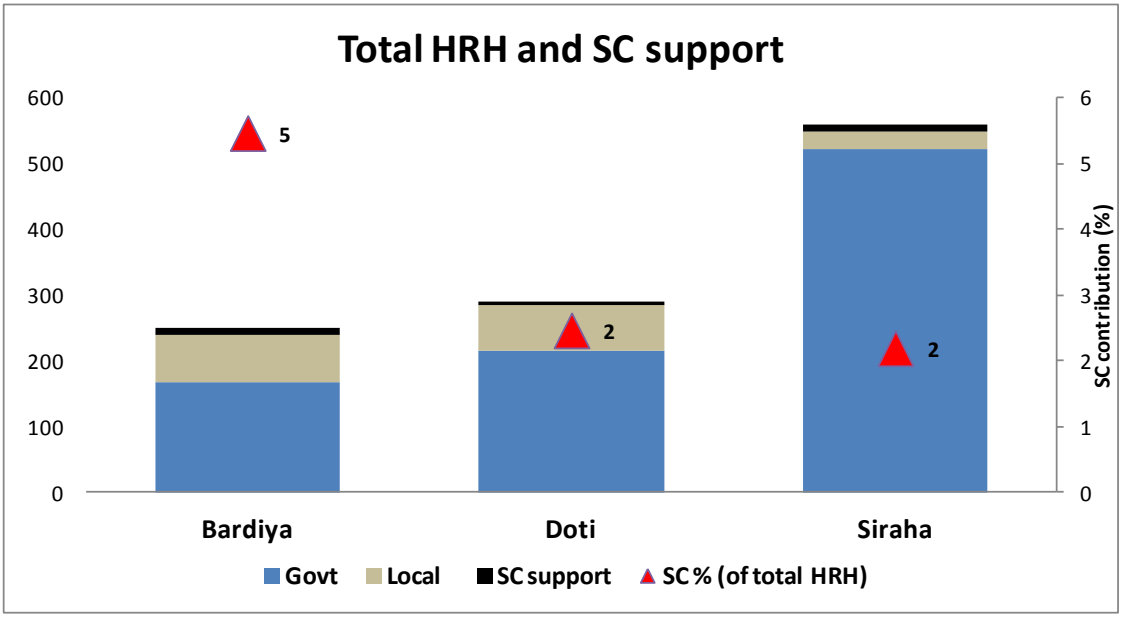
Funding support from Save the Children for local recruitment is much appreciated and has certainly ameliorated some of the problems of shortage of HRH in the short term, but in the long run this is no answer of HRH issue in the country. There is already a policy and practices to recruit health workers locally with support from DDC/VDC or from other local sources. Request for salary support to Save the Children is made by DHO where it is assumed that DHO made such request based on some specific priority and criteria. Local contribution to HRH recruitment (in terms of number of health workers) through SC is only between 2 and 5 percent of total HRH situation in the district (Figure 5).

Local recruitment appeared to be guided by three factors; move to set up **birthing centre at the health facility, acute shortage of service provider and managing transfer issue within the district** (Siraha).

> *During a visit in one health post in Siraha (Bayarpatti HP) where SC has supported full salary of a CMA, assessment team observed (and also briefed by the HP in charge) that the new CMA was recruited because the existing CMA was seeking transfer nearer to his home village. Apparently the local recruitment is made to manage the local pressure and dynamics of transfer. Though this step in itself may not be ill motive move, there is always risk of manipulating the local recruitment.*

The project also supported the most needed training of Skill Birth Attendants in the project areas. This is crucial training particularly in the context when government has plan to upgrade SHPs into HPs and setting up birthing centres in almost all HP with the aim of reducing maternal and infant mortality rate towards meeting MDGs.

Figure 5: Total HRH in the districts and SC support



A national training on 'Innovative HRH Management Practices for Public Sector Authorities' was organised for government and non government partners with expertise from Queen Margaret University, Edinburgh, UK.

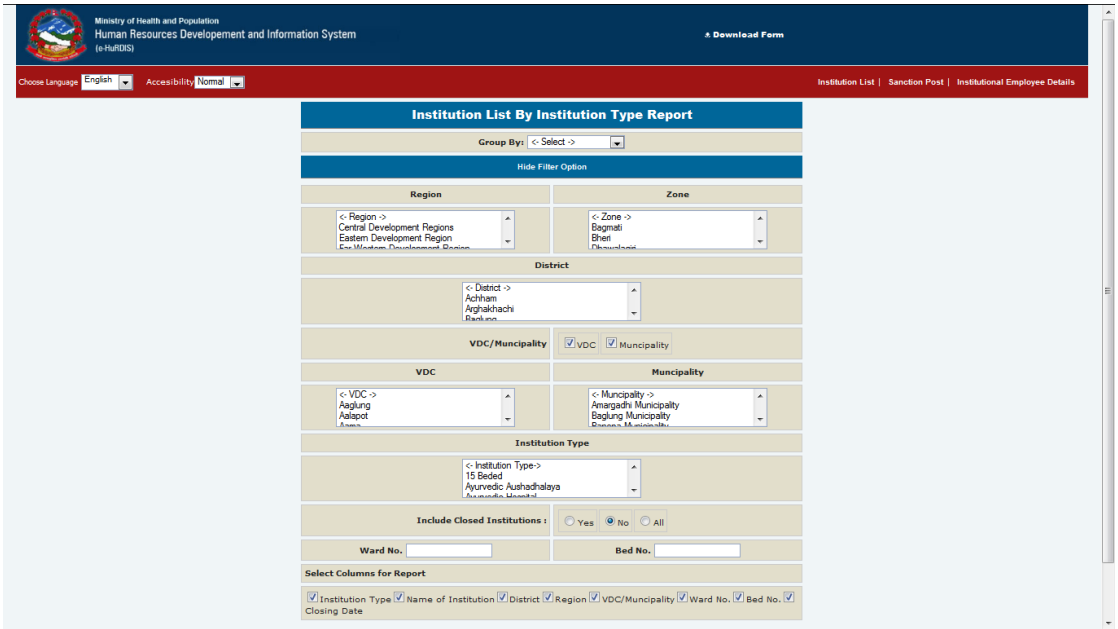
Inputs were also provided to HuRIS making its web search interface easier for the users. HuRIS when established was found to be very good and were used by MoHP and other departments of Ministry to obtain detail information for planning, monitoring and capacity building of health worker (Figure 6). But over the period, HuRIS did not function to the extent it was designed. The HR information (recruitment, transfer, training, promotion etc) was not regularly updated and critical data was not available. Therefore, for the HR portal to function properly, it is crucial that HuRIS system is functional in the first place. At the central level, a **Human Resource portal** is being developed with the aim of linking it with existing HuRIS. The portal is being designed to provide details of HR working under MoHP in all 75 districts. This is innovative and in the long run it will be upgraded to GIS system that is being developed by MoHP.

Similarly, plan exists to install GIS for HRH at the three project districts. When MTR team checked, there seemed a mixed level of acceptance of this initiative at the district level. However, since GIS at district level is not yet government activity (though plan exists), this activity is likely to be taken as additional work by Statistical Assistance (who is responsible for data management at DHO), therefore time and effort required to run the system may not be readily available. As such, a DHO also opined that at the initial stage some 'incentive' might be expected until GIS becomes part of government programme.

DHO also opined that since there is increasing requirement from MoHP and others for updated, accurate and timely data of district health indicators, there is strong need to establish e-network of HPs and PHCs to DHO. This will not only reduce the workload at

HP and PHC in transferring and compiling data from one register to another, compiling it in different format and send hard copy to DHO, but also allow DHO to efficiently compile and upgrade it to HSIS format as well as easy access to data for district planning and monitoring.

Figure 6: e-HuRIS front interactive page



Ombudsperson

Concept of 'ombudsperson' for health is relatively a new concept in Nepal though the country has been practising a few similar mechanism for overall vigilance of government functioning. There are currently following such statutory body formed through the act of legislature, National Human Rights Commission, Commission for Investigating the Abuse of Authority, National Vigilance Centre (*Rastriya Satarkata Kendra*) and Parliamentary Committee for State Affairs, Hello Sarkar, Governance and accountability committee under Ministry of health and population etc.

Recently, 'hello sarkar' (hello government) – a mechanism set up within the prime minister office to hear complains and public grievances on government function has played an important role as ombudsperson.

Governance and Accountability Committee under the ministry of health and population is mandated to look into grievances and complaints from public on overall health related issue and prepare recommendation to address it.

The experience in Nepal on Ombudsperson or performance of similar bodies is mixed or limited. Clearly, ombudsperson performs best in an environment of responsive and elected government, stable political system and in decentralised decision making process. Currently conducive environment is absent and the country is passing through a transitional political process. As a result, recommendations made by such existing bodies have not been acted upon effectively by the government. **Keeping in view of this, achieving the results related to 'ombudsperson' is challenging within remaining period of 9 months**.

Some preliminary work and production of a concept papers should be possible in remaining project period. Moreover, setting up the 'ombudsperson', building its capacity and making it functional require much longer 'incubation' period.

Diaspora engagement

The concept of diasporas engagement in HRH is also a new concept that requires careful and thorough analysis and preparation before getting it off the ground. Diaspora engagement in Nepal has just begun and so far diasporas appeared interested primarily in corporate sector. Some involvement is also seen in social charity sector e.g. building hospital in own mothers name, building trust in own parents name, providing one off grant and equipment to schools and health facility). There are unrecorded and anecdotal experiences that Nepali diasporas come to Nepal in their holidays and make their time and expertise available in different fields (teaching, health care, charity work). Government policy and legislations are not yet clear on diasporas. Association of Non Resident Nepali diasporas has been advocating for more open legislation, dual identity, property rights and so forth. Therefore this result area in the project also requires much longer preparation, careful analysis and planning.

Fellowship and international exposure

Fellowship support was made available to participate in international training and events related to HRH. So far 14 persons (three DHOs from project districts, 3 MoHP, 8 Save the Children HRH team) participated in HRH seminars and training in Bangkok, Philippines and the UK (Scotland). There are further plan of fellowship and international exposure in 2013.

CHAPTER 3: DISCUSSION AND CONCLUSIONS

Context regarding Human Resource for Health had started to change rapidly and positively since the project was designed in 2010. These earlier and or simultaneous developments have implications to HRH project management and its implementation as some of the results and activities anticipated with the project inputs had also reflected in government documents. The challenges therefore for project management was to carefully align the project activities to avoid duplication while at the same time spending the resources where there is best value for the money. Some of the major changes or initiatives that had taken place are as follows

- HRH Strategy (2011 – 2015) development process had already begun before this project was initiated. Number of background papers (situation reports, working documents) was prepared and collaboration with international group had already begun.

- A Country Coordination and Facilitation (CCF) was set up (based on Kampala Declaration and Agenda for Global Action) with membership drawn from almost all sectors concerned with human resource production, deployment and employments (medical colleges, training institutes, private hospitals, NGOs/INGO and so on), quality assurance and standardisation agencies (medical councils, nursing councils), research organisations (National Health Research Council, other national research agencies). The objective of the CCF was to solicit the wider views and inputs from different sectors in designing the national HRH strategy apart from engaging non state actors in different stages of HRH strategy development process. Most of central Alliance members are also member of CCF.

- Interagency working group in health sector governance was set up by ministry of Health under the leadership of National Planning Commission. This group was mandated to guide ministry of health and other ministries regarding overall health including human resources in health.

- Local Health Governance Project had started as a pilot in number districts (5 districts) with the aim to support local governance system (particularly in VDCs and DDC in general) to look into overall health issues from local perspective, plan local health delivery mechanism including recruiting health workforce locally as per the need in the local context. Given the positive experiences from the pilot district, MoHP has planned to expand this programme to other districts.

- Government has identified critical issues on retention and developed an appropriate health workforce retention policy (location based incentive, performance based incentive – both monetary and non monetary). Government has also drafted amendment of existing Health Act making it more specific and expanding its scope particularly in recruiting and retaining health workforce locally and centrally (this information is based on personal meeting with MoHP officials).

- A governance working group in MoHP has been set up in order to address grievances and preparing recommendation for redressing public grievances in line with good governance act.

3.1 Relevance

Nepal's health system has been struggling for long in addressing some of the anomalies growing in the health sector particularly in the management of human resources for health. There is a growing mismatch between production and utilisation of human resources in the country. The vacancy rates are particularly high for skills that are most needed. The data clearly indicates that vacancies are particularly acute for specialist doctors, nursing and technicians. The current and previous health plans (NHSP IP 2 and NHSP IP 1) clearly emphasised the need to improve human resource management in the country.

Keeping in view of overall national HRH situation, the current project is very relevant and its launch was received very positively by stakeholders including the MoHP. MoHP has signed a MoU with SC to work together in HRH and appreciated its interest and engagement in HRH process. Moreover, up until now HRH issue had not been a serious agenda of action among the non-governmental actors, this project along with other has established the fact that HRH in public sectors should be and can be a developmental agenda of NGOs. Though the media and some organisations were active in raising the voice and concerns on the overall health issue in the country including the issue around HRH, the formation of Alliance is an incremental step that aims to bring the diverse and isolated efforts into a collective and concerted effort focusing on human resource for health.

Before the HRH project was started, MoHP process of designing HRH strategy (2011 – 2015) was already progressing. HRH project has opportunity to participate in the Strategy development process and influence the HRH Strategy towards making it more functional that addresses the real HRH gaps and issues in the country. Though the magnitude and exact nature of contribution and policy influences that can be directly attributed to the project or to the activities of Alliance is not possible /available to measure, it was clear that central Alliance member had made number of interaction with MoHP officials during the process either participating in the CCF or in other forum.

Some activities at the district and central level appeared very ambitiously designed that needs careful attention, such as Diaspora engagement, setting up ombudsperson for HRH and role of (and expectation from) CSO/NSA Alliance at the district level. All these three are new concepts that require longer inputs for effective functioning and careful monitoring. Given the short duration of the project, providing inputs and monitoring for longer period is not possible after the completion of the project.

3.2 Efficiency

The start up of the project was delayed for various reasons. Moreover, withdrawal by initially agreed partner not only delayed the beginning of the project, but also was a setback that resulted in re doing some of the work plan activities and slow implementation. But after the start up of the project, progress was rapidly made in number of result areas (Table 1). The project was designed for 30 months and activities were planned and spread accordingly

over the period of 30 months. By the time office was set up and full-fledged staffs were recruited in place, it was already first quarter of 2011. Therefore, in practical term, the project began its operation only sometime in May/June 2011. In other words, there was loss of almost 6 months from the date of signing the project. Six months loss in a 30 month project is a major setback and almost impossible to recover and implement all the planned activities in remaining 24 months.

The initial phase (during January 2011 – mid 2012) appeared to be heavily focused in coordination and rapport building with various stakeholders; initiating preparatory work; and setting up Alliance and building its capacity (Table 1). Research process began quite late largely due to delay in identifying new partner following the withdrawal of initially agreed partner. Situation assessment report was ready only in August 2012. Field research has just begun (Sept 2012).

Advocacy and policy dialogue by default appeared largely remained the responsibility of Alliance. Given the current organisational structure and lack of funding, Alliance so far has limited success in its advocacy activities. District level dissemination of situation assessment report is one initial step towards advocacy and policy dialogue at the district. Alliance member felt that advocacy at the district level only does not produce much impact, therefore suggested that district advocacy efforts needs to be picked up and complemented by central advocacy by central Alliance.

3.2.1 Delay in project implementation

The project implementation was delayed by various factors some of which was beyond the control of project team and the implementing agency. Major reasons of delay are as follows;

- The agreement was signed by EU on 13 December 2010 and signed by SC on 21 December 2010
- Project lead was hired in 2011 February but shortly resigned in May, other staffs were hired March onward. District based staffs were hired in April –May, 2011. Current project lead was hired in August end 2011.
- The staffs who were involved in the development of project had left the organization and some of the concepts were not clear to the current staffs. Neither there were background materials or supplementary documents available to help new staff in implementation.
- Frequent changes of Government staffs causes delay in MOU & Agreement
- CSO/NSA Alliance took much longer time and inputs to arrive to the present shape than initially planned in the project document. This is one of the main causes of delay in development of plan of action of Alliance of CSO/NSA
- Took longer to identify international HRH expert to conduct HRH Management Training
- Limited number of local experts in HRH to obtain technical services and support in time
- Discontinuation with initially identified implementing partner not only delayed the project agreement with EU, but also left a gap particularly in understanding in some of the concept of implementation. This event also made everyone

critical in selecting new partner; as a result selection of new research partner took longer than expected.

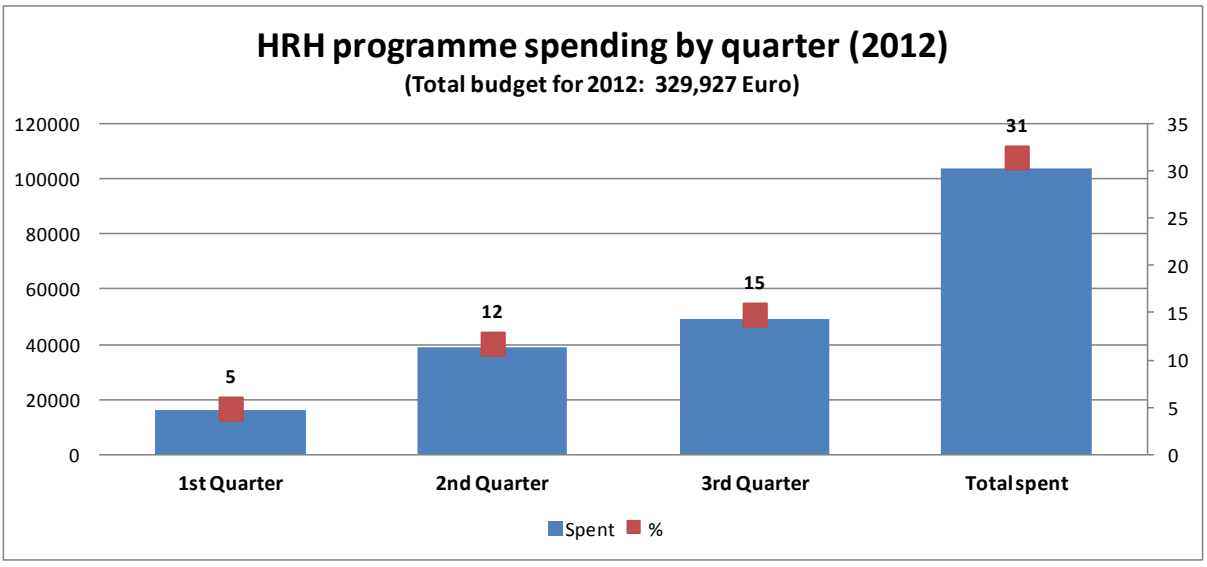
3.2.2 Budget and spending

Based on information supplied by the HRH project team, it is apparent that budget monitoring is based on cost item (budget line). Budget monitoring by result areas or by main activity is not done. Therefore spending details or details spending weighted by result area is difficult draw.

The budget allocation reflected that nearly 70% of budget is allocated to central level activities which also include research and trainings to Alliance members. 31% of budget that is allocated to districts are intended to cover support to DHO for local recruitments and other supportive activities at the district level.

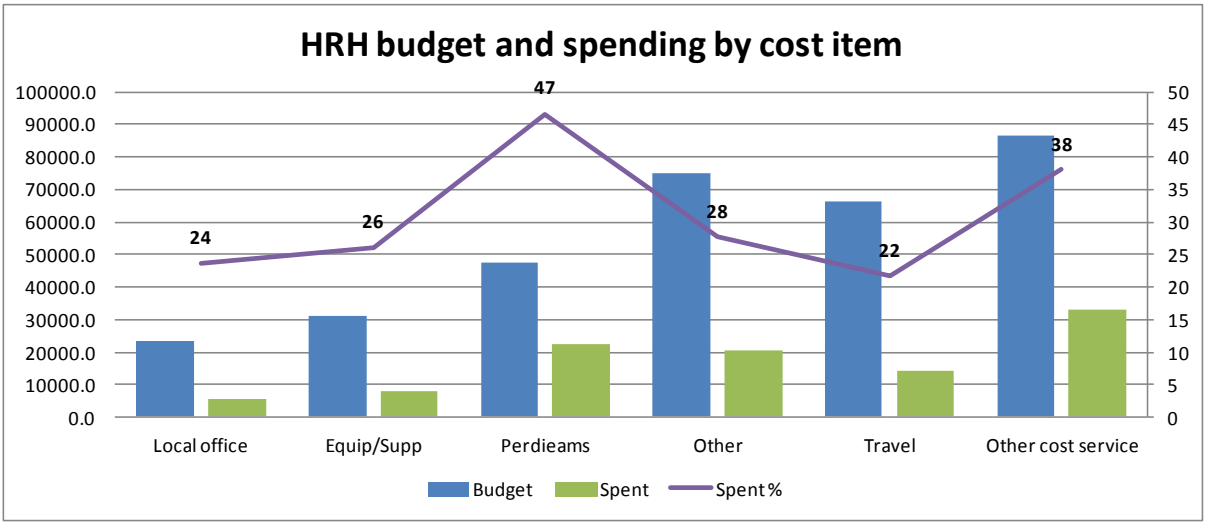
In 2012 the overall programme spending (excluding salary of project staff) is 31% of the allocated budget. At the beginning (first quarter of the year) the spending was quite low, but over the period along with increased programmatic activities, the spending progressed slowly and by September 2012 it reached at total of 31% spending. It is anticipated that spending would rise on 4th quarter when research activities will be completed (Figure 7).

Figure 7: HRH spending by quarter



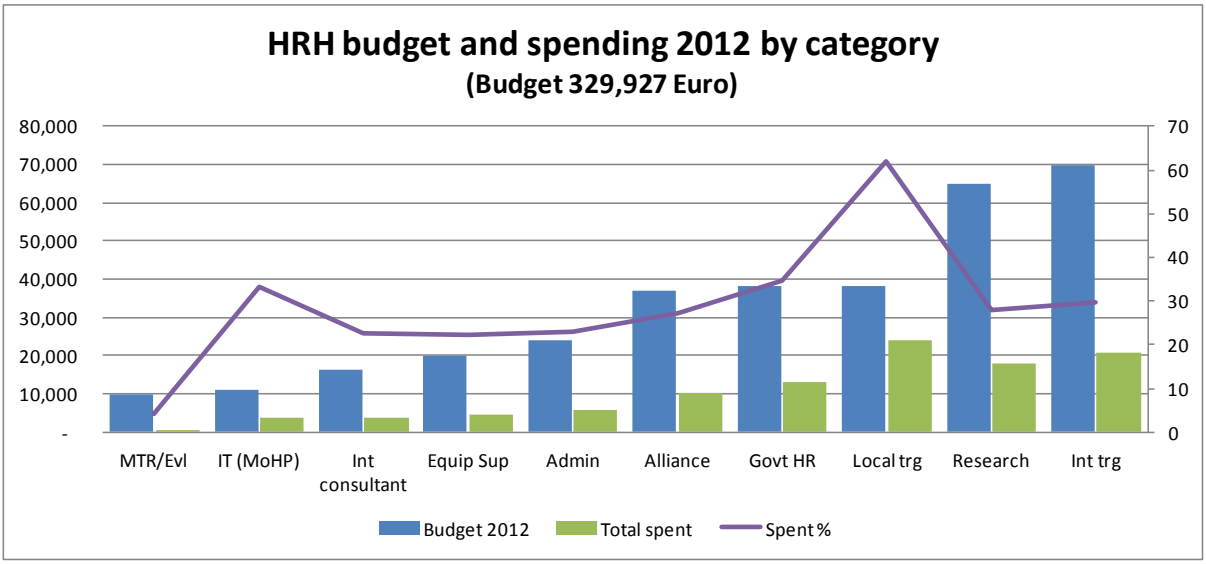
The routine budget monitoring is done by cost item (account heads). The account heads are categorised into six major heading with number of sub heading under it. Looking at the spending by cost items, the highest allocation is on other cost service (26%) which includes research activities, midterm evaluation and final evaluation, printing and publication of reports etc. the spending in this category as of September was 38% of allocation. Highest spending percentage (47%) is on per-diems where total allocation in 2012 was 14% of total budget (Figure 8). Higher spending in high cost area (high budget allocation areas) is desirable. In the current case there are higher spending in low to medium cost areas. This makes the overall budget burn rate low in 2012.

Figure 8: HRH budget and spending by cost items



The spending information was arbitrarily categorised into ten groups to draw broader perspective on spending by programmatic areas. The highest budget allocation is on international training followed by research and local training. The spending is highest on local training category (Figure 9) which has third highest budget allocation. There are overlaps in the category, for example local training is also for training to alliance members, and as such some of it is part of cost to Alliance. Therefore the categories and expenditure needs to be cautiously interpreted.

Figure 9: HRH budget and spending by programme category



The spending information shows that in last 9 months the spending is 31% and it is highly unlikely to have bulk spending in the remaining three months of 2012. This under spending would add on to the pressure for next year. Though the detail information is not available, the spending in 2011 was also reported to be quite slow. Moreover, Alliance related

activities seem to have allocated only 11% of total budget in 2012 – where as there is highest expectation from Alliance for advocacy and policy dialogue.

3.3 Sustainability

The project document envisioned sustainability from number of perspectives. Some are quite ambitiously perceived and designed. First, it anticipated a Critical mass of CSO/NSA – leading to local and decentralised management of HRH with evidence based HRH projection and management, local resources mobilised for recruitment HRH. The review findings in this aspect are as follows.

- As for the critical mass, trainings and fellowship inputs from the project strengthened the capacity of health workers and advocates (i.e., Alliance members) so that they can use their knowledge and skills to improve human resource situation in the project area. Some advocacy activities were initiated by the district and central Alliance – but continuity and effect of such effort is yet to emerge.
- Decentralised management is critical. HRH management in public sector is guided by Health Act, Civil Service Act and other prevailing rules and regulation of MoHP. In other words, in the current political and legal framework, there is very little flexibility of decentralised management of human resources at the peripheral level (district level). Local Self Governance Act (1998) has offered some scope for decentralised management, which is being used to a limited extent at the local level – but the Act has been largely ineffective due to lack of elected government at local level.
- Local resources mobilisation for health improvement and local recruitment of critical human resources has been in practice for quite some time now. The Local Self Governance Act (1998) further allowed authority and flexibility to DDC and VDC to allocate local resources for health improvement and recruitment of local health workers. Moreover, Health Facility Management Committee at HP, SHP, PHC and hospital development board at hospital has played important role in mobilising local resources for health improvement.

  In the current HRH project areas, the effect of project inputs (particularly funding support for local recruitment) in improving the local resource mobilisation from current situation is yet to emerge.

Project document also anticipated replication of the Alliance model

- CSO/NSA Alliance model can be replicated in other district but capacity inputs needs to be ensured which is most complex and require longer duration. Though the impact of Alliance model is yet to be visible, the effort so far and early indication of 'pressure' felt by local health workers is positive sign of change, However, given the Alliance being a new concept in itself and level of inputs required to set up Alliance and build its capacity, replication of this model in other district would be equally challenging.

3.3.1 Sustainability of Alliance:

This is most seriously thought about issue by the Alliance member and others – but so far no concrete and clear idea has emerged for sustaining the Alliances. **Despite the inputs and supports provided by SC, district Alliances are fully dependant on Save the Children for coordinating and other functions. SC should encourage the Alliance to set its own agenda and operate independently**. Broadly there are three issues around the sustainability of Alliance.

- **Working modality and structure**
  So far Alliance is a loose network mainly of institutions concerned with health agenda and wants to remain loose, therefore its working modality depends on individual interest, motivation, skills and expertise, time availability and to some extent institutional interest and priority. Secretariat role and coordination role is assigned to institutions – but except in central Alliance, such role is not carried out by the assigned individual but carried out by Save the Children staff. Alliances have developed its work plan but have not been able to mobilise resources to implement it.
- **Group dynamics and leadership in the Alliance**
  Given the diversity in the membership of the Alliance, it brings wide range of expertise and skills in one forum, but harnessing such diversity into a functional workforce depends on leadership and the group dynamics. Some form of collective leadership and group dynamics is emerging, but it is yet to demonstrate its strength and credibility. Central Alliance has better credibility and acceptance perhaps largely due to individual members with high professional calibre; number of interactions and activities it has conducted and opportunity to participate in CCF. **Some input towards leadership and group dynamics would be useful particularly to the district based Alliance.**
- **Resource mobilisation**
  As discussed earlier, this is one of the most talked about subject within and outside Alliance. There are many good ideas floated for covering expenses related to advocacy and basic operation, but so far no concrete action is visible. There is a consensus among the Alliance members that though they do not need huge sum of resources, but some resource mobilisation is crucial for carrying out its research and advocacy functions.

3.3.2 Strategic partnership

Signing of MoU with Ministry of Health and Population specifically for execution of HRH project in partnership is a strategic decision. Similarly, bringing NHRC on board and engaging representative of Ministry of Federal Affairs and Local Development through Project Advisory Team are strategically well placed as these government agencies has strong influencing role in policy making and monitoring its implementation. It was also to the advantage of the HRH issue in the country to have two other strong organisations (BNMT and Merlin) simultaneously working on HRH issue. Efforts of all three organisations to coordinate the implementation and bring synergy are appreciated. Effort is required to ensure continuity of such partnership after the project ends on 2013.

3.4 Achievements against the project logframe

Comparing the results so far against the logframe of the project, number of results has been achieved or project is moving towards achieving the results. As discussed elsewhere, project needs to speed up to achieve all the results it has specified in the project document and logframe.

Objectives	Intervention logic	Objectively verifiable indicators of achievements	Achievements/MTR observations
Overall objective	To set the issue of HRH into the wider context of health system reform by engaging civil society organizations (CSOs) and non state actors (NSAs) towards building the knowledge base of all and policy advocacy leading towards achieving 'good health for all'	HRH agenda become a priority in the health sector development/ reform processes ass evident by the government's plan and reports The HRH plans/policies of the government include evidence based inputs from CSO and NSA	To be measured at the end of the project
Specific objectives	a) HRH research and policy advocacy capacity of CSOs and NSAs b) To promote research for building knowledge base on HRH issues in country, relating it to regional and global context c) To instigate and propagate national and sub national debates and advocacy campaigns on HRH issues through strategic Alliance led by CSO d) Capacity of public sector authorities for better and evidence based design, implementation and monitoring of policies related to HRH management	• CSO/NSA Alliance at each level will have a plan to led at least on HRH advocate campaign and produce an annual HRH situation in the year beyond the project period • Critical HRH policy recommendations based on the evidence generated from operational researches and innovations are reflected in the government actions. • By the end of the project, a national sub national HRH projections and management plan	To be measured at the end of the project Situation assessment reports shows that districts and MoHP already do have some mechanism of HRH projection

Objectives	Intervention logic	Objectively verifiable indicators of achievements	Achievements/MTR observations
		is developed by the government.	
Expected result 1	1. Alliance of CSOs and NSAs for HRH agenda built	By the end of first year, CSO/NSA Alliance for HRH research and advocacy is established and operational at both national level as well as three project areas at sub-national (district) level	• Alliance established (Kathmandu, Siraha, Bardiya and Doti) • Partially operational, number of issues are facing Alliances (group dynamics and leadership, coordination and communication, resource mobilization, sustainability)
Expected result 2	2. Capacity of CSOs and NSAs for HRH research and advocacy built	By the end of 2nd year, 75% of CSOs/NSA Alliance members at each level are involved in HRH research and advocacy	• District situation assessment disseminated • Alliance has work plan • Some members are involved as data enumerators for the research • Bardiya Alliance made initial monitoring visits to health facilities
Expected result 3	3. Knowledge base on HRH issues through action research enhanced	At least 5 research reports are available on different dimensions of HRH during the project period	• Field research has just begun (Oct 2012) • District situation assessment 2012 prepared and disseminated by the Save the Children. • Support to set up Human Resource Portal at MoHP. Setting up GIS at district is planned. Initial work started (Sept 2012)
		At least two Annual HRH situation reports are disseminated by CSO/NSA Alliance during the project period	
		By the end of the project, a national level knowledge management centre on HRH is established by the government	
Expected result 4	4. Policy dialogue on HRH at different level intensified	At least 2 HRH advocacy campaign are organized by CSO/NSA Alliance at national and project areas at sub	• Though some informal dialogue held with DHOs, no advocacy campaign as such yet started

Objectives	Intervention logic	Objectively verifiable indicators of achievements	Achievements/MTR observations
		national (district) levels during the project period.	
		Recommendations to address policy gaps are derived from the project areas at the sub national (district) level	• Recommendations presented in situation report, • No other recommendations prepared
		HRH policy brief are produced at the national level incorporating the recommendations of sub national level	• Policy brief planned for 2013
Expected result 5	5. Capacity of public sector for HRH management improved	By the midterm of the project, sub-national (district) local authorities in the project areas will have prepared their own medium term HRH projection and plan based on self conducted and need analysis	• District situation reports (Doti, Bardiya, Siraha) has cited HRH projections by DHOs. DHOs are required to present their projections regularly to MoHP
		By the end of project period, the government will have a national system for projecting HRH needs	• Budgetary support to DHOs for local health worker recruitment • National level training on HRM and SBA training at project districts • International trainings and seminars attended (14 persons) • Government already do have some system of projection

CHAPTER 4: RECOMMENDATIONS

Overall all

1. Given the delay in initiation of the project and some ambitiously planned activities, coupled with slow spending rate, Save the Children and EU should critically consider extension of project period beyond June 2013. Extension is not only necessary to be able to successfully implement all the activities, but also necessary in ensuring the inputs and efforts made so far produced the output.

2. Budget monitoring along with programme monitoring needs to be aligned to project logframe along the result areas. This will allow the up to date monitoring inputs to the HRH project management team for early correction and adjustment of the implementation schedules.

3. An exit strategy needs to be developed with engagement of all relevant stakeholders so that project exist is smooth and essential responsibilities are taken over by appropriate partners. While so doing it is recommended that Save the Children explore the possibility of linking this project (i.e. Alliance of CSO/NSA) into other ongoing projects so as to ensure continuity.

Alliance of CSO/NSA

1. More facilitation and mobilisation support to Alliance members is required to build its group dynamics and leadership. Some inputs (training or other) would be needed to make Alliance capable and sustainable in the long run.

2. Alliance at district and centre needs to be provided with some financial support to carry out its plan of advocacy on task basis. In such support cost sharing should be encouraged so that Alliance will be exploring other funding sources. This kind of task based funding will not only create a visibility of Alliance it also promotes ownership, build group dynamics and promotes collective leadership culture. These are crucial element for sustaining the Alliance and its activities.

3. Linkage and communication of district Alliances to central Alliance needs to be explored and promoted.

Knowledge base on HRH issue

1. Research on HRH has just begun. Three districts situation assessments and one national situation assessment has been completed. The current ongoing research is a standalone activity in nature, though according to project document and logframe it is part of operational research. Clarity on current standalone research and operational research is necessary. Since the remaining project period is only about 8/9 months, designing an operational research and implementing within such a short period is quite a challenge.

Policy dialogue

1. Number of recommendations is available in the situation assessment report for policy dialogue. Further issue were identified and discussed in the Alliance both at

centre and districts. Agenda is yet to be prioritised for policy dialogue and put into action.

Capacity of public sector

1. Explore for more sustainable funding support for local recruitment of health staff under DHO. Build cost sharing elements in Doti and Siraha as well

2. More advocacies are required at DDC and VDC level to allocate resources for health sectors capacity particularly in Siraha and Doti.

3. GIS in district – ensure it is not a burden and does not clash with district IT need and is aligned with MoHP plan.

4. Ombudsperson and Diaspora engagement – preliminary exploration and concept paper could be possible in remaining period

5. Fellowship and international exposure should be based on principle of 'best value for money'

Some of the recommendation and critical observations are also highlighted (bold) in the main body of the report in respective sections.

CHAPTER 5: ANNEXES

Annex 1: References

Brent D Fulton et al (2011); Health workforce skill mix and task shifting in low income countries: a review of recent evidence. Human Resources for Health 2011, 9:1 http://www.human-resources-health.com/content/9/1/1

WHO (2012); Country Coordination and Facilitation, http://www.who.int/workforceAlliance/en

Save the Children (2012); National situation analysis on Human Resource for Health, Save the Children Country office, Nepal

SOLID Nepal and Merlin Nepal (2012); *Barriers to Effective Policy Implementation and Management of Human Resources for Health in Nepal: The Distribution and Skill Mix of Human Resources for Health in Nepal*. Lalitpur, Nepal: SOLID Nepal; 2012

MoHP/NHSSP (2011), Human Resource Information System Assessment, Liverpool Associates in Tropical Health, Anson House, 25 Anson Street, Liverpool L3 5NY, United Kingdom, www.lath.com

Annex 2: Terms of Reference for Midterm review

Tackling Human Resources for Health (HRH) Crisis in Nepal through Informed Policy Decisions and Actions

1. Project Background

Save the Children (SC) has been implementing the Human Resource for Health (HRH) Project in coordination with the Ministry of Health and Population (MoHP) at the central level, District Health Offices (DHOs), District Development Committees (DDCs) at the district level (Siraha, Doti, and Bardiya), and Civil Society Organizations (CSOs) and Non State Actors (NSAs) at both the national and the district levels.

All the components in this action framework have been carefully interlinked with CSOs/NSAs. The proposed five result areas, and major activities under these (cf. project log-frame), are directed to 'setting HRH agenda into the wider context of health sector reform' with significant involvement of CSOs/NSAs. To implement the aforementioned two-pronged engagement from demand and supply side, the first four results of the project targets CSOs/NSAs while the fifth aims to capacitate the state institutions to respond to the policy dialogues and translate them into action. All five result areas have either explicit or implicit focus on formative or operational research to ensure that a stronger evidence-base underpins the HRH policy dialogue.

Overall objective:

To set the issue of HRH into the wider context of health system reform by engaging civil society organizations (CSOs) and non-state actors (NSAs) towards building the knowledge base for all and policy advocacy

Specific objectives:

1. To enhance HRH research and policy advocacy capacity of CSOs and NSAs
2. To promote research for building knowledge base on HRH issues in-country, relating it to regional and global context
3. To instigate and propagate national and sub-national debates and advocacy campaigns on HRH issues through strategic Alliance led by CSO
4. To strengthen capacity of public sector authorities for better and evidence-based design, implementation and monitoring of policies related to HRH management

Summary of the Project:

Project Title	Tackling Human Resources for Health (HRH) Crisis in Nepal through Informed Policy Decisions and Actions
Project Coverage	National level and 3 Districts (Doti, Bardiya and Siraha)

Project Duration	30 months
Key Stakeholders	**Civil Society:** CSOs working on social sector (delivering services, producing human resources and/or advocating social agendas), Professional Councils and Associations, Trade Associations, Research Institutes, Academic Institutes, Media Persons **Policy Makers:** National Planning Commission, Social Sector Committee of the Parliament, Ministry of Health and Population (MoHP), Ministry of Finance, Ministry of Local Development **Public Sector Authorities:** MoHP (Human Resource Division and Department of Health Services), Nepal Health Research Council, Public Service Commission, Local Government Bodies (DDC and VDC)
Final Beneficiaries	Underserved and disadvantaged people – particularly those living in remote areas; poor and deprived communities; vulnerable population including women and children
Expected Results	• Formation of CSOs and NSAs capable of generating and propagating evidence as well as raising stronger voice to support HRH policy design, implementation and monitoring; • Increased commitment and capacity of public sector authorities to work better towards tackling HRH crisis; • Strengthened health care delivery to the general population through improved HRH situation
Main Activities	• Engage CSOs and NSAs and Build Capacity: Formation of HRH advocacy Alliance including several actors led by CSOs-NSAs; Orientations, training, fellowships, seminars, meetings, workshops, e-learning; Collection and sharing of information; Exchange of experiences and expertise; Advocacy work, events, campaigns, media broadcasts; Monitoring HRH interventions; Designing and conduction of operational research and dissemination of results • Conduct HRH Research: HRH gap analysis in relation to national objectives and priorities; Operational research on various qualitative dimensions of Nepali HRH – decentralized management of HRH, inclusion in HRH, HRH monitoring, HRH retention, absenteeism, skills transfer, incentive schemes, Diaspora engagement, twinning, HRH skill-mix and size vis-à-vis morbidity pattern, effects of globalization and General Agreement on Trade in Services (GATS) in national health; Dissemination • Strengthen Public Sector: Training, e-learning, fellowships, workshops; Sharing information; Exchanging experiences and expertise; Review/ update of HRH policies and strategies; Monitoring HRH interventions

Rational of the Mid Term Review:

The HRH project has been already completed a 15 months period of total 30 months of the project period. It is important to track the progress, review the processes, relevancy of the project activities and improve the quality of the project for remaining periods. Though there are frequent reviews meetings of the projects at district and central level. Besides there are regular field visits and tracked the progress of the project. However there is need of overall review of the progress of the project. Being seasonal effect of the nature of outputs and results, it needs continuous and overall reviews to improve the progress. Hence it is planned to conduct Mid term Review of the project.

This mid-term review will cover all aspects of HRH project from the period of 1st January 2011 to 31st March 2012. The review will be carried internally through a team consisted of SC staffs, an independent consultant and stakeholders led by Sr. Program Coordinator HRH. The team together with public sector authorities, direct beneficiaries and stakeholders will explore the level of progress, changes made by the programme, project design, appropriate suggestion recommendation, team composition, challenges and document learning and analyse the achievements of the programme objectives and outputs.

2. Objectives of the Review

The main objective of this review is to share learning and challenges among HRH partners and stakeholders, look over the progress and process of intervention, the efficiency and effectiveness of the project team in implementation to achieve results, feedbacks and recommendations for future references.

- To review the activities that are being implemented according to the work plan and within the planned budget
- To verify the expected results of the project as specified by the indicators and targets are being achieved
- To identify shortcomings and challenges to allow for immediate measures to rectify them in timely manner
- To make availability of documentation and lessons learnt will be used for reporting and planning in the next phase of the project
- To identify the level of effectiveness and efficiency of the project to achievement
- To review the processes of intervention, quality and sustainability of the actions
- To assess the relevancy of action at activity level and contribution to achieve results

3. The Review Team:

A Midterm review team consists of five members- Senior Program Coordinator-HRH, Monitoring & Evaluation Coordinator HRH, Technical Coordinator HRH, Research Coordinator HRH and one independent consultant; the consultant will lead the whole process of the review. At central and each project district level, a representative from

Ministry of Health and Population (MoHP), Nepal Health Research Council (NHRC), Ministry of Local development (MoLD), CSOs/NSAs Alliance members, District Public Health Officer (DPHO) and Local District Development Officer (LDO) will be involved for field survey along with team member.

A national level Advisory Committee will form including SC Program Implementation Director, M & E Advisor, H & N Advisor, Health and Nutrition Manager, representative from MoHP and NHRC, RPMs of SC ERO, MWRO and FWRO respectively. This advisory committee will review the ToR; provide feedback in the process of implementation and final report.

4. The Process/Methodology

Principle Approaches:

- Analyse and select the relevant tools for the review process.
- Analyse and review the process of planning and documentation (strategic document, HRH proposal, detail implementation plan of the project, periodic reports, visit reports and observation of HRH project.
- Assess progress of the programme to date and analyse the roles and responsibilities of CSOs/NSAs and DHOs and DDCs to implement HRH interventions. Look over the trends of progress, effectiveness in action planning, implementation, resource mobilization and building networks through CSOs/NSAs.
- Review the findings, meeting with relevant CSOs/NSAs Alliance members, partners and beneficiaries in HRH project districts, regional office, stakeholders at both levels.
- Report on the findings against the results and objectives of the project and provide recommendations for remaining phase of the project.

B. Methodology of Field Survey

- Review of related programme documents/agreements/progress reports and field report etc.
- Key informant interviews and discussions with relevant key stakeholders, CSO/NSA members and public sector authorities at both level.
- Focus Group Discussions (FGDs) with the CSO/NSA Alliance members, partners and beneficiaries.
- Personal observation of the programme sites.
- Stakeholders meeting, feedbacks, comments and recommendations at both level

5. Areas of Assessment

The mid-term review report will focus on the following areas:

- Level of CSOs/NSAs Alliance members' participation in programme planning and implementation on HRH.

- Effectiveness of the project and level of awareness, knowledge and skills of the CSO/NSA Alliance members, beneficiaries of HRH project.
- Successful cases/stories of the programme, which can be replicated in other areas/ programmes, and failure cases and the lesson learn (best practices) in HRH
- Sustainability and cross cutting component- the process and strategy of intervention.
- Coordination, networking and collaboration among stakeholders, beneficiaries and public authorities.
- Identify the key challenges, issues, strategies and gaps.
- Analyse achievements and outcomes based on each of five results of project frames.

6. Time table

Below table gives the rough estimation of total number of days and time for this review:

Date/Month	Programme	Responsible	Remarks
	MTR ToR preparation	M&E Coordinator - HRH	
	Review of ToR	Sr. PC - HRH and PC - M&E-HRH	Support from Advisors H & N Manager
	Define approach and methodology of field work	Sr. PC - HRH and PC - M&E-HRH	Support from Advisors H & N Manager
	Prepare ToR and hire consultant	Sr. PC –HRH	
	Initiate field survey and data collection	Review Team	Consultant
	Analysis and draft report preparation	Review Team	Consultant
	Share draft report with Advisory Team and HRH Region	Sr. PC HRH, PC-M&E HRH and Consultant	Final report will share among MoHP, EU and stakeholders
	Prepare Final Report	Consultant	
	Final report submission	Consultant	

Annex 3: Data collection tools

Review objectives, review questions and tools for data collection

This mid-term review will cover all aspects of HRH project from the period of 1st January 2011 to 31st March 2012. The review will be carried internally through a team consisted of SC staffs, an independent consultant and stakeholders led by Sr. Program Coordinator HRH. The team together with public sector authorities, direct beneficiaries and stakeholders will explore the level of progress, changes made by the programme, project design, appropriate suggestion recommendation, team composition, challenges and document learning and analyse the achievements of the programme objectives and outputs.

Objectives	Review questions and date need	Data collection tool
review the activities that are being implemented according to the workplan and within the planned budget	• Work plan and budget • How work plan was developed (i.e. involvement of stakeholders)	Document review (work plan and budget), initial proposal
verify the expected results of the project as specified by the indicators and targets are being achieved	• Indicators and targets, time frame • Results	Project document review - Consultation with implementing partners at district and centre - Periodic progress report and financial delivery
Result 1 Alliance of CSOs and NSAs for HRH agenda built	• Number and types of member organisations in Alliance • Issue and challenges of Alliance	Progress reports Meeting notes and minutes District consultations with partners, govt officials and other
Result 2 Capacity of CSO and NSAs for HRH research and advocacy built	• Capacity development activities and direct beneficiaries • Actions initiated by CSOs and NSAs after capacity built	Progress report Meeting with selected beneficiaries Consultation with district team
Result 3 Knowledge base on HRH issues through action research enhanced	• Knowledge generation on HRH (document collection, types of research, information collection) • Use of knowledge generated (i.e. advocacy,	Documents review Consultations with district and central members

Objectives	Review questions and date need	Data collection tool
	publications)	
Result 4 Policy dialogue on HRH at different level intensified	• Type and number of policy dialogue (i.e. fact sheets, meetings, delegation visit)	Documents review Meeting with MoHP officials District consultations
Result 5 Capacity of public sector for HRH management improved	• Type of capacity building activities (training, exposure visit, other) • Activities initiated after capacity built	Document review Consultations with district team and MoHP
identify the level of effectiveness and efficiency of the project to achive the result	**Efficiency** - Timely kick off of the project, timely recruitment of human resources - Timely formation of district teams and committee - Timely set up and regular meeting with Project Advisory Team **Effectiveness** - Desired action initiated by district and central team - Early indication of desired results being achieved	Progress reports Activity completion reports Financial delivery Meeting minutes and action initiated according to decision District and central consultations Progress report District consultations Interview with selected project trained personnel
review the processes of intervention, quality and sustainability of the actions	How the planned activities was initiated at district and central level Quality assurance plan and activities (M and E Plan, field visits, trainings,)	District consultations M and E plan, activity completion report, district consultation, PAT meeting
assess the relevancy of action at activity level and contribution to achieve results	National context and latest developments Situation and issue of HRH at the district level How the project activity contributed in addressing the problem of HRH	Meeting with PAT members Project document Consultation with stakeholders at district

This tool and instruments may be further refined as required to include more tools
Along this line check list will be develop for key informant meeting, district consultation.

Annex 4: People met

Date	Name (first)	Name (family)	Organisation/Position
Siraha district			
14-Sep-12	Rohit	Mandal	District Alliance member
	Prakash	Adhikari	District Alliance member
	Santosh	Yadav	District Alliance member
	Lalita	Das	District Alliance member
	Ganesh	Saha	District Alliance member
	Dr Daya Shankar Lan	Karna	DHO, Siraha
	Rajkumar	Das	DHO - Supervisor
	Rajbir	Yadav	DHO - Supervisor
	Ramjulum	Mandal	Bariyapatti HP (Sr AHW)
	Bishnudev	Yadav	Bariyapatti HP
	Pashupati	Das	Bariyapatti HP
	Rajan	Mukhiya	Bariyapatti HP
15-Sep-12	Arun Kumar	Saha	DDC - Programme Officer
	Jgdish	Mandal	Health Post Incharge
	Navraj	Lama	District Alliance member
	Surendra	Chaudhary	District Alliance member
	Lekh bahadur	Katuwal	District Alliance member
	Sunil	Singh	District Alliance member
	Surya N	Yadav	District Alliance member
	Ran Sebak	Raya	District Alliance member
	Armendra K	Kusiyeit	District Alliance member
Bardiya district			
23-Sep-12	Rajendra	Yadav	AHW, Mohamadpur SHP Bardiya
	Kamal	Bhattrai	AHW, Kalika SHP Bardiya
24-Sep-12	Achuyat	Lamichhane	Sr. DPHO, Bardiya
24-Sep-12	Dhukh ram	Tharu	Free Kamai Manch - Alliance member
	Navin Kumar	Bhatta	FPAN
	Komal Prasad	Tharu	Geruwa Rural awareness Sangh
	Sabitra	Gautam	Single Women's Group
	Yadav prashad	Acharya	Helping Hand
	Kamal Prashad	Regmi	New Nepal - Bardiya
	Durga	Rawal	FCHV
	Rajendra	Dhittal	Nepal Journalist Association
	Sudhakar	Mishra	Bardiya Medical Institute
	Kamal	Panthi	Kantipur Publication
	Balkrishna	Oli	Bardiya CSO Network
26-Sep-12	Shivraj	Regmi	LDO, DDC Bardiya
	Devraj	Chaulagain	PO, DDC Bardiya

Date	Name (first)	Name (family)	Organisation/Position
Doti district			
27-Sep	Ramswartha	Yadav	Acting DHO
	Puskar	Bijuchhe	Planning officer DHO
	Mr.		LDO Doti
	Tek	Khadga	Programme Officer DDC
28-Sep	Anil Kumar	Bista	AHW Khirsain SHP Doti
29-Sep	Prem Singh	Singtan Lama	UMN Doti
	Mohan	Shahi	Kantipur Publication Doti
	Dhirgharaj	Ojha	Samaj Sewa Doti
	Khem	Bhandari	Community Development Centre Doti
	Sunita	Koirala	Seti Technical School Doti
	Tekendra	Deuba	Nepal Journalist Association Doti
	Tek bahadur	Balayar	Rural Development Centre Doti
	Dhrendra raj	Chataut	Radio Nepal Doti
	Kali Prashad	Padal	FPAN Doti
	Min bahadur	Bam	Print media network Doti
	Sher Bahadur	Malla	CEAD Nepal Doti
	Tek Bahadur	Chand	Tribeni FM Doti
	Ganesh Bahadur	Mauni	Youth Network Doti
	Chandra	Thapa	NEWAH Doti
	Dikshya Singh	Shaha	SOURCE Nepal Doti
	Shyam Prashad	Joshi	RUWDUC Doti
Project Advisory Team members			
05-Oct-12	Surya Prasad	Acharya	Ministry of Health and Population
	Puspa Raj	Katuwal	Ministry of Health and Population
	Kabirraj	Khanal	Ministry of Health and Population
	Shankar Pratap	Singh	Nepal Health Research Council
	Chop Lal	Bhusal	Nepal Health Research Council
	Ramesh	Adhikari	Ministry of Local Development
	Raj Kumar	Mahato	Save the Children
10-Oct-12	Dr. Amit	Bhandari	DFID