

Delivering on Commitments of IHP+: The Challenges and Opportunities

Honourable Director General of World Health Organization, Dr. Margaret Chan

Honourable Chair, Executive Director of UNAIDS, Michel Sidibe

Honourable Ministers,

Excellencies,

Head of global organizations working for health,

Distinguished delegates,

More than a year ago we signed the historic ‘Global Compact’ of the International Health Partnership. On that occasion, we made commitments for a coordinated and transparent effort to ensure good health including universal coverage for the poor and the most vulnerable people. We agreed that national health policies and plans that are embedded in our overall development frameworks will guide the development of our health system and the internal and external resources for health will be coordinated around its priorities. When our health plans needed to be updated we would work with our national stake holders and international agencies to develop a common vision for the health sector. We vowed to engage and involve the civil society in these activities so they know what to expect, and can give feedback. We also committed ourselves to ensure increased public funding for health care and protect our people from excessive health expenditure, within our national budgetary strategy and macro-economic constraints.

Directing our efforts toward meeting the Millennium Development Goals was high on our agenda and, acting with our civil society, we were bent on ensuring enough trained and motivated health workers in the most needed area.

Today, We have assembled here to reflect over these commitments.

Mr. Chair, I note with great satisfaction that we in Nepal have made substantial achievements in these past 16 months. And just three days ago, these achievements were crowned by the signing of the ‘national compact’ of the International Health Partnership. We call it “Nepal Health Development Partnership”. All the external development partners working in the health sector in Nepal have either signed or

showed their support to this compact. This event has given the Ministry of Health and Population a lead over other ministries in tangibly increasing aid effectiveness, a fact acknowledged by our Minister of Finance, in view of the forthcoming meeting of the National Development Forum in Nepal.

A chronology of events may highlight the efforts underwent to observe these commitments and also shed light on challenges and opportunities. Immediately after signing the Global Compact we declared the policy of Universal free health care at the sub-health post and health post level. Earlier, our 10-point health policy guideline, Interim Constitution and Three Year Interim Plan had already established a right-based approach to health, particularly the right of Nepali citizens to basic health care free of cost. A year ago we introduced targeted free health care policy to the poor, deprived and marginalized people in district hospital and primary health care centres. However identifying the poor was an additional burden to the health personnel. We have now scaled up universal free care at Primary Health Care Centres. Under this provision the Nepali citizens have right to all health care services provided by these facilities free of cost, including the listed essential medicines. At District hospitals, the poor enjoy targeted free care, while the listed essential medicine are now free to all.

While declaring universal free health care we also publicly announced our intention to introduce Free Maternity Care and pass a bill on reproductive rights. Nepal, as you know, is already on track for MDG4 and may achieve the target before 2015. Nepal Demographic and Health Survey, 2006, has shown the impressive improvement in many health indicators. However, to meet the target of reduction in maternal mortality and improvement in reproductive health remains a difficult task. So it was extremely important to introduce these policies and programs for meeting MDG5, which will at the same time ensure health rights and address the equity issue. From January 15 of this year, free maternity care policy is in force in Nepal. The draft bill on reproductive rights is at present under nation-wide discussion in civil society forums and among parliamentarians, and will soon be taken to the cabinet.

Although these policies have increased the access to basic health services by the poor and the marginalized, the challenge we are facing now is that of strengthening the entire health system: adequate, motivated and skilled human resources, infrastructure, equipment, communication and transport, and coordination with multiple stakeholders.

This is the most daunting task we face today. And central to all these challenges is attraction and retention of human resources in government services. Unlike some countries of Africa where there is an absolute lack of health professionals, we suffer from relative scarcity. There are abundant unemployed or partially employed doctors and nurses. But we have not been able to attract and retain them in government services. To do so we have developed an incentive package for human resources but unfortunately could not get adequate budget for the program this year. This is an area where IHP can be a great support for us. In fact, we have just introduced a short-term incentive for personnel in the most remote and underserved area of Nepal, utilizing a moderate additional funding from IHP. We do hope IHP+ and committees like the High Level Taskforce on Innovative International Financing for Health Systems will come forward to address such gaps in countries like Nepal.

Though such budgetary gaps are unavoidable, we have consistently fought for increased public funding for health care and to protect our people from excessive health expenditure. In the last two years we have been able to increase the budget by 75% . Most of the increase is being channelled to free basic health services and public health activities. As a result, even in district hospitals, research shows that along with increased utilization by the poor, socially marginalized groups are also being benefited. (see appendix).

Mr. Chairman,

Since the Lusaka IHP meeting and submission of IHP stock taking report, Nepal has undergone major political developments. Constituent Assembly elections were held, the country has been transformed from monarchy to republic and a new elected government has come into power. Health is the only sector to enjoy continuity of political leadership through the tumultuous transitions of the past few years. The IHP roadmap for strengthening the health sector was developed and refined in this period and has begun to be implemented. Drafting of the IHP national compact was also carried forward in this turbulent period of transition. Its completion demanded not only intense interaction between the ministry and external development partners, but also with civil society. Civil society led the discussion of the IHP draft in all the five regions of Nepal, engaging female volunteer community health workers and non-government sector health professionals from every single district, who enriched it with

their feedback. I believe this process itself is an outstanding achievement, and for assistance in carrying it out I want to acknowledge the support of the IHP+ core team, WHO/World Bank/DFiD, and the civil society representative organization. Resource Center for Primary Health Care.

Now that we have our national compact signed, the next challenge is to implement it. However we view this challenge as a great opportunity. The process of drafting the compact has further strengthened the understanding and cooperation between the government and the external development partners. Mechanisms are in place for regular dialogue such as the quarterly Nepal Health Development Partner's Forum, and the twice-yearly Joint Annual Review meetings. External development partners are supportive of the government's achievements and policy directions in health. We are consolidating our policy innovations into a New Health Policy and drafting the second implementation plan of Nepal Health Sector Program which is to take effect from 2011.

Nepal has already made substantial headway on some important aspects of the IHP+ workplan for April 2009-2011, such as civil society engagement, addressing equity issues, and developing results focused plans. So we believe our combined effort will generate the necessary force to tackle the most vexing problem of all: the strengthening of the health system. If, together with a strong system to deliver our free care programs, we could also ensure good nutrition to our people, we do believe Nepal would become an exemplar of rapid improvement in the health of the people under difficult socio-economic conditions.

Fellow colleagues,

At the end let me say we are acutely aware that the present global financial crisis may make our task much more difficult. Mobilizing additional funds at a time when the global economy is in turmoil is a major challenge to our international friends. But they are aware that reducing health spending will have long term consequences for developing countries especially their effort to meet health related MDGs. To save the lives of 10 million mothers and newborns, the Global Campaign for Health has estimated the need of raising 30 billion US dollar. At the UN High Level event in New York last September, the world leaders have responded by calling to raise this amount. While such effort would go a long way in saving lives of the most vulnerable people,

we also want to say that cancellation of debt of economically poor countries would greatly help these countries to finance health in this difficult time.

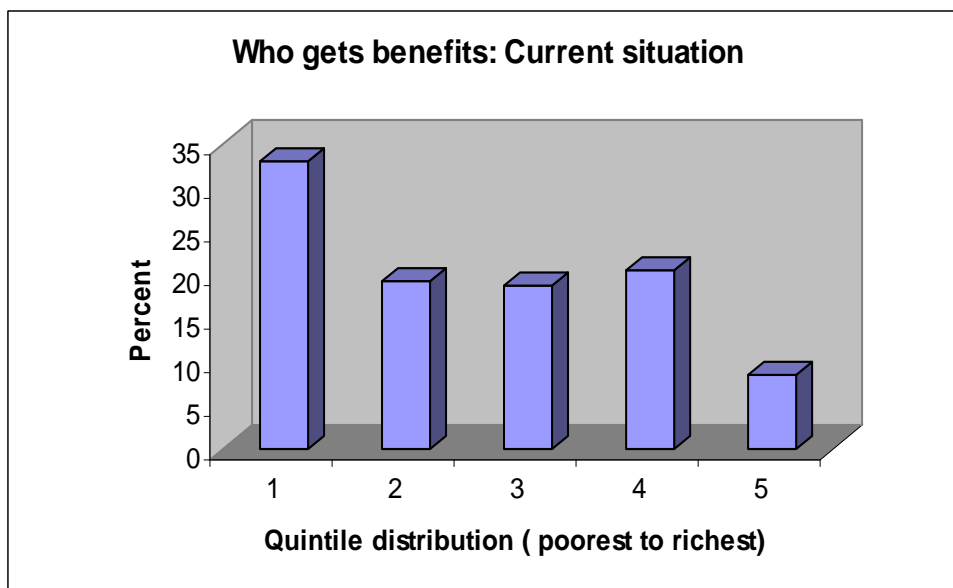
I thank the organizers for the honour and privilege of speaking before you, and sharing our experience to this very distinguished gathering. Thank you very much.

Mr. Girirajmani Pokharel
Minister for Health and Population
Federal Democratic Republic of Nepal

Geneva
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Appendix:1

Data from seven hospitals which represent all development regions and ecological belts,



**Utilization of services in percent
by Ethnicity/caste category**

Caste /Ethnicity	District Population (sampled districts)	Inpatient	Outpatient
Dalit (Hill &Terai)	11.69	18.07	18.41
Disadvantaged Janajatis (Hill & Terail)	23.70	20.68	23.65
Disadvantaged Non dalit Terai caste groups	25.70	12.57	7.64
Religious Minorities	4.64	4.40	2.44
Relatively advantaged Janajatis	4.70	6.76	10.39
Upper caste groups	29.57	37.53	37.45
Total	100.00	100.00	100.00