Strengthening state/non-state service delivery partnerships in the health sector in Nepal

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Abstract

Background: State non-state partnerships are of crucial importance globally to health improvement in low resource settings as they to increase resources, expertise, and legitimacy for action. This is especially true in in Nepal where partnerships between the Ministry of Health and Population (MoHP) and external actors have been fundamental to Nepal making progress in meeting millennium development goals and improving citizens' health status. However, partnerships have developed in the absence of a policy framework and strengthening them through the introduction of a state non-state partnership policy is a priority for government.

Method; In order to identify the strengths and limitations of current health sector state non-state partnerships a systematic search of MoHP policy documents, partnership evaluations and academic literature about health sector partnerships in Nepal was undertaken.

Results: There is a range of partnership modalities providing flexibility but standardization of partnerships is difficult. There are some strong health outcomes achieved although there is limited conceptual understanding and practice of partnering. Limited evaluation of partnerships results in inability to align partnership types with service delivery outcomes.

Conclusion: Although there are limitations Nepal's experience in state/non-state partnership working provides useful information about state non-state partnership processes in resource poor countries.

Key words: Nepal, health reform, state non-state partnership policy, public private partnership

Introduction

The Government of Nepal (GoN) is committed to improving the health of all its citizens, particularly women, children, and poor and the marginalized populations, and to achieving its millennium development goals (MDGs). It has made significant progress. Nepal won the 2009 Global Alliance for Vaccines and Immunization Award for its success in reaching MDG 4 (child survival) and the 2010 MDG 5 (maternal health) award for reducing maternal death [1]. Between 2000 and 2010 Nepal's neonatal mortality rate fell by 3.6% per year [2]. Immunization coverage for children aged below 12 months increased to 96 per cent in 2011 from 82 per cent in 2010 [3]. Most of these achievements took place over a relatively short period and during a period of conflict and political instability [4]. Partnerships between the MoHP and external development partners (EDPs), donors, international non-governmental organisations (INGOs), non-governmental organisations (NGOs) and private sector organizations have played a significant role in each of these health improvements. State/non-state partnerships or public private partnerships (PPPs) are terms used interchangeably in Nepal to refer to collaborations between the MoHP and all its partners for the purpose of achieving "similar goals, certain objectives and common interests effectively and equitably" [5]. The generic term PPP refers to a Ministry partnership with for-profit oriented private sector agencies as well as with not-for profit entities such as NGOs and INGOs. There are many examples of effective partnerships in Nepal and some of the innovations in partnerships could well be transferred to other low resource settings internationally. However, there has been no overall policy framework or strategy, limited monitoring, evaluation and review and

some lack of clarity among stakeholders about what state/non-state partnerships actually means [6] [7].

The current plethora of PPPs or state/ non-state health sector partnerships in Nepal must be understood in the context of the development of modern medicine and health services in Nepal, both of which are relatively recent. Significant progress in establishing modern health services has only been achieved since the 1950s. Prior to this, state provision of hospitals and dispensaries was very limited and the majority of citizens lacked access to even basic health services [8]. Consequently, from the1950s onwards, non-government mission organisations played a critical role in setting up hospitals and basic and essential health services.

The introduction of democracy in Nepal in 1991 proved highly significant in the development of the nation's health services. The government reintroduced modern medicine and institutionalized the Ayurvedic[1] system of medicine through the Health Act Nepal 1991. A planned health development process commenced with more public health institutions established to increase access to basic health care [8]. In 1991 the Government of Nepal (GoN) made explicit the need for partnerships with both for-profit and not-for profit organizations and mainstream economic liberalization supported this approach [9].

With the popular People's Movement of April 2006 came a period of transition that led to an Interim Constitution, the electing a Constituent Assembly, and the intention to establish a Federal Republic. The Interim Constitution established the right of all Nepalese citizens to primary health care services, including maternal health, the right to a clean environment, access to education, and a means of livelihood in a social and political environment free from discrimination and institutionalized inequality [10]. It

[1] The Ayurvedic system of medicine is a generic term for "traditional medicine" in Nepal

must also be noted that the post democracy period has been one of continuous political instability with parliamentary elections conducted in 1992, 1994, 1999, and 2008 without a single parliament running its full term [11].

Rationale for state/non-state partnerships

Nepal has difficulty in securing sufficient resources in the public sector to discharge the fundamental functions necessary to maintain the health of its citizens [5]. Despite an increase in the public funds allocated to health, the supply of public health care remains insufficient to address the needs and demands of the nation [6]. Funding and programmatic partnerships with external development partners (EDPs), non-government organizations (NGOs), and international government organizations (INGOs) are critical to addressing the full range of Nepal's health needs including access to safe water supplies, sanitation and adequate nutrition. Recent data from the Nepal National Health Accounts suggests that in 2013/14 GoN contributes 66.2% and EDPs 33.8% of the public health budget of NR 30.43 billion [12].

Nepal's difficulty in securing health sector resources is ameliorated in part by the availability of international funds to address global health concerns, particularly the control of communicable diseases [13]. Significant financial resources from global agencies and resource rich countries have supported efforts in Nepal to meet millennium goals to improve maternal, child and neonatal health, to decrease TB, HIV and malaria, and to decrease poverty. While additional financial resources are critical, the World Health Organization (WHO) acknowledges the need to work in partnership with resource poor countries in order to improve health. The Partners for Health in South-East Asia Conference in 2011, sponsored by the WHO Regional Office for South East Asia, [14] was devoted to improving partnership processes in the

health sectors of low resource countries.

While there is a wealth of literature about the processes of inter-sectoral and community partnerships in resource rich countries there is less literature on state/non-state partnerships in resource poor countries where the health budget is dependent on contributions from external development partners. It is against this backdrop that the GoN seeks to implement a policy framework in which to operate state/non-state partnerships [7].

Methods

This paper reports on a literature review to source information that might assist in strengthening state/non-state health sector partnerships in Nepal. We searched both the "grey literature" and the international peer reviewed literature. We extracted MoHP policy documents on state/non-state health sector partnerships [7 10] and three partnership evaluations [1 6 15]. We searched external development partners' web sites for partnership reports for example, Nepal Health Sector Support Program, World Bank, the German Development Bank KfW, and the Department for International Development UK. We searched INGO and NGO web sites, for example the Nepal Red Cross and the Nepal Netra Joyti Sangh, who we knew to be influential operating partners in the health sector.

The second source of information was peer-reviewed literature, published in English, about state/non-state partnerships in Nepal's health sector. We used the key search term 'Nepal' and combined this with 'public private partnerships', or 'state/non-state partnerships', 'health', or 'health outcomes'. Databases searched included PubMed,

EBSCOhost, ScienceDirect, and MedLine, as well as key journals including Health Policy and Planning, Global Health, and International Health. Papers were included where there was an explicit reference to health service delivery in Nepal conducted through a partnership process and the names of the partners were specified. Twenty-four papers[2] met the inclusion criteria and we critically reviewed these to identify information about state/non-state models and processes. The bulk of peer reviewed material reported health intervention outcomes but with limited analysis of the partnership modality and rarely any attempt to relate partnership outcomes to the nature of the partnership. We then broadened the search to include papers about other resource-poor or low-income countries and their experiences with state/non-state partnerships in the health sector in order to ascertain whether this material could throw light on the situation in Nepal. Using the same inclusion criteria we identified 31 papers that referred to partnership modalities and processes in the health sector of resource-poor countries.

Results

The Ministry of Health and Population has diverse partnerships with a wide range of partners. It is reported that non-state actors, working in partnership with the MoHP, have ensured better access to services, offered safety nets for targeted groups, increased the number of beneficiaries, improved the supply and availability of necessary services, improved infrastructure and facilities and eased pressure on the public sector health care facilities [6]. In addition, partnerships have helped build stronger government policy responses to diseases, helped place key issues on the national agenda, and provided services in areas where, because of cultural values and

[2] The list of papers included in this review is available from the corresponding author Email munuoli@gmail.com.

practices, it was difficult for the Ministry to do. There are a number of innovative partnership modalities.

The academic literature indicates some very positive health improvements involving state/non-state partnerships in tuberculosis control [16], vitamin A deficiency prevention [17], the Women's Right to Life and Health Program [4], and newborn health [2]. In 1994 the Nepalese government, in conjunction with the UK Department of Foreign International Development and WHO, initiated the Safe Motherhood Program followed by the introduction of emergency obstetric care services, the presence of skilled attendants at birth, and an enhanced public awareness of safe motherhood issues [4]. This program is associated with some strong improvements in neonatal and maternal health.

Partnerships have not been without challenges and the challenges are not all specific to Nepal. Most government instrumentalities have difficulty effectively monitoring and developing inter-sectoral partnerships.

Multiple partnership modalities

Several different types of partnership and contracting arrangements are in place in Nepal's health sector. They include community management arrangements for health facilities, direct service provision, facility management, and lease contracts as well as Built, Own, Operate, and Transfer arrangements, joint ventures, and performance based payment schemes. Some of these arrangements are complex and include more than one type of partnership. [6]

The operation of the Lamjung Community District Hospital is an example of contracting-out the management of a hospital to improve service delivery, The Human Development and Community Services, a faith-based national NGO manages the hospital while the MoHP owns the facility, is responsible for all agreed-upon fiscal

requirements, and oversight. [15]

Another type of arrangement is the performance-based contracting arrangement that operates for the provision of comprehensive emergency obstetric care [18.] The current arrangements include memoranda of understanding between a district health office (DHO) in Nepal and a service provider that might be a medical college, an INGO, or a private doctor in line with the Government procurement rule. Funding for services is negotiated between the DHO and the service provider.

From a planning perspective state/non-state partnerships for service delivery have grown haphazardly in response to needs or recognized problems, or through the initiatives of donor agencies, and each partnering opportunity is usually handled as unique. While this provides a degree of flexibility to ensure that needs are met appropriately, it also means that partnerships are time consuming to negotiate and monitor.

Weak conceptual understanding of partnering

The reviews of state/non-state partnerships undertaken by the MoHP use this term extensively [6 9 10] 'Weak conceptual understanding' refers to a lack of awareness at central and district levels of the goals and objectives of partnerships and the roles and responsibilities of the partners, largely reflecting the incremental and haphazard manner in which the partnerships developed. It is likely that government staff and non-state partners have disparate and potentially conflicting understandings of what state/non-state partnership means in general and in specific instances.

The ambiguity that surrounds state/non-state partnerships is reported to arise partly because of the lack of a policy framework for the development of partnership goals, funding arrangements, responsibilities and monitoring. In addition, the fragility of the public health sector often results in weak leadership within MoHP. In addition, the

pre-requisite environment of trusting relationships and cooperation at the local and central levels is not always apparent. The evaluation of the Nepal Red Cross blood transfusion service in comprehensive emergency obstetric care pointed to problems resulting from the lack of legal frameworks and central MoHP support [19].

Partnership sustainability issues

Non-state partners identify the insecurity caused by the government's standard one-year funding commitment as a problem [19]. Partners also note the time lag in funds dispersal that occurs at the beginning of Nepal's fiscal year [6]. The fiscal year of the MoHP and those of EDPs and are not aligned and there are numbers of factors that influence the Nepal health sector's budget including the extent of commitment from EDPs. Although the 2008 Paris Declaration for Aid Effectiveness states the need for EDPs to commit funds on a longer-term basis, in reality this does not always occur. Consequently ensuring sustainable funding for partnership activities from both the MoHP and development partners is frequently problematic.

Discussion

The responsibilities facing the MoHP in health sector reform to implement this new state/non-state partnership policy are considerable. The MoHP must increase the current level of service delivery while sensitively negotiating with partners to introduce a regulatory framework and performance monitoring system. However, there is a dearth of empirical data from resource poor countries providing information about effective health sector reform strategies [13 20 21].

Standardizing partnership types with common frameworks

The MoHP must clarify appropriate models for service delivery within the overall

policy framework. Standardizing partnerships requires a set of standardized operational models for each type of partnership. Within this model, the goal and outcomes of the partnership should be made explicit along with the roles and responsibilities of partners and the funding arrangements. Each partnership type should have a set of outcome indicators. Flexibility should be maintained but within an overall policy framework.

Moving from a 'silent partner' to an active facilitator and strong leader

The introduction of a state/non-state partnership policy in the health sector highlights MoHP's role in partnership development allowing it to move from a 'silent partner' to an active facilitator and strong leader. There are several challenges in taking on this more active role. First government staff do not always know about all of the health related activities of the for-profit sector, INGO, and NGO partners as there are so many of them [22]. There will need to be a process of knowledge sharing and improved communication. Second, there has not always been acknowledgement of the different roles and responsibilities of the state and non-state actors in partnerships and where they overlap.

Communication between state and non-state partners has not always been open and misunderstandings about respective roles have arisen [6].

In addition, partners have been operating for some time without protocols or guidelines and the introduction of new regulations and review processes might be considered to be intrusive.

Currently, district health officers have the oversight of state/non-state partnerships in their work role but there is no written protocol to guide their activities. The introduction of the new PPP policy will overcome this, and provide much needed clarity, but staff will need to take a proactive role in facilitating partnerships. Given

that there are likely to be almost 1,000 NGO and INGO partners are already involved in health this is a considerable task on top of an already busy workload. To become an active facilitator and strong partnership leader will require meaningful incentives and a high level of staff motivation.

Access and equity in service delivery

One of the problems related to health services provided by INGOs in response to emerging local needs is that there might be inadequate service coverage. Some excellent specialized service systems of care are available in some districts in Nepal but not in others. Often it is the more remote and mountainous regions that are not covered. In some instances services provided by INGOs and NGOs are running parallel to the public system and services are not well integrated. On occasion there are difficulties in making referrals from the district health care system to the specialist system resulting in access and equity disparities. [6]

Implementing a state/non-state partnership framework has the potential to act as a lever to stimulate the development of a more integrated health planning system. The issue of disease specific vertical planning and service delivery, and the planning problems that can be associated with it, are debated in international health development literature [20 21]. Vertical approaches to planning and service delivery use systems that are specific to a particular disease while horizontal approaches work through existing health-system structures. Nepal has a complex mix of both vertical and horizontal planning and service delivery systems. In the eye care system and for some diseases, TB and HIV for example, vertical planning and service delivery are the accepted mode of delivery. The problem is that when there are multiple organisations delivering different disease-specific initiatives at the district or community level, then there problems of integration, overloading of staff, and

overlapping regimes may occur [21]. While the introduction of a state/non-state partnership policy may not eradicate this, it promises to provide a useful first step in bringing potential partners together with government to open dialogue on a collective way forward.

Sustainability

A funding method that helps MoHP commit funds on a longer-term basis is the Sector-Wide Approach (SWAp). The SWAp is a mechanism whereby funds from different donor sources are combined and applied to a government sector-specific plan. [13 20 23].

In Nepal's health sector this type of funding has enabled more certainty about longer term funding, facilitated integrated planning, rationalized accountability requirements, and given more budgetary and programming control to MoHP.

Capacity building to enable partnership policy implementation

The issue of 'capacity building' is important in Nepal, even though there is considerable debate about its meaning in the international literature [24]. In the context of the implementing the state/non-state partnership policy, it is necessary that both MoHP and DoHS staff and representatives from EDPs, INGOs and NGOs negotiate desired partnership outcomes and the roles and responsibilities of partners. There are important contextual factors that act as enablers and one of these is a trusting environment in which clear communication between partners can occur. Another requirement is that relevant government staff have the technical and managerial capability to design, implement, manage, and monitor partnership arrangements, as well as to regulate the non-state sector [7]. Having capacity in this regard is likely to lead to government staff becoming motivated, independent and self-sufficient so that they are able to take responsibility for implementing the partnership policy. This is

consistent with how Khul [23] defines the outcome of capacity building of health sector staff in low resource countries.

Conclusion

In any resource poor country there is very real pressure to reduce mortality and morbidity and improve the health outcomes of citizens' most in need. To achieve this, interventions are chosen which have been shown to be most effective and efficient given the context in which they are to be applied. Health outcomes data resulting from these interventions provides vital information. However, this is not the full story. An analysis of the effectiveness of the partnerships involved and the types of staff or volunteers that deliver the interventions provides a fuller picture. The dynamics of the health system that supports the intervention and the role of government leadership and commitment together with the level of community involvement are also important. Nepal's constitution, budget, and the Nepal Health Sector Plan II (2010-2015) all give priority to state/non-state partnerships. If these partnerships are to flourish then there must be a solid evidence-base of what processes work and which ones are less successful in conducting these partnerships. This is especially the case in Nepal where there has been such significant progress in achieving health improvements. There is still an extraordinarily weak evidence base to support (or challenge) the ways in which the interventions are being implemented and the partnerships which are supporting the interventions.

Nepal is at the forefront of an opportunity to provide information about health sector strengthening, negotiating partnerships with the private for-profit sector, INGOs, NGOs and external development partners, aligning outcomes with partnership types, and assessing the extent of integrated planning. If this opportunity is to be realized

there will need to be an effective partnership monitoring system so that key outcomes and processes are identified. There will also need to be a robust set of base-line data on partnership functioning so that changes over time can be measured. If the GoN monitors the implementation of the new PPP policy, and makes public this information, then it may prove instructive for other resource poor countries that are experimenting with different styles of partnerships and funding modalities.

Author's disclaimer

The opinions expressed in this paper are those of the authors and do not necessarily reflect those of the Ministry of Health and Population in Nepal or the Australian Department of Foreign Affairs and Trade.

Author's contributions

BM, CC, and JT conceived of the study and the paper. CC and JT conducted the literature review. BM, CC, and JT conducted analysis and interpreted the data and JT drafted the manuscript. BM and CC critically revised the manuscript and all authors agreed to the final version and are guarantors.

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Competing interests

None declared

Ethical approval

Not required

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