

**Using Social Research to Inform and Influence
Public Policy and Practice: Case Studies
Documenting Good Practices and Lessons Learnt
in South Asia**

**Mobility & Health Research policy
assessment**



Final Report

DRSP / RHDP

30th November 2009

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Table of Contents

Executive Summary

- 1 Introduction**
- 2 Methodology**
- 3 Policy Review – Desk Study**
- 4 Qualitative review - Interviews**
- 5 Outcomes**
- 6 Analysis**
- 7 Conclusions**
- 8 Recommendations**

Annexes:

- | | |
|----------------|--|
| Annex 1 | Executive Summary of M&H research project |
| Annex 2 | Organogram of Department of Health Services |
| Annex 3 | Questionnaire |
| Annex 4 | List of Interviewees |
| Annex 5 | Summary of Interview Transcripts |
| Annex 6 | Programme for Interaction Meeting |
| Annex 7 | Participants for Interaction Meeting |
| Annex 8 | Matrix of Findings |

Acronyms

ACAP	Asia Community Access Programme
AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante-Natal Care
BBC	Beyond Beijing Committee
BEOC	Basic Emergency Obstetric Care
CEOC	Comprehensive Emergency Obstetric Care
CEPA	Centre for Poverty Analysis
DAG	Disadvantaged Group
DDC	District Development Committee
DDG	Deputy Director General
DFID	Department For International Development
DG	Director General
DIMC	Decentralisation Implementation Monitoring Committee
DoHS	Department of Health Services
DoLIDAR	Department of Local Infrastructure Development & Agricultural Roads
DRSP	District Roads Support Programme
DTMP	District Transport Master Plan
DTO	District Technical Office
EHCS	Essential Health Care Services
FCHV	Female Community Health Volunteers
GIS	Geographic Information System
GoN	Government of Nepal
HDI	Human Development Index
HF	Health Facility
HIV	Human Immunodeficiency Virus
HP	Health Post
IFRTD	International Forum for Rural Transport Development
ILO	International Labour Organisation
IMT	Intermediate Means of Transport
IRAP	Integrated Rural Accessibility Planning
ISAP	Institutional Strengthening Action Plan
LGCDP	Local Governance and Community Development Programme
LID	Local Infrastructure Development
LSGA	Local Self Governance Act
MDG	Millennium Development Goal
MoF	Ministry of Finance
MoHP	Ministry of Health and Population
MoLD	Ministry of Local Development
NDHS	Nepal Demographic Health Survey
NFRTD	Nepal Forum for Rural Transport Development
NGO	Non – Governmental Organisation
NHSP	National Health Sector Programme
NHSP - IP	National Health Sector Programme – Implementation Plan
NPC	National Planning Commission
ODI	Overseas Development Institute
PA	Practical Action
PEI	Poverty and Environment Initiative

PHCC	Primary Health Care Centre
PM	Prime Minister
RAIDP	Rural Access Infrastructure Development Project
RBN	Roads Board Nepal
RHDP	Rural Health Development Project
RRF	Rural Roads Forum
RTI	Rural Transport Infrastructure
RTIMIS	Rural Transport Infrastructure Management Information System
SA-ebpdn	South Asia Evidence Based Policy Development Network
SBA	Skilled Birth Attendant
SDC	Swiss Agency for Development and Cooperation.
SHP	Sub Health Post
SLTHP	Second Long-Term Health Plan
SSMP	Support to Safer Motherhood Project
SWAp	Sector Wide Approach
TA	Technical Assistance
TBSU	Trail Bridge Support Unit
TYIP	Three Year Interim Plan
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
VDC	Village Development Committee
WHO	World Health Organisation
WoREC	Women's Rehabilitation Centre
WTO	World Trade Organisation

Foreword

This report was written by Robin Workman (DRSP) and Binjwala Shrestha (Independent Public Health consultant). DRSP is a road building and maintenance programme funded by SDC, which aims to alleviate poverty and build capacity of local government organisations in six districts of Nepal. DRSP undertook a research project on Mobility & Health in conjunction with another SDC project, RHDP, from 2005 to 2007 (see Annex 1 for the Executive Summary from that research report). This case study is based upon the results from that research project and focuses upon how those results have been translated into policy, or not.

The authors would like to thank all of the people who were interviewed for this case study and all of those who gave their time to comment on the document and attend the Mobility & Health policy interaction meeting. Special thanks must go to Mr. Niraj Shah for having the enthusiasm to arrange the interaction meeting between both the local development and health sectors.

Executive Summary

Using Social Research to Inform and Influence Public Policy and Practice: Case Studies Documenting Good Practices and Lessons Learnt in South Asia

Introduction

This policy case study involves the Mobility & Health research carried out by the District Roads Support Programme (DRSP) and the Rural Health Development Project (RHDP), both funded by the Swiss Agency for Development and Cooperation in Nepal. The research was funded by IFRTD, with some additional funds being provided by SDC and much of the logistics being covered by the two projects. It was started in 2005 and concluded in late 2007.

Methodology

The case study consists of a desk study and a series of interviews. The desk study looked at government policy, and specifically policy that was new or had been changed over the past three years, in the fields of rural transport infrastructure and health. The interviews were held with all stakeholders who were involved with the Mobility & Health research. These interviews act as qualitative data to support the reasons why or why not policy change has taken place, as well as determining to what extent any changes were as a result of the research itself. A total of 14 stakeholders were interviewed, many of them were present at the advocacy workshop for the original research, but many were also not available for interview for various reasons.

Outcomes

It was found from the desk study and confirmed by the interviews that no significant changes in policy had taken place in either the rural infrastructure or the health sectors. However, a number of policy interventions are being planned in both sectors, which could be influenced by the research. In the infrastructure sector a Sector Wide Approach is under way, which is revising policy for Planning procedures for rural roads, maintenance of rural roads, transport services and cooperation with other ministries. There is a good opportunity now to integrate the Mobility & Health research into this policy. There are also various health sector reforms that are planned where the research can give useful evidence.

Analysis

There are a number of potential changes that are still possible as a result of the Mobility & Health research. They are related to the nine recommendations from the original Mobility & Health research project for DRSP.

In Nepal there is no formal knowledge-practice interface related to incorporating research findings into policy. For research to find its way into policy usually requires personal intervention and persuasion from someone involved with the research itself. Without a formal mechanism for incorporating research into policy, the capacity to do this is limited. The government changes regularly with consequent changes in administrative positions. It is also often unstable whilst in power, which limits its capacity for policy development.

Much of the research undertaken in Nepal is funded by donors, rather than government. As such they are a major actor in this process. However, the support often ends when the research ends. In the present climate if a research project has a clear message for policy reform, it is necessary to continue support to advocate for that policy reform.

The findings of this research will be shared with the relevant stakeholders and disseminated through various regional and international networks.

Conclusions

The following conclusions were drawn from the desk study and interviews.

- Research is more effective for policy when there is a clear gap in knowledge.
- There is no formal process for using research to develop policy in Nepal. Research can be used to support policy development but it usually takes personal intervention from someone who is involved with the research and has an interest to see it taken up.
- Where the research falls between two ministries, one has to take the lead to take it further. In the case of Mobility & Health neither were willing to take the lead, possibly because the research was undertaken by a project and no government people were actually involved in carrying out the research itself.
- Research is more easily transformed into policy when there is a champion willing to devote time and energy into advocating the research for policy change or development. The champion can come from the state, donor or private sector, but this sort of motivation seems to be essential to take the policy development forward.
- Dissemination of the research was effective whilst the research was still ongoing, but when support stopped, so did the dissemination.

Recommendations

The following recommendations have been made:

- Ministries should be involved right from the beginning of the research, probably most effectively by seconding a person to be part of the research team.
- ‘Champions’ should be identified and supported at an early stage in the research.
- When the research falls between two ministries, as in the case of the mobility & health research, there should be a clear leader. Experience from the Mobility & Health research showed that neither Ministry was willing to take the lead.
- Media can be helpful to raise the profile of the research and get grass roots support, but it needs a strategy to maintain interest in the longer term.
- Dissemination of research information should be focused to the relevant stakeholders.

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Mobility & Health Research policy assessment – DRSP / RHDP

1 Introduction

Background

This policy case study involves the Mobility & Health research carried out by the District Roads Support Programme (DRSP) and the Rural Health Development Project (RHDP), both funded by the Swiss Agency for Development and Cooperation in Nepal. The research was funded by IFRTD, with some additional funds being provided by SDC and much of the logistics being covered by the two projects. It was started in 2005 and concluded in late 2007. It was carried out in three districts across the country and looked at accessibility to health services for poor and disadvantaged communities, with a special focus on maternal mortality and Millennium Development Goal No. 5. The two Nepali government Ministries that were focused on for the research were the Ministry of Local Development and the Ministry of Health and Population.

The aim of this case study is to determine what policy changes have taken place since the research was finalised in 2007, and whether / to what extent those changes were influenced by the research project. If there were no changes, or the changes were not influenced by the research, the aim of the case study is to investigate the reasons for this and make recommendations as to how improvements can be made to include research more in policy development.

Context

The research is set in the context of a country that is just emerging from 10 years of civil unrest. An approximate 13,000 people lost their lives during that time and much of the infrastructure of the country was damaged or destroyed. Since 2006 an interim government has been in charge and violence has decreased, but political instability remains. A coalition has been formed to draft a new constitution, but political in-fighting is delaying the process and optimism over the future of the country is waning.

It is not clear what the new constitution will contain exactly, but it is almost certain that the rights of poor and disadvantaged will be maintained at least to the same degree as in the old constitution.

Progress has been made in maternal mortality issues (MDG5) but the public perception seems to be that maternal care is going backwards, as can be seen in the box opposite.

The original research highlighted some important issues that could help Nepal to reach its target for MDG 5.

Nepalnews.com website, 19th October 2009

Maternal mortality rate in Nepal is getting more alarming every year. As such, we asked some women in the capital to give their opinion on escalating trend of maternal mortality rate in the country. Their views are as follows:

“Many pregnant women are dying before getting proper treatment as the country severely lacks necessary physical infrastructure to deliver prompt medical services. Poverty, illiteracy and ineffectiveness of reproductive health programmes are major culprits behind increasing maternal mortality rate.” *Street interview*

Review of existing policy.

Traditionally in Nepal policy has been made for each Ministry, but involving little consultation with other Ministries. This research was particularly challenging as it requires two different Ministries to work together at policy level. The research specifically looked at the affects of access restrictions on health, necessitating assessing the functions of roads/access and the effectiveness of maternal health, in particular.

This case study started by looking at existing policies and relevant documentation of the two ministries to see what can be related to the research. It then considers the recommendations made as part of the research and how they should have been converted into policy. Then changes in policy were explored, if any, and how they were influenced by the research, and of not, why not.

The political situation is not as conducive for policy development as it could be, the government has been changing every few months and is struggling to draft a new constitution for the Nation, having just emerged from a 10-year conflict. With frequent changes of government and subsequent staff transfers, there is no continuity for ministries to develop policies within their own sector. The chance of developing cross-sectoral policies is even less likely as they generally have to be referred to cabinet for approval. Many delays have been experienced in cabinet over the past few years, most recently the opposition parties have prevented any cabinet meetings for over 3 months (preventing the approval of the budget) due to a procedural dispute over high level army appointments.

2 Methodology

Desk study

The desk study looked at existing government policy in the areas of rural transport and maternal health, and specifically policy that was new or had been changed over the past 3 years. The aim was to identify whether the Mobility & Health research had had any impact on the policies developed since the research was completed.

Whilst reviewing the literature the team tried to identify aspects of existing policies that would have benefited from or could be improved by the results of the Mobility & Health research. Where changes had taken place in relevant policies the team had the aim of trying to determine whether those changes had been influenced by the M&H research.

Interviews

Interviews were held with all stakeholders who were involved with the Mobility & Health research, a total of 12 people as can be seen in Annex 5. The people interviewed were mostly involved in the original research in some capacity, so that they were able to give an informed view on whether policy change had taken place and if so, how it had been influenced by the research. These interviews act as qualitative data to support the reasons why or why not policy change has taken place, as well as determining to what extent any changes were as a result of the research itself. The Questionnaire and interview transcripts can be seen in Annexes 3,4 and 5.

A total of 12 interviews were achieved within a two-week period. This included stakeholders from both health and infrastructure sectors, as well as the National Planning Commission. These interviews can be seen in Annex 5

Limitations:

Staff turnover

The project used the original research advocacy workshop (see box opposite) attendees as the basis for interviews. Upon further investigation a significant number of people on that list were either not in the same position or not with the respective projects. For example the two members of the National Planning Commission were no longer in post, the GoN task manager for DRSP has been moved to another project, the DDG of DoLIDAR is no longer in post and several project employees are no longer with those projects.

As well as hampering the case study data collection, this does not create a conducive environment in which to develop policy as the institutional memory tends to be lost when a person moves on or leaves. Despite a GoN requirement for a 2 week handover, this guideline is never followed and in the vast majority of cases not even an overlap is made.

M&H Advocacy Workshop, Kathmandu

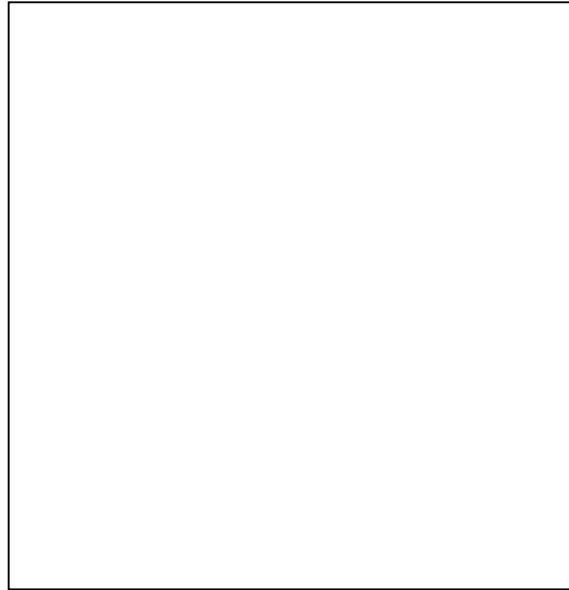
The original M&H research project arranged a regional advocacy workshop to disseminate the results of the research. The main aims of the workshop were:

- 1) To prepare and agree an Advocacy plan for the countries where the research was conducted.
- 2) To prepare and present the Advocacy Plan of Nepal to the policy makers through a workshop where interaction between practitioners, researchers and selected policy makers is expected.
- 3) To start preparing a Regional advocacy plan and contribute for an international advocacy and dissemination plan
- 4) To agree on a common policy advocacy agenda and platform on health and transport issues

In the NPC the staff tend to be recruited from various other Ministries, so specific information on research projects such as Mobility & Health can easily be lost. Also 14 staff have recently taken early retirement under the GoN voluntary retirement scheme.

Festivals

Due to the limited time available and the fact that the study was conducted during the festival season when many people take leave, the team were not able to interview all of the potential stakeholders. In addition many staff had left their post or had transferred jobs, which again meant that the institutional memory of the research was not as in-depth as it could have been. It was not possible to complete all of the interviews planned as many people take 3 or 4 weeks leave over this period due to the festivals of Dashain and Tihar. However, we believe that the interviews made were sufficient to support the findings that have been presented.



3 Policy Review – Desk Study

This chapter describes the desk study, which was designed to establish what new policies, or changes in existing policy, had been made since the research was completed. The team looked at all relevant policies to the subject of the original research and reviewed the timescale to see if any had been revised or created since the original research had been completed in 2007. The relevant policies that are related to the research are:

Policy Documents on Health:

National Health Policy 1991 - The National Health Policy was adopted in 1991 (FY 2048 BS) to bring about improvements in the health conditions of the people of Nepal. The primary objective of the National Health Policy is to extend the primary health care system to the rural population so that they benefit from modern medical facilities and trained health care providers.

Second Long Term Health Plan, 1997 to 2017 - The Ministry of Health and Population of His Majesty's Government has developed a 20-year Second Long-Term Health Plan (SLTHP) for FY 2054-2074 (1997-2017). The aim of the SLTHP is to guide health sector development for the improvement of the health of the population, particularly those whose health needs are often not met.

Tenth Five Year Plan 2059/60 to 2063/64 - The Tenth Plan represented the commitment of the Government of Nepal to poverty reduction. It helped to achieve a remarkable and sustainable reduction in the poverty level in Nepal from 38% of the population at the beginning of the Plan period to 30% by the end of the Tenth Plan, and planned to further reduce the poverty ratio to 10% in about 15 years time.

Interim Constitution of Nepal 2063 (2007) – This interim constitution has enshrined and declared the state's commitment and responsibility to people's health for the first time in the history of Nepal.

National Health Sector Programme (NHSP-IP) – Nepal Health Sector Program (NHSP) is a sector wide Program focused on performance results and health policy reforms implemented under a Sector Wide Approach (SWAp) with an agreed set of programme performance indicators and policy reform milestones for the programme duration. The policy reform milestones are outlined in the Nepal Health Sector Program Implementation Plan (NHSP-IP)

Institutional Framework of the Department of Health Services - The overall purpose of the Department of Health Services is to deliver preventive, promotive and curative health services throughout Nepal. The Department of Health Services is one of three departments under the Ministry of Health and Population. The organisational structure of the MoHP (Annex 1) outlines how different levels of the health system relate to form a network under the DoHS.

Pro Poor Health Policy 2004 to 2010 – This provides constitutional provision to make basic health a fundamental right of all citizens. Reproductive health and child health are also basic rights of women and children. It focuses on the NHSP-IP, providing a safety net to the poor & vulnerable population, whilst focusing towards social protection & social inclusion.

Ministry of Health Three Year Interim Plan 2064/5 to 2066/7 - This Plan is developed in the context of the current scenario in Nepal and aims to provide continuity to the ongoing NHSP-IP, including measures to strengthen it. It also includes programmes to operationalise the constitutional provision of "Free Basic Health Service to all" starting with the poor and socially excluded living in 22 low HDI districts, women, people living in

geographically difficult regions where all the health indicators are low, and also includes measures to mitigate the mental and physical problems for conflict victims.

Millennium Development Goals 1990 to 2015 – Research was specifically linked to MDG 5, to reduce maternal mortality. Official figures show that Nepal is making good progress towards this goal, although public perception seems to be different.

Policy Documents on Local Development:

The Three Year Interim Plan (TYIP) emphasises aspects like reconstruction and rehabilitation of physical infrastructures, social reintegration, economic recovery, inclusive development, and economic and social transformation. Similarly, policies will be taken to move the development process ahead by using opportunities from continuity of successful programs of poverty alleviation strategy, commitment to millennium development goals, opportunities after membership in the WTO, and industrial development and trade relations between immediate neighbours China and India.

Local Infrastructure Development Policy 2061 (2004) – Developed by DoLIDAR for MoLD, this document sets out policy for rural infrastructure development. The objective is that ‘by means of physical and social infrastructure, the access of local people including women, disabled, backwarded oppressed, neglected and Dalit class to social service, economic opportunities and resources shall be increased’.

Rural Infrastructure Development National Strategy 2054 (1998) – This strategy has the objective of pursuing a widely accepted process in the implementation of rural infrastructure development work, as coordinated by various line ministries, donor agencies and local bodies. The strategy visualised an institutional outline for ten years, with the necessary projected funds.

Policy Paper on Decentralisation (by Nepal Development Forum) 2002 – This policy paper on decentralisation looks at the history of decentralisation in Nepal and the progress being made towards this goal. Under the provision made in the LSGA, a high-level Decentralisation Implementation Monitoring Committee (DIMC) was put in place. Based on the recommendations of a Peer Review, a joint effort of GoN and donors was formed to determine the status of decentralisation in Nepal.

Tenth Five Year Plan 2059/60 to 2063/64 - In the Tenth Plan it mentions the objective of ‘alleviating poverty by making available to an easy access to services and benefits’. The Tenth Five Year Plan (draft approach paper) has adopted decentralisation as a crosscutting theme. It has included several strategies to facilitate the devolution process in line of the commitment made in the LSGA. All these efforts reveal that reviewing and revisiting of the role and functions of MoF, NPC, MoLD and the line ministries in linking the goals of LSGA and implementation of overall programmes in achieving the objectives and principles of decentralisation will be strengthened.

District Periodic Planning Guidelines 2001 – The Local Self-Governance Act, 1999, has stipulated that each DDC should prepare their district development plan by encompassing all aspects of the district. It also made mandatory that the Annual Programme has to be drawn up and implemented in the same spirit. The underlying purpose of the Act is to institutionalise the development process at the local level through a participatory approach. These Periodic Planning Guidelines have been prepared and enforced throughout the country with a view to ensure that the concerned stakeholders in the respective district authorities receive support in the overall periodic planning process in order to translate the legal provision into action.

Local Self Governance Act 2055 (1999) – This Act sets out the conditions for decentralisation for the districts, across all sectors. Based on the recommendation of a High Level Decentralisation Coordination Committee formed under the Chairpersonship of the Prime Minister in 1996, the Local Self-Governance Act (LSGA) was enacted in 1999. The Act laid the foundation for a local self-governance system in the country. It has statutorily recognised the role of local self-governance and devolution to make local bodies more responsive and accountable to their populace. The constitution directs the MoLD to ‘provide maximum opportunities for peoples’ participation in governance through decentralisation’.

Department of Local Infrastructure Development and Agricultural Roads Approach Manual 1999 – This Manual sets out the DoLIDAR approach to rural infrastructure, including a policy of using labour-based methods and equitable planning. The principles included in this manual have guided all of the rural road programmes in Nepal. It is at present being updated under the RTI-SWAp project.

National Transportation Policy 2058 (Ministry of Physical Planning and Works) – This policy covers all types of transport and is relevant to DoLIDAR for rural roads, although it was produced by a different Ministry. The objective is to provide uninterrupted flow of goods and people with safety and transport services available at least cost, and help poverty reduction efforts through broad based economic growth including balancing regional development by generating employment, providing access to the market to local products and accelerating the potential economic growth in other sectors like tourism and hydropower.

Mobility & Health Research

The Mobility & Health research (The effects of restricted access on maternal health in remote and mountainous areas of rural Nepal, 2007) carried out by DRSP / RHDP was funded by IFRTD and undertaken between 2005 and 2007 in three districts of Nepal. The Executive Summary from the original research can be found in Annex. 6. The following recommendations were made as part of the Mobility & Health research. Of the nine recommendations, all have some policy implications, but the most important are numbers 2, 5 and 9 as these will only be implementable with change in government policy. In addition, these three recommendations would require that both Ministries work together to effect the policy change.

Recommendation 1: *Raise awareness of available access and ANC service opportunities, and of the risks of not accessing such services in an equitable way, at least at household level, for an improved maternal health sector.*

Recommendation 2: *A review of strategic positioning of health facilities, particularly for maternal health, is required to bring the service facilities within 2 hours walk of all the population and encourage transport coverage.*

Recommendation 3: *Health Service provision should be locally managed and equitably offer quality and reliable services with special regard to access problems of disadvantaged groups.*

Recommendation 4: *Establishment and strengthening of BEOC and CEOC service centres is necessary to complement often inaccessible Health Centres.*

Recommendation 5: *Equitable and Inclusive Planning of rural access provisions, with a health service focus, needs to be integrated into the transport planning process.*

Recommendation 6: *Quality of access infrastructure, mainly roads, should be one of the highest priorities for improving maternal health.*

Recommendation 7: *Communities and transport entrepreneurs need to work out an approach for regular and affordable public transport services in rural roads*

Recommendation 8: *Critical health services, including maternal health, should be given special exemption from political activities and disruptions by conflicting parties to ensure reliable service delivery.*

Recommendation 9: *Integrated and equitable advocacy initiatives need to be organised by relevant forums and institutions for favourable policy and strategy changes.*

The Poverty and Environment Initiative (PEI)

This is a new project that will consider very similar issues to those being assessed in this case study. The following areas will be studied:

- Impact national policy development process led by NPC that is now in the preparatory stage following completion of term of current 3 year interim plan (TYIP) in 2010.
- Impact how Ministry of Local Development (MLD) links and guides the local government bodies (the DDC and the VDCs) through local governance acts, guidelines, and instructions (including monitoring mechanisms)
- Reach out to the wide national level coverage through potentially influential that reach out to the grassroots institutions and communities. This is where LGCDP is discussed in detail as one of the most potential programmatic entry point.
 - 1) National Planning Commission
 - 2) Ministry of Finance
 - 3) Ministry of Local Development
 - 4) Ministry of Environment
 - 5) District Development Committee
 - 6) Village Development Committee

The Poverty and Environment Initiative (PEI) Programme in Nepal can help to institutionalise this knowledge and impact the policy so that the benefits of this knowledge and experience is shared at the national level by all the people. Only sincere application of national policies can realise this through a well designed and targeted environmental mainstreaming process.

The South Asia Evidence-Based Policy in Development Network (SA-ebpdn) has just been established in Nepal with the initiation meeting being held in October 2009. The aim is to give a regional focus to the existing Global Network coordinated by the Overseas Development Institute (ODI). The Nepal branch is managed by the Centre for Rural Technology, Nepal.

Context of policy reform in the Health Sector

Findings on policy reform in health sector are synergy of multiple activities such as movement of health right, political awareness and also utilisation of recommendations of the research and report of regular health monitoring programme. The policy level stakeholders of health sector reviewed the report of mobility and health study recommendation which are not much new for health sectors specially it was identified before this study and some of policy to increase access already begun. This study is milestone to infrastructure sector and now there should be coordinated approach to supplement each other policy and program to develop health infrastructure and the rural access road to reduce the distance.

Findings of Desk review in Health

Recommendations for increasing access to health services: Political commitment

Nepal Health Sector Programme (2004-2010) - Systems for priority access for poor and vulnerable groups. The key actions outline is Criteria to identify the poor, expansion of EHCS in underserved areas, subsidised drugs and services; safety net: appropriate mechanisms will be developed and tested for public sector financing for a safety net for the poor accessing these services and for catastrophic illnesses.

To meet the first objective of Three year interim plan regarding -social inclusion the strategies are development of necessary policies and statutes to operationalise the concept of providing free Basic Health Service to all as per the provision in the Interim Constitution 2063, further expansion of the ongoing free health care services targeted to poor, socially disadvantaged women and indigenous people making provision of matching funds for improvement of Community hospital and co-operative hospital run on not for profit basis. In the current context GoN policy actions focusing towards social protection & social inclusion necessary legal frameworks and policies need to be developed to operationalise thus "defined" provision into practice.

4 Qualitative review - Interviews

The study team interviewed a total of 12 stakeholders. The questionnaire developed was used as a guide during the interviews. The questionnaire used and the list of people interviewed with the transcripts of the interviews can be seen in Annexes 2 and 3 respectively. The interviewees are mainly stakeholders who were involved in the original research or who have an interest in policy review. The list for the advocacy workshop under the original research was used as a basis to decide who to interview.

The questionnaire was designed to confirm the desk study in terms of what policies had changed and whether any changes were influenced by the mobility and health research.

Interviews were held with all stakeholders who were involved with the Mobility & Health research. These interviews act as qualitative data.

Interviews were used to explore:

- Status of policy reform/change as per the study recommendations
- Identify the reasons why or why not policy change has taken place
- Identify the determinants of the policy reform
- To what extent any changes occurred in policy and in which sectors?

Rural infrastructure

The main interviewees in this sector were from DoLIDAR and Roads Board Nepal. Although there were different people in the relevant positions, there was still some institutional memory of the research and the people interviewed were able to give relevant and considered comments on the case study.

Although no new policies have been confirmed in DoLIDAR since the research was completed, it was possible to identify some of the main barriers to policy implementation. The interviewees were consistent in naming the following barriers:

- Lack of advocacy, no-one to consistently take forward the messages from the research. The PEI project is looking for ‘champions’ to take policy change forward. “At present policy is made on a reactive basis, if specific to a particular Ministry it can be made internally, but if inter-Ministerial it has to be approved by cabinet.” – DoLIDAR stakeholder.
- Lack of a clear gap in knowledge; most of the recommendations had already to some extent been explored in other work so a clear need for policy change was not apparent. “At present there is no functional inter-ministerial coordination committee, although the NPC oversee such things. Successful coordination depends a lot on how well the relevant Ministries get on!” – Stakeholder NPC.

There are however some success stories of advocacy:

Practical Action have set up a forum for indoor air pollution and household energy, which is a legal body with Practical Action as the secretariat, following research on the subject. This forum is developing policy and guidelines under the Ministry of the Environment. The Director of Practical Action believes that it is essential to involve GoN people in research right from the beginning, in order to give the research legitimacy and provide a local ‘champion’ who can take the research further to influence policy.

Health

In the health sector all of the stakeholders interviewed were still in position. The depth of knowledge of the original research project was greater in the health sector and the interviewees were able to give clear and appropriate comments on the case study. The health sector is mainly focused on improving the quality of health care and reducing the cost barriers to accessing health services, whilst ensuring equity. In this regard reform is under way in the health sector.

The recognised constraints in health are non-availability of skilled health professionals, frequent turnover of staff and lack of motivation. The issues raised in the mobility and health research pertaining to access barriers are less important than these fundamental problems. Access barriers are recognised, “In some communities the health facility is not located near to the settlement and do not have road connections, so they are not used due to the difficulty in travelling.” Dr. Rana.

No major policy change has occurred in health since the mobility and Health research was concluded. The most recent and relevant policy change has been the introduction of operating guidelines for ambulance services in the districts. This has been drafted and is in the process of being implemented.

The RHDP project has had some success in this area. The distribution of stretchers to the local community has been done in an equitable way, plus one success story from Manthali (Ramechhap) reports how local groups have liaised to provide free ambulance services to Kathmandu, including utilising DDC social funds.

Previously RHDP was designed mainly based on the demand of the community. Now RHDP is changing the policy of stretcher distribution. Based on recommendations they are now distributing them as per the need of the community and they have reached mother's groups of each ward of each village. There was special support for the DAG community after the Mobility and Health research. This increases the access to health care by helping to carry the patient to the health facility. The community is managing the maintenance and storage of the stretchers in the community.

“The keys to success for policy reform in health are cash, recognition, prestige and power – research and policy dialogue must involve the Ministry strongly from the start.”

Comparisons between research projects

There were three Mobility & Health research projects carried out in Nepal under the same programme. Practical Action and the Trail Bridge Programme carried out research in addition to DRSP / RHDP. The Practical Action research seems to have been more influential in affecting policy than the other two. DoLIDAR has recognised the research and is in the process of developing a policy and specifications for gravity ropeways, which were the focus of the research. The research helped with raising the profile of gravity ropeways and demonstrated how they can influence the health of communities who live away from the road.

DoLIDAR identified the following factors which have been attributed to the success of this research in influencing policy:

- There was a gap in knowledge in this area; gravity ropeways are a new technology for Nepal and are appropriate for remote areas where roads are not feasible. The research was able to demonstrate the advantages of gravity ropeways to the extent that DoLIDAR want to include them in their rural transport infrastructure policy. The DRSP / RHDP research did not look at new areas, but served to reinforce previously held views on the subject.

- Practical Action strongly supported the research and advocated effectively to DoLIDAR. They have the funds and time to do this and have provided training of trainers, plus they are planning technical assistance in this area to develop the technology and support policy development.
- There was an interest within Practical Action to promote gravity ropeways as an alternative means of transport and the research was able to support this. Practical Action approached the research very much from an infrastructure perspective, whereas DRSP was evenly split with health.
- There was a ‘champion’ within DoLIDAR who was willing to support the policy development in an active and dynamic way. He had enough seniority and influence to push the policy development through, plus he was supported by the DG and DDG.
- Practical Action has established experience in policy development in other areas. Under the Ministry of Environment they formed a ‘forum for indoor air pollution and household energy’, which is a legal body with Practical Action as secretariat. This forum is developing policy and guidelines in this area, supported by Practical Action.

Because Practical Action is not affiliated to any one ministry, it may have been easier for them to promote the research.

5 Outcomes

It was found from the desk study and confirmed by the interviews that no significant changes in policy had taken place in either the rural infrastructure or the health sectors.

However, a number of policy interventions are being planned in both sectors, which could be influenced by the research, they are explored below:

Rural Transport Infrastructure Sector:

SWAp

DoLIDAR are at present undergoing a transition to a Sector Wide Approach (SWAp) within the Rural Transport Infrastructure (RTI) sector. A consultant was employed to carry out the preparation of the SWAp and a number of pilot studies are about to start. Despite a number of DoLIDAR staff attending the Advocacy workshop for the Mobility & Health research study, this information had not filtered through to the preparatory activities for the RTI SWAp.

However, DoLIDAR staff and SWAp members who were interviewed have agreed to consider the findings from the Mobility & Health study in the SWAp pilot studies. In particular Helvetas are reviewing the DTMP process. This is important for integrating a higher priority for health in the rural road planning process.

Planning

For rural roads health has a very low priority in the planning process. The districts select roads to construct through the District Transport Master Plan, which is an inclusive and bottom-up planning process that prioritises roads based on nine local criteria. One of these criteria is called 'Economic Structure and Central Services'. Within this criteria health has a 15% weighting and has to compete with other services such as education, water, electricity and market forces such as industry and business. So overall health has a 1.5% influence on the priority for selection of local roads.

As part of the report from the Mobility & Health research it was recommended that health is given a higher profile when planning local roads. The recommendation was that 'A review of strategic positioning of health facilities, particularly for maternal health, is required to bring health service facilities within 2 hours walk of all the population and encourage transport coverage'. This followed a finding that the poorer and most disadvantaged communities were in general located further from the road. A policy of outreach was also proposed for ANC care, with the aim of bringing more people to within the government's target of 2hrs walk from a health facility.

There is a policy to locate primary health posts in VDC centres, and VDCs centres often get priority for connection to the road network. However, most people walk to primary health centres. More important for expecting mothers is the access to emergency health care.

Maintenance

Maintenance is also being considered under the SWAp, although DoLIDAR have recently (about 3 – 4 years ago) produced a maintenance manual and maintenance directives for rural roads. This was done in conjunction with Roads Board Nepal (RBN). SWAp are considering developing an information database for the rural roads sector which will produce an inventory of roads and a system that will allow them to scientifically prioritise roads for maintenance. In addition it will be linked to a GIS system. A similar database was initiated under DoLIDAR through the DRSP programme in 2003, but was given a low priority and was not maintained. SWAp are intending to use this database as a basis for the revised version. This is clearly one area where the research could provide evidence to help

in the development of the database and hence subsequent changes to the maintenance policy.

Transport services

Equitable and affordable use of transport services is a difficult area to control. DRSP recently undertook a socio-economic review of the programme which found that transport services are being manipulated by cartels and the poorest and most discriminated people are the ones who suffer most from this. Although cartelling is illegal in Nepal, the practice is widespread and inevitably leads to limited and overcrowded transport services, with inflated prices.

Despite in the original research the transport entrepreneurs claimed to provide special rates and assistance to expectant mothers, there was no evidence of this on the ground. Officially the operation and monitoring of transport services is beyond the remit of DoLIDAR, there should be scope for liaison with the district authorities to ensure that disadvantaged groups and expectant mothers are not discriminated against.

World bank are at present carrying out a transport services study that will look specifically at cartels and other barriers to equitable and affordable public transport services.

Coordination and Cooperation

Coordination and cooperation between the two Ministries has been minimal so far. There are several issues around this, but there seems to be no formal mechanism to discuss such issues, except through high level committees chaired by the Prime Minister, which seldom take place due to heavy workload. Fundamentally the two Ministries have different approaches, especially in terms of decentralisation, which is fundamental to the MoLD but is not fully embraced by the MoHP. As the research fell between two Ministries, and was not led by either, the findings and recommendations have failed to be actively followed up by either ministry. For such changes it is necessary to have a “champion” who can take the issues and advocate them to the relevant people / bodies.

Health Sector (with focus on expectant mothers):

The main access barriers identified in the Mobility and Health study:

- Find out the use of available rural road for health care and
- Why not they are not using the road access for health service?

Recommendation and Mobility issues	Policy	Limitations
Extension	Only 36% of population accessible by road, huge gap in coverage and can not reach door to door so 2 hrs (terai), 4 hrs (Hill) and 6 hours (mountainous districts) policy to reach rural road due to difficult geography	Difficult geography
Quality of road	Policy exists to upgrade the road in process of implementation	Resource constraint
Means of transport	Public service is not available in all roads, if available not often user friendly for pregnant women	No coordination with transport sector

		Curtailling political issue
Cost of transport (Public)	Pregnant women need to take 2-3 seats for patient (and helper) which is again expensive, also expensive during off hour emergency period	No social service policy in transport sector for sick or pregnant persons
Ambulance services	Expensive ambulance service, mainly private operators	New ambulance policy operation guideline drafted, needs to be implemented by MoHP

In summary

Recommendation Health issues	Barrier	Policy changed
Service availability	Still problem, but in process of improvement	HR Retention policy Service upgrading as per need in phased manner
Cost of the service	Expensive	Now free at all public HFs
Quality of service	Human resources, time, service delivery, coverage of service	New policy of Doctors recruitment in PHCC and District Hospital SBA policy implementation in process
Location of HF	policy to identify the location / upgrading of health facility	VDC centre, Ilaka centre Availability of land and distance an issue!
Not using ANC services – why?	Culture, distance, poverty, low quality of health service	Promotion of outreach clinic and universal access to maternal health care
More home deliveries	Culture, distance, poverty, low quality of health service	Policy of free maternity care at HF Cost sharing for travel by system as per geography. Delivery case only Rs. 1,500 for mountain region, 1,000 for hill and 500 for terai districts) Other sectors are working for women empowerment
Transportation incentive for referral cases	Not enough budget as per the need Target group are not aware about the policy	Transportation cost sharing for poor patient from district to referral hospitals as per the geography Rs1000 for Plane, 2000 for hill and 5000 for mountain districts.

6 Analysis

Potential changes.

There are a number of potential changes that are still possible as a result of the Mobility & Health research. The changes are shown below related to either the Mobility or Health parts of the research. The 9 recommendations are those from the original Mobility & Health research project for DRSP. They are:

6.1 Mobility:

Recommendation 5: *Equitable and Inclusive Planning of rural access provisions, with a health service focus, needs to be integrated into the transport planning process.*

The DTMP process is being reviewed at present by the SWAp project. The DTMP review team should consider giving the health indicators a higher importance within the criteria for deciding which rural roads should be selected for construction / maintenance. The research can be used to demonstrate the importance of health when making such decisions.

Recommendation 6: *Quality of access infrastructure, mainly roads, should be one of the highest priorities for improving maternal health.*

There is an opportunity for the research to influence the level of maintenance on roads that are important for access to hospitals and health centres. Roads Board Nepal are willing to discuss this in a board meeting and the SWAp team should be interested to see the research results when they develop the new DoLIDAR information database. The research can support why and how roads that would be used by expectant mothers should get a higher priority for maintenance.

RBN reported that there is an informal system to prioritise roads in the district, mainly based on political or cultural parameters, for example district officials are often requested to maintain roads to religious sites. This system by-passes the DTMP rehabilitation functions, but there would be scope to formalise this through RBN policy.

Recommendation 7: *Communities and transport entrepreneurs need to work out an approach for regular and affordable public transport services in rural roads*

It is difficult to see how this issue can be tackled in the short term, as regulations already exist for controlling cartels, but they are not being enforced. Until there is a stronger government it is unlikely that anything will change. The best hope is probably for a grass-roots movement from the people to campaign for better transport services at a more reasonable cost. Some special provisions for expectant mothers could also be built in.

6.2 Health:

Recommendation 1: *Raise awareness of available access and ANC service opportunities and of the risks of not accessing such services in an equitable way at least at household level for an improved maternal health sector.*

One Sub Health Post in one VDC and monthly one outreach clinic within 2 hour distance

Health service infrastructure	Total
District hospitals one each district	65
PHCC in each electoral constituency	210
HP one in each Ilaka	676
SHP one each VDC	3,134
Total outreach clinic	14,292
FCHV	48,514

Source: Annual Report 207/08 DoHS

The Government of Nepal is planning to upgrade Health facilities with improved quality of care, as shown below:

Future Plan:(3 Years)

Present		Future
1000 SHP	→	Health Post
3 Bed PHC	→	10 Bed PHC
15 Bed Hospital	→	25 Bed Hospital
25 Bed Hospital	→	50 Bed Hospital

Ref: Department of Health Services

Budget allocation for 3009/2010

- 224. Service delivery will be made effective by upgrading rural health institutions and urban hospitals, as recommended by the O&M Surveys, through physical improvements and beds increments on the basis of patients flow/pressure, population and geographical conditions. Sub-health posts, in infrastructural developed Village Development Committee, will be upgraded to health posts. Likewise, maternity centers will be established in the health posts and sub health posts having necessary infrastructures.
- 230. Grants for the establishment and operation of the community hospitals will be provided on the basis of specified norms. Also, emphasis will be given to the physical infrastructure development of health institutions. A sum of Rs. 2 billion 190 million has been allocated for the forthcoming year for the construction of the hospital buildings and their maintenance and infrastructure development.

Pro poor health Policy 2: Free Essential Health Care¹

- Main objective is to remove financial barrier and increase access & availability of enlisted essential drugs (25 items in SHP, 35 items each in HP & PHC & 40 items in district hospital) in health facilities throughout the year
- Constitutional provision to receive free basic health care
- Initially in 2007 users fee abolished & essential drugs declared free in health posts and sub health posts
- In the current year free essential health care expanded to primary health centre and district hospitals

¹ MoHP Joint Annual Review presentation in 2009)

Health Programme Regular ANC services are being conducted free of cost in each health facility and outreach clinic. Female community volunteers (FCHV) are raising awareness program to increase utilisation of ANC at household level

Other development sectors

Education: formal and non-formal education programme.

Women's development: district women development section is regularly conducting women empowerment programmes.

Awareness programme for gender equity, equality and social inclusion

Recommendation 2: *A review of strategic positioning of health facilities, particularly for maternal health, is required to bring the service facilities within 2 hours walk of all the population and encourage transport coverage.*

- The building of sub health posts or health posts is mostly shared with the office of the village development committee (Source: MoHP).
- The policy for construction of rural roads is to ensure that everyone is within reach of a motorable road: 2 hours walk for terai, 4 hours walk for hills and 6 hours walk for mountainous regions of the country (DoLIDAR).
- Local development sector will work at district and village level as per the need with consultation with district health office.

Recommendation 3: *Health Service provision should be locally managed and equitably offer quality and reliable services with special regard to access problems of disadvantaged groups.*

Decentralisation was intended to bring more bottom-up accountability to communities to give them more opportunity to tackle local problems, respond to local priorities, and hold service providers accountable to those they serve. Over 1,400 health facilities have been handed over to be managed by Health Facility Management Committees compared to the target of 1,800 by 2006.²

Health facility management committee must be functioning to plan, implement and monitor the SHP, HP, PHCC level health services. The members of the health facility management committee must be inclusive as per gender, disadvantaged group from the local community. (*Health facility management guideline*)

The implementation of policy at health facility level is being practiced with guidance of district health system management with support of local development office. All development and health sectors are working in rights based approach and conducting health awareness programme to ensure health rights.

The Right to Health: This right is central to the creation of equitable health systems. The right to the highest attainable standard of health encompasses medical care, access to safe drinking water, adequate sanitation, education, health-related information, and other underlying determinants of health; such as the right to be free from discrimination, involuntary medical treatment, and entitlements, such as the right to essential primary health care.¹ Like other human rights, the right to health has particular concern for disadvantaged people and populations, including those living in poverty. The right to health requires an effective, responsive, integrated health system of good quality that is accessible to all.¹

² *Review of Nepal Health Sector Programme: A Background Document For The Mid-Term Review*
Mick Foster, John Quinley, Raghav Regmi and Binjwala Shrestha Final Report November 2007

Recommendation 4: *Establishment and strengthening of BEOC and CEOC service centres is necessary to complement often inaccessible Health Centres*

Phase wise implementation in priority LHDI districts: Policy of birthing centre in each HP, District Hospital with CEOC services in District hospital and BEOC service in PHCC.

Recommendation 8: *Critical health services, including maternal health, should be given special exemption from political activities and disruptions by conflicting parties to ensure reliable service delivery:*

The following policies are already in place and will help with reliable service delivery, but all parties need to agree that ambulances and emergency services for pregnant women should not be disrupted by conflict.

Pro-poor Policy-1: Maternity Incentive Scheme-1 (1)

Main objective is to improve maternal health by increased utilisation of maternity service & remove financial and social barriers Policy decision on maternity incentive scheme in February 2005 and programme launched in July 2005 with free maternity service in 25 low HDI districts

Demand side financing introduced in this scheme with cash incentive to women attending health facility for child delivery Rs 1,500 in high mountain districts, Rs 1,000 for hill districts & Rs 500 for Terai districts as transport cost compensation

Achievement encouraging with delivery attended by trained health personnel 31.7%

Pro poor Policy-1: Maternity Incentive Scheme-2 (1)

- Home delivery by trained government health personnel - Rs 200 (Rs 300 in 2005)
- Rs 5,000 cash support for women in civil service up to two children only (2006)
- In 2008 all maternity services including complicated pregnancy declared free and programme renamed as “Maternal Security Programme”

Recommendation 9: *Integrated and equitable advocacy initiatives need to be organised by relevant forums and institutions for favourable policy and strategy changes*

The following advocacy initiatives are operating and can be enhanced:

- NGO forum and Safe motherhood network is already doing this
- Government drafted bill to ensure right to health and right to life for mothers and new born health
- Many advocacy tools produced and distributed to community and policy makers of national and district to increase access to reproductive health services.; UNFPA, WHO, Government, Safe motherhood Network, WoREC, BBC and many more.
- Rural Roads Forum, NFRTD / IFRTD, SA-ebpdn, Transnet, etc.

Knowledge-practice interface

In Nepal there is no formal knowledge-practice interface related to incorporating research findings into policy. The consensus from the people interviewed was that it does happen, but usually informally through a 'champion' who will promote the research from a personal perspective. In this particular case study there was no translation of recommendations into policy. The main reason for this seems to be that the recommendations were mostly for changes in existing policy and not of an urgent nature, so could be taken up in the normal revision process. Also at present policy revision and development is rather slow due to political issues, as mentioned earlier, so it may have been too early to see any major changes. Feedback and enthusiasm for the research and its findings was strong when it was completed in 2007, and the regional advocacy workshop that was held was successful, with both RTI and Health ministries accepting the need to work together to influence policy.

However, since that time there has been no momentum to take the research recommendations forward, as the research was not 'owned' by any government department there was no champion to further its cause. The researchers themselves have made personal efforts to maintain awareness of the research, mainly from Binjwala Shrestha who works in the public health area and has promoted awareness of the original research to relevant people in the Ministry of health, but there has been no focal person as the research fell between two ministries. With neither ministry taking the lead, the momentum was lost and the research was 'left on the shelf'.

At present DoLIDAR Are reviewing existing policies that would benefit from the experience gained in this research. A sector wide approach is being implemented which is reviewing all existing policies and standards, funded by multi-donors. It has fallen upon the researchers to remind and promote the results of the original research to DoLIDAR. Had the researchers not been present, it is likely that this research would not have been considered when revising the policies. Even though there was an advocacy workshop for the original research attended by many DoLIDAR personnel, the institutional memory of this was limited.

The Health ministry is slightly different in that many more research projects are being undertaken in this sector and they are more accustomed to using research to influence policy. Research is mostly supported by SSMP (DFID), relevant reports can be found on the SSMP website http://www.nsm.org/publications_reports/index.html. The research is mostly related to address the barriers of transport, cost and quality of health care.

Capacity to incorporate research into policy

Without a formal mechanism for incorporating research into policy, the capacity to do this is limited. The government changes regularly and is often unstable whilst in power. With a new constitution being the priority, other policy issues tend to take a back seat. The writing of the constitution is behind schedule and there are talks about extending deadlines.

Although policy dialogue within ministries is still going ahead, the capacity at present to achieve this is limited. A workshop has been planned between the local development and health sectors to discuss how a mechanism can be developed to facilitate the incorporation of research into policy. The objective of the workshop is to review the needs of the health sector in order to reduce the distance barrier of health services; to share the preliminary findings of the review and review the process of policy assessment ; to share the policy and planning of rural road infrastructure to match the needs of the health sector and to strengthen coordination between the Health and Local Development Sectors at local and national levels in order to develop a system of needs based planning . The process, outcome and the participants list can be seen in Annex 7.

Roles and factors in influencing policy

Much of the research undertaken in Nepal is funded by donors. As such they are a major actor in this process. However, the support often ends when the research ends. In the present climate if a research project has a clear message for policy reform, it is necessary to continue support to advocate for that policy reform.

Regional research organisations such as ACAP are successful in carrying out specific research projects within a region, but in order to influence policy that research must be rooted in a specific sector or ministry.

The context of the political situation in a country can make a massive difference to how a research project is able to influence policy. As mentioned before if a research project involves two ministries who are able to communicate and coordinate together, then it has a reasonable chance of success. However, if the two or more ministries are not communicating it may well be doomed to failure.

Local forums such as the 'South Asia Evidence-based Policy in Development Network' can be influential in supporting policy development through research. Such forums should have the ability to pull together all the different actors necessary to advocate for policy development.

Communication of Research

The method in which research is shared in Nepal is fairly traditional. It tends to be in the form of a workshop or seminar, often headed by an important person who has little prior knowledge of the research itself. Events tend to be too big and are not conducive to getting detailed feedback from individuals. This form of communication should be more focused and a dedicated team involving both ministries should be formed to take it forward. Meetings rather than seminars or workshops could be more productive if they are limited to the specific professionals who have an in-depth knowledge of the subject, who can then use their own networks to share and communicate results. Results are often shared too early, professional feedback should be sought first from focused meetings and only later should the results be disseminated more widely.

Websites are used as secondary means of disseminating research. Formal networking via internet is not often used. There are some useful forums where information is shared, such as the Rural Roads Forum (RRF), Nepal Forum for Rural Transport Development (NFRDT) and the Safe Motherhood Network Federations (forum of NGOs working for women's health rights). The media can be a good way of dissemination, but tends to be short term. It requires a continuous effort to sensitise and provoke them because in Nepal the media are mostly focused on political agendas and less on social issues. However, nowadays a few media organisations are continuously raising issues of maternal mortality and access barriers.

The Rural Roads Forum is an informal group of implementing programmes and projects working primarily in rural roads in Nepal. It meets on a bi-monthly basis to discuss issues, share experiences and coordinate efforts. This forum provides the opportunity for inter-programme coordination in the rural roads sector. It does not represent the Government of Nepal or the donors' opinions, but serves to improve and coordinate the technical and institutional services being provided to such bodies.

The Mobility & Health advocacy workshop was covered in newspapers and on TV, but the interest did not sustain past a few days; for policy influence the interest needs to be maintained for months or even years.

Strategy for sharing outputs via regional and global networks

As stated in the Expression of Interest, the findings of this research will be shared with the relevant stakeholders and disseminated through various regional and international networks, once it has been finalised. It was planned that the team would hold an inter-sectoral workshop to disseminate the results of the case study and gain consensus on a way forward, although not all stakeholders thought this would be effective. As there is one researcher from each sector, mobility and health, in the research team, they will use their respective contacts to take the advocacy forward.

The Nepal Forum for Rural Transport and Development is an open forum of professionals, practitioners, development workers and academics concerned with rural transport and development. The Forum's role is to co-ordinate a network for information sharing, carry policy dialogue, debate on national interest/issues and lobby on purposes and exert as a pressure group at the policy level. NFRTD is a national level autonomous group acting as a Country Chapter of the International Forum for Rural Transport and Development (IFRTD) in Nepal.

7 Conclusions

The following conclusions were drawn from the desk study and interviews.

- Research is more effective for policy when there is a clear gap in knowledge. This is highlighted by DoLIDAR's embracing of the gravity ropeway technology. For research such as the DRSP project, which advocates small changes in existing policy, there seems to be less motivation.
- There is no formal process for using research to develop policy. It is easy for research findings to be passed over when policy on relevant issues is being made. Even high level committees are not effective in the present political environment.
- Where the research falls between two ministries, neither are willing to take the lead. In the example of the DRSP project, the research was split fairly evenly between Infrastructure and Health, there were even two projects jointly sharing the research, DRSP and RHDP. In terms of talking the research forward no 'champion' emerged from either camp.
- Research is more easily transformed into policy when there is a champion willing to devote time and energy into advocating the research for policy change or development. The champion can be an individual or a project or a department, but they have to be motivated and persistent to get the research recognised and used in policy development. This is demonstrated by the Practical Action research, where the organisation itself advocated strongly and the government department had one or two individuals who were willing to put time and effort into developing the research into policy.
- Dissemination of the research was effective whilst the research was still ongoing, but when support stopped, so did the dissemination. Continued awareness raising of the research issues and advocacy to the relevant government departments would probably have helped a lot in promoting the research recommendations for policy development.

8 Recommendations

The following recommendations have been made:

- Ministries should be involved right from the beginning of the research. It would be best if a person from the ministry or relevant department could be part of the research team. This would foster ownership and provide the potential for a ‘champion’ from the government sector.
- ‘Champions’ should be identified and supported at an early stage in the research. They can be from any background, but would probably be most effective from the government sector.
- When the research falls between two ministries, as in the case of the mobility & health research, there should be a clear leader. Must be rooted in one sector.
- Media can be helpful to raise profile, but needs a strategy to maintain interest in the longer term
- Dissemination of research information should be focused and coordinated, especially when more than one sector is involved. For this policy case study it is recommended that the findings are disseminated in the following forums:
 - ~ RRF: There is an RRF meeting at the end of November, this will be added to the agenda and a presentation will be made. All of the important Rural Infrastructure Stakeholders will be present in this meeting. IN advance the executive summary will be sent to members and guests for comment.
 - ~ NFRTD: Mr. Shah from DoLIDAR (also the President of NFRTD) will be requested to disseminate the findings to the NFRTD members and if possible to invite the research team to make a presentation.
 - ~ IFRTD: This forum will be requested to disseminate the findings of the case study regionally, through Ranjith Da Silva, and internationally through their head office in London.
 - ~ An organisation called the ‘South Asia Evidence-based Policy in Development Network (SA-ebpdn) has just been initiated in Nepal, this will be a useful forum for disseminating case studies such as this, so the organisers will be requested to use their network to raise awareness of the study.
 - ~ Local media will be used to disseminate the study within Nepal.
 - ~ The Transnet web-based forum based in Switzerland will be requested to disseminate the case study through their website, which is worldwide.

Annex 1

Executive Summary of M&H Research Project

1. What are the key barriers to poor people's use of existing transport facilities to access health services?

2. How might female access to health services, and that of disadvantaged groups, be improved with mobility interventions?

Introduction

The research work was undertaken in Nepal by a team from the District Roads Support Programme (DRSP) in association with the Rural Health Development Project (RHDP), both of whom are funded by the Swiss Agency for Cooperation and Development (SDC). A researcher was employed from the public health sector to oversee collection and analysis of data. The focus of the study was on poor people's access to health facilities, especially that of the discriminated castes in Nepal. Maternal mortality was given a central role in the study, with special regard to Millennium Development Goal number 5.

Three districts were selected to be part of the study; Dolakha, Ramechhap and Baglung. They were selected on the basis of being associated with the DRSP or RHDP Programmes, as well as having existing access and health facilities. The districts are all in the hill and mountainous areas of Nepal, have high poverty and poor health indicators. Criteria were developed for selecting road corridors and study areas, based on length, connectivity, geography, population and incidence of discriminated castes. The research was focussed on caste and ethnicity as this is a core area of concern for SDC and DRSP / RHDP in Nepal. All data was disaggregated in this respect in order to determine the links between disadvantage through caste / ethnicity and mobility / maternal health.

Methodology

The research team identified the main respondents as mothers with children between 0 – 2 years old. Additional data was collected from fathers and grandmothers, as well as from other stakeholders such as health workers, district officials, transport organisations, etc. in order to get a full picture of the situation from all perspectives. Household surveys were undertaken, as well as focus group discussions, exit interviews and various other recognised methods of data collection. As well as the primary data, information was collected on specific maternal mortality case studies which complement the main analysis. The data was then entered into the SPSS database for review and analysis.

Outcomes (Findings)

The data was checked and organised into tables and graphs. Some gaps and discrepancies were found, most of which were resolved following recaps with the facilitators and assistant researchers. After rigorous analysis the findings were then assessed and produced in the report as Outcomes:

Outcome 1: In Nepal rural areas have lower human development indicators and higher maternal mortality. Demographics of the study areas show that increased awareness, income levels, literacy, access, exposure to outside world, etc. contribute towards positive maternal health indicators. One of the districts has had extensive intervention from an internationally funded maternal care project, this has greatly increased awareness and changed people's attitudes and practices in a positive way.

Outcome 2: Disadvantaged groups in the study districts have poor social indicators, with low participation of women and poor people in accessing education, income generation

activities and productive use of their time. Women have less opportunities and power within the family; as a result maternal mortality is still high compared to other countries.

Outcome 3: Maternal deaths depend on multiple factors, including decision-making, disadvantage through caste and transport to health centres; they are complex and require detailed analysis of these factors. The reasons for maternal mortality are many and varied, this research concentrated on people's practices and how they need to change to affect maternal mortality.

Outcome 4: Analysis of actual case studies have shown that the presence of transport access to reach a health facility has a more direct impact in reducing maternal mortality, irrespective of varying levels of awareness. Even in the district with higher awareness, the usage of appropriate health facilities was lower, due to restricted access.

Outcome 5: The cost of services at the health facility itself is an important factor in accessing health facilities, especially for disadvantaged groups. For ANC, cost is an important factor; but for emergency care, if people recognise that the mother is in danger, cost is much less important due to the acute nature of the situation. People will take loans or even give their property as collateral to pay for treatment, if necessary.

Outcome 6: The cost of transport is also a contributing factor in deciding to access a health facility. Despite government incentives to use health facilities most women continue traditional practices, partly due to difficulties in claiming such incentives.

Outcome 7: The quality of infrastructure and transport, i.e. roads, is a significantly important factor in the decision-making process to access maternal health services. There was found to be a definite link between road condition and the frequency with which women use road transport for maternal health visits. Transport on poor condition roads is also significantly more expensive.

Outcome 8: Decision making, often referred to as the 'first delay' in accessing health care, was gender-biased and a major factor in higher maternal mortality in remote rural areas. Although women have a higher level of awareness of maternity requirements and danger signs, they have very low decision-making power within the family. This contributes significantly towards maternal mortality.

Outcome 9: Good levels of awareness of risks and opportunities, both on access and health services, play an important role in accessing ANC services. In rural Nepal ANC services are located closer to the user and are therefore easier and cheaper to access than emergency facilities such as hospitals; in this context higher awareness is important in facilitating women to access such services.

Outcome 10: Quality of available ANC services, both actual and perceived, is instrumental in women actually accessing such services. There is little awareness amongst women of the required level of service of health facilities, with the consequence that demand for improved services is low. This has an effect upon the access to those services, focus group discussions showed that if women perceive the service to be poor they simply don't attend, rather than demanding an improvement in the quality of service.

Outcome 11: The travel time to access health services, which is a function of efficiency of a transport system, and the distance to be travelled played a significant role in accessing maternal health services, especially for disadvantaged groups. In some cases it was found to be as fast to walk to the health facility as to take public transport, in which case women will walk, if they can. However, if it is an emergency then considerations such as cost and comfort decline and practical considerations such as time and distance become more important.

Conclusions

The findings have shown links between access and maternal health, with several barriers being identified. The more remote communities have less access, but this is significantly affected through their position in society, as well as through physical accessibility. The disadvantaged groups tend to live further from the road, which gives them poorer physical access to health facilities, but their lack of awareness, lack of funds and lack of mobility also present serious barriers for them to access maternal health facilities. Other barriers are linked to decision-making, service coverage, transport and conflict in Nepal.

It is clear that disadvantaged groups are at a significant disadvantage when it comes to accessing maternal health facilities. ANC services are more accessible than delivery or emergency services. For people without access to a motorable road it is very difficult and expensive to access emergency services, which only tend to be located at the district centres. Most health facilities tend to be located close to the road network, but an outreach policy is also being developed by government which intends to bring health services closer to the people who live in very remote areas countrywide.

Transport and health sectors do not coordinate well. Policy revision is necessary with greater cooperation between the two sectors. Although transport planning policy is to make infrastructure inclusive and equitable, and health policy is to bring health facilities within easy reach of all the population, the reality is that many people still suffer from barriers to accessing health services that are exacerbated by their poverty or position in society.

Recommendations

This chapter makes some recommendations for both the transport / roads sector, as well as for the health sector. Many of the recommendations impact on both sectors, for which regular liaison and coordination will be required. The country is at present undergoing fundamental political change and in such an environment it may be difficult to implement some of the recommendations in the short term, but the long-term visions will still remain valid.

The recommendations focus on overcoming the barriers to access health facilities, by raising awareness, more effective planning and locating of infrastructure, increased level of service and facilities, plus a shift towards more effective maintenance of roads and away from ad-hoc road construction. In addition to this, public transport needs to be allowed to operate in a competitive and fair environment, as well as serving the more remote and inaccessible areas. There is also scope for alternative modes of transport in the hills of Nepal. Disadvantaged groups must be given special consideration in all of these recommendations as the research has shown that they have less access to maternal health.

Lastly, the findings from the three Nepal research projects for Mobility and Health should be consolidated and used to influence at the policy level, through transport and health institutions, agencies, etc. A programme of advocacy is recommended to support and promote the recommendations in these papers.

Annex 2

Organisational Structure of the Department of Health Services

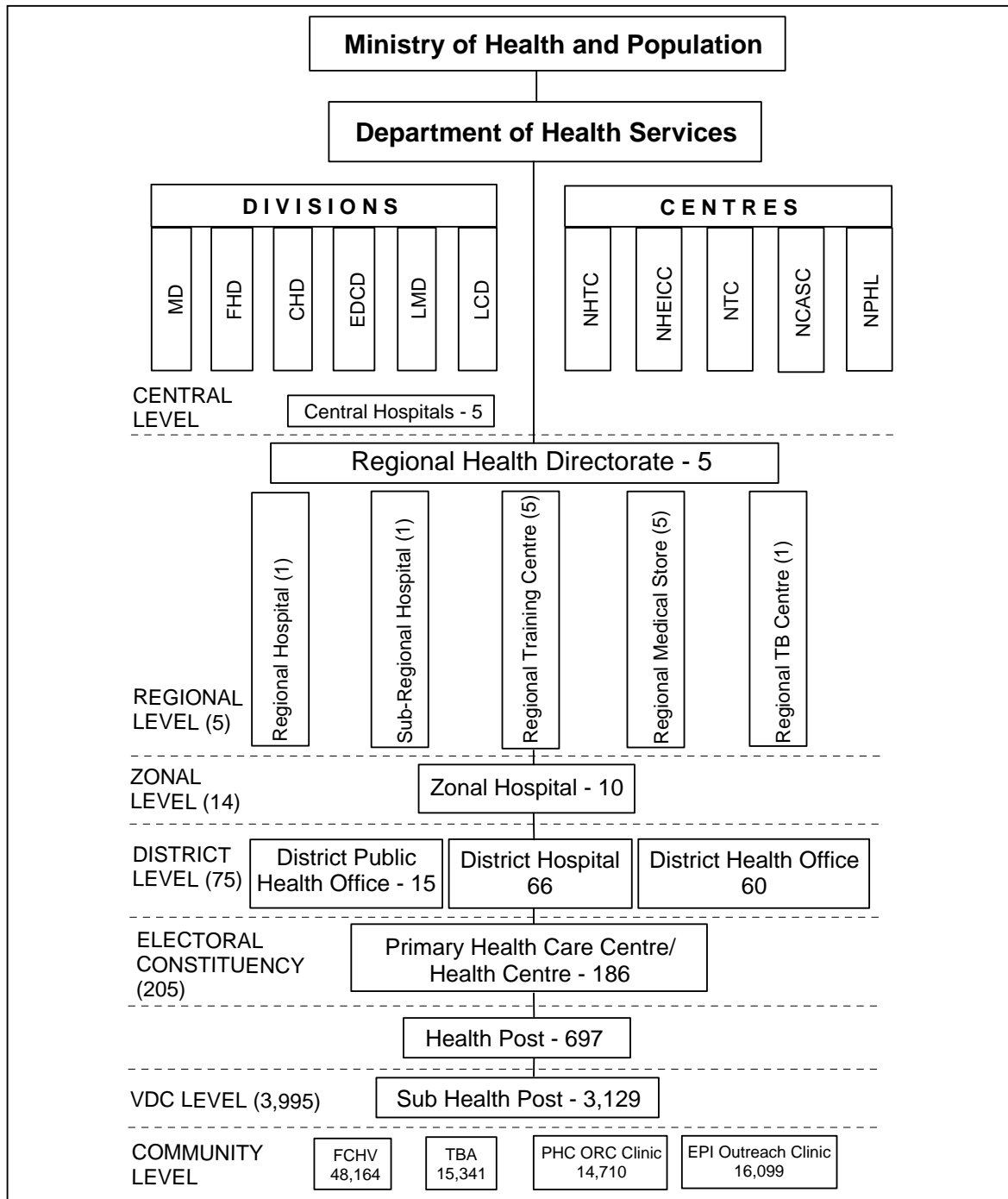


figure 1b.1 Source: HMIS/MD, DoHS

Acronym	Full title	Acronym	Full title
MD	Management Division	NTC	National Tuberculosis Centre
FHD	Family Health Division	NCASC	National Centre for AIDS and STD Control
CHD	Child Health Division	NPHL	National Public Health Laboratory
EDCC	Epidemiology and Disease Control Division	FCHV	Female Community Health Volunteer
LMD	Logistics Management Division	TBA	Traditional Birth Attendant
LCD	Leprosy Control Division	PHC/ORC	Primary Health Care Outreach Clinic
NHTC	National Health Training Centre	EPI	Expanded Programme on Immunisation
NHEICC	National Health Education, Information and Communication Centre		

Government Health Service Structure

<i>Table 1 Government Health Service Structure</i>					
S. No.	Type of Health Facility	Location	Provision number	Existing Number	Remarks
1	National/Central Hospitals	Mostly in Kathmandu, the capital of Nepal.	Not specified	8	Government hospitals only. High level of services in all areas.
2	Regional Hospitals	In Regional Headquarters	5	3	General health facilities including maternal health offer normally good level of services
3	Zonal Hospital	In Zones	14	8	There is no Zonal hospital where regional hospitals are located
3	District Hospital (min 15-bed)	One in each District	75	65	Generally not adequately equipped.
4	Primary Health Care Centres (PHCC)	One in Election Constituency	205	209	Not emphasised and well equipped.
5	Health Post (HP)	One in each Ilaka	Not Specified	677	Reasonably accessible facilities.
6	Sub Health Post (SHP)	One in each VDC	3995 VDCs	3126	These are the most accessible facilities for poorer communities. SHP is not available where Health post is located.

Source: DoHS Annual Report 2005/6

Annex 3

Questionnaire

Name:

Designation:

Sector:

What is your position?

Do you have any influence on departmental policy?

Does your project / programme make any policy recommendations to GoN?

Have there been any changes in GoN policy in your sector over the past 2 years?

If Yes – go to **A**:

If No – go to **B**:

A Please describe the policy changes:

Are you aware of the Mobility & Health Research undertaken by DRSP / RHDP in Nepal in 2007?

Did this research have any influence on the policy changes you mentioned above?

If YES, go to **A/1**:

if NO go to **A/2**:

A/1 Describe the influence it had.

Were the findings and recommendations from the report used directly in determining the policy change?

Would the policy have been different if the M&H findings were not used?

How could the M&H report findings and recommendations have been improved to assist in policy change?

Any other comments?

A/2 Was the relevant Ministry made aware of the M&H findings / recommendations?

If not, why not?

If the Ministry was aware, why were the recommendations not considered?

How could this be improved in the future?

B Are you aware of the Mobility & Health Research undertaken by DRSP / RHDP in Nepal in 2007?

Do you think that any of the findings / recommendations of the M&H report would be useful to feed into policy change?

If YES, go to **B1**

If NO, go to **B2**

B1 Which findings / recommendations would be useful and why?

Will there be opportunities in the near future to influence policy in your sector? Describe:

How can DRSP / RHDP help with this?

B2 How would the findings / recommendations be differently presented in order to make them more useful for policy change?

Will there be opportunities in the near future to influence policy in your sector? Describe:

Annex 4

List of Interviewees

1	Mr. Dipak Chalise	Director, Roads Board Nepal (GoN employee)
2	Mr. Sushil Tiwari	Chief of ISAP project, DoLIDAR (GoN employee)
3	Dr. Baburam Marasini	Nepal Health Sector Programme (GoN employee)
4	Dr. Tirtha Rana	Consultant to UNFPA,
5	Mr. Shuva Sharma	Consultant to RTI SWAp and to PEI of UNDP.
6	Mr. Harka Thapa	Project manager, RDHP, SDC
7	Dr. Chet Raj Pant	National Planning Commission member – (GoN employee)
8	Dr. Dinesh Devkota	National Planning Commission member – (GoN employee)
9	Mr. Hom Nath Subedi	Equity & Access advisor, Support to Safer Motherhood Project, DFID
10	Mr. Niraj Shah,	Senior Divisional Engineer, TBSU Chief, DoLIDAR and President of NFRTD (GoN employee)
11	Mr. Jamuna Shrestha	Consultant, RAIDP, World Bank
12	Mr. Achyut Luitel	Director, Practical Action Nepal

Annex 5

Summary of Interview Transcripts

1 Mr. Dipak Chalise

Director, Roads Board Nepal (GoN employee)

12/10/2009

Mr. Chalise was not present at the original Advocacy workshop held at the Himalaya hotel in 2007, but was familiar with the research. The main relevant recommendation for RBN was No. 6, which refers to road maintenance and riding quality. He informed that health was getting a higher priority within the roads sector, especially with issues such as HIV/AIDS, although this had not yet had any concrete effect on policy.

Informally there are a number of ways that DDCs get funds from roads board and health concerns are one of these. Another popular way is religious sites; often local people request a road to a temple or place of worship. This type of prioritisation is not built into policy but there is scope to do so.

The procedure for incorporating health as a major factor in prioritisation of maintenance is to present the argument at a board meeting of the RBN. This would then be discussed and taken up if agreed. Mr. Chalise suggested that an inter-ministerial committee should be formed to look at such cross-sectoral issues. At present there is no such committee, although the NPC oversee such things. His opinion was that at present it needs one ministry to take the lead on such issues. An example of this would be road safety, but which ministry would lead it. There are two different ministries that deal with roads, which further complicates the situation.

Mr. Chalise suggested that a high level committee could be formed. As the roads sector is shared between two ministries, both would need to be involved.

2 Mr. Sushil Tiwari

Coordinator Institutional Strengthening Action Plan project, DoLIDAR (GoN employee)

13/10/2009

There have been no policy changes in DoLIDAR since the research was completed, but there are some changes being planned. DoLIDAR is in the process of developing a Sector Wide Approach, which will revise all existing approaches to make them more integrated. In particular the DoLIDAR Approach Manual will be revised, which sets out the basic principles under which DoLIDAR works, including the planning process in the districts. Districts have to prepare a District Transport Master Plan (DTMP), which sets priorities for selecting roads to be constructed and rehabilitated. This process will be revised and there is a good chance that health will be made a more important indicator as a result of the research.

The OLI devised Integrated Rural Accessibility Planning (IRAP) tool was introduced to Nepal some years ago and takes a greater account of local services when planning a road. Mr. Tiwari informed that DoLIDAR had tried to integrate the IRAP tool before (4-5 years ago), but it was never made compulsory. This considers basic services such as health.

The Sector Wide Approach Project (SWAp) of DoLIDAR is planning to revise the DTMPs in 7 pilot districts with new guidelines. Accessibility will be a major factor, using GIS planning. At present population and maintenance are the main factors, but health can be considered.

Other policies such as the Local Infrastructure Development (LID) policy and the Local Self Governance Act (LSGA) will remain unchanged. It is expected that DTMPs will also take into account the next level of roads – VDC roads.

At present there is no inter-ministerial coordination. ST suggested that research can be included in policy through a Policy Coordination Committee – which is present in MoLD. This is chaired by the Secretary or the Minister. At present policy is made on a reactive basis, if specific to that ministry it can be done internally, but if inter-ministerial it has to be approved by cabinet. If inter-sectoral the question arises about who will take the lead.

Planning can be considered whilst updating approach manual. DoLIDAR already have maintenance directives and a maintenance manual. RTIMIS database will be updated under SWAp. It will also be integrated with GIS. The inventory is in the first stage.

3 Dr. Baburam Marasini

Coordinator, Nepal Health Sector Programme (GoN employee)

13/10/2009

Mr. Marasini attended the advocacy workshop at the Himalaya Hotel and recalled it as being very useful. However no major policy change has occurred in the health sector since that time. Minor changes have been made in Ambulance policy.

Mr. Marasini was also planning a workshop on access barriers with GTZ, but it was dropped as being less important than other health issues in Nepal. The NHSP is basically the SWAp for the health sector. They coordinate donor funds for the Health Ministry.

Mr. Marasini's idea is for interaction between all sectors; bridges, roads, water, education, etc. He gave an example of the disease Kalazar, the insects that spread the disease can't fly above 7ft. – need for roads for access to health care.

He also consulted with MoLD SWAp in past. Plus with suspension bridge project for access. Sub Health posts are located close to VDC building – hence the location. VDC building often on road. Not easy to reposition SHPs. IMTs and Susp. Bdgs.

He recommends regular dialogue and cross cutting meetings, 1 or 2 a year. At present there is no mechanism for cross-sectoral policy making. In other countries they have committees, in Thailand it is chaired by the PM.

Mr. Marasini asked whether we can we organise a seminar with all stakeholders to discuss how to take policy forward in this area?

4 Dr. Tirtha Rana

Consultant to UNFPA,

14/10/2009

There have been no new policies in the last two years for Health sector, the most recent was the transport subsidy which was introduced in 2004. NHSP 2 – is cross sectoral.

Health posts are often located in inaccessible areas, and are therefore not user-friendly. Talk to Mr. S. Joshi at World bank if possible. LDO calls shots in the district. Also see Dr. Tiwari at MoPPW, who heads the working group on Physical Access Management, which deals with jobs over 1M Rs.

DIMC (Decentralisation Implementation Monitoring Committee) – high level committee. LGCDP includes health indicators. Speak to Ranji Dhakal at UNFPA. Multi sectoral approach didn't work in Pakistan, cross-sectoral policy not effective under NPC, should be directly under PM. Policy to convert SHP to HP and HP to Community Hospital, needs some input from research such as this.

5 Shuva Sharma

Consultant to RTI SWAp and to PEI (Poverty Environment Initiative) of UNDP.
14/10/2009

There are already many committees under PM, so many that he doesn't know them all. DTMP revisions – Helvetas is reviewing under SWAp, they will pilot in 7 districts from November 2009. Hari Ram Shrestha is the main manager. SWAp is also updating the DoLIDAR Approach manual.

Shuva is also involved in the Poverty Environment Initiative (PEI) project – at the moment they are designing the framework, it is designed to mainstream environment and poverty issues and influence policy accordingly. Poverty vs Environment – they adversely affect each other. The aim is to identify issues and lobby for change, but they have to decide the process. It may be managed through the SWAp?

They have already identified that it needs a champion to take it forward to policy. PEI are looking for champions who can be projects, individuals, institutions, govt. people, etc. This is especially important if the policy is cross-sectoral.

LGCDP will have a huge impact at the local level. They are looking at how LGCDP can be influenced by PEI to implement policy. MoLD must be included as well. Also when people are making policy they should search for relevant research to back it up. At the local level the gap between sectors is less, so more chance of them working together. Shuva is doing a review of the LGCDP.

6 Harka Thapa

RDHP, SDC
15/10/2009

Mr. Thapa said that in his experience most policy is made through practical experience, rather than research. For example the stretcher project in RHDP has developed a good way to distribute and maintain/manage stretchers, so this will be fed back into policy. RHDP give feedback to GoN on policy issues, district staff report to centre, then centre analyse and pass on to GoN.

RHDP have ½ yearly and annual reporting, they use lessons learned and other findings, but not usually based on research. Their project support unit advocate policy changes or development to GoN.

There is a Health Facility Operation Management Committee at district level, they decide how information used – the committee consists of the VDC chairperson, the HP in-charge, DAG representation, etc.

Stretchers are used to increase access. Three focuses for RHDP: Road, HP cost and Maternity cost. To manage inter-sectoral research a coordinator should be assigned who can then take forward research recommendations to both Ministries and other policy bodies.

GoN has a Development Committee which is sitting for first time in 5 years (due to conflict in the country).

He recommended to talk to Dr. Subedi in Family Health Division. Also to discuss with Planning Department of the Ministry of Health for policy change. An External Development Partners Forum is coming up, where the report could be presented. It should focus on MDGs.

Stretchers have increased accessibility. Eg/. from Manthali. PHC has collected enough money (from DDC, VDC and private sources) to supply free ambulances to Kathmandu for emergency maternal cases. This could be a good example for new policy. The DDC has a social fund it can use for this purpose. This is an example of practice into policy.

7 Dr. Chet Raj Pant

National Planning Commission – GoN employee

15/10/2009

Dr. Pant is new in NPC and had no prior knowledge of the research. He deals with health, women's and children's health, within NPC. All NPC members have changed recently.

At present they are preparing a new 3/5 year interim plan. They are focusing on an increase in services. He recommended that research papers are sent to NPC, who will then consider them when making policy. He also recommended we talk to his colleague in charge of infrastructure, Dr. Dinesh Devkota.

NPC seeks resources when making policies, from several sources. Also monitors policy implementation. One recent issue is health insurance, the effect on poor people.

ORGANOGRAM

8 Dr. Dinesh Devkota

National Planning Commission – GoN employee

16/10/2009

Dr. Devkota has been with NPC for 7 months and was previously working on various rural road projects in Nepal. He is in charge of the infrastructure department of NPC.

He opined that DoLIDAR and engineers in general often neglect social issues; the same will be true for health.

He noted that NPC has recently extended the number of departments within DoLIDAR to include irrigation, resettlement, etc. There are 4 levels at which rural roads work – VDC, DDC, DTO and DoLIDAR. Rural roads were not a priority issue for NPC. There is a coordination committee in NPC which coordinates between ministries and helps reflect things in national planning documents.

At present NPC is planning for the 3 year interim plan, to be finished by July 2010. Dr. Devkota suggested that a health unit be formed within DoLIDAR.

9 Hom Nath Subedi

Support to Safer Motherhood Project, DFID supported.

16/10/2009

Hom Nath Subedi is the Equity and Access technical advisor for SSMP. He gave an example of how policy is made, by quoting the NSMP costing study of 2002/3. This looked at all costs involved in maternal delivery. All the relevant Ministry people were called together, i.e. MoF, MoH, etc. and all agreed to study cost as a barrier to health. Within these costs transport costs were found to be very high. For example Rs. 5,000 for normal delivery and up to Rs. 15,000 for Caesarean Section.

At the time there was a coalition with UML in power. Ministers from both Health and Finance were UML (United Marxist-Leninists). The findings recommended that allowances should be given for births and this was accepted and is still in place now. DFID agreed to support this policy and suggested to do pilots, but the Ministry disagreed and took the stand that DFID should help to fund all districts, or the Ministry would manage the funding themselves. Now there is free delivery for all.

Key to success: Research was agreed by all parties at Ministry level as an essential study. It had support and motivation and provided hard evidence to base policy change on. Mobility & Health falls between 2 ministries, with neither taking the lead. Mr. Subedi was of the opinion that research needs a 'Champion' in the ministry to lead it. It also needs incentives and advocacy. Results should be disseminated strongly.

He was also of the opinion that the MoLD and MoH don't get on. Health is not keen on decentralisation, whereas MoLD has embraced it. MoH are reluctant to devolve power to the districts. The reasons for success are cash, recognition, prestige, power – the research and policy dialogue must involve the Ministry strongly from the start.

The Health Research Council is relevant body. Our proposed meeting with stakeholders won't help!!! NPC is ineffective in coordinating the Ministries. Success depends on individuals. SDC should take the study to the districts. Critical mass is required, then pressure from below needs to be built up in order to influence policy change. We should present in DDC council meeting. Start some small projects to prove it. Document and report.

Dissemination is key, a think tank could work. E.g. / NSMP gave cash to BBLL for bridges – criticised by DFID review (2000). May be because the bridge building philosophy needs community contribution for ownership.

10 Mr. Niraj Shah,
DoLIDAR,
21/10/2009

Mr. Shah is head of the Trail Bridge Support Unit (TBSU) in DoLIDAR and also the focal person for the Trail Bridge SWAp, he is a government employee. In addition he is the President of the NFRTD.

TBSU also did a research project for Mobility & Health at the same time as DRSP. He confirmed that the GoN recently had a decentralisation meeting under the PM for the first time in 9 years. He reiterated the GoN policy of 2/4/6 hrs walk to a motorable road. He also confirmed that SHPs and HPs are located in VDC centres, which also have high priority for road access.

He confirmed that Helvetas are revising DTMP criteria under SWAp. He also informed that DoLIDAR are in the process of making a policy and specifications for gravity ropeways. Practical Action also did a research project for Mobility & Health on gravity ropeways at the same time as DRSP, and it seems that this research helped to raise the profile of gravity ropeways to the extent that DoLIDAR are using it to make policy. Mr Shah's perception for this success was firstly that there was a clear need for it, as no policy existed before, plus that Practical Action pushed for it to happen and that there was motivation within DoLIDAR (both personal and institutional) for it to happen. These are the main factors that drove the research to be considered in policy development.

Mr Shah also informed that there is a study under RAIDP (World Bank project) to look at transport issues, the 'Rural Transport Services Study and Policy Development' project. Paul Starkey is undertaking this. This is relevant to Recommendation No. 7, but the study is still being carried out. However, RAIDP have not considered the M&H research yet.

Mr. Shah proposed the need for coordination between ministries, ie. a hospital is less effective without a road, and a road is less effective if the people can't access health facilities. At present there is no coordination mechanism. Successful coordination depends a lot on how well the ministries / ministers get on! Example of health and implementing transport payment policy.

He also suggested that the SWAps should coordinate. He suggested we see Jun Hada or Achyut Luitel of Practical action. Health sector are also demanding bridges for access to health, although it is more often for the health personnel to get to the community, rather than the other way around.

11 Mr. Jamuna Shrestha
RAIDP
21/10/2009

Mr Shrestha confirmed that the IMT study is still ongoing. He will send any information on when he receives it.

12 Mr. Achyut Luitel
Director, Practical Action Nepal
23/10/2009

Mr. Luitel confirmed that DoLIDAR are keen to incorporate gravity ropeways into their portfolio of rural infrastructure. They have formed a task force to finalise standards, guidelines and norms. The first draft is finalised. Their research in mobility and health had highlighted the benefits of gravity ropeways as an alternative means of transport. This had sparked some interest in DoLIDAR and from then on Practical Action advocated to DoLIDAR for inclusion in their policy. There were 2 or 3 people in DoLIDAR who also drove for inclusion of the technology and one person wants to include a trial within another (ADB funded) project.

PA have provided some funding for training of trainers, some TA funds will also be provided to help the policy development and technical support. It seems there was a clearer gap in knowledge and a clearer need for this, as opposed to the DRSP research -where the policy already existed but only fine tuning of policy was necessary.

Also PA did the research very much from an infrastructure perspective with little health involvement, whereas DRSP was more evenly distributed.

PA also has other experience in policy development. They set up a forum for indoor air pollution and household energy, which is a legal body with PA as secretariat. This forum is developing policy and guidelines under the Ministry of the Environment. Significantly this is under one ministry, but has links to health.

Mr. Luitel thinks that it is necessary to involve GoN people in research from the beginning.

Annex 6

Programme schedule - Health and Mobility Policy Interaction Meeting

DRSP / RHDP

Thursday 3rd December, Hotel Summit, Sanepa

Chairperson: D.G. of DoLIDAR

Time	Contents	Responsible
10.00 – 10.05	Welcome Remarks	Neeraj Shah, DoLIDAR
10.05 – 10.15	Brief introduction and objective of the seminar	Robin Workman, DRSP
10.15 – 10.30	Presentation on health policy and issues of access	Dr. Babu Ram Marasayani, MoHP
10.30 – 10.45	Presentation on rural transport policy and potential revisions	Sushil Chandra Tiwari, DoLIDAR
10.45 – 11.00	Presentation on preliminary findings of review	Binjwala Shrestha, Research Consultant
11.00 – 11.15	<i>Tea break</i>	
11.15 – 12.30	<p>Discussion in plenary on issues raised in the Case Study: - Suggested Subjects:</p> <p>1 How can two different Ministries work better together to formulate policy?</p> <p>2 Identify the role of research to formulate needs based policy and determine how research experience can be more effectively disseminated?</p> <p>3 What practical and feasible approaches to develop needs based policy can be developed and how can we formalise the process to convert research experience into policy?</p>	<p>All participants</p> <p>Facilitated by Kalpana Ghimire & Robin Workman</p>
12.30 – 12.40	Summary, Conclusions and Recommendations	Organiser and participants
12.40 – 12.50	Closing Comments	DG DoLIDAR
12.50	<i>Lunch</i>	

Annex 7

Name list of participants – Health and Mobility policy interaction meeting

3rd December, Hotel Summit

S. N	Name	Designation	Organisation
1.	Dhana Bahadur Tamang	Director General	DoLIDAR
2.	Bhim Prasad Upadhya	Deputy Director General	DoLIDAR
3.	Neeraj Shah	Senior Division Engineer	DoLIDAR
4.	A. K. Jha	Programme Coordinator	RAIDP
5.	Sushil Chandra Tiwari	Programme Coordinator	ISAP
6.	J.K. Shrestha	Programme Coordinator	RAP
7.	Thakur Raj Panta	Senior Division Engineer	RRRSDP
8.	Mani Ram Gelal	Project Manager	SBD
9.	Dr. Babu Ram Marasayani	Health Sector Programme Coordinator	MoSP
10.	Dr. Y.V. Pradhan	Director General, DoH service	DoH
11.	Dr. Shambhu S. Tiwari	Director, Health Management Divn.	DoH
12.	Dipak Chalise	Director, Roads Board Nepal	RBN
13.	Hom Nath Subedi	Equity & Access Advisor	SSMP
14.	Achyut Luitel / Jun Hada	Director	Practical Action
15.	Shuva Sharma	Consultant	SWAp
16.	Harka Bdr. Thapa	Team Leader	RHDP
17.	Robin Workman	Institutional Development Advisor	DRSP
18.	Kalpana Ghimire	Community Development Specialist	DRSP
19.	Binjwala Shrestha	Research Consultant	DRSP

Annex 8 – Matrix Recommendations from original research	Were the policy recommendations made in the research, appropriate and practical?	Were the policy recommendations taken up by the relevant government agency?	What were the barriers to the policy recommendations being accepted in full?
<i>Recommendation 1: Raise awareness of available access and ANC service opportunities, and of the risks of not accessing such services in an equitable way, at least at household level, for an improved maternal health sector.</i>	Relevant with MDG 5, 3, 2 Gender equality Education , Maternal health	Already exist, fine tuning needed Promoting out reach clinics with a rights-based approach	Low socioeconomic condition of rural community people Gender bias
<i>Recommendation 2: A review of strategic positioning of health facilities, particularly for maternal health, is required to bring the service facilities within 2 hours walk of all the population and encourage transport coverage.</i>	Relevant to MDG 5 and women’s health rights Health rights Equitable access to health care	Phase-wise establishment of -birthing centre in existing health post -upgrading of SHP to HP -Repositioning of health facility is not possible due to local political reason and availability of the land in nearby community	Slow pace due to lack of funds and human resources
<i>Recommendation 3: Health Service provision should be locally managed and equitably offer quality and reliable services with special regard to access problems of disadvantaged groups.</i>	Relevant policy regarding equity in access to health services, to ensure equal participation and raise profile of DAGs.	HFMC is now represented by local community members (women/DAGs) chaired by village development chair and member secretary is in-charge of the health facility	Effective participation needs to be evaluated
<i>Recommendation 4: Establishment and strengthening of BEOC and CEOC service centres is necessary to complement often inaccessible Health Centres.</i>	MDG 5	Improve quality of service in PHCC as BEOC and in district hospital by CEOC. Policy for free maternal care, cost sharing for travel for institutional delivery, incentive for referral transportation. Skilled birth attendant training programme and recruitment of trained health workers in health facility. Ensure medical officer in PHCC and district hospital.	Utilisation of service is increasing
<i>Recommendation 5: Equitable and Inclusive Planning of rural access</i>	Increasing access in health by developing road network with	Planning process is at present under review by DoLIDAR and it is hoped	Lack of advocacy within the department, no

<i>provisions, with a health service focus, needs to be integrated into the transport planning process.</i>	health facility in mind	that this recommendation will be considered.	champion to promote the policy change
Recommendation 6: <i>Quality of access infrastructure, mainly roads, should be one of the highest priorities for improving maternal health.</i>	Maintenance of road to ensue it is user-friendly for ambulance or public transport (carrying serious patients / emergency cases / pregnant women).	Policy and procedures on maintenance already in place, but GoN willing to consider health as an important criteria when prioritising maintenance.	Lack of funds for maintenance Political interference in the local planning process No maintenance culture at district level
Recommendation 7: <i>Communities and transport entrepreneurs need to work out an approach for regular and affordable public transport services in rural roads</i>	Local planning, Promotion of decentralisation on transport management	DDC and local VDC can work together to ensure the cost of transportation MoHP develop guideline to manage ambulance, need to implemented. World Bank at present carrying out a study on the effect of cartelling	Cartelling in transport system Political instability Lack of enforcement of existing regulations
Recommendation 8: <i>Critical health services, including maternal health, should be given special exemption from political activities and disruptions by conflicting parties to ensure reliable service delivery.</i>	Appropriate to MDG 5 And MDG 1	Free maternity care in public facilities Implementing and now service utilisation is increasing	Private sector not free Service availability in remote district is challenging due physical access barrier, lack of human resource.
Recommendation 9: <i>Integrated and equitable advocacy initiatives need to be organised by relevant forums and institutions for favourable policy and strategy changes.</i>	Appropriate to multisectoral coordination and collaboration under MDG 8, international partnership for resource allocation to achieve MDGs	National Decentralisation committee Development committee under PM NPC	Political instability