Workshop Report
on
Evidence Based Policy and Programming in Public Health

September 19, 2011
Hotel Everest, Kathmandu

Organized by:
Nepal Health Research Council

Supported by:
USAID Maternal and Child Health Integrated Program, Nepal

Background

The basic principles of Evidence Based Medicine (EBM) began to have a marked influence in a number of non-clinical public policy arenas in the late 1990s. Policy-makers working in these areas are now being urged to move away from developing policies according to political ideologies to a more legitimate approach based on "scientific fact," a process termed "evidence-based policy-making" (EBPM).

In recent years there has been a significant increase in the number of evidence based policies are formulated and programs are designed to reduce public health issues/problems.

Nepal has made remarkable achievements in several public health areas and also in bringing global evidence based (best) practices and adapting those in Nepal and demonstrating success in public health whether it maternal health or child health. But Nepal must do more of what it is currently doing to goals it has set for millennium development. New innovating programs must be identified, tested and introduced. Nepal Health Support Sector Program 2 (NHSSP-2) of MoHP has explicitly mentions improving its routine monitoring and evaluation and identified need for policy research and special studies to support it as well as to inform the development of policies and programs based on evidence. NHSP-2 also mentions that it will focus more on building institutional capacity at different levels of government.

It is important that the goals and objectives of a program are consistent with country's overall the goals and objectives and quality of program itself need to be good. Currently, Evidence-Based Policymaking (EBPM) increasingly becoming popular and plays vital role in the public health policy making and practices as well as for funding decisions. To increase the effectiveness of EBPM, it is important to build the capacity of national level stakeholders to develop and use diverse forms of research from multiple disciplines in an effort to respond more effectively to local problem solving.

In this connection, National Health Research Council (NHRC) with the help of USAID organized this workshop which would help Nepal initiate important steps towards improving formulating policy and programming, based on evidence by sensitizing importance of research and data in developing policy and programming and identify key approaches for Nepal.

Objectives of the workshop

The objectives of this one-day workshop were as follows:

- Sensitize on the importance of research and data on developing policy and programs.
- Discuss Nepalese and external examples of taking evidence into new and existing program and policy development.
- Identify approaches and necessary capabilities/infrastructure to support decision making and program implementation.

Proceedings of the workshop

Opening and welcome

The session started with self-introduction of the participants. This was followed by welcome and opening speech by Dr. Choplal Bhusal, Chairperson, NHRC. In his speech he emphasized importance of the evidence based policy and programming as well as need to building capacity in country.

Han Kang, Deputy Director, USAID explained the purpose of the workshop. During his speech he highlighted importance of using evidence.

Technical session

Steve Hodgins, MCHIP did a presentation on 'Why evidence-based Public Health'. In his presentation he highlighted importance of understanding, interpreting, learning and synthesizing the evidence within and beyond immediate program setting in planning and taking decisions and implementing.

Following this, Neal Brandes, USAID Washington made a presentation on," Consideration for Integrating, Evidence into Practice.' During his presentation he highlighted challenges related to setting, intervention, and design of the research as well as interaction pertaining to using evidence into practice.
(See appendices for presentations)

Under 'Critical Review of Nepal's Experience', Dr. Shilu Aryal, FHD - shared 'Nepal's Experience for Prevention of Post-partum Hemorrhage at Homebirth using Misoprostol – Progress towards National Level Expansion from Pilot Study. In her presentation she highlighted how international evidence was brought into Nepal to do a pilot, generated our own evidence and later scaled up.

Dr. Suresh Tiwari, NHSSP shared *Experience of AAMA Program* (AAMA program combines free delivery care with incentive for women). In his presentation he highlighted how evidence was used to design the intervention and continuously modify it so it benefits intended population.

After small group work, Franziska Fuerst, GIZ shared Nepal experience '*Evidence informed Policy for Social Health Protection and Health Financing for Nepal.* In her presentation, she highlighted what we know, where the knowledge gaps are and how to address political and technical dimensions of social health protection which were much more complex that other health interventions.

This was followed by discussion in plenary. Some of the key points came during the discussion were:

- There should be some organization to look into data (such as NHRC) or high level committee which can take decision in policy level
- There should be Research Unit in public sector as there is gap and it should be part of district health system and with research activities supported by budget.

- It important to think about political aspect, and how to go with evidence based policy and programming
- It is important to consider how other sectors gets linkages including other ministries
- Within health sector there is HMIS and how this could be linked. Data system is different for HMIS and LMIS and this should be talking to each other.
- We need to think about use of existing data versus developing new.
- For sharing of research and data, internet/ website would be appropriate way. One example could be "Clearing House" of USAID.
- It would be difficult to manage 'mega data-base' and it should be sensible data
- In the long term database could be integrated.
- Data could be made available for the payment
- Regarding role of the NHRC, the primary role would be regularization (e.g., IRB) and advising to government of Nepal (GoN). There is need to improve capacity NHRC to review research proposal and support research activities.
- In order to have evidence based programming systematically, a mechanism should be there. And should have research in different level (where there is need).

Small Group Work
Strengths, Challenges, Opportunities and Actions

The participants (in small four groups) discussed the strengths, challenges that Nepal faces in area of evidence based policy making and programming and write at least three concrete actions to advance this areas.

All the four groups presented their recommendations for concrete actions and this was followed by brief questions and answers (See Appendix 4 for details)

Prioritization of Actions

Prioritization exercised done with colored voting and key recommendations for actions made were as follows:

- Establish a national health information center (based on HMIS, LMIS and other MIS)
- Research/analytical capacity building of public sector at different level
- National level coordination committee for evidence based decision making
- Develop and strengthen national M&E framework, based on NHSP II Results Framework
- Strengthen capacity of NHRC as a research regulatory body and advisory body to the government
- Develop mechanism for exchange between EDP/MoHP/NHRC/Academia
- Formalize institutionalized linkages between EDP/MoHP/NHRC/Academia

At the end, Deepak Paudel, USAID gave concluding remarks. In his remark, he shared that this is just a start and USAID would like to provide support in this area but this would be a collaborative process involving all the key stakeholders. He also thanked all the organizers, resource persons, presenters and participants.

Appendix 1

Agenda of the workshop

Time	Agenda	Facilitator
9:00 – 9:15	Introductions and Welcome	Dr. Chop Lal Bhusal, NHRC
9:15 – 9:20	Purpose and Objective	Han Kang, USAID Nepal
9:20 – 10:00	Why evidence-based Public Health? 20 minutes presentation	Steve Hodgins, MCHIP
10:00-10:20	Critical Review of Nepal's Experience Part I • Misoprostol for PPH • Aama Program 10 minutes presentations each	Dr. Shilu Aryal, FHD Robin Houston, NFHP II Dr. Suresh Tiwari, NHSSP
10:20 – 10:30	Tea Break	
10:30-10:45	Consideration for Integrating, Evidence into practice? 10 minutes presentation	Neal Brandes, USAID Washington
10:45-11:15	Plenary Discussion How are we doing in Nepal for making use of evidence for better policy and program ?	Dr. Rajendra Bhadra, MCHIP
11:15-12:00	Small Group Work	See Assignment Sheet
12:00-12:45	Small group report-out Each group will have 10 minutes (5 minutes to present their recommendations and 5 minutes for Q and A)	Kathleen Handley, USAID Washington
12:45 – 1:45	Lunch	
1:45 – 2:15	Critical review of Nepal's Experiences Part II Social Health Protection 10 minutes presentation	Franziska Fuerst, GIZ
2:15 – 3:00	Prioritization exercise and discussion	Kathleen Handley, USAID Washington
3:00 – 3:30	Conclusions and Word of Thanks	Deepak Paudel, USAID Nepal

Appendix 2

Participants Name List

S.No.	Name of the Participants	Designation	Organization	Contract no.	Org. Address
GON					
1.	Dr. C.L. Bhusal	Chairperson	NHRC	4254220	Ramshahpath
2.	Dr. Shankar Pratap Singh	Member Secretary	NHRC	9851030517	“
3.	Dr. Krishna Kumar Aryal	Sr. Res. officer	NHRC	4254220	“
4.	Ms. Shushhma Neupane	Research officer	NHRC	9841419790	“
5.	Ms. Namita Ghimire	Research Officer	NHRC	4254220	“
6.	Dr. Shilu Aryal	Consultant & MNH focal person Obs/Gyn.	FHD	9841377610	
7.	Parashuram Shrestha	Section Chief CB-IMCI	CHD	4261463 4261660	Teku
8.	Dilli Raman Adhikari	Sr. Public Health Officer	NCASC	4258219 4262753	“
9.	Dr. Yedu Chandra Ghimire	Sr. IMO	EDCD	4255796 4262268 9741056773	“
10.	Dhruba Raj Ghimire	Statistics Officer	HMIS Section Mgt Division	4262063, 4251242 975116141	“

S.No.	Name of the Participants	Designation	Organization	Contract no.	Org. Address
EDPs					
11.	Neal Brandes	Health Research Advisor/Health. Specialist	USAID/ Washington DC	202-712-4122	
12.	Kathleen Handley	Senior Technical Advisor	USAID/ Washington DC		
13.	Han Kang	Acting Director	USAID Nepal	4007200	Maharajgunj
14.	Dr. Anne McCauley	Sr. Public Health Advisor	USAID Nepal	"	"
15.	Deepak Paudel	Program Specialist	USAID Nepal	"	"
16.	Ms. Marie Ahmed	Health Officer	USAID Nepal	"	"
17.	Shanta Gurung		USAID Nepal	"	"
18.	Maureen Dariag	EHCS Advisor	NHSSP	4262110 9851014681	Teku
19.	Suresh Tiwari	Advisor	NHSSP	9851104178	"
20.	Ghanshyam Gautam,	Prog. Off.	GIZ	4261404	"
21.	Eva Schildbach	Team Leader	GIZ	9851034850	"
22.	Franziska Fuerst	Social Health Protection, TL	GIZ	4261404	"
23.	Bindu Bajracharya	SBA Coordinator	UNICEF	9851114101	UN Building
24.	Dr. Mihal	Medical Off.	WHO	5523200	Pulchowk
25.	Dr. Manav Bhattarai	Health Specialist	World Bank	4226792	Durbar Marg (Yak & Yeti Buld)
26.	Dr. Kusum Thapa	Sr. Consultant Gyn/obs	Maternity Hos.	9841555740	Thapathali
27.	Ashoke Shrestha	Program Director	NFHP	5524313	Patan Dhoka
28.	Robin Houston	Deputy Director	NFHP	"	"

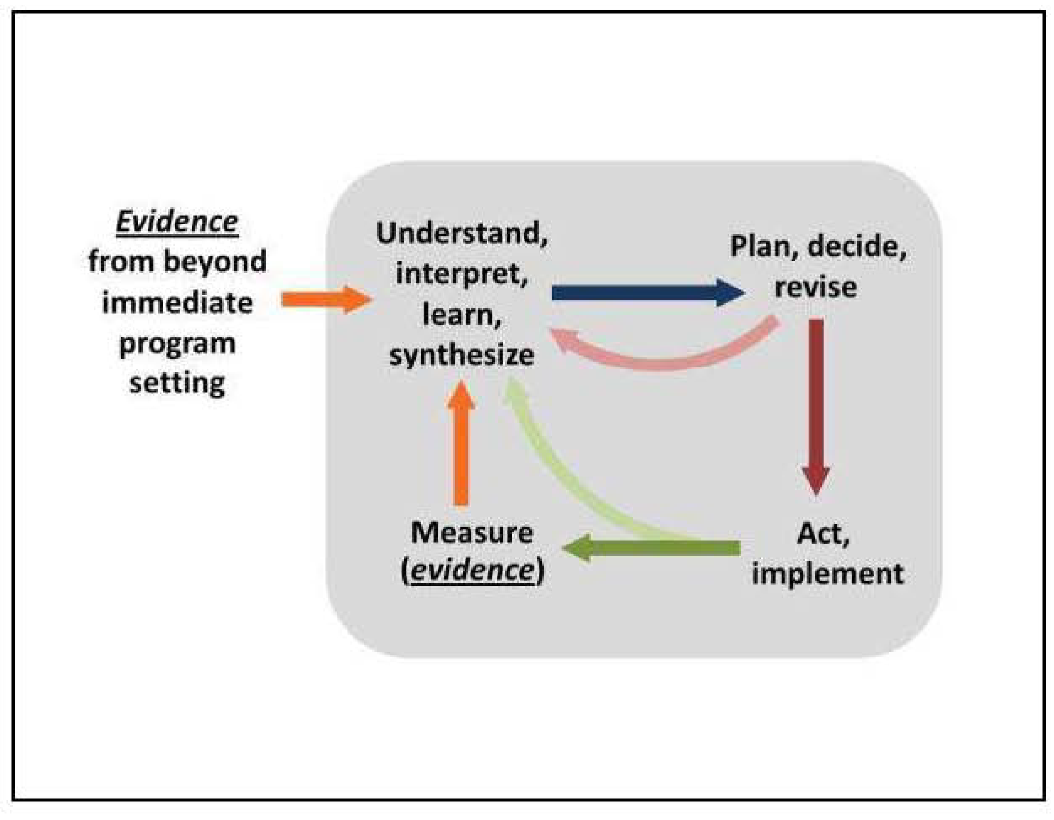
29.	Ram Chandra Silwal	Sr. Program Off.	NFHP	"	"
30.	Sabita Tuladhar	Program Officer	NFHP	"	"
31.	Leela Khanal	Program Officer	NFHP	"	"
32.	Dr. Steve Hodgins	Global Leadership Team Leader	MCHIP		Baltimore
33.	Dr. Rajendra Bhadra		MCHIP	5524313	Patan Dhoka
34.	Stephanie Suhowatsky	Program Manager	MCHIP	5544948	Sanepa
35.	Dr. Neeta Shrestha	Technical Off.	FHI 360	4437173, 4413629 9841202914	Baluwatar Anamika Galli
36.	Dr. Prakash Dev Pant	Advisor	FHI 360	9841525718	'
Academic Institutions					
37.	Ishwar Shrestha	Prof.	TU, IOM	4410911	Maharajgunj
38.	Sujan Marahatta	Asst. Prof.	KUSMS	9851126717	Dhulikhel
39.	Rekha Khatri	Research Associate	Social Science baha	9841467716	Battisputali
Research Organizations					
40.	Jagat Basnet	Deputy Director	New Era	4423176, 4413603	Kalopool
41.	Neera Joshi	Deputy Research Officer	New Era	9841451876	Kalopool
42.	Dr. Mahesh Puri	Associate Director	CREHPA	5521717, 5546487	Kusunti

S.No.	Name of the Participants	Designation	Organization	Contract no.	Org. Address
Professional Organizations					
43.	Salau Din Myia	Secretary	Nepal Public Health Association	4248513 9851012661	Teku
44.	Roshanee Shrestha	Sister	Nepal Nursing Association	4421738	Lazimpat
45.	Dr. Ashma Rana	President	NESOG	4252315	Thapathali
46.	Dr. YB Karki	Director	PHD Group	9851071942	Bagbazar
47.	Dr. Gajananda P. Bhandari	Director	Nepal Public Health Foundation	4412787, 4410826 9849077000	Maharajgunj Dhara Marg
48.	Dr Sharad Sharma	M&E Associate	IPAS	4215265	FHD Building Teku
49.	Jona Bhattarai	Program Assistant	MCHIP	5524313	Patan Dhoka

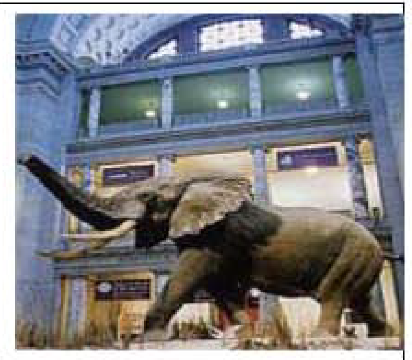
Appendix 3

Copies Presentation

Presentation 1 :Why Evidence Based Public Health by Steve Hodgins, MCHIP



Presentation 2: Consideration for Integrating , Evidence into Practice by Neal Brandes, USAID/ Washington DC



Now is the time to make it happen where it matters, by turning scientific knowledge into effective action for people's health

J.W. Lee, former WHO Director General

Public health is the convergence of science and politics

Coleen Kivilihan, former Missouri Public Health Director

What limits the health systems from consistently delivering solutions at scale?

USAID

Translation Challenges (adapted from Glasgow and Emmons, Annual Review Pub Hlth, 2007)

SETTING
- COMPETING DEMANDS
- EXTERNALLY IMPOSED
- FINANCIAL/ORGANIZATIONAL INSTABILITY
- SPECIFIC NEEDS OF CLIENTS AND SETTING
- LIMITED RESOURCES
- LIMITED TIME
- LIMITED ORGANIZATIONAL SUPPORT
- PREVAILING PRACTICES WORK AGAINST INNOVATION
- PERVERSE INCENTIVES OR REGULATIONS
- IMPLEMENTING WITH QUALITY

INTERVENTION CHARACTERISTICS
- COST
- INTENSIVE TIME DEMANDS
- LEVEL OF REQ'D STAFF EXPERTISE
- DIFFICULT TO LEARN OR UNDERSTAND
- NOT PACKAGED OR MANUALIZED OR MODULARIZED
- NOT DEVELOPED FOR USER NEEDS
- NOT SUSTAINABLE
- HIGHLY SPECIFIC TO PARTICULAR SETTING

RESEARCH DESIGN
- NOT REPRESENTATIVE
- FAILURE TO EVALUATE:
  - COST
  - REACH
  - SETTING
  - ADOPTION
  - IMPLEMENTATION
  - MAINTENANCE
  - SUSTAINABILITY

INTERACTION
- PARTICIPATION BARRIERS LEAD TO LOW REACH
- INTERVENTIONS ARE NOT FLEXIBLE
- INTERVENTION IS NOT APPROPRIATE FOR SETTING
- STAFFING PATTERN DOES NOT MATCH INTERVENTION NEEDS
- ORGANIZATION AND INTERVENTION PHILOSOPHIES NOT ALIGNED
- ORGANIZATION IS UNABLE TO IMPLEMENT INTERVENTION ADEQUATELY

Leading Factors of Successful Intervention Implementation

Strategy	RCT OR	Adequacy studies OR
• Community coordination and organization	-	4.6
• Local adaptation of the intervention	9.3	4.3
• Broad-based support of various stakeholders	-	3.9
• Consultation and engagement of powerful interest groups	2.8	3.8
• Flexibility and modification through stakeholder feedback	-	3.4
• Representation from powerful interest groups	2.4	3.0
• Constraints reduction plans	6.7	2.7

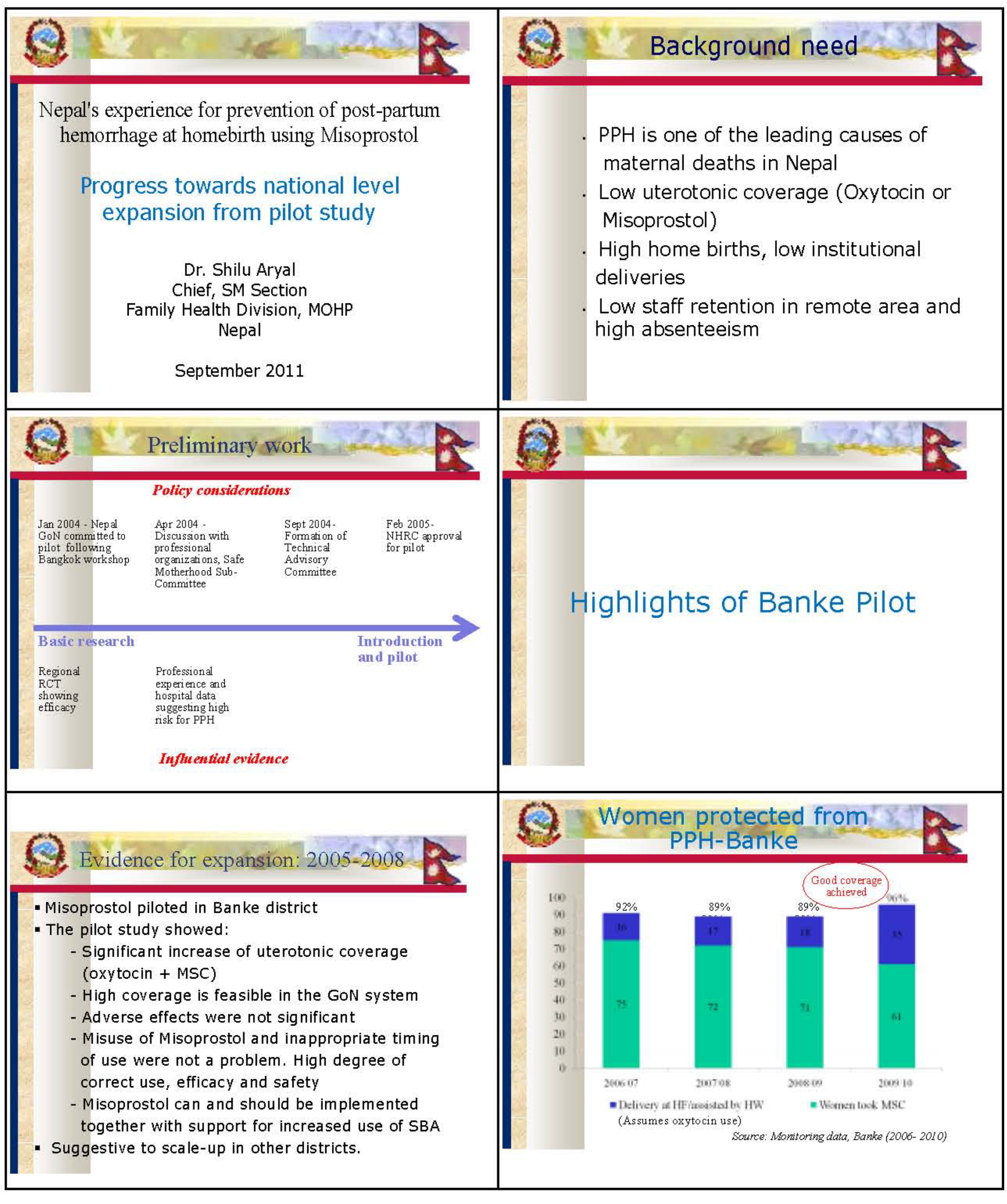
Selected Challenges and Differences between Researchers, Program Managers, and Policy Makers

- Language
- Framing questions of interest
- Timeframes for evidence generation and use
- Risks and incentives

Selected Country Examples to support for Policy and Programs

- Ghana
  - policy research unit in Ministry of Health
  - Ministry commissions on an as needed basis of independent, but trusted contract and university researchers
- Mexico
  - Ministry commissioned external independent evaluation of Progessa- Social Protection program
- Vietnam
  - Semi-autonomous policy research unit
- South Africa- University of Capetown- Health Econ Unit
  - Independent training and research group
  - Valued by government for equity analysis
- Thailand
  - long history and training
  - Large number of government and NGO organizations engaged

Presentation 2: Nepal's Experiecne for Prevention of Post-partum Hemorrhage using Misoprostol; Progress towards National level from Pilot Study by Dr. Shilu Aryal, FHD



Reported adverse effects
Some increase in shivering
Percent
Dizzy
Shivering
Nausea
Fever
Loose motion
Headache
Used MSC
Not used MSC
Source: NFHP follow-up survey, 2007
Timing of MSC Use
Used appropriately
(Data source: NFHP follow-up survey, 2007)
The Use of Skilled Birth Attendant
Associated with increased SBA use
Baseline survey (2005)
1st Follow-up survey (2007)
2nd Follow-up survey (2011)
(data source: Field surveys)
Expansion from pilot: Progress after Bangkok conference 2007 and 2010
Achievements: Misoprostol expansion (2008- 2010)
- Misoprostol TAG reformed
- Misoprostol included in national essential drug list (for prevention of PPH)
- Misoprostol intervention expanded to remote districts
List of districts with Misoprostol
CHINA
INDIA
Progression to scale
Policy considerations
Mar 2010- Nepal country team committed for national level expansion of MSC (Reconvening BKK conference)
April/May 2010- Sharing and advocacy at the national level
June 2010- MOHP approved for national level expansion
July 2010- Developed implementation guidelines
Pilot
National scale
Regional RCT used for advocacy
Pilot results used to demonstrate feasibility
Influential evidence
Current GON Strategy for Preventing PPH
Prevention of PPH
Active Management of Third Stage of Labour (AMTSL)
Use of Misoprostol at home birth
Use of uterotonic drugs: Inj. Oxytocin within a minute after delivery of baby
Controlled cord traction
Uterine massage
Use of uterotonic drug: Tab Misoprostol (600 mcg) after delivery of a baby
Only trained health workers can do AMTSL
Feasible in community settings
Challenges/problems
• Distribution of Misoprostol, ensuring availability, and transportation up to remote areas
• Collection of reports from grassroots level
• Ensuring the quality of training according to the guidelines
• Ensuring the use of Misoprostol only in PPH

Keys for successes

- Coordinated effort and strong commitment of GoN, professional organizations and external development partners
- Safe Motherhood program is a priority program. Policy/ approval for national scale-up of Misoprostol was obtained in a short period of time.
- The GoN has approved expansion of Misoprostol for prevention of PPH at homebirth with focus on promotion of institutional deliveries.

The way forward

- GoN funding for procurement and distribution of Misoprostol in all districts through its logistic system from this FY (2011/12).
- Continuous expansion of Misoprostol with technical assistance from the partners.
- GoN funding for implementing Misoprostol in remote districts from this FY (2011/12) where there is limited support from EDP's.

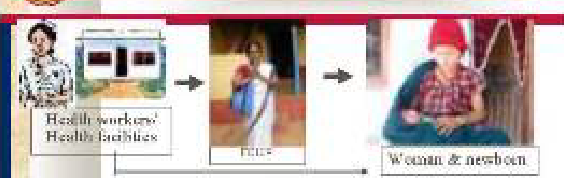
THANK YOU

Extra slides

Highlights of MSC implementation guideline

- Distribution only by FCHVs with counseling
- Use only for PPH prevention as (Matri Suraksha Chakki (MSC)
- Strengthened referral system and network
- Defined role of stakeholders
- Implement together with BPP review
- Partners work closely with FHD
- Training/orientation to HWs and FCHVs
- Recording/Reporting in line with HMIS
- Partners funding this year and expansion in next year with GON funding

Community service delivery system



- FCHVs and HWs work closely for promotion of ANC, Institutional delivery and PNC. They have key role in:
  - Promotion of ANC, institutional delivery and PNC, self-care, hygiene, essential Newborn Care
  - Use of iron/folic, deworming tablets, TT, post-natal Vitamin A
  - Birth preparedness (money, transport, SBA and blood)
  - Identification of danger signs (pregnancy, delivery and post-natal) and referral
- At 8th month, FCHVs distributes Misoprostol. During PNC home visits confirms use and retrieves if unused

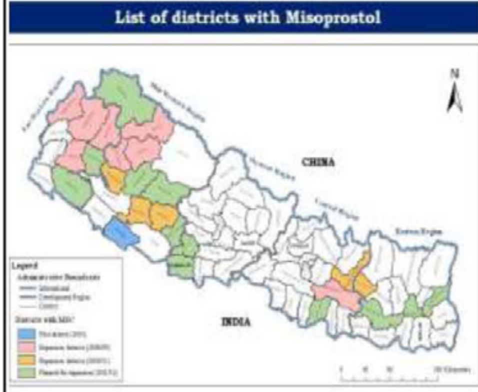
Implementing Partners

- Government of Nepal (FHD -program lead)
- Partners
  - USAID/NFHP II and its partners
  - UNICEF
  - CARE Nepal
  - Rural Health Development Program (RHDP)/SDC
  - Health Right International, Nepal Society of Obstetricians and Gynaecologists (NESOG), One-heart worldwide (planning to support in expansion)

Preliminary work

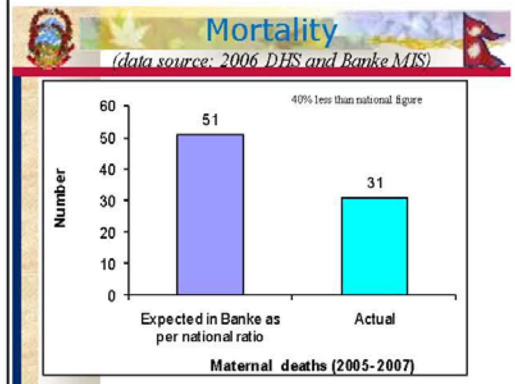
- Jan 2004 - Nepal GoN committed to pilot Misoprostol following PPH prevention workshop, Bangkok
- Apr 2004 - Discussion among stakeholders, professional organizations, Safe Motherhood Sub-Committee
- Sept 2004- Formation of Technical Advisory Committee (MoHP, FHD/DoHS, DDA, NHRC; Professional organization- NESOG; partners: USAID/NFHP, SSMP, UNICEF)
- Feb 2005- NHRC approval for pilot with DDA recommendation to use Misoprostol by FCHVs

List of districts with Misoprostol



Mortality

(data source: 2006 DHS and Banke MIS)



Achievements: National level expansion of Misoprostol

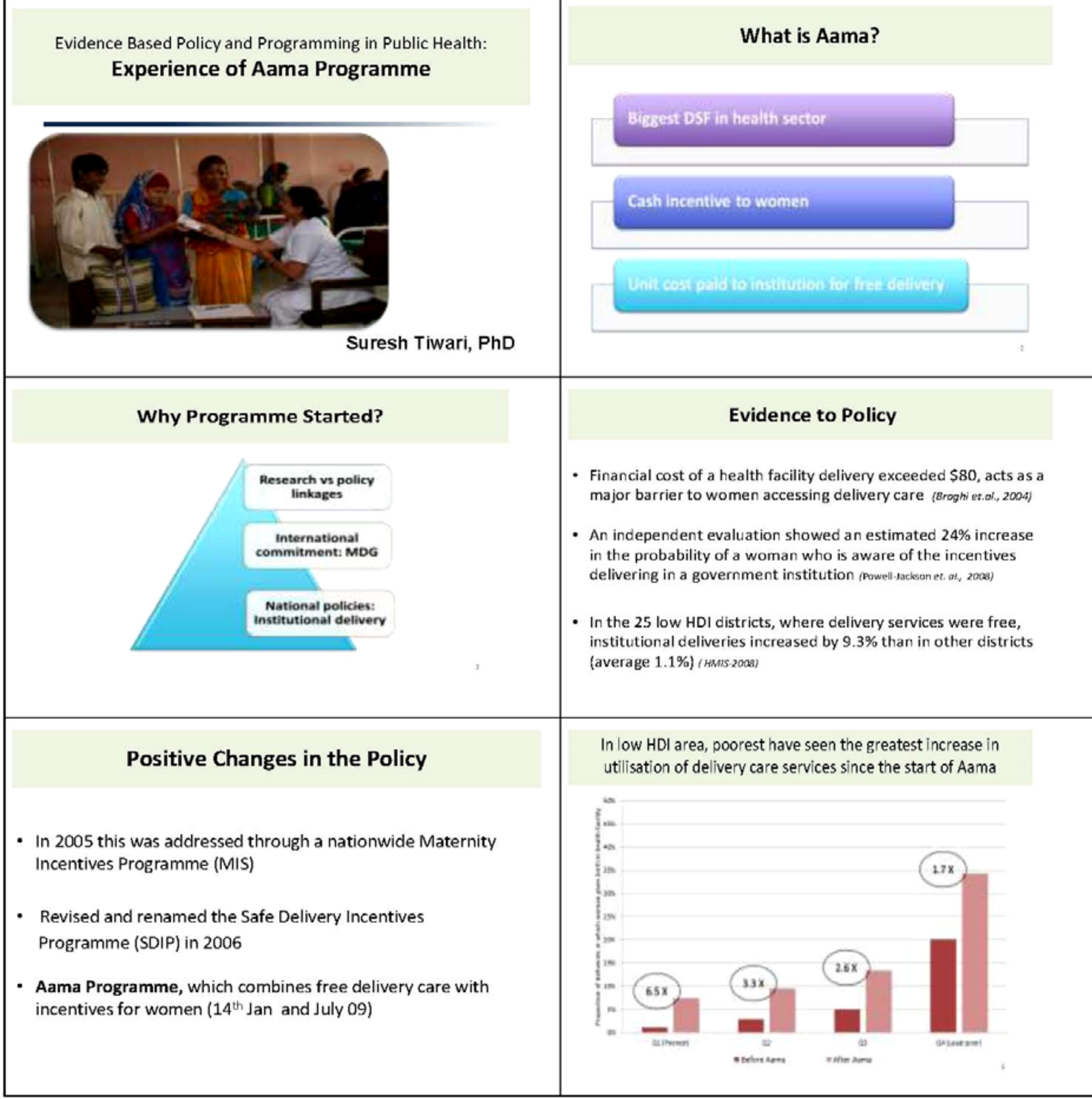
Mar 2010-
Nepal country team committed for national level expansion of MSC (Reconvening BKK conference)

April- May 2010-
Sharing/advocacy at the national level

June 2010-
MOHP approved for national level expansion

July 2010:
Developed implementation guidelines (next slide)

Presentation 3: Experience of AAMA Program
by Dr. Suresh Tiwari, NHSSP 2



Policy Actors

- MoHP (Minister and Secretary)
- Parliamentarian
- Director and team of FHD
- EDPs
- Technical support agencies and research groups/individuals

Policy Areas

- Sustainability
- Funding availability
- Expansion of services
- Ensuring the quality of care
- Linking the similar type of DSF schemes
- Addressing the issues related to transparency

Research Areas

- Impact in reducing maternal death
- Impact on household economy
- Quality of care
- Cost effectiveness
- Best use of fund
- Equity in utilization

Lessons Learned

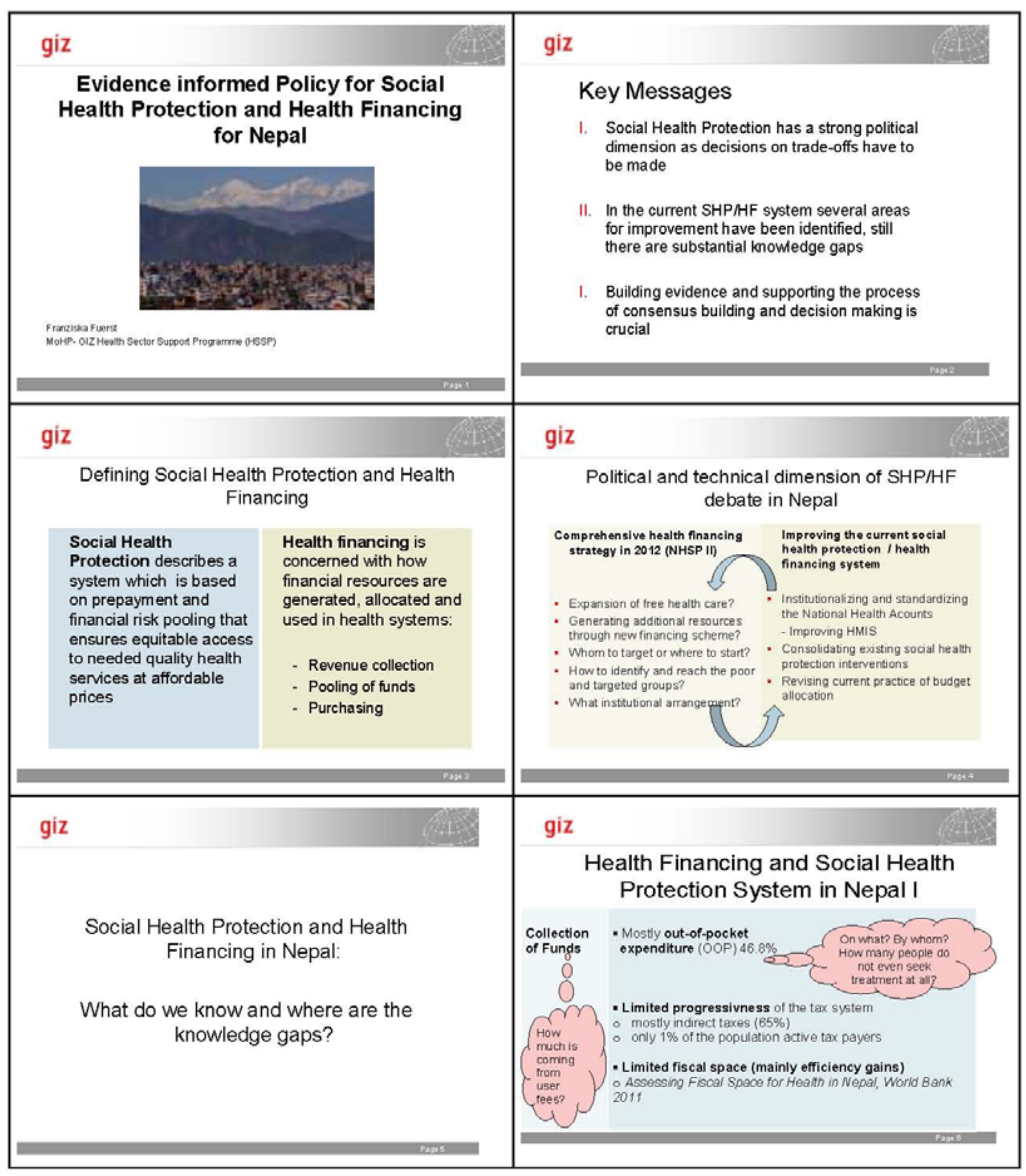
- Common understanding to use the evidence
- Positive attitude towards policy amendment
- Better understanding between GoN and EDPs
- High level of ownership by GoN
- Included Aama related questions in routine monitoring

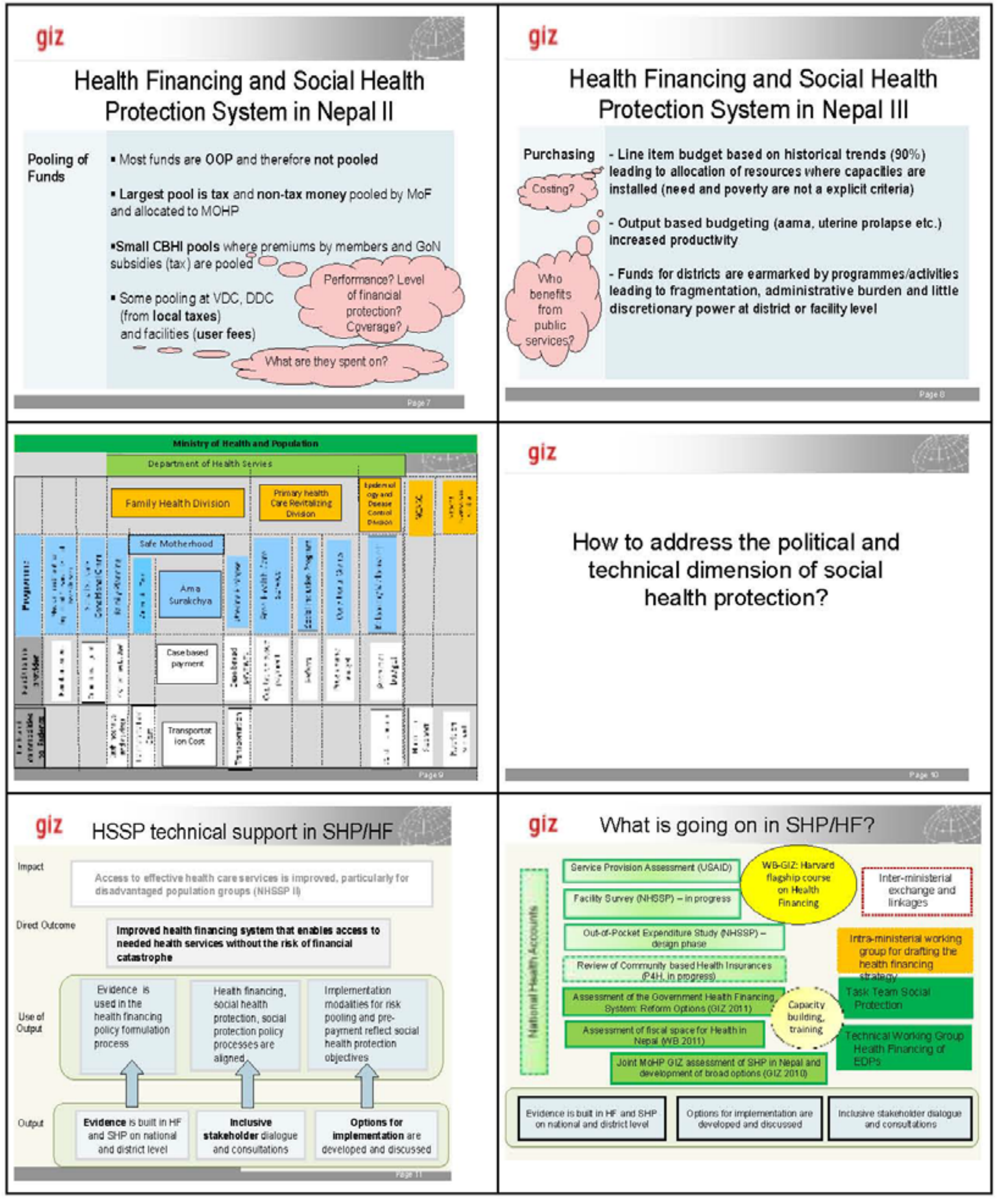
How Research Progressed?

- Linked the Aama related questions to research activities i.e. NDHS
- Integrated facility based surveys
- Integrated household surveys
- Diagnostic approaches (rapid assessment, cross verifications)

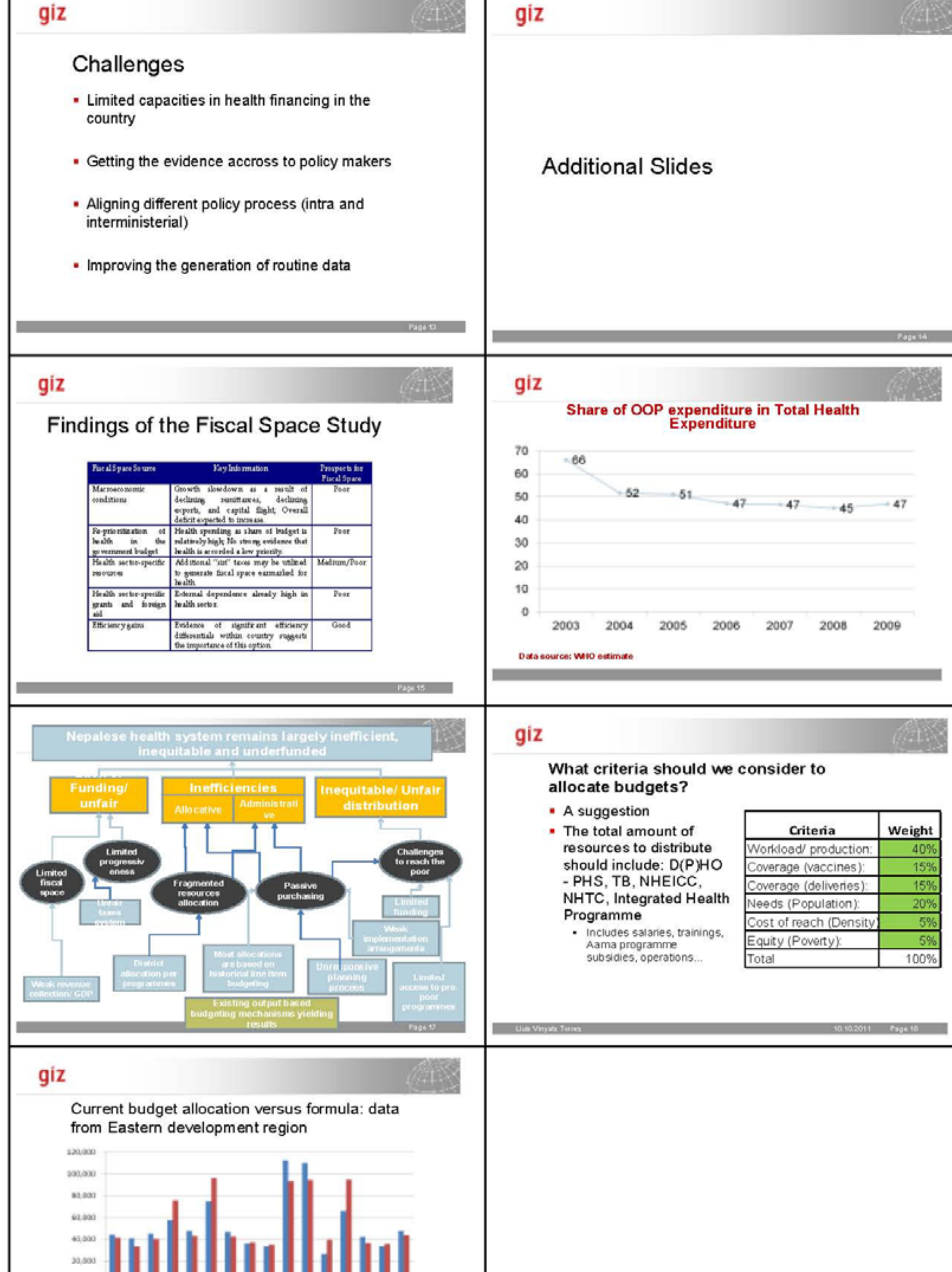
Thank You

Presentation 5: Evidence informed Policy for Social Health Protection and Health Financing for Nepal by Franziska Fuerst, GIZ





giz
Health Financing and Social Health Protection System in Nepal II
Pooling of Funds
▪ Most funds are OOP and therefore not pooled
▪ Largest pool is tax and non-tax money pooled by MoF and allocated to MOHP
▪Small CBHI pools where premiums by members and GoN subsidies (tax) are pooled
▪ Some pooling at VDC, DDC (from local taxes) and facilities (user fees)
Performance? Level of financial protection? Coverage?
What are they spent on?
Page 7
giz
Health Financing and Social Health Protection System in Nepal III
Purchasing
Costing?
Who benefits from public services?
- Line item budget based on historical trends (90%) leading to allocation of resources where capacities are installed (need and poverty are not a explicit criteria)
- Output based budgeting (aama, uterine prolapse etc.) increased productivity
- Funds for districts are earmarked by programmes/activities leading to fragmentation, administrative burden and little discretionary power at district or facility level
Page 8
Ministry of Health and Population
Department of Health Servies
Family Health Division
Primary health Care Revitalizing Division
Safe Motherhood
Programme
Ama Surakchya
Case based payment
Transportation Cost
Page 9
giz
How to address the political and technical dimension of social health protection?
Page 10
giz
HSSP technical support in SHP/HF
Impact
Access to effective health care services is improved, particularly for disadvantaged population groups (NHSSP II)
Direct Outcome
Improved health financing system that enables access to needed health services without the risk of financial catastrophe
Use of Output
Evidence is used in the health financing policy formulation process
Health financing, social health protection, social protection policy processes are aligned
Implementation modalities for risk pooling and pre-payment reflect social health protection objectives
Output
Evidence is built in HF and SHP on national and district level
Inclusive stakeholder dialogue and consultations
Options for implementation are developed and discussed
Page 11
giz
What is going on in SHP/HF?
National Health Accounts
Service Provision Assessment (USAID)
Facility Survey (NHSSP) – in progress
Out-of-Pocket Expenditure Study (NHSSP) – design phase
Review of Community based Health Insurances (P4H, in progress)
Assessment of the Government Health Financing System: Reform Options (GIZ 2011)
Assessment of fiscal space for Health in Nepal (WB 2011)
Joint MoHP GIZ assessment of SHP in Nepal and development of broad options (GIZ 2010)
WB-GIZ: Harvard flagship course on Health Financing
Capacity building, training
Inter-ministerial exchange and linkages
Intra-ministerial working group for drafting the health financing strategy
Task Team Social Protection
Technical Working Group Health Financing of EDPs
Evidence is built in HF and SHP on national and district level
Options for implementation are developed and discussed
Inclusive stakeholder dialogue and consultations



Fiscal Space Source	Key Information	Prospects for Fiscal Space
Macroeconomic conditions	Growth slowdown as a result of declining remittances, declining exports, and capital flight; Overall deficit expected to increase.	Poor
Re-prioritization of health in the government budget	Health spending as share of budget is relatively high; No strong evidence that health is accorded a low priority.	Poor
Health sector-specific resources	Additional "sin" taxes may be utilized to generate fiscal space earmarked for health.	Medium/Poor
Health sector-specific grants and foreign aid	External dependence already high in health sector.	Poor
Efficiency gains	Evidence of significant efficiency differentials within country suggests the importance of this option.	Good

Criteria	Weight
Workload/ production:	40%
Coverage (vaccines):	15%
Coverage (deliveries):	15%
Needs (Population):	20%
Cost of reach (Density)	5%
Equity (Poverty):	5%
Total	100%

Appendix 4

Key points of small group work presentation

Discussion points for groups:

- The strengths and challenges that Nepal faces in this area.
- The opportunities for action
- What would be three or more concrete activities or actions to advance this area?
- What is required to support these actions?

Group	Strengths	Challenges	Recommendation/ Opportunities	Actions	Required Support
Group 1	• Generating data source – HMIS/DHS/NCSS/ CENSUS • Increasing interest for using data by - Policy makers - Programmers • Addressing more issues – looking at quality, scope of research, context – specific design • Increase participation of various research stakeholders	• Design research that can address GESI • Limited disaggregation of data • Information gap in revaluing health issues – e.g. HIV/MANP • Provision of user friendly data format - quality (distorted) - system (single institute) • Inter-institutional linkages	• Building a nationally acceptable institutional home for data mix • Demand for evidence creation • Increasing tendency to accept – “translating evidence into practice” • Interests from donors • Availability of HSISS/ NHSP II results framework	• Develop national M&E framework – MOHP/ EDP	
Group 2	• Openness of policy makers to take research findings into action (Readiness to accept) • NHRC is controlling (regulatory body)	• Frequent changes in leadership as well as implementers • Limited capacity in identification of research agendas within government	• Strengthen NHRC as a capacity as regulatory and advisory body. • Strengthen government capacity to identify research agenda	• NHRC: Strengthen the capacity of NHRC as regulatory + advisory body	

Group	Strengths	Challenges	Recommendation/ Opportunities	Actions	Required Support
	research work country wide • Supporting partners • Research activities in program • Research institutions like academia, other research agencies	system. • Limited capacity of NHRC –slightly long process of approval, inadequate supervision and advices • Lack of strong link between Academic institutions, research findings and government policy formulation. • Lack of clear recommendation on policy implication from research findings • Weak ownership and participation of public sector in research. • Low focus in health system research in academic institutions	• Linking NHRC and government for utilization of research findings and long term sustainability of management of research activities and its utilization.		
Group 3	• There are many research organizations which are capable of doing surveys and quality researches • Progressive Government • Stability and structure of the HMIS framework • Autonomous NHRC	• Co-ordination between government, academia and EDPs, not optimal • Delays in approval • Capacity limitation in government for research • Gaps in data quality	• Improve active participation from all collaborative organizations to discuss the new evidence • Improved formal between government agencies, EPDs academia and research	• Formalize association/ linkage between MOHP and MPH/ PHD students • • Include exchange between MIHP, EDPs, civil society and research	• Institutionalization of the mechanism to link between the government and agencies

Group	Strengths	Challenges	Recommendation/ Opportunities	Actions	Required Support
			organizations • *Strengthen the capacity of NHRC and government*	institutions on new evidence during existing coordination mechanism e.g., jar	
Group 4	• Enabling environment for conducting research - Political commitment - Community acceptability • NHRC - coordinates research - standard guidelines - identified research priorities • HMIS – - well defined from grassroots to center • Research as priority in national policies (e.g., NHSP IP-2)	• Insufficient HR/ research capability in public sector • Relay on some researcher's vague recommendations • Very less RCT done + OR • Effectiveness of intervention: gap in HMIS/ survey findings • HMIS – Under utilized (data) • Lack of co-operation between academia and program sectors • Consumer's participation in research – low • Need-based research Vs Research – based program ??		• Establish a national health information - Mechanism to have reports from different institutions - Comprehensive database - (NHRC as a bridge) • Research capacity development in public sector (district, RD and centre) • National level co-ordination committee/ forum for evidence-based decision making	• Government/ NHRC provide opportunity to capacitate district/ RD/ Central professionals with - activities - budget - capacity building - research unit

Voting rates on main actions	**Green (1)**	**Pink (2)**	**Black (3)**	***Remarks***
1. Develop national M&E framework – MOHP/ EDP	1	6	3	Group – 1
2. Establish a national health information - Mechanism to have reports from different institutions - Comprehensive database - (NHRC as a bridge)	4	4	4	Group - 4
3. Research capacity development in public sector (district, RD and centre)	4	2	1	
4. National level co-ordination committee/ forum for evidence-based decision making	2	6	4	
5. NHRC: Strengthen the capacity of NHRC as regulatory + advisory body	8	1	5	Group 2
6. Include exchange between MIHP, EDPs, civil society and research institutions on new evidence during existing coordination mechanism e.g., jar			3	Group 3
7. Formalize association/ linkage between MOHP and MPH/ PHD students	2	2	1	Group 3

Glimpses of Workshop Activities

Group Discussion

Dr. Steve Hodgins Presents- Evidence based Public Health

Kathleen Handley facilitate the group

USAID representatives observing the presentation

Chairperson of NHRC participate on discussion

Group Discussion