NHSSP Nepal Health Sector Support Programme

Nepal Health Sector Support Programme

Quarterly Report

Reporting Period: October – December 2012

Contents

Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
AWPB	Annual Work Plan and Budget
BCC	Behaviour Change Communication
BEONC	Basic Essential Obstetric and Neonatal Care
BTS	Blood Transfusion Services
CAPP	Consolidated Annual Procurement Plan
CB-IMCI	Community-based Integrated Management of Childhood Illness
CHD	Child Health Division
COPP	Certificate of Pharmaceutical Production
D(P)HO	District Public Health Office(r)
DFID	UK Department for International Development
DG	Director-General
DHO	District Health Office(r)
DoHS	Department of Health Services
DSF	Demand-side Financing
DUDBC	Department of Urban Development and Building Construction
EAP	Equity and Access Programme
EDP	External Development Partner
EHCS	Essential Health Care Services
EOC	Emergency Obstetric Care
FCHV	Female Community Health Volunteer
FHD	Family Health Division
FMIP	Financial Management Improvement Plan

FY	Fiscal Year
GAAP	Governance and Accountability Action Plan
GBV	Gender-based Violence
GESI	Gender Equality and Social Inclusion
GiZ	Deutsche Gesellschaft für Internationale Zusammenarbeit
GMP	Good Manufacturing Practice
GoN	Government of Nepal
HF	Health Financing
HIIS	Health Infrastructure Information System
HIV	Human Immunodeficiency Virus
HKI	Helen Keller International
HMIS	Health Management Information System
HPP	Health Policy and Planning
HR	Human Resources
HRH	Human Resources for Health
HSIS	Health Sector Information System
ICB	International Competitive Bidding
IEC	Information, Education, and Communication
IMCI	Integrated Management of Childhood Illness
Ipas	International Pregnancy Advisory Services
JAR	Joint Annual Review
KIG	Key Informant Group
LATH	Liverpool Associates in Tropical Health
LHGSP	Local Health Governance Strengthening Programme
LMD	Logistics Management Division
M&E	Monitoring and Evaluation
MD	Management Division
MDG	Millennium Development Goal
MIS	Management Information System

MNCH	Maternal, Neonatal, and Child Health
MNH	Maternal and Newborn Health
MoGA	Ministry of General Administration
MoHP	Ministry of Health and Population
MPDR	Maternal and Perinatal Death Review
NCP	Newborn Care Programme
NGO	Non-governmental Organisation
NHEICC	National Health Education, Information, and Communication Centre
NHSP-2	Second Nepal Health Sector Programme
NHSSP	Nepal Health Sector Support Programme
NHTC	National Health Training Centre
NPHL	National Public Health Laboratory
NRCS	Nepal Red Cross Society
NUTEC	Nutrition Technical Advisory Committee
OCMC	One-stop Crisis Management Centre
OPM	Oxford Policy Management
OT	Operating Theatre
PEER	Peer Ethnographic Evaluation and Research
PFM	Public Financial Management
PHAMED	Public Health Administration and Monitoring and Evaluation Division
PHCRD	Primary Health Care Revitalisation Division
PMIS	Population Management Information System
PP	Procurement Plan
PPICD	Policy, Planning, and International Cooperation Division
RA	Rapid Assessment
RHCT	Regional Health Coordination Team
RHD	Regional Health Directorate
SBA	Skilled Birth Attendant
SC	Steering Committee

SNP	State Non-state Partnership
SPA	Senior Procurement Advisor
SSU	Social Service Unit
STS	Service Tracking Survey
SWAp	Sector-wide Approach
TA	Technical Assistance
TABUCS	Transaction Accounting and Budget Control System
TAG	Technical Advisory Group
TB	Tuberculosis
TC	Technical Committee
TOR	Terms of Reference
TWG	Technical Working Group
UNICEF	United Nations Children's Fund
VDC	Village Development Committee
VfM	Value for Money
WB	World Bank
WFP	World Food Programme
WHO	World Health Organization
WRHD	Western Regional Health Directorate

1. Introduction

The Nepal Health Sector Support Programme (NHSSP) is pleased to submit this quarterly report for the period of October to December 2012, the seventh quarter of this programme.

NHSSP is a programme of Technical Assistance (TA) to the Ministry of Health and Population/Department of Health Services (MoHP/DoHS), managed by the UK Department for International Development (DFID) on behalf of the pool partners in the Second Nepal Health Sector Programme (NHSP-2). Options leads a consortium of its partners: Crown Agents, Liverpool Associates in Tropical Health (LATH), Oxford Policy Management (OPM), Helen Keller International (HKI), and Ipas. The inception period for NHSSP was between September and December 2010. During that time, the consortium carried out a series of capacity assessments covering each output of NHSSP described from Section 2 onwards. The capacity assessment reports, which included proposals for the focus of TA, were approved by government in December 2010.

The purpose of this report is to document the activities and results delivered by NHSSP between October and December 2012. The work of NHSSP Advisors is based on: the requirements of NHSP-2; the ongoing activities and plans of the Divisions and Centres; the capacity assessment reports prepared by NHSSP in December 2010 outlining their strengths and needs; and the work plans of the Advisors. All work plans have been agreed with the Advisors' counterparts. The counterparts of NHSSP Advisors are the heads or directors of Divisions and Centres, such as the Family Health Division (FHD), Policy, Planning, and International Cooperation Division (PPICD), Logistics Management Division (LMD), and so on. All NHSSP activities are designed to enhance the capacity of MoHP/DoHS to carry out NHSP-2. Enhancing capacity, for our purposes, is defined as: *the changes in organisational behaviour, skills, and relationships that lead to the improved abilities of organisations and groups to carry out functions and achieve desired outcomes.*

2. Summary of Progress

Overall Context:

On November 21, 2012, the Government of Nepal (GoN) presented a two-thirds budget for the current Fiscal Year (FY), after the President had endorsed this through an ordinance. This budget is equivalent to the actual expenditure of the last FY.

Political differences about the way forward have continued. As of January 14, 2013, the political parties had missed for the ninth time the deadline set by the President to forge consensus and form a new government.

Summary of Key Events in this Quarter

In **Essential Health Care Services (EHCS)**, the final draft of a strategy to address maternal under-nutrition in Nepal was produced with the support of HKI and the World Food Programme (WFP). This strategy provides guidance for a focus on maternal nutrition both within and outside MoHP. A study of the issues around the high demand for delivery care in higher-level hospitals resulted in a review of options for improvement of delivery care in such hospitals and in birthing centres, which will feed into work plans and budgets for the next FY.

In **Gender Equality and Social Inclusion (GESI),** Social Service Unit (SSU) Guidelines were finalised, and a road map for establishing and strengthening SSUs developed. The guidelines will be piloted in eight hospitals. Social Audit Guidelines were finalised, using experience from different pilots by MoHP, Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ), and NHSSP. Institutional Structure Guidelines specifying the location of GESI responsibility within the health system have been approved, and will be followed by GESI Operational Guidelines for service providers. Five curricula of the National Health Training Centre (NHTC) were reviewed from a GESI perspective.

In **Health Policy and Planning (HPP)/Health Systems Governance**, a policy on State Non-state Partnership (SNP) has been endorsed. A draft of the District Planning Guidelines has been finalised, to be endorsed by the Steering Committee (SC). The Governance and Accountability Action Plan (GAAP) has been revised to make monitoring more feasible and is awaiting the agreement of MoHP and External Development Partners (EDPs).

Human Resources for Health (HRH) saw the approval of the HRH Strategic Plan by the Cabinet in December. A plan for its dissemination has been prepared. Data are being collected on the number and characteristics of Human Resources (HR) in the public and private sectors, which will feed into workforce

planning for the health sector. The key recommendation of the institutional assessment of the NHTC was agreed, that NHTC should be a training management body.

In **Health Financing (HF)**, MoHP endorsed the Financial Management Improvement Plan (FMIP), which will help to improve financial reporting and auditing processes. The system specifications of the Transaction Accounting and Budget Control System (TABUCS) were finalised and eleven cost centres selected for piloting of the software. A process for institutionalising the Rapid Assessment (RA) of Demand-side Financing (DSF) programmes within FHD has been taken forward.

In **Procurement**, over 400 technical specifications for hospital furniture, instruments, equipment, and drugs have been developed and uploaded to LMD's website. A market survey of 44 drugs was completed. World Bank (WB) approval of the Consolidated Annual Procurement Plan (completed in August) was received. Multi-year contracting, the requirement for Good Manufacturing Practice (GMP) product certification, and other improvements to procurement processes have been established.

In **Infrastructure**, a Value for Money (VfM) study of e-bidding for construction showed that e-bidding reduced the costs of construction and made the tendering process more efficient and transparent. A study of the new standard integrated designs for health facilities showed that their use resulted in significant cost savings and improved service provision. The Health Infrastructure Information System (HIIS) has been updated, and will be made web-based, allowing monitoring of construction and financial progress.

In **Monitoring and Evaluation (M&E)**, the NHSP-2 Logical Framework Progress Report for 2012 was completed. The Maternal and Perinatal Death Review (MPDR) tools and review process have been revised in collaboration with the World Health Organization (WHO), and the tools, indicators, and reporting process for the Health Management Information System (HMIS) were substantially revised, in preparation for field testing and roll-out in FY 2013/14. Work to standardise district population profiles is underway.

Eight publications were produced in this quarter and uploaded to the NHSSP website (See Annex 1).

3. Detailed Thematic Updates

Output 1: DoHS/Regions have capacity to deliver quality and integrated EHCS, especially to women, the poor, and underserved.

3.1.1 EHCS

A concept paper and Terms of Reference (TOR) for a **situational analysis of Maternal, Neonatal, and Child Health (MNCH) services in remote areas** were developed in partnership with government counterparts. NHSSP will conduct the analysis in partnership with the WB, which is co-funding this study. The study will be used to identify strategies and approaches for improving access to MNCH services in these remote locations of Nepal. In the coming months, the following steps will be taken:

- The concept paper will be developed into a detailed methodology and will be forwarded to the Research Committee under the chair of the Director-General (DG) for approval.
- A Key Informant Group (KIG) will be formed with government and partners who are working in MNCH and have interests in remote areas, in order to guide the study team.
- The KIG will select the study districts based on the initial statistical analysis and literature review.

The Nutrition Section of the Child Health Division (CHD) has completed the final draft of a **Health Sector Strategy for Addressing Maternal Under-nutrition** in Nepal, with the support of HKI/NHSSP and WFP. The strategy will be used to guide the MoHP and its Departments and Divisions collectively to address maternal under-nutrition, and will also be used to advocate for the need to focus on maternal nutrition within and outside the MoHP. The strategy has been circulated to the DG and FHD Directors for their review, and a meeting is planned with the Nutrition Technical Advisory Committee (NUTEC) to approve and further submit to MoHP for endorsement in early 2013.

The **Integrated Management of Childhood Illness** (IMCI) Section of CHD completed a costed Community-based (CB) IMCI and Newborn Care Programme (NCP) multi-year work plan for 2012/13-2016/17, with support from NHSSP, the United Nations Children's Fund (UNICEF), and a range of IMCI/NCP stakeholders. The planning process for developing the costed plans has allowed the IMCI Section of CHD to prioritise work areas for improving child and newborn health. The plan will be used to advocate for support to child and newborn health at various levels by partners, and will be a guide for the IMCI Section for preparation of the annual work plan. Over the coming months, the CHD will organise a meeting with concerned DoHS Divisions and partners to request their financial support for

implementation of the work plan, which will then be forwarded for MoHP endorsement. The CHD will also print and disseminate the plan among stakeholders.

The process of developing the costed CB-IMCI and newborn care work plan has been frustrated by a high turnover in government staff. There have been three CHD Directors, and the IMCI Section Chief post has been vacant for several months. This has made finalising the plan difficult, and completing the draft took more than a year. The draft has still not been forwarded for further approval, as the IMCI Section Chief is yet to be appointed. The delay in completion of the CB-NCP pilot evaluation has also resulted in a delay in finalising the plan. A change in implementation model, which is expected after the recommendations from this evaluation, will have an impact on the cost of the multi-year plan.

3.1.2 Maternal and Newborn Health (MNH)

An NHSSP study team supported the FHD to identify options for responding to the **increased demands made on delivery services in higher-level hospitals** as institutional delivery rates continue to grow. The situational analysis and emerging options and recommendations were discussed with a KIG and at a workshop for stakeholders in the six study districts. As a result, both specific recommendations for the study districts and overall recommendations have been developed. These findings and recommendations will be shared in the Joint Annual Review (JAR) meeting and will be used to inform the 2013/14 FHD Annual Work Plan and Budget (AWPB). The study will be used to inform an action plan for responding to increased delivery rates, without which appropriate quality of care cannot be maintained in higher-level institutions.

NHSSP Advisors and consultants assisted with a meeting of representatives from the National Public Health Laboratory (NPHL), Nepal Red Cross Society (NRCS), and FHD to develop: a recording and reporting tool for free Blood Transfusion Services (BTS); planning of free BTS for maternity cases; and a monthly blood usage form for the re-imbursement of free BTS under the Aama Programme.

As part of the '**Strengthening District Referral Systems**' operational research pilot in Banke District, support was provided to the District Public Health Office (D(P)HO) to organise an Ambulance Providers' Organisation Committee. The committee identified that in order to improve referral, a call centre for ambulance service providers, and a district-level ambulance fund to provide a discount to maternity cases, are needed. By improving coordination of services and removing financial barriers to referral systems, it is anticipated that women in remote parts of the district will experience fewer delays in accessing Emergency Obstetric Care (EOC). Although the committee has identified the main barriers to referral, and devised locally appropriate responses, there is a lack of funds locally which can be used to establish a call centre. This, and other issues effecting implementation, will be discussed at the next planning meeting.

In other work to improve referral processes, NHSSP worked with FHD and UNICEF to support the development of **MNH Referral Guidelines**. It is anticipated that the National Referral Guidelines will help FHD to strengthen the district referral system. The guidelines will be used to develop local MNH Referral

Guidelines in Kalikot and Banke, the two districts involved in the NHSSP operational research referral pilot.

NHSSP Advisors supported the FHD to revise and prioritise activities for the second trimester based on budget cuts from the MoHP. The budget reduction will mean that many important activities have been cut: for example, as a result of cuts to the training budget, 50% fewer Skilled Birth Attendants (SBAs) will be trained, no Operating Theatre (OT) management training will take place, and no MNH update training will be provided to nurses for birthing centres.

Output 2: MoHP has capacity to develop and implement an effective HRH Strategy for the health sector.

The HRH Strategic Plan was approved by the Cabinet in December 2012. A plan for its dissemination has been agreed with MoHP. The strategic plan provides the basis for annual work planning of the MoHP and partners' collaboration, as well as for long-term plans for improvements in HR in the health sector. The approved plan will be produced in English and Nepali, and will be disseminated at central, regional, and district levels. Unfortunately, budgetary constraints will affect implementation of new HR activities in 2012/13. The weak and fragmented nature of current HR functions is also affecting implementation.

A contract to develop an **HRH assessment and profile in the public and private sectors** was awarded to a research agency in October, and the collection of the data is almost complete. Unfortunately, there was a limited choice of contractors to undertake the HRH assessment; the agency selected requires a substantial amount of technical support and oversight. The process is being overseen by a Technical Working Group (TWG) of the MoHP, including WHO and NHSSP, which conducted monitoring visits to support and observe the data collection process in all five regions. The information generated from the assessment will provide a baseline of accurate HR information for the private sector for the first time in Nepal, as well as comparative data for the current HR information systems in MoHP and the Ministry of General Administration (MoGA). The information will act as the basis for developing workforce projections and a long-term workforce plan. These are needed in order to inform and support health service development and HRH plans, as well as educational developments.

An **institutional assessment of the NHTC** has been carried out under the guidance of a Technical Committee (TC); the assessment's main recommendation, that NHTC be a training management body, has been agreed. The report will be discussed by the SC, and a change management process developed and put into action. This will enable a Training Strategy to be developed in line with the institutional structure and mandate of the NHTC. The assessment reviewed the NHTC from a GESI perspective; as a result of findings from the review, the NHTC has decided to develop GESI modules and materials for the five curricula that were reviewed from a GESI perspective. Once the GESI modules are integrated in the training curricula, trained persons will be oriented on GESI. NHSSP Advisors and consultants will continue to work with NHTC in the development of the GESI modules and materials.

Output 3: MoHP and DoHS have systems, structures, and capacity to implement the GESI Strategy.

With NHSSP TA support, the National Health Education, Information, and Communication Centre (NHEICC) developed **District-specific Behaviour Change Communication (BCC)/Information, Education, and Communication (IEC) Strategic Plans** in sample districts. These will be finalised during the next reporting period, when the NHEICC TWG will review the plans and prepare for implementation. Implementation of the district-specific strategic plans will improve district-level coordination of BCC/IEC work in sample districts, and lessons learned from these districts will inform scale-up across the country.

SSU Guidelines were finalised and approved by the Secretary. A road map for establishing and strengthening SSUs was also developed. SSUs will be established as per the guidelines in eight hospitals (central, regional, and zonal) in 2013 on a pilot basis with backstopping support from NHSSP. Scale-up will take place after two years of piloting. Orientation and regular backstopping support will be provided to the SSUs in 2013. A key challenge for effective implementation of SSUs will be the identification of service users from target groups, as no robust systems are in place to identify the poor and the extreme poor. If these challenges can be overcome, the SSUs will ensure that health services will be more easily accessible to poor people, Gender-based Violence (GBV) survivors, and other target groups in the eight hospitals where they have been established.

Advisors have continued to provide support to establish **One-stop Crisis Management Centres** (OCMCs): preparations for a referral protocol and users' guide on GBV are underway. Pamphlets have been developed and distributed to disseminate correct information to communities. Discussions are ongoing with the Prime Minister's Office and the Ministry of Women, Children, and Social Welfare to develop unified comprehensive OCMC Guidelines. OCMCs are to be established in eight additional hospitals during the current FY, based on the findings of RAs of different hospitals. The centres will ensure that GBV survivors are better informed about available services, and can access relevant services in one place. Clients will not be required to share their case history repeatedly, and service providers will be trained to provide good quality services to GBV survivors. Developing an effective mechanism for coordination and collaboration between different ministries and NGOs to address the complex needs of GBV survivors continues to be a challenge.

The Primary Health Care Revitalisation Division (PHCRD) finalised comprehensive **Social Audit Guidelines** based on experiences from pilots by MoHP, NHSSP, and GiZ. The approval process is ongoing. Once MoHP approves the guidelines, a road map for their incremental roll-out will be developed. However, budget cuts may delay roll-out of the guidelines. The revised social audit process will help establish a mechanism for downward accountability, and increase local ownership of public health services.

Work to establish effective **GESI leadership and coordination structures** continued to progress well. The Institutional Structure Guidelines specifying the location of GESI responsibility within the health system have been approved and are ready for dissemination. The Institutional Structure Guidelines will provide mandatory responsibilities for an institutional mechanism on GESI. This will ensure that the different TCs and TWGs implement their responsibilities regarding GESI. The development of **GESI Operational Guidelines** is also underway. The guidelines will provide direction to service providers across the health system on how to address GESI issues in their routine work. A final draft of the guidelines will be presented to the GESI SC and the Secretary for approval.

The **Equity and Access Programme (EAP) review** report was finalised and the findings are being disseminated. The review identified factors constraining programme implementation: single-year contracting of EAP implementing Non-governmental Organisations (NGOs), delays in receiving budget approval, and political, administrative, and social pressure. The EAP review findings will be shared with respective decision makers. The file memo for approval of multi-year contracts for NGOs implementing the EAP has been initiated. he review will help to establish a mechanism for multi-year contracting of NGOs implementing the EAP.

Output 4: MoHP and DoHS have capacity to develop and implement a transparent and sustainable supply- and Demand-side Financing (DSF) framework.

In December 2012, the MoHP endorsed the **Financial Management Improvement Plan** (FMIP), which was developed with support from NHSSP. The plan has been discussed in the Public Financial Management (PFM) Committee and recommended for endorsement. The MoHP Finance Section is the institutional home for the FMIP and will also prepare the periodic progress reports on FMIP. The PFM Committee will review the progress periodically and make suggestions for improvements in FMIP and its proper implementation. The DoHS Finance Section will also be actively engaged in implementing the FMIP. It is anticipated that implementation of the FMIP will support progress towards:

- A reduced volume of irregularities in the audit report;
- Improved timeliness of trimester progress reports so that they are prepared within 45 days of the end of each trimester;
- Improved timeliness of audit reports so that they are prepared and submitted within nine months of the end of the FY;
- Performance-based disbursal of funds to hospitals.

System specification of the TABUCS has been finalised following a five-day workshop to prepare the system specifications. The specification will now be used to finalise the TABUCS software before piloting begins in early 2013 across the 11 cost centres selected by the MoHP. Lessons learned from piloting will be used to finalise the software.

In consultation with the FHD, advisors developed a revised TOR for RA using core and full monitoring indicators. Focal persons within FHD have been identified to participate in the entire RA process. This will build staff capacity and institutionalise the RA in FHD. The focal persons from FHD will be involved in finalising tools, training researchers, and field monitoring, as well as in report writing. A RA is planned to take place between March and May 2013. The revised TOR for the RA will help institutionalise RA within FHD, and will also distinguish between Core and Full RAs. A Core RA will include those indicators which are essential for programme monitoring and are not covered by Household Surveys (HHSs) or other surveys, while Full RAs will contain both core and supplementary indicators.

Output 5: MoHP has capacity to strengthen and effectively use an information system to support planning and delivery of quality EHCS.

The **NHSP-2 M&E Logical Framework Progress Report** of 2012 has been prepared for the Public Health Administration and Monitoring and Evaluation Division (PHAMED), MoHP. The report draws on a range of data sources to report progress against NHSP-2 indicators. Knowing the NHSP-2 M&E logframe progress status for 2012 will enable monitoring of the progress made in 2012 against the listed indicators. The result will be shared and discussed in the JAR 2013.

Progress is being made on producing annual and **quarterly HMIS Bulletins**. The bulletins will improve access to and utilisation of data at different levels for monitoring and planning purposes, and will improve the quality of data. The Management Information System (MIS) will release an electronic quarterly bulletin within one month of the end of each quarter, and an annual bulletin within one month of completion of the regional reviews; these will be posted on the DoHS website.

An **M&E Operational Plan** has been developed for the FHD, as agreed in the national Reproductive Health (RH) review in December 2012. The plan will strengthen M&E within FHD enabling better monitoring and decision making about programmes. The Demography Section, FHD, will take the lead in implementation and monitoring of the planned activities, and will report progress in the next national RH review 2013.

The **MPDR tools** and review process have been revised and guidelines are being prepared, in collaboration with WHO. The revised tools and process will strengthen and support institutionalisation of the MPDR process, and lead to reducing maternal and perinatal deaths through improved quality of care. The revised tools, process, and implementation guidelines will be rolled out to all the MPDR implementing hospitals.

Progress is being made in developing a document **analysing thematic recommendations from different national-level health-related studies** and the policy implications of the findings and recommendations so far. This will help the government monitor the policy implications of these surveys and rationalise the different surveys to make best use of the available resources. PHAMED, MoHP, will be supported to institutionalise this process.

HMIS indicators, recording and reporting tools, reporting process, and review process have been revised. The revised HMIS will better address the needs of NHSP-2, the Health Sector Information System (HSIS), and programmes. The revisions will:

- generate data disaggregated by caste/ethnicity;
- provide facility- and Village-Development-Committee- (VDC-) level data;
- include all facilities – public and non-public;

- enable electronic data entry at the district level and web-based reporting;
- integrate vertical systems (Aama Programme, EOC monitoring, nutrition, HIV/AIDS and TB programmes) into HMIS;
- improve hospital recording and reporting to generate institutional mortality and morbidity data by age, sex, and cause;
- improve data quality through user-friendly recording and reporting tools that minimise the burden on staff and reduce duplication of work;
- enable NHSP-2 to be monitored effectively during 2013/14 and 2014/15;
- provide disaggregated data to help with planning of NHSP-3.

The revised tools, reporting, and review process will be field tested and scaled up at the national level by the government. Scaling up is urgently required for the effective monitoring of the last two years of NHSP-2 and for providing disaggregated data to help with planning of NHSP-3. However, in order to achieve this, the government needs to allocate an adequate budget for scaling up for scaling up.

Progress is also being made in the development of **HMIS Guidelines and manuals** as part of the wider HMIS reform. The guidelines and manuals will help standardise data, and improve the reporting and review process. The guidelines will form the main basis for training all staff linked to data management at different levels and will help to improve quality of HMIS training.

The Population Division is making progress on developing the **web-based ePopInfo**. The ePopInfo template and database have been developed based on Census 2011. ePopInfo will strengthen information management within the Population Division and improve data quality and their use at various levels. The Population Division will identify a mechanism for the regular and timely update and release of data for use. The Population Division will 18nstitutionalise the ePopInfo, and the website will be incorporated in the MoHP website. The ePopInfo will be an online database of selected population-related data and will serve as one of the hubs of the Population Management Information System (PMIS).

In addition, TOR for a consultant to develop **standardised district population profiles** have been developed. A Technical Advisory Group (TAG) will advise the consultant who will be responsible for preparing the standardised profiles and producing guidelines for District Health Officers (DHOs) to use in maintaining the profiles.

The **Service Tracking Survey** (STS) 2012 and HHS 2012 are in process. Findings of these two surveys related to the NHSP-2 logframe indicators have been shared with and endorsed by the TWG. Full draft reports are due in February 2013. These surveys will help GoN monitor both selected indicators in the NHSP-2 logframe and other programme-specific indicators related to the Aama Programme and free health care, household expenditure on health, and knowledge of, perceptions about, and participation in health service governance. With enhanced capacity, by 2015 MoHP will gradually take the lead in the process of research implementation, dissemination, and utilisation of findings for monitoring and planning purposes.

Output 6: MoHP and the Ministry of Physical Planning Works, and Transport have capacity to develop and implement procurement in accordance with the procurement arrangements for the health sector.

3.6.1 Procurement – Goods and Services

Over 400 **technical specifications** for hospital furniture, surgical instruments, medical equipment, and drugs have been developed and uploaded on LMD's website. The bank of standard, agreed specifications will be publically available, allowing anyone to view and comment on the specifications. The specifications will potentially improve the efficiency of bidding processes as they can be simply inserted into bidding documents by Procurement Officers. The main challenge associated with the work will be to keep the data bank up to date. This will require a dedicated person in LMD. At present, no staff members have been nominated to take responsibility for this task.

A short **market survey report** of 44 drugs was developed and presented to LMD, and a second market survey of drugs was developed, comparing local pharmacy prices, internet prices, and those actually obtained in International Competitive Biddings (ICBs) 7, 11, and 22. The survey was inconclusive in that the prices from elsewhere bore little resemblance to those achieved in actual procurement. The market analysis will allow more accurate cost estimates for the drugs to be developed and used in all Bidding Documents for these drugs. However, prices for all commodities are notoriously difficult to predict for Nepal. This study compared the actual average prices obtained over the past three years with price quotations obtained from two pharmacies, but the data are imperfect. The survey and database will have to be kept up-to-date by LMD, requiring input from an IT specialist, to ensure its ongoing value.

The **Consolidated Annual Procurement Plan** (CAPP), which was presented to the World Bank in August, finally achieved a final non-objection letter after considerable discussion this quarter. Delays were caused mainly by the reluctance of LMD to bundle equipment adequately, despite the Senior Procurement Advisor's (SPA's) advice so to do.

A similar process of developing a CAAP will take place next year; however, planning will be brought forward to start in January to allow for an even earlier presentation of the CAPP (before the end of this FY). In 2013 plans will be put in place to include all agencies within MoHP, not only the Programme Divisions, in an even more consolidated plan. However, Advisors anticipate that MoHP/LMD may face challenges incorporating more procurement centres into a single Procurement Plan (PP). LMD staff numbers may be insufficient to deal with considerably greater procurement.

As a result of the consolidated procurement planning process, there has been closer co-operation between Divisions, and opportunities to achieve economies of scale have been identified by consolidating plans and bundling together goods into larger tenders.

Steps have been taken to **improve the quality of drugs** procured and accepted:

- WHO GMP products' certifications are now habitually required in the Bidding Documents, where appropriate. Additionally, Certificates of Pharmaceutical Production (COPPs) are also required in the Bidding Documents, as appropriate. By adding these certification requirements into the Bidding Documents, bidders are forced to meet these standards, as failure to do so will result in a bid being declared non-responsive.
- Lab tests are currently used but are usually restricted to the government laboratory owing to lack of budget.

However, these developments will only drive up quality if main (and large) suppliers are prevented from changing the rules, and such mandatory requirements are kept in the Bidding Documents. The success of the lab testing is also dependent on the ability of the government laboratory to assay the drugs accurately. A budget needs to be included to hire independent, competent, private national laboratories to outsource this process.

A further 10 **multi-year contracts** have been included in the Procurement Plan for 2012-13, making a current total of 22 multi-year contracts either running (2011-12) or planned. This increase in multi-year contracting should help deliver economies of scale.

3.6.2 Infrastructure

HIIS upgrading and updating work, using information from districts, has been completed. The updated HIIS will be used to produce information on the budget required for repair and maintenance for different health infrastructure projects, and will also be used to provide up-to-date figures on the number and types of health infrastructure projects underway across the country. The revised HIIS also has a provision to update the PP and will be used to deliver progress reports on civil works. As a result of these improvements:

- Rational budgeting for repair and maintenance will be improved;
- The ease with which PPs and progress reports can be developed will be improved;
- Once the system is made web-based, all stakeholders will be able to monitor the physical and financial progress of construction projects online.

Future NHSSP support to HIIS will focus on institutionalising its use, and making it web-based.

HIIS is likely to face a number of challenges. Regular operation, maintenance, and updating of HIIS from the different cost centres will only be possible if MoHP strictly follows the process of budget release to the districts based on progress reported in the system. There should not be any political decisions on the budget release procedures nor should the vested interests of officials be considered.

A number of **joint monitoring visits** took place during quarter four with NHSSP support. A joint monitoring team was formed, comprised of officials from Management Division (MD), architects/engineers from DUDBC, the NHSSP Infrastructure Advisor, and local officials from concerned

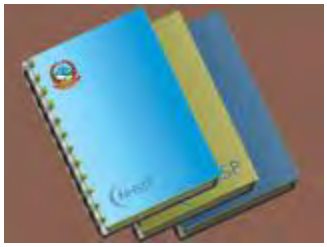
districts and regions, both from DUDBC and the health sector. Frequent monitoring throughout the year has helped resolve many long-standing issues concerning delays in construction, and has provided MD with lessons for future project planning. The monitoring visits have helped drive up the completion rate and handover rate of building, and the numbers of "sick" projects has decreased by half. Standard bidding procedures and documents are being used during the visits. The GoN has realised the importance of monitoring: regular monitoring will become part of the upcoming standard guidelines for health facility construction.

The Value for Money (VfM) study on the implementation of **e-bidding** demonstrated that the system has facilitated more efficient and transparent tendering, and has also contributed greatly to reducing the costs of construction. e-bidding has enabled better and fairer competition, and improved prices for GoN. In the future, the system will be continued and expanded for ICB, and a system for a preliminary evaluation process will also be developed. However, expansion of e-bidding is likely to face a number of challenges:

- A reliable power backup system is needed to make it easier for bidders to access the system (and even to keep the system running).
- Regular operation, maintenance, and updating of the system by DUDBC is necessary in the long run.
- For ICB e-bidding, the DUDBC server requires approval by the WB appraisal team, which has been long pending.

VfM studies on infrastructure development work completed during quarter four showed that implementation of **standard integrated designs** has already resulted in significant cost saving and improved service provision; these benefits are expected to increase in the future. Improvements to the designs are ongoing, and feedback received during the two years of their use has led to revisions which are being incorporated into the existing standard designs. Amended designs will be completed within a month and put forward for endorsement.

Technical staff from DUDBC and the District Technical Office will be trained on the use of standard designs. Orientation will be given to officials at central and district levels on the use of standard guidelines and implementation procedures. Ongoing use of the designs will lead to more efficient service provision, and the infrastructure will be easy for service providers to manage, with lower operation and maintenance costs in addition to lower construction costs. Sanitation, hygiene, and waste management will be improved. However, if the site selection criteria in the standard guidelines are not followed, the new integrated design will not be functional. If the existing sites do not have a water supply, the standard designs will not improve the situation with regard to sanitation and hygiene.



Output 7: PPICD has a clearly defined and functional role as the focal point of the planning and policy process for the whole health sector.

A **SNP Policy** for the health sector in Nepal was developed and has been endorsed by the SC. The policy defines the roles and responsibilities of key stakeholders, such as government, for-profit, and not-for-profit organisations, in terms of the scope of service, partnership, structure, financing options, and other partnership attributes. It will create a supportive environment for the state and non-state sectors to work closely with each other, encouraging synergy between the resources of both sectors to achieve optimal health outcomes.

A plan for a dissemination workshop has been agreed with MoHP, after which the formal process of approval will be initiated. The MoHP will send the policy to the Cabinet after consulting other concerned ministries. It is possible that the ministries will take some time to respond. In the meantime, the MoHP needs to begin work on institutional strengthening for effective implementation of the policy as specified.

A workshop on the **'Experiences of the Sector-wide Approach (SWAp) in Nepal's Health Sector'** was organised for senior officials of MoHP and other related government organisations to orient them on the conceptual aspects of SWAp, recent developments, and experiences in other sectors. The participants asked to have similar orientations on a regular basis and suggested that this also be rolled out at regional and local levels. A similar programme focusing on procurement was requested. This type of orientation programme should be continued. The participating officials acquired wide knowledge on different aspects of SWAp, and this is expected to bring a positive impact on their performance.

Early preparation work for the upcoming **JAR** was accomplished in close coordination with MoHP and EDPs. As a result of these preparations, it is anticipated that JAR thematic reports will be distributed on time and that the JAR will be conducted in a planned and structured way.

Support was provided to the MD to develop **District Planning Guidelines**, which have been finalised by the TC. As a result of having developed the guidelines, the DoHS MD will have the potential to decentralise planning, and D(P)HOs will have the tools to produce periodic district plans based on local needs. As a next step, the DoHS MD will submit the finalised District Planning Guidelines to the SC for endorsement. However, for the guidelines truly to enable more bottom-up, locally responsive planning, changes in planning and budgeting at central level are requiredso that they take account of district plans. This issue is beginning to be discussed in DOHS.

An **annual calendar of events** for health-related activities has been developed. It highlights international and national events, including the annual planning cycle. The calendar will facilitate proper planning by harmonising the activities of GoN and EDPs, and will reduce the duplication of efforts. The calendar is

being shared with EDPs. After EDP inputs are received, it will be forwarded to MoHP for wider circulation.

Revisions to **GAAP** indicators have been proposed to make the targets and indicators more measurable and verifiable. Improvements to the indicators will make implementation and monitoring of the GAAP more straightforward and effective. The revised version of the GAAP will be discussed with EDPs and finalised.

Support was provided to PPICD to disseminate the **Urban Health Policy**. The policy will provide the MoHP/DoHS with clarity around urban health services, and will build a partnership with the Ministry of Local Development, District Development Committees (DDCs), and municipalities. The policy will also be used by the PHCRD to draft a strategy and plan of action for implementation. As a next step, the MoHP will submit the draft policy to the Cabinet for endorsement.

4. Regional Update

Region	Achievement	What will change as a result?	How will this be taken forward?
Eastern Region	NHSSP Specialists, in consultation with the Regional Health Directorate (RHD), developed the Regional Health Profile.	The profile will help to promote evidence-based health planning and decision making to ensure that quality health services are accessible to excluded populations. It supports strengthening the performance of the health sector's actors.	• The RHD will publish the Regional Health Profile for wider dissemination and use. • D(P)HOs will take this profile as a reference document when preparing the District Health Profile, which will be useful for district health planning. For example, it will be used when piloting the District Health Planning Guidelines after their endorsement by MD/DoHS.
	Established and scaled up the documentation and information system at the RHD.	Contextual information will be available on a timely basis for the regional health team. A culture will be established for the collection, maintenance, and use of various sources of health information at the RHD. The use of information through self-learning and sharing among the regional health team will enhance their capacity. This will also contribute to strengthening the documentation and information management system at the RHD.	• The use of information through electronic systems will be promoted. • The HMIS Section of the region will be strengthened as a unit of operational research. • An information-based feedback mechanism from the region to districts will be operationalised.
	Made functional the Regional Health Coordination Team (RHCT).	The functional RHCT will support bringing all actors together at the regional level to coordinate programmes and resources for better health sector results, avoid duplications in resource sharing, and accelerate joint review of the plans, programmes, and progress.	• Enhancing regular updates and information sharing among RHCT members. • The roles and functions of RHCT will be endorsed by DoHS/MoHP, and guidelines developed for its effective functioning. • The resource mapping of stakeholders, and formulation of periodic health sector plans will be accelerated.

Region	Achievement	What will change as a result?	How will this be taken forward?
Central Region	Undertook an assessment of effectiveness of antenatal rural ultrasound in a pilot district, and prepared an article entitled "An effective strategy to increase ANC coverage and institutional delivery in the remote districts." Key findings of the assessment were shared in the annual regional review workshop.	• Based on the assessment the recording and reporting tools have been revised, and the service providers are using them without difficulty. • The district has been encouraged to continue the initiative while maintaining quality of the procedure, recording, and reporting. • A service provider from the pilot district provided inputs in the training and encouraged new trainees. • The pilot district's coverage in terms of safe motherhood will increase continuously.	• Other districts in the region are willing to scale up this initiative to serve poor, vulnerable, and marginalised people.
	Facilitated the formation of a GESI TWG for institutionalising GESI issues at the regional and district levels. The TWG was oriented on the strategies and guidelines for mainstreaming GESI in the health sector, and analysed the services provided at different levels. Thirteen districts formed the committee.	• The TWG will discuss GESI issues at the regional and district levels, and will mainstream the issues by analysing the services provided from a GESI perspective.	• The region will review the service statistics and provide feedback to the districts and concerned organisations to focus on poor, vulnerable, and marginalised people. • The districts will also concentrate on providing services to the excluded groups in coordination with the regional TWG.
	Facilitated the development of an annual calendar of operations and an integrated supervision and monitoring plan.	• Developed an integrated plan (calendar of operations) and supervision plan for the region and districts. • Progress is reviewed based on the calendar of operations. • Monthly meetings have been established in RHD and the districts, and a participatory decision-making process established	• In coordination with and with support from the RHD, one district is going to develop strategic periodic planning. Makawanpur District started the process of preparing a periodic health plan. • This will increase ownership in the annual work plan.

Region	Achievement	What will change as a result?	How will this be taken forward?
Western Region	NHSSP, in consultation with RHD staff, developed a Regional Health Profile.	This has created a database of the regional health system. The information contained in this profile will be used by health planners and programme managers to prepare their annual and periodic health plans.	The Western RHD (WRHD) will circulate the Regional Health Profile to all D(P)HOs in the region and tell them to use the information in this profile during district-level planning. This will help to improve the regional- and district-level planning process and the quality of health planning.
	NHSSP, in close coordination with the VDCs, DDC, DHO and Local Health Governance Strengthening Programme (LHGSP) District Technical Team, developed Village Health Profiles of 12 LHGSP Programme VDCs in Myagdi District.	The LHGSP District Technical Team in Myagdi District endorsed the Village Health Profiles. Other VDCs in the district can replicate this process and prepare their own village health profiles.	Information contained in these profiles will be used to prepare the Periodic VDC Health Plans of respective VDCs. The Periodic Health Plans will be prepared in the first quarter of 2013.
	The NHSSP Western Regional Team, on request of the Regional Director, prepared the regional review meeting process report.	The process report, including recommendations from the meeting, has been circulated by the Regional Director to all District Managers, Hospital Superintendents, the Health Secretary, DG, and central-level MoHP Division and Centre Chiefs for implementation of the recommendations.	WRHD will review the implementation status of the recommendations at the district level during half-yearly and annual review meetings.
Mid-western Region	The Mid-western Region has categorised 15 districts of the region based on NHSP-2 indicators on MNCH for further planning, intervention, monitoring, and supervision.	A planning meeting with focal persons in low-performing districts will be conducted. Awareness will be created and the district team sensitised on the NHSP-2 indicators and their importance for reaching the Millennium Development Goals (MDGs). A plan of action will be developed to improve the MNCH status in low-performing districts. In particular, a plan will be developed to strengthen Basic Essential Obstetric Neonatal Care (BEONC) services	Monitoring and supervision priority will be given to low-performing districts. The regional team will follow up the process and achievements, based on the developed action plan, for further improvement. A special action plan will be developed focusing on the lowest performance in three districts.

Region	Achievement	What will change as a result?	How will this be taken forward?
		through birthing units.	
	Successful GESI orientation was given to all staff of eight D(P)HOs and the RHD; staff were supported to form a GESI TWG.	The GESI TWG will: • guide and support the smooth running of OCMCs and SSUs in the region; • prioritise GESI in planning, programming, budgeting, and M&E at the local level to ensure poor and excluded communities have access to health services; • address the GESI-related barriers by properly identifying target groups, ensuring that remote communities are reached, and emphasising programmes to reduce morbidity and mortality among poor and excluded communities; • develop a strategy to enhance the capacity of service providers to deliver EHCS to poor, vulnerable, and marginalised castes and ethnic groups in an equitable manner, and to make service providers responsible and accountable; • empower the target groups to demand their rights and also to realise their responsibilities by guiding the EAP and other programmes in the region and districts.	• The guidelines are in process, and the GESI TWG will move forward as per the guidelines developed by the government. • Regular meetings will be organised to discuss the latest progress, constraints, and the way forward. • Regular technical support will be provided as needed. • Synergy will be established between different stakeholders in the region and districts for better results.
	The NHSSP Mid-western Region Team assessed free health services at the Mid-western Regional Hospital, Surkhet, and analysed the use of free health care by sex, ethnicity, and free health	Now that baseline data on the use of free health care services in the regional hospital are available, monitoring will be easier. The information will be helpful to plan to improve further delivery of free health services to the targeted population (very poor and destitute,	• The report will be disseminated in a meeting with hospital staff, the Hospital Development Committee, and stakeholders. An action plan will be developed to increase access for the targeted population.

Region	Achievement	What will change as a result?	How will this be taken forward?
	criteria.	poor, disabled, senior citizens, and Female Community Health Volunteer (FCHVs)).	
Far-western Region	Prepared a Family Planning Mobile Camp Plan for Kailali District.	The focus on a hard-to-reach and underserved area will result in an increased Contraceptive Prevalence Rate, and will encourage, in particular, long-term spacing.	Results in Kailali District suggest that the programme can be replicated in other districts.
	Developed the annual work plan of the region, including the GESI programme.	GESI will be incorporated at regional, district, and health facility levels, and as a result GESI perspective information will be mainstreamed in service utilisation. Socio-cultural barriers will be addressed the region and the district, as well as through health staff behaviour.	Make the GESI TWG functional and strengthen coordination (internal, intra- and multi-sectoral) for implementing the GESI-related programme mechanisms.
	Coordination Guidelines for Regional Health System Strengthening are being developed in consultation with the Far-western RHD to support smooth coordination at the regional level for optimum utilisation of available resources.	With the help of the guidelines, RHD will have a clear idea of taking an integrated approach for better results, especially in increasing accessibility and utilisation of health services.	The DoHS will review and endorse the guidelines, which will be useful to all RHDs, D(P)Hos, and EDPs supporting the regions.

5. Payment Deliverables

Eleven payment deliverables were submitted this quarter:

- A market analysis of the most commonly procured drugs in Nepal (deliverable 53)
- Draft SNP Policy Report completed for MoHP review and approval (deliverable 34)
- One detailed VfM case study (deliverable 43b)
- A quarterly progress and performance report (Q3 2012) (deliverable 45)
- Increased demand for institutional delivery at higher-level facilities in Nepal – an appraisal of Options. a) Presentation of preliminary findings and discussion of options at FHD workshop (deliverable 48a)
- Revised HMIS indicators, recording tools, and reporting tools developed (deliverable 32)
- A draft Maternal Nutrition Plan developed for government review (deliverable 47)
- A final draft CB-IMCI/NCP multi-year costed plan for submission to MoHP (deliverable 28b)
- Updated SSU Guidelines prepared by Population Division with support from NHSSP and ready for sign-off by MoHP (deliverable 26b)
- Completed TABUCS design (deliverable 23)
- PEER report on barriers to service uptake (deliverable 50).

The following deliverables will be submitted in the first quarter of 2013:

- Draft 2012 HHS to be submitted for government review
- Institutional Capacity Assessment of NHTC final report approved by government
- Draft Technical Specification Bank (with approximately 400 technical specifications for medical equipment), User Manual, and a Maintenance Manual for approval by government
- Increased demand for institutional delivery at higher-level facilities in Nepal - an appraisal of Options. b) Draft report for discussion at JAR and summary of JAR recommendations
- Quarterly progress and performance report (Q4 2012)
- Draft GESI Operational Guidelines for discussion with government
- Draft STS 2012 Report for circulation to government.

Annex 1 – Publications Produced During This Period

Concept Paper – Integration of Family Planning Services in the Expanded Programme of Immunisation

Concept Paper – Strengthening the Delivery of Postnatal Care

Health Service Coverage Fact Sheet 2068-69 [2009/10 to 2011/12]

NHSSP Review of MoHP Committees

NHTC Capacity Assessment Report

Pulse Quarterly Report July to September 2012

Pulse Update: Infrastructure

Strategic Review of the Equity and Access Programme