NHSSP Nepal Health Sector Support Programme

Nepal Health Sector Support Programme

Quarterly Report

Reporting Period: January - March 2013

Contents

Acronyms and Abbreviations

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
CMYP	Comprehensive Multi-year Plan
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 NHSP-2	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
HFOMC	Health Facility Operation and Management Committee
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
IUCD	Intra-Uterine Contraceptive Device
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
NHIP	National Health Insurance 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
SOLID	Society for Local Integrated Development
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
VCAT	Value Clarification and Transformation Workshop
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 January to March 2013, the eighth 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 January and March 2013. 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 March 14, 2013, the four major parties - UCPN-Maoist, Nepali Congress, CPN-UML and the Madhesi Alliance - signed a deal to form an election government headed by Chief Justice KR Regmi i.e. he is chairman of the interim Cabinet until an election can be held. This decision was opposed by another 33 political parties. It ends 10 months of political deadlock since the demise of the Constituent Assembly over the issue of replacing the coalition government. The Election Commission has agreed to hold an election in mid-November (as of April 15, 2013). The Interim Cabinet has 11 members consisting of retired senior bureaucrats, and will be responsible for holding the elections and overseeing day-to-day administration. Mr Bidyadhar Malik has been appointed as the Minister for Health and Population.

Summary of Key Events in this Quarter

Significant progress was made in the thematic areas as follows:

In **Essential Health Care Services**, Phase 1 of an analysis of the situation of maternal, neonatal and child health (MNCH) services in remote areas was started. NHSSP TA supported FHD and regional health directorates (RHDs) to review implementation of the integration of family planning services in Expanded Programme of Immunisation (EPI) clinics in Kalikot district. FHD was also facilitated to explore government and partner reproductive health clinics where high numbers of IUCD and implant services are provided.

In **Gender Equality and Social Inclusion**, Operational Guidelines for Mainstreaming GESI in the Health Sector were drafted and submitted to the health secretary for approval. Guidelines for the establishment and operationalisation of GESI institutional mechanisms, which specify the location of GESI responsibilities within the health system, were approved by the health minister. TA also supported NHEICC to develop draft implementation plans for its national behaviour change communication (BCC)/information, education and communication (IEC) strategies for safe motherhood, neonatal and child health (SMNCH), adolescent sexual and reproductive health (ASRH) and family planning.

In **Health Policy and Planning/Health Systems Governance**, NHSSP supported the well-received Joint Annual Review (JAR) of January 2013. Draft district health planning guidelines were finalised by the steering committee and are now being edited. NHSSP supported a 3-day workshop on planning the 2013/14 AWPB while its M&E TA helped MoHP prepare data for the NHSP-2 Mid-term Review report carried out by independent consultants. A ToR was developed to develop standard performance based contracts for hospitals.

In **Human Resources for Health**, the HRH Strategic Plan was officially launched. Some progress was made with collecting, entering and analysing data collected through the HRH profile assessment. NHSSP TA also supported the MoHP-led Workforce Planning Technical Working Group to secure funding for regular meetings while the findings and recommendations of the NHTC capacity assessment (Phase 1) were presented and endorsed by the health secretary and steering committee. The main recommendation was that NHTC become a 'training management body' responsible for managing and quality assuring all training carried out for MoHP and its departments.

In **Health Financing**, MoHP's national health insurance policy steering committee was endorsed and a draft design document prepared for implementing the policy in selected districts. NHSSP supported Family Health Division (FHD) to draft a monitoring and evaluation (M&E) framework for demand-side financing schemes and helped finalise a capacity assessment for piloting of the Transaction Accounting and Budget Control System (TABUCS) in eleven cost centres. TA also helped to finalise a report by independent consultants on a review of MoHP's internal control system.

In **Procurement**, LMD's technical specification bank was upgraded with a further 80+ specifications, making 480+ in total, and introduced at the annual meeting of the Bio-Medical Engineering Association of Nepal (BEAN). NHSSP's two bio-medical engineers continued to conduct market surveys to help prepare and update these technical specifications. Several small procedures and policies were prepared as contributions to LMD's Operations Manual (Procurement) including notes on framework contracts, contract amendments and bid securities. A strategic paper on framework contracts was also drafted and provided to the DoHS director general and LMD's director.

In **Infrastructure**, the upgrading of the Health Infrastructure Information System (HIIS) was completed and now includes new output formats for use in planning, monitoring and reporting. Several joint monitoring visits were undertaken to help resolve delays and quality issues related to ongoing building contracts. NHSSP TA worked to improve coordination between the Management Division and DUDBC and TOR were prepared for a review of MoHP funded infrastructure procurement for health facilities.

In **Monitoring and Evaluation**, field testing and scaling up plans were approved for the revised HMIS indicators, recording and reporting tools and reporting process. A first HMIS Bulletin covering 5 years of data based on NHSP-2 indicators was prepared and presented at the JAR. ePopInfo (a user-friendly electronic database that provides accurate information on population characteristics, health service provision and water and sanitation) was developed and will be posted on MoHP's website shortly.

Twenty one new publications were produced in this quarter with all non-sensitive documents uploaded to the NHSSP website (See Annex 1). A NHSSP twitter account was also opened to support dissemination and advocacy efforts.

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

Following on from last quarter, where TORs were developed for the **analysis of the situation of maternal, neonatal and child health (MNCH) services in remote areas of Nepal**, Phase 1 (with the leadership of the DoHS director general, and the Directors of the Family Health and Child Health Divisions (FHD and CHD), and with support from the World Bank) is now underway**.** During Phase 1 the conceptual framework, methodology and tools for use in the implementation phase of the study will be designed. The study will take place in 5 districts, and the results will provide recommendations for the government and its partners to improve the access of women and children in remote areas to MNCH services.

NHSSP, in coordination with FHD and regional health directorates (RHDs), reviewed the implementation of the **integration of family planning services in Expanded Programme of Immunisation** (EPI) clinics in Kalikot district. These are regular government programmes. Three review workshops with service providers and health facility in-charges came up with recommendations for improving service delivery. The workshop discussions and review findings will help improve the integration of family planning into EPI in the planned future scale up of this initiative – which the FHD plans to expand to three more remote districts. However, this initiative has been frustrated by the widespread absence of vaccinators and extensive transfers of health workers from Kalikot in mid-2012.

NHSSP continued to support CHD to review its **comprehensive multi-year plan (CMYP)** (2012/13 to 2016/17) and costings based on discussions and recommendations from the Joint Annual Review (JAR). A CMYP will help CHD to prioritise activities based on identified needs in its annual workplan and budget (AWPB). The CHD will decide whether or not to review the CMYP based on an evaluation of the Community Based Neonatal Care Programme (CB-NCP) and recommendations from a meeting chaired by the health secretary in April 2013.

Following the completion last quarter of the **Health Sector Strategy to Address Maternal Under-Nutrition**, FHD's Maternal and Newborn Health Sub-Committee has recommended that the strategy be endorsed. This strategy will guide the government to implement activities to improve maternal nutrition. In early April 2013 the CHD will ask the Nutrition Technical Committee to recommend the endorsement of the strategy. NHSSP will support DoHS to develop a plan to implement the strategy involving CHD, FHD, the National Health Training Centre (NHTC) and the National Health Education, Information and Communication Centre (NHEICC). In addition, NHSSP's sharing of the Maternal Under-nutrition Strategy with safe motherhood, neonatal and child health (SMNCH) partners will encourage them to work and link up on maternal nutrition in their programme districts.

NHSSP participated in and supported **FHD and CHD's annual planning and budgeting for 2013/14**, focussing on reaching unreached women and children. As a result the focus of the new plans is more targeted and evidence-based. Going forward, NHSSP will continue to support the production of the FHD and CHD AWPBs for 2013/14.

3.1.2 Maternal and Newborn Health (MNH)

During this quarter, NHSSP supported the FHD to revise and simplify the **maternal and perinatal death review** (MPDR) forms and supported the assessment and analysis of maternal death records and MPDR records in Janakpur Zonal hospital. This assessment uncovered several shortcomings in the way forms are filled out, which the assessment team was able to address with the hospital personnel. Overall, the revised forms will lead to better record keeping and reporting, which in turn will make it easier to identify avoidable causes of death. However the regular implementation of maternal and perinatal death reviews (MPDR) in hospitals will continue to be a challenge due to inadequate human resources.

NHTC was facilitated to be able to effectively monitor the quality of **SBA training** in Janakpur, Biratnagar and Birganj as well as to develop an advanced skilled birth attendant (ASBA) training site at Koshi zonal hospital. The first ASBA training was provided to six doctors in March. These inputs from NHSSP will enable improved provision of SBA training and as well as the availability of ASBA training in the eastern region.

Following the identification last quarter of options for responding to **the increased demands made on delivery services in higher-level hospitals**, a policy brief on findings and recommendations was produced and shared at both the JAR and reproductive health review meetings. A costed proposal focusing on key steps to improve the situation in the 6 hospitals involved in the study was also presented at a SMNSC meeting aimed at encouraging partners to fund and support the recommendations. Continuing to support follow up to this important study will improve strategies addressing the overcrowding challenge in referral hospitals in the Terai. The FHD will budget for follow-up in next fiscal year.

As part of NHSSP's support to **safe abortion activities**, safe abortion services were provided in Myagdi and Kalikot districts through International Pregnancy Advisory Services (IPAS). Eight auxiliary nurse midwives from Myagdi were trained in carrying out medical abortions, and medical abortion providers

mentored and provided with on-site feedback by public health nurses. An abortion attitude and value clarification and transformation workshop (VCAT) was conducted in February in Myagdi and Kalikot districts and information, education and communication activities (street drama, video documentary shows, FM radio programme) and orientation to social mobilisers of 41 Myagdi VDCs took place to inform and increase access to safe abortions services. These training activities will result in the wider availability of abortion services in these two districts in particular. The VCAT training will lead to service providers and health facility in-charges showing more empathy towards clients and their families. IPAS will continue to implement this piloting and learning initiative up to August 2013 to inform the government's scaling up of these types of activities.

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

The **Human Resources for Health (HRH) Strategic Plan**, which was approved by Cabinet in December 2012, was officially launched in Kathmandu on 23 January, 2013. The event was well attended and provided an opportunity to raise awareness about the plan. The speakers, who included MoHP's secretary the director general of DoHS, and the WHO health advisor, used the opportunity to present key human resource issues and challenges. The media received additional information at a press conference held after the event.

Officials from MoHP's Human Resources and Financial Management Division (HRFMD), the Planning Division and the Human Resources Management Information System (HuRIS) section continued implementing the dissemination strategy and plan for the HRH Strategic Plan. In this quarter they used HuRIS monitoring and training visits to disseminate the plan in 8 districts. NHSSP supported the Joint Secretary of the HRFMD to develop a presentation on human resources for the JAR, which provided another opportunity to update stakeholders on human resource issues. The English and Nepali versions of the HRH Strategic Plan were disseminated to participants at the JAR meeting and queries addressed.

The launch was well attended and provided an opportunity to increase awareness about the plan and highlight key human resource issues and challenges. The information provided to the media will ensure more accurate reporting on HRH in the media. The dissemination of the plan at sub-national levels will create greater awareness about the plan while stakeholder engagement will build support for its implementation and help address human resources issues and challenges. Overall, the use of the plan by all stakeholders will promote more coordinated and coherent responses to the HRH challenges. The recognition of the plan as the official MoHP position and approach to HRH will help ensure that HRH is seen as a strategic and priority area within MoHP and other sectors.

NHSSP will support MoHP to continue to disseminate and discuss the plan with stakeholders, to use it to mobilise resources and support, and to promote more coherent approaches to addressing HRH issues and challenges across the health sector.

Some progress was made with collecting, entering and analysing data collected through the **HRH assessment**. Almost all the data have been collected for the public and private service delivery and training facilities surveyed and most have been entered, cleaned and verified. The MoHP-led HRH Assessment Core Technical Team, which included representation from NHSSP and WHO, has met regularly. It provides technical oversight and support to the Society for Local Integrated Development Nepal (SOLID), the agency carrying out the assessment. The dataset and findings will be used to develop and inform the workforce plan and projections. It will also improve the overall quality and comprehensiveness of the data available on HRH across the public and private health sectors. NHSSP support to the HRH assessment process is strengthening the capacity of MoHP to manage and

coordinate HRH research and the capacity of the local agency to develop and implement research methodologies and study protocols. Going forward, the MoHP-led HRH Assessment Core Technical Team, with NHSSP and WHO, will continue to support the process ahead of SOLID's submission of the completed database and other reports. The dataset will then be used to develop and inform the workforce plan and projections.

NHSSP supported the functioning of the **MoHP-led Workforce Planning Technical Working Group (TWG)** and supported MoHP to develop a proposal that secured financial support to facilitate regular meetings of this TWG. This high-level multi-sectoral group of officials from MoHP and its departments, and stakeholders from the National Planning Commission, the Ministry of Education, Ministry of General Administration and public and private training institutions met regularly this quarter. It is responsible for overseeing workforce planning and the development of a long-term workforce plan and human resource projections. This quarter the TWG worked on identifying current and future health service delivery requirements and the training capacity to meet requirements. The group split into three sub-groups to explore and develop specific planning assumptions to inform the plan and projections. The broad representation on the TWG will ensure greater ownership of the workforce plan, more realistic projections and greater commitment to its implementation. It will promote greater alignment of the plan and projections with service delivery needs and training capacity. The international consultant will both work with and mentor the core technical team, thus building MoHP's and stakeholders' capacity for workforce planning. The sub-groups will present the outputs of their work to the full TWG next quarter and these will be consolidated to inform the next phase of the work. This will involve the formation of a core technical team, which will be supported by an international workforce planning consultant, contracted by NHSSP to develop projection scenarios based on agreed service needs, the current supply of health workers and gap analysis. They will also be responsible for overseeing the development of costed strategies to fill the projected staffing gaps and to improve the effectiveness of the workforce.

The findings and recommendations of the **NHTC capacity assessment** (Phase 1) were presented and endorsed by the health secretary and the steering committee this quarter — one of two bodies established to coordinate and oversee the assignment. The main recommendation was that NHTC become a 'training management body' responsible for managing and quality assuring all training carried out for MoHP and its departments. The steering committee also gave the go-ahead for Phase 2 of the current assignment. In February/March a new change management team was formed sponsored by the health secretary and co-sponsored by the DoHS director general. Phase 2 was initiated by developing a ToR and contracting the consultants to undertake the work. The consultants began consultations with the change management team and NHTC to prepare the road map. As a result a more efficient and effective NHTC will improve the coordination, management and quality of the training carried out for MoHP and its departments and centres. Phase 2 of the assignment will focus on establishing a change management team to develop and support the implementation of the road map. The road map will outline the strategy, organisational design and structure, staffing, skills, financing, reporting arrangements and other elements required for NHTC to perform as a training management body. The change management team, which is led by the DoHS deputy director general, will be responsible for proposing the structure and systems needed for NHTC and preparing a road map for the transition.

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 draft **implementation plans for its national behaviour change communication (BCC)/information, education and communication (IEC) strategies for safe motherhood, neonatal and child health (SMNCH), adolescent sexual and reproductive health (ASRH) and family planning**. These plans will be finalised in the next reporting period. Following on from last quarter, the NHEICC also finalised two sample district-specific BCC/IEC plans. As a result, the national plans will guide the implementation of the national strategy. The district plans will facilitate more context-sensitive planning to better address important local issues. NHEICC's TWG will review draft district implementation plans and plan for implementation from the next fiscal year.

A final draft of the **comprehensive social audit guidelines** are under the approval process with MoHP. In the meantime, NHSSP (with GiZ) supported the Primary Health Care Revitalisation Division (PHCRD) to organise a capacity building event in Kathmandu for social audit focal persons from 21 districts where budgets have been allocated for this work in 2012/13. These districts are contracting NGOs to carry out social auditing. The monitoring of the social audit piloting is on-going in Palpa and Rupandehi and will be completed in the next reporting period. The health facility-wise social auditing of health service delivery will help establish a mechanism for downward accountability. This will develop local ownership and create an enabling environment for more responsive service delivery. Following approval of the social audit guidelines, PHCRD will develop a roadmap for implementation across all districts of Nepal.

The **Operational Guidelines for Mainstreaming GESI in the Health Sector** were drafted by a technical working group after participatory consultations. They were submitted to the health secretary for approval in February 2013. These guidelines provide practical guidance for addressing GESI issues in MoHP's planning, programming, monitoring, supervision and reporting and in delivering health services. Once implemented, they will enable policy makers, programmers and service providers to identify and respond to issues experienced by women and poor and excluded people in using health services and so improve their health outcomes. Once approved the guidelines will be rolled out based on a road map prepared by the Population Division. GESI technical working groups at various levels will be orientated and they, in turn, will orient health facilities to implement the guidelines.

Guidelines for the establishment and operationalisation of GESI institutional mechanisms, which specify the location of GESI responsibilities within the health system, were approved by the health minister in this reporting period. District GESI technical working groups were formed in 19 new districts meaning that these TWGs have been formed in a total of 69/75 districts. NHSSP also facilitated PHCRD, the Population Division and NHTC to run GESI capacity building workshop-cum-training events at central and district levels

for GESI focal person from 18 districts and focal persons of DoHS divisions and centres. The guidelines outline mandatory responsibilities on GESI. This will ensure that the different technical committee and working groups are bound to work on GESI issues. The training input will provide conceptual clarity and practical guidance for addressing GESI issues in divisional and district programming, monitoring, supervision and reporting processes. This training will enable district teams and service providers to identify and respond to issues of women and poor and excluded people in accessing health services. The established entities will be guided on how to implement the GESI operational guidelines. Staff will apply their GESI skills to influence district teams and in local level action planning to meet the needs of poor and excluded people.

Social service units (SSUs) were established and orientations provided to hospital staff, hospital development committee members and stakeholders at western regional hospital and Seti zonal hospital while a SSU sub-committee was formed and an orientation held at Bharatpur Hospital. A preliminary meeting was held on establishing a SSU at Koshi zonal, maternity and Bir hospitals. All the implemented activities were based on the SSU road map. A concept note for outsourcing SSU facilitation to local NGOs was also developed and finalised in consultation with the Population Division. As a result, health services will be more easily accessible to poor, helpless, disabled, gender violence survivors and other target groups in the eight hospitals where SSUs have been operationalised. SSUs will be established in six more hospitals (Bir, Maternity, Kanti, and Bharatpur, Koshi and Bheri zonal hospitals) in FY 2012/13 on a pilot basis and will be scaled up after two years. Regular backstopping will be provided to SSUs by the Population Division and NHSSP.

One-stop Crisis Management Centres (OCMCs) were established and basic orientation provided in Nawalparasi and Dang district hospitals. Orientation was provided and a district coordination committee was formed in Sagarmatha Zonal Hospital. Consultation and preliminary meetings were held at Sarlahi and Tanahu district hospitals on establishing OCMCs. Discussions with Dhulikhel community hospital led to it agreeing to establish an OCMC under a public-private partnership. Support was also provided to develop a resource book on gender based violence (GBV) and information pamphlets on GBV/OCMC, the latter have been distributed. As a result, GBV survivors will be better informed about available services and able to access services at one place. Importantly, they will therefore not be required to repeatedly share their case histories. Trained service providers are able to extend good quality services to women who come to the OCMCs. Going forward, OCMCs are to be established in six more hospitals by mid-July 2013. Areas of partnership will be identified with UNFPA and other external development partners and operationalised.

About half (12 out of 20) of the DHOs/DPHOs under **the Equity and Access Programme (EAP)** completed NGO selection for this fiscal year and are now orienting these NGOs ahead of implementation. The other 8 are currently undertaking NGO selection. NHSSP provided technical support to develop and disseminate NGO contract documents and capacity development support for needy districts. Multi-year contracting of these NGOs will increase the efficiency of implementation and reduce transaction costs. The EAP will contribute to community empowerment which is the intended number one outcome to facilitate service use by poor and excluded people. The findings of the EAP review (2012) are being

shared with key decision makers at DoHS and MoHP. This will continue in next quarter via government counterparts. The file memo for approving multi-year contracting of NGOs is in MoHP and is due to go to NPC and the Ministry of Finance for approval.

NHSSP supported NHTC to finalise ToR for developing **GESI modules and materials for integration in five curricula**. Drafts of materials to be incorporated in the SBA training curricula were reviewed by SBA trainers. Materials for integration within FCHV, HFOMC, BCC and assistant health worker curricula and facilitators' guides are being developed by consultants under guidance of the GESI team. As a result, NHTC's regular training programmes will incorporate GESI sessions and service providers will receive training on GESI and on being GESI-responsive. Once drafts are finalised, the materials will be pre-tested and incorporated in the curricula. Until reprinting happens, the GESI modules and materials and facilitators' guide will be inserted into the printed training curricula.

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

In March, MoHP's steering committee endorsed the **national health insurance policy**. NHSSP, as a member of the technical committee for this initiative, provided inputs to prepare the policy. A draft design document was prepared for policy implementation in selected districts. MoHP plans to implement the National Health Insurance Programme (NHIP) from fiscal year 2013/14. The Ministry of Finance (MoF) has allocated NPR 500 million for implementation in 5 selected districts (Kailali, Banke, Baglung, Sarlahi and Ilam). The draft design document will support MoHP to finalise the modality, recommend the benefits' package and fix annual premiums. MoHP will request the technical committee to finalize the design of NHIP and prepare an implementation and monitoring plan. The technical document will then be discussed by the technical committee. Note that NHIP will be implemented through an independent agency and that MoHP will strengthen the Health Economics and Financing Unit (HeFU) to run the scheme with additional technical assistance support.

NHSSP supported the Family Health Division (FHD) to draft a **monitoring and evaluation (M&E) framework for demand-side financing schemes**. As a result, there will be more efficient use of resources (better value for money) by avoiding stand-alone M&E activities of the Aama, 4 antenatal care and uterine prolapse programmes. FHD will present the draft M&E framework to concerned stakeholders for feedback and finalisation. Once approved, NHSSP will provide technical support to build the capacity of concerned FHD staff to implement the framework.

During this quarter, the capacity assessment of the Transaction Accounting and Budget Control System (TABUCS) piloting in eleven cost centres was finalised. NHSSP also supported a training of trainers course for finance and planning officers from these centres within MoHP (e.g. DoHS, divisions, centres hospitals, and DHOs). The TABUCS piloting will begin in 11 cost centres from 1 April, 2013. The same modality will be used while conducting the assessment in the remaining 267 cost centres under MoHP. MoHP has instructed all 11 cost centres to assign a focal person for TABUCS and to implement the TABUCS piloting as a priority one programme. The trained finance and planning officers will be engaged in piloting TABUCS and MoHP will subsequently use the trained personnel to roll-out TABUCS across the country.

Together with the MoHP, NHSSP finalised a report by independent consultants of a **review of MoHP's internal control system**. Based on review findings, MoHP will prepare an implementation plan for the internal control system and include some related activities in its AWPB to strengthen its internal control system.

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

NHSSP supported the revision of indicators, recording and reporting tools and the reporting process of the **Health Management Information System (HMIS).** This was done to address NHSP-2 and programme needs. Field testing and scaling up plans were worked out and agreed with government counterparts. District Health Information Software 2 (DHIS2), a free open-source software, is a data reporting, management and analysis toolkit that is used in more than 30 countries. Considering its potential to meet Nepal's health information needs, including a more integrated approach to information management, NHSSP supported government officials from MoHP and DoHS to attend a DHIS2 Academy Workshop in Chandigarh, India in February 2013. The officials interacted with software designers, managers and implementers from different countries, and observed the software's implementation in health facilities. MoHP is now considering adopting DHIS2 for district and facility level data management. These initiatives will strengthen data management in the health sector, help institutionalise the demand-driven supply of information, help institute effective, efficient and robust technology and the development of an integrated health information system. More specifically the changes will:

- enable the generation of health facility and VDC level data;
- facilitate data analysis, interpretation and use at different levels;
- enable the generation of more disaggregated data (by caste and ethnic group);
- make data available from all public and non-public health facilities;
- integrate client tracking for antenatal care, HIV, TB and leprosy programmes;
- integrate mobile reporting on special cases such as maternal deaths;
- address the needs of hospital information systems;
- integrate geo spatial (GIS) data into the HMIS;
- allow web-based data entry and reporting;
- allow for better data quality control;
- integrate paper-based and electronic reporting;
- enable the generation of tables, maps, and charts;
- enable the generation of monthly, quarterly, biannual and annual reports; and
- enable functional linkages with other health-related management information systems using uniform codes.

NHSSP will support the field testing of the revised HMIS in 3 districts in the next quarter. The revised HMIS will then be scaled up to all 75 districts from next fiscal year (2013/14). Different divisions and centres have expressed their commitment to support this particularly for training health volunteers,

health workers and data managers as a part of their 2013/14 AWPBs. The customisation of DHIS2 tools, training and infrastructure and in-country capacity building will begin soon.

For the first time an **HMIS Bulletin with 5 years' data based** on the revised NHSP-2 indicators was prepared. The availability of information in the bulletin will improve data utilisation for monitoring and planning purposes; allow trend analysis and provide a base for planning future programmes and activities; and help stakeholders to access the detailed dataset before publication of the annual report. From this year, DoHS's HMIS Section will prepare annual rolling bulletins with data for all HMIS indicators and make them available to stakeholders immediately after completion of regional reviews.

ePopInfo has been developed with support from NHSSP, and is in process of being posted on MoHP's website. It is a user-friendly electronic database that provides accurate up-to-date information on population characteristics, health service provision, and water and sanitation in Nepal. e-PopInfo provides access to national, regional and district level information. The data comprises population by age, sex, urban/rural, literacy, human development index, human poverty index, government health facilities (including all levels, provision of emergency obstetric and neonatal care, safe abortion sites, and outreach clinics) and the coverage of drinking water and sanitation. ePopInfo will help decision makers, researchers and others who need authentic and reliable population related data. It will promote the understanding of population issues and can be used for population related planning and programming. This will lead to the more effective use of data to aid research, programmes, planning and policy. This database was developed under MoHP's Population Division, which will be responsible for updating it. The population related data comes from the 2011 census. Therefore future population projections need to be done. The Population Division should take the lead for producing these projections in coordination with the Central Bureau of Statistics (CBS), HMIS and other stakeholders.

All DHOs and DPHOs in Nepal have to prepare, print and distribute **district population profiles**. With the support of NHSSP, the standardisation of these profiles is currently being finalized. After MoHP's approval, a standardised template will be used to produce these profiles. A standardised set of data will be available in one place. District population profiles will be authentic data which all sectors can use to help to plan and programme. This initiative was developed under the leadership of the Population Division. The regular updating of data will be the responsibility of DHOs and DPHOs. The Population Division will take the lead in producing population projections.

A document was prepared on the achievements in 2012 against targets in the NHSP-2 logical framework (2010-2015). The household survey 2012, service tracking survey 2012 and HMIS data for FY 2011/2012 were used to develop this document and the data was verified. An NHSP-2 progress report was also prepared for the joint annual review (JAR) 2013. The printed report will serve as a reference and will be posted on MoHP's and NHSSP's websites. This will enable divisions and centres to revisit the logical framework targets. These MoHP documents should be prepared by the Public Health Administration, Monitoring and Evaluation Division (PHAMED). Because of limited dedicated staff, PHAMED has yet to lead this process and NHSSP will continue its support while building the capacity of staff is built.

The draft Household Survey 2012 and Service Tracking Survey 2012 reports were finalised and in March circulated to government officials and EDPs for comments and feedback. The survey findings are key references for developing NHSP-3. Once received, feedback will be incorporated and reports finalised and published.

Output 6: MoHP and the (Ministry of Urban Development[1]) have capacity to develop and implement procurement in accordance with the procurement arrangements for the health sector.

3.6.1 Procurement – Goods and Services

The bank of **400+ technical specifications** for hospital furniture, surgical instruments, medical equipment and drugs was uploaded on the Logistics Management Division's (LMD) website in December 2012. This databank was improved by inputs from an international bio-medical engineer and an international pharmacist in February 2013 with duplicates deleted and amendments made. A further 80+ specifications were uploaded in March 2013. The bank was introduced at the annual meeting of the Bio-Medical Engineering Association of Nepal (BEAN) and was positively received. All LMD's contract and warehouse managers were informed about it at a small workshop. The police and cancer hospitals find the specifications useful and expect to use them in the near future while some district health offices have shown an interest and been provided with printouts of the specifications to overcome their difficulties in downloading them from the internet. Some prospective bidders have checked the equipment they are able to provide against the specifications. However, LMD has yet to receive any comments on the specifications in the bank. LMD now has a bank of standard, agreed technical specifications that are available to all, including bidders, thus improving transparency; to all DHOs and DPHOs to make their procurement processes more efficient; and to all interested parties to comment on. The databank will also improve efficiency of procurement officers and users in LMD and district health offices. Going forward, the bank's specifications will form an integral part of the development of bidding documents.

NHSSP's two bio-medical engineers continued to conduct **market surveys** to help prepare and update the technical specifications bank. For ICB-36 (international competitive bidding for the procurement of contraceptives), one contract was awarded for 104% of the estimated cost whilst all the others came in under the estimates. This is a considerable improvement over last year's identical procurements. This will result in more accurate cost estimates of drugs and equipment. The estimates serve as background knowledge for bidding documents for these drugs. These will be passed back to programme divisions so they can more accurately draft their budgets as part of the AWPB for following years. The cost estimates will provide inputs for the market analyses planned for NHSSP Phase 2.

Several small **guidelines for procedures and policies** were developed and presented to LMD's management. These included notes on framework contracts, contract amendments and bid securities. However, LMD's management has shown limited interest in these. After LMD management's long indifference to the need for a procurement manual, the deputy director was appointed this quarter as the contact person for developing such a manual. The work started with visits by the deputy director

[1] The Ministry of Physical Planning and Works has been replaced by the Ministry of Urban Development (MoUD) and Ministry of Planning. DUDBC now falls under MoUD.

and four contract managers to central, regional and district warehouses, as the contract managers had never seen warehouses other than Teku and had no in-depth knowledge of the challenges faced by other warehouses for stream management. The result will be 1) an operations manual describing all procedures, including information flows, in LMD's supply chain, and a step-by-step guide for staff, 2) staff who know what is expected of them and what to do in different situations, and 3) improved communication between different actors in the supply chain. Draft chapters of the operations manual will be developed, discussed and adjusted at small workshops.

A **higher level of certification of WHO pre-qualification** (WHO-PQ) has been introduced for the procurement of drugs and vaccines where appropriate and where there are a sufficient number of bidders or manufacturers that qualify to ensure proper competition. Where this is not the case, the requirement has been introduced that bidders must have successfully supplied the public sector within the past three years. Note that laboratory tests are used but are usually restricted to the government laboratory due to a lack of budget. This will result in a higher quality standard of drugs being procured as low quality drugs will no longer be accepted. Currently, the absence of these requirements results in many bids being declared non-responsive, which this will also help to resolve.

A further **10 multi-year contracts** were included in LMD's procurement plan for 2012/13, and the procurement of these is underway. There is evidence that the increased quantities over either two or three years have resulted in an increase in bids from 'abroad', although only from South Asia. A strategic paper on framework contracts was drafted and provided to the DoHS director general and LMD's director. This will result in economies of scale from the supply of cheaper and higher quality commodities.

3.6.2 Infrastructure

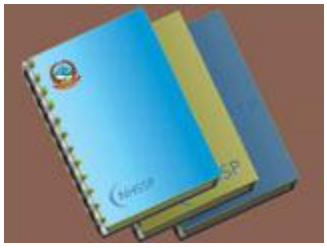
The **upgrading and updating of the Health Infrastructure Information System (HIIS)** was completed in March 2013. Different output formats (database reports) were designed for health infrastructure planning, monitoring and reporting. The upgrading of the HIIS will result in more rational budgeting for the repair and maintenance of health buildings; improved planning of health facility building (new and extensions); improved support to divisions to prepare procurement plans and progress reports; and better value for money from more efficient working. Once the HIIS becomes web-based (planned for April-June 2013) concerned stakeholders will be better able to monitor construction and expenditure progress. This will improve access to information resulting in time saving in data collection and reduced ad-hoc planning.

Updating of **standard integrated designs of health facility building** was initiated in last quarter of 2012. Updated standard designs for district hospitals, PHCCs and health posts have been prepared as related to doors, windows, sanitary fittings and other details. As required by the National Public Health Laboratory, blood supply units have been added to the designs of all types of health facilities. What change will result?: the use of improved standard health facility designs will enable service providers to better manage service provision; reduce operation and maintenance costs; reduce construction costs; and improve sanitation, hygiene and waste management. The revised standards are ready for presentation to stakeholders (proposed for April 2013), and once agreed will go for printing. The next

stage is to train officials from DHOs/DPHOs, technicians from DUDBC and district technical offices to use the standard designs.

Joint monitoring visits have helped resolve delays and **quality issues pertaining to on-going building contracts**. A joint monitoring team of Management Division officials, architects and engineers from DUDBC, the NHSSP infrastructure adviser and DUDBC and local health sector officials made monitoring visits to five districts (Darchula, Baitadi, Banke, Baglung and Parbat). Examples of impacts include supporting Baitadi district DUDBC office to initiate the needs assessment for building a new hospital in the district and inspecting a delayed comprehensive essential obstetric care (CEOC) works at Darchula District Hospital. The technical problems that had caused delays were resolved. Site shortcomings were noted and drawings accordingly revised. This helped the DUDBC divisional office to expedite the construction work and has enhanced the capacity of this office's personnel to understand the requirements of health infrastructure construction. The monitoring visit to Bheri zonal hospital (Nepalganj) helped resolve the long-pending incompletion of its emergency ward. It led to the design being revised to resolve technical problems. Problems regarding contractual complications are being discussed and are expected to be resolved and initiated by April 2013. This monitoring will result in the resolution of issues that are causing delays in construction in the sites visited. It will also enable DUDBC and DHOs to better plan future projects including issues of site selection, progress documentation, the vested interests of different groups in site selection. This will result in the more timely completion of buildings for handover to health personnel. Going forward, standard monitoring tools and guidelines will be part of the Standard Guidelines for Health Infrastructure Development Works. And different tiers of monitoring teams will be formed with the frequency of their visits being defined in these guidelines.

In March NHSSP started efforts to **improve coordination between the Management Division and DUDBC**. In addition, a discussion was initiated with the Management Division to put the ownership of all types and levels of health facility buildings under its umbrella (as was previously the practice) to enable the better coordination of procurement plans, progress reporting and monitoring, including the budget planning and release schedule. At the March meeting between the Management Division and DUDBC, it was agreed to have a progress and issues sharing meeting at least once every two months. It was also agreed that the Management Division would plan and initiate action and advocacy to get all construction planning and implementation to come under its portfolio. In this regard TOR were prepared for a comprehensive review of health infrastructure procurement. Improved coordination will result in increased efficiency in preparing procurement plans and progress reporting; and the improved implementation and completion of projects. The establishment of a steering committee and working group committee is planned for infrastructure development works and will be made up of MoHP, DUDBC, Ministry of Finance, National Planning Commission and DoHS officials.



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.

NHSSP supported a stakeholder workshop to finalise the '**State-Non State Partnership Policy** for Nepal's Health Sector'. Once formally approved the policy will create a supportive environment for state and non-state sectors to work together and encourage better synergies on achieving optimal health outcomes. MoHP has sent the proposed policy to other concerned ministries for their inputs. After receiving and addressing responses, it will be sent to Cabinet for approval.

NHSSP supported the well-received **Joint Annual Review (JAR)** of January 2013. This third JAR of NHSP-2 was conducted in a more structured and planned manner than in previous years. This improved the effectiveness of the meeting and is likely to improve the quality of future JARs. The Aide Memoire describing follow-up actions was signed within one week. The JAR proceedings report which identifies key issues and ways forward was prepared. Going forward, future JARs will include a greater emphasis on the representation of civil society including NGOs.

Draft **district health planning guidelines** were finalised by the steering committee and are now being edited. The Management Division of DoHS will soon have its own district health planning guidelines and DHOs and DPHOs will be facilitated to make district health plans based on the guidelines. The Management Division is the focal point for the health planning process. This initiative will lead to the standardisation of district level planning processes following recommended good practices.

The **Local Health Governance Strengthening Programme (LHGSP)** completed VDC planning in Myagdi district and the report is currently being written. This work will lead to the institutionalisation of participatory planning for the health sector at VDC level. This will enable health facility management committees (HFMCs) to conduct planning meetings, identify and prioritise local health needs, cost them and assess logistical needs. The Myagdi pilot will help inform the replication of this initiative in other VDCs and districts.

NHSSP supported a 3-day workshop in March on **planning the 2013/14 AWPB and preparing MoHP's position on the NHSP 2 Mid-term Review report**. All DoHS directors were involved in the workshop and planning process. NHSSP also supported the preparation of a report highlighting the key findings and recommendations from the Mid-term Review of NHSP-2 (MTR), priority activities from the Aide Memoires of the 2012 and 2013 JARs, national health surveys completed in 2011 and 2012, and HMIS data. The report was shared with high level departmental officials at the March workshop. It is expected that the 2013/14 AWPB will be more evidence based with proposed activities linked to outcomes; more GESI-responsive planning; more innovative strategies to reach the underserved; less duplication of activities and resources; and all divisions and centres proposing budgets within the budget ceiling.

The interactions between DoHS divisional and centre chiefs enabled them to cross-verify their programmes. It facilitated a consistent approach to prioritising programmes and avoiding duplication. The workshop also facilitated a common understanding on MTR findings. The workshop facilitated the government to prepare its position regarding the key findings and recommendations of the MTR report and also made concerned divisions and centres more responsive and accountable to the indicators of the NHSP-2 log frame. DoHS divisions and centres will work with stakeholders to make the AWPB more evidence-based and avoid duplication of activities and resources. MoHP's position on the MTR will be shared with external development partners following which a course of action will be agreed. Divisional programmes will be further consolidated and discussed with external development partners. There will be **c**ontinued advocacy, lobbying and facilitation for sound planning. Support to DoHS divisions and centres to prepare the 2013/14 AWPB based on evidence and analysis of data.

A ToR was developed for a consultancy to develop **standard performance based contracts for hospitals**. The ToR has been shared with senior government officials and external development partners. These contracts will promote the more efficient use of financial resources by service providers and programmes. Allocating resources on the basis of performance-based contracts will improve financial management and efficiency. As agreed at the 2012 JAR, these contracts will first be introduced in seven hospitals and will then be extended to others.

An **operational manual for managing health facilities** was drafted and shared at a consultative meeting chaired by the health secretary with participation of divisional and ministry heads. This manual will help officials take a consistent approach to managing health facilities. This will result in more rational decision making and support improved knowledge on procedures related to the daily operation of health facilities at all levels with a focus on management and medico-legal aspects. Additional inputs will be solicited to further improve the manual which will be further discussed at field level and finalised.

4. Regional Update

Region	Achievement	What will change as a result?	How will this be taken forward?
Eastern Region	Regional Health Profile (public and private) printed and disseminated.	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 further supports referral practices and public awareness of service availability.	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 following their endorsement by MD/DoHS.
	Updated Calendar of Operations for fiscal year 2069/70 for region and 5 districts.	Improved planning of regional and district resources including improved timeliness of implementation, support and monitoring processes.	Through the annual planning process.
	Supported preparation of annual budget and program for 2070/71.	Improved quality of budgeting; inclusion of demand responsive budget lines; inclusion of GESI budgeting.	Through the annual budgeting process
	Supported web based reporting system in Khotang, Terhathum, Jhapa, Udayapur, Saptari, Morang and Dhankuta districts.	Improved information flows and reporting leading to increased responsiveness of support including supplies of essential drugs and deployment of contracted staff.	Scaling up to other districts in the region

Region	Achievement	What will change as a result?	How will this be taken forward?
	Supported rapid assessment to establish OCMC in Saptari district; Supported efforts to establish SSU in Koshi zonal hospital	Improved access for victims of violence to confidential counseling, medical services and other support. Improved social protection. Improved access to affordable health services for women, and people from poor and marginalised groups.	Monitoring of OCMCs and scaling up to other districts.
Central Region	Regional Health Profile updated.	Improved health planning and decision making including increased resources for priority, poorly served, districts. Improved referral practices. Improved information from districts and VDCs on profile gaps leading to improved accuracy and utility of profile.	Dissemination to all D(P)HOs in the region for use in district-level planning. District data used to update the profile as part of annual review process.
	Districts supported to prepare plan of action for micro-planning to Reach Every Child (REC); additional district level plans made to improve access to EHCS services by excluded populations.	Improved targeting of children for immunisation, nutrition, awareness and other services; improved access by excluded populations to EHCS services at appropriate levels.	Through implementation of the plans following inclusion in annual planning and budgeting process.
	GESI working groups formed in 7 districts - Sindhupalchowk, Dolakha, Rautahat, Bara, Chitwan, Kathmandu and Lalitpur; monitoring of Social Inclusion Information System (SIIS) carried out in 3 districts.	GESI responsive planning and implementation at district level leading to improved targeting and access of excluded groups to health services and "voice" in social auditing processes. Improved likelihood of OCMCs and SSUs being established. Improved data on exclusion.	Through GESI focused district planning and implementation in 2070/71 financial year.
	Regional maternal death cases reviewed and report prepared	Improved understanding of causes of maternal deaths leading to improved access to facilities, more timely treatment and improved quality of care.	Through inclusion of findings in annual review and planning meeting and feedback to facility level.
	Resource (Documentation) Centre established at RHD	Improved access to policy, strategy, planning, technical and reporting documents including those of other agencies operating in the region.	Promotion of the resource centre in regional sector meetings including requests to agencies for additional resources.

Western Region	EOC regional strengthening plan updated and revised during half yearly review meeting.	Improved efficiency and use of available resources. Improved planning and decision making for EOC including improved support to districts.	Through AWPB for region and districts.
	Ten LHGSP programme VDCs in Myagdi district prepared their draft three year periodic health plan.	Much sought after decentralisation of health planning and monitoring at sub-district level.	Through review of the LHGSP programme, revision of guidelines, endorsement and mainstreaming.
	GESI TWGs formed and orientation sessions run in six districts (Arghakhanchi, Nawalparasi, Rupandehi, Tanahun, Lamjung and Gorkha).	GESI responsive planning and implementation at district level leading to improved targeting and access of excluded groups to health services and "voice" in social auditing processes. Improved likelihood of OCMCs and SSUs being established. Improved data on exclusion.	Through GESI focussed district planning and implementation in 2070/71 financial year.
	Orientation on Social Service Unit Guidelines and their use to key staff in Western Regional Hospital, Pokhara.	Improved functioning and performance of the SSU at Western Regional Hospital.	Through annual plan and budget for SSU.
	Guidelines for Conducting Effective Meetings revised, finalised and distributed to districts and more widely across the Ministry.	Improved planning, implementation, decision making and recording of various types of meeting in different contexts.	Through review and regular use by senior officials at RHD and district level.
Mid-western Region	Regional health profile shared at RHTC meeting for feedback.	Improved health planning and decision making including increased resources for priority, poorly served, districts. Improved referral practices. Improved information from districts and VDCs on profile gaps leading to improved accuracy and utility of profile.	Dissemination to all D(P)HOs in the region for use in district-level planning. District data used to update the profile as part of annual review process.
	GESI Technical Working Groups formed in Pyuthan, Kalikot, Jajarkot and Mugu districts.	Improved district level priority for GESI in planning, programming and budgeting including improved targeting of hard to reach communities; improved running and	Through district level AWPB exercise and implementation, particularly in remote, hard to reach areas.

		effectiveness of OCMCs and SSUs in the region.	
	Assessment of ANC cost analysis in the region completed.	Improved understanding of the cost burden of ANC including the effectiveness of GoN's 4-ANC cash incentive scheme.	Through regional and national review meeting and DSF evaluation.
	Developed plan of action on RH programme by DPHO Jumla.	Improved RH programming in Jumla.	Through the district AWPB process and implementation plan.
	Assessed EOC services availability and utilisation in the region.	Improved understanding of service availability, quality, costs and EOC operational bottlenecks in MWR.	Through regional review meeting and FHD EOC monitoring and review.
	Updated integrated monitoring checklist for districts.	Improved effectiveness and efficiency of monitoring and support visits by RHD staff.	Through work plans and protocols of RHD staff
	Finalised ToR for regional health documentation centre.	Improved access to policy, strategy, planning, technical and reporting documents including those of other agencies operating in the region.	Promotion of the resource centre in regional sector meetings including requests to agencies for additional resource materials.
Far-western Region	Regional Health Sector Strategic and Periodic plan prepared incorporating both GESI and MNCH activities.	Improved priority to MNCH and GESI within a comprehensive and timely regional health plan.	Through the AWPB approvals process and programme implementation.
	Identified additional EDP resources for capacity building of GESI TWG's activities. UNFPA is committed to supporting TWGs in 2 districts.	Increased resources available for GESI planning and programming; improved alignment of GESI inputs among EDPs.	Through the regional AWPB process and during implementation.
	Developed action plan of Social Service Unit at Seti zonal hospital.	Improved functioning and performance of the SSU leading to improved equity in service availability at affordable cost.	Through the HMC at Seti Zonal Hospital.
	Private hospitals and nursing homes committed to improve services and follow the free health guideline as suggested by the RHD.	Improved quality of services and availability of incentive schemes for service users in both public and private sectors. Closer relations between RHD and private sector.	Through annual RHD review and DSF monitoring processes.

	Analysed composition of HR of the RHD by sex, caste and ethnicity. Also analysed composition of FCHVs in Doti by caste and ethnicity.	Improved understanding of HR profiles in the region with improved evidence to press for recruitment of health workers from marginalised groups.	Through the HR profile work being carried out in MoHP by SOLID.
	Monitored and facilitated Social Audits and EAP in Doti, Achham Kailali and Darchula.	Improved understanding of user perceptions of service availability, quality and costs leading to service provider and facility commitments for change.	Through the Social Audit review process.

5. Payment Deliverables

Nine payment deliverables were submitted this quarter:

- Institutional Capacity Assessment of National Health Training Centre final report approved by govt. (Deliverable 54)
- Quarterly progress and performance report (Q4 2012) (Deliverable 52)
- Draft Technical Specification Bank with approx. 400 tech specs for medical equipment, User manual and a Maintenance manual for approval by government (deliverable 72)
- Increased demand for institutional delivery at higher level facilities in Nepal - an appraisal of Options. Draft report for discussion at JAR. Final report including JAR recommendations (January) (Deliverable 48b)
- Draft GESI Operational Guidelines for discussion with government (deliverable 51)
- Review of Planning Guidelines for the AWPB Process conducted. (evidence = draft planning guidelines and report summarizing review findings and recommendations for implementation) (deliverable 39)
- PEER Report on Barriers to Service Uptake (deliverable 50)
- Draft 2012 Household Survey to be submitted for government review (deliverable 46)
- Draft STS 2012 Report for circulation to government (deliverable 55)

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

- Successful 2013 JAR conducted (evidence = signed off JAR report; aide memoire and a brief evaluation of progress towards improved implementation of JAR within NHSSP project timeframe)
- Draft Rapid Assessment of Aama programme completed and recommendations for strengthening implementation developed for discussion with government
- Preliminary Findings of HR Profile Study
- Analysis of Barriers to MNCH in Remote Areas (based on literature, secondary data and key informant interviews) shared with Government, joint identification of potential solutions and further research agreed.
- Increasing Access to Safe Abortion Services including Medical Abortions in Remote Areas: summary of lessons learnt and recommendations from service expansion in two remote districts to inform scale-up
- Draft value for money case study from across the programme for approval by DFID
- Revised SSU Guidelines introduced and implemented with support from NHSSP in 2 hospitals
- Quarterly progress and performance report (Q1 2012)

Annex 1 – Publications Produced During This Period

EHCS	Responding to Increased Demand for Institutional Childbirths at Referral Hospitals in Nepal
	Pulse Report: Comprehensive Emergency Obstetric and Neonatal Care in Nepal - Are Health Facilities Ready?
GESI	Updated PEER report on barriers to service uptake
	Updated Social Service Unit Guidelines
	Draft GESI Operational Guidelines
	Institutional Structure Establishment and Operational Guidelines for Gender Equality and Social Inclusion
HPPHSG	JAR Briefing Papers (8 No.)
	JAR Proceedings
	Guidelines for Conducting Meetings
HRH	Dissemination Plan for the HRH Strategic Plan
Procurement	Procurement Specification Bank General Users' Manual
	Pulse Report: Procurement of Goods and Health Sector Goods
	Pulse Report: Buildings that work for health services
PFM	TABUCS Design and System Specifications
	Operating manual for e-AWPB
	Financial Management Improvement Plan
	Pulse Report: Electronic Annual Work Planning and Budgeting
M&E	Draft Service Tracking Survey 2012
	Draft Household Survey 2012
Other	NHSSP Annual Review Report for 2012
	Quarterly Report (Oct-Dec 2012)
	Pulse Quarterly Report: Oct-Dec