NHSSP Nepal Health Sector Support Programme

UKaid from the British people

Nepal Health Sector Support Programme

Quarterly Report

Reporting Period: April – June 2014

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Acronyms and Abbreviations

AIDS	acquired immune deficiency syndrome
AWPB	annual work plan and budget
CA	Constituent Assembly
CAPP	consolidated annual procurement plan
CBIMCI	community based integrated management of childhood illness
CBNCP	community based newborn care package
CEONC	comprehensive emergency obstetric and neonatal care
cGMP	current good manufacturing practices
CHD	Child Health Division
CIAA	Commission for the Investigation of the Abuse of Authority
CMAM	community based management of acute malnutrition
CMS	contract management information system
CPN(Maoists)	Communist Party of Nepal (Maoists)
CPN(UML)	Communist Party of Nepal (United Marxist Leninists)
C/S	caesarian section
DDC	district development committee
D(P)HO	district (public)health office(r)
DFID	UK Department for International Development
DG	DirectorGeneral
DHIS-2	District Health Information System-2
DHO	district health office(r)
DoHS	Department of Health Services
DUDBC	Department of Urban Development and Building Construction

EAP	Equity and Access Programme
EDP	external development partner
ENAP	Every Newborn Action Plan
EOC	emergency obstetric care
EPI	ExpandedProgramme on Immunisation
FCGO	Financial Comptroller General's Office
FCHV	female community health volunteer
FHD	Family Health Division
FMIP	Financial Management Improvement Plan
FMR	Financial Monitoring Report
FMT	Fund Management Team
FP	family planning
FY	fiscal year
GAAP	Governance and Accountability Action Plan
GBP	Great British Pound
GBV	gender-based violence
GESI	gender equality and social inclusion
GIS	geographic information system
GiZ	Deutsche Gesellschaft für Internationale Zusammenarbeit
GoN	Government of Nepal
H4L	Health for Life
HFOMC	health facility operation and management committee
HIIS	Health Infrastructure Information System
HIV	human immunodeficiency virus
HMIS	Health Management Information System
HR	human resources
HuRIS	Human Resource Information System
ICB	international competitive bidding
INGO	international non-governmental organisation

IT	information technology
JAR	Joint Annual Review
KFW	Kreditanstalt für Wiederaufbau (German Development Bank)
LGCDP	Local Governance Community Development Programme
LMD	Logistics Management Division
LMIS	Logistic Management Information System
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
MoF	Ministry of Finance
MoFALD	Ministry of Federal Affairs and Local Development
MoHP	Ministry of Health and Population
MoU	memorandum of understanding
MS	medical superintendent
NC	Nepali Congress
NCB	national competitive bidding
NGO	non-governmental organisation
NHSP-2	Second Nepal Health Sector Programme
NHSP-3	Third Nepal Health Sector Programme
NHSSP	Nepal Health Sector Support Programme
NHTC	National Health Training Centre
NPAS	Nepal Public Sector Accounting System
NPC	National Planning Commission
NSI	Nick Simons Institute
O&M	Organisation and Management
OAG	Office of the Auditor General

OB/GYN	obstetrics/gynecology
OCMC	one-stop crisis management centre
OPM	Oxford Policy Management
OPMCM	Office of the Prime Minister and Council of Ministers
PAF	Poverty Alleviation Fund
PBGA	performance based grant agreement
PD	Population Division
PDT	Project Development Team
PEER	peer ethnographic evaluation and research
PFM	public financial management
PHCC	primary health care centre
PHCRD	Primary Health Care Revitalisation Division
PIP	Procurement Improvement Plan
PNC	postnatal care
PO	procurement office(r)
PPICD	Policy, Planning, and International Cooperation Division
PS	procurement specialist
PSI	Population Services International
QA	quality assurance
QA&ITWG	quality assurance and improvement technical working group
QI	quality improvement
QITAC	quality improvement technical advisory committee
QoC	quality of care
RA	rapid assessment
RH	reproductive health
SARA	Service Availability and Readiness Survey
SBA	skilled birth attendant
SAVE/SCI	Save the Children International

SM	safe motherhood
SMNSC	Safe Motherhood and Neonatal Steering Committee
SNP	state non-state partnership
SPA	Service Provision Assessment
SSU	social service unit
STS	Service Tracking Survey
TA	technical assistance
TABUCS	Transaction Accounting and Budget Control System
TAG	technical advisory group
TARF	Technical Assistance Resource Fund
TB	tuberculosis
ToR	terms of reference
ToT	training of trainers
TWG	technical working group
UML	United Marxist Leninists
UNDB	United Nations Development Business
UNFPA	United Nations Family Planning Association
UNICEF	United Nations Children’s Fund
USAID	United States Agency for International Development
VDC	village development committee
WB	World Bank
WB-PQ	World Bank procurement quality
WDO	Women’s Development Office
WHO	World Health Organization

1. Introduction

The Nepal Health Sector Support Programme (NHSSP) is pleased to submit this quarterly report for the period April to June 2014, the fourteenth quarter of the programme and the second of its second phase following the inception report.

NHSSP is a programme of Technical Assistance (TA) to the Ministry of Health and Population(MoHP) and the Department of Health Services (DoHS), managed by the UK Department for International Development(DFID) on behalf of the pooled funding partners of the Second Nepal Health Sector Programme (NHSP-2).

Phase 1 of NHSSP ended in August 2013. Under Phase 2, Options leads a consortium of partners made up of itself, Crown Agents and Oxford Policy Management (OPM).In September 2013, an inception period took place during which priority work areas, outputs and a new draft logframe were developed. In addition, a flexible Technical Assistance Resource Fund (TARF) was established under MoHP's Policy Planning and International Cooperation Division (PPICD) to fund new initiatives put forward by MoHP and external development partners (EDPs). The phase 2 log frame was revised during the DFID Annual Review in January 2014 and progress against each of its outputs is described in Section 2 of this report.

The purpose of this report is to document the activities and results delivered by NHSSP between April and June 2014. The work of NHSSP advisors is based on:

- the requirements of NHSP-2;
- the ongoing activities and plans of the various MoHP departments, divisions and centres;
- the NHSSP phase 2 inception report, and
- the individual work plans of advisors.

All work plans have been agreed with advisors' counterparts who are mostly the heads of divisions and centres including the Family Health Division (FHD), PPICD, the Logistics Management Division (LMD) and so on. All NHSSP activities are designed to enhance the capacity of MoHP/DoHS to deliver NHSP-2 and prepare the ground for NHSP-3. Enhancing capacity, for NHSSP 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

PM Sushil Koirala of the Nepali Congress (NC) party was diagnosed with cancer and is undergoing treatment in the US. Deputy PM and Home Minister Bam Dev Gautum now leads the coalition government.

The government of Nepal (GoN) announced a 2014/15 budget of NPR 6181 billion (GBP 3.7 billion) with the health sector allocation being NPR 33.5 billion (GBP 0.2 billion) or 5.4% of the total. The ruling parties are putting pressure on the government to allocate NPR 50 million to each of Nepal's 240 constituencies under a constituency development program. Opponents suggest this is likely to fuel misappropriation and corruption.

Investigations by the Commission for the Investigation of the Abuse of Authority (CIAA) reported in the last quarter led to the arrest and charging of the Logistic Management Division's (LMD's) director, a procurement officer and several former LMD officials. These charges relate to irregularities in drug procurement.

In May, NHSSP participated in meetings with a delegation from the Independent Commission for Aid Impact (ICAI) which is responsible for scrutinising the impact of UKaid. The team also reviewed DFID projects in public financial management, local governance, education and community support. NHSSP also helped facilitate a visit by the Organisation of Economic Cooperation and Development's (OECD) Development Assistance Committee which evaluatesofficial development assistanceprogrammes around the world.

Summary of Key Events in this Quarter

In the reporting period, significant progress was made against NHSSP's three programme logframe outputs as follows:

In Strengthening Core Health System Functions

Progress in procurement included the successful quality assurance (QA) of all bidding documents submitted for review. Additional reports and features were added to the electronic Contract Management System (CMS) and its piloting began in three districts and two DoHS divisions. The consolidated annual procurement plan (CAPP) for 2014/15 has not advanced as expected but with the release of 2014/15 budget information is now expected in August. LMD's Technical Specifications Bank reached 1050 specifications, thereby exceeding the total NHSSP programme target.

Prospects for improved budgetary control in MoHP improved through the training of 331 finance and planning officers from 222 cost centres in 75 districts on the Transaction Accounting and Budget Control

System (TABUCS) and the establishment of a help desk in MoHP. 158 cost centres have now taken TABUCS into routine use. Following the distribution of MoHP's Internal Financial Control Guidelines and Audit Clearance Guidelines, 28.9% of the total audited amount of audit queries has now been cleared. Further, MoHP's Public Financial Management (PFM) Committee reduced the number of financial reporting templates required from 33 to 6.

Health infrastructure planning and construction management improved through the enforcement of punitive actions, including levying fines, withholding bank guarantees and bid bonds, for delinquent contractors. DUDBC's second trimesterly report recorded significant improvements in construction completion rates, and with over NPR 2.3 million collected in penalties up to the end of May.

Management Division's Health Infrastructure Information System (HIIS) was used to prepare a prioritised list of new constructions and facility upgradesfor 2014/5 using rational variables including population, mobility, and the condition and size of each building. Geographic information system (GIS) maps showing the catchment areas served by each health facility across the country were also producedwhile Management Division's Land Selection Guidelines for the Construction of Health Facilities were endorsed by ministerial level decision.

In Strengthening Information and Monitoring Systems

The development of a uniform data coding system for Nepal's health management information systems (MIS) advanced with stakeholder agreement on the adoption of the district and VDC codes developed by the government's Central Bureau of Statistics (CBS). Compilation of a registry of state and non-state health institutions having unique identification codes also got underway.

National roll out of the revised HMIS advanced with the recruitment of 100 facilitators by the consultancy New Era to assure the quality of HMIS training. To date around 20,000 health staff and 50,000 female community health volunteers (FCHVs) have been trained. Training is expected to be completed by August 2014 coinciding with the launch date of the revised HMIS at the start of the new financial year. The provision of additional funds from DFID allowed HMIS reporting forms to be printed and distributed ahead of timeand agreement has been reached with the Management Division, HMIS and DFID to provide further trouble shooting support and mentoring at selected health facilities during the first year through the hiring of five HMIS facilitators to cover the regions and work with DPOs/DHOs to support underperforming facilities.

Meeting information needs for the design of NHSP-3 has already begun with advisers using evidence from various studies, surveys and research to inform discussions in their respective NHSP-3 thematic working groups. Comments from key stakeholders were also incorporated in the 2013 Service Tracking Survey (STS) to be disseminated in the coming quarter.

During this period, MoHP and EDPs agreed to rationalise and harmonise facility based surveys under a single Nepal Health Facility Survey (NHFS) and a scoping exercise supported by USAID was carried out to plan NFHS 2015. In addition, NHSSP identified critical indicators required for the NHSP-2 end line which were originally included in the recently cancelled STS 2014 survey and worked with UNFPA and DFID to

reach agreement that UNFPA would incorporate these within their planned Facility Based Assessment for Reproductive Health Commodities and Services.

The development of a system to monitor and manage the quality of maternal, neonatal and child health (MNCH) in FHD advanced with the finalisation of a hospital QI toolkit and running of a 3-day workshop to establish the QI process in Taplejung District Hospital. This exercise included a self-assessment which identified 16 issues requiring attention. The QI committee in Hetauda Hospital held a follow up meeting to review progress against the action plan prepared during its initial self-assessment with generally encouraging results.

Efforts to address overcrowding in referral hospitals included planning workshops in two hospitals and follow up review meetings in three. Significant improvements were noted including additional health staff appointed, additional beds and equipment purchased and essential infrastructure repairs made.

Support for remote area planning continued with the preparation of detailed activities and implementation guidelines using materials provided by several agencies. These will be tested in Taplejung district under a remote areas MNH pilot (RAMP). M&E plans were also developed and an application made to Nepal Health Research Council (NHRC) for their approval, following which the pilot will begin.

In Supporting Institutional Reform Processes

Thematic groups for the design of NHSP-3 werepopulated with government officials and various technical experts. The NHSP-3 Project Development Team(PDT) is now fully staffed with two national experts, a secretary and a part-time international TA, supported by H4L. Each thematic group began generating content following a format prepared by the PDT and most are on track to submit initial recommendations by 15th July

The integration of MoHP's Equity and Access Programme (EAP) within the Ministry of Federal Affairs and Local Development's (MoFALD's) Local Governance and Community Development Programme (LGCDP) (social mobilisation component) advanced with the appointment of the Health Research and Social Development Forum (HERD) to conduct a study of existing health and governance social mobilisation schemes andassess the value and challenges associated with this planned integration in four vdcs of 2 districts. Data collection was completed in June.

Efforts to institutionalise social service units (SSUs) in MoHP in the quarter included the preparation of revised SSU guidelines based on the recommendation of the SSU study (August 2013), SSU review workshop (2014) and the preparation of a monitoring and evaluation (M&E) framework.

The orientation of staff in five H4L supported districts on social auditing took place ahead of 50 such auditsplanned in local health facilities. NHSSP also contracted the Human Resource Development Centre (HURDEC) for a process evaluation of social auditing in health facilities in 2014 and 2015 and the first round of data collectionin 10 facilities in Jhapa and Ilam districts was completed.

Population Division supported by NHSSP TA provided follow-up support to staff of 10 OCMCs including orientation on gender based violence (GBV) and discussions on ways to overcome commonly experienced problems. AnOCMC monitoring and reporting manual was prepared and tested in Hetauda.

Last quarter's review of Aama programme implementation in the private sector showedthat several non-accredited private hospitals were implementing Aamabut that their data were not included in routine FHD reporting. ToR for the analysis of Aama unit costs were approved together with the study's design and methodology while preliminary work began for a third revision of the Aama Programme Guidelines. In a landmark initiative, the 2013/14 Aama rapid assessment was contracted out directly by FHD (to the Nepal Environment Protection Agency (NEPA)) – the first time that budgeted MoHP funds have been used for this purpose.

Technical Assistance Response Fund (TARF) Funding

TARF funded activities in the quarter were as follows:

1. As requested by PPICD, the TARF Fund Management Team supported the appointment of two consultants (one full time and one part time) and one secretary for the NHSP-3 Project Development Team (PDT). These staff have been in place since May 2014.
2. At the request of FHD, contracts were extended for the Sr. SM Coordinator and CEONC Mentor for FHD for six months (May- October).
3. MoHP was supported for an Organisation and Management (O&M) survey ahead of the appointment of an additional 1485 staffing positions including doctors, paramedics, nurses, dentists and pharmacists. This input was requested by the ministry's HR & Finance Unit.
4. PHCRD was supported for social audit refresher training.
5. A senior GESI consultant was contracted at NHTC's request to design the gender component of its master trainer of trainers' curriculum.

Summary details of the expenditure on the TARF are given below:

Descriptions	Amount	Remarks
Total Fund Value	£500,000	
Spent to date	£97,362	
Committed to date	£45,963	
Remaining Balance	£356,675	
Management fee	£2,854	

Additional support

In addition to the activities funded under NHSSP phase 2, Options is managing several sub-contracts on behalf of DFID as described below and in greater detail in the appropriate sections of this report.

a) In Monitoring and Evaluation (M&E)

At the request of MD,a contract was awarded to the local consultancy New ERA to assist the division to quality assure training on the revised HMIS at all levels and across all districts (see 3.1.2).

b) In Financial Management

Funds were provided for the roll out of TABUCS at all cost centres across the country (see 1.2.1).

c) In Essential Health Care

A sub-contract was issued to SAVEto provide technical support for the strengthening of new born care in Nepal, including the development and implementation of context-specific new-born care plans in high-need areas;the strengthening of government programme quality, and government monitoring and supervisory systems. At the time of writinga first rapid assessment in Nuwakot district had taken place.

Provision has also been made to implement recommendations from the phase 1 remote areas study. As noted, Taplejung has been selected as the pilot district, preliminary assessments of a selection of facilities have been carried out and the design and planning of the pilot completed.

14payment deliverables and 13publications were produced in this quarter with all final,non-sensitive documents uploaded to the NHSSP website (www.nhssp.org.np). Visitors to the website reached over 13,000 (roughly 15 a day since Jan 2012) and Facebook 'likes' exceeded 375.Over 120 people follow NHSSP on twitter. The process of uploading NHSSP documents to MoHP's website began and NHSSP revised its document and presentation templates in accordance with DFID guidance on use of the UK aid logo.

3. Detailed Thematic Updates

TA Output 1:
Core Health SystemFunctions Strengthened

NHSP-2 Outputs: **Improved physical assets and logistics management (7)**
Improved heath governance and financial management (8)
Improved sustainable health financing (9)

Indicator 1.1:Logistics Management Division's (LMD's)capacityfor transparent and timely procurement

1.1.1. Increase Logistics Management Division's (LMD's) capacity to conduct procurement and contract management in a transparent, timely and accountable manner in line with procurement guidelines and the Consolidated Annual Procurement Plan (CAPP)

Performance this quarter washampered by CIAA investigations into irregular procurement practices and a stalling of LMD's procurement activities with officials proving reluctant to sign procurement documents. The investigation also resulted in the arrest and charging of the LMD Director, a Procurement Officer and several former LMD employees.Legal action notwithstanding, the TARF funded procurement specialists kept processes moving forward, albeit slowly. One of them, a highly experienced pharmacist, has added considerable value to the TA team in a critical technical area.

The CAPP for 2014/15 did not progress as expected in the quarter despite numerous exhortations to advance it. The recent finalization and announcement of MoHP's budget for 2014/5 should however allow all DoHS divisions to now finalise and forward their requirements to LMD for compilation.The CAPP is expected to be completedwithin August 2014.

1.1.2 Quality assurance (QA) procedures for annual procurement plans and bid documents established and disseminated with approval by DFID and Logistics Management Division (LMD)

Effective quality assurance is essential if the quality of bidding documents, evaluation reports and draft contracts for international competitive bidding (ICB) and national competitive bidding (NCB) is to improve. In the reporting period, QA procedures were completed for all documents submitted for review. However some documents,mostly NCBs,were approved by LMD without appropriate QA. TA will continue to work to ensure that the new QAsystem is applied to all bids requiring inspection (c. 80% of

the total). The main risk to this initiative is that LMD staff will continue to by-pass it without reference to the advisersand so undermine effective QA processes.

1.1.3 Support improvements in systems, procedures and processes for procurement and contract management

Additional reports and features were added to the electronic Contract Management Information System (CMS) which aims to support effective contract management, procurement planning, financial reporting and other supply chain related activities.TA also helped build related capacity through several training courses and on-the-job trainingsessions. These focused on both specific technical content (e.g. contract management for goods) and more generic professional skills (e.g. IT training).

In addition, TA visited several regional and district centresto review local supply chain processes andparticipated with other agencies in meetings of the 'Friends of LMD' group tohelp the department improve supply chain coordination and resource sharing.Importantly, and as requested by several DoHS divisions, information from the CMS was used to forecast demand and for other planning purposes. TA also liaised with DoHS' Financial Section for effective financial reporting under CMS.

1.1.4 Strengthen linkages between procurement, contract management and finance through an electronic contracts management system

Following completion and acceptance of the CMS feasibility report, demand and delivery forecasting progressed with the installation and commissioningof the CMS in selected locations and piloting in three regions, three districts and two DoHS divisionsbegan. Further, DoHS' Finance Section and LMD agreed on common reporting formats to be used by the Finance Section and the programming of these reports is now underway.

In the next quarter, piloting will be completed and, subject to approval by key stakeholders including LMD and DFID, a CMS roll-out schedulewill be prepared. In addition, anorientation and training workshop detailing the CMS will be held for LMD and Finance Section staff.

1.1.5 Enhance value for money in procurement practices by improving Logistics Management Division (LMD) knowledge of the supplier market for selected procured goods

No significant developments in this area in the quarter.

1.1.6 Expand capacity of Logistics Management Division (LMD) to effectively ensure quality of goods procured through use of technical specification bank and appropriate use of biomedical engineers

LMD's technical specifications bank provides standard specifications of equipment and pharmaceuticals that are open to anyone to view and download from LMD's website. The bank plays an important role in determining the quality of procured items in Nepal's health sector. As of 30 June 2014, 1,055 technical specifications had been designed, drafted and uploaded into the databank, which is housed on LMD's website (www.dohslmd.gov.np). This exceeds the NHSSP target of 1,000 specifications and is an increase of 60 on last quarter's total.

As of 30 June 2014 there have been 1,231 hits (up 35% from 798 at the end of the last quarter)and 1,305 specification downloads (up 31% from 895 in the same period).Encouragingly the bank continues to be used by a number of organisations in Bangladesh and by an increasing number of medical establishments in Nepal.In the reporting period, LMD's and NHSSP's biomedical engineers visited eight hospitals in Kathmandu, Bara and Makawanpur districts to promote use of the bank.

Also in the reporting period, ahighly successful workshop on Product Specifications for Pharmaceuticals was attended by all MoHP stakeholders during which the way ahead for determining pharmaceuticalspecifications was agreed. In this regard, an internal debate is ongoing on whether to procure WHO procurement quality (WHO-PQ) items (high quality, high confidence and high price) or less stringent current good manufacturing practices (cGMP) items (low{er} quality, less confidence and lower price). If DoHS selects cGMP standard items, there is a risk that many items may prove ineffective at the point of use.

Also in the quarter, NHSSP'sbio-medical engineers 'coached' their LMD counterparts on post-shipment inspection and the rejection on equipment during which two recently delivered berth mortuary chambers and cold boxes were rejected.

In the coming quarter TA will continue to design, draft and upload technical specifications including several items requested by other medical establishments and visit Nepal's three regions to promote use of the bank.

Recognised risks to the technical specification bank include a failure to keep it up to date, the potential for officials to lower quality requirements in the future and the non-renewal of LMD's bio-medical engineers' employment contracts.

Indicator 1.2 Timeliness ofBudgeting and Financial Reporting

1.2.1. Improve budgetary control by supporting roll out of Transaction Accounting and Budget Control System (TABUCS) nationally and building capacity ofMinistry of Health and Population (MoHP) to effectively manage and use TABUCS

TABUCS was designed to help improve the timeliness and quality of MoHP's financial reporting through improved data collection, including on local revenue collection and payroll payments, and the generation of consolidated expenditure reports against AWPB commitments. By the end of the reporting period, 331 finance and planning officers from 222 cost centres in 75 districts had been trained and a TABUCS help desk in MoHP established. Further, 158 cost centresin 68 districts had begun using TABUCS as their principal financial management tool.

In the next quarter, TA will support refresher training, follow up on data entry and report production and carry out a system audit.

The principal risks affecting the introduction of TABUCS include the poorreliability of power supplies in cost centres, user willingness to enter data and the transfer of trained officials to posts outside of MoHP.

Work streams identified by TA to be carried forward under NHSP-3 include:

- linking TABUCS with other MIS including HMIS, HuRIS, HIIS and LMIS
- Ensuring consistency between TABUCS and the Nepal Public Sector Accounting System (NPSAS) reporting system, and
- Upgrading TABUCS to include an inventory control and procurement system.

1.2.2. Capacity of Ministry of Health and Population (MoHP) cost centres to deal with audit queries and provide financial reports built

Following the endorsement (January '14) and distribution (April '14) of MoHP's Internal Control and Audit Clearance Guidelines,28.9% (of the total audited amount) of audit queries have been cleared. Improvements in clearing audit queries are central to improving the fund flow system, absorptive capacity and levels of accountability across MoHP cost centres. They also facilitate timely responses to audit queries, and increase MoHP's ability to prepareaudit status reports.

Planned activities for the next quarter include a workshop on the clearance of audit queries, training for financial staff from all cost centres across the country andthe monitoring ofinternal control and audit queries. It should be noted that these activities are being carried out in collaboration with the PFM reform team from Crown Agents.

The main risks associated with this work are failures to implement the provisions across all cost centres and the limited availability of funds to train staff from each of the 278 cost centres.

Looking ahead to NHSP-3, TA recommends that dedicated units within MoHP and DoHS be established and capacitated to implement the internal financial control and audit clearance guidelines.

1.2.3. Support wider public financial management (PFM) programmes by providing inputs on issues including fiduciary risk review (and supporting Financial Management Improvement Plan(FMIP) governance structures)

In April 2014, MoHP endorsed the first revision of its Financial Management Improvement Plan (FMIP) and its Procurement Improvement Plan (PIP). Building on this achievement, TA supported the monitoring of 11 performances based grants agreements (PBGAs) in autonomous and semi-autonomous hospitals. Seven institutions are implementing full PBGAsand five are receiving regular annual grants. A draft report on findings was prepared and submitted to DFID for review.

Frequent meetings of the PFM Committee and Working Committee were held and progress on financial management was shared. In addition, the PFM Committee endorsed the use of a simplified FMR reducing the number of reporting templatesto be completed from 33 to 6.

In the coming period TA propose to support implementation and monitoring of the FMIP and PIP. The main threat to these initiatives is the transfer of audit and PFM staff and working committee members.

Work streams identified for advancement under NHSP-3 include the development of a comprehensive PFM framework covering GAAP, FMIP and PIP indicators.

Indicator 1.3: Availability of Standards and Criteria for Expansion of Health Infrastructure

1.3.1 Support rationalisation and coordination of procurement planning for infrastructure (including maintenance)

TA supported DUDBC to prepare its second trimester procurement progress report which was submitted to the World Bank andcirculated at the final JCM meeting for the year in June. The report showedsignificant improvements in health projectconstruction completion rates as a result of improved contract management and monitoring. The enforcement of punitive actions such as fining contractors for delays, retaining bank guarantees and bid bonds, posting public notices in newspapers and blacklisting poorly performing contractors have all proved effective. According to DUDBC's records the total amount collected in punitive fines as of the end of May was NPR 2.3 million (GBP 14,000).

In the coming reporting period TA will help further enhance the capacity of DUDBC officials to prepare trimesterly monitoring reports to a high standard and in a timely manner.The main risk associated with this activity is the transfer of staff who have been trained in progress report preparation.

a. Health facility construction and upgrading criteria

The HIIS' geographic information system (GIS) application together with other information was used to preparea prioritised list of new construction projects and others for upgrading in 2014/15. The rational model developed in 2013 which uses population, accessibility, morbidity, HDI, condition and size of existing buildings as key variables was used in the analysis. GIS maps showing catchment areas served by each level of health facilitywere also generated for all 75 districts during this exercise.

The major risk to this activity is the entry of inaccurate GIS data from the HMIS and population data from CBS which may undermine the prioritisation process. The major HIIS related challenge under NHSP-3 will be to institutionalise use of the HIIS for all MoHP funded health facility construction and upgrading.

In the reporting period TA also provided support to MD to prepare its AWPB for 2014/15including responding to commitments made during JAR and JCM meetings and recommendations from evidence based studies including FHD's overcrowding study. In the coming quarter TA will work with MD officials to justify the AWPB in response to any Ministry of Finance queries and to support detailed planning for implementation.

b. Land selection guidelines

As previously noted, MD's Land Selection Guidelines for the Construction of Health Facilities were endorsed by a ministerial level decision. Key objectives on land selection in the coming period include increasing levels of community awareness on the importance of locating health facilities appropriately, identifyingplanned facilities that are inappropriately located and, in such cases,working with HFMCs to identify suitable land for new construction.

The principal risk associated with this activity is the non-compliance of district authorities with land selection guidelines as a result of pressure from local communities and other government entities.

Activities identified for action under NHSP 3 include monitoring implementation of the guidelines, and upgrading them to accommodate climate change related factors including seismic zones, flood plain areas, landslide prone areas and sustainable access to water sources etc.

1.3.2. Improve monitoring of health infrastructure projects by strengthening the Health Infrastructure Information System (HIIS)

This HIIS offers policy makers and planners an opportunity to systematically plan the location of new health buildingsand track the condition and maintenance requirementsof existing facilities. During the reporting period, technical staff from 16 districts in Eastern Development Region were trained inits use and verified the GIS coordinates of each facility in the districts. In addition, TA helped support interactions between district level DUDBC and DoHS officials facilitated by central level officials from both departments. Upcoming tasks include coordinating with MD, DUDBC and their district level offices to conduct HIIS training in the remaining districts, update data and make other modification as required to the database.

The main risks associated with this activity are shortages of the financial and human resources needed to fully institutionalise the HIIS (estimated to take 2-3 years) and the possibility of a break down in the relationship between the two departments involved in planning and implementation.

TA Output 2:
Information and Monitoring System Strengthened

NHSP-2 Output: Improved monitoring and evaluation (M&E) and Health Management Information System (HMIS) (6)
Improved Service Delivery (4)

Indicator 2.1: Monitoring and evaluation (M&E) framework for strategic plan developed and evaluation tools institutionalised in MoHP

2.1.1 Support the integration of the Ministry of Health and Population (MoHP) and the Department of Health Services (DoHS) Management Information Systems (MISs) by developing a unified coding system

Thedevelopment of a uniform coding system will enable the greater integration of data sets and improved analysis of public health status and service use. For example the logistics data from LMIS and human resource data from HuRIS may be joined and integrated in the DHIS2 'data warehouse'.

In the reporting period, agreement was reached for all MISs in the sector to use the district and vdc codes developed by the Central Bureau of Statistics. The development of a schema for unified codes for both state and non-state health institutions and a registry is underway,ahead of its planned introduction in 2071/72 (2014/15). The development of a registry for is also underway.

2.1.2 Support the roll out of the revised Health Management Information System (HMIS) to ensure quality data and promote better use of data (including disaggregated data)

NHSSP continued its support to MD to assure the quality of training during the national roll out of the revised HMIS. 100 training facilitators were contracted through New ERA to support district level trainingof health staff, and female community health volunteers. To date around 20,000 health workers and 50,000 FCHVs have been trained.

Anticipating the projected shortfall in HMIS forms at the start of the new financial year, DFID provided additional funding through NHSSP for their printing. This was completed and the forms distributed to all 75 district (public) health offices for onward delivery to sub-district health facilities in time for the new fiscal year. NHSSP and Health for Life jointly supported MD for the printing and supply of arevised HMIS users' manual for recording and reporting, a booklet that compiles all recording and reporting tools and a second booklet that containing all the revised HMIS indicators. These materials are designed to improve data quality and encourage its use in local planning.

NHSSP TA continued its support toMD for the development of DHIS-2 and the capacity building of government staff to support its introduction and institutionalisation. In this regard, district staff

responsible for HMIS data reporting were trained on DHIS-2 in the quarter. Programme managers in districts, regional health directorates and central divisions and centers will be trained in July/Aug to improve the quality of data entered and encourage the use of HMIS outputs in local priority planning. Support to MD for the development and introduction of DHIS-2 is a collaborative effort by WHO, H4L and NHSSP.

In response to a request from MD, NHSSP with additional funding from DFID plans to provide additional support for a one year period to districts and health facilities for the effective implementation of HMIS. This will be achieved through the hiring of five HMIS facilitators to cover the regions and work with DPOs/DHOs to support underperforming facilities.

2.1.3 Support the generation of primary information for NHSP-2

The revised HMIS will help monitor NHSP-2 performance using disaggregated data and provide the evidence needed to inform NHSP-3 preparation and the development of accurate baselines against which NHSP-3 (2015–20) indicators and targets can be set.

2.1.4 Improve the availability and use of evidence/data for planning and policy design by strengthening information sources – see 2.1.5

2.1.5 Support the generationand analysis of primary information for NHSP-2 and to inform NHSP-3

NHSSP advisors worked closely with programme divisions and centres to track recent health sector performanceand synthesise the findings ofvarious research studies and surveysto feedinto the preparation of divisional AWPBs and business plans for 2071/72 (2014/15).

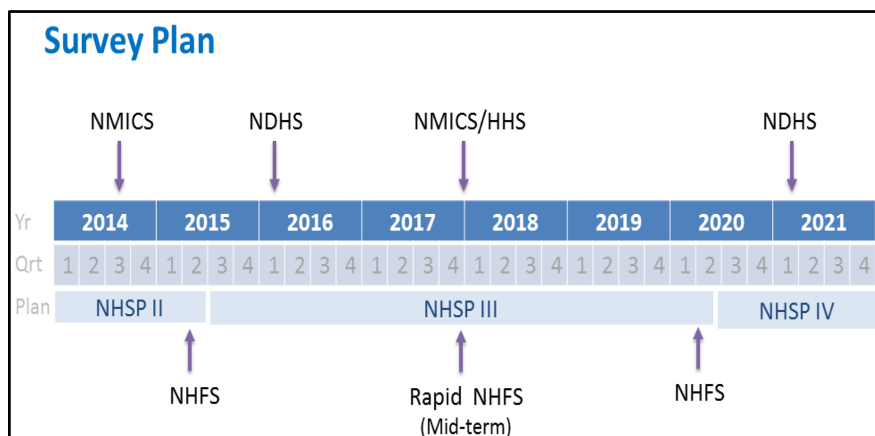
TA also began to feed evidence into the early stages of the NHSP-3 design process using their participation in the various thematic groups as a platform. Similarly, advisers contributed to the development of an M&E framework and guidelines to support MoHP’s various performance reviews. These guidelinesareseen as an important milestone in harmonising and integrating the different reviews including DoHS’ National Annual Performance Review and MoHP’s Joint Annual Review (JAR).

Surveys and operational research

The draft service tracking survey (STS) 2013 report was shared with Government and DFID for comments and all concerns raised were addressed prior to its finalisation and planned dissemination in the next quarter.

Harmonisation of various national health sector surveys has been a priority for MoHP and EDPs for a number of years. Early examples of success include integration of the Nepal Demographic and Health Survey (NDHS),which is carried out every five years, and other surveys such as the Nepal Multiple Indicator Cluster Survey (NMICS) which is carried out between NDHSs.

In the reporting period, MoHP and EDPs agreed to harmonisethe various facility-based surveys being carried out or planned by different agencies. This initiative will help save scarce sector resources, provide MoHP with the information it needs to monitor sector progress, and informplanning processes. In this regard, agreement was reached with UNFPA and DFID that 11 critical indicators that inform the NHSP-2 results framework and are essential to its end line in July 2015 and NHSP-3's baseline will now be collected by UNFPA through their Reproductive Health Commodity Security Survey. These data were originally planned for collection as a part of the now cancelled STS 2014.The figure above shows the proposed schedule for the major national level surveys-NDHS, NMICS and the NHFS.



In addition to supporting consensus building for the harmonisation and implementation a single Nepal Health Facility Survey (NHFS), NHSSP supported MoHP and EDPs to review approaches and methods followed in globally accepted health facility surveys such as the World Health Organization's Service Availability and Readiness Assessment (SARA), USAID's Service Provision Assessment (SPA), MoHP's STS and UNFPA's Reproductive Health Commodity Security Survey. The comparative strengths of each of these studies will be considered during the design of the NHFS which will be specific to Nepal but use standardised methods and modules for ready comparability across countries and over periods of time. It is expected that the NHFS will be conducted at regular intervals, preferably every five years adjusting the timeline with the NDHS with the first survey planned in 2015.

Also in the reporting period, NHSSP advisors worked closely with a survey expert from ICF International, supported by USAID,on a scoping exercise to plan NHFS 2015. MoHP approved the survey concept and general agreement was reached among key stakeholders on funding and national and international TA arrangements. The survey will be led by MoHP with technical and financial support from USAID through ICF International, DFID through NHSSP, WHO, UNFPA and other health partners.

Additionally inputs in the quarter sawNHSSP's Research and M&E advisorsand others support FHD in planning, designing and implementingthe monitoring and evaluation plan for the 'Remote Areas MNH Access Pilot Project'. NHSSP'sResearch Advisor along with government and EDP colleagues participated in a workshop on 'Impact Evaluation of PHN Programs' organised by the Public Health Foundation of India with support from USAID.

Indicator 2.2: Quality of care (QoC) in maternal health services

2.2.1 Support the development of a system and tools for monitoring and managing the quality of maternal, neonatal and child health (MNCH) in health facilities

The Quality Assurance and Improvement Technical Working Group (QA&ITWG) met four times at MDin the reporting period to discuss efforts made to improve the quality of care in hospitals including quality improvement (QI) process establishment, district quality assurance working committees (QAWC), health facility QI implementation and district health facilityquality assurance (QA) guideline revisions.

Also in the reporting period FHD and MD finalised the hospital QI toolkit for MNH which includes a self-assessment tool, score sheet and action plan and carried out a 3-day workshop to establish the QI process in Taplejung district hospital. A hospital QI committee with 15 members was formed, a self-assessment carried out which identified 16 issues related to infection prevention, family planning (FP) counselling, electricity, supplies/logistics, recording etc. requiring attention, and an action plan was made.

The QI committee in Hetauda hospital held a follow up meeting in April to review progress against the action plan prepared in its first assessment. Of the 10 activities planned, 6 had been accomplished and 4 were in process. Actions taken related to infection prevention including the purchase of 21 buckets of three different colours to collect waste in wards, the repair of leaking water lines and health education to patients in the waiting area. The committee also carried out a second self-assessment and identified 16 further issues requiring attention and made a plan to address them, thereby completing a full plan-do-check-act quality assurance cycle.

In the coming quarter, TA will support MD to conduct regular meetings of the QI TAC and QAI TWG, support Hetauda and Taplejung hospitals in follow up meetings and carry out a second self-assessment in Taplejung and a third in Hetauda.

Under NHSP-3this QI process needs to be introduced in other hospitals and QI indicators need to be incorporated with the NHSP-3 monitoring framework.

2.2.2 Support theimplementation of strategies to address overcrowding in tertiary facilities

Planning workshops wereheld to address overcrowding in Narayani Sub-regional Hospital (64 participants) and in Bheri Zonal Hospital (61 participants) and 1-year and 5-year plans wereprepared.
Three hospitals (Seti Zonal, Bheri Zonal, and Narayeni Sub-regional) also held follow-up meetings to prioritise MNH activities to be supported by FHD in the 2014/15.

FHD supportedby NHSSP then reviewed progress made since the workshops noting significant improvements. Seti Zonal Hospital had recruited 6 extra nurses and procured15 extra beds, bedside lockers, an ECG machine, vacuum extractor, suction machine, oxygen cylinder case anda laptop. It had also initiated construction of a biogas plant for sewage and placenta disposal. Bheri Zonal Hospital had recruited 3 staff nurses and procured 8 beds, while Narayani Sub-regional Hospital had recruited 3 nurses, 2 doctors and 1 anaesthetic assistant,andprocured additional beds, mattresses, bedside lockers and 2 autoclaves. It had also initiated a process to secure a 24-hour electricity supply.

Looking ahead, the main challenge is seen to improve the quality of care provided at referral hospitals since most SBAs are trained in these hospitals.

TA also supported FHD to carry out rapid needs assessments in 5 locations in Banke district to develop appropriate selection criteria for the siting of strategically located birthing centres. In addition, costings were preparedwith the DPHO and concerned HF in charges for the purchase of equipment and various other activities.

In the coming quarter, TA will help FHD prepare a central level response to address the needs of referral hospitals including monitoring and the provision of support to implement action plans. It will also continue efforts to help FHD refine its support plans and align its budget for FY 2014/15.

As with the majority of work streams, the main risk to this initiative is the transfer of key hospital staff and its potential impact on service delivery.

Looking ahead to NHSP-3, referral hospitals will need continuous support to improve the quality of services while managing increased demand,especially for maternity services.

2.2.3 Support effective implementation of comprehensive emergency obstetric and neonatal care (CEONC)funds

FHD supported by NHSSP hosted a second CEONC meeting in June to discuss the tool developed to improve utilisation of the CEONC fund, the functionality study, district selection criteria and the prospective study districts (Sankhuwasabha/Khotang, Lahan, Bara, Arghakhanchi, Dailekh, Achham/Baitadi). A visit to Lahan and Bara hospitals was also made and key informant interviews carried out.

FHD staff,supported by the TARF funded CEONC consultant and mentor visited seven CEONC hospitals (Bhratapur, Udapur, Janakpur, Sagarmatha, Mahottari, Trishuli, Lahan) to review services and provide clinical mentoring.In Bharatpur 2 staff nurses, 2 ANMs and 1 anaesthetist had been recruited, and a foetal doppler, vacuum extractor and perennial light procured. In Udayapur,an anaesthetic assistant had been recruited,an emergency blood transfusion service started and 24 hour CEONC services begun. CEONC funds were also used to clean out the hospital's septic tank.

In Janakpur, 10 beds were added in the postnatal ward, the labour room and toilet were renovated, and various furniture and equipment purchased. Sagarmatha Hospital recruited 3 nurses and procured an OT lamp, 2 baby warmers, a cardiac monitor, oxygen concentrator and autoclave drum. It alsorepaired its air conditioning and electrical generator. Mahottari hospital (supported by NSI) set-up its OT and began C/S services, blood transfusionservices were initiated,and staff oriented on creation of an enabling CEONC environment. Trishuli Hospital resumed C/S services which had ceased for 45 days and recruited a lab assistant. Lahan Hospital hired an ASBA doctor and anaesthetic assistant, repaired the labour roomand purchased suction machines, a C/S set, an autoclave, several delivery sets and other equipment.

In the coming period FHD and NHSSP will carry out key informant interviews in the remaining hospitals. The CEONC consultant will support FHD to improve the functionality of the CEONC working group and liaise with Unicef, H4L, CARE and SAVE to strengthen CEONC provisions.Support will also be provided for monitoring tool to track use of the CEONC fund and its functionality in district hospitals. The strengthening of selected hospital development committeeswill also be a core activity.

Additional inputs planned include TA working with MoHP and local government in selected districts to develop decentralised district health plans with at least NPR 110 million available from the centre to improve servicesin district level hospitals and NPR 60 million available for repair and maintenance. Advisers will work with MD to develop criteria for allocating funds to district, and possiblysub-district, level facilities. WHO and GIZ have undertaken tosupport the development of district hospital management guidelines for the fund while NHSSP will support planning in 5 CEONC district hospitals and 3 new CEONC districts based on MD and CEONC needs.

2.2.4. Support review, planning and budgeting of Family Health Division/Child Health Division (FHD/CHD) and others

As planned, TA supported FHD to finaliseits AWPB and business plan. Advisers also joined the NHSP-3 working group on family health.

Other activities in the quarter included supportingMoHP delegates to prepare a remote areas study presentation for the WB supported Remote Areas Conference in Sri Lanka and financial support to the Public Health Nurse conference in Kathmandu in May.

NHSSP also supported FHD to carry out obstetric first aid training in Taplejung district where 40 paramedics from rural health facilities participated in the 3 day programme

A key objective for the coming period will be to use the evidence from NHSSP's experience of supporting MNH to influence the design of NHSP-3.

2.2.5. Support to disseminate study findings on integration of FP services in EPI clinics

As planned, TA supported FHD's Family Planning Section to disseminate the findings of its evaluation on the integration of FP services in EPI clinics in Kalikot district.Next steps including winning approval for the scaling up of integrated services in EPI clinics in hill and mountain districts where the clinics tend not to be too crowded. It should be noted that CHD has already agreed to scale-up this approach in remote districts with UNFPA and H4L willing to provide support.

July 2014 update: Due to the recent discontinuation of PSI/DFID support to MoHP's FP programme, the proposed strategy to reach post-partum women for FP services through EPI clinics in Terai districts may not now be developed but may feature as an early NHSP 3 activity.

2.2.6. Support to design and preparation of remote areas MNH pilot in Taplejung district

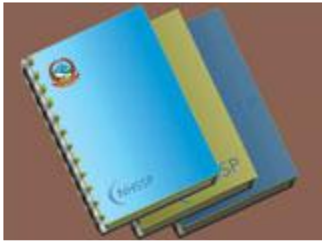
A detailed design and implementation plan for the remote areas MNH pilot (RAMP) in Taplejung district was developed under FHD's leadershipwith the full participation of the DHO in Taplejung and support of the RHD in Eastern Region. Detailed activities and implementation guidelines were developed using materials from various agencies,DoHS divisions and centres. The national consultancy HERD supported the design and development of M&E plans and tools, and approval for the pilot's monitoring and evaluation component was sought from the Nepal Health Research Council (NHRC).WHO, UNICEF, H4L and other SMNSC members are supporting the approach at the centre while Su-aahara, LGCDP and PAF are involved in supporting district and sub-district level activities.

Next steps include securing NHRC's and the DG's approval for implementation of the pilot at district, health facility and community levels in Taplejung and beginning implementation.If shown to be successful, the remote areas approach should be scaled-up under NHSP 3 in remote areas of Nepal.

2.2.7. Support for the design and preparation of new born care support through SCI (Save the Children International)

As reported, context specific planning at district level combined with focused implementation in remote and poorly performing areas in the district may improve access to quality MNH services in these areas and lead to improved health outcomes. Accordingly CHD has decided to integrateits new born and child health programmes (CBIMCI and CBNCP) and SCI has been contracted to develop this approach. In the reporting period, TA supported SCI to prepare their integrated newborn care plan, monitoring plan and programme milestones and a first rapid assessment was carried out in Nuwakot district. SCI's progress report is included as Annex 2. In the coming period, TA will continue to support CHD to monitorimplementation and SCI to carry out assessments and context specific planning in an initial three districts.

It should be noted that this initiative is being carried out in liaison with UNICEF, WHO and other partners in the context of the Every Newborn Action Plan of Nepal (ENAP Nepal).



TA Output 3:
Institutional Reform Processes Supported

NHSP-2 Outputs: **Improved Sector Management (2)**
Improved Sustainable Health Financing (9)
Reduced cultural and economic barriers to accessing health care services (1)

Indicator 3.1 Draft NHSP-3 Document

3.1.1 Support to strategic planning for NHSP-3

Experiences from NHSP-2 design showed that in order to develop a coherent, measurable, aspirational yet realistic strategy fully owned bygovernment, effective steering structures and processes are needed. In practical terms this translates to creating an efficient management structure with responsibilities clearly defined and adequate resources allocated. In addition, clearly defined processes, including effective communication and consultation mechanisms are needed.

In the first quarter of 2014, the NHSP-3 design process got under way with the formation of Cross-sectoral Steering and High Level Advisory Committees, the identification of thematic groups[1] and appointment of the majority of group leaders. In the current reporting periodthesegroups werepopulated with government officials and technical experts and external resource people were assigned to guide them. Such resource people were provided by the Project Development Team (PDT) which was formed by MoHP to guide the process using TARF funds to recruit two national experts and a secretary. Part-time international TA was also recruited with the support of H4L.

3.1.2 Support the development of the five-year (2015-2020) health sector strategic plan

Using aPTD designed template, all thematic groups began generating content and most are on track to make submissions by 15th July. The PDT meets regularly and guides the thematic groups as required. During the international TA's first visit, a core group of the PDT including national experts and NHSSP's Health Planning and Policy Adviser defined the thematic scope and framework of NHSP-3. This was shared with the wider PDT and EDPs, feedback was incorporated, and the document is on track for endorsement by the NHSP-3 Steering Committee in July.

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[1] Health Care Financing and Public Financial Management; 2. Health Workforce; 3. Medical Products, Logistics, Technologies and Procurement; 4. Health Infrastructure Management; 5. Family Health (including MNCH); 6. Non-communicable Diseases; 7. Communicable Diseases; 8. Occupational and Environmental Health; 9. Ayurveda and Traditional Medicine

The Evidence Support Group (ESG) formed to ensure that NHSP-3 is evidence referenced continues to compile available materials, both local and global, and respond to queries from the thematic groups.

In the forthcoming period, thematic groups will submit their draft content,key elements of which will be presented to EDPs in early August. In addition, the NHSP-3 Steering Committee is expected to endorse the scope and framework including its vision, mission, goals and key strategic components. The PDT will start preparing the NHSP-3 document with a first working draft scheduled for delivery at the end of August following which drafting of the NHSP-3 implementation plan will begin. In keeping with the principles of collaborative planning, various line agencies, EDP partners, I/NGOs and civil society inputs will input during the development process.

It should be noted that several thematic groups have members representing technical interests lying outside of MoHP'straditional remit(e.g. WASH and climate change). The Steering Committee has joint secretaries and members from several ministries while the high level NHSP-3 committee, chaired by the Health Minister, includes secretaries from several ministries.

The major risk to this activity is that Nepal's new constitution or federal structure will create bottlenecks or ambiguities that affect MoHP's abilities to implement NHSP-3. For this reason, a risk assessment matrix will be included in the NHSP-3 strategy document.

3.1.3 Strengthen State Non-state Partnership (SNP) functions within Policy, Planning and International Cooperation Division(PPICD)

Only through effective partnerships between the state and non-state actors can Nepal successfully achieve universal health coverage and tackle emerging and re-emerging disease burdens within a changing socio-political and socio-economic paradigm.

Progress in securing MoHP's endorsement of its draft SNP Policy,a key JAR 2014 recommendation,remains slow although MoHP reportedly remains committed to this action.At the operational level, NHSSP organised a meeting of MoHP officials and other stakeholders to take stock of on-going SNP initiatives on hospital management, administration, contracting and partnerships and to discuss possible synergies going forward. All partners agreed on the importance of the agenda and committed to advancing effective SNPs in the health sector.

In the coming quarter,partners will continue to advocate for endorsement of the SNP Policy and enactment of Health Institutions Operations Act. Relevant partners will support MoHP to review existing state non-state partnership models and recommend suitable option(s) for the future. Further, NHSSP will support MoHP to organise a workshop to further refine MoHP's Performance-based Grant Agreements (PBGAs)and ensure that SNP is appropriately captured in NHSP-3.

Most of risks associated with 3.1.2 apply and there remains a risk that SNP Policy may not be endorsed by government. This risk is best mitigatedby ensuring the SNP related activities are capturedin the NHSP-3 Strategic Plan.

Indicator 3.2: Refocused and sustainable Equity and Access Programme (EAP)

3.2.1 Technical strengthening, expansion and improved sustainability of the Equity and Access Programme (EAP)

In December 2013, MoFALD agreed to integrate MoHP's EAP into the social mobilisation component of its Local Governance and Community Development Programme (LGCDP). In this reporting period, the Health Research and Social Development Forum (HERD) was contracted to assess the value and associated challenges of this integration in four vdcs of two districts (Dhading in the hills and Rupandehi in the Tarai). Data collection was completed in June and transcription and translation work is now underway with the final report due for submission to PHCRD and LGCDP by mid-August. NHSSP is providing TA to PHCRD for this assessment.

The main risk potentially undermining this work is if LGCDP proves unwilling to implement recommendations from the assessment.In the event that integration is recommended, a one year pilot is proposed under NHSP-3.

3.2.2 Social service units (SSUs) piloted across 8 zonal and referral hospitals and an institutional home for SSUs established

Several important activities to strengthen and institutionalise SSUs in hospitals and thereby improve disadvantaged peoples'access to free and subsidised health care were carried out in the quarter. TA helped to draft revised SSU guidelines taking forward recommendations from the SSU study (August 2013), inputs from the SSU review workshop (January 2014) and feedback provided during follow-up visitsto SSUs. NHSSP also provided technical backstopping,including orientation on M&E indicators and Gender and Social Inclusion,to SSUs in Bharatpur, Seti, Bheri, Western Regional, Maternity and Bir Hospitals.

In the coming quarter, the revised guidelines are expected to be approved by the Minister and translated into English. SSUs in Bharatpur, Bheri, Western Regional, Kanti and Bir hospitals will be visited by Population Division and NHSSP TA to review progress and provide capacity building support. PD will also plan an annual review workshop of SSU progress.

The main risk that could undermine government support for SSUs is if they stimulate a demand for subsidised and free health services that exceeds government's capacity to provide the resources needed. It is noted with some concern that most SSUs failed to receive allocated fundsin the current financial year and that where funding was provided it was less than received in the previous financial year. A funds shortage led to Koshi Zonal SSU closing 3 months ago although intervention by MoHP's Secretary has now allowed it to reopen. SSUs are crucial for improving access to health services for the underserved and yet remain a long way from being institutionalised. Accordingly, support for SSUs should be a core objective of NHSP-3 including ensuring that all referral hospitalsoperateSSUs by 2016/17.

3.2.3 Scale up of social audits based on lessons learned from piloting

The following events designed to build capacity of health workers on social auditing took place:

TA inputs were provided to orient staff in five H4L supported districts ahead of social audits in 50 health facilities. In addition, NHSSP contracted the Human Resource Development Centre (HURDEC) for a process evaluation of social auditing in health facilities in 2014 and 2015 and the first round of data collectionin 10 health facilities of Jhapa and Ilam districts was completed.

In the coming quarter, review meetings will be organised with concerned EDPs who signed up to the collaborative framework agreement reported last quarter and the field report of the first phase of process evaluation of social auditing will be submitted to PHCRD and NHSSP.

The main risk associated with this work is that social audits may be given lip service only and not carried out correctly. This will result in meaningless and ineffectual plans. Recommendations from the process evaluation (2014–2015) will need to be carried forward under NHSP-3.

3.2.4 Pilot One-Stop-Crisis Management Centres (OCMCs) and develop a multi-sectorial response to gender based violence at the district level

Important progress was made with PD and NHSSP providing follow-up support to staff from 10 OCMCs (Panchthar, Sunsari, Saptari, Tanahu, Nawalparasi, Dang, Kanchanpur, Doti, Maternity and Dhulikhel). This activity included orientation on gender based violence (GBV), reviewing progress made and discussing ways to overcome common problems.

NHSSP also supported PD for the preparation of an OCMC monitoring and reporting manual. Hetauda OCMC participated in this process which included the testing of draft monitoring indicators and reporting formats. The final draft manual was prepared and will be submitted to the Office of the Prime Minister and Council of Ministers (OPMCM) and MoHP's Secretary for their approval in the coming quarter.

Following the high level joint monitoring visit to Saptari and Sunsari OCMCs in February,NHSSP helped MoHP prepare a presentation for the central level OCMC Coordination Committee which agreed in April to develop integrated OCMC operational guidelines. The Ministry of Women, Children and Social Welfare and the Ministry of Health and Population were assigned to lead this proves while considering various existing guidelines to address gender based violence.

Also in the reporting period a 5-day psychosocial training course for health staff from OCMCs in Maternity and Makwanpur hospitalstook place. In addition to improving technical skills, this input sought to develop a critical mass of informed and committed health workers able to help institutionalise OCMCs.

In the next quarter, backstopping support will be provided to a further 4 OCMCs in Dhulikhel, Bardia, Baglung and Tanahu hosptials. The revision of the OCMC operational guidelines will be finalised and approved by both the OPMCM and MoHP's Secretary. The OCMC monitoring and reporting manual will also be translated into Nepali. In addition, meetings will be organised with MWCSW to discuss implementation of OPMCM's decision to develop integrated GBV national guidelines. The roles of the two ministries will be worked out and potential EDPs will be identified to provide support.

Other

A GESI ToT event was held from 6-9 April 2014 for NHTC, regional health directorate and regional health training centre trainers. These trainees implemented a 3-day training course for facility in-charges and

district supervisors of 14 districts to enable the roll out of GESI to the facility level. The training was managed by NHTC. NHSSP provided technical support for the training as and when required. NHSSP also provided training on GESI (concept and application, social auditing, OCMC, SSU, EAP) for induction training participants (newly appointed doctors and health staff) as requested by NHTC. In addition, training was provided to upgraded health staff on the GESI concept and its application.

Indicator 3.3: Aama delivery unit costs identified

3.3.1 Review the Aama Programme

In the last quarter FHD completed aninitial rapid review of Aama programme ('Aama')implementation in the private sector to better understand the increasing trend of C/Ss in the private sector and how central Aama funds are allocated and used. Thereview showed that a number of non-accredited private hospitals were implementing Aama,but that their data were not being captured inFHD reporting. Also in the quarter, abriefing note was prepared on the use of the capitation mode of payment for C/Ss in private hospitals implementing Aama. This will be reviewed in the light of findings from the Aama unit cost study described below.

A further briefingand monitoring template was prepared for the rapid assessment of Aama in districts reported to be experiencing irregularities including facilities charging for 'free'services, ghost claims, unexpectedly high CS rates, and failures to provide transport incentiveson time. As has been shown since the launch of Aama, rapid assessments are instrumental in addressing management problems and identifying policy level issuesrequiring attention. The rapid assessment will be carried out by the Nepal Environment Protection Agency (NEPA) under direct contract to FHD – the first time government funds have been used to commission an Aama rapid assessment.

In the coming quarter, FHD will continue to collect information including bycalling officials in all 75 districts to identify the status of Aamaimplementationin the private sector. It will also contract an agency to carry out the Aama Rapid Assessment.

The principal risk facing this initiative is that FHD may not take action against those individuals and institutions found to be performing poorly including abusing the Aama programme for personal gain.

Key activities identified for implementation under NHSP-3 include harmonising the Aama programme within a broader framework of social health protection, and further developing modalities for involving private sector institutions in Aama implementation through SNP arrangements.

3.3.2 Conduct Unit Cost Analysis of Aama

ToR for this analysis were finalised and agreed by DFID and FHD and a draft protocol was prepared and peer-reviewed. In addition, FHD formed a committee under the leadership of Dr. Shilu Aryal to oversee implementation of the study. Thecommittee agreed the study'sdesign and methodology, selected the health facilities for the study and hired a resource person to provide the required support. FHD also organised a meeting to finalize the scope of the study which was attended by representatives from Maternity Hospital, Tribhuvan University Teaching Hospital, Kathmandu Model Hospital and Kathmandu Medical College.

In the coming reporting period the study protocol will be endorsed by FHD and tools prepared, pre-tested and finalised. FHD and NHSSP TA will recruit, train and deploy the national consultant, supervisors and enumerators and supervise field activities and data entry and cleaning processes, A draft report will then be presented in a national workshop and finalised following which a policy note for the revision of the Aama programme guidelines will be prepared.

The main risk facing this initiative is that FHD may lack the resolve to revise the Aama programme guidelines based on the findings of the costing study.

Under NHSP-3, it is anticipated that FHD will need to develop a plan of action and build its capacity to integrate Aama into the national social health protection framework.

3.3.3 Develop Aama Family Health Division (FHD) plan of action and/or review Aama guidelines

Preliminary work was undertaken for a third revision of the Aama Programme Guidelines. In this regard, FHD organised a meeting to discuss the scope of the two review components (the programme review in the private sector and the unit cost analysis) described above and likely revisions to the guidelines.

In the coming quarter recommendations from the review findings will be captured in revised guidelines and TA will work to secure a separate budget heading for Aama in the AWPB.

The principal risk associated with this exercise is that there may be insufficient evidence having coherent policy linkages (e.g. direct implications for national social health insurance) to warrant revision of the guidelines in the eyes of senior officials. This said, the continued development of the Aama Programme in-line with social health protection and national social health insurance policy is likely to be an important area of interest under NHSP-3.

4. Payment Deliverables

14payment deliverables were submitted in thereporting quarter:

Area	No.	Deliverable
Proc	4.2	IT linkage tool designed for piloting in selected warehouse(s)
HMIS**	HMIS 2	Training delivery support plan, monitoring tools and reporting format
HMIS**	HMIS 4	MTOT completed in 5 development regions
TABUCS	T2	MOHP capacity building to use TABUCS up and running
CB-NCP	1	Contract signed
Mngmt	M3	Quarterly report
HMIS	HMIS 3	Induction, training and placement of HMIS facilitators in different districts
HMIS**	HMIS 5	Training of district focal persons (TOT) completed in 60% districts
HMIS**	HMIS 6	Training of district focal persons (TOT) completed in 100% districts
HF	15.1	Unit cost study design agreed
Infra	2	System developed to improve decision making on location of new health facilities
HMIS**	HMIS 7	Quality assurance training completed in 60% of public health facilities
HMIS**	HMIS 8	Quality assurance training completed in 80% of public health facilities
Remote Areas	RA1	Detailed work planning completed

Annex 1: Publications Produced

The following publications were prepared in the reporting period:

Core Health Systems	IT linkage tool for piloting in selected warehouse(s)
	Guidelines forthe location of new health facilities
	TABUCS Help Desk Report
	TABUCS Training Report
Information and Monitoring System Strengthened	Remote Area Study Design incl. M&E plan
	Overcrowding Planning Workshop Reports: Bheri and Seti Zonal and Narayani Sub-regional hospitals
	Guidelines on the use of the QoC Fund
	SAVE NBC Monitoring Framework and Payments Deliverables
	FP into EPI Pulse Summary Report
Institutional Reform Processes	EAP Guidelines for Remote Area Pilot (Nepali with English translation)
	Aama Unit Cost Study Design
Management	Quarterly Progress Report Jan – March 2014
	Pulse Quarterly Progress Report Summary Jan – March 2014

Annex 2: Technical Assistance for Strengthening Nepal's Newborn Care Programme

Quarterly Report for the period April – June 2014

Save the Children

1.0 Inception Phase and Overarching Activities:

1.1 Inception meeting with DFID/Options/NHSSP

DFID/NHSSP intends to extend additional technical assistance to the Nepal Ministry of Health and Population (MoHP) in strengthening its newborn care program, with a focus on identifying the right strategic approach for implementation and ensuring the continued and adequate support for services to reduce neonatal mortality. In this context, DFID/NHSSP contracted Save the Children International (Nepal) to carry out this assignment on 24 March, 2014.

1.2 Inception meeting with DFID/Option/NHSSP to clarify technical scope of work

An inception meeting was held with DFID/NHSSP on 26 March 2014 to develop a common understanding on technical aspects of the assignment and the scope of work. Discussions focused on the development of a context specific, tailored approach to strengthen the implementation of maternal and newborn care in programme districts.

1.3 Project introductory meeting with CHD and FHD

Save the Children Nepal held an introductory project meeting with the directors of CHD and FHD, DFID and NHSSP and on 2nd May 2014 at the Hotel Himalaya. During the meeting a brief presentation was made outlining project objectives, the implementation strategy and implementation districts.

A second meeting was held with CHD's director on 19th June 2014 which focused on; the context specific implementation of the IMNCI programme; the involvement of NGOs/consulting firms in monitoring and facilitating training; district selection for full implementation of IMNCI, and letters to the concerned districts for implementation of IMNCI program. The following decisions were taken in the meeting:

a. Context specific planning will be conducted in the concerned districts and a revisedintegrated IMNCI package will be implemented to address gaps identified. A particular focus is needed on remote areas, bearing in mind their particular circumstances, needs and the resources available in each district.

b. A monitoring framework is needed containing clear indicators. It has been noted that successful intervention can potentially impact in development of NHSP-3.

c. Districts should be selected from all three ecological regions and one district should have a current CB-NCP program. Accordingly, Rasuwa (mountain), Nuwakot (hill) and Nawalparasi (terai)were selected with Nawalparasi being a CB-NCP district. In these three districts a district level situation analysis will be carried out and implementation and monitoring support provided. In addition to the above, Gorkha district was selected as a suitable district for context specific planning.

d. NGO/consulting firms[2] can be used for facilitation of HF and community level training with close monitoring.

1.4 Development of monitoring and reporting plan of the project

A project workplan with detailed activities and timelines was developed and shared with Option/NHSSP. Based on this workplan, the project deliverables/payment milestones were also developed in close cooperation with Options/NHSSP. These are essential documents which will guide the effective execution of the project.

1.5 Hiring of project staff and consultants

Five project staff members were hired, three of whom will be based at the central level while two will be based in the districts. These staff members have been oriented on their roles and responsibilities, project objectives, strategy and possible activities for program implementation.

Project office equipment such as computers has been procured while the procurement of other equipment and supplies is underway.

The process of hiring local consultants for context specific planning, implementation and monitoring support had been initiated. However, since the full scope of work is as yet undecided, this process will be taken forward only once it is finalised. It is noted that CHD's director did not have any specific objections to hiring consultants for implementation of the IMNCI package.

2 District Situation Analysis/Rapid Assessment

2.1 Development of methods and Tools for Rapid Assessment

Implementation of the IMNCI programme based on context specific tailoring plans is one of the major objectives of the project. To assess the status of IMNCI services in the chosen districts, with a focus on MNCH, rapid assessment tools have been prepared. These were developed to be tested in Nuwakot as the first pilot district. These include tools to collect the required information for:

- D/PHO level
- General tools for HF level
- Birthing centers
- BEOC sites
- CEONC sites

[2] NHSSP notes from the meeting record that the CHD director expressed some doubts over the abilities of NGOs to carry out these assessments and recommended that other modalities including contracting medical colleges be explored.

- FCHV level
- Drug retailers/pharmacists
- Mothers (recently delivered women)

Based on the experience of Nuwakot, the tools are currently under review.

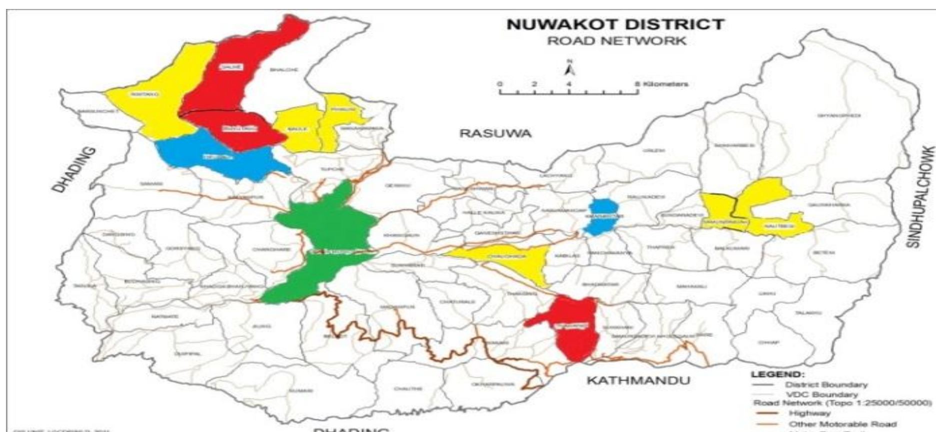
2.2 Conduct district situation analysis in first district

A district situation analysis was carried out in Nuwakot in close coordination with CHD, the DHO in Nuwakot and NHSSP from June 26 to July 2, 2014. Dr. Steve Hodgins from the SNL home office provided technical support to carry out the situation analysis. Options/NHSSP also provided support to establish effective coordination with the DHO. The situation analysis was helpful in identifying gaps in service performance at service centers. Key areas that were assessed include: knowledge and skills of service providers; infrastructure; logistics, and human resources. The following steps were adopted in order to conduct the SA in the district.

- **Meeting with district stakeholders**: The SCI/SNL team first met the Local Development Officer (LDO) of the district development committee (DDC) of Nuwakot to brief him on programme objectives, working strategy and implementation activities. This was necessary to secure his agreement to launch the program in the district.

Project introductory meeting Nuwakot with DHO staff

Following the meeting with the LDO, the team held a half day meeting with DHO, Mr. Ratna Lal Shrestha and other DHO staff who were briefed on project objectives and working modalities. It was highlighted that IMNCI program is one of GoN's priority programmeswhich will be rolled out across the country. To implement the programme the DHO agreed to lead the activities with TA support from SCI/SNL. To conduct the situation analysis, health facilities/VDCs were jointly selected based on criteria that focused on remoteness, the performance of the HF, and HF with birthing centers and basic emergency obstetric care. The following HFs were selected for situation analysis:



Map showing selected sites for SA

SN	Name of HFs	Type of HFs	Remarks
1	Nuwakot district hospital	CEONC	
2	Kharanitar	PHC/BC	
3	Deurali	PHC/BC	
4	Rautbasi	HP/BC	
5	Samundratar	BC	
6	Chaughada	HP/BC	
7	Thanpati	SHP	
8	Salme	SHP	
9	Kaule	HP/BC	
10	Kimtang	SHP	
11	Bungtang	SHP/BC	
12	Phikuri	HP/BC	

Collection of information and sharing: Three teams were formed to carry out situation analyses in the district with each team comprising at least one staff from the DHO Nuwakot. All members with clinical backgrounds visited birthing centers/CEONC while other team members visited health facilities without birthing centers.

On the way to Health Facility

Dissemination meetings for sharing the findings

Following data collection from 12 HFs, data were compiled and analysed. Based on the analysis a brief presentation was prepared focusing on program strengths, areas to be improved and possible actions to be conducted to fulfill the gaps.

On the next day a dissemination meeting was held. The

presentation was made both by SC staff as well as DHO officials involved in the situation analysis. Due to time constraintsthe DHO requested that the detailed planning exercise be deferred to July. A separate report of the district situation analysis will beprepared.

3.0 Revise SA Methods and Tools

Upon return from Nuwakot an internal discussion was held to discuss the Nuwakot experience. As Nuwakot was the first opportunity to conduct a SA, there are ample opportunitiesto modify the tools. The SA team felt that the tools were too long and needed to be more specific and focus on programme support and that the methods applied had been useful for modifying the tools. Accordingly the tools and methods are currently being reviewed and will be applied in the other districts. The revised tools are included in "SA guidelines and tools for district assessment", which will be submitted separately.

4.0 Support for integration of CB-IMCI and NCP package

As per the CHD's decision processes for the integration of CB-IMCI and CB-NCP are ongoing. This is an important task as the revised package has to be rolled out in all districts of Nepal. The integration process was begun before the district situation analysis in Nuwakot. To support these efforts, a technical working group comprising nine members representing various institutions was formed and has met several times to discuss how this activity should be moved forward. Following integration the package will help provide more comprehensive care considering the continuum of care and effective management of neonatal and childhood illness including use of the birth preparedness package (BPP). .

5.0 Challenges

Since the technical response was submitted, finalization of the IMNCI package by the Government has taken longer than expected. A further challenge is that while the expected content of IMNCI includes antenatal counseling and health education by FCHVs using BPP - an area that traditionally comes under FHD, there has generally been little participation from FHD in the working group tasked with IMNCI development. For these various reasons, we have not been able to proceed as quickly as anticipated with implementation support for the revised package. However, as noted, agreement from CHD's Director has been obtained and project implementation is expected to progress rapidly once the remaining district situation assessments have taken place.