NHSSP Nepal Health Sector Support Programme

Nepal Health Sector Support Programme

Quarterly Report

Reporting Period: April - June 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/PHO	District Public Health Office(r)
DFID	UK Department for International Development
DG	Director-General
DHO	District Health Office(r)
DoHS	Department of Health Services
DSF	Demand-side Financing
DUDBC	Department of Urban Development and Building Construction
EAP	Equity and Access Programme
EDP	External Development Partner
EHCS	Essential Health Care Services
EOC	Emergency Obstetric Care
FCHV	Female Community Health Volunteer
FHD	Family Health Division

FMIP	Financial Management Improvement Plan
FY	Fiscal Year
GAAP	Governance and Accountability Action Plan
GBV	Gender-based Violence
GESI	Gender Equality and Social Inclusion
GiZ	Deutsche Gesellschaft für Internationale Zusammenarbeit
GMP	Good Manufacturing Practice
GoN	Government of Nepal
HF	Health Financing
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
MDGP	Medical Doctor/ General Practitioner
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
NHRC	Nepal Health Research Council
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
WDO	Women's Development Office
WFP	World Food Programme
WHO	World Health Organisation
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 April to June 2013, the tenth quarter of the 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 International Pregnancy Advisory Services (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 April and June 2013. The work of NHSSP advisors is based on: the requirements of NHSP-2; the ongoing activities and plans of the various 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 who are commonly 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 deliver NHSP-2. 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:

This quarter was dominated by discussions around the forthcoming national election and by budget planning. The Election Commission set November 19, 2013 as polling day for the Constituent Assembly. Altogether 139 parties, including 60 new political parties, had registered as of 30 May. However, CPN-Maoist and some other smaller parties have not yet registered and continue to resist election plans. Other unresolved issues include the size of the Constituent Assembly and issues around electoral regulations, all leading to concerns that the election may not happen in November. Many pieces of important legislation have not been passed because of the absence of the legislature, and the constitutional and political crisis may worsen.

At MoHP, four Grade 12 Chief Specialists were appointed as heads of PPICD, PHAMED, and Curative Services and as D-G of DoHS. These clinicians are receiving extensive briefings by advisers and staff to help them adjust to their new portfolios, which remain somewhat unclear vis-à-vis existing staff mandates.

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 maternal, neonatal and child health (MNCH) services in remote areas was completed and data collected in five remote districts under phase two of the assessment. This aims to generate evidence-based recommendations for improving services in remote areas. NHSSP TA supported efforts to document the mainstreaming of gender equality and social inclusion (GESI) in annual work plans and budgets (AWPBs) of FHD and CHD over the last two years.

The National Health Training Centre (NHTC) was assisted in planning intra-uterine contraceptive device (IUCD) training for SBAs to include postpartum insertion while a FHD-led evaluation of the integration of family planning (FP) services in expanded programme of immunisation (EPI) clinics in Kalikot district was completed. This showed that the use of FP devices among vulnerable groups, including Dalit women, had increased. A draft abstract of the evaluation was submitted to the organisers of the global FP conference to be held in Addis Ababa later this year.

Also in the quarter, IPAS carried out a mid-term assessment of safe abortion services in two remote districts (Myagdi and Kalikot) ahead of MoHP's planned scale up in 2013/14. Sensitivity of subject matter and frequent transfers of trained staff were reported as major challenges facing service provision.

Regional directorates carried out emergency obstetric care (EOC) reviews in all districts in order to update regional records on the availability of services. As a result, FHD has included a budget for follow-up monitoring visits to referral sites in 2013/14.

In **Gender Equality and Social Inclusion**, TOR for a review of process documentation on GESI mainstreaming in the health sector were approved by the GESI Secretariat (report due in August). Population Division was supported to establish social service units (SSUs) in six additional hospitals and to undertake a progress review of existing SSUs in five hospitals (report due in August). The main challenge reported in the early stages of the review is the lack of ownership of the SSUs by hospital managers. TA also supported efforts to establish six additional one-stop crisis management centres (OCMCs) including one in Dhulikhel Hospital through a public private partnership arrangement. MoHP's comprehensive social audit guidelines were approved by the Health Minister and field work to evaluate the pilot social audit facilities was completed (report due in August).

In NHTC, materials to support the integration of GESI in core health worker training courses (skilled birth attendants **(**SBAs), female community health volunteers (FCHVs), health facility operation and management committees (HFOMCs), behavior change communications (BCC) and assistant health workers) were finalised. A GESI training guide was also prepared for facilitators. Further, TA provided support to NHTC staff for training on inclusive governance at the Nepal Administrative Staff College.

In **Health Policy and Planning/Health Systems Governance**, A planning workshop was held in Lumjung district for the piloting of MoHP's District Health Planning Guidelines and a draft English version of the guidelines prepared. TOR were drafted for the design of a financial regulation framework for government hospitals while the final draft of an **o**perational manual for the management of health facilities was prepared and submitted to MoHP for approval.

A concept paper on the multi-year contracting of health workers was submitted to MoHP and a draft performance based contract template was prepared to pave the way for MoHP to partner with seven private hospitals for the provision of health services. This is one of the ministry's first initiatives under its new State, Non-state Partnership Policy (2013).

In **Human Resources for Health**, MoHP's Human Resources for Health (HRH) Strategic Plan was translated into English and disseminated with the Nepali version at the national HRH conference in June which was attended by over 300 people. Agreement was reached with the Joint Secretary on priority HR activities for the 2013/14 AWPB although two Joint Secretaries and several key staff in the HRD Section were transferred during the reporting period thus potentially slowing progress. The HRH database was received from the consultants SOLID and is now being refined to complete the national HRH profile. Key challenges have been delays and data quality issues.

The MoHP-led Workforce Planning Technical Working Group (TWG) formed a core technical team that facilitated the preparation of workforce planning and projection scenarios based on WHO's HRH Planning and Projection Tool. A first draft workforce plan was prepared and disseminated. NHSSP TA also supported the development of a preliminary map of HR functions and structural arrangements in MoHP, its departments and other selected ministries, departments and agencies to help identify gaps, overlaps and bottlenecks in the national HR system. Regarding phase two of the capacity assessment of

NHTC, TA continued to work with NHTC's Change Management Team to produce the final draft report including options for transforming NHTC to a 'training management body' (final report due in July).

In **Health Financing**, the Transaction Accounting and Budget Control System (TABUCS) was officially launched by the health secretary and piloting began in 11 cost centres across the country. A visiting Filipino health delegation was briefed on this innovative MoHP monitoring tool. TA also supported MoHP to prepare a series of Financial Control Guidelines which have been endorsed by the Secretary.

NHSSP TA trained MoHP staff and other stakeholders on the Benefit Incidence Analysis (BIA) approach using the Nepal Living Standards Survey (NLSS) and Public Expenditure Review (PER) as source data. Key BIA-related activities were also identified for incorporation in the AWPB for 2013/14.

Advisers continued its support to FHD to develop a Monitoring and Evaluation Framework for all Demand-side Financing (DSF) Schemes and the latest framework was used by the local consultancy HERD to complete round seven of the DSF Rapid Assessment (RA) monitoring series. Significantly, and for the first time, the principal author of the report was FHD's director – evidence of increasing ownership of the tool by the ministry.

In **Procurement**, LMD's technical specification bank was expanded to include over 800 technical specifications for hospital furniture, surgical instruments, medical equipment and drugs and uploaded to LMD's website. NHSSP's two bio-medical engineers continued to conduct market surveys to both prepare and update these specifications. An encouraging increase in the number of international bidders for certain procurements, notably ICB-36 (contraceptives) was noted in the quarter. This is possibly a result of more accurate estimates, based on effective market analysis, being provided and a perception that malfeasant practices in LMD have reduced.

Several small procedures and policies were added to LMD's Operations Manual (Procurement) including notes on framework contracts, contract amendments and bid securities. In order to help contract managers contextualise their work and other colleagues in the supply chain, field visits were made to central, regional and district warehouses. In addition, a three-day workshop on 'Supply Chain Communication' was held for contract managers and warehouse managers to describe the two groups' roles, tasks and communication activities, map LMD's supply chain and describe procedures and requirements in the supply chain. Representatives from USAID and UNICEF also participated.

In **Infrastructure**, the technical upgrading of the Health Infrastructure Information System (HIIS) to a web-based application with a Google GIS interface was completed and training sessions held for officials from MoHP and DUDBC from 35 districts. Approval was received from the ministry for the use of HMIS' GIS data to locate health facilities on the Google earth platform. Among other capabilities, this web-based application facilitates the local updating of infrastructure construction progress by district officials. The updating of standard integrated designs for health buildings continued with the preparation of designs for SSUs, OCMCs and blood supply units in selected facility types, and detailed designs for doors, windows and sanitary fittings completed. Preparation of 3-D (orthographic) drawings for all facility types began and the upgraded facility designs were presented to DUDBC, MoHP and DoHS officials.

TA also supported efforts to improve communications and coordination between MoHP, Management Division and DUDBC related to health infrastructure planning, procurement, monitoring and maintenance. TOR were prepared for a review of MoHP funded infrastructure planning and procurement with a view to streamlining associated processes and improving the effectiveness and transparency of decision making.

In **Monitoring and Evaluation**, the revision of HMIS indicators, recording and reporting tools and reporting processes was completed and a field testing plan developed. The HMIS will now be adapted to run on District Health Information Software 2 (DHIS2) which, among other capabilities, will generate VDC level and socially disaggregated data. NHSSP TA also supported Population Division to standardise the template used to prepare district population profiles and helped orientate D(P)HOs on PD's district level population management programme.

In addition, the ePopInfo (a user-friendly electronic database that provides accurate information on population characteristics, health service provision and water and sanitation) developed in the last quarter was posted on MoHP's website.

18 publications were produced in this quarter with all non-sensitive documents uploaded to the NHSSP website (See Annex 1). Traffic to NHSSP's website reached 8500 hits (since Jan 2012) and Facebook traffic increased by 60% in the quarter compared with the previous 15 month period. By the end of June the programme had 43 followers on Twitter.

3. Detailed Thematic Updates

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

EHCS

Phase one of the **situational analysis of the maternal, neonatal and child health (MNCH) services in remote areas of Nepal** was drafted based on secondary data analysis, interviews with key informants and a literature review. Building on phase one findings, a conceptual framework, methodology and tools for phase two of the study were developed, which have now been approved by Nepal's Health Research Council (NHRC). By the end of the reporting period data collection had been completed in five remote districts and data analysis was underway.

The Phase 2 report will include evidence-based recommendations to MoHP and its partners for improving access to, and utilisation of, MNCH services in remote areas. A Key Informant Group led by the FHD and CHD directors will then meet to discuss the findings and provide feedback following which district stakeholders will be invited to verify the feasibility of recommendations made. The final report will then be submitted to relevant bodies for consideration during forthcoming planning processes.

Difficulties encountered during data collection included the early arrival of monsoon rains which impeded mobility of the study team leading to delayed completion of the phase one report. The following activities have been scheduled for the next quarter: key informant group meeting – tentative 14th July , district level meetings – by 22nd July, final national level consultation, final report submission – end of August '13.

Evaluation of the **integration of family planning (FP) services in Expanded Programme of Immunisation (EPI) clinics in Kalikot district** was completed. The evaluation involved baseline and end-line data collection and included interviews with women, service providers and managers. Evaluation findings indicated that integrating FP and EPI services increased the use of FP devices among vulnerable groups – primarily women with children under the age of one and Dalit women. Service users also expressed their appreciated for the integration of services which allowed them to receive both procedures during a single visit to the health facility. This integration promises to result in easier access to FP services particularly for women with infants under the age of twelve months.

An abstract drawn from the evaluation findings was submitted to organisers of the international FP conference to be held in Addis Ababa in November 2013 with a view to sharing Nepal's experiences with a global audience. FHD plans to implement this service integration in four additional districts - three to be funded by GoN and one by UNFPA. Evaluation findings will inform the development of district implementation guidelines and identify issues to be monitored closely during the scaling up process.

Challenges encountered during this initiative included the absence of vaccinators in many VDCs in Kalikot district, largely as a result of these local-hire staff being issued with short term (< 1 year) contracts. Key activities for the coming quarter include: discussing the evaluation findings with the FP sub-committee, developing national FP/EPI implementation guidelines and sharing the FP/EPI integration tools with the global FP/EPI working group.

Helen Keller International (HKI) continued its efforts to support FHD in finalising the **health sector strategy to address maternal under-nutrition** and develop an action plan, a training manual and a set of operational guidelines. These will help guide the government in implementing activities to improve maternal nutrition and, in this regard, five working groups have been formed. The major challenge faced is completing the work within the NHSSP phase 1 project time frame.

During the next quarter, development of an implementation plan and operational guidelines will be taken forward along with discussions on extending the timeframe and increasing support beyond August 2013, possibly through HKI or the USAID funded Su-ahara project.

Also in the quarter, advisers provided inputs on **process documentation on mainstreaming GESI in CHD and FHD** over the last two financial years. GESI related activities and budgets appearing in FHD's and CHD's AWPBs were reviewed and analysed. The resulting document promises to help MoHP and partner efforts mainstream GESI activities in future work plans and budgets. A major challenge faced during the analysis was the difficulty of documenting inputs and processes that did not lead to tangible outputs, but were nonetheless important for advancing GESI thinking, practice and an enabling environemnt. The report will be finalised in July 2013.

Maternal and Newborn Health (MNH)

During the reporting period, NHTC was assisted in planning **IUCD training including postpartum IUCD insertion as a standard component of SBA training.** The intention here is to help SBA training sites provide postpartum IUCD skills to trainees. NHTC plans to expand this training to all training sites but is currently hampered by a shortage of trainers. Looking forward, NHTC plans to assess potential SBA training sites and prepare trainers for onsite post-partum IUCD training.

Regarding **FP activities**, NHSSP's FP coordinator supported FP sub-committee discussions on issues and challenges facing adolescent and migrant populations and the choices available to them. Inputs were also made to the 2013-14 FP commodity procurement plan which now makes provision for the re-imbursement of costs associated with FP complications management. FP data from the current HMIS were also shared with Central Region districts for verification.

NHSSP TA also continued support for the **monitoring and mentoring of staff in CEONC facilities.** The new advanced skilled birth attendant (ASBA) trained doctor of Argakhanchi district hospital and the medical doctor/general practitioner (MDGP) of Bhairhawa District Hospital were supported to begin CEONC services in their facilities. An enabling environment for Caesarean Section (CS) services and team building is also being created and continuing medical education (CME) is ongoing to help hospital staff improve the quality of services offered. Both hospitals initiated CEONC services and each carried out four CS during June. Blood transfusion services (BTS) have also been revitalised in both facilities. FHD hopes to continue CEONC mentoring activities although the limited budget in the current financial years presents a particular challenge.

NHTC was supported to **monitor the quality of SBA training** in Pokhara, Baglung, Teaching Hospital, Maternity Hospital and Dhulikhel Hospital with feedback provided to encourage performance improvements and moral support. A list of teaching models and equipment was prepared for incorporation in NHTC's procurement plan for 2013/14. The national SBA Forum meeting was supported and a date fixed for a SBA trainer's annual review meeting and planning workshop which will aim to improve the quality of SBA training and prepare a participatory SBA training plan for 2013-14. Major challenges here are maintaining the quality of training given shortfalls in the availability of SBA trainers and other service providers, and the lack of regular on-site monitoring and support visits.

FHD was assisted in posting nine newly trained anaesthesia assistants (AAs) to CEONC sites in Lahan, Dhankuta, Rautahat, Ilam, Baitadi, Udaypur, Nuwakot, Sarlahi and Dang. The availability of these staff promises to enhance the capacity of these hospitals to provide CEONC services. NHTC and the Nepal Academy of Medical Science (NAMS) will now provide AA training on an on-going basis. A major challenge here will be to find suitable candidates from districts where AA services are most needed. During the next quarter NHSSP advocacy efforts will focus on recruiting AAs for permanent postings in all CEONC sites.

Also in the reporting period, regional directorates were supported to carry out **EOC reviews** in all districts to update records on CEOC, BEOC and birthing centres. These visits were judged to have increased staff morale by providing context-specific guidance and personal support. The major constraint anticipated is the limited number of RHD staff available to carry out such visits in the future.

FHD was also supported in its efforts to **strengthen overcrowded referral hospitals** in the Terai. In this regard, FHD decided to budget for follow-up monitoring visits to referral sites. The main challenge faced here was to draw the attention of senior officials to the plight of referral hospitals and to prioritise the actions needed which include increasing demand for services at lower level facilities. A key activity for the next quarter will be to support FHD in preparing implementation guidelines for districts to address these concerns.

IPAS was supported to carrying out a **mid-term assessment of safe abortion services** in two remote districts (Myagdi and Kalikot). The assessment report details lessons learned and actions recommended. IPAS will continue to pilot this initiative until August 2013 with a view to scale up of the programme by MoHP. Major challenges reported include the difficulty of monitoring activities due to the sensitive nature of the services provided and the frequent transfer by government of trained staff.

Other activities planned for the next quarter include:

- Facilitate CEONC mentoring visits to Bara, Rautahat and Dhading, and CEONC planning visits to Rukum and Sindhupalchok district hospitals;

- Undertake a review of CEONC services in Bhojpur and Taplejung and advocate for the establishment of blood transfusion services;
- Review and plan for SBA training.

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

The English version of the **Summary of the Human Resources for Health (HRH) Strategic Plan** has now been printed and both the English and Nepali versions were disseminated to participants at the national HRH conference hosted by SCF in June 2013. A number of discussions were held with the Joint Secretary of the HR and Financial Management Division and the HRD Under-secretary, and agreement was reached on the priority human resource activities to be included in the AWBP 2013/14. The national HRH conference was well attended (over 300 people) and provided an opportunity to create awareness about the HRH Strategic Plan, share information on the on-going work planning process and highlight key human resource issues and challenges.

Dissemination of the plan at all levels will create greater awareness of the HRH strategic plan; stakeholder engagement will build support for its implementation and help address HR issues and challenges. Prioritised HR activities from the strategic HRH plan included in the AWPB will have a greater chance of funding and implementation. NHSSP will support MoHP to continue disseminating and discussing the plan with stakeholders, and will continue to work with the Joint Secretary of the HR and Financial Management Division and other Division Chiefs to ensure priority strategies and activities are included in the AWPB. Challenges in this area have arisen in the form of frequent HR staff changes (e.g. two joint secretaries were re-posted during this reporting period and the Under-secretary and key staff in the HRD section were also transferred) and the impacts of this turnover on institutional memory and the continuity of efforts to coordinate HRH responses and implement the plan. Mechanisms for discussion and prioritisation in preparing the AWPB are also lacking. Dissemination of the plan will continue, with an updated dissemination strategy and dissemination plan. Nepali and English versions of the full plan will then be printed. There will also be follow up on the activities to be included in the AWPB for 2013/14.

The **HRH database** was received from the consultancy group Society for Local Integrated Development (SOLID) and is now undergoing scrutiny and being refined in preparation for the development of a national HRH profile and input for workforce planning. The dataset and findings from the analysis of the data will be used to complete the HRH profile and 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. The MoHP-led HRH Assessment Core Technical Team will, with NHSSP and WHO, continue to support the process until the HRH profile is complete. The dataset will then be used to develop and inform the workforce plan and projections. On-going delays in completing the profile and workforce plan as a result of quality issues with the entry and analysis of the HRH data collected are presenting a challenge. During the next quarter, work will continue on refining the HRH database, reviewing the analysis and findings and completing the WHO HRH Profile.

NHSSP continued to supporting the functioning of the MoHP led **Workforce Planning Technical Working Group (TWG)**. It supported the formation of a core technical team (CTT), composed of TWG members and senior MoHP officials, and supported two in-country visits by an international workforce planning consultant to support the CTT to develop the workforce plan and projection scenarios based on agreed service needs, the current supply of health workers, and the gap analysis. CTT members were orientated on the WHO HRH Planning and Projection Tool and, from April to June, the assumptions and technical details for the supply production, workforce stock, and requirements modeling were agreed.

The first draft of the Workforce Plan was disseminated to stakeholders for feedback in May 2013 and the second draft is under development. The leadership of the Joint Secretary of the TWG and CTT, the participation of senior MoHP officials from planning and service delivery areas and the representation of public and private health stakeholders on the TWG will ensure greater ownership of the plan, more realistic projections, greater alignment with service delivery needs and training capacity and greater commitment to its implementation. The workforce plan and projections could be used by the MoHP to develop recruitment and deployment plans to ensure that the right staff with the right skills are attracted, recruited and deployed to fill essential and critical vacant posts in facilities and locations with the greatest need. They could also be used to justify the need for a review of current staffing norms to determine if the norms (numbers and skills mix) for each level of the health service and/or each facility are adequate and appropriate for the delivery of current and future health services. The MoHP could also use the workforce plan and projections to negotiate with the Ministry of Finance, NPC, MoGA, etc. for financing and approval of an expanded health workforce and/or to increase the number of sanctioned posts. NHSSP and the international consultant will continue to support the CTT and the TWG in developing the workforce plan and projections.

The final draft of the workforce plan and projections will be produced by mid-August. The delays caused by the poor quality of the entry and analysis of the HRH data collected during the HRH Assessment and the time needed to refine the dataset so that it can be used to develop the workforce plan and projections were a challenge, as was the difficulty getting consensus on future health service needs and scenarios. The following activities will be undertaken during the next quarter: complete and disseminate draft 2 of the workforce plan to the CTT and TWG for review and feedback, draft the 2030 vision for the health sector and the 3rd scenario for the projections, facilitate meetings of the CTT and TWG and provide technical support to produce the final draft of the workforce plan and projections.

Regarding the **capacity assessment of NHTC**, NHSSP continued to support the development of the roadmap and to work with the change management team to produce the final draft report and a set of options for transforming NHTC's role to a 'training management body'. A more efficient and effective NHTC will improve the coordination, management and quality of the training carried out for the MoHP and its departments. The change management team will agree on a number of options for the way forward which will be included in the final draft report. The MoHP will facilitate further internal discussions and agree on the most feasible option to adopt. Challenges include maintaining stakeholder participation and involvement in the change management team, reaching consensus and agreement on the way forward and the most feasible set of options for the transformation of NHTC. Key activities for next quarter are to **p**resent the draft report and options to the change management team, facilitate discussion with the NHTC Director and incorporate feedback into the final draft report.

NHSSP has developed a preliminary **map of the HR functions and structural arrangements** in the MoHP, its departments and within other selected Ministries, Departments and Agencies. **T**he findings of the HR

mapping exercise will help to identify gaps, overlaps or bottlenecks in the overall HR system, and could be used to strengthen strategic HR decision-making and resource allocation. They will feed into the planned MoHP organisational review and will also support planning of the next health sector support programme – NHSP 3, as well as help to ensure that health sector goals, objectives and programmes are supported by appropriate MoHP functions and structures. NHSSP will continue to refine the map, identifying the HR roles and responsibilities across the MoHP and within selected external ministries and agencies. The findings will be analysed and recommendations made for improving current arrangements and strengthening HR functions, strategic HR decision-making and resource allocation. One challenge will be to verify official information on roles and responsibilities and to distinguish between the official position and what happens in practice. During the next quarter NHSSP will continue mapping HR functions and structures, and will recommend actions based on an analysis of the findings. Key findings will be presented to the MoHP to inform a wider organisational review.

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) began finalising implementation plans for its three national BCC/IEC strategies:** safe motherhood, neonatal and child health (SMNCH); adolescent sexual and reproductive health (ASRH), and family planning (FP). The plans will be finalised in July. From 2013/14 onwards, NHEICC will coordinate with MoHP and external development partners for additional resources and technical support to implement these plans widely. A limited budget allocation from the centre and a lack of technical skills among district BCC/IEC focal persons may present challenges that compromise the execution of thes plans.

The **comprehensive social audit guidelines** were approved by the Health Minister and monitoring of the social audit pilots has now been completed. Evaluation of the guidelines is underway with the consultant's report due in July 2013. Work to develop a road map for implementing the guidelines also began together with efforts to mobilise additional funds from EDPs to increase the number of social audits that can be carried out each year. Social auditing will help establish a mechanism for downward accountability, encourage local ownership and create an enabling environment for responsive service delivery. A potential obstacle to roll out is uncertainty over MoHP planning and budgeting for social audits.

Comments were received from MoHP's legal section on the **Operational Guidelines for Mainstreaming GESI in the Health Sector**. These guidelines aim to provide practical guidance on addressing GESI issues in MoHP 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 problems experienced by women, and poor and excluded people, in using health services. Once approved, the guidelines will be rolled out based on a road map currently being prepared by Population Division. GESI technical working groups at various levels will then be orientated and help health facilities implement the guidelines. In the next quarter, the final draft incorporating all comments will be submitted to the health secretary for approval and the road map for roll out will be finalised.

A District GESI technical working group (TWG) was formed in one new district bringing total coverage to 70/75 districts. Orientation of the TWG was completed and included information on MoHP's various GESI initiatives including: the GESI Institutional Structure Guidelines, GESI Operational Guidelines, One-stop Crisis Management Centres (OCMC), Social Service Units (SSU) and Social Auditing. The guidelines outline mandatory responsibilities for GESI and ensure that the various technical committees and working groups are bound to work on GESI issues. The training input provided conceptual clarity and practical guidance for addressing GESI issues in divisional and district programming, monitoring, supervision and reporting processes. It also enabled district teams and service providers to identify and respond to issues and concerns faced by women, and poor and excluded people, in accessing quality

health services. One challenge limiting progress has been the failure, due to pressures of time on the health secretary, for him to convene a GESI Steering Committee meeting. Key activities for the next quarter include: disseminating the Institutional Structure Guidelines, supporting organisation of a GESI Steering Committee meeting at MoHP and a GESI Committee meeting at DoHS, and follow-up support for trained district and divisional focal persons.

The Population Division was supported to **establish Social Service Units** (SSUs) in six more hospitals with appropriate orientation provided. Bharatpur and Bheri Zonal Hospitals (where NHSSP is supporting SSU piloting) were supported to hire local NGOs and orient them on their roles. A progress review which includes the development of a SSU monitoring and evaluation framework is on-going in five hospitals. This promises to lead to effective SSU functioning in eight additional pilot hospitals (Bir, Maternity, Kanti, Koshi, Western, Bharatpur, Bheri and Seti) over the next two years. The main challenge observed relates to hospital managers and medical superintendents' reluctance to take full ownership of SSUs. Another challenge lies is attracting SSU target groups, especially the extreme poor, in the absence of a reliable system to identify them. During the next quarter backstopping support to all SSUs and completion of the progress review are planned.

One-stop Crisis Management Centres (OCMCs) were established in six additional hospitals in the reporting period and appropriate orientation provided. In addition, and on request of the Population Division/MoHP, the privately operated Dhulikhel Hospital in Kavre district formed an OCMC through a public private partnership arrangement. An assessment of the performance of OCMCs is on-going including examining progress made, issues and challenges faced, and the tracking of GBV survivors who have accessed services. OCMCs aim to ensure that GBV survivors are better informed of available services and can access them confidentially in one place without the need to repeat their normally traumatic case histories. Based on the findings and recommendations of the assessment, Population Division and NHSSP plan to refine the operating guidelines, provide regular backstopping support to OCMCs and establish coordination and collaboration mechanisms among key (multi-sectoral) government and NGO stakeholders at central and district levels. Developing an effective mechanism for coordination and collaboration between different ministries is seen as a major challenge. Key activities for the next quarter include: finalising the assessment and organising a review workshop for OCMCs to share the major findings and recommendations of the assessment and plan next steps.

Dissemination continued of **Equity and Access Programme** (EAP) review results and backstopping support is on-going to PHCRD and districts for NGO contracting, capacity building and implementation. Approval for the multi-year contracting of EAP implementing NGOs was pursued with the file memo forwarded to the Finance Ministry. Implementation of EAP activities is underway in all 20 districts planned for 2012/13 although budget shortfalls and disbursement delays have effectively restricted activities to the VDCs targeted in 2011/12. PHCRD will develop a road-map for EAP scale-up after approval is obtained for multi-year contracting of NGOs. Key activities planned for next quarter include supporting Population Division to secure approval from the Finance Ministry for multi-year contracting and planning next steps for NGO contracting and EAP scale up.

Draft materials to support the integration of **GESI in NHTC training courses** including those for SBAs, FCHVs, HFOMCs, BCC and assistant health workers curricula and facilitator's guide were finalised and submitted to NHTC. Field level consultations with RHD and D(P)HO teams helped to design inputs into the various curricula which are intended to improve levels of GESI sensitivity and responsiveness among

service providers. Once approved, the materials will be pre-tested and finalised during a review workshop in July and fully incorporated in NHTC training. Challenges include orienting NHTC trainers to deliver GESI focused modules and budget shortfalls that have delayed pre-testing and caused the cancellation of several training programmes.

At the request of NHTC, NHSSP provided support for T**raining on Inclusive Governance**. This course, which covers GESI concepts and their integration in accountability, responsiveness and integrity concepts of governance, was developed by Nepal Administrative Staff College with the support of NHSSP. NHTC staff were included as master trainers, and the NHTC Director decided to make this training available to additional NHTC staff, including SBA trainers. in May. A second round is planned for mid-July. Importantly, the NHTC Director committed to adding one day to all NHTC training programmes to incorporate these concepts. A key challenge remains incorporating GESI principles into all NHTC training programmes. Another challenge is ensuring that trainees use their new skills in the workplace.

Under the guidance of the FHD and CHD Directors, a **GESI Financial Allocation Analysis** of AWPBs in 2011-12, 2012-13 and 2013-14 was started in order to identify disbursement trends on activities targeted at women and other excluded groups and those more general in nature but which help to create an enabling environment for the excluded to access services. This analysis will help identify the resources allocated to overcome specific barriers and enable policy makers to identify strategies to improve GESI mainstreaming including influencing future years' financial allocations. The main challenges in this work are difficulties of attributing GESI impacts to particular inputs and failures of some decision makers to recognise GESI related programming gaps and allocate adequate funds to address them. It should be noted that **t**he financial allocation analysis will be incorporated in the process documentation of GESI integration in MCH described above.

TOR for a review of **process documentation related to GESI mainstreaming in the health sector** were approved by the GESI Secretariat. Information collection is currently underway with Population Division (current and former staff), DoHS divisions, EDPs and NHSSP advisers. This will be a key learning document that can be used by the GESI Steering Committee to further strengthen the ministry's commitment to social inclusion. The principal challenge here relates to the effective use of learning from the review and its dissemination to other sectors. During the next quarter, interactions will be held with the Population Division, several other divisions, and with GESI TWGs in the regional headquarters and selected districts.

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

Piloting of the **Transaction Accounting and Budget Control System (TABUCS**) began in 11 cost centres as recommended by the Public Financial Management Committee and endorsed by the health secretary. MoHP has taking a lead role in monitoring the pilot sites and seven MoHP and DoHS officers visited several cost centres to learn about the system. The TABUCS team also presented the system to a visiting Filipino delegation, thus helping to share MoHP's cutting edge FM innovation at the Asia regional level.

Staff from MoHP, NHSSP, an independent consultant and an IT vendor subsequently reviewed progress made in the pilots and offered suggestions on ways to make the system more user-friendly – particularly in higher level facilities where local revenue collection, and the number of transactions - is very high. TABUCS piloting will be completed by the end of August 2013 and rolled by the middle of September. An encouraging sign is that MoHP has already dispatched letters to 260 cost centres instructing them to begin preparations to launch TABUCS in FY 2013/14.

Also in the reporting period, an international expert on **Benefit Incidence Analysis (BIA)** trained staff from MoHP, FHD, HMIS, local universities, research agencies and policy makers on the approach. The objective of the training was to provide skills related to the design and analysis of BIA using Nepal Living Standards Survey (NLSS) and Public Expenditure Review (PER) data. The group also identified the key findings to be incorporated in the AWPB for 2013/14. MoHP officials expressed the view that this is effective capacity enhancement model and committed to playing a lead role in facilitating the next BIA.

NHSSP supported FHD, including its demography section, to prepare a **monitoring and evaluation (M&E) framework for its demand-side financing schemes**. This will result in the more efficient use of resources and improved value for money by avoiding stand-alone M&E activities related to the Aama, 4 antenatal care visits and uterine prolapse programmes. FHD presented the draft framework to concerned stakeholders and used feedback provided to revise it.

In this process FHD staff:

- helped design the framework to incorporate all DSF programmes;
- learned to analyse reported programme information to create appropriate M&E indicators;
- learned how to use M&E framework indicators to inform policy and programmes.

Following a report from the Office of Auditor General (OAG) which mentioned the importance of MoHP having **internal financial control guidelines,** NHSSP support was provided to help prepare such guidelines under the leadership of MoHP's Finance Section. The health secretary has subsequently endorsed them.

Regarding the DSF Rapid Assessment (RA) VII, the local consultancy HERD was recruited to implement the field survey but with the FHD director serving as the first author of the report for the first time. Management level information from the report has now been circulated to all cost centres and FHD has included the DSF-RA VIII in its AWPB 2013/14 – an important breakthrough in signaling FHD's ownership of the tool.

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

In the reporting period, NHSSP supported the revision of the **Health Management Information System's (HMIS)** indicators, recording and reporting tools and reporting processes. This was carried out to better address NHSP-2 monitoring needs. A detailed field testing plan was developed with trainers and district level personnel and HMIS training sessions were developed. Following field testing of the new tools and checks on reporting at various levels, scaling up will take place in FY 2013/14.

Further, the MIS section plans to operate HMIS using District Health Information Software 2 (DHIS2), a free open-source programme with data reporting, management and analysis capabilities currently used in more than 30 countries. DHIS2 is regarded as particularly suitable for data storage, analysis and retrieval. Customisation of the DHIS2 to meet HMIS demands will begin in the third quarter of this year together with staff training and the upgrading of IT infrastructure. The revised HMIS 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.

Another successful initiative in the quarter was the positing of **ePopInfo** on MoHP's website. ePopInfo 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. It also provides access to national, regional and district level information. The data includes 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), disability, female ownership of fixed assets and the coverage of drinking water and sanitation. ePopInfo will support decision makers, researchers and others who need reliable population-related data. It will also promote wider understanding of population issues and can be used for population related planning

and programming. The database was developed under the guidance of MoHP's Population Division, which will be responsible for updating it with population data drawn from the 2011 census. Future population projections have been initiated by Population Division and, once fully developed, will be fed into the ePopInfo.

All D(P)HOs in Nepal are required to prepare, print and distribute **district population profiles**. With the support of NHSSP, these profiles have now been standardised using a single template under the leadership of Population Division. Once approved by MoHP, the template will be used to prepare all district population profiles across the country. This will allow standardised data sets to be compiled and made available in one place. District population profiles will provide reliable data which all sectors can use for planning and programming purposes.

NHSSP also supported Population Division to organise orientations on the **district level population management programme**. The main objective of the orientation was to help district personnel become conversant with population and development issues, the terminology of population dynamics, and current levels and trends in Nepal and globally. The orientation agenda was designed to be learning, rather than teaching, focused. Additional orientations in western, mid-western and far-western regions are planned for the next quarter.

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.

Procurement – Goods and Services

As part of the **Technical Specifications Databank**, at the end of this reporting period, over 800 technical specifications for hospital furniture, surgical instruments, medical equipment and drugs had been prepared and uploaded to LMD's website. This databank continues to be improved by *ad hoc* inputs from an international bio-medical engineer. By the end of Phase I of the project a total of approximately 1,000 specifications are expected to have been uploaded. It should be noted, however, that the Specification Bank has not yet been formally launched, nor has it yet received DoHS approval. There has been (and continues to be) some resistance from DoHS to an official launch due to the specifications needing 'some further discussion'. This will hopefully be resolved in the next quarter.

LMD now has a bank of standard, agreed technical specifications (except, so far, by DoHS) that are available to all, including bidders, thus improving transparency: to all D(P)HOs to make their procurement processes more efficient, and to all interested parties to comment on. The databank will also improve the efficiency of procurement officers and users in LMD and district health offices. In future, the bank's specifications will form an integral part of the development of bidding documents.

Keeping the databank up-to-date will prove a challenge. NHSSP is doing this currently but it is hoped that LMD can accept responsibility by the end of NHSSP Phase 1. This requires a dedicated IT person and regular inputs from LMD biomedical engineers under the tutelage of the NHSSP Bio-Medical Engineers. A maintenance manual with suggestions for maintaining the bank has been drafted, but LMD is still to appoint a responsible person to work with NHSSP to approve and implement the policy. Key activities for next quarter include a complete uploading of the remaining specifications and an expanded and improved number of keywords in the search engine. The bank will be officially launched, and LMD will take ownership of the bank, including its administration and keeping it up-to-date.

NHSSP's two bio-medical engineers continued to conduct **market surveys** to help prepare and update the technical specifications. 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. Due to some more accurate estimates, and the perception that malfeasant practices have been reduced in LMD, an encouraging increase has been seen in the number of international bidders and manufacturers who are prepared to bid. This will result in more accurate cost estimates of drugs and equipment. Since the estimates serve as background knowledge for bidding documents for these drugs, they will be passed back to programme divisions so they can more accurately draft their budgets as part of the

[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.

AWPB for following years. The cost estimates will provide inputs for the market analyses planned for NHSSP Phase 2. The following challenges are recognised:

- The work being performed is being achieved on an *ad hoc* basis without a structured approach.
- Implementing a structured market and price survey requires input from a specialist market analyst.
- The system will need to be implemented and kept up-to-date by LMD, and this will require inputs from an IT specialist and LMD bio-medical engineers.
- The prices of all commodities are difficult to predict in Nepal. LMD has managed to achieve some lower and some higher offers than the UN organisations' on-line prices, thus confirming the difficulty of estimating prices in Nepal. The reasons for this are that 1) Nepal is a small market, 2) international bidders are loath to enter the market as they consider Nepal procurement to be corrupt/collusive; and 3) high transport costs. The relatively high level of supply from middlemen rather than directly from manufacturers also causes price fluctuations.
- Many recent procurements have resulted in the awards of contract well below the estimated cost.

During the next quarter market surveys will continue as appropriate.

Several small guidelines for procedures and policies were developed into an **Operations Manual** and presented to LMD management. These include notes on framework contracts, contract amendments and bid securities. LMD management has shown limited interest in these, however. The LMD deputy director was appointed this quarter as the contact person for developing a procurement manual. 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 work started with visits by the deputy director and four contract managers to central, regional and district warehouses.

A three-day workshop on '**Supply Chain Communication'** for contract managers and warehouse managers was held in April to describe the two groups' roles, tasks and communication activities, map LMD's supply chain and describe procedures and requirements in the supply chain. The workshop included representatives from USAID and UNICEF, as they support LMD on warehouse management. This was followed by a half-day workshop with LMD contract managers and DoHS finance officers to improve communications between the two groups and to ensure input to a Contract Management Database. These were the first in a series of workshops where the LMD deputy director and staff will contribute to the LMD Operations Manual. These workshops have included staff from both the LMD Procurement and Contract sections. The theme was 'Bundling of goods' for the Consolidated Annual Procurement Plan.

The result of this work will be 1) an Operations Manual describing the main procedures, including information flows, which are to be followed in the LMD supply chain, and a step-by-step guide for staff and managers concerning who are responsible for which tasks, where to find what information and the possible approaches to take in different situations, 2) staff who know their responsibilities, what is expected of them and what to do in different situations, and 3) improved communication between different actors in the supply chain. The manual will also suggest quality assurance procedures to be implemented in the LMD procurement process. Draft chapters of the Operations Manual will continue to be developed, discussed and adjusted at small workshops. LMD will be encouraged to revisit the manual, discuss improvements and adjust it in the process of moving towards written instructions and polices for procurement and contract management. A challenge, however, is LMD management's

disinclination toward drafting the operations manual. There is a serious risk that the initiatives involving staff might not occur, even though the contract management section staff have been positive. During the next quarter, workshops based on the draft manual will be conducted in LMD in order to discuss the manual's content with the LMD staff. LMD's Deputy Director is the key person for this.

To improve **Drug Procurement Certification** a higher level of certification for WHO pre-qualification (WHO-PQ) has been introduced for procuring drugs and vaccines where appropriate and where a sufficient number of bidders or manufacturers 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, due to lack of budget, are usually restricted to the government laboratory. By the end of the period, neither Pre- nor Post-Shipment Inspection regimes had been procured. It has been suggested that, if DoHS agrees, Post-Shipment Inspections (estimate NPR 15 million over three years) will be achieved as follows:

a. For Equipment – by the NHSSP Bio-Medical Engineers with the LMD Bio-Medical Engineers in attendance, and

b. For pharmaceuticals, drugs and vaccines, by contracting with the only ISO Certified Laboratory in Nepal by Direct Contracting.

Pre-Shipment Inspections (estimated cost NPR 90 million over three years) will have to be procured by means of International Competitive Bidding procedures. This should result in a higher quality standard of drugs as low quality drugs will no longer be accepted. It will be taken forward by incorporating these requirements in all bidding documents. Currently, the absence of these requirements results in many bids being declared non-responsive. The challenges to be faced include the following:

- Avoiding meddling by main (and large) suppliers to attempt to change the rules and to keep the mandatory requirements in bidding documents.
- Bidders complain at the raised requirements; but this should be overcome with time.

Doubts have been raised about the ability of the government laboratory accurately to assay drugs due to lack of expertise, equipment and funding. A budget needs to be included to hire independent, competent, private national laboratories for the outsourcing of this process. The Central Laboratory needs to be strengthened. (But, see b. above)

Regarding **LMD store management,** although enhancing the storage and distributive capacity of medical stores is contained within the WHO matrix as a task for NHSSP, this is already being (or has been) undertaken by USAID's Deliver Project. The situation either needs to be clarified or this item removed from NHSSP's responsibility.

Additional **multi-year contracts** were included in the LMD procurement plan for 2012/13, and the procurement of these is well underway. Evidence indicates that the increased numbers over the past two or three years have resulted in an increase in bids from 'abroad', not only from South Asia but also from the USA and Europe. This is an encouraging trend. Also encouraging is the entry of some new bidders and some manufacturers into the procurements. Economies of scale should result from cheaper and higher quality commodities. A strategic paper on framework contracts was drafted and provided to the DoHS DG and the LMD director, but there has been no reaction so far. Challenges for the next quarter include the following:

- To encourage LMD to begin the 2013/14 procurements immediately following the passing of the 2013-14 budget but in the meantime to encourage LMD to prepare the documents so they are immediately available for launching via the World Bank.
- Further effort is needed to encourage more international competition.
- To encourage procurement staff to conduct actual procurement rather than relying upon consultants to do the work.
- To encourage LMD staff to build on the work achieved so far, particularly on updating databases.

Key activities for next quarter will be to begin procurement for 2013-14.

3.6.2 Infrastructure

Under the leadership of Management Division, with technical support from NHSSP, the **Health Infrastructure Information System (HIIS) was developed as a web-based system with a Google GIS interface**. The web-based HIIS allows updating of the construction procurement plans and progress reporting by each district. Three-day orientation programmes were conducted in Pokhara, Chitwan and Kathmandu with officials from DUDBC Division Offices, DHOs and Regional Directorates from 35 different districts taking part. The first day was attended by all participants and the second and third days were exclusively for the staff members responsible for data management in the districts. The cost of the training was shared with TA costs paid by Management Division. Future work planned includes:

1. Getting domain registration for www.hiis.mohp.gov.np, setting up the web server, and installation of the web based system in the server;
2. Digitising the coordinates that have been collected through the GPS survey by the HMIS section of Management Division into a GIS shape file;
3. HIIS Installation and preparing a data DVD including installation and a system manual will be prepared for distribution to interested users.

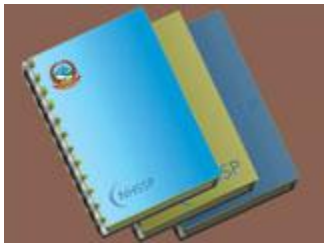
Updating of **standard integrated designs of health facility buildings** was initiated in the last quarter of 2012. Updated standard designs for district hospitals, PHCCs and health posts have been prepared relating to doors, windows, sanitary fittings and other details. As required by the National Public Health Laboratory, blood supply units have been added to the designs of all types of health facilities. 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 were presented to officials and experts from DUDBC, MoHP and DoHS during this quarter. Participants agreed on the standard drawings, including SSUs and OCMCs in the district hospitals. In addition, 3D drawings are being prepared for all facilities. During the HIIS orientation in June a presentation of standard designs was made to officials from DUDBC and District and Regional Health offices. Once the 3D drawings are completed in July, the standard drawings will go for printing. The next stage is to train officials from D(P)HOs, technicians from DUDBC and district technical offices to use the standard designs.

In March NHSSP began efforts to **improve coordination between Management Division and DUDBC on infrastructure procurement**. In addition, a discussion was initiated with the Management Division with a view to assigning ownership of all types and levels of health facilities to its own portfolio (as was previously the practice) to enable the better coordination of procurement plans, progress reporting and monitoring, including the budget planning and release schedule. To institutionalise this process a tippani

has been raised by MD and submitted to the DG's office for further action. The tippani proposes a one-door planning, monitoring and progress reporting process, authorising MD to be the main entity to handle all construction works under the MoHP. Once agreed by the Ministry, MD will be able to coordinate all construction planning and authorisation work, which will support the preparation of a consolidated procurement plan for public works and consolidated progress reporting. This will bring more transparency to the implementation and expenditures for construction work. Support has also been provided to LMD to establish a well-planned physical space for bid-opening with cubicles for contract managers. In addition, TA helped FHD to plan and design a meeting hall that can accommodate 40 people. Support was also provided to USAID to identify potential sites for the development of health facilities in Kailali and Banke Districts.

A TOR was prepared to address the JAR Aide Memoire requirement for a "**review of the role and performance of DUDBC in the procurement and implementation of public health infrastructure**". While DUDBC plays a central role in health infrastructure procurement, this recommendation was seen to not go far enough to capture the full complexity of health infrastructure planning, contracting, implementing and monitoring, responsibility for which falls under several divisions across two ministries. For this reason, it was proposed to expand the study to include an assessment of the roles played by all entities within MoHP and MoUD. The overall purpose of the assignment is to improve the planning, budgeting, procurement, implementation, maintenance and monitoring of all public health infrastructure in Nepal with reference to the roles played by MoHP and MoUD at various levels and the systems and procedures in place to guide, regulate and monitor this work. The specific objectives are to:

1) Review relevant GoN legislation and EDP guidelines related to infrastructure planning, budgeting, procurement, implementation, monitoring and maintenance for all types of public health infrastructure;
2) Review the roles and responsibilities currently played by various officials, units, divisions and departments across the two Ministries;
3) Describe the processes used to determine planning priorities, budget allocations, procurement practices, implementation and monitoring procedures for each funding stream and infrastructure type;
4) Identify any strengths, weaknesses, overlaps, gaps and ambiguities in the current system; and
5) Based on the above, make recommendations to improve the infrastructure planning and procurement system.



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

A draft **English translation of the District Health Planning Guidelines** has been completed and is currently being edited. A planning workshop for piloting the guidelines in Lamjung district was held and a full report is forthcoming. Following a planning workshop conducted by the DHO in Lamjung, DHOs are now able to make periodic district plans based on the guidelines, and can develop an implementation and monitoring plan for carrying out VDC-level activities. Recognised challenges include impending political transition that can delay the take-up of local planning processes. In addition, the transfer of key officials involved may delay the process. Late release of the budget may also hamper planning and implementation activities.
During the next quarter, the following activities will be carried out: dissemination of the MoHP committee review findings, support in selecting a district for piloting of the guidelines and support for initiating the LHGSP implementation phase in 12 VDCs.

TOR were also developed to design a **framework for financial regulations of government hospitals** (see PFM section above). A consultant was hired to help develop a framework to help standardise and improve financial management in government run hospitals, and provide guidance to other government health facilities. The draft framework aims to meet the needs of different levels of hospitals while ensuring consistency with broader government policies and acts. The draft will be shared at a workshop of concerned stakeholders in the next quarter prior to being finalised.

A concept paper was prepared on **multi-year contracting of the health workforce.** NHSSP facilitated interactions on this with ministry officials and divisional directors under the leadership of the PPICD chief. As agreed in the interaction, a proposal has been drafted to ensure the uninterrupted service of the health workforce and submitted to PPICD and the Finance section for formal approval. The suggested provision will support the uninterrupted service of specified contracted health workforce groups such as ANMs, Staff Nurses and the like. Once approved, the multi-year contracts will be issued and MoHP will give the necessary instructions to district offices at the beginning of the fiscal year.

A draft of a **performance based contract template has been prepared for seven hospitals** and is being shared with concerned government officials and EDPs. The Ministry has sent the drafts to the respective hospitals for their comments and inputs. Performance based contracts will improve financial management and efficiency. The process will begin will be expanded to additional hospitals in the future.

The final draft of an **Operational Manual for the management of health facilities** has been submitted to the ministry, and upon the ministry's request has been given for peer review by concerned experts in the respective fields. This manual is designed to promote consistency of management approach among health facilities, which will ultimately help to strengthen overall governance systems. Following peer

review, the manual will be discussed with concerned officials and forwarded for formal approval in the next reporting period.

Changes made in the recently amended **Health Services Act** were analysed and implications for the recruitment of health personnel were shared with DFID.

4. Regional Updates

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 will further enhance referral practices and public awareness of service availability.	D/PHOs will take this profile as a reference document when preparing the District Health Profile, which will be useful for district health planning. For example, it will be used when piloting the District Health Planning Guidelines after their endorsement by MD/DoHS.
	Updated Calendar of Operations for fiscal year 2069/70 for the 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 programme 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.	Improved access for victims of violence to confidential counselling, medical services and other support. Improved social protection.	Monitoring of OCMCs and scaling up to other districts.
	Supported efforts to establish SSU in Koshi zonal hospital.	Improved access to affordable health services for women, and people from poor and marginalised groups.	Scaling up to other districts.
Central Region	Reviewed Calendar of Operation 2069/70 of Region and 5 districts.	Planning system improved, including time line and monitoring processes, following extensive discussions with different level staff.	Through the annual planning process.
	Revisited supervision plan and annual budget.	Improved quality and transparency of budgeting and supervision.	Through the annual supervision and budget planning process.
	Supported establishment of evidence based programme performance reviews in Rasuwa and Parsa.	Improved quality review, low performance interventions improved.	Through the quarterly review process.

Region	Achievement	What will change as a result?	How will this be taken forward?
	All the district heads and planning focal personnel were orientated on district planning guidelines and formed a district health planning management team (DHPMT) in Bhaktapur as a pilot district.	The planning system, including bottom up context specific planning, was improved.	Through the annual planning process.
	Updated the HR situation in Central Region Health Directorate and analysed compositions of FCHVs in Chitwan, Dhading, Rasuwa, Bhaktapur, Ramechap and Makwanpur districts by caste and ethnicity.	Improved understanding of HR profiles and evidence will promote recruitment of health workers and volunteers from disadvantaged groups.	Through the HR profile from MoHP.
	Supported the special mission for strengthening institutional delivery in Parsa district.	Utilisation of modern health services, improved institutional delivery.	Through the regional AWPB process.
	Records of CEOCs, BEOCs and Birthing Centres updated.	Improved the planning system.	Through the annual planning process.
	Stakeholders/members of the SSU in Bharatpur hospital have been oriented on "SSU Establishment and Operation	Improved access to affordable health service to the people from targeted groups.	Regular supervision and support will help strengthen the SSU.

Region	Achievement	What will change as a result?	How will this be taken forward?
	Manual, 2069".		
	Established OCMCs in Sarlahi and Kavre districts.	A well-established institution will provide all essential service to victims of GBV.	Through the regular support and provision of permanent staff for OCMC.
	Produced a video on OCMC establishment in Sarlahi district.	The video will serve as a source of reference and will be kept in the "Gender Information Centre".	Documentation of information for future use.
	Mentored/coached the Staff Nurse of Sarlahi OCMC on the overall operation and management of OCMCs.	The OCMC established in the district hospital will be more functional.	Counseling training will be provided to a staff nurse. The OCMC staff nurse will also be taught to manage the OCMC more efficiently.
	Facilitated a cooperation visit of the Staff Nurse to the Womens' Development Office (WDO) and its rehabilitation centre.	Institutionalised partnership for coping with GBV cases.	Establishing a network with district level EDPs and other organisations who are working with women and children who are victims of GBV.
	Supported DHO Sarlahi to organise a OCMC District Coordination Committee meeting for a status review.	Improved coordination among the stakeholders for combating problems related with GBV.	Through regular meetings of the District Coordination Committee.
	Supported preparation of a OCMC leaflet for Sarlahi.	Increased awareness about OCMC in the district.	The OCMC leaflet will be printed and used to provide information and promote advocacy.
	Coordinated gender training for the OCMC staff nurse in	GESI mainstreaming in the OCMC services.	The staff nurse will analyse OCMC cases from a GESI perspective.

Region	Achievement	What will change as a result?	How will this be taken forward?
	Sarlahi (15-17 June).		
	Supported GESI orientation for TWGs in Dhading and Sarlahi.	GESI mainstreaming in the health programme.	Through the annual programme and budgeting process.
	Continued the Social Inclusion Information System in Mahottari, Kavre and Dolakha.	Improved planning to cope with the health problem among the ethnic communities.	Findings will be reviewed in the district's annual progress review meeting as well as in the regional review meeting.
Western Region	EOC regional strengthening plan was updated and revised during the half yearly review meeting.	Improved efficiency and use of available resources. Improved planning and decision making for EOC, including improved support to districts.	Through the AWPB for the region and districts.
	Ten LHGSP programme VDCs in Myagdi district prepared their draft three year periodic health plans.	Much soughtafter decentralisation of health planning and monitoring at sub-district level.	Through review of the LHGSP programme, revision of guidelines, endorsement and mainstreaming.
	GESI TWGs were formed and orientation sessions run in six districts: Lamjung, Tanahun, Arghakhanchi, Nawalparasi, Rupandehi and Gorkha.	GESI responsive planning and implementation at district level leads 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 FY 2070/71.

Region	Achievement	What will change as a result?	How will this be taken forward?
	Orientation on SSU 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 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 and poorly served districts. Improved information from districts and VDCs on profile gaps leading to improved accuracy and utility of profile and improved referral practices.	Dissemination to all D/PHOs in the region for use in district-level planning. District data used to update the profile as part of the 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 management and effectiveness of OCMCs and SSUs in the region.	Through the district level AWPB exercise and implementation, particularly in remote, hard to reach areas.
	Assessment of the regional ANC cost analysis 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 meetings and DSF evaluation.
	Developed plan of action on the RH programme by DPHO	Improved RH programming in Jumla.	Through the district AWPB process and implementation plan.

Region	Achievement	What will change as a result?	How will this be taken forward?
	Jumla.		
	Assessed regional EOC service availability and utilisation.	Improved understanding of service availability, quality, costs and EOC operational bottlenecks.	Through regional review meeting and FHD EOC monitoring and review.
	Updated district level integrated monitoring checklist.	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 at regional sector meetings, including requests to agencies for additional resource materials.
Far-western Region	Prepared the Regional Health Sector Strategic and Periodic plan incorporating both GESI and MNCH activities.	Improved priority for MNCH and GESI within a comprehensive and timely regional health plan.	Through the AWPB approval 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 for SSU at Seti zonal hospital.	Improved functioning and performance of the SSU, leading to improved equity in service availability at affordable cost.	Through the Health Management Committee at Seti Zonal Hospital.

Region	Achievement	What will change as a result?	How will this be taken forward?
	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 the public and private sectors. Closer relations between RHD and the private sector.	Through the annual RHD review and DSF monitoring processes.

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	Mid-term Assessment of Safe Abortion Services in Two Remote Districts (Myagdi and Kalikot)
	Pulse Report: Case Study – Saving Mothers and Neonates
	Pulse Report: Responding to Increased Demand for Childbirth at Referral Hospitals
	Pulse Report: Antenatal Rural Ultrasound Programme
GESI	GESI Training Guide for NHTC Trainers plus support materials
HPPHSG	Draft English translation of District Health Planning Guidelines
	Draft Operational Manual for the Management of Health Facilities
	Concept paper on Multi-year Contracting of the Health Workforce (internal)
	Draft Performance Based Contracts for Private Hospitals (internal)
HRH	English Translation of the HRH Strategic Plan
	First Draft of HRH Workforce Plan (internal)
	Preliminary map of HR Functions and Structural Arrangements (internal)
Procurement	Supply Chain Communication Workshop Reports
PFM	MoHP Financial Control Guidelines (internal)
	Rapid Assessment VII of FHD's Demand Side Financing Schemes
M&E	Draft District Population Profile Template
Other	Quarterly Progress Report: Jan-Mar 2013
	Pulse Quarterly Progress Report: Jan-Mar 2013